

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

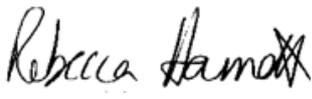
1) PLAN DETAILS

a) Summary of Plan

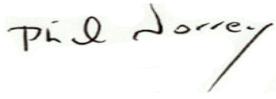
Local Authority	Devon County Council
Clinical Commissioning Groups	NHS Northern Eastern Western (NEW) Devon Clinical Commissioning Group NHS South Devon and Torbay Clinical Commissioning Group
Boundary Differences	NHS Northern, Eastern, Western Devon CCG's western locality will also contribute to Plymouth Council BCF submission. NHS South Devon and Torbay CCG will also contribute to Torbay Council BCF submission. Arrangements have been put in place to ensure clarity of schemes and plans for each BCF submission.
Date agreed at Health and Well-Being Board:	11 September 2014 with Chair executive agreement following meeting for any amendments
Date submitted:	19 September 2014

Minimum required value of BCF pooled budget: 2014/15	£19,677,000
2015/16	£55,631,000
Total agreed value of pooled budget: 2014/15	£19,677,000
2015/16	£59,687,000

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Northern, Eastern and Western Devon Clinical Commissioning Group (NEW Devon CCG)
Signature	
By	Rebecca Harriott
Position	Chief Executive
Date	18 September 2014

Signed on behalf of the Clinical Commissioning Group	NHS South Devon and Torbay CCG
Signature	
By	Simon Tapley
Position	Director of Commissioning
Date	18 September 2014

Signed on behalf of the Council	Devon County Council
Signature	
By	Phil Norrey
Position	Chief Executive
Date	18 September 2014

Signed on behalf of the Health and Wellbeing Board	Devon Health and Wellbeing Board
Signature	
By Chair of Health and Wellbeing Board	Cllr Andrea Davies
Date	18 September 2014

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Devon Joint Strategic Needs Assessment (JSNA)	<p>The Devon JSNA looks at the current and future healthcare needs of the local population to inform and guide the planning and commissioning of health, wellbeing and social care services.</p> <p>We have provided the link to the key JSNA overview document, but also to the main JSNA webpage, which itself provides further links to specific topic pages, and local health improvement plans.</p>
2012/13 Joint Strategic Needs Assessment for the South Devon and Torbay Clinical Commissioning Group	<p>This report provides a narrative overview on the needs of the local population through a life course framework within South Devon and Torbay CCG. It brings together a summary narrative to describe the needs of the South Devon population but this is included in the Devon JSNA Attached as Appendix A</p>
Vision for Transforming Community Services	<p>This document sets out our strategic vision for Transforming Community Services. This document explains the context for this strategy and so there is detailed explanation about the issues that are influencing are the visions for future service delivery. We have also set out a detailed description of how services will be delivered in the future.</p>
The Devon and Plymouth challenged health economy (CHE) strategy (also adopted as NEW Devon draft Strategic Plan)	<p>This document provides the basis for moving forward with a whole-system strategy for health and social care in Devon and Plymouth. It describes the establishment of the NHS Futures Programme to drive forward the required transformational change. It sets out how partners across health and social care will work together as a system to tackle the challenges we face and move forward to deliver changes in a way we meet the needs of people who use our services. This programme is supported by this document draft NEW Devon CCG5 year strategy.</p>
The Journey to 'I'- an integration plan for health, wellbeing and care in Devon	<p>A plan which describes the foundations of integration already in place across Devon, and how we plan to build and scale up integration so that experiences of truly joined up health, wellbeing and care become the norm for everyone. This Integration Plan can be found to download on the following CCG website page</p>
Co-commissioning of Primary Care Expression of Interest NEW Devon CCG	<p>This is NEW Devon CCG's expression of interest in having delegated responsibility for co-commissioning of primary care (currently this responsibility sits with NHS England, Area Teams). Commissioning primary care supports the delivery of the BCF plans and personalised proactive care as outlined in Transforming Primary Care.</p>

NEW Devon CCG Commissioning Framework	The NHS NEW Devon CCG commissioning framework is a set of modules detailing how we plan to provide health care services, working collaboratively with providers, across the region over the next two - five years.
Devon County Council Children, Young People and Families Plan 2013-2016	This plan will set out the vision, values and guiding principles for supporting children, young people and families and a commitment to integrated and personal services. Engagement will shortly be undertaken to give people a chance to contribute to the draft plan.
Devon County Council: Vision of care and support for vulnerable adults in Devon	A document setting out the vision, values and priorities for vulnerable adults in Devon.
Joint Health and Wellbeing Strategy (JHWS)	The initial Devon Joint Health and Wellbeing Strategy 2013-2016 was produced in September 2012 by the Devon Shadow Health and Wellbeing Board. An update was produced in 2014 which re-iterates the role of the Board, highlights where progress is being made, and sets out a small number of additional priorities to be addressed in 2014/15. It also describes working arrangements with other health and wellbeing related bodies and partnerships.
Carers at the heart of 21st Century families and communities in Devon- planning for progress South Devon & Torbay Integrated and personalCare Organisation Business Case	A strategy covering carers in Devon , the ways that their needs are identified and met, and how they are treated by public services. It outlines the key priorities for carers the outcomes we plan to achieve. The full business case for the merging of Torbay and Southern Devon Health and Care NHS Trust (TSD) with South Devon Healthcare NHS Foundation Trust (SDH). It sets out the background for the merge and demonstrates why this proposal is the best option for TSD& SDH and for the people they serve. SDH's Trust Board and its council of governors will use this full business case (FBC) to support a final decision regarding commitment to the merger before wider publication.
Pioneer application June 2013	The vision for whole system integrated and personal care in South Devon and Torbay Pioneer bid here
South Devon & Torbay CCG Strategic Commissioning Plan 2014-2019	This sets out the ambitions and intentions for the CCG which is consistent with identifying priorities which have a focus on integrated and personal planning and delivery in order to deliver on the challenges faced by health and social care. Strategic Plan (2014-19) here
South Devon and Torbay CCG Engagement report	The report analysing the feedback from our extensive community services engagement process Engagement report here
South Devon & Torbay CCG Commissioning Template	Planning document setting out ambitions for improving a range of key outcomes here

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Introduction

The Devon Health and Wellbeing Strategy outlines our ambition to achieve full integration of health and social care based on our understanding of need (encapsulated in our Joint Strategic Needs Assessment) and the engagement we have already undertaken with the people we serve. The JSNA shows us that in Devon there are a higher number of older people than the national average who can be classified as frail and that this number, along with consequent demands on health and social care, will increase in the future.

This move towards integration and personal care is reflected within both CCGs (Northern, Eastern and Western Devon CCG (NEW Devon CCG) and South Devon and Torbay CCG (SD&T CCG) 5 year strategic plans. The progress towards integration is different – the journey to ‘I’ in NEW Devon and the formation of the integrated and personal care organisation in South Devon are the mechanisms that we are using to create a fully integrated and personal health and social care service for the people of Devon

This Devon Better Care Fund (BCF) plan will act as a catalyst for this integration journey in Devon and for the purposes of this submission BCF is reported as a discrete programme of work (particularly to ensure monitoring and evaluation of BCF). However it is an integral part of the wider health and social care transformation programme where it will sit as one strand of work. For SD&T CCG the BCF sits within their already well-established integration programme.

Context

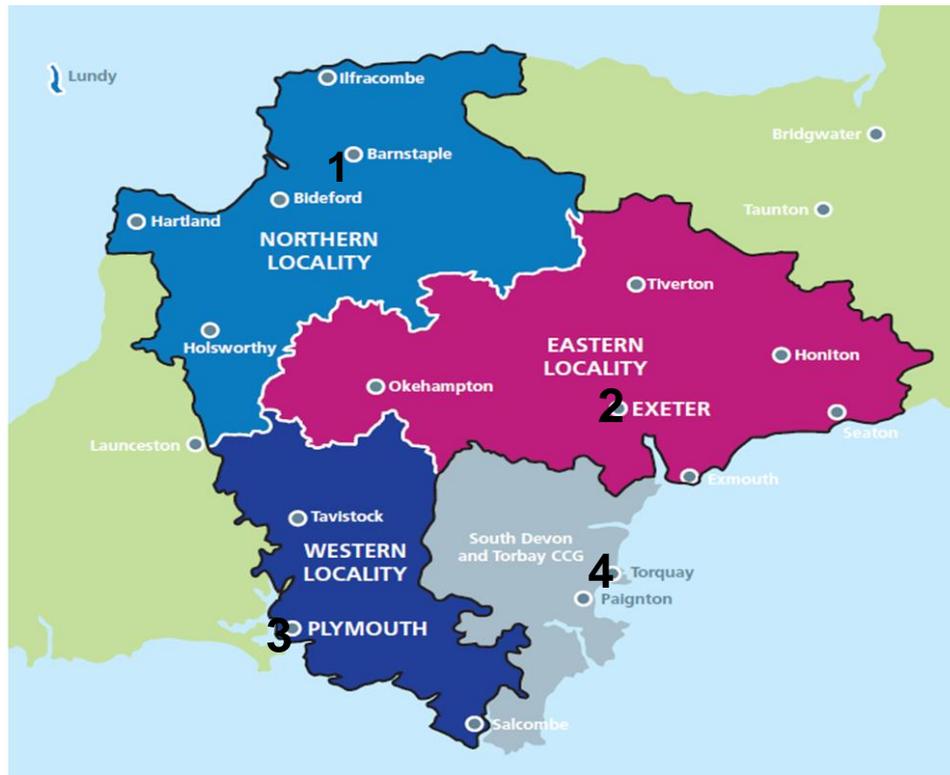
Devon is the third largest county in England, covering 2,534 square miles. The county has over 750,000 residents, with a higher proportion of older people than the national average. It is also one of the most sparsely populated counties, with few large settlements and a dispersed rural population. The transport network is limited which results in considerable travel times, proving a barrier to access for many residents and an operational challenge for Providers.

Cross boundary working

Devon BCF plan spans the area covered by Devon County which includes one local authority, two Clinical Commissioning Groups (NHS South Devon and Torbay CCG and NHS Northern, Eastern and Western Devon CCG) and four acute providers.

We recognise that effective working at both County level and more local System Resilience Group (SRG) level is critical in enabling commissioners and providers to work together on whole system transformation and delivery of the BCF plan. Our Joint Commissioning Coordinating Group (JCCG) includes representation from each of the commissioning organisations, and retains a strategic overview of our integration plans, as well as monitoring the performance against the BCF metrics. SRG’s provide the forums for engaging providers in the local geographies as illustrated below. We will continue to

refine our programme governance for the BCF plan in Devon to achieve integrated system leadership and management with the organisations and across the boundaries.



System Resilience Groups / Acute Providers

- 1 Northern Devon Healthcare NHS Trust
- 2 The Royal Devon and Exeter Foundation Trust Hospital
- 3 Plymouth Hospitals NHS Trust
- 4 South Devon Healthcare NHS Foundation Trust

NHS Futures – transforming care in Plymouth and Devon

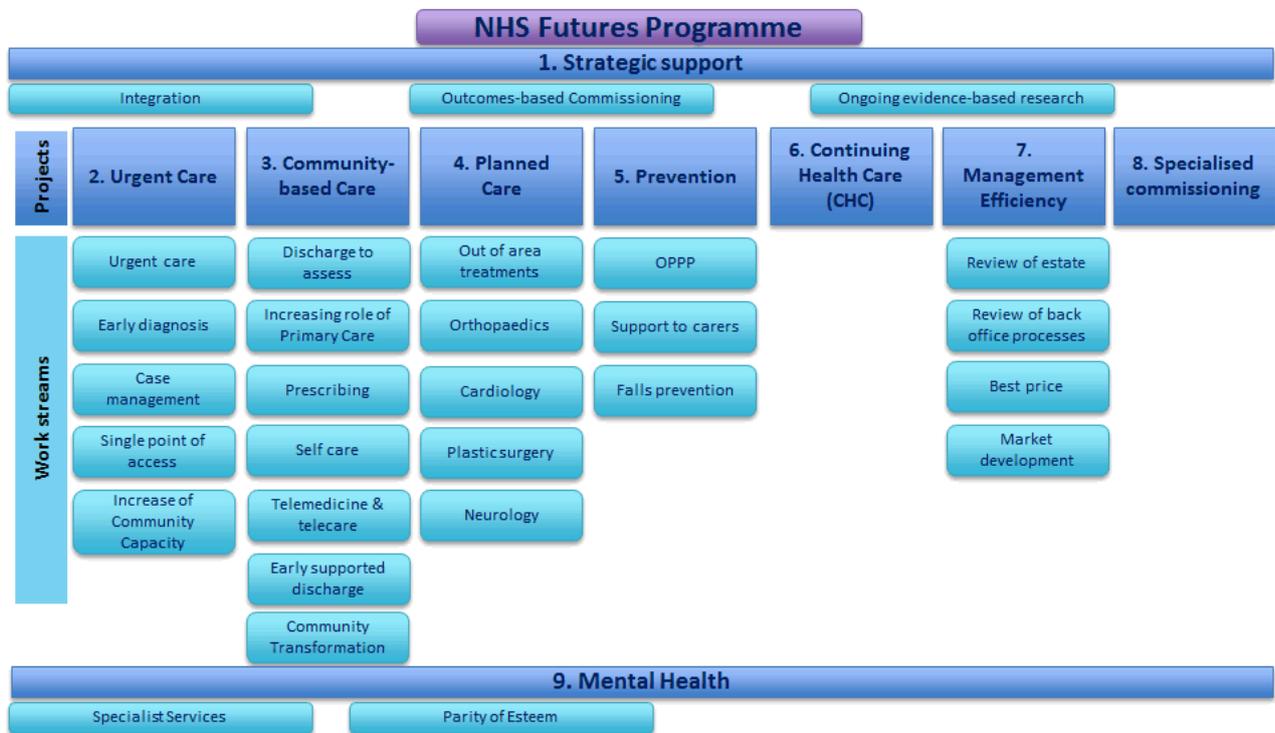
Since the Devon BCF submission in April 2014 there has been much work undertaken as part of the financially challenged health economy position for Devon and Plymouth. This has included the development of a whole-system strategy for health and social care and a delivery programme that has involved all key organisations including: Devon Partnership NHS Trust; Plymouth Hospitals NHS Trust; Royal Devon and Exeter NHS FT; Northern Devon Healthcare NHS Trust; Devon Doctors; South West Ambulance Services NHS FT; Devon County Council; Plymouth City Council; Virgin Care; NHS England, Monitor and Trust Development Authority.

