Northern, Eastern and Western Devon Clinical Commissioning Group

PLYMOUTH CITY COUNCIL

Strategic Commissioning Intentions for the Plymouth Health and Wellbeing System 2018-20

Context and Case for Change

Plymouth and the wider Western Locality has a long and established record of cooperation and collaboration with a formal commitment to Integration being set down by the Plymouth Health and Wellbeing Board in 2013, based around Integrated Commissioning, Integrated Health and Care Services and an Integrated System of Health and Wellbeing.

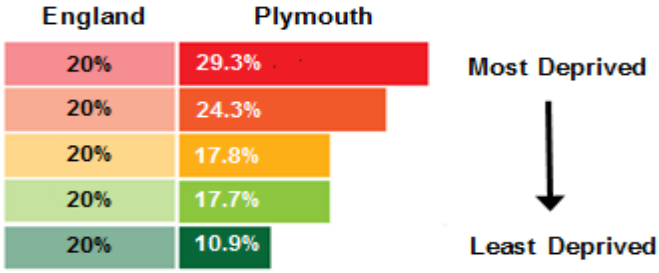
Since then there has been some significant progress and notable achievements towards achieving this aim. In 2015, commissioners established the Integrated Fund, developed four Integrated Commissioning Strategies and established an Integrated Commissioning function and governance arrangements. At the same time, Plymouth City Council (PCC) transferred 170 Adult Social Care staff to the Community Health Provider (Livewell Southwest) who also took on the Community Health functions of South Hams and West Devon. More recently, Livewell Southwest (LWSW) and Plymouth Hospital NHS Trust (PHNT) have collaborated to deliver an Integrated Sexual Health Service, MIUs for the Western Locality and there has been further co-operation and colocation of staff and services to deliver the Acute Assessment Unit. In response to urgent care pressures, the two providers have also appointed a Joint Director of Urgent Care driving changes required around D2A2 and Intermediate Care. More widely, PHNT, LWSW and PCC have collaborated to develop an Integrated Community Health, Wellbeing and SEND Support Service.

Despite this progress, the current system configuration is still not deriving optimum benefits and a number of significant challenges remain:

Health Inequalities, Changing Demographics and Rising Demand

As illustrated in the diagram below, the 2015 Index of Multiple Deprivation indicates that 29.3% of the population of Plymouth (75,624 people) live in the most deprived 20% of England.

Percentage of Plymouth's population living in each national deprivation quintile area



In comparison to the England average, health and wellbeing across the Plymouth population is mixed. Of the 30 indicators presented in the 2017 Public Health England Health Profile, Plymouth has 10 that are significantly worse ('red') compared to England, which is an improvement on the 2016 position and demonstrates a positive shift in adult smoking prevalence, under-18 conceptions and life expectancy in women. The impact of child poverty is also visible in outcomes for children, with educational attainment below national averages in most indicators. This in turn influences health and well-being statistics.

As well as poor health outcomes and health inequalities, the system is also facing rising demand for services in part bought about by demographic changes. The number of people aged over 65 is forecast to grow from 17.5% (45,500) of the population to 18.4% by 2020, 21.3% by 2030 and 22.5% by 2035 As a result, demand for over-65s care home places, extra care, community domiciliary care, reablement and hospital discharge services continues to increase. There has also been an increase in the number of people who need urgent and emergency treatment. The complexity of those presentations means we are seeing an increase in those who then have to be admitted, which places increased pressures in other areas of the hospital. In general, patients occupy one third of the hospital beds in Plymouth over the age of 80 and two thirds of patients staying more than 10 days in hospital are over the age of 70. The pressure on the urgent care system in turn means that there is less available capacity for elective care – national comparisons show that Plymouth Hospital has among the lowest rate of available beds for the elective care system. In addition, the system is seeing higher numbers of people becoming homeless and the numbers of Children in Care remains high with too many young people ending up in Residential provision. This is also evident in the education system with rising demand for SEMH support.

Financial Sustainability and Equity

In 2015, NEW Devon CCG became part of the Success Regime in part due to the financial challenge it was facing. The size of the financial challenge was acknowledged in the Devon-wide STP, which outlined that, if nothing changed, and then by 2020/21 there would be a funding gap across health and care of £557m. In an effort to return the system to financial balance, local health and social care organisations are facing significant Cost Improvement Programmes, with the Acute Trust facing a CIP of 8% (£40m) for 2017/18. The changing demographic profile and the increased cost of providing care means that in a "do nothing" scenario we are forecasting an increase pressure on the Adult and Children's Social Care budget. The same is true of the SEND (Special Needs and Disability) system, with significant budget pressures forecast which has required remediation to reduce an overspend in the High Needs Block of the Dedicated Schools Grant.

As well as facing a significant financial challenge, Plymouth and West Devon are also facing an Equity challenge. Work as part of the STP Case for Change has highlighted that 10% less is spent on health care for each person in western Devon in comparison to northern and eastern Devon. This is in the context of Plymouth having very significant health need alongside evidence that this need is not being adequately met, as evidenced by inequalities in outcomes such as life expectancy. The majority of patients in Devon waiting in excess of 18 weeks for a planned intervention are on a Plymouth waiting list.

Whilst NHS funding should reflect additional costs associated with elderly, rural and deprived populations through the Market Forces Factor (MFF), estimates have shown that acute hospitals in Devon receive less funding for the MFF in comparison to similar hospitals in other areas.

