directors of adass adult social services | think local act personal | Local Government Association | NHS England

Integrated Personal Commissioning programme – application form

Please send to england.ipc@nhs.net by Friday 7 November 2014

1. Partners: Which organisations have agreed to join the programme?

Voluntary sector organisations including user-led organisations
Parkinsons UK, British Lung Foundation, Age UK Cornwall, Volunteer Cornwall, Healthwatch Bristol, Compass Disability Services, Voscur, Enham Trust, Autism Somerset, Living Options Devon, WECIL
Clinical Commissioning Group(s)
South Devon and Torbay, Wiltshire, Bristol, Cornwall and Isles of Scilly, South Gloucestershire, Gloucestershire, NEW Devon, North Somerset, Bath and North East Somerset, Somerset, Swindon
NHS Trust(s) or other NHS-funded provider(s)
Local authority (the application should cover only one upper tier council)
Bristol, Torbay, Swindon, North Somerset, Gloucestershire, South Gloucestershire, Somerset, Plymouth, Devon, Wiltshire, Cornwall
Other organisations (see list in section 2 for suggestions)
South West Strategic Clinical Network , Health Education South West, South West Academic Health and Science Network, West of England Health and Science Network, South West Commissioning Support Unit, Avon Primary Care Research Collaborative

2. Sign-off: Who has confirmed support for this application?

Please ask each person to provide their name, job title and organisation, and **to sum up in no more than 50 words** why they support this application. Signatures are not required.

ESSENTIAL: We will only shortlist your application if it has the support of the people listed in this section.
Lead voluntary sector organisation chief executive
Please see attached appendix 1 – endorsement
CCG chief officer(s)
Please see attached appendix 1 – endorsement
Director of adult social services
Please see attached appendix 1 – endorsement
Children's director (if children and young people are included)
Please see attached appendix 1 – endorsement
Health and Well-Being Board chair[1]
Please see attached appendix 1 – endorsement
DESIRABLE: Please confirm who else supports your application and why. It is up to

[1] If possible also please send confirmation in writing that the Health and Wellbeing Board has discussed and approved your application. Your application does not need to list all the organisations taking part in the board, and it may cover only part of the board area.

you to decide who needs to be included; suggestions are listed below.

- User-led organisation chief executive
- Other voluntary sector organisations
- CCG finance director
- NHS Trust (or other NHS-funded provider) chief executive
- NHS Trust (or other NHS-funded provider) finance director
- Other providers
- Local authority chief executive
- NHS England area team director
- Healthwatch chief executive

Please see attached appendix 1 – endorsement

3. Aims and priorities

Why do you want to join the Integrated Personal Commissioning programme?

The South West region has a population of 4.7million spread across 9000 square miles – the largest regional footprint in England. A region with distinct challenges coming from our unique profile with an older than average population and many rural communities. Experience has taught us that systems solutions designed in England's great urban conurbations are not always easy to implement here. We believe that the South West needs to be part of shaping the Integrated Personal Commissioning (IPC), as we want to maximize the potential benefits for people's health and wellbeing in this region and for our local care systems. We have a will to identify implementation solutions at scale and want to be key contributors to the national demonstrator programme.

Yet we know that a will alone is not enough - we are fortunate in this region with having a strong track record of leading integration innovation; 2 of the 14 Integration Pioneer sites are in this region, 3 of the 20 SEND Pathfinders are here too – all of these sites are part of our collaboration (Cornwall and the Isles of Scilly, South Devon and Torbay, Devon and Wiltshire).

Complementary to our local integration experience, as a region the South West has a history of working successfully together. An instance of this can be seen in the regional End of Life network activity. This habit of working together has helped us maintain the highest aggregated regional performance of people supported to die in usual place of residence for some years. All communities here outperform the England average and some (like the area served by North Somerset CCG with 41.42% of people dying in hospital compared to the England average of 50.71%) have an exceptional performance (source PHE's NEoLCIN). We have the proven ability to co-operate effectively sharing developments for delivering personalized care in this region over a sustained period, essential in providing good care for dying people and, we believe, a core element required for the IPC to succeed.

We know co-operation across the region has helped us progress further, faster, for longer already and we think building in sustainability at the outset is critical for implementing the IPC. This is the fundamental reason why we are applying as a region, rather than as individual communities based around our Health and Wellbeing boards. By looking for learning and constantly sharing, combined with the scale of our approach, will allow us to use limited resources available both locally and regionally to maximum impact. Whilst at the same time minimizing the risk for individual partner organizations, critical in these times of austerity.

We are putting co-production at the heart of our programme design and consequently allowing localism

to florish. We are endorsing and encouraging different areas within the region to tackle different elements in ways that meet their local priorities, on a timescale that is realistic to them.

Our regional approach builds on the diverse development strengths of local partners. Somerset's work on the Symphony Project has illustrated the potential released if we work differently through their financial modelling of the health costs of people with multiple long term conditions. Cornwall's Integration Pioneers are now using Symphony data to inform a financial model to fit the Living Well Programme in their Integration Pioneer site. This work is changing the relationship between people, the voluntary and community sector and health professionals. These are just some examples of how different parts of the region already tackling elements of this agenda. We will make it easy for the early adopters to share our learning through our South West IPC network, providing fertile ground for new developments to embed and mutual support to improve the resilience of our change agents to keep going when some parts of the system push against this transformation, as will inevitably happen. Effective networks do accelerate progress and we have chosen to work in this way to ensure we succeed.

Coming together will also enable us to accelerate mainstreaming the benefits, by supporting each other and preventing duplication of development work. It will also prevent a gulf emerging between the early adopters and the rest of the region as everyone is involved to some degree and will be part of the culture change required to deliver IPC.

No single area felt able to cover all groups and all elements of the programme, but collectively we can. This will allow for equitable access for people in the South West faster. We don't want the benefits of IPC to be only available for one group of people in one place - that's not personalized care and it's not transformational change. And we are clear that transformational change is what is needed to mainstream integrated personal commissioning.

What do you hope to achieve?

We want to make significant strides towards embedding the culture change required to truly deliver personalized care. We want personalized care plans for all who may benefit. We want a greater emphasis on preventative support than crisis provision. We also know that to achieve this we need to engage and involve the people, their families and the whole system in true co-production, sharing the risks and the gains equally to ensure sustainability.