In the strategy we set out how we will work together as a system to tackle the challenges we face and move forward to deliver changes in the way we meet the needs of people who use our services. The strategy describes a framework for system-wide action and detailed plans are currently being developed so that we can move forward with confidence and pace, including the Devon BCF Action Plan outlined in this submission.

The BCF will sit within the overarching NHS Futures Programme Architecture within its strategic support work stream which includes integration – in fact it will act as a catalyst for this work. It will also span across a number of the other work streams in particular Urgent Care. All partners have contributed to the development of this structure and it will

drive forward the whole system transformation programme of work.

Programme Architecture:



There are pressures in health and social care funding across the country because of challenging demography, increasing complexity of need and the need to deliver better services with less public resource. We also know that Devon and Plymouth face a particular financial challenge because of the local demography and our historic pattern of provision – the Devon health economy is facing a severe financial environment with its two largest Acute Trust providers operating deficit budget in 2014/15, the CCG itself is in deficit and its remaining providers only planning for breakeven or minor surpluses. The health economy will be facing the financial challenge and constraints which will be experienced by the NHS and social care system nationally however this will be acute in Devon given the collective opening deficit position of NHS providers and the CCG.

Until recently the complexity and scale of our system-wide challenge has been difficult to understand and local organisations have, as a result, focussed mainly on meeting their own challenges. A lot of this work has been successful and this has delivered much that is good right across our system.

Our local NHS trusts and other organisations provide excellent acute, community, and mental health services and many of the area’s aggregated performance metrics are very good.

However we know that this existing good practice will not be enough to meet the current challenge. This means a new imperative for joint and collaborative working across all the organisations that commission and delivers health and social care in our area and this is the larger context within which the Devon BCF plan sits.

Vision

The vision of our BCF will be the driver for the Health and Well-being strategic aim towards full integration and reflects the population's health and social care needs as identified in Devon's JSNA.

The overarching vision for greater integration and personalised services in Devon, including the Better Care Fund plan, builds on and responds to detailed engagement with local people and professionals as part of our Transforming Community Services (TCS) strategic work, and the extensive community services engagement undertaken in South Devon during the same period. These resulted in the "I" statements which are outlined in next section. Our BCF plan will provide a key mechanism to deliver integrated and personal health and social care for the people in Devon that helps people who are older, frail or have complex general health needs by providing:

- **Targeted Prevention and Maintenance** – supporting people to maintain healthy and independent to reduce the risk of unwarranted admission to hospital;
- **Support when Crises Occur** – providing the best support whenever possible when a person is in crisis and admission is required
- **Enhanced Recovery and Independence** - enabling people to return home as soon as possible by supporting them to recover/rehabilitate from periods of acute illness.

Delivery of the Vision

The BCF plan will build upon the current integration within the two CCG areas and further move us along this journey.

In 2013 South Devon and Torbay became one of 14 national Pioneer sites for integration. The joint bid from the health and care community set out an ambitious goal of whole-system integration, extending beyond health and social care to encompass acute care, mental health and the voluntary sector.

The bid articulated a vision for integrated care and personal support, underpinned by the creation of an Integrated Care Organisation (ICO) that further broadens the current model of health and social care to include acute health care provision. This offers an opportunity for an entirely new approach.

The strategy for delivering on Pioneer and the ICO extends beyond the local authority boundary of Torbay into the whole CCG area, and thereby into South Devon within the scope of Devon County Council. The improvements set out in this submission will therefore form part of the wider system changes across a larger geographical area. The Better Care Fund sits within this longstanding programme of integration.

INTEGRATION - The Journey to "I" - An Integration Plan for Health, Wellbeing and Care in Devon

In Devon joined up approaches are already in place or are recognised as important:

- Joint commissioning arrangements for carers; mental health; older people with mental health needs; learning disabilities; children and young people; older people

with physical disabilities - mostly supported by joint teams and a number of existing or developing joint strategies.

- Joint delivery arrangements between the local authority and health providers with services focused around **complex care teams** (CCT) to support people when they are most vulnerable working closely with primary care. These are multi-disciplinary teams that focus on the most frail and vulnerable, identified by risk stratification in GP surgeries, who coordinate care around the individual
- Tangible examples of jointly commissioned services for example Integrated Children Services; Community Equipment Service and a range of commissioned tests of change supported by section 256 funding
- Engagement between Devon county council and eight district councils for example in relation to Extra Care Housing, Disabled Facilities Grants and planning.

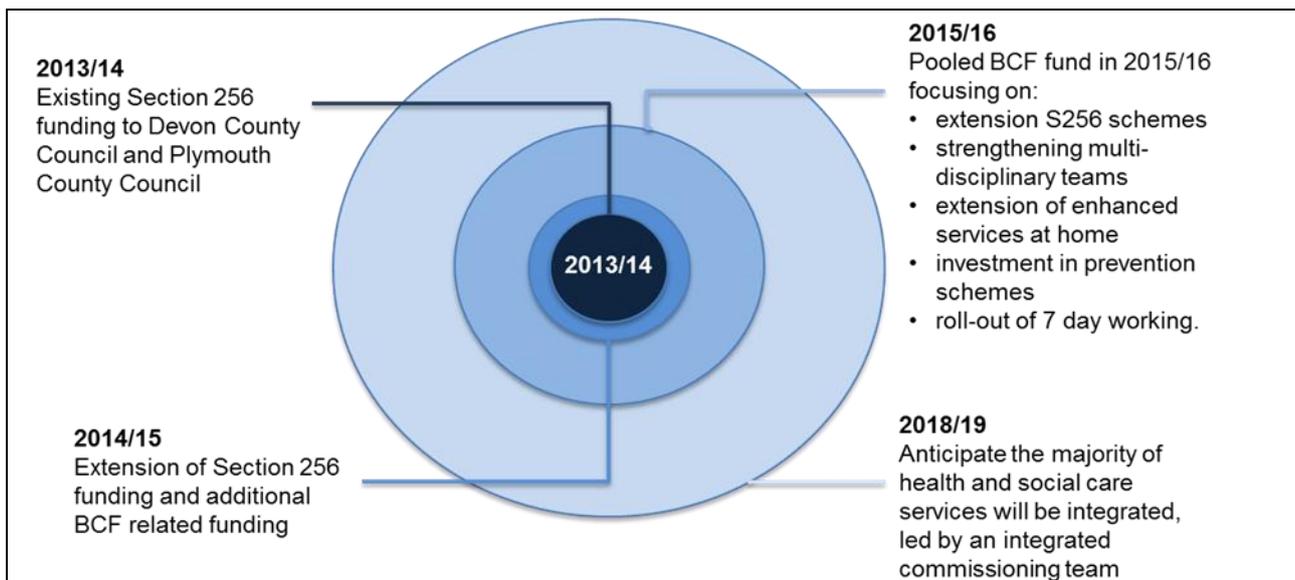
Devon County Council (DCC), SD&T CCG and NEW Devon CCG are committed to the integration and personalisation agenda, to explore the opportunities provided by the BCF. SD&T CCG have their integrated care organisation and the proposal in NEW Devon CCG is to trial the work in Exeter before extending to other areas of Devon (Integrated Care Exeter –ICE). This is a proposal to create a system of care that is:

- Built around the person
 - Accountable for person centred outcomes
 - Coordinating partner contributions
 - Likely to be Capitation based
- Enabling a transformed delivery network for people in their natural communities
 - Focussed on wellbeing and maximising independence
 - Providing comprehensive support
 - Signposting and where appropriate care managing interactions with networked and specialist services
- The ICE Partnership is broader than health and social care and includes the city council , the third sector in the city, the Devon and Cornwall Police service and representation from the newly formed GP consortium in the city.

All commissioners and providers are facing similar financial and delivery challenges and the BCF offers a unique opportunity to do things differently in the future. Learning from the work in South Devon as described above and the step change underway which introduced systems and processes by creating a genuine partnership between providers, sharing both opportunities and risks.

The journey to 'I' describes how we plan to build on the best and scale up integration so that experiences of truly joined up health, wellbeing and care become the norm for everyone and can be found at CCG [website page](#)

Our BCF plan includes the minimum required pooling of funds for 2015/16. However, we are currently exploring other areas which could be pooled as part of this fund. Our ambition is to integrate the majority of health and social care services by 2018/19:



Given the scale of the ambition and the challenge in Devon it is recognized that the BCF will support the first steps of our integration journey. Implementing the schemes outlined within this plan will provide a catalyst to expand this work in 2015/16, building upon the learning from schemes of 2014/15. However this in itself will not be sufficient to realise the scale of our ambition and therefore a range of co-dependent strategies are described below which also contribute to the realisation of our vision.

Transforming Community Services (TCS) is another key programme of work which will enable us to achieve our vision of integrated and personal health and social care delivery in both CCGs.

The overarching TCS vision is for care to be provided outside of acute hospital settings, either in the patient’s own home or within community based services where it is clinically and financially viable to achieve this. Where this is not achievable, care will continue to be delivered using in-patient services.

The TCS programme has four areas of work which dovetail into the three strands of the BCF:

- Preventive and personalised support
- Pathways for people with complex health needs
- Urgent care in the community
- Community specialty services

Planning for future design of community services, the CCGs will take into account the mixed rural and urban nature of the geography, demographic pressures, and considerations such as rural isolation, transport links and access to services for individuals and carers.

Commissioning for outcomes

This strategic approach supports the direction of the local health economy and work with local authorities where an outcomes and population based capitated approach is being looked at to incentivise delivery of commissioning intent. The model for services is focused on reliable and quality services that help people to remain in their own homes

and a wide range of services particularly outpatient and multi- disciplinary support in closer to home care settings with access to inpatient services outside of large acute centres where this is clinically indicated.

With our local communities, we are resolved to make a major difference to the quality of life of our population, to support people to be as well and independent as they can be, and to provide care with compassion when they cannot. To do this, we need to join up with each other to make our care seamless and put more power in the hands of those who need our care and support.

In the future, people in Devon will make a single call for any health or care service. Their GP practice will be integrated with other community providers, where they can find not just health and social care but personalised support for their mental health and general wellbeing needs, too, all organised with a single named care coordinator. Thanks to information-sharing across all parts of the system, whenever they receive care for one condition it automatically and electronically triggers others that are needed, for support or prevention. Acute hospital interventions are included, but most care is delivered closer to home, including hand-held diagnostics and intravenous treatment, GPs can monitor vital signs remotely.

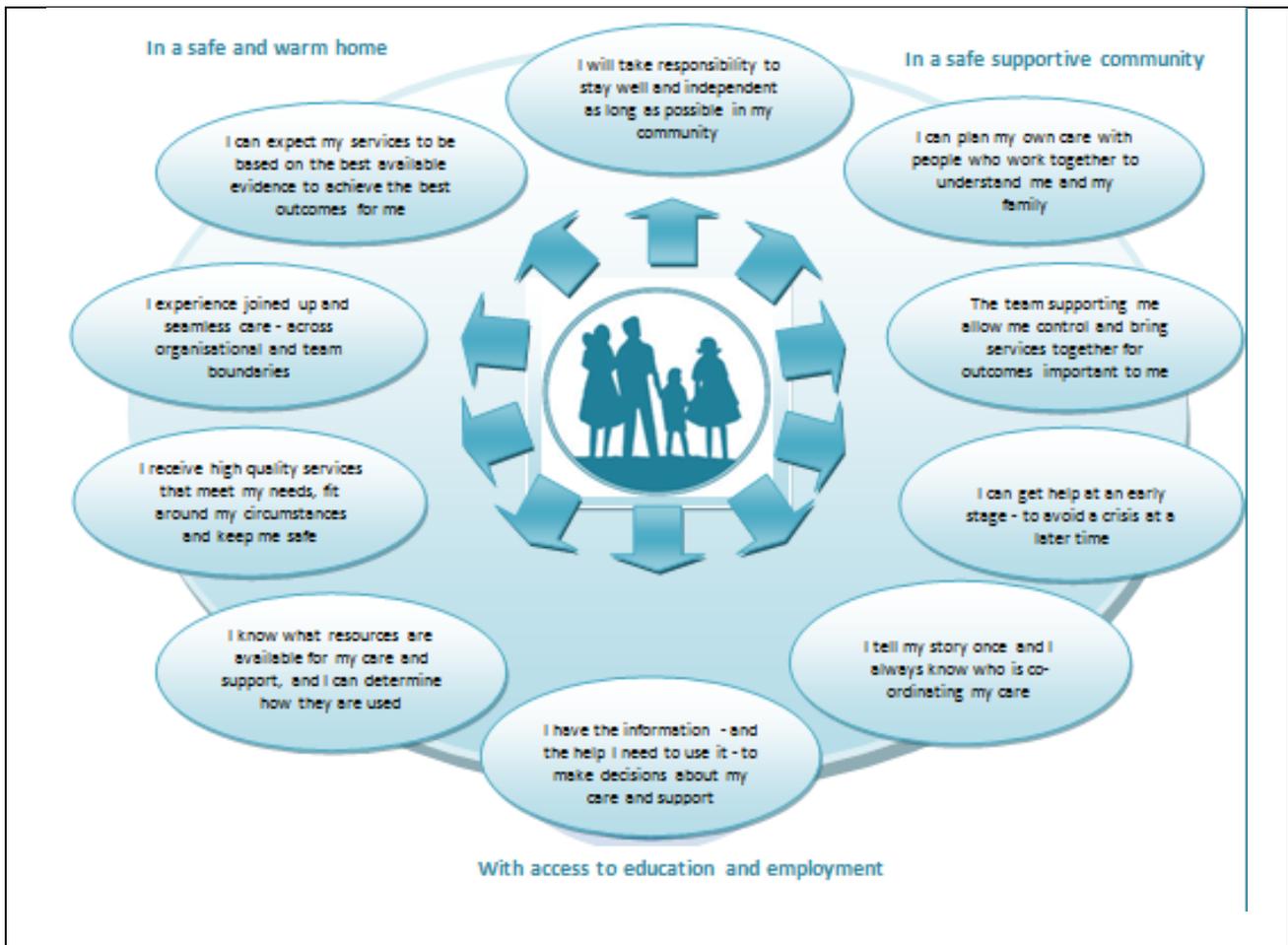
Testing schemes via resilience plans

The resilience funding allocation that the CCGs should receive from NHSE is being planned to be used to support services aimed at the urgent care pathway to prevent admissions to acute and will ultimately support the BCF aspirations – these resilience plans include the focus on the support when crisis occurs and enhanced recovery and independence elements of the BCF plan – details can be seen in Section 4d. Evaluation of the efficacy of these schemes will be built into the BCF plan to inform where further investment should be given.

b) What difference will this make to patient and service user outcomes?

Our joint system planning for the BCF has been underpinned by a number of principles for the way that people experience our services. These statements were developed from the TCS strategic engagement process during which we received over 250 responses, reflecting the views of over 2000 people.