System Flow

Multiple system reviews have been undertaken, including ECIP, Home to Hospital, the STP ICM professional peer review team and a 5-week NHSI/E support programme where consistent themes have been identified. These broadly relate to interface issues that inhibit patient flow in different parts of the system. These issues have led to high numbers of Delayed Transfers of Care and people spending too long in intermediate care.

In addition, access to services 7 days per week is inconsistent and this impacts on the number of discharges achieved over the weekend.

Primary Care

General practice sustainability and capacity in Plymouth is currently particularly challenged. Several GP Practices have recently closed and a procurement by NHS England to secure longer-term provision for 34,000 patients was not successful (a temporary contract is in place). All practices are rated by CQC as good or outstanding and practices are increasingly working at scale. There are a number of vacancies for GPs and other members of the increasingly varied multi-disciplinary team in primary care and, albeit with some innovative recruitment and retention packages being offered, recruiting GPs is proving a stubborn challenge, reflecting the national picture. Whilst there is no evidence of cause and effect across the system, there is some association between the most challenged primary care and patients presenting for care from MIU and ED.

Planned Care

The Referral to Treatment time (RTT) in Plymouth has significantly worsened during the year. The March 2017 figure was 85.7% RTT achievement and at January 2018 this had reduced to 81.6% (4580 patients waiting in excess of 18 weeks). The forecast outturn for year-end is in the region of 81%.

Workforce and Market Sufficiency

There are a number of workforce issues across the system and the hospital faces significant challenges in medical staffing and, specifically, there are difficulties in recruiting to some medical staff grades and filling junior doctor rotas. Similarly, recruitment of pharmacists, particularly in the hospital is proving difficult. Whilst generally we have had a good supply of personal care services during periods of escalation, the sufficiency of dementia care home beds (both nursing and non-nursing) and placements of individuals with more complex behavioral needs can be more difficult. This winter we have also seen home care capacity become stretched and struggling to meet the level of discharge flow.

Recognising the challenges, commissioners are setting out a number of high impact changes that will drive commissioning activity and service design for the next two years. These intentions are high level to set down a *direction of travel* with detailed programmes of work being developed to take forward each area. They should not be seen as a departure from the existing policy direction of achieving whole system population based integration rather a scaling up and acceleration based on learning to date. In this context, they represent a key part of delivering the last two years of our five-year commissioning plans of Wellbeing, Children and Young People, Community and Enhanced and Specialised Care.

They also sit within the STP Framework and should be seen as the local response to delivering the seven priorities: Prevention and Early Intervention, Integrated Care, Primary Care, Mental Health, Acute Hospital and Specialised Services, Productivity and Children, Young People and Families.

Overview of Commissioning Outcomes and Priorities

The Plymouth Health and Wellbeing Board set down in 2013 the strategic ambition to create a fully integrated system of population based health and wellbeing where people start well, live well and age well. In doing so, the aim is to:

- To improve health & wellbeing outcomes for the local population;
- To reduce inequalities in health & wellbeing of the local population;
- To improve people's experience of care; and
- To improve the sustainability of our health & wellbeing system.

These commissioning intentions represent a further stage in the delivery of this ambition. At the heart remains a focus on meeting the needs of the whole person and ensuring they receive "the right care, at the right time, in the right place" To deliver this vision of care we will need to continue to ensure we meet the triple aims of the five-year forward view:

Through these commissioning intentions, the local system will be integrated and configured to provide the best start to life, promote independence, wellbeing and choice, with home first acting as the central philosophy and services integrated, local, accessible, seamless and responsive. An enhanced system of Primary Care will underpin the integrated system and there will be No Health without Mental Health. In order to make a sustainable system these commissioning intentions will make best use of the public estate and achieve cash releasing efficiencies.

In order to drive the changes a small number of Strategic Commissioning Priorities will be taken forward at pace:

- Developing Integrated Commissioning as a System Enabler
- Commissioning for Wellbeing and Prevention
  - Thrive Plymouth
  - Wellbeing Hubs
  - Making Every Adult Matter
- Transformed and Sustainable Primary Care
- Integrated Children's Young People and Families Services,
- Commissioning an Integrated Care Partnership

- Local, Integrated and Responsive Mental Health Services,
- Enhanced Care and Support

Following on from the recent CQC Local Area Review, the footprint of these Commissioning Intentions are initially based on the Plymouth Health and Wellbeing Board boundary, as the system requires both an urgent and bespoke response. However, recognising Plymouth's role in the wider STP and in particularly its place in relation to South Hams and West Devon and South East Cornwall commissioners will begin discussions with other commissioners, partners, stakeholders and providers about system alignment and join up where it makes sense to do so. Where these commissioning intentions stretch beyond the boundary of Plymouth, they are referenced.

The establishment of the Local Care Partnership will oversee the move towards the next level of integration. Such an approach will provide for jjoint system ownership of problems and issues and the development of collective system solutions, with key agencies engaged as full and equal system partners. This will provide for, faster decision making and allocation of resources to system priorities, a ccollective focus on improving key system performance faster and shared ownership of system risk. An enhanced Taking Change Forward Group will become the LCP Board with a priority to expand membership, develop terms of reference and a system wide MOU.