We hope to create a social movement for change that will to begin to challenge public attitudes about what is the best way to spend healthcare budgets – away from beds and buildings and onto personalised care and prevention. Our programme aims to help achieve the transformational change set out in the NHS five year forward view published October 2014.

A big part of this change is in how the NHS and local government works with the voluntary and community sector. We see the voluntary and community as equal partners and as a symbol of this stance we have agreed that, if successful in our application, the IPC programme here will be hosted by one of the voluntary sector partners.

Key developments we hope to achieve are:

1. a flexible co-commissioning framework which is tested and fit for purpose;
2. a significant increase in the numbers of people within the workforce that understand, practice and promote personalization;
3. a vibrant network of peer support groups helping to empower people to take more control back over the management of their health;
4. an appropriate brokerage model delivered by the voluntary and community sector and flexible enough to be applied across the region;
5. market development strategies that includes all providers and commissioners and the

wider community. We want to create a space were people, commissioners and providers can come together to co-produce solutions on how to deliver the type of services people want to choose themselves. We also want to tackle some of the longstanding market gaps. We know that finding flexible support for people in rural locations, especially for periodic support (e.g. crisis plan within someone's care plan) is challenging to do. Community support and new partnerships with non-health and care sector employers allowing staff to undertake this work in social and community responsibility initiatives, are the types of creative solutions we seek to explore over the lifetime of this programme;

6. removing the barriers to implementation at scale without 'double-funding' through phased contracting method change;
7. finding methods to allow the controlled release of some of the funding tied up in secondary care that could be more effectively utilized in personalized care support, without destabilizing acute care;
8. an ongoing and rigorous culture of ongoing evaluation and quality improvement driving up standards and ensuring best value from health spending.

We have already identified areas of work that need addressing, but we have not defined yet what all the answers should be. It would be wrong to do so now only two months after the prospectus is published. If we did that would show a lack of co-production. We believe the solutions lie in true co-production and we will invest the time that that takes. The first step will be to bring all partners and local communities together to explore future solutions early in the programme.

We have already made a commitment to work together and we can define what our next steps are. Between now and April 2015 we will continue to work with each and every local area - talking to people and partners at Health and Wellbeing Boards, with Healthwatch organisations and other voluntary and community sector organisations (this engagement work has already started thanks to the help of the South West Forum – see South West Forum IPC PHB handout). We will also increase our engagement with providers.

South West Forum
IPC PHB handout.doc

We will bring senior leaders together with people who have already benefited from personalized care in January at our South West IPC Conference where we will:

- Start the region's social movement for change
- Scope the workstreams needed to deliver the systems change programme, and the governance for the programme – including for agreeing a flexible co- commissioning framework
- Start to define delivery mechanisms in more detail together

We are already identifying first phase sites and are booking practitioners onto a two day residential accelerated learning event on the 7th, 8th and 9th of January to start progressing this work at a micro level. We will start and get integrated plans (and budgets where possible) up and running for different groups of people in multiple, small sites, in different parts of the region. (Not all partners feel ready to taking part in the 1st phase but the majority are – this illustrates our flexible approach in action) This will quickly give us a robust level of data when aggregated across the region to inform the thought leadership programme, which is achievable quickly on a regional basis, whilst maintaining low risk to individual areas as the numbers per CCG/LA is low.

We want to be opportunistic and flexible to grasp opportunities as they arrive and our programme management will allow for that.

How does this fit with local priorities for the NHS and local government including the

joint health and wellbeing strategy?

We are under no illusions that this ambitious programme will be easy to achieve - if it was there would no need for a regional collaboration like ours. We believe our facilitative approach is an innovative way of garnering ideas from the ground up and escalating them to widespread application quickly.

From the outset we are focusing on sustainability. We have asked each community (for ease of administration we have defined the area by CCG boundary) to match the scope of the IPC programme requirements against their locally identified priorities. These responses are the core of our regional programme (please see attached appendix 2 for more information by local area) and will immediately interweave achieving local aspirations with successful implementation of IPC .

4. People who will benefit (see prospectus for examples): Which groups will take part and why; how many people do you expect will benefit?

What is already in place?

We have agreed together a commitment to developing the IPC for all people identified in the prospectus. Different areas within the region have identified different groups they wish to prioritize, based on local needs and existing development activity. (Please see appendix xxxx for a breakdown of groups of individuals who will benefit by geographical area).

What will be different within 2 years (by March 2017)?

We are conscious that 30% the population of the South West have one or more long term conditions, all of whom, may potentially benefit from the work undertaken in this programme. However we are realistic in defining this programme as being about developing the required system change to allow true personalization of the health and care system here. Full implementation will go beyond the end of 2017. But by March 2017:

- We will have more than 1,000 people, (over and above the number of adults eligible for Continuing Health Care) who will have a personal health budget, or an integrated personal budget.
- All people with long term conditions will be offered a personalized care plan and encouraged to take more control over the management of the condition to minimize the impact it has on the things that matter to them.

What are you proposing to do to achieve this?

How will the South West IPC Programme work?

A South West IPC Network will be created to oversee the programme. It will use action learning principles and quality improvement methodology. The programme has three core strands, which taken together will deliver sustainable transformational change. They are:

1 – Thought leadership change programme – launch conference of senior leaders in January 2015 will bring together the whole system to define the scope of system change. This structure of the conference will be to embed co-production at the outset. Input from people who have already benefited from personalisation and their families and carers will demonstrate the benefits. Workstreams supporting necessary change will run from April 2015 including: financial modelling, impact on block contracts, risk sharing strategies, development of the market, growth of peer support and patient activation. Local areas will accelerate implementation by benefiting from each other's strengths using the 'regional expertise time bank'. All areas across the region will be active contributors to this thought leadership change programme to ensure that it is fit for purpose across

the region and to maximise opportunities to share learning and development.