These 'I statements' describe what people should expect from us and we have adopted these and are shown on the next page.



c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

As previously described our BCF plan is focused on the following three strands – focusing on the patient pathway from end to end.

- **Targeted Prevention and Maintenance** – supporting people to maintain healthy and independent (e.g. Community Equipment Service (BCF002) and enhanced service to carers (BCF001))
- **Support when Crises Occur** – providing the best support whenever possible (e.g. Integrated front door for community – single point of access (BCF005), SWAFST Right Care (BCF003) and Rapid Response (BCF004))
- **Enhanced Recovery and Independence** - enabling people to return home as soon as possible (e.g. Social Care Reablement (BCF008) extending the work of the Complex Care Teams within frail and community care scheme (BCF007))

The illustration from the work of ‘Integrated Care Exeter’ provides a helpful picture of how the care delivery system needs to change increasingly directing the focus of care towards prevention and help at home and is shown on the next page

SHIFT TO PREVENTION AND PRO-ACTIVE CARE

1. Staying healthy, healthy active ageing and supporting independence	2. Helping people to live well with simple or stable long-term conditions	3. Helping people live with complex co-morbidities, including dementia and frailty	4. Rapid support close to home in times of crisis	5. Good acute hospital care when needed	6. Good discharge planning and post-discharge support	7. Good rehabilitation & re-ablement (outside acute hospitals) after acute illness or injury	8. High-quality, long term nursing residential care for those who need it	9. Choice, control, care & support towards the end of life
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Given the complexity of Devon we recognise that one size won't fit all but the intention is to reconfigure services – shifting care away from acute hospitals into the community.

In our TCS we have outlined our intention for the future footprint of community services.. Our TCS proposal will support our BCF plan as set out below for each community :

Northern SRG Area

Health and social care services within the Northern Locality are already integrated across acute and community health services. There are joint health and care teams with Devon County Council providing coordinated care services across the locality ensuring that service users receive a seamless care pathway. These services are not included within the procurement as they are part of the core contract with Northern Devon Healthcare Trust, however, further transformation work will continue to strengthen the efficiency, effectiveness and quality of the services provided.

Eastern SRG Area

There are joint health and social care teams in Eastern locality. The Local Authority has expressed support for our proposal of integration of health services in the urgent care system as an important part of the next steps in the journey towards integration of delivery. In identifying that complexity leads to system inefficiencies, we checked this with clinical leaders and have identified the following:

- Multiple clinical governance systems requiring clinical time to duplicate forms for two providers
- Bed management complexities between community and acute providers leading to clinically unnecessary and inappropriate acute bed usage
- Potential risk or delays due to the transfer of documentation during patient handovers from the acute to the community provider
- System incentives which can prolong length of stay within the acute setting
- Potential for different clinical pathways due to separate clinical leadership across the system
- Impact on the use of community resources as community provider unable to influence whole care pathway

By moving to a position of greater integration of provision within the Eastern locality urgent care system, we consider there would be significant benefits to the system and to users of services including considerably increased opportunities for the use and allocation of finite and restricted resources.

It should be noted that the CCG will not be making a decision on this proposal until November 2014 and will be made in light of issues around contestability and competition.

Western SRG Area

Plymouth Community Healthcare and Plymouth City Council formally agreed in July 2014 to integrate the provision of health and social care services within the City of Plymouth. Within the West Devon and South Hams areas of the Western Locality there are joint health and care teams with Devon County Council. Our direction across the other two localities is one of progressing through integration of healthcare towards a fully integrated health and social care delivery model. Within the Western Locality, it is essential to continue within the integration of community services and social care services across the whole locality.

The system within the Western locality has additional complexity because users of services within South Hams and West Devon may attend Derriford for acute services, but receive other parts of their care through the system in Southern Devon. By having one community services provision system across the locality which faces the urgent care system in Western locality, this would be addressed. Furthermore, by further developing the provision of community services and making better use of community facilities in Tavistock and Kingsbridge we will be able to provide more clinical services closer to home. This will be of significant benefit to the rural communities in South Hams and West Devon.

We acknowledge that there will still be inefficiencies in the system as a result of not progressing at this time to a wholly integrated solution as in the other two localities. While this is not ideal, it is more important that we take the steps that deliver the best possible benefits to the population of the Western locality given the current model of service provision.

South Devon SRG Area

The ambition that we have set out for the Pioneer Programme and Integrated Care Organisation is already underway. The Better Care Fund is seen as complementary to this with many of the above service changes already planned prior to the BCF. However it has been helpful in strengthening the drive and commitment for pooled resources in addressing the challenges and pressures that we currently face on our hospitals and health spend, as we shift from high-cost reactive to lower-cost preventative services, supporting greater self-management and community based care. Our social care spend will be going further, as new joint commissioning arrangements deliver better value and improved care at home reducing the need for high-cost nursing and care home placements.

The Better Care Funded work will help to increase independence at home, we will have delivered further extra care housing units, re-commissioned community equipment services and community care and support will be focused on meeting individual outcomes to re-able people quickly and keep them independent and well at home.

The changes needed to bring about a self-supporting, self-reliant and resilient community that can deal with many of the challenges that would otherwise become the responsibility of statutory sector partners is challenging. However, one of the first steps is to build the 'social capital' needed which will be an inherent part of our integration plan, and requires an active relationship between local communities and voluntary and community sector partners.

The SD&T CCG strategic plan sets out the detail along with the key outcomes and

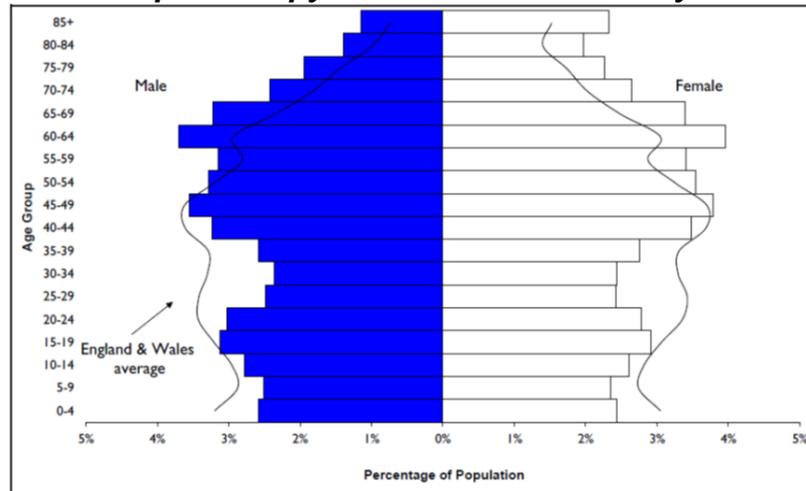
indicators for each of its high level priorities in line with the vision for integrated care and support. This also demonstrates the number of work streams in place to make it happen within the context of the challenge of a flat cash environment: prevention, primary care, community, urgent care, mental health, long-term conditions, learning disability, planned care, medicines, joint commissioning and children’s services.

2) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Devon has an older population profile than nationally, particularly in those aged 55 years of age and above, reflecting significant in-migration in this age group, and those aged 85 years and over, reflecting an ageing population and longer life expectancy.

Table :Population pyramid for Devon County Council



Source: Mid-Year Population Estimates 2012, Office for National Statistics licensed under the Open Government Licence v.1.0

There is significant age variation across Devon and the approach within localities needs to reflect this. In Sidmouth, the area has a significant ageing population and in Exeter the area has a much younger population but with areas of significant deprivation which will impact on many emergency admissions.

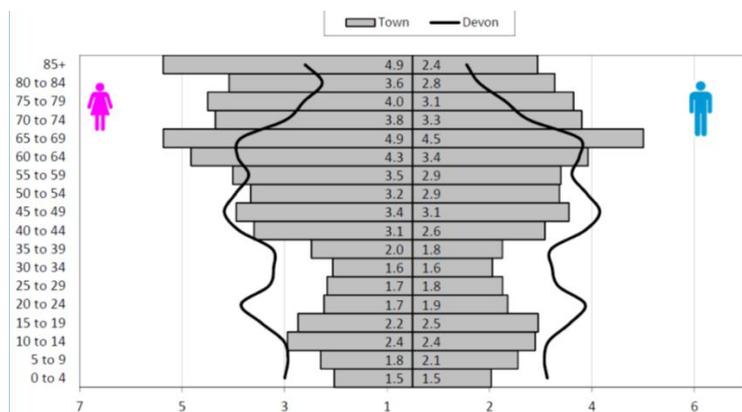


Figure 3: Sidmouth population pyramid (showing % of total population) compared to Devon (June 2012) Data Source: Patient and Practitioner Services Agency

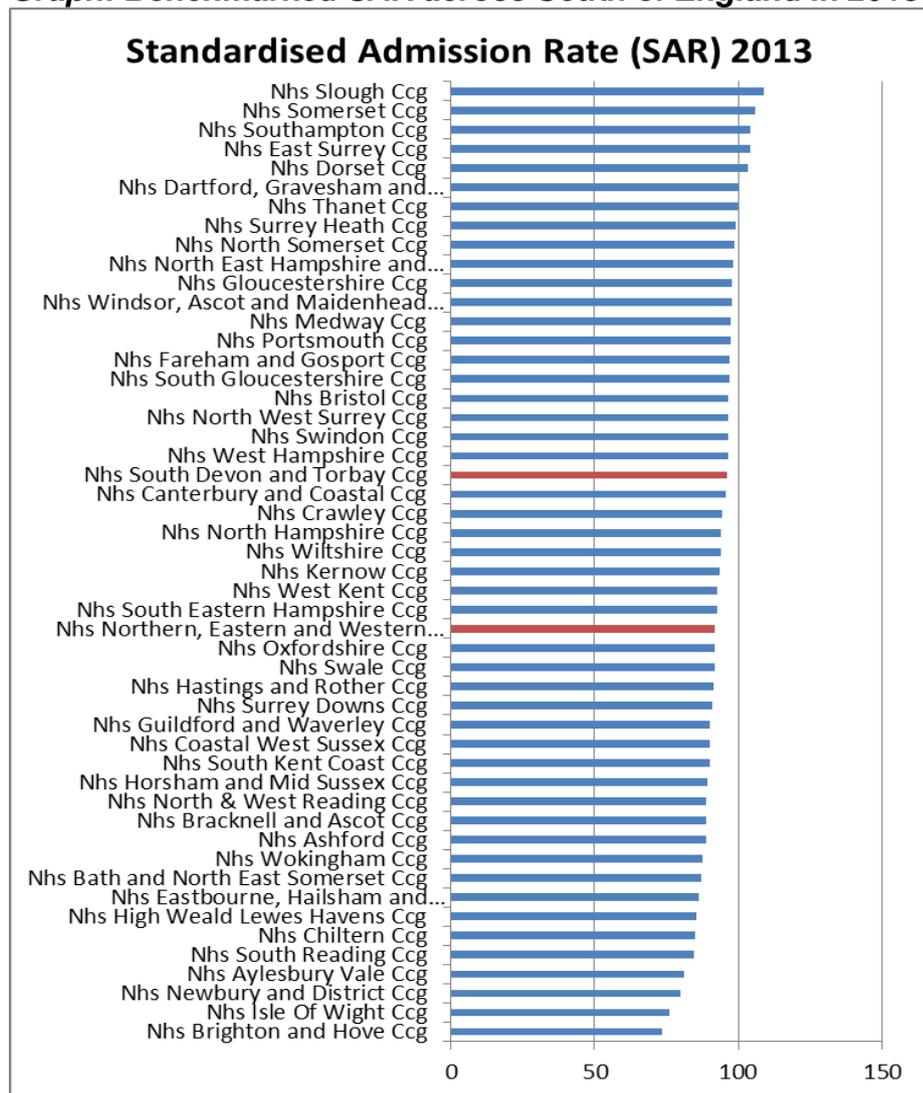
Considering the mosaic profiles in the JSNA the largest groups in Devon are group residents of isolated rural communities and residents of small and mid-sized towns with strong local roots. Services are designed to reflect the different urban and rural areas and the multitude of market towns.

Further population segmentation is being developed in Devon and a LTC HNA is underway which will consider the impact of LTC's and multi-morbidity this will assist with further development of the prevention and targeted LTC work reflecting the needs of the older population and the younger population.

Benchmarking non-elective activity

To understand the scope for reducing the level of non-elective admissions it is important to understand how our current rate of admissions compares to other areas. NEW Devon CCG had a Standardised Admissions Rate (SAR) for non-elective admissions of 91.9 in 2013 and South Devon & Torbay had a SAR of 96.2 over the same period. This compares to an average of 94.2 across the South of England commissioning region. A 3.5% reduction in non-elective admissions would ensure that activity moves from around average in the South of England to top quartile.

Graph: Benchmarked SAR across South of England in 2013 (Dr Foster)



Benchmarking length of stay

The table below benchmarks the average length of stay for patients admitted as an emergency. Both NEW Devon CCG and South Devon & Torbay CCG have a lower than average length of stay for emergency admissions compared to other CCGs in the Southwest. South Devon & Torbay have the lowest length of stay in the region. Thus the scope for reducing length of stay is greater in NEW Devon CCG. This should be considered alongside the reported delayed transfers of care.

Table: Benchmarked length of stay across Southwest (Dr Foster)

Peer (Southwest CCGs)	Spells	Inpatients	LoS
NHS SOUTH DEVON AND TORBAY CCG	27,636	27,636	4.6
NHS KERNOW CCG	49,707	49,707	4.8
NHS DORSET CCG	81,116	81,116	4.9
NHS NORTH, EAST, WEST DEVON CCG	80,595	80,595	5.4
NHS GLOUCESTERSHIRE CCG	51,229	51,229	5.6
NHS SOMERSET CCG	54,978	54,978	5.7
NHS BATH AND NORTH EAST SOMERSET CCG	15,790	15,790	6.1
NHS NORTH SOMERSET CCG	16,764	16,764	6.6
NHS BRISTOL CCG	38,228	38,228	6.8
NHS SOUTH GLOUCESTERSHIRE CCG	17,204	17,204	7.3
All	433,247	433,247	5.5

Risk stratification

The Devon predictive model is used to risk stratify patients to ensure those patients with the greatest needs are supported by the complex care teams. Across both NEW Devon and South Devon & Torbay CCGs the top 2% of patients account for 32.4% of the total emergency admissions and 38.4% of the total cost of emergency admissions. These patients are over 23 times more likely to have an emergency admission over the last 2 years.