PLYMOUTH HEALTH AND WELLBEING SYSTEM- COMMISSIONING OUTCOMES AND PRIORITIES

Local System Outcomes

To improve health and wellbeing outcomes for the local population	To reduce inequalities in health and wellbeing of the local population	To improve people's experience of care	To improve the sustainability of our health and wellbeing system

Commissioning Priorities

The Health and Wellbeing Gap	The Care and Quality Gap	The Funding and Efficiency Gap
Integrated Children and Young People Services Development of Wellbeing Hubs Making Every Adult Matter	Integrated Care Organisation Local, Integrated and Responsive Mental Health Services Transformed and Sustainable Primary Care Enhanced Care and Support	Integrated Commissioning Review One Public Estate and One Public Infrastructure

Key System Performance Objectives

- Reduced Hospital Admissions
- Reduction in Smoking Prevalence
- Reduced Delayed Transfers of Care
- Less Admissions to Long Term Care
- Improved A/E 4 Hour Performance
- Increased Physical Activity
- Reducing Demand and delivering Financial Efficiencies
- Improved access to Primary Care
- Reduced levels of homelessness and Rough sleeping
- Reduction in the number of looked after children
- Improved IAPT Access and Recovery Rates
- Improved Reablement Performance
- Increased numbers of carers receiving an assessment
- Improved RTT Performance
- Reducing packages of care
- Less Bed Based Care
- Improved Educational Attainment Levels

Commissioning as a System Enabler

In line with the wider Organisational Design workstream of the STP, we will undertake a review of our existing integrated commissioning governance arrangements in order that they are flexible and an enabler to achieving change and system transformation. In doing so we will seek to simplify, streamline and collaborate to achieve reduced operating costs. The Integrated Commissioning Review will focus on the following key areas:

Governance- A review of Integrated Commissioning Governance arrangements to determine overall effectiveness and to make recommendations to eliminate duplication and streamline decision-making.

Finance- To review the effectiveness of the Integrated Fund and to make recommendations as to future direction and scope including hosting arrangements, management and potential to extend.

Staffing- To review the current staffing arrangements and evaluate whether there are further opportunities to integrate in order to remove duplication and ensure there are the right capabilities and capacity to deliver change.

Strategic Commissioning and Placed Based Commissioning- To work with the emerging Strategic Commissioning Function to develop an operating model that supports a Devon Wide Strategic Commissioning Function and Local Care Partnerships.

A key role of our Commissioning approach is to provide System Leadership, Oversight and Assurance and to relentlessly drive system improvement. In order to fulfil these functions NEW Devon CCG has established a System Improvement Board made up of Commissioners, Providers and Regulators. The central focus of the Board will continue to be:

1. To reduce patient safety and quality risks across the system predominantly related to Patient Flow
2. To improve performance around key constitutional targets
3. To deliver the required financial improvement.

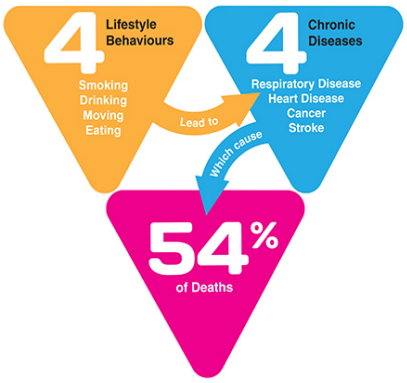
The Board will also oversee and drive transformation programmes with three initial immediate priority areas being identified as-

1. Transforming intermediate care activity to prioritise home based non-bedded care including improving Out of Hospital responsiveness to prevent admissions and avoid delays in discharge home.
2. To deliver the Primary Care Improvement Plan
3. To deliver the revised Ambulatory/Frailty and GP Streaming function at PHNT

As these commissioning intentions move towards implementation, the Board will oversee and drive delivery of these priority programmes.

Wellbeing and Prevention

Thrive Plymouth is the city's ten year programme to get everyone working together to improve health and wellbeing in Plymouth and narrow the gap in health status between different people and different communities. The things that cause us the most ill health largely result from what we eat and drink, whether we smoke and how active we are. These four behaviors are more common in some communities than others and so therefore are the diseases that they cause. This means that some parts of our society experience greater levels of ill health in their lives and are more likely to die younger. We know that there are considerable differences in the life expectancy between different communities in Plymouth- neighborhoods just a few miles apart can have life expectancy values varying by years.



Thrive Plymouth's aim is to create collective action across the City focusing on enabling and encouraging positive choices for health- eating a healthier diet, being more physically active, drinking sensibly and not smoking. It follows three principles;

1. Population prevention: This is about the whole population taking whatever steps they can to make improvements in these behaviours. If individually we all make small positive changes, we can achieve significant benefits for our City and ourselves.
2. Common risk factor: Unhealthy behaviours tend to cluster both for the individual and in communities. Focussing on single behaviours may be less effective than taking a holistic approach and addressing underlying reasons or risk factors.
3. Changing context of choice: Most of us know what to do to improve our health and many of us want to do it. However, despite good intentions making changes can be hard. In the past, we have not always recognised the importance the world about us has in determining what we do. Whether we positive choices is influenced by how easy it is to do, what we think our peers and communities do, what the media and advertising tells us, and how our environment is designed.

Thrive Plymouth provides a mechanism for achieving the NHS Forward View aspiration of a radical upgrade in prevention and public health for the city. Thrive Plymouth principles are central to these commissioning intentions as we continue to build a system of health and wellbeing. As such, we will focus on:

- Working with our network of providers, and community and voluntary sector, to ensure that the purpose and principles of Thrive Plymouth are considered in all services

- Embedding "'Making every contact count' to address those behaviours that impact on health and wellbeing across all of our providers.
- Rolling out Wellbeing Champions across Residential and Domiciliary Care Provision
- Continuing to promote wellbeing in specific settings such as schools and workplaces to change the context of choice making the healthier choices the easier choices (remembering that the health and social care workforce are also embedded in our communities)

Over the next two years, our intention is to commission a network of Wellbeing Hubs that enable and support people in the local community to tackle the underlying social issues that they face, and make life choices that will improve their health and wellbeing. The hubs will be based on a tiered model of Universal, Targeted, Specialist support and will involve community and voluntary sector as well as statutory providers. The framework and principles are common across the STP area, with local delivery being based on the needs of the population and the availability of resources. For example, some Hubs will focus on Wellbeing with a strong virtual link with local Primary Care; others will include Primary Care within the premises. Some (the Specialist Hubs) will include clinical services.