2 – 1st phase roll out of PHBs/integrated budgets for people who may benefit - This will start in those areas that are ready to start implementing now. Support includes training, mentoring, use of quality improvement methodologies and evaluation of impact (outcomes and financial). This series of micro sites in variety of settings, working with different groups of people, in different CCG/LA areas will provide an achievable, low risk place to start. Findings aggregated across the region will provide robust data to inform application at scale quickly, including financial modelling. Sustainability is achieved by 1st phase people and practitioners mentoring 2nd phase roll out sites, and so on. Over the lifetime of this programme, if successful as a demonstrator site, we aim to run 5 cohorts of implementation sites, thereby achieving significant scale by end of 2017. We recognise that different areas are starting from a different place and not all CCG/Local Authority areas are willing to start in the 1st or second phase sites. Areas will join the implementation at a time that is right for them

3 – Social movement for change – communicating the benefits to people, organisations providing care and staff. This element of our programme will promote patient self-management / activation and support the development of peer support networks. Creative use of social media and a focus of demonstrating the difference personalisation can make to people's lives via the use of patient stories will feature highly. We will ensure that this communications work will start early and continue throughout the programme with a constant drip of information. It is via this interactive debate across our communities that we hope to begin to challenge attitudes about what is the best value way to spend healthcare budgets to deliver positive outcomes for people– away from beds and buildings and onto personalised care and prevention.

5. Financial model: How will you develop a financial model which enables NHS and social care money to be brought together?

What is already in place?

The Symphony project in Somerset has provided valuable modelling around the costs of multiple long term conditions.

Ray Heal, as Practitioner Advisor for the South West IPC programme, has developed an information sheet based on people's stories. This is being used by areas to help identify people to initially extend the offer of Personal Health Budgets (PHBs) or integrated personal budgets within the South West's IPC programmes first phase sites, where in year savings are likely to achieved (eg reduction in avoidable emergency admissions).

Information sheet.docx

The South West AHSN within their Integration programme have agreed to work with our 1st phase sites to help ensure cost benefits are captured consistently on all sites so can be aggregated to inform the though leadership work on financial modelling.

What will be different within 2 years (by March 2017)?

We will have a developed a system for identifying the annualized capitated budget for individual patients, and / or categories of patients, based on available data ie HES, social services spend, primary care spend and medications and equipment spend. This combined with Symphony data and ongoing

financial evaluation from first phase sites, will provide aggregated financial data for our systems change programme.

The workstreams concerned with block contacting, market development and risk sharing strategies will have provided models to overcome or minimise the barriers to implementation at scale. Splitting up and decommissioning of block contracts (where appropriate) will attract substantial clinical, financial and legal risk. By tackling this as collaborative, rather than as individual CCGs, this will enable us to share and minimise this risk whilst realising a significant goal in transforming commissioning for the future in support of personalisation and integration (if the perceived benefits are realised). In addition, we hope to achieve a confidence throughout the collaborative in introducing an alternative method to block contracting.

For calculating mental health spend we will work with the local authorities and CCGs to identify the historic split of Section 117 funding (which reflects proportionality split locally, contextualized by local variance in provision) to simplify the process of decision making (a model already developed by Dorset).

For children with complex needs the calculator developed with In Control will be market tested and amended as needed.

What are you proposing to do to achieve this?

The financial modelling workstream, using information gathered via Integration Pioneer sites in the region, the Symphony project and the first phase site financial evaluation work, will oversee the development and implementation of our financial model.

This workstream will be mindful that they need to ensure the sustainability of the financial model beyond 2017.

6. Person-centred approaches: What support will be offered to people in your cohort?

What is already in place?

1) Representatives for all CCGs have participated in personal centred planning sessions linked to the Year of Care model
2) Local Authorities have also developed person centered training programmes for appropriate staff
3) An intensive residential accelerated learning event is booked for January to bring together for the first time people from health, social care and the voluntary and community sector working alongside peer support leaders and people with lived experience who will develop the programme in our first phase sites. This group will be supported on an ongoing basis through mentoring and their own peer support group to promote person centred approaches.
4) There are currently three accredited Year of Care trainers who are contributing to the programme.
5) Work currently developed in partnership with industry to support patients to self-manage by clinical networks and AHSN's will be incorporated into the programme.
6) Work with WECIL on the further development of a web based self-directed person-centred care planning and assessment tool will be included in the programme
7) CCGs and Local Authorities within the partnership are or have developed personalization strategies.

What will be different within 2 years (by March 2017)?

1) We aim to ensure that personalization and integrated approaches to care brokerage and delivery are the norm. Thereby ensuring practice accurately reflects revised and new legislation,

most notably: The Care Act 2014, The Mental Capacity Act 2005, and The Equalities Act 2010.

2) Marked increase in the numbers of people benefiting from personalization to meet the expectation in 'Everyone Counts Planning for Patients 2014 -2018' that everyone with a long term condition has a personal care plan. We will have provided appropriate and tested ways in which primary care can play their part, and enabling GPs to realize the benefits too - freeing up their time from trying to co-ordinate a disjointed system when patients are in crisis, so that they can focus more time on giving personalised care and in shared decision making with their patients.

3) An ever growing network of practitioners (including those with lived experienced) who are able to share learning to continue the cascade roll out of personal centred approaches, towards achieving the goal that all those who could benefit have not just a personal care plan, but support in place tailored specifically to theirs and their families' needs and which includes a crisis management plan.

4) Web based open, dynamic resource bank including people's stories, methodologies, toolkit and learning materials.

What are you proposing to do to achieve this?

1) To ensure that person centered approaches are a cornerstone of the South West IPC Network and feature in all activity.

2) Ensure that existing accredited staff time is focused on the roll out of personal care approaches.

3) Provide the support framework, including training and mentoring for the cascade roll out of sites starting with the first phase sites in Jan 2015 with a new cohort identified and trained every 6 months for the lifetime of the programme.

4) Formalize the 'expertise time bank' to ensure that all areas within the partnership receive an equitable proportion of time focused on their local priorities, to accelerate progress and prevent duplication of development effort.

7. Personal budgets: What will be the scale and pace for rollout of personal budgets for people with health needs, and how will funding be made available?

What is already in place?

1) A commitment by all partners to the principles of personal budgets

2) All participating CCGs have put the processes in place for PHBs to be available for people with CHC and all Local Authorities offer Personal Budgets. See appendix 2 for current numbers of PHBs in place.