Table: Emergency admissions over last 2 years for both NEW Devon and SD&T CCGs

Patient group	Total emergency admissions	Patients	Emergency admissions person	% of total admissions
Top 2%	53,301	21,487	2.48	32.4%
Others	111,006	1,052,388	0.11	67.6%
Total	164,307	1,073,875	0.15	100.0%

The table above shows that the top 2% of patients had 53,301 total emergency admissions over the last 2 years with an average of 2.48 admissions per patient (39,722 in NEW Devon CCG and 13,579 South Devon & Torbay CCG). It has been estimated that a 3.5% reduction in non-elective admissions across the Devon BCF would be a reduction of 2,790 admissions per year.

Table: Cost of emergency admissions over last 2 years for both NEW Devon and SD&T CCGs

Patient group	Total cost of emergency admissions	Patients	cost /person	% of total cost
Top 2%	£105,816,119	21,487	£4,924.66	38.4%
Others	£169,790,662	1,052,388	£161.34	61.6%
Total	£275,606,781	1,073,875	£256.65	100.0%

The total spend across both NEW Devon and South Devon & Torbay CCGs was £105.8m over the last 2 years on emergency admissions for the top 2% of patients. This corresponds to an average cost per patient of £4,924 over this period for emergency admissions and £7,778 for all PBR related activity.

It has been estimated that an 8% reduction in emergency admissions across the top 2% of patients would deliver the target reduction in non-elective activity. A significant proportion of the schemes in the Better Care Fund are targeted at these top 2% of patients. Thus the top 2% of patients as identified via the Devon predictive model represent the biggest opportunity to reduce the level of non-elective activity.

The JCCG has an established outcome reporting framework which has informed the decision making process (appendix 3) The outcomes report demonstrates that within Devon the rate of permanent admissions to care homes in older age groups is below regional and national averages and is falling over time with in-year data for 2013-14 suggesting further falls. Reablement service effectiveness at 91 days is currently above regional and national rates and remains around the 90% mark at the end of 2013-14. Higher levels of delayed transfers of care are seen in Devon, although rates have fallen over recent years. During 2013-14 delayed transfers peaked in May to October and are currently slightly above trajectory. Rates of avoidable emergency admission are below England and comparator group levels, but have increased during 2013-14 and are above the target trajectory. The dementia diagnosis rate has increased over recent years but is still below regional and national average.

Joint Commissioning Indicator List and Summary

Theme	RAG	Indicator	Latest Month	2013-14	L/T Trend	Dev/SW/Eng
Overarching	-	Non-Elective Admissions (rate)	9880.0	10003.1	-	-
Supporting	G	Care home admissions	527.5	556.4		
	G	Re-ablement (effectiveness)	89.2%	89.8%		
	-	Re-ablement (coverage)	-	2.0%		
	R	Delayed transfers of care	363.7	360.4		
	R	Avoidable emergency admissions	1827.2	1787.8		
Local	-	Dementia Diagnosis Rate	-	41.9%		

RAG Rating Definition

Red	R	Failing to meet Better Care Fund target trajectory, statistically significant difference
Amber	A	Failing to meet Better Care Fund target trajectory, difference not statistically significant
Green	G	Meeting or exceeding Better Care Fund target trajectory

RAG rating based on latest reported position (monthly), current RAG rating thresholds shown on page 2.

The report provides an overall picture and benchmarks nationally and regionally, within localities and against nearest neighbours. The full outcome report which can be found at Appendix 1.

Permanent admissions to care homes benchmark well as have the earlier indicator of avoidable emergency admissions providing evidence that the investment and services for care closer to home are showing signs of effectiveness. Devon has benchmarked below England and South West rates despite the population profile. Delayed transfers of care have been improving but do not benchmark well supporting investment in discharge facilitation to ensure the system keeps moving. Reablement is an investment priority as effectiveness benchmarks well but we need to improve coverage. Further detail is provided in BCF009 – Annex – Reablement. Part of the resilience plans are to increase Reablement from Dec 2014 and if this proves successful we will continue this into 2015/16 as part of the BCF (using disinvestment from current underperforming s256 schemes)

Since the publication of the new BCF assessment, improvement and approval process. Public Health Devon has undertaken a rapid review of evidence and BCF schemes and their impact on admission avoidance. The Better Care Fund (BCF) has an expectation of a minimum of a 3.5% reduction in ALL emergency admissions. Based on demographic change in Devon the number of emergency admissions is likely to increase by 1.2-1.3 % per annum for the next five years or so. In the short-term this is similar to the national average but in the medium to long-term this will have a more significant impact. The earlier indicator; avoidable admissions in Devon were below England and comparator group levels suggesting Devon was doing well in its work to reduce avoidable admissions. The metric now includes all age and a wider range of emergency admissions. This gives a minimum expectation of real time 4.7% reduction from the baseline. In any event the emergency admission reduction will be significant and equate to ~ 2,790 admissions per annum.

The review has considered many of the strands of work in place and being developed in Devon. A number of themes emerge which are consistent with work underway across the area. The review of spend needs to determine whether investment needs to be shifted, removed, mainstreamed or uplifted to impact on emergency admissions to meet the necessary targets to allow a shift in resources. The local themes can be grouped into 3 areas: Targeted prevention and maintenance, support when crisis occurs, and recovery and independence, and include the following:

- Prevention including falls, smoking, alcohol, CVD work and influenza vaccination - **targeted prevention and maintenance**
- Care closer to home supported by integrated teams – **across all strands (targeted prevention and maintenance /support when crisis occurs/recovery and independence)**
- Understanding the future role of community hospitals and care homes in the transforming community services programme - **enabler for all three strands**
- Appropriate crisis response with clarity on respective roles from primary care and community teams - **support when crisis occurs**
- Long term conditions management (including multi-morbidity) and development of a self- care model - **targeted prevention and maintenance**
- Recognition of the importance of dementia diagnosis and support - **targeted maintenance**
- End of life care pathway to minimise unnecessary hospital admissions - **support when crisis occurs to allow to die where they chose**

The 2011 census reported that there were 84,492 unpaid carers in Devon. Carers work is

well established and based on evidence of need and remains important. The role of the voluntary and community sector and the approach to support social isolation are less clear and need to be developed based on local assets to support local need. Both of these issues are addressed later in this document. The importance of health inequalities should be considered and a focus on all age rather than just the older population as the indicator includes all age. As part of our BCF plan we have an enhanced carers offer (BCF001) which will help support carers.

The information within this review have been used to assess current BCF and inform the decision making for future BCF schemes as outlined in this plan. The detail of this review can be seen in the Appendix 2

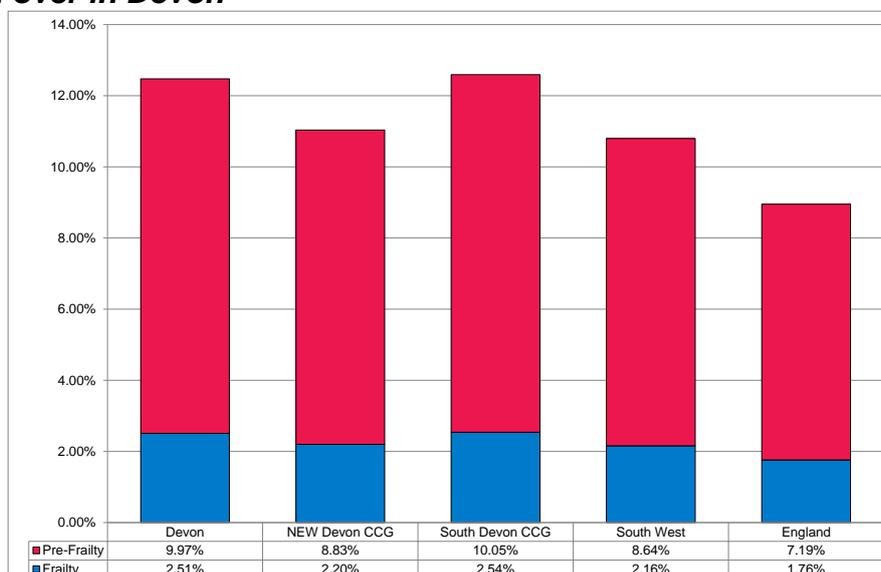
In addition a report on frailty was presented to the Health and Well-being Board on 11 September and has also informed this BCF plan. The frailty paper provides further segmentation of the population to allow a greater understanding of the local population. An increased risk of adverse health outcomes can be predicted by early identification of frailty, and adverse outcomes prevented by appropriate multidisciplinary interventions – (BCF007 – Frailty and Community (enhancing the work of the CCT is included in this); BCF001 – Enhanced Carers Offer and BCF008 – Reablement).

Frailty in older people negatively impacts on their quality of life and causes ill-health and premature mortality. Older people who are frail have an increased risk of falls, disability, long-term care and death. There is also a significant cost associated with the frail older population. Over half of gross local authority spending on adult social care and two thirds of the primary care prescribing budget is spent on people over 65 years of age.

It is estimated that approximately 11% of over 65 year olds are frail, defined as having three or more symptoms from weight loss, self-reported exhaustion, low energy expenditure, slow gait speed and weak grip strength. About 42% of over 65 year olds have one or two of these symptoms and are categorised as pre-frail.

This equates to 2.51% (19,001 people) of the Devon population who are frail and 9.97% (75,546 people) who are pre-frail (graph 1 and table 1).

Graph: Estimated percentage of total population who are frail or pre-frail and aged 65 and over in Devon



This is significant for an ageing population and number of individuals who are 85+ in Devon and important for certain areas. As these estimates focus on older people over 65 years of age with either frailty or pre-frailty, it is important to note that these are likely to be underestimates, as a proportion of the under 65 year old population will meet the criteria for frailty and pre-frailty.

Table : Older People Frail Estimates: Devon (Devon County Council), 2013

Age Group	Reported Frailty Rate	Reported Pre-Frailty Rate	Population	Estimated Frailty	Estimated Pre-Frailty
65 and over	-	41.6%	181,600	19,001	75,546
65 to 69	4.0%	-	56,422	2,257	-
70 to 74	7.0%	-	40,334	2,823	-
75 to 79	9.0%	-	32,639	2,938	-
80 to 84	15.7%	-	25,408	3,989	-
85 and over	26.1%	-	26,797	6,994	-

The guidance set out in NHS England's *Safe, compassionate care for frail older people using an integrated care pathway* aims to transform the way frail older people experience health and social care. The recommendations contained within the document can be condensed into the following 4 principles:

1. Prevention is key – (BCF 001 and BCF 002)
2. Care decisions should be based on functionality, not age alone
3. Promotion of integrated and personal care
 - Shared decision making with older people (BCF007)
 - Person-centred care, not disease specific care (comprehensive geriatric assessment and personalised care plan) (BCF007)
 - Continuity of care (relational continuity) (BCF007)
 - Coordination of care (improved communication between and links across services) (BCF007, BCF005)
4. Improvements to the quality of care
 - Responsiveness (BCF003 – BCF005))
 - Safety (BCF006)
 - Compassionate services (BCF001)

Further details can be found in Appendix 3 the frailty paper. The submission has built on the national evidence base provided through BCF guidance and local performance monitoring and evidence reviews to build the areas that will have the most significant impact on avoidable admissions. Many of our BCF schemes involved specific identification and targeting of the frail elderly – including the Unplanned Admission DES and named care co-ordinator, and the South Devon Pioneer frailty service pilot in Newton Abbot.

Our model of care involves greater collaboration between patients, carers, voluntary sector, health and social care in community and acute settings to support older persons within Devon. The pathway of care will shift resource and expertise across the system rather than patients always having to attend an acute hospital for specialist treatment which is often a detrimental setting for their needs.

Our BCF plan is targeted at those who are at greatest risk of admission and frailty, the schemes then focus on prevention and maintenance to stop patients going into crisis; but if crisis occurs then providing quick and targeted support to get them back to independence. We will be learning from the work being undertaken under the Resilience plans and will roll forward any plans that are effective.

Risk 002: *There is a risk that there is insufficient time or resources to carry out a systematic review of the current s256 expenditure currently in place. Thus funds will not be released for investment in to other areas*

Mitigation *Action plan outlines the further work to be done on evaluation of current s256 schemes and the resilience schemes in the SRGs to inform the BCF on where to roll out further schemes and stop schemes that are not performing*

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Key milestones for BCF going forward:

This BCF plan details the progress to date on identifying the appropriate schemes to contribute towards the 3.5% reduction in emergency admissions and the other metric. We recognise that there is further work to be done, working with our partners, in particular providers in the next couple of months to:

- undertake further population segmentation and agree the most vulnerable cohort of patients and to focus our schemes on this group
- further evaluate the current schemes in BCF identifying how schemes interface and integrate into an overall system architecture and transformation– with a view to decommissioning those that are not effective and to scale up those which are successful
- to learn from the resilience work – with a view to continue the most effective schemes within the BCF from April 2015
- to build stronger links between the SRG and the BCF programme for ongoing monitoring of schemes and recommendations for future schemes

This is built into the action plan on next page.

Key Interdependencies

Challenged Health Economy – NHS Futures Programme

The Programme Director for the NHS Futures – transforming care in Plymouth and Devon - has recently joined NEW Devon CCG (15th September). He will lead on establishing the 9 streams of work to address this significant challenge as a matter of urgency, ensuring Senior representation across the health economy (the structure is outlined in Section 3a). The Urgent Care stream will be Chaired by a CEO from an Acute provider which will assist in securing buy in of providers in this transformation work which will support the further development and implementation of the BCF Integration work.

Transforming Community Services

A decision on procurement and integration of services will be November 2014 and will be a major delivery vehicle for this BCF plan.