THE HUBS OFFER
Universal Effective website, service directory & digital offer and high quality consistent and effective information and signposting across all universal services
Targeted Will support the local universal network and act as a focal point for services that respond holistically to people and communities Colocation of key services such as Community Connections, VCSE, Livewell SW, PHNT, Primary Care Example Intervention / Services - Community 'bridging' roles - Advice and information - Healthy lifestyles - Peer support / volunteering - Group work – self-care and management, healthy lifestyles, parenting, employment - Education, Employment, Training - One-one enabling support
Specialist Develop a new model of care where specialist clinical health and care services are delivered in a local community setting, driven by need and may include: Community Health Services/Social Care/Community beds/Rehabilitation and Reablement/Specialist Clinics/Complex diagnostic (e.g. imaging, pathology)/Therapy services (e.g. physiotherapy)/Children's health services/Follow up / outpatient appointments

The targeted and specialist hubs implementation roll out is as follows:

Phase 1 (to be complete by March 2019)	**Phase 2 (to be complete by March 2020)**
Jan Cutting Healthy Living Centre	Estover - tbc
Guild House (Mannamead Centre)	Southway - tbc
Four Greens Community Trust (CEDT)	Efford Youth and Community Centre
Ocean Health Centre (Stirling Road Surgery)	Plymstock - tbc
Cumberland Centre	Mount Gould LCC site
Rees Centre	City Centre

To support this implementation, we will ensure planned and developing commissioning activity around Advice & Information, Health Improvement, Wellbeing & Prevention, and Integrated Early Years is taken forward under the oversight of the Wellbeing Hubs Commissioning Framework.

Nationally a growing number of people are experiencing addiction, homelessness, offending and poor mental health because of changes in welfare reform, constrained budgets and increasing health inequalities. Locally, we have experienced an increase in the numbers of single homeless people with complex needs and are anticipating an increase in the number of people with mental health support needs and/or substance dependence over the coming years.

Recognising the specific challenges faced by people with multiple needs we will adopt the ***Making Every Adult Matter*** (MEAM) vision of ensuring that people experiencing multiple needs are supported by effective coordinated services and empowered to tackle their problems, reach their full potential and contribute to their communities. To achieve this we will commission an Integrated Substance Misuse, Homelessness and Offender System utilising an Alliance approach and aligning Mental Health services. Using an Alliance model, the focus will be on creating systemic change: changes to culture, funding structures, commissioning and policy that will support a new way of working. Together we will create a contractual environment where suppliers share responsibility for achieving outcomes and are mutually supportive, making decisions based on the best outcome for the service user.

The Alliance aims to improve the lives of people with complex needs by supporting the whole person to meet their aspirations, whilst also contributing towards national outcome targets in relation to statutory homelessness, children in care and care leavers, drug treatment, reoffending rates, preventing admissions to hospital and urgent care targets.

Transformed and Sustainable Primary Care

Primary care is required to be the foundation of our system both now and in the future system of integrated care. Yet our primary care workforce and resources are facing unprecedented demand at a time when the workforce is under capacity and our system needs robust and accessible primary care more than ever.

Our commissioning will encompass delivery of the **Strategy for General Practice 2017-2021** and **General Practice Forward View**. We will work collaboratively and led by the **Western Primary Care Partnership** we will systematically deliver a **Primary Care Improvement Plan** (owned and delivered across the system) to deliver such services as social prescribing, investing in primary care and extending access for the population through national and local determination.

As a key priority, we will collaborate with providers, commissioners and other stakeholders to design and implement a sustainable system based on the **Primary Care Home** model. Rolling out the principles of Primary Care Home, we will support and facilitate groups of primary care organisations working together and with others to serve populations of 30,000 to 50,000. Working with the ICO delivery will be based on an Enhanced Primary Care Team (EPCT) model which will pool the knowledge, care and resources of primary care, community and mental health services, social care, pharmacists and voluntary, community and social enterprise sector partners, to manage the population health of their community. Increasingly specialist services, delivered in hospital settings, will be delivered as part of the EPCT wherever there is a population benefit of doing so.

As a priority, we will work with partners and providers to develop an **integrated pharmacy service** for Western spanning the whole system through acute, community, care homes and primary care. This will ensure system prioritisation of workforce improving recruitment, retention and efficiency and effectiveness of the workforce.

Developing this model will involve engagement towards co-production; using data and communication so that population priorities and outcomes are understood by all stakeholders; developing service models such that care and information is integrated across providers delivering personalised care; developing the workforce to support the models of care; aligning strategic and financial drivers; and, using evidence and evaluation to ensure outcomes are right for people, populations, the workforce and the system.

Underpinning the primary care commissioning activity we will work with NHS England and Member practices to enable NEW Devon CCG to take on **Joint Commissioning** from May 2018. Going forward, and following appropriate engagement the ambition is to move to **Delegated Commissioning**.