What will be different within 2 years (by March 2017)?

1) Children with complex needs and their families will be offered Integrated Budgets across the South West (unless there are overriding clinical or legal reasons why this is not appropriate) as defined in the Children and Families Act 2014 for people with CHC).

2) People with long-term conditions, particularly older people with frailty will be able to request a PHB or Integrated Budget. The rate of roll out to this group of people will different across the region depending on the type of condition and pace of roll out in each area and, of course, individual choice. Local communities will be expected to deliver on the aspirations they are committing to in the IPC programme planning process. The amount of direct support they receive from the programme will be matched to this local commitment.

3) People with learning disabilities with high support needs will have the option of an integrated budget in the areas who have agreed to develop these as a first priority group locally. In other

areas a published commitment to when people with learning disabilities will be able to access this locally will be available.

4) People with significant mental health needs will have the option of an integrated budget in the communities who have agreed to develop these as a first priority group; this will include the development of early intervention support for people entering crisis, to avoid admission, and as the standard offer for people eligible for section 117 after care and/or community treatment orders. In other areas a published commitment to when people with significant mental health needs will be able to access this locally will be available.

Across all groups we will achieve over 1,000 people with personal health budgets who are eligible for adult CHC and over 1,000 other people will have an integrated or health personal budget.

We will have amassed a significant body of evidence, to add to the nationally published evaluation and stories for people who have benefited showcasing the benefits of personalisation and integration. Thanks to the structure of our evaluation we will also provide detailed costings information evidencing financial efficacy, and add to the national and international integration methodology/evidence bank. Through designing our evaluation collaboratively we will aim to produce outcomes and integration measures which can be applied at scale.

What are you proposing to do to achieve this?

The network and phased site cascade approach will provide a support framework to allow a critical mass of PHBs and integrated budgets to develop locally over the course of the programme.

This will be supported by the leadership, financial modelling and evaluation elements of the South West IPC programme – please see sections 5,8 and 12 for details.

8. Leadership and partnership: How will you get key people on board and build capacity in the voluntary and community sector?

What is already in place?

In developing a sustainable region wide programme a lot of initial focus has been on building a broad partnership from across all communities.

Support from commissioners in each area of the region - The timescale of the application process and the requested endorsements has required us to focus on the sign up of all commissioning organisations within the region as a first priority. As you see from the endorsements required in section 2 (attached as appendix 1) we have successfully gained the endorsement of CCGs, Local Authorities and the Health and Wellbeing Boards from all areas within the region. With such large region we have inevitability got some gaps in terms of official sign off and we will continue over the next few weeks to ensure all of the above formally endorse the programme.

Support from voluntary and community sector - We have had several voluntary and community sector partners involved in the initial concept and design of our regional programme proposal and involved local Healthwatch organisations. We have also presented to the South West Forum and started the wider engagement we need to do early to ensure that representatives from the voluntary and community sector are involved in all parts of our programme. We will continue this process. We will continue to build on the work already undertaken around regional brokerage support standards to be implemented and through the CHC personal health budgets project managers in the region to inform future market development.

Support from regional bodies - We have received the formal support from the Peninsula and BNSSSG Area Team's Joint Executive Committee on 3rd November and are hoping to present to the other Area Team's Executive Group to seek their endorsement too shortly. Both AHSNs in the region are supportive of the application. The Peninsula AHSN is providing practical support via with evaluation and is, together with local CLARKS, gathering international research evidence to inform our financial modelling. The

Avon Primary Care Research Collaborative is also supporting our evaluation development and analysis. We are benefiting from the West of England AHSN's Quality Improvement Methodology roll out (Masterclasses for Medical Directors are already being delivered) and we will use this methodology with leaders acting as sponsors for appropriate implementation pieces as the South West IPC programme develops). Health Education South West aims to use the IPC programme as the delivery vehicle for its integration workforce development priority. The South West CSU will ensure that the IPC programme benefits from the CSU's existing work within the region in areas such as, the Patient Voice programme and procurement support and can help with project management support where appropriate. The South West SCN is linking each of networks priorities where applicable to the IPC programme. The structure, as set out in the IPC prospectus, is allowing us to align many existing initiatives; this in itself is building a sense of momentum and accelerating the pace of development. We will continue to act in this way.

Support from primary care and providers - We have had some involvement in early design from primary care and providers, but this is the area we need to increase our engagement with as an immediate priority now our application is complete. CCG Commissioning lead GPs input from Devon and Cornwall has made sure our planning for delivery is focused and realistic. We have first phase sites identified which will start implementation early. In other areas not ready to implement yet we are working to support local communities get their foundations in place, such as linking with Wiltshire's Primary Care pilot sites for developing integrated working to deliver personalized care planning.

What will be different within 2 years (by March 2017)?

We will have developed a different relationship balance between the statutory sector commissioners and providers and the voluntary and community sector.

We will have seen a growth in the brokerage support roll within the voluntary and community sector.

We will have greater participation from people with lived experience in the design and delivery of care support.

A greater number of operational managers will be confident in how to support and develop further personalization in practice.

Quality Improvement methodologies will be used in many and varied settings as a core means of constant improvement in care standards and outcomes.

People and staff at all levels will have a greater understanding of the cost of care at a granular level, as an essential prerequisite to driving out savings.

What are you proposing to do to achieve this?

Our IPC programme has been designed with its three core strands (as described in section 4) to ensure we can deliver the sustained partnership necessary to achieve this. We are fortunate that so many leaders within our region are already supporting the South West IPC Programme (as evidenced by the endorsements in appendix 1). We will continue to rapidly build our collaboration further through the launch of the thought leadership change programme in January 2015. The delivery workstreams will work through the detail of specific solutions, such as consistent standards developed for brokerage support services, for sharing with all partners.

9. Co-production and culture change: How will you change attitudes throughout the system, and ensure that people and families lead the new approach?

What is already in place?

The principal of co-production is paramount in the development of the South West IPC programme's approach. From the outset we have asked people with lived experience to join us at our scoping meetings for this application and have opened each session with their stories. Listening to them has

undoubtedly influenced how we have framed our proposals and given us rich ideas for design of delivery.