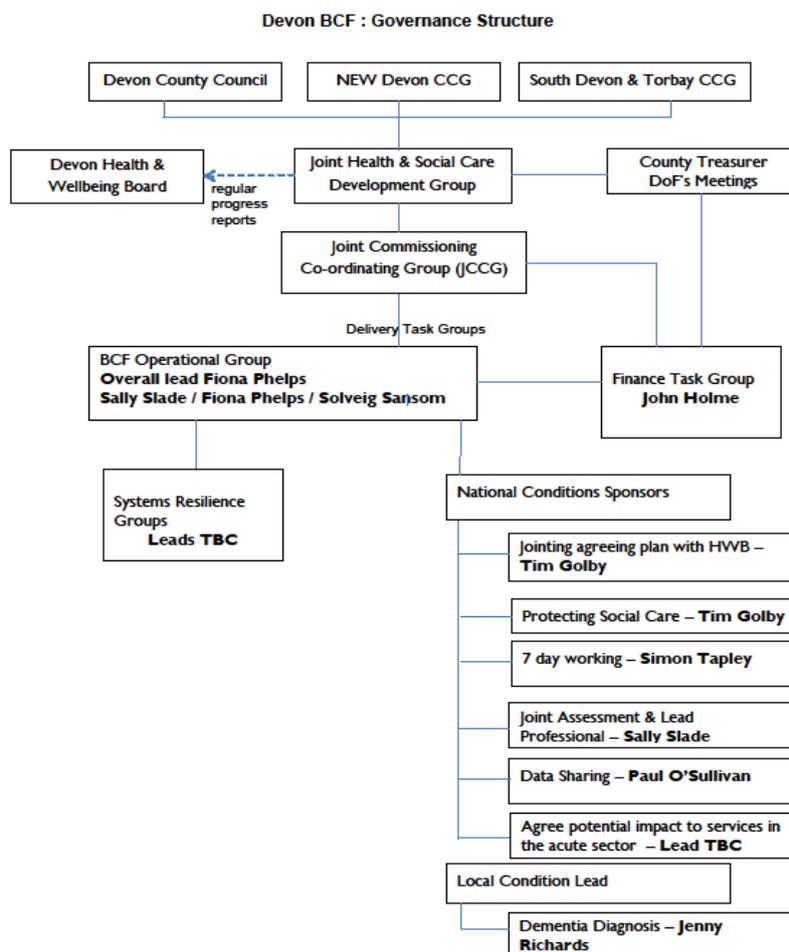
REF			Deadline	Lead
IMPLEMENTATION OF SCHEMES				
1	More refined identification of cohort of patients	Further segmentation of population – building upon the risk stratification and segmentation to date – cut by LTC and other criteria	30-Sep	DS, TH
2	Sharing of information/data further	Sharing and agreement of vulnerable cohort of patients with acute trusts as well as current sharing between CCT	Jan 15	JCCG
3	Agreement of up scaling or new initiatives	Based upon evaluation of current schemes, cohort of patients and evidence base - also including resilience plans	31-Oct	CH
4	Recruitment of permanent staff	Following outcome of approval process	Jan-15	Operational leads
5	Commence schemes	Up-scaled and continued schemes	Apr-15	Operational leads
PROJECT MANAGEMENT ARRANGEMENTS				
6	Develop project structure and project manager resource	Link with CHE programme and also SRGs	30-Sep	TG, ST and PO
POOLED FUNDING AGREEMENT SET UP				
7	Agree governance arrangements	Within Challenged Health Communities and wider integration programmes	31-Oct	JCCG, H&WB Development Group
8	Agree risk sharing arrangements	Build upon agreements within BCF plan for wider integration	31-Oct	Joint Commissioning Executives
9	75 Agreement	Agreed and signed by all partners	01-Dec	Joint Commissioning Executives
MONITORING AND MANAGING BCF PROGRAMME				
10	Clarity of roles of JCCG, Operational Group and SRGs	Build upon current arrangements in BCF and revise TOR	31-Oct	JCCG and CD
11	Expand membership of JCCG	To include Locality Commissioners and provide stronger link with SRG	30-Sep	TG, ST and PO

12	Monitoring impact of BCF and mitigating actions	Agree reports - building upon current monitoring reports to JCCG and link to operations to take mitigating actions	31-Oct	JCCG
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b) Please articulate the overarching governance arrangements for integrated care locally

We have created robust programme and finance governance arrangements for BCF and these are interim arrangements while the wider integration and pooled funding arrangements are developed as part of wider integration programme.

The new Operational Group and Finance Task Group have agreed Terms of Reference (Appendix 4a and 4b) These are to be reviewed in light of the establishing a strong connection with the SRGs as the BCF plan goes forward.



We know that we have work to do in order to deliver our aims and objectives around integration, to achieve our plans for the national conditions, and to improve outcomes for our patients so that people consistently receive joined up care. Working in a co-productive way between joint commissioners and providers, we have made good progress and have a strong platform on which to build.

As mentioned earlier in this plan we recognise the importance to link closer with the newly established SRGs across the area – this will lead to a new structure for BCF going forward with Operational Group membership of representatives from all four SRGs covered by Devon BCF to support collective system management between organisations and across boundaries.

In addition the JCCG is likely to develop into an overarching Integration Programme Board to ensure that the opportunity of the BCF as a catalyst for transformational change is maximised.

Risk 004: *There is a risk that without an early warning system possible missed targets will not be identified early enough to rectify the situation*

Mitigation: *Operational task group established and ToRs agreed and individual scheme monitoring at SRG level to be enhanced*

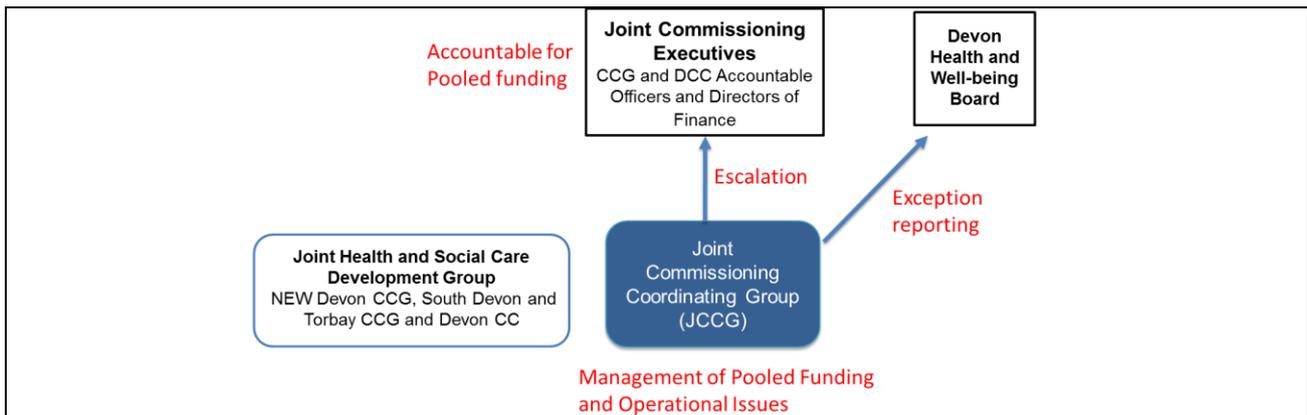
Risk 007: *There is a risk that a lack of a systematic approach to new investment will lead to inequalities in the service provided and lack of investment in the key areas of concern*

Mitigation: *Operational task group established. Per ToR they will recommend schemes but decisions rest with JCCG. Involvement of SRG to be built into membership of JCCG and Operational task group in future (see action plan)*

Risk 008: *There is a risk that contingency plans are not in sufficient detail to give the required corrective action*

Mitigation: *Operational task group established. Per ToR they will recommend schemes but decisions rest with JCCG. Involvement of SRG to be built into membership of JCCG and Operational task group in future (see action plan) and BCF monitoring built into SRG ToR*

c) Please provide details of the management and oversight of the delivery of the Better Care Fund plan, including management of any remedial actions should plans go off track



These are interim arrangements while the wider integration and pooled funding arrangements are developed as part of wider approach to integrated system leadership.

The establishment of Joint Commissioning Executives group to be accountable for the pooled funding has been agreed and this will delegate to the JCCG the management of the pooled funding on a day to day basis. In turn the Operational Group and SRGs will be

managing operational issues of the BCF plan.

As part of the ongoing BCF project work these arrangements will be further refined and expanded to include further integration and pooling of funding (See Action Plan)

d) List of planned BCF schemes

The detailed scheme descriptions (Annex 1) can be found in the attached Annex 1 file

Much of the planning around the BCF has focused on admission avoidance reduction of 3.5% - the schemes are linked to work streams related to differing parts of the urgent care pathway. We will review the impact and effectiveness of resilience schemes (detailed below) and enhance existing schemes or identify additional schemes in order to be confident that the 3.5% reduction will be realised as well as the other metrics being delivered. Further refinement will continue as part of the ongoing BCF plan up until implementation in April 2015 – see Section 4a for action plan.

Ref	Scheme Name	Description
Group A - Targeted Prevention and Maintenance		
Targeted prevention and maintenance is focused around the identification of the cohort of patients at greatest risk of hospital admission as well as those most vulnerable to the sequelae of hospital admission		
BCF001	Enhanced Carers Offer	Improving the skills of carers in the community to ensure preventable measures are taken and avoidable admissions to hospitals are reduced.
BCF002	Enhanced Community Equipment Service (CES)	CES will ensure that individuals have the equipment and telecare services that they require to support themselves to live at home and to maintain as much independence as possible.
Group B - Support When Crisis Occur		
Focused on providing the best support wherever possible when crises occur. Where the underlying diagnosis is clear, this will require community health and social care infrastructure to be sufficiently resourced to support community management. For those individuals where concerns exist regarding an underlying life-threatening diagnosis, urgent assessment and resource is required to make or rule out this diagnosis, thereafter informing the subsequent management plan.		
BCF003	SWAFST Right Care	Callers to 999 receive assessment, advice and treatment proportionate to their need but with the specific aim of treating the patient in their own home or as close as possible to their own home rather than take them to the Emergency Department
BCF004	Rapid Response Domiciliary Care	Rapid Response is a service that provides support at home to clients who are undergoing acute medical crisis and/or sudden carer breakdown.
BCF005	Single point of coordination	The service aims to provide a multi-professional single point of coordination for health professionals which allow access to a range of community services via one contact number – building upon the social care single point of access.
BCF006	Step Up Step Down Care	Step up and step down care provides support for individuals who require extra support to avoid hospital admission or require short-term residential care placements following discharge to enable a period of recovery prior to returning home.

Group C – Recovery and Independence

The Group C schemes reflect our commitment to developing community services to ensure that individuals experience enabled recovery allowing them to regain independence, duplication is reduced through single points of access, assessment and potentially intervention, and improvements are made in transfers of responsibility of care.

BCF007	Frailty and Community Care	Community services will focus on patients most at risk, integrating and linking up health, social care and voluntary providers and teams to support through improving patient preventative and rehabilitation pathways, and thereby reducing hospital stays by number and length of stay. Multidisciplinary Complex Care Teams will focus on case finding, case management and sharing of data to provide comprehensive care to patients
BCF008	Social Care Reablement	Reablement is focussed on strengthening and improving key aspects of community intervention, namely admission avoidance, through home therapy and timely discharge from hospital setting.

Learning from Resilience Schemes for future BCF investment

The following schemes are in our Resilience plans (subject to approval):

- Extension of Psychiatric liaison to support A&E departments in managing patients with Mental Health issues who present (targeted prevention and maintenance)
- Additional Step up and Step down beds to increase independent short notice capacity – (BCF006)
- Addition Nursing Home places to increase reablement places (BCF008)
- Increase capacity in Rapid Response (BCF004)
- Enhanced clinical streaming by in 111 by Devon Doctors (targeted prevention and maintenance)
- Increasing 7 days therapies to allow assessment by OT over weekend

These schemes will commence in December 2014 and evaluation will occur in early 2015 to inform where BCF investment should be targeted further.

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

The following risks are the highest risks on our overall BCF risk register – we will be allocating leads and timeframe to each risk at our next JCCG and SRG meeting. However they will dovetail with the leads/deadlines within the Action Plan in Section 4 a) where appropriate

Ref	There is a risk that:	Likelihood	Potential impact	Overall risk factor <i>(likelihood *potential impact)</i>	Mitigating Actions
001	There is a risk that there will not be significant buy in from the acute, community and other providers to facilitate reductions in their budgets and to share the risk	3	5	15	Discussion underway at high level between CCG and Trusts as well as more detailed scrutiny of schemes via SRGs
002	There is a risk that there is insufficient time or resources to carry out a systematic review of the current s256 expenditure currently in place. Thus funds will not be released for investment in to other areas.	3	5	15	Action plan outlines the further work to be done on evaluation of current s256 schemes and the resilience schemes in the SRGs to inform the BCF on where to roll out further schemes and stop schemes that are not performing
003	There is a risk that services will not be redesigned in the round and will therefore not address the key aspects of BCF namely: Protection for social services Providing 7 day services to support patients on discharge and prevent avoidable admissions at the weekends Improve data sharing between health and social care Ensuring a joined up approach to assessments and care planning Agreement on the potential impact of changes to services on the acute sector Local target - dementia	3	4	12	BCF operations group and JCCG are designed to enable commissioners to work together on common objectives. Further work to join up SRG and BCF operations group is in train and within action plan

Ref	There is a risk that:	Likelihood	Potential impact	Overall risk factor <i>(likelihood *potential impact)</i>	Mitigating Actions
004	There is a risk that without an early warning system possible missed targets will not be identified early enough to rectify the situation	3	5	15	Operational task group established and ToRs agreed and individual scheme monitoring at SRG level to be enhanced
005	SRGs are still embryonic at this time but much of the work of the BCF rests with these groups.	4	3	12	SRG recognise role within BCF and ongoing project structure being developed to strengthen this – see action plan
006	Contracts with providers will not reflect the anticipated level of savings associated with the 3.5% emergency admission target	3	4	12	Greater involvement of providers in future evaluation and joint decisions around schemes in action plan via SRGs and Operational Group agreed
007	There is a risk that a lack of a systematic approach to new investment will lead to inequalities in the service provided and lack of investment in the key areas of concern.	3	3	9	Operational task group established. Per ToR they will recommend schemes but decisions rest with JCCG. Involvement of SRG to be built into membership of JCCG and Operational task group in future (see action plan)
008	There is a risk that contingency plans are not in sufficient detail to give the required corrective action	3	3	9	Operational task group established. Per ToR they will recommend schemes but decisions rest with JCCG. Involvement of SRG to be built into membership of JCCG and Operational task group in future (see action plan) and BCF monitoring built into SRG ToR
009	That the risk share for the pooled funding is not agreed between all parties	3	5	15	Executives of all Organisations have met to agree to work through the issues over next month with scoping of risk across schemes to agree a Section 75

Ref	There is a risk that:	Likelihood	Potential impact	Overall risk factor (likelihood *potential impact)	Mitigating Actions
010	Work on implementing 7 day services is piecemeal and not part of a coherent overall strategy. Risk that local pilots will be repeated or information not shared.	3	5	15	Progress discussed at BCF Ops group and link with SRGs
011	The pace and extent of bureaucracy of the BCF process drains valuable time and is distracting effort from implementing the BCF	3	3	9	Additional resource obtained for completion of the submission and additional finance resource obtained plus external support
012	The delay in getting the NHS number as currently on batch process - once a week/month with an inherit time lag for Social Services to get the NHS number which reduces sharing of information	3	3	9	We are moving to a batch process that is more swift and regular to mitigate this risk.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The HWBB has been consulted on this plan of action at their meeting on 11 September and that they are aware of next steps

The risk share agreement is split in to two elements.

- a) The payment for performance and
- b) the overall under or over spend of the fund.

The under / over spend will be managed on a 'bottom line' basis to maintain flexibility within the fund recognising the geographical constraints of two CCGs inputting in to the same BCF. This allows a system wide view to be adopted on the effectiveness of the fund.