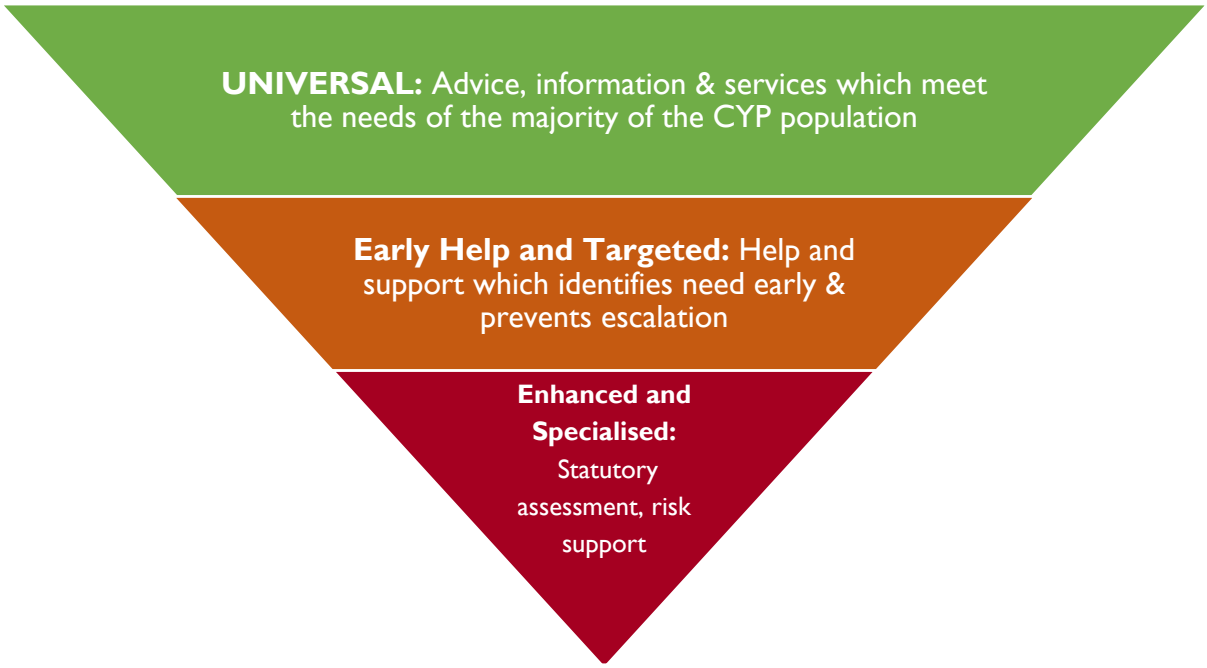
Integrated Children, Young People and Families Services

The Plymouth ambition is to commission Integrated Children, Young People and Families services that provide the best start to life. Children, young people and families will be supported to stay healthy, achieve and aspire. We will identify challenges that our families are experiencing as early as possible, so that they can be enabled and supported at the earliest opportunity. Our children, young people and families will be able to access what they need at the right time and in the right place, whether this is advice by phone or on the internet, an assessment or longer-term intervention or support.
We will:

- **listen**, and champion the voice of our children and young people in all that we do;
- **co-create** to support and enable partners and communities to work together to design the services they need;
- be **fair and equitable**, ensuring our children and young people feel included and can access opportunities that make a difference to them;
- have **high aspirations**, celebrating strength and success and being optimistic about the futures of all our children;
- Make sure that what we do is **sustainable**, having a real impact on the lives of children, young people and their families for this generation and those that follow.

(Taken from Plymouth – our shared narrative, CYPSDG, 2017)

The ambition is for three system offers:



System	A system which…	Key work streams 2018/20

Element		
Universal	Provides comprehensive, timely information, advice and sign posting	• Develop a single information, advice and access service enhancing the web based offer
	Offers "core support" to schools through the provision of statutory functions and other traded services	• Plan for Education
	Raises awareness of and reduces incidence of Child Sexual Abuse	• Implementation of the NSPCC "Together for Childhood" 10 year programme
	Ensures children have the Best Start to Life, from birth to being ready to start school	• Implement perinatal & maternal mental health services & pathways. • Improve Maternity Services through the delivery of Better Birth's Initiative & Saving Babies Lives. • Development of School Readiness project
Early Help and Targeted	Has a Single Point of Access for those with additional needs, where they and their families can access the right support at the right time	Community Health, Wellbeing and SEND integration: • Shared governance and performance monitoring • Implementation of "Access", trusted triage and single view of need • Delivery of tender and implementation of contract
	Has a locality based, multi-agency 0-19 offer (Family Hubs) which enables the delivery of a range of support to manage need and prevent escalation	• Redesign of children's centre creating a network of Family Hubs around 4 localities • Remodel of Early Help and Targeted Support offer to link with the Family Hubs
	Delivers effective emotional health and wellbeing provision, including offer to schools, which enables CYP to engage and attain	• Implementation of CAMHS Transformation Plan • Plan for Education • Securing future funding for EHWB in schools services
Enhanced and Specialised	Offers local support to parents, pre and post Proceedings, which maximises their ability to parent, or make informed and timely decisions about not becoming parents	• Tender and implementation of PAUSE Social Impact Bond • Remodel and co-locate Family Support Services to intervene early to meet the needs of parents who are at risk of entering Proceedings • Increased capacity in young parents supported accommodation to reduce the number of families placed out of area
	Delivers effective crisis response, for those edging towards care, on the edge of care and in care, when needs and risk escalate	• Development of a flexible, multi-disciplinary response to escalation, through a range of support to prevent entry to care and placement breakdown • Development of crisis/assessment provision in the Peninsula and locally • STP Risk Support work stream activity • Complex Families/Adolescents work streams
	Has sufficient good quality local accommodation to prevent children and young people in care from needing to be placed out of area and at distance	• Implementation of residential block contract • Implementation of Peninsula fostering contract • Scoping of future special school requirements • Scoping of future complex needs 16+ requirements (Peninsula/local) • Alignment with intentions for in-house fostering
	Enables children to be adopted in a timely way and for adopted children and their parents to be supported to maintain a stable home life	• Implementation of the Regional Adoption Agency (RAA) with Devon as lead