We are fortunate in having two integration pioneer sites within our region, they are already leading the way in showing the culture change required. Our IPC network assists them in their duty as Pioneers to share in their learning and we will use it to build our system's change solutions. E.g. Living Well's 'Guided Conversation' is changing the relationship between people, the voluntary sector and health professionals. Torbay's history of integration gives so much learning on how to grow and sustain multi-disciplinary, cross-organisational teams.

There are also many other positive pockets of personalization great practice that we can draw together and share. E.g co-ordinated care planning in Gloucestershire and the peer support network (supported by WECIL) in Bristol.

What will be different within 2 years (by March 2017)?

Within the next two years we will also have enshrined the principals and practice of co-production at all levels within the IPC program, supporting our providers and frontline staff to this end and including direct representation of IPC holders on the leadership board.

We will have established a network of people who have benefited from a personal care plan/budget and will have built peer support networks across the region, to provide leadership for increasing personalization in the longer term.

We will have changed the relationship between people and health and social care professionals – making shared decision making common practice.

What are you proposing to do to achieve this?

We pledge to maintain co-production throughout the lifetime of this programme. Here is an outline of some of the ways we plan to honour this pledge:

At a micro level all individual personal plans will be co-produced with the person and the professionals as equal partners. "There will be no decision about me without me" is not just our vision, but is central to our practice. The first phase sites' rapid learning event will have people with lived experience helping to shape and deliver the training. All sites will use tools suitable for personalization and we are delighted that we have the Personal health Budgets national online toolkit to support us. Our evaluation of the programme, led by the South West Academic Health and Science Network, will, of course, include health outcomes for people, along with comparative costings, but it will also qualitative analysis of their experience of care and its impact on their wellbeing, this holistic approach will include the impact on their families and carer's health and wellbeing too (where applicable). An illustration of co-production in action is our decision to include the impact on families and carers in our evaluation , as this comes from the input at our Bristol development session from a peer leader telling their own families story.

Our thought leadership programme will drive both the systems and cultural change required to implement at scale. And will put people and families' experience at the forefront. From the launch conference onwards we pledge to include people with lived experience throughout the design process.

There is already a commitment from a number of organisations including all the Clinical Commissioning Groups, Local Authorities and the Health and Wellbeing Boards within the region. A significant number of third sector organisations are already part of the design process, and we will continue to work on the breadth of voluntary and community sector experience within this programme.

Some practical ways we can help achieve and embed co-production in the programme include:

- Providing training and mentoring for practitioners in co-production of individual plans with people for our implementation sites – we have our 1st cohort training booked for January 2015;
- Our intention to engage with an organization such as "People Hub" to work with the program in

establishing independent user groups to represent the views of the people; and

- Establishing an on line forum for budget holders as in instrument for social change

10. Managing risk: How will make sure that progress is not held up by unforeseen problems?

What is already in place?

Key risks to the programme we can foresee are:

- Maintaining a partnership on this scale
- Achieving individual integrated budgets when budgets are currently held in multiple organisations, with varied legal parameters on charging between NHS and Local Authority services
- Resources are currently tied into block contracts and there is no resource for double funding a transition approach to personalization implementation

What will be different within 2 years (by March 2017)?

We will have used the learning from the South West IPC Programme to support local partners to develop risk and gains sharing strategies which release, in a planned and controlled way appropriate resources from:

- block contracts; and
- secondary care tariffs (particularly 'bad income' from the acute sector – eg excess emergency admissions which impact negatively on Trusts being able to maximize elective work)

which are being spent on personalized care plans supporting people to live well and manage their conditions better.

We will have tested IPC financial modelling and integrated models that will provide evidence of cost implications to inform sustainability beyond 2017 and contribute to national and international evidence of this new commissioning approach.

We will have navigated the legalities around integrated and pooled budgets in order to provide guidance.

We will streamline, and produce clear guidance on the appropriate way to share necessary information across organisations to meet the legislative requirements of the Data Protection Act 2003.

What are you proposing to do to achieve this?

The South West IPC programme has been designed to minimize and mitigate the impact of these the risks from the outset in the following ways:

a) this collaboration has been designed to be flexible allowing all partners to contribute at the pace that is right for them, those areas wishing to forge ahead are free to do so, those wanting to contribute in the network, but are not yet ready to join the implementation programme are supported to get themselves ready working in their local priorities. The partnership is built on valuing localism and sharing learning, this approach we believe is the most likely way of holding this partnership together. The expertise time bank is our regional currency for exchanging practical support as well as sharing ideas. It will ensure resources are shared equitably with local areas accessing the support they really want at the time they need it.

b) The thought leadership change programme will be the method by which we can explore solutions together pooling learning to create and test co-commissioning and alliance frameworks and other tools (e.g. c-quins, pooled budget arrangements). We are mindful that we are asking providers to change without a definite contracting structure in place. By creating a space where leaders from across the commissioning and provider landscape can come together to explore how to manage the market change we aim to engender an honest conversation about what needs to happen and that can be realized, by when.

c) By running several 1st phase implementation sites in different areas we can aggregated data to quickly gather accurate costs with low levels of risk to local budgets due to the small numbers in each place. By targeting certain high cost users first we can drive out in year savings to mitigate any cost pressures.

We welcome the opportunity to be part of the demonstrator sites so that we can work with the national team and be confident that we will be working to a single legal view on the charging legislative impact on integrated budgets. We would seek to test on individual case basis how this works in practice and build up case examples that can be shared.

11. Capacity and resources: What people and other resources will you put in place to deliver Integrated Personal Commissioning?

What is already in place?

The NHS Five Year Forward View identifies the IPC is a means of using existing resources more effectively and we will use this philosophy in resourcing the programme itself.

To that end there are a range of resources already identified within the region to support integration development. We are aligning these where we can to the IPC programme. The prospectus has already acted as a helpful framework to provide a clear focus and direction to a complicated agenda which has hitherto been tackled from diverse angles within our area. We will continue to use the IPC framework to draw in and align existing resources where appropriate and sharing knowledge and ideas via our network.

However we have recognized that the organization of this programme does require some dedicated resources.