Providers are an essential part of the risk share agreement as this places the incentives with the people delivering the schemes. The multiple acute trusts in the Devon LA footprint add a layer of complexity in agreeing the risk share. Discussions are ongoing between the CCGs, Local Authority and the multiple providers regarding exact percentages of risk borne by each party. The HWB are being kept informed of the on-going discussions.

Once finalised these percentages will be built in to the contracts with each party and

payments / charges will be made accordingly.
Performance fund

The SRGs are involved in discussions on how to reduce the emergency admissions and designing schemes to achieve the 3.5% reduction. Funds at risk have been calculated from the 3.5% reduction in emergency admissions multiplied by the average national cost to give a performance fund of £4,114k.

The performance element of the fund will be used to expand existing successful services to avoid admissions and deal with crises that would otherwise result in admissions, chiefly through intermediate care, rapid response and reablement.

If the target is not achieved this will result in increased costs for the two CCGs. The risk is limited by the fact that the performance fund will be used to expand the existing services and that the performance fund is set at full cost of the admission whereas the CCG only pay 30% for A&E attendance.

If the planned reduction in admissions does not materialise then the expansion of these services will be scaled back or delayed to allow for the cost of admissions over plan. Therefore under performance in admission avoidance will not impact on services already being delivered.

Invoices for services are received quarterly so payment will not be required until we can confirm that the planned admissions reduction has been achieved. Performance reports show trend analysis to provide advance warning of any deterioration in the admissions targets prior to final figures being available. This will provide the opportunity to prevent incurring the costs prior to failing the admissions avoidance target.

Next steps

We recognise that the following next steps need to be completed

- 1) Finalise the exact split of the risk share for overspend of funds.
Work has commenced establishing the risk exposures for each organisation, by individual scheme, to allow the split of risk in overspend to be apportioned.
- 2) Draft and sign the risk share agreement, including consultation with the HWB.

Risk 009: *That the risk share for the pooled funding is not agreed between all parties*

Mitigation: *Senior Executives of all Organisations have met to agree to work through the issues over next month with scoping of risk across schemes to agree a Section 75 agreement.*

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

NEW Devon CCG

The following are the programmes, strategies and projects to which the BCF work programme aligns. They have been more fully described elsewhere in the document and so are not repeated here.

- Health and Wellbeing Strategy (which includes housing and wider determinants of

health and well-being)

- Integration – ICE in Exeter and SD&T Integrated Care Organisation
- NEW Devon CCG - NHS Futures - transforming care in Devon and Plymouth
- Transforming Community Services Strategy
- Transforming Primary Care (see section 6c)

Implementation of personal budgets

A priority for the CCGs is to transform services and ensure that the population we serve has equitable access to high quality, sustainable services that promote health and wellbeing. The organisation therefore intends to design services that can be delivered when, where, and how people choose. Promoting and commissioning person-centred care through the implementation of personal health budgets will enable the CCGs to deliver personalised care packages with choice and flexibility enabling people with long-term conditions to live more independently.

Personal Health Budgets (PHBs) present an opportunity to pool health and social care budgets and reduce overall system costs through smarter commissioning.

Our ambition for personal health budgets is to use the concept as a spring board to foster person-centred care and deliver care in a more integrated and personal way with social care partners. PHBs will enable patients to have greater choice and control over the services commissioned to meet their health needs. Implementation will help us to support this BCF Plan by supporting the ***Prevention and Maintenance and Enhancing Recovery*** of patients by helping people with long-term conditions in Devon to live more independently, staying in their own communities and remaining in their own homes for longer by reducing the need for emergency admissions.

Progress to date

We have already begun the process of joint commissioning, for example, we have a jointly commissioned Direct Payment Support Service for Devon, which is provided by DCC's in-house direct payment support team. The CCG has an SLA with DCC so that health clients can access this service. This is still a joint service, serving both health and social care clients. This means that budget holders will experience little or no disruption to the service they receive if the source of their funding changes. The benefits of our NHS Personal Health Budget scheme (PHB), can best be demonstrated by Marilyn who was able to choose her own carers and have the care she wants when she needs it most. Her health improved so much she was able to go on a short break – for the first time in 10 years.

PHBs give people greater freedom to buy services and other items which help them achieve their desired health outcomes and stay independent.

Marilyn said: *“My life has changed immensely. It’s hard to describe. The stress has moved from my shoulders. I’m no longer a patient, I’m a person.”*

Our intention is to build upon this success and commission services in a number of areas to support the roll out of personal health budgets.

System Impact / benefits

We know that 70% of the NHS's £110bn budget – £77bn – is spent on patients with long-term conditions. Improvements in the care for these patients would produce significant

savings across the system (for example, in reduced A&E attendances, shorter stays in hospital and reduced GP visits). Evidence from the personal health budget evaluation showed that personal health budgets had a significant positive impact on both the care-related quality of life and psychological wellbeing of budget holders. In terms of costs, the evaluation of personal health budgets found that inpatient, Accident & Emergency and GP costs were lower for the personal health budget group compared with the control group.

Implementation

In order to prevent the duplication of services as personal health budgets are implemented, the CCG will need to decommission those services not chosen by budget holders. This must be done at a pace that allows providers to adapt, otherwise there is a risk that the market will shrink, leaving individuals with fewer choices. To date it has been possible to introduce personal health budgets and run existing systems side by side as the double running costs that have been incurred, have not been significant. However, the extension of personal health budgets to other long-term conditions presents a tougher challenge, particularly in community services where block contracts are often still the norm. In tackling this issue, there is a range of transition strategies that we will need to explore, for example:

- Taking a phased approach, keeping the total contract value with a provider the same but introducing a percentage of the contract that must be delivered as personal health budgets. This percentage can increase year-on-year to allow providers to unbundle their services and develop unit costs over time.
- Use of Quality and Innovation (CQUIN) payment framework as a tool to stimulate changes towards personal health budgets

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

We can confirm that the schemes described in this BCF plan are included in both NEW Devon and SD&T CCGs' 2 year operation plans and 5 year strategic plans as demonstrated through-out this submission. The BCF is a key means of delivery and catalyst for more integration which is a key strand within both NEW Devon and SD&T CCG's 2 year operational plans and 5 year strategic plans. There are no discrepancies or risks identified of any non-alignment.

The programme management office that is overseeing the 2 year operational plan and the challenged health economy (NEW Devon CCG 5 year strategic plan) outlined above will have oversight of the Plymouth and Devon BCF plans which are a key catalyst for transformation of the health and social care system

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

NEW Devon CCG covers a large geographical area which is sub divided into three localities. As a general principle the CCG engages with its member practices and clinical commissioners at the locality level. Commissioning responsibility is devolved to locality (or sub locality) level to ensure that services commissioned are appropriate for local factors such as patient demographics, local priorities and geography. There are regular primary care forums – including member practices and as primary care providers in each locality where the TCS and BCF plan have been shared.

NEW Devon CCG has devolved the responsibility for commissioning and service redesign to locality level, in order to maximise the benefits from greater responsibility around co-commissioning of primary care services it is important to replicate the engagement in commissioning and redesign happening at locality level.

The priorities for the BCF are very similar to the CCG 5 year Strategic plan so it is imperative that there is a joined up approach to ensure maximum benefit for the population.

As outlined above NEW Devon CCG has devolved commissioning responsibility, where appropriate, to locality level. If co-commissioning of primary care does not proceed then NEW Devon CCG would still utilise its locality focus to engage with member practices on all issues relating to the commissioning of services, including BCF and the transformation of primary care.

There is a greater risk if we do not involve primary care in taking forward the BCF. As part of the 5 Year Strategic plan NEW Devon CCG has identified the development of 'at scale' General Practice' with registered lists as the organising unit of care as one of the key developments to enable the CCG to meet its 5-year strategic priorities.

This can be further broken down into the following areas; Co-commissioning of at scale general practice creating access for patients 8-8, 7-days a week, General practice becoming the central point of integrated and personal health and social care services, development of wider primary care including core role of pharmacy.

It is important that primary care be involved in taking forward the BCF to ensure that we can stimulate and facilitate the development of new models for the delivery of primary services e.g. BCF, Urgent care agenda, PMS reviews, Long Term Conditions agenda, PM challenge fund, enhanced services, local health needs.

South Devon

Our plans for primary care co-commissioning are structured around seeking a high degree of delegation to CCG. This will maximise the opportunities available to us in seeking to contract with primary care providers in a manner which means entire patient pathways are available as defined within our commissioning intentions.

In saying this we are mindful that provision of complementary and robust pathways within primary and community settings maximises the likelihood of delivering patient tailored care. Such care will be delivered within or close to the patients usual place of residence, and where possible on a proactive basis, decreasing the likelihood of providing reactive

care with default approaches leading to higher than necessary admission rates.

This is an aspiration articulated within our commissioning intentions and which therefore is core to both our plans for primary care as well as BCF.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

The vision in Devon is that people will live in supportive and inclusive communities and their physical, mental and emotional wellbeing is promoted. When circumstances make people vulnerable, they will be protected from abuse and neglect and have the maximum opportunity to regain their independence and to participate in community life. People in Devon, wherever they live, will experience good quality care and support which puts them in control and responds to their personal needs and circumstances; it is all this that we must protect. Our vision, values and priorities are stated in our [vision document](#).

Our current arrangements for accessing social care support and our current eligibility and checklist are available in Appendix 4

This invites individuals to look for alternative methods of support before contacting the local authority for a social care assessment – a key part of our demand management strategy is community capacity, resilience and support. Our community directory offers suggestions and alternative options for individuals and their carers to consider before requesting a social care assessment. For those still requiring an assessment of need our current eligibility is set at critical and substantial with descriptors available on-line in our eligibility criteria checklist. In line with the Care Act requirements we will be refreshing our criteria following finalisation of national guidance.

We are committed to retaining our current eligibility threshold for care in Devon and this is the basis of our local definition of “protecting social care”. To evidence this we consider:

- Anticipated future demand based on known demographic changes including other known legislative or statutory requirements – we model expected costs and build those into our service and financial planning cycles.
- We consider and benchmark our current profile of spend (including unit costs) and activity and drive major service change to address areas of high cost or poor performance. An example is the authority has recently decided to cease to be a provider of residential care where unit costs were significantly higher than the independent sector. The resultant saving is contributing to the protection of social care by ensuring eligibility criteria are sustained at the current levels.

The County Council budget has significantly reduced over the last four years and social

care has made contributions to that whilst mounting current levels of eligibility for support. The authority is looking towards demand management strategies across all areas and supporting communities to help themselves – leaving statutory services to focus on more targeted groups. There are significant investments in preventative services both at a universal and more targeted level. Specifically voluntary sector representatives are integrated within our multi-disciplinary community complex care teams targeting known individuals at risk of crisis. This is a key part of our whole systems risk stratification and demand management approach.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Devon is a good performer both nationally and against our comparator authorities on a range of outcomes. Good performance areas include the rate of people in and entering residential/nursing care, proportion of carers receiving services, we also continue to perform well in the number of people receiving personal budgets.

Good performance in Devon has not been brought about by a change in eligibility thresholds but by strong, rational and measured decision making to refocus the social care provision of Devon. This has been demonstrated by our disinvestment in high cost services such as our in-house residential homes and a move towards a more personalised approach that enables people to have more choice and control in how they use and access services to meet their desired outcomes. Not only is this bringing better outcomes to those receiving services, but greater value has been realised in terms of a gaining a more efficient unit price for the cost of care.

Funding will be allocated to ensure the current level of eligibility criteria is maintained to meet increased demand and the increasing complexity of needs.

Our schemes will focus on:

- **Targeting Prevention and Maintenance**

Building and sustaining community resilience with targeted investment at high risk groups alongside a broadened risk stratification group.

- **Support When Crisis Occur**

Responding promptly but also linking with independent sector providers to provide immediate, safe and effective services. Rapid response services are key in this area.

- **Recovery and Independence**

Improved weekend/out of hours' arrangements and inclusion of independent sector providers. A re-commissioning of personal care will take place in 2015 with a focus in this area.

Our community assessment teams are key to effective demand management and investments to secure and increase capacity in targeted areas are within the schemes.

Risk: *There is a risk that services will not be redesigned in the round and will therefore not address the key aspects of BCF namely:*

- *Protection for social services*

Mitigation: BCF operations group and JCCG are designed to enable commissioners to work together on common objectives. Further work to join up SRG and BCF operations group is in train and within action plan

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

- 1) £10m (£8m relating to NEW Devon geographic area) of additional funding to support the protection of adult social care services commissioned by the council
- 2) £4.2M (£3.4M relating to NEW Devon geographic area) funding from the existing S256 allocation
- 3) £2m (£1.6M relating to NEW Devon geographic area) of funding to support the implementation of the Care Act.

This will form part of the Devon Better Care Fund pooled budget for 2015/16 and deployment of the funds will be subject to ongoing review with health and social care commissioners and NHS provider organisations across the Devon County Council footprint area. A financial risk share agreement between all partners will be developed in advance of establishing the pooled fund.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The Care Act will impact on the future landscape of adult social care and the delivery of integrated and personalised services. A Programme Board has been established with senior local authority and NHS representation to coordinate activity and manage risk. It has 8 work streams:-

- (1) Operational Delivery - Increasing assessment capacity to meet expected demands.
- (2) Supporting Carers - Increasing the capacity and strengthening the service offer to carers.
- (3) Enhanced markets - Market management to secure high quality, sustainable and diverse markets.
- (4) Prevention - Community capacity building and developing community resilience.
- (5) Care accounts and charging - Developing care accounts.
- (6) Financial Planning - Understanding financial implications of Dilnott changes
- (7) Communications, engagement and information - Strengthening our advice and information offer.
- (8) IT systems - Having IT systems capable of supporting new requirements.

The focus of the programme is to ensure that Devon is statutorily compliant for new duties from April 2015 and for the financial elements in April 2016.

The prevention work stream is key to the universal offer to Devon residents and is expected to be an enabler mitigation of future demands. It links to the prevention and maintenance schemes in the BCF.

v) Please specify the level of resource that will be dedicated to carer-specific support

Devon already has a pooled carer's budget (current S75 agreement is attached as Appendix 5) and this will be developed further to support the requirements of the Care Act.

Our refreshed [strategy for carers](#) builds on the national strategy and the requirements of the Care Act 2014 has four primary outcomes:

1. Supporting those with caring responsibilities to identify themselves as Carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages.
2. Enabling those with caring responsibilities to fulfil their educational and employment potential.
3. Personalised support both for Carers and those they support, enabling them to have a family and community life.
4. Supporting Carers to remain mentally and physically well.