System Enablers	
A shared vision for workforce development across vulnerable CYP and complex adults, increasing system resilience, multi-agency learning and maximising efficiencies through shared training	Workforce development plan draft by end March 2018 (VCS leading)
A CYP system strategic engagement offer which enables the voice of CYPF to be meaningfully heard	Draft strategic engagement out for consultation spring 2018. Review of Children in Care participation service effectiveness with an aspiration to Commission a "Voice of the Child" service including participation and advocacy

Integrated Care

As noted previously despite some significant progress in Integrating Care for Adults and Older People our system remains challenged including performance against key NHS Constitutional Targets. There remains an over reliance on bed based care rather than a home first philosophy and System Flow remains a significant issue resulting in too many delayed transfers of care in all parts of the urgent care system. Primary Care, particularly in Plymouth is vulnerable facing workforce shortages and sustainability challenges. The Western System is experiencing a significant increase in A&E attendance including an increase in Ambulance conveyances. Across the whole system, there are workforce challenges with recruitment and retention being an issue in a number of areas. Our system also remains fragmented with several external reviews identifying that relationships within the Plymouth system could be improved and that organisational cultures, relationships, organisational boundaries and lack of shared risk particularly between the acute and community sectors were negatively affecting system flow. These issues are set against a backdrop of financial sustainability and despite a track record of delivering efficiencies the system remains financially challenged and inequity of funding across wider Devon remains an issue.

In response to this compelling case for change and in order to ensure joined up whole person care, we will commission an **Integrated Care Partnership (ICP)** for adults and older people. The ICP will bring together Core Community Health, Adult Social Care, Acute, Local Mental Health Services and potentially certain Primary Care Services (Table on Page 12 provides an overview of functions)

The drivers for this are transformational not transactional and the remodelled service will be designed to deliver benefits both for service users, carers and communities but also the wider health and social care system:

- Make local health and social care easier to navigate for people.
- Ensure people only have to tell their story once- through digital and interoperable care records
- Promote personalised care and self-care by working with users and carers as equal and valued partners
- Promote prevention, independence, wellbeing and health improvement by intervening earlier and shifting resources upstream

- Provide seamless care by removing hand-offs; reducing duplication of appointments and assessments through integrated service models and pathways.
- Deliver more care in communities and closer to home
- Transform service provision, with a focus on integrating pathways, supporting primary care and the wider integrated system.
- Sharing corporate and support services to reinvest as much money as possible into front-line service delivery.

The intention of commissioners is to commission an integrated care partnership through *one overarching contract* with a *single provider.* Due to the scale of the challenge and the system complexity, this has been identified as the preferred delivery model as there is a need to achieve greater structural, functional and financial integration than collaboration and partnership working alone can achieve.

Integrating care under a single model will bring together constrained resources under a single governance and management arrangement. Pooling resources, workforce and assets will provide sufficient scale, greater sustainability and be more cost effective. In addition, it will facilitate a more consistent seamless approach to care delivery by working as a single whole, facilitating better communication through single systems and operating to consistent standards.

Commissioners will not specify organisational form, which it is recognised could be a Single Organisation or Prime Provider Model. Commissioners will however be expecting the integrated provider function to have integrated governance arrangements, integrated executive and senior managements arrangements, and a single workforce plan. It is however acknowledged that the contracting approach will need to be set within the Context of EU procurement and competition law. Principally, The Public Contracts Regulations 2006 and National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 will apply and will be adhered too. This process will involve early and close discussions with regulators and legal advisors.

Although Commissioners wish to see the ICP in operation from the 1st April 2019 it is recognised integrating services, aligning systems and processes, creating one workforce and one culture takes time and it is acknowledged that the journey to develop a mature and high performing ICP will take a period of several years. Therefore, in order to form and crucially develop the ICP we will actively work with providers to develop a comprehensive implementation programme based around four high level stages:

- Mobilisation
- Detailed Planning
- Initial Integration of new functions
- Transformation

Underpinning this whole process will be extensive staff engagement, organisational development and clear communications.

The establishment of the ICP is a key element of the Plymouth's System response to the challenges that it is facing. However, it is recognised that the new ICP will operate within the context of the wider System of Health and Wellbeing and is one of a series of parallel commissioning work programmes that collectively will work to achieve a more integrated system. The ICP will therefore need to work with others as equal system

partners but due to its size and system centrality it will enable, support and help transform other key system elements.

In addition to the overarching ambition to establish an Integrated Care Partnership there are also clear quality and performance areas that require an urgent focus if we are to meet constitutional standards and deliver integrated care. Priorities include:

- Commission an End of Life Coordination Services through a Lead Provider arrangement. The aim of the service are to coordinate end of life care for patients registered with GP's in the Western locality and ensure that care provided to people at the end of life at home or in care homes in the western locality is commensurate with their need and equitably distributed

- Embedding and accelerating the Home First Philosophy through the full implementation of Discharge to Assess Pathway 1 to deliver 'assessment' and 'rehab/reablement care plan' at home within 2 hours of discharge with same day access to reablement or domiciliary care 7 days per week

- Reducing the reliance on bed based intermediate care through implementing the Discharge to Assess Pathway 2 provision to deliver 'assessment' and 'rehab/reablement care plan' within 48 hours of admission to care home. Undertake professional reviews of goal achievement and optimise step down and length of stay for patients. This will lead to a reduction in DTA2 care home beds; Local Care Centre beds converted to DTA2 pathway beds and reduced average length of stay to 14 days.