We have already got Programme Management time provided via the South West SCN - which is also funding (via its programme budget) the thought leadership launch conference and the first phase site training and Ray Heal as our Practitioner Advisor to mentor the implementation sites.

The Personal Health Budgets team's regional lead Liz Little has an established PHB Project Managers forum whose support and knowledge we will draw on, that has already started working together on developing a regional view on the practical implications relating to personalisation and personal health budgets.

What will be different within 2 years (by March 2017)?

The South West IPC programme will aim to mainstream personalisation, personal health budgets and integrated personal commissioning throughout the region – which reflects a significant change in culture.

Resources will be, or being transferred, to allow many more people in this region to benefit from personalization.

We will have a detailed evaluation of the effectiveness in both health outcomes and cost benefits of the programme.

We will have developed a wealth of practitioners who are trained and can deliver this agenda.

What are you proposing to do to achieve this?
We will establish a Programme Board to oversee the programme and agreements between partner organisations over the deployment of aligned resources held in different budgets. We are developing an expertise time bank to provide a currency for sharing of implementation support between different local areas of the region which cross organizational and community boundaries. We will use the financial model created to baseline existing resource and compare with IPC plan spend on a case basis, using the same format so that this can be aggregated as an evidence base for IPC spend. The baselining will include: existing cost of social and NHS care, medications and equipment spend, spend extrapolated from HES data and primary care and community spend (based on use of appointments), so that whole system impact can be calculated.

12. Learning from results: How will you share your learning and ensure robust evaluation [2]?

What is already in place?
As a consortium, we recognise that sharing learning is the key to the success of an effective network and have mainstreamed it within our approach through the development of a cascade model of training and our commitment to co-production. We already utilise a tried-and-tested collaborative approach through a number of established regional and local forums with proven governance mechanisms that will underpin the dissemination of evaluation and learning throughout the region. An agreement is in place for first phase sites to time bank expertise and knowledge to be used for mentoring future sites. Several of our partners are already signed up to participate in the national evaluation of Personal Health Budgets utilising InControl's Personal Outcomes Evaluation Tool and in addition to this, some partner sites have developed individual evaluation plans to consider the implementation of the personalisation agenda in their localities according to their own priorities. For example, South Gloucestershire CCG has established a plan to assess staff experience, and Bristol CCG has identified that one of their objectives is to assess the merit of Brokerage Services in terms of service provision and costs. Furthermore, we have identified and linked with appropriate experts in the region. A case-based cost-benefits model utilising HES data has already been developed. In addition, utilising quality improvement methodology, the South West Academic Health Science Network (SWAHSN) has supported us to plan an analysis framework across all sites to collect before-and-after aggregate data to assess cost-implementation at scale. We have also established a link with the Avon Primary Care Research Collaborative (APCRC), who are a key partner of the West of England AHSN. APCRC are hosted by Bristol CCG and can advise on approaches to whole programme evaluation through their role as Chair of the West of England Evaluation Strategy Group (WEESG). They are committed to driving the evidence-informed commissioning agenda and one of their core functions is to provide expert advice to NHS and Public Health professionals and researchers around evaluation methodologies, feasibility and dissemination in order to ensure that evidence-informed approaches are embedded into the culture of the NHS. We have secured commitment from APCRC that they can act in an advisory capacity and support the coordination of sites for participation in the proposed national evaluation to ensure a consistent and timely response.
What will be different within 2 years (by March 2017)?
In addition to participation in the national evaluation, it is envisaged that an evaluation and learning

[2] We are currently developing plans for a national evaluation of the programme; more information will be available in due course. All sites taking part in the programme will be expected to take part in the national evaluation.

work stream would look the accelerated learning programme for developing expertise in person-centered approaches for each of the four target groups. Through this work stream, it is intended that the following outputs will contribute to the national evidence-base: 1) An accessible review of the evidence for the approach available in a range of formats. 2) A robust test-of-concept report of the first phase of residential training and recommendations for improvement. 3) A co-produced approach to evaluating the impact of mentoring and support function. 4) Resources developed to enable workforce development initiatives to change practice. In addition, all sites would be utilising the Personal Outcomes Evaluation Tool at a level appropriate to their stage.
What are you proposing to do to achieve this?
We recognise that a national evaluation of the programme is currently in development and project implementation plans have scope for incorporating the national guidance into our evaluation and learning work stream. However, we also believe that individual elements of the programme will benefit from formative evaluation utilising mixed methods during both the delivery and to establish whether we have achieved our aims and to define what specific lessons can be learnt through this process. We will link with APCRC and the WEESG to advise throughout. *Methodology*: Depending on the level of guidance advanced through the national evaluation, we will develop an evidence-based framework for evaluation set against the programme's stated aims and objectives. We will undertake a rapid evidence appraisal of the literature of the mentoring and support function suggested in our approach and disseminate learning of the cascade approach. We will work with key stakeholders and to further develop, define and gain buy-in on the theory of change and associated pathways. The evaluation is likely to be a mixed methods longitudinal evaluation with a formative element looking at what works, for whom and in what circumstances (Realist Evaluation – Pawson and Tilley). As this is a programme of work across a wide-range of sites and with personalisation and co-production at its core, it is anticipated that multiple evaluation methods will be explored. It is felt, for example, that an approach such as Experience-Based Design will be a unique and exciting way to evaluate change by capturing the *experiences* of a range of people, rather than just their views on the system processes. This approach deliberately draws out subjective and personal feelings and experiences at key 'touchpoints'. *Analysis:* The analytical framework will depend on the final design, however we do expect a mixed methods approach and so the quantitative data will use descriptive and/or inferential statistics, and thematic analysis will be used for the qualitative aspects. The approach will underpinned by the robust financial modelling data that will be generated as a key feature of the programme, and regular monitoring will minimise risks. *Ethics and Governance:* APCRC, as our advisor on the evaluation, have a number of core functions which include research governance assurance on behalf of all primary care research across their patch. As such, APCRC will be able to advise the steering group on the final design and whether assurance (research governance) and/or NHS ethics are required. Regardless of whether formal research ethics are required, we are committed to ethical data collection and commit following to good practice guidelines for all ethical and governance issues.

13. Main contact person

We will send all correspondence to the person named below.