The existing support to carers is £3.524m (DCC £1.994m. NEW Devon CCG £1.243m, South Devon and Torbay CCG £0.287m) which will be within the pool. We are expecting to invest more than the £0.737m pro-rata Department of Health allocation arising from the Care Act to this for 2015/16.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

Given the agreement of funds outlined in iii) there is no expected adverse impact on the local authority budget compared to the original BCF plan.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

We consider that seven day services are a key driver of quality and we are committed to providing seven-day health and social care services, with the optimal pathway of care available for the patient regardless of the day of the week. We are committed to providing seven-day health and social care services, supporting patients being discharged and preventing unnecessary admissions at weekends (BCF007)

There are already a number of 7 days services across the NEW Devon CCG localities and South Devon (SD&T CCG) which are outlined in Appendix 6

We recognise that not all services are necessary to be delivered seven days a week, and we have pilots underway to help inform which additional services would be needed both to meet the needs of the population and to facilitate flow through the whole health and care system seven days a week. Early findings have evidenced the value of therapy staff working in community hospitals at weekends, and shift patterns are being examined to see how best to achieve this – this is being tested as part of the resilience plans.

These pilots will ensure we will see a continued roll out of six/seven day provision across key services, as informed by those pilots and through on-going evaluation, with fully joined-up services across the health and care system providing continuity of care and support seven days a week.

People with urgent but non-life threatening needs will be provided with highly responsive, effective and personalised services, outside of hospital wherever possible. These services will wherever possible be configured to deliver care on a consistent seven day a week basis as close to people's homes as possible, thereby minimising disruption and inconvenience for patients and their families.

Our plans include working towards fully joined up 7 day provision of which Primary Care is identified as being a key element. Key to delivering this will be continuing the work which is underway to develop General Practice Federations so that care will be able to be provided to a population rather than to the registered Practice list. This will enable a federation of Practices to work together to provide different care models, including extension of existing services into periods of the week during which access to General Practice is currently restricted. As part of this collaborative approach we will be seeking to optimise the current workforce capacity by continuing our pursuit of technology based solutions that complement traditional face to face consultations, so that not only is access extended in terms of timings but also in terms of styles. To allow federated working and also improve quality of patient interactions with other health and social care providers we are working to extend the ability to share patient records (where consent to do so exists) across providers, thus delivering better informed consultations and improved outcomes.

Next steps Our intention is to improve the provision for 7 day/week social care assessment for those priority areas to enable patients to be discharged over the weekend. This will be by extending Care direct plus working hours and also to enhance

community staff capacity to enable 7 day response from social care to admissions avoidance and hospital discharge activity. The majority of commissioned social care providers already provide services across a 7 day period but the ability to commence services will be reviewed and addressed where they may be gaps (e.g. personal care).

The need to deliver services 7 days a week has been picked up in the SDIPs and our CQUINs with each of our health providers. During 2014/15, we will continue to monitor performance against both of these documents through our Integrated Provider Assurance Meetings, held monthly with our providers. As part of our planning and contracting process for 2015/16/17 we will expect our providers to continue to roll out 7 day services on an incremental, needs based process – with the highest priority areas to move into the standard contract in 15/16 and then all clinical standards in 2016/17.

Both CCGs 2 year operational plan describe the ambition to develop primary care at scale as previously described in alignment section – will allow primary care to offer services 7 days per week with General practice becoming the central point of integrated health and social care services, development of wider primary care including core role of pharmacy

Risk 003: *There is a risk that services will not be redesigned in the round and will therefore not address the key aspects of BCF namely:*

- Providing 7 day services to support patients on discharge and prevent avoidable admissions at the weekends

Mitigation: *BCF operations group and JCCG are designed to enable commissioners to work together on common objectives. Further work to join up SRG and BCF operations group is in train and within action plan*

Risk 010: *Work on implementing 7 day services is piecemeal and not part of a coherent overall strategy. Risk that local pilots will be repeated or information not shared*

Mitigation: *Progress discussed at BCF Operations group and link with SRGs*

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

The NHS number is used as the primary identifier for correspondence across all health and care services. We are working with the HSCIC Demographics Batch Service, and recognise that HSCIC are in the process of changing the National system over (which our systems connect to). They are installing a new system from the 26th August. We have been through the application process, set up our servers and systems and are waiting for them to provide installation codes in preparation for the new service. We have the go ahead to include NHS numbers on all our printed documentation e.g. My Assessment, My Plan so these changes will be made.

We are working towards having shared information at the beginning of the patient journey rather than after their care has been completed. By enabling cross access to information, this will support the integration of services, resulting in reduced duplication and increased transparency.

Risk 012: *There is a risk of delay in getting the NHS number as currently on batch process - once a week/month with an inherit time lag for Social Services to get the NHS number*

Mitigation: *We are moving to a batch process that is more swift and regular to mitigate this risk.*

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Devon County Council currently use Carefirst 6 as their client record system to provide a range of services to social care clients, while allowing the involvement of health care partners.

There are no further elements of work to ensure this is business as usual as is already embedded in Social Services as business as usual. There are no identified risks relating to using Open APIs and Open Standards.

We are committed to adopting systems that are based on Open APIs and Open Standards where it is appropriate and necessary for them to be so. All solutions requiring interoperability are procured as such and will contain contractual references to ensure compliance with the necessary standards. Carefirst 6 have confirmed that they meeting Open API and Open Standards We have assured ourselves in our discussions with the supplier that within the scope of our BCF plan that systems will be provide interfaces that are accessible to those that need to use them; that all significant business functionality provided by the host system should be available and their commitment to publish and document their interfaces

We are also exploring other ways of sharing data in a safe way. In North Devon we have run a pilot of the Medical Interoperability Gateway (MIG) which allows information to flow between the majority of GP practices, Devon Doctors (out of hours service) and social care systems. The concept of MIG is to allow any healthcare professional access to live data through their own system, to enable better care through more informed decisions.

The MIG was set up in North Devon as a 'Test of Change Pilot', specifically to determine the impact that improved access to patient information would have in improving patient care. It was focused on one group of patients, those suffering from COPD and the MIG is most closely associated with the CREADO team, as it was seen as a means of creating a COPD patient medical record that could be shared across providers. Whilst the MIG is not a perfect solution with compatibility issues between systems e.g. community information systems and some primary care systems it does offer an interoperability that has not previously been available.

South Devon

The GP clinical systems we use are ITK compliant and any future systems will be to link in. NHS mail is used for email correspondence within the NHS including CCG staff and and GCSX is used by Devon County Council for secure email. We also ensure that our 3rd sector partners use secure email when exchanging emails with PID.

CCG staff work with data held on a secure drive (hosted by South Devon Health

Informatics Service) with role-based access granted for each of the work area folders – e.g. staff working in Finance cannot see the Safeguarding data.

All solutions requiring interoperability are procured as such and will contain contractual references to ensure compliance with the necessary standards.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practice and in particular requirements set out in Caldicott 2.

Currently we have the entire infrastructure to potentially share information but have not commenced sharing any patient information between and health and social care. There is work underway being led by NEW Devon CCG to formulate and agree a NEW Devon IMT Strategic Vision Statement and as part of the implementation of this the detail of IG arrangements and protocols will be agreed.

We are fully committed to ensuring that the appropriate IG controls are in place. Further detail of the current state by organisation is included below:

SD&T CCG

The CCG enters into service agreements using the NHS Standard Contract. In the event that this is found to be lacking in IG / Confidentiality requirements, an additional bespoke clause will be inserted for signature by the contracted party.

The CCG enters into data sharing agreements to ensure the secure and legal processing of personal data.

The CCG published its IG Toolkit (version 11) on 30 September 2013 at level 2 for all requirements. The supporting evidence has been audited by Audit South West and also by the HSCIC. The CCG has been granted Accredited Safe Haven (ASH) status in order to process personal data for specified purposes; this has been authorised by the Secretary of State and agreed by the Confidentiality Advisory Group (CAG) who ensure that the Caldicott2 guidelines are adhered to. The CCG delivers face-to-face Information Governance training for all staff, which includes the Caldicott2 guidelines.

NEW Devon CCG

NHS NEW Devon CCG complies with the NHS Standard Contract Requirements. We are Level 2 compliant with our IG Toolkit with HSCIC, and are on the HSCIC Register of [Stage One Accredited Safe Havens](#).

The CCG enters into service agreements using the NHS Standard Contract. In the event that this is found to be lacking in IG / Confidentiality requirements, an additional bespoke clause will be inserted for signature by the contracted party.

The CCG enters into data sharing agreements to ensure the secure and legal processing of personal data. NHS NEW Devon CCG is actively working with its GP practice members and providers to ensure that existing information sharing agreements are

robust and fit for purpose and that under Caldicott guidelines we have a justified and legitimate reason for sharing information which is mapped across the organisation.

NEW Devon CCG ASH status was approved by NHSE and a contract and information sharing agreement for these approved purposes is held between the CCG and HSCIC – for all accredited organisations this is due for review in October 2014, but it is understood that a national agreement of an extension until January 2015 will be granted by the CAG – this is to accommodate further work being undertaken by NHSE to formally assign Level 2 ASH status to approved organisations across the Country. NHS NEW Devon CCG is actively preparing and gathering information to support its submission to NHSE as a Level 2 ASH in line with NHSE requirements

For more information see Appendix 8 – NEW Devon’s CCG IM&T Strategic Vision Statement for Service Transformation 2014/15 -2017/18

DCC

Appropriate clauses on IG compliance and requirements have been inserted into contracts and agreements with contracted organisations We comply with standard contract clauses as required by the IG Toolkit return. We are progressing work on the relevant recommendations identified in Caldicott 2.

Risk 003: *There is a risk that services will not be redesigned in the round and will therefore not address the key aspects of BCF namely:*

- *Improve data sharing between health and social care*

Mitigation: *BCF operations group and JCCG are designed to enable commissioners to work together on common objectives. Further work to join up SRG and BCF operations group is in train and within action plan*

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

We have outlined in the Case for Change Section (3) the segment of our population of highest risk of hospital admission as well as an explanation of the approach used to identify this group. This section adds further detail to the process we have adopted and our ambitions to build upon this in the future.

Devon has a model of integrated health and social care teams built around geographical clusters and primary care practices. These teams provide three core functions to enable:

- Proactive identification of people at risk and admission to hospital or inappropriate care settings, including those people with dementia or mental health issues.
- Integrated and assessment and personalised support planning for people with long-term conditions and/or complex care needs.
- Urgent reactive care to people in crisis to avoid immediate risk of admission.

These teams work in partnership with primary care and include representation from the voluntary and community sector.

DCC, NEW Devon CCG and SD&T CCG have a strong track record of proactively

seeking to identify those patients at risk of hospital admission, and working jointly to reduce this risk through an integrated and personal approach. This has been supported through a 'Locally Enhanced Service' initiative to incentivise input from Primary Care. There is a willingness to build upon the successes of this project to widen the scope and scale and meet the expectation of the 'accountable GP' initiative, as set out within 'Everyone Counts; Planning for Patients 2014/15 to 2018/19'.

NEW Devon CCG and SD&T CCG employs the Devon Predictive Model to risk stratify the patient population according to their risk of emergency admission(s) to hospital in the following 12 months. This information is used by GP Practices and by complex care teams to identify those patients who would benefit most from individual case management support for the purpose of preventing these predicted emergency admissions.

Here is a table from the King's Fund that lays out the recommended strategy for each strata of risk:

Relative Risk	% of Patient Population	Emergency Admissions	Outpatient Attendance	A&E Attendance	Interventions
Very High Relative Risk	0.5%	18.6 x average	5.8 x average	8.5 x average	Case Management
High Relative Risk	0.6% - 5%	5.5 x average	3.8 x average	2.9 x average	Disease Management
Moderate Relative Risk	6% - 20%	1.7 x average	1.9 x average	1.4 x average	Supported Self Care
Low Relative Risk	21% - 100%	0.5 x average	0.6 x average	0.8 x average	Prevention & Promotion

We use the Devon Predictive Model to identify patients at risk of hospital admission in the next 12 months. The top 0.5% of our population is then pro-actively case-managed on our monthly community virtual wards. The virtual ward teams use the predictive tool to objectively identify patients who are then pro-actively and holistically case-managed by a multi-disciplinary team, including primary care, community and rehab teams, palliative care, mental health, social care and the voluntary sector. Each patient is allocated a named case-manager who then co-ordinates their care and support. We have built on this highly-successful model to incorporate the features of the Unplanned Admissions Enhanced Service for primary care for 2014/15, with 2% of our population then being proactively case-managed.

Further Population Segmentation

Further population segmentation is being developed in Devon and a Long Term Conditions (LTC) Health Needs Assessment is underway which will consider the impact of LTC's and multi-morbidity this will assist with further development of the prevention and targeted LTC work reflecting the needs of the older population and the younger population.

Next steps

The introduction of the Unplanned Admissions Directly Enhanced Service for primary care in 2014/15 has built upon this work with 2% of practice population being identified within practices. Sharing of this information wider with other agencies differs across and this is an area of focus as BCF goes forward. Discussions at the SRGs on how to share the identified vulnerable patients by different sections of the patient pathway are being highlighting the need to triangulate this information to identify an agreed list of most vulnerable patients. The work to agree this will be done within the SRGs in collaboration with all providers.

We are also working on the integration of single point of co-ordination, building on the current cost efficient delivery model and on successful piloting in South to provide co-ordinated access, assessment, co-ordinated care planning for vulnerable individuals across health and social care.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

South Devon

As described above, we already have monthly community virtual ward meetings – multi-agency meetings to discuss the list of patients at risk of admission, as risk-stratified by the Devon Predictive Model. The model is evidence-based and combines data from both primary and secondary care, and has been in use for four years. Up until April 2014, this process covered 0.5% of our patient population, with each of those allocated a case manager / lead professional as appropriate, with multi-disciplinary input from the rest of the team as required.

For 2014/15, NHS England have developed a new enhanced service for primary care which builds on the virtual wards and risk stratification already in place in Torbay. All of our GP practices have signed up to this new service, which will see the number of patients proactively case-managed and with their own care co-ordinator rise to 2% of the population.

NEW Devon

Practices have all signed up to the new enhanced service for primary care and this information is shared across the multi-disciplinary Complex Care Teams to focus their activities – the next steps are to share this with acute providers and to triangulate the different risk stratification and segmentation information to have a combined agreed cohort of patients. Again this covers 2% of patients.

Next steps will be to explore greater integration of single point of co-ordination building on Care Direct Plus model and on successful piloting in Southern to provide co-ordinated access, assessment, co-ordinated care planning for vulnerable individuals (adults) across health and social care based on existing cost efficient delivery model.