Integrated Care Partnership- Overview of Functions	
Core Functions Single Accountability for Service Delivery and Outcomes Single Point of Access/Comprehensive Assessment Person Centred Care Planning/Promotion of Self Care Digital and Interoperable care records	
Acute Services	Treating people with complex care needs in Devon Making acute care resilient; 24 hours a day, 7 days a week. Consistent 7-day standards for emergency NHS care, in hospital and community settings. Ensuring safe and sustainable services and addressing gaps in service provision Achieving equity of access and national standards Recruiting and retaining workforce Flexible workforce operating to professional standards Minimise bed use by getting people home and eliminating unnecessary stays Safe level of staffing in hospitals to ensure effective acute services Increase the use of technology to optimise the available workforce Manage the networked approach for services which are not delivered locally Align specialist workforce with community/primary care services in community settings wherever possible to do so.
Integrated Care Model	**Integrated Urgent and Emergency Care** Urgent Treatment Centres/ Acute Assessment Hub/GP Streaming/ join up offer for same day primary care and minor injury care Optimised the use of urgent care services which support the local system – pharmacy, 999 and IUCS (111and OOH) Home First Philosophy with Simplified and Streamlined Discharge Pathways and an embedded Trusted Assessor Model **Localised and Personalised Community Services** Coordinated service model with primary care, voluntary and community sector services as well as community based health mental health and social care Independence model of care with less Bed Based Care Comprehensive and consistent risk stratification linked with alternative options for care and support Enhanced support for care home residents Continuity in care through MDT Core community service function remodelled to improve admission avoidance for the vulnerable GP practices and pull from the Acute site. Coordinated Long Term Condition management based on empowerment and self-care with a scaling up of IPC Coordinated, timely and compassionate End of Life Care

Local, Integrated and Responsive Mental Health Services

The Devon wide STP mandate for Mental Health services has set down a cross Devon plan for Mental Health which supports transformative new models of delivering care, promotes mental health and wellbeing and is ambitious in improving outcomes, addressing inequalities and achieving national standards. Central to this is the development of a Care Partnership for Mental Health services with local delivery.

Set within the context of the wider STP and the 5YFV for Mental Health, our local Commissioning Intentions for Mental Health are based on the principle of No Health Without Mental Health. As such, Local Mental Health Services will be commissioned to be an integral component of the Integrated Care Partnership, wrapped around Primary Care and supporting the MEAM Agenda so that individuals with complex needs; including homelessness, substance misuse and risk taking behaviours have access to appropriate mental health support. In doing so, it is the expectation that mental health services will work across pathways and organisational boundaries to provide seamless and integrated support and treatment.

We understand the impact that the wider determinants of health such as poor housing, employment and loneliness can have on an individual's wellbeing and long-term outcomes. We also recognise the role the Voluntary and Community Sector (VCSE) adds in terms of supporting people to appreciate, understand and improve their lives so that we ultimately reduce health inequalities through an integrated, whole system, whole life approach. We recognise the growing evidence base and added benefits of working in partnership with the VCSE can bring in terms of enabling peer support and helping people manage their own mental health generally, but also more specifically in times of crisis and so the intention is for them to become a delivery partner of Mental Health services.

In rolling out our approach, key initial commissioning priorities for development include:

- The expansion of services for children and young people. We will invest year on year to increase capacity and reduce waiting times in line with national targets
- Re-design of the Recovery Pathway. This work commenced at the end of 2017 and will deliver proposals by April 2018, supported by an implementation timescale stretching to 2020
- Extension of Psychiatric Liaison provision, working towards Core24. We will deliver a 24/7 assessment service into the Emergency Department by April 2018 and then expand over the next 3 years until we meet the CORE 24 standards
- Rapid Response Community Crisis Services. We will implement a local extended hours crisis assessment service, supporting Primary care by October 2018
- A remodelled and expanded Psychological Therapies offer. We will expand services from delivering 15% of predicted need within the population to 16.8% by April 2018 and then expand this further into 2018/19 and beyond. Our priority will be individuals with co-morbid Long Term Conditions (LTC's)
- We will improve the diagnosis rate and pathway for users and carers experiencing dementia, integrate services further where possible and eliminate inappropriate out of area placements. By November 2018, we will meet the standard of 66% of individuals receiving a diagnosis. We will also integrate the dementia navigation service into the Dementia pathway by November 2018

- Commissioning additional Recovery College capacity so that individuals have more control and understanding of their own mental health and how they can manage this better themselves and are able to access support to help with addressing issues such as employment, recreational activities and housing. To support this, we will deliver an additional 350 placements by April 2019
- Enhance the Social Prescribing offer and test out whether an integrated approach with IAPT services delivers better outcomes for people living in some of the more deprived areas. We will run a pilot starting in April 2018 and make recommendations for learning and implementation for 2019/20
- Opening a Crisis Café for those with mental health issues in crisis and as an alternative to the Emergency Department by April 2018

Running alongside the development of locally integrated mental health services, it is recognised that services must work within, and be connected to the wider Mental Health Care Partnership. There is a clear requirement to create a wider community of practice around Mental Health, in order to both maximise clinical expertise and ensure specialist mental health services operate at scale to be sustainable and able to deliver appropriate care and support for those with highly complex needs.