Name

Frances Tippett
Job title
Quality Improvement Programme Manager
Organisation
South West Strategic Clinical Network
Email address
Frances.tippett@nhs.net
Direct landline
0113 824 9034 (Tessa Farrow, Administrative Support for the Programme)
Mobile phone number
07825 420546 (please use mobile number to get through direct)

Appendix 1

Endorsements

Voluntary & Community Sector

Steve Ford, Chief Executive, Parkinson's UK

"Parkinson's UK is pleased to lend its support to this bid. Introducing personal health budgets in the region will give people with Parkinson's greater choice and control over their care which, along with a cure and access to high quality services, is exactly what they want."

Dr Penny Woods, Chief Executive, British Lung Foundation

"The BLF are happy to endorse, in principle, the South West Regional IPC Network. The Network looks an excellent vehicle for driving patient empowerment by focusing on the issues that will make a difference to them: supported self-management, opportunities for peer support and person-centred care."

Tracey Roose, Chief Executive, Age UK Cornwall

"I am happy to endorse the South West IPC application, as it will help ensure older people gain from personalised care. This bid compliments Cornwall's Integration Pioneer work, as it is built on the principle of co-production and sharing learning. We are pleased that Cornwall is including older people with long term health conditions in the first phase implementation."

Scott Bennett, Chair, Volunteer Cornwall

"Volunteer Cornwall endorses the South West IPC bid, as it supports personalisation and focuses on changing the culture of care to shared decision making. Voluntary and community organisations have much to contribute and this application recognises the importance of the sector."

Healthwatch, Bristol

"Healthwatch Bristol welcomes the opportunity to support the Bristol CCG application to help build a new integrated and personalised commissioning approach working together to pool budgets around individuals and extending the personalisation agenda.

Healthwatch Bristol is particularly interested in in how Personal Health Budgets and integrated commissioning will be piloted."

Richard Pitman, Chief Executive, Compass Disability Services

"We have worked alongside the Somerset CCG since 2009 during the pilot and supporting service users to access a PHB since in Somerset and the surrounding CCG's. We are working regionally and nationally on PHB development. We would like to support the South West regional collaborative IPC bid."

Wendy Stevenson, Chief Executive, Voscur

"Voscur supports Bristol CCG's proposal because it understands VCS organisations are the bedrock of local communities and are key to empowering people to take ownership of their health. Bristol CCG demonstrates innovative approaches with VCS organisations, which have an important part to play in making personal health budgets a reality."

Peta Wilkinson, Chief Executive, Enham Trust

"Enham Trust fully endorse this regional application for the Integrated Personal Commissioning Programme. As an organisation that delivers support to both social care and health care service users across the South West region, we know that integration of these services and the personal budgets that go with them is essential to improve service user experiences. We are also aware of the disparity between different Councils and CCGs in their progress towards integration and personal budget provision. Joining together as a region will enable best practice to be shared and achieve greater progress. We look forward to involvement in this project."

Campbell Main, Founder, Autism Somerset

"Those affected by autism, a lifelong impairment, uniquely stand to benefit from the cross generational, cross sector, cross agency, person- centred approach to which Integrated Personal Commissioning aspires. Autism Somerset, whose membership includes individuals and their families, Health, Education and Social Care professionals and providers, strongly supports this initiative."

Diana Crump, Chief Executive, Living Options Devon

"We endorse the involvement of Voluntary and Community sector as central to the success of this programme. Living Options Devon (Devon's Disabled Peoples User Led Organisations) is keen to be involved with the SWIPC Programme to ensure service user voice is heard and acted upon during decision making processes."

Anna-Clare Temple, Business and Funding Manager, WECIL

"WECIL believes that a person-centred, integrated approach to commissioning will result in individuals achieving outcomes that are more relevant to them and enable them to exercise greater choice and control over their care and support, leading to an increased level of independence, longer community tenure and greater health and wellbeing."

CCG Accountable Officers

South Devon and Torbay

Simon Tapley, Director of Commissioning

"The CCG working with its partners is keen to build on the success of the integrated health and social care model. Through the Pioneer programme for change and Integrated Care Organisation we view the IPC as an opportunity to take the next steps in offering greater choice and accessibility for personal held budgets with improved outcomes for the individual."

Wiltshire

Deborah Fielding, Chief Officer

"I am happy to support the SW regional bid for the IPC programme. Here at Wiltshire CCG we intend to work with our partners to roll out personalised care plans for people with long term conditions and feel that the integrated approach will enable us to share learning and best practice as it is developed through the collaborative approach to the benefit of our patients."

Bristol

Jill Shepherd, Chief Officer

"Involvement in this programme fits perfectly with the CCGs vision to deliver better health and

sustainable healthcare by working with local people to ensure that they (as patients, carers and families) are at the heart of our decisions. This programme will also complement our successful bid for the Better Care Fund."

Cornwall & Isles of Scilly

Andrew Abbott, Director of Strategy

"I endorse in principle the SW IPC Proposal which will complement our plans for integration and add pace to our intentions to support our service users to have more control over their care needs which we are exploring through our Pioneer status; we are keen to share our learning and benefit from good practice in other areas."

South Gloucestershire

Jane Gibbs, Chief Officer

"South Gloucestershire CCG supports this regional proposal for the IPC programme. The programme goals are aligned with our thinking, and will support existing and future workstreams for personalisation, integrated working, and system change. These are being undertaken jointly with the local authority and partners and are reflected in the principles and priorities of the Joint Health & Wellbeing Strategy. Whilst noting that the final submission will require support from Health and Wellbeing Board, this will not be possible before 28th November."

Gloucestershire

Mary Hutton, Accountable Officer

"We support the South West IPC and would want the CCG to be fully involved in this programme as we feel that this will enable development of managed and sustainable solutions in the most effective manner."

NEW Devon

Rebecca Harriot, Chief Officer

"NEW Devon CCG's commissioning strategy includes a personalised and preventative approach. Therefore we support the South West collaborative approach to the Integrated Personal Commissioning Programme which provides an opportunity to further integrate the systems and processes which underpin personalisation with partner organisations as we collectively work towards delivering improved outcomes and experiences for individuals across Devon."