Risk 003: *There is a risk that services will not be redesigned in the round and will therefore not address the key aspects of BCF namely:*

- Ensuring a joined up approach to assessments and care planning

Mitigation: *BCF operations group and JCCG are designed to enable commissioners to work together on common objectives. Further work to join up SRG and BCF operations*

group is in train and within action plan

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

In Devon, as at 31st March 2014, 0.5% of our population had a joint care plan in place as part of the virtual ward. Each of our practices has signed up to the NHS England Proactive Care service, which will see this number increase to 2% from September 2014.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Strategies and initiatives underpinning the BCF plans have been co-produced via the Transforming Community services engagement. The final Transforming Community Services Strategic Framework has been completed following 15 months of working with stakeholders and clinicians to develop a vision for the future of Community Services within the NEW Devon CCG geographic footprint. The results of this extensive co-production phase are documented in this Strategic Framework through the proposed service delivery models.

The co-production phase commenced in May 2013 until March 2014 and was designed to hear views before strategies or proposals were developed. With the majority of engagement being clinically -led this included:

- Local health summits in every town and the two cities in the NEW Devon CCG area
- Engagement of Health Scrutiny and Health and Wellbeing boards
- Engaging local Healthwatch who led events for hard to reach groups
- Discussions with Devon's Joint Engagement Board which includes user led organisations including learning disability, older people, mental health, carers, physical and sensory disability.
- Range of direct conversations with key groups including carers, care home quality group and others
- Voluntary and community sector engagement

The six strategic priorities and commissioning principles in the TCS strategic framework were a direct response to the views and insights gathered from engagement.

The draft TCS Strategic Framework was published in May 2014 with a further eight week period to comment. During this time there were over 250 responses, many on behalf of larger groups or organisations, reflecting the views of over 2,000 people. A report of this engagement was prepared and published. Comments were received from the following groups:

- Healthcare Providers
- Primary Care Providers
- Community services staff
- MPs and Local Councillors
- Patients, carers and the public
- Voluntary and independent sector
- Local Authorities
- Local Healthwatch Groups
- Other organisations/groups

Some people noted they were pleased to have been asked their views and to have the opportunity to comment on the draft Strategic Framework. It was clear from the length and depth of a number of responses received that many individuals and groups had put significant time and thought into their replies, demonstrating yet again the importance placed on community services.

The results of this eight week period, and the previous work done over the last 15 months were incorporated into the final TCS Strategic Framework document, have informed the locality community services proposals and the Case for Change document. Additionally comments that relate to implementation will continue to be taken into account as this work progresses.

Localities proposed commissioning intentions for community services are now being published for further involvement and consultation before decisions are made in relation to implementation. This takes place from 17th September to 12th December 2014.

Providers have had the opportunity to and have engaged at different stages of the process. A large stakeholder reference group made up of system leaders was established during the co-production phase and this group met twice during the process. Additionally there were two events - an introductory event and a system event focused on integration involving providers and other stakeholders. This is in addition to meetings and opportunities to comment as described above.

In South Devon, we have undertaken an extensive public engagement process for our community services, taking three months and including 21 public events across the CCG footprint plus additional meetings with staff, district councils, the voluntary sector and local groups. A number of key themes were common to each event, and have used these to inform our plans for community services for 2014/15 and beyond. Local people are involved in the steering groups which co-ordinated these events, and will also be involved in developing these plans. We received feedback from over 1200 people during the three month process. We also engaged with people who use mental health services, their families and carers, allowing them to directly influence the commissioning process.

The core messages from all of these events have been instrumental in the development of this plan and our vision for integrated and care and support, and we will continue to engage and consult with the public as we begin to implement it.

We recognise that a “one size fits all” approach will not work, and for this reason each of SD&T CCG’s five localities has developed a steering group made up of local people. These groups initially helped to inform and run the full engagement process, and continue to meet and act as expert reference groups as our plans are implemented and

further developed. Our local Healthwatch are represented on each of the steering groups and were wholly involved in the engagement process.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Provider Landscape

Devon Partnership NHS Trust; was established in 2001 and supply mental health and learning disability services and at any one time, they support almost 18,000 people across Devon and Torbay. They employ around 2,500 staff and also have around 100 staff assigned from Devon County Council and Torbay, including social workers and support workers.

Plymouth Hospitals NHS Trust is the largest hospital trust in the south west peninsula and is a teaching trust in partnership with the Peninsula Medical School. The Trust has an integrated Ministry of Defence Hospital Unit which has a staff of approximately 250 military personnel who work within a variety of posts from lead doctors to trainee medical assistants.

Plymouth Hospitals provides comprehensive secondary and tertiary healthcare to people in the South West Peninsula. They also we provide comprehensive training and education for a wide range of healthcare professionals.

More than 48,000 people pass through the main entrance of Derriford in a week. The hospital has more than 900 beds and 1,000 public car parking spaces.

The Royal Devon and Exeter Foundation Trust Hospital employs around 7,000 staff and serves a core population of more than 400,000 people in Exeter, East Devon and Mid- Devon. They admit more than 115,000 patients and hold 450,000 outpatient clinics every year.

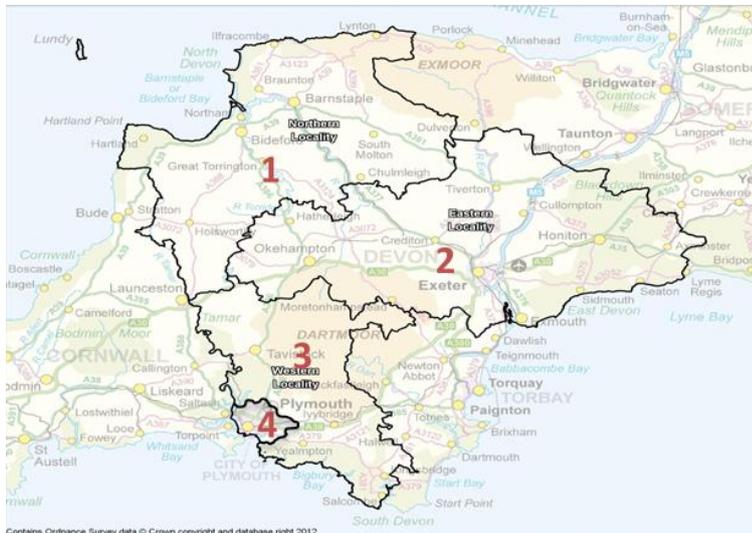
Northern Devon Healthcare NHS Trust a rurally isolated District General Hospital with a catchment area that stretches from Tiverton in the east to Bude in the west, and from Ilfracombe in the North to Chulmleigh in the South. The acute hospital has 341 beds and 2,000 staff.

Integrated and personalwith the acute hospital are 17 community hospitals across the totality of Devon and Health & Social Care Community services across Northern and Eastern Localities. There are 303 beds across the Community hospital with 2,480 staff. The Trust is committed to achieving Foundation status.

South Devon Healthcare NHS Foundation Trust (SDH) runs the District General Hospital in Torquay, South Devon. It serves a population of 300,000, has 508 beds and employs around 4,000 staff with an additional 700 staff registered on the staffing bank.

Torbay and Southern Devon Health and Care NHS Trust (TSD) employs around 2000 staff from a variety of professions, including nursing, therapies, social care, and the allied health and care professions. It provides community based health and care services through seven designated locality zones and eleven community hospitals.

Community Provision in NEW Devon CCG



- 1+2** community services provided by Northern Devon Healthcare Trust
- 3** community services provided by Torbay and Southern Devon Health and Care Trust **(also provision to Southern Devon and Torbay CCG Area)**
- 4** not included in this BCF plan

Engagement around BCF

Each locality has an Urgent Care Network which are currently evolving into Locality System Resilience Groups. The System Resilience Group (SRG) is a senior leaders group, responsible for ensuring the preparation and sign-off of the Operational Resilience and Capacity Plan (ORCP) for the xx Locality NEW Devon CCG

Purpose

The principle purpose of the group is to drive the delivery of the ORCP by:

- ensuring determination of need across the geographical footprint
- initiating local change
- eliminating barriers to whole system improvement
- ensuring all relevant perspectives as to both unplanned and planned care within the
- local health and social care system are adequately considered
- Holding each other to account in the delivery of the ORCP

This work will be undertaken being mindful of the requirements and associated guidance issued by NHS England (NHSE) and partner agencies, including but not being limited to, the NHS Trust Development Authority (NHSTDA), Monitor, and the Association of Directors of Adult Social Services (ADASS).

Key roles and functions

- Provide an opportunity for all parts of the local health and social care system to

- co-develop strategy
- Collaboratively plan safe and efficient services for patients
- Provide the forum for system wide planning of service delivery.

It is via these forums where the BCF plan and individual schemes have been discussed and agreed with the providers – however we recognise that further engagement is required over the next few months as we receive greater evaluation of the key streams of work under BCF and agree the process for decision making around which schemes should be up scaled or decommissioned on an ongoing basis.

Individual meetings and discussions with the four acute providers Senior Management has been held during the formulation of this plan as reflected in the provider commentaries.

Further engagement around BCF has been within the NHS Futures – transforming care in Plymouth and Devon as previously described in this plan.

In **South Devon** we have a long history of including our providers in service planning and redesign, and have a number of multi-disciplinary Clinical Pathway Groups, which in turn feed into senior level multi-disciplinary Service Redesign Boards. The care and service delivery model described in this submission have been developed and led by the Joined-Up Cabinet, which brings together local system leaders to discuss the health and social care challenges and to develop innovative solutions.

Risk 003: *There is a risk that services will not be redesigned in the round and will therefore not address the key aspects of BCF namely:*

- Agreement on the potential impact of changes to services on the acute sector

Mitigation: *BCF operations group and JCCG are designed to enable commissioners to work together on common objectives. Further work to join up SRG and BCF operations group is in train and within action plan*

ii) Primary care providers

Provider Landscape

Locality	Number of GP Practices within Devon BCF Area
SD&T CCG	
South Devon (exc Torbay)	18
NEW Devon CCG localities	
Northern	22
Eastern	51
Western	12

Engagement with BCF

South Devon Our extensive engagement process outlined in 8a above was led by our GP colleagues. The plans referred to within this document reflect those developed by our GPs in each of their localities, in response to that engagement. The redesign board

which oversees the engagement process is chaired by a Torbay GP.

NEW Devon similarly the engagement process outlined in 8a and 6c shows how GP colleagues have been involved. The plans referred to within this document reflect those developed by GPs in each of their localities in response to that engagement.

iii) Social care and providers from the voluntary and community sector

The social care provider landscape is extremely complex made up of a wide variety of service providers across a range of services delivered to key client groups and delivered by a range of organisational forms (i.e. DCC directly provided services, independent sector providers, housing support providers, not for profit, voluntary and community providers, social enterprises etc.

But in summary DCC are in contact with;

- 377 care home providers
- 235 personal care and support providers (regulated services)
- Up to 1314 providers including community and voluntary groups, social enterprises etc (this number includes some care home providers and personal care and support providers)

Engagement with BCF

Engagement with these providers takes place through a number of key engagement approaches Principally through the Devon County Provider Engagement network <https://new.devon.gov.uk/providerengagementnetwork/>

Through this network presentations and discussions have taken place regarding the better care fund and the broader impacts of the Care Act. Those presentations are available to be viewed by all social care providers through the PEN website. Further discussions/workshops are planned with providers on the BCF and the impact of the Care Act, the timetable for which is currently being formulated with provider representatives.

It is important to note that the PEN is the recognised method of provider engagement across the whole of the administrative area of Devon County Council and representatives of NHS commissioners and providers regularly attend PEN workshops.

South Devon Our extensive engagement process outlined in 8a above was undertaken in partnership with Torbay Council and Healthwatch Torbay. The plans referred to within this document reflect those developed by our GPs in each of their localities, in response to that engagement, and in partnership with those organisations.

Our Clinical Pathway Group model outlined elsewhere in this document includes representation from health and social care, as well as the charitable and voluntary sector providers, including Rowcroft hospice and Marie Curie Cancer Care. Our three-month engagement process involved these sectors in both the design and delivery of the process, as well as engaging with their staff to ensure we captured their views.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

As this BCF plan has been developed we have ensured that no schemes are being double counted – such as QIPP and resilience plans. The modelling of the impact of the aggregate total of the schemes is outlined in Part 2 and show a total 3.5% reduction in emergency admissions.

We recognise the need to work with providers further to ensure that they have the capacity and capability within their workforce to deliver but initial discussions with providers is that they will be able to recruit and deliver as long as they have a decision by early November 2014.

We have established an urgent care work stream at CCG level as part of local NHS Futures – transforming care in Plymouth and Devon programme that is led by acute trust Chief Executive and will review and inform how we can best work together across the system to reduce activity. In addition we will capitalise on the opportunity of newly formed SRG's to deliver an integrated approach in each community and incorporate the work already underway through the deployment of resilience funding

We recognise the need for further work around ensuring parity for people with Mental Health issues and this will be a focus as we move forward, learning from the resilience scheme of the Psychiatric Liaison service in A&E.

Initial conversations with the providers have been had around the implications on them as an individual providers and this is reflected by their completion of the commentaries as part of this submission. They recognise the aggregate target reduction of 3.5% of emergency admissions for each trust and wish to be more fully engaged with the decision making and monitoring of the schemes within the BCF going forward.

It is recognised that due to the time restraints in preparing this plan over the summer their involvement has been less than ideal. However they are supportive in principle and will be working closely with the BCF project as we move forward, particularly via the SRGs to review the current schemes, identify alternative schemes (building on the resilience work) to gain greater confidence in the deliverability of the target emergency admissions reduction.

The table on the next page shows the estimated impact of the 3.5% emergency admission reduction across the acute trusts:

	Devon BCF	
	Apportionment	Impact
Planned reduction		2761
PHNT	11.9%	330
NDHT	22.9%	633
RDE	43.3%	1,197
Other (incl SDHT)	21.8%	601
Total	100.0%	

Risk 001: *There is a risk that there will not be significant buy in from the acute, community and other providers to facilitate reductions in their budgets and to share the risk*

Mitigation: *Discussions underway at high level between CCG and Trusts as well as more detailed scrutiny of schemes via SRGs going forward.*

Risk 005: *SRGs are still embryonic at this time but much of the work of the BCF rests with these groups*

Mitigation: *SRG recognise role within BCF and ongoing project structure being developed to strengthen this – see action plan*

Risk 006: *Contracts with providers will not reflect the anticipated level of savings associated with the 3.5% emergency admission target*

Mitigation: *Greater involvement of providers in future evaluation and joint decisions around schemes in action plan via SRGs and Operational Group agreed*

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Descriptions – See Annex 1 zip file

ANNEX 2 – Provider commentaries – See Annex 2 zip file