Enhanced Care and Support

Significant work has already been undertaken to improve the sufficiency and quality of the Residential and Domiciliary Care Markets. However as we move towards a home first philosophy, coupled with a recognition that the sector is having to meet increased levels of acuity then new models of care and support will need to be developed.

Building on the learning of the Vanguards, we will develop an **Enhanced Health in Care Homes** model. This will build on the work already undertaken including QAIT support, Quality Reviews, Dignity in Care Homes Forum, Dementia Quality Mark, Leadership Programme and the Health & Wellbeing Champion Programme, Red Bag Scheme and Skype facility to reduce 999 calls. Working with providers, the ICO and Primary Care we will develop the following best practice model:

Care element	*Sub-element*
1. Enhanced primary care support	Access to consistent, named GP and wider primary care service
	Medicine reviews
	Hydration and nutrition support
	Access to out-of-hours/urgent care when needed
2. MDT in-reach support	Expert advice and care for those with the most complex needs
	Helping professionals, carers and individuals with needs navigate the health and care system
3. Re-ablement and rehabilitation to support independence	Reablement / rehabilitation services
	Developing community assets to support resilience and independence
4. High quality end of life care and dementia care	End-of-life care
	Dementia care
5. Joined up commissioning and collaboration between health and social care	Co-production with providers and networked care homes
	Shared contractual mechanisms to promote integration (including continuing healthcare)
	Access to appropriate housing options
6. Workforce development	Training and development for social care provider staff
	Joint workforce planning across all sectors
7. Harnessing data and technology	Linked health and social care data sets
	Access to the care record and secure email
	Better use of technology in care homes

In terms of Domiciliary Care then we will work with the Market and the emerging ICP to develop a Single Accountable Provider (SAP). The SAP will be responsible for coordinating all home services including Reablement, timely hospital discharge, Community Domiciliary Care and Carer's Emergency Response Service, with the aim of developing/sustaining a person's capacity to live independently at home in the community. The SAP will provide the opportunity to develop a single workforce ensuring carers have the skills and knowledge to offer personalised services, to support people with a range of needs, be outcomes driven and where possible, aim to reduce the need for ongoing long-term support by improving individual's health and wellbeing.

Working as system enabler commissioners will work with planners, developers and care providers to develop new build care and support developments including Extra Care, Specialist Nursing Provision and Supported Living for working age adults including Learning Disabilities and adults with multiple needs.

System Enablers

Responding to the recent CQC System Review, we will facilitate system partners coming together to develop a fully resourced System Wide Workforce Development Plan. Key activities will be review of existing organisational plans, development of system wide work force profile and gap analysis, shared workforce principles, alignment of existing resources to priorities and active pursuit of additional revenue opportunities.

Building on the work already commenced through the OPE Programme we will facilitate a review of our health and care estate including developing a masterplan for the Mount Gould Site and the roll out of Wellbeing Hubs.

High Level Road Map								
	2018				2019-20			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3/Q4**	**Q1 (20)**
Integrated Commissioning	Commissioning Intentions Consultation	Publication of Commissioning Intentions						
Integrated Care	Development of contracting options Publication of Contracting Approach	Mobilisation		Detailed Planning Completed	Initial Integration of new functions completed		Transformation	
Transformed and Sustainable Primary Care		Joint Commissioning of Primary Care in place		Integrated Pharmacy Service Designed	Integrated Primary Care System Designed Integrated Pharmacy Service Signed Off		Integrated Primary Care System Signed Off	Integrated Pharmacy Service in place
Integrated Children and Young Person and Families Services	Launch of CHWB and SEND tender	Residential block contract implemented. Children's Centre statutory consultation Together for Childhood place based consultation. Peninsula	PAUSE implemented. Award of CHWB and SEND contract Implementation of Crisis Response provision (complex adolescent and	Schools funding sought for EHWB offer from Aug 19 onwards Children's Centers out to tender as part of EH and TS offer		CHWB and SEND contract begins	EH and TS offer implemented	

		fostering contract implemented Peninsula residential tender launched	step-down)					
Local Responsive Mental Health Services		Crisis Café Opened Recovery Pathway Work Commences 24/7 Assessments Launch Enhanced Social Prescribing Pilot commences		Dementia Diagnosis Improvement Achieved Integration of Dementia Pathway and Navigation service Rapid Response Community Crisis Service in place Enhanced Social Prescribing Pilot Ends	Recovery Pathway Proposals Developed	Plans Developed around Recovery Pathway Proposals		
Health and Wellbeing Hubs	1st phase of training commences 1st Hub Pilot Launches	First Targeted Hub Open First Universal Offer New website in place	WFD Phase 1 completed Wider Hubs Design completed		Full launch of IT Solution Phase 1 of Targeted Hub programme complete			Phase 2 of Targeted Hub programme complete

	Full WFD Framework Agreed	1st Hub Pilot ends	Development of IT solution completed					
MEAM	Development of Service Model Market Engagement Procurement Commences			Contract award Cabinet Implementation Period commences	Service Mobilization Implementation ends	Alliance Contract Goes Live	Implementation and Delivery	
Enhanced Care and Support	Baseline Assessment against EHCH Model	Mobilisation		Detailed Planning Completed	Initial Integration of new functions completed		Transformation	SAP for Dom Care in place
System Enablers			Phase 1 Planning Consent Approved for Efford H&WB Hub	Plymstock Health Hub Occupied Construction Contract let for Efford H&WB Hub			Implementation of Phase 1 works at LCC Deliver OPE Hub Implementation Plan	