North Somerset

Mary Backhouse, Chief Officer

"Happy to endorse on behalf of North Somerset CCG."

Bath and North East Somerset

Tracey Cox, Acting Accountable Officer

"On behalf of BaNES CCG and my Local Authority Colleagues, Ashley Ayre, Strategic Director People & Communities and Councillor Simon Allen, Chair of H&WBD, we are happy in principle to support this application."

Somerset

David Slack, Managing Director

"Somerset CCG supports participation in a regional bid on the basis that within this bid we

can have a Somerset pilot project scheme which we develop locally with our identified cohorts. The regional bid will give us the benefit of sharing learning from the other area's projects as we go forward."

Local Authorities – Director of Adult Services & Director of Children Services

Bristol

Mike Hennessey, Director of Adult and Children Social Services

"Engagement in this project will undoubtedly improve the range of options for people with long term and complex conditions and their carers, reducing stress, increasing choice and control and improving outcomes for people. This fits really well with our ambition for integrating care and the broader ambitions of Towards Excellence in Adult Social Care."

Netta Meadows, Service Director - Strategic Commissioning (People Directorate)

"I think that working together to maximise the benefits of Personal Health Budgets and Integrated Personal Commissioning. Engagement in this project will undoubtedly improve the range of options for people with long term and complex conditions and their carers, reducing stress, increasing choice and control and improving outcomes for people. Of course a key benefit would be building on and adding to the range of integrated approaches and services targeted at reducing attendances at Emergency Department and the demand for admission to acute hospital services. This fits really well with our ambition for integrating care and the broader ambitions of Towards Excellence in Adult Social Care."

Torbay

Caroline Taylor, Director of Adult Services

"Torbay supports the regional proposal as the authority is committed to joint and partnership working, has shared learning and considers such approaches key to market development. This will enable a sound infrastructure to support developments by providers in offering choice and accessibility to better informed budget holders; Making the Right Thing to Do the Easy Thing to Do, which is part of our pioneer status approach."

Swindon

John Gilbert, Board Director Commissioning (DCS/DASS)

"I am happy to support this bid for demonstrator status, as it focusses upon a range of cohorts of clients that are a focus for Social care and Health who have high levels of need. Ideally these groups could also help benefit on individuals with learning disabilities and frail older people"

North Somerset

Sheila Smith, Director, People and Communities

"As DASS and DCS for North Somerset Council I confirm my agreement to the proposal. If we are to be successful then there needs to be greater collaboration within the region moving forward."

Gloucestershire

Linda Uren, Director of Children's Services and Margaret Willcox, Director of Adult Services

"We too support the proposal. Greater collaboration is required if we are to be successful."

South Gloucestershire

Peter Murphy, Director for Children, Adults and Health

"South Gloucestershire CCG and South Gloucestershire Council supports this regional proposal for the IPC programme. The goals programme are aligned with our thinking, and will support existing and future workstreams for personalisation, integrated working, and system change . These are being undertaken jointly by the CGG, local authority and relevant partners and are reflected in the principles and priorities of the Joint Health & Wellbeing Strategy."

Somerset

Patrick Flaherty, Chief Executive,

"We recognise the benefits of an integrated commissioning programme and wish to support the proposal."

Plymouth

Carole Burgoyne, Strategic Director for People

"*We are fully committed to the IPC and endorse the regional approach believing this will deliver the greatest benefit across the health and social care community.*

I am responding on behalf of Plymouth City Council as Strategic Director for People covering Children's and Adult's Social Care and on behalf of the Chair of the Health and Wellbeing Board."

Devon

Jennie Stephens, Strategic Director People

"Devon County Council promotes personalised care as a standard offer for social care. it supports the collaborative approach to the development of personalised health and social care proposed by the South West Integrated Personal Commissioning Network"

Wiltshire

James Cawley, Associate Director – Adult Social Care Commissioning and Housing

"Wiltshire Council supports the IPC bid. The Council is an innovator in the commissioning of outcome based services focused on improving personalisation in Wiltshire and support moves to look at improving personalisation through joint health and social care personal budgets."

Health and Wellbeing Board Chairs

Cornwall & Isles of Scilly

Jeremy Rowe, Health and Wellbeing Board Chair

"I endorse the SW IPC proposal which will complement our plans for integration and add pace to our intentions to support our service users to have more control over their care needs which we are exploring through our Pioneer status; we are keen to share our learning and benefit from good practice in other areas."

Devon

Andrea Davis, Health and Wellbeing Board Chair

"The proposal is endorsed because Integrated Personal Commissioning offers an opportunity for those with the most complex needs to benefit from greater control over their condition and their lives, empowering them and their families, to help them achieve better wellbeing, and which is fully consistent with Devon's Joint Health and Wellbeing Strategy."

Torbay

Dr Caroline Dimond Vice Chair HWB (absence of Cllr Chris Lewis)

"I am happy to endorse this approach. Chris Lewis is still away until 10th so as Vice Chair HWBB I hope I can act on his behalf"

Bristol

Martin Jones, Joint Health and Wellbeing Board Chair

"Involvement in this programme fits perfectly with the CCGs vision to deliver better health and sustainable healthcare by working with local people to ensure that they (as patients, carers and families) are at the heart of our decisions. This programme will also complement our successful bid for the Better Care Fund."

Somerset

Christine Lawrence, Health and Wellbeing Board Chair

"As Chair of the Somerset Health and Wellbeing Board, I am happy to support the submission to become a demonstrator site for the IPC. However, due to the short timescales required for this return, I would like to note that this issue has not been discussed by the Board and so I am responding in my role as Chair. Somerset is committed to supporting a personalised approach across the health and social care economy that recognises and values the different contributions of organisations in pursuit of the best outcome for individuals."

South West Strategic Clinical Network

Caroline Gamlin, Medical Director and Chair

"The South West SCN endorses this application. We will continue to support the South West's IPC programme actively from the Quality Improvement Programme team and through aligning to the priorities of the Network groupings. The Integrated Personal Commissioning programme is an illustration of the transformational change that networks can help deliver. The SCN looks forward to helping see the potential of this programme realised in the South West over the next three years."

Health Education South West

<u>Derek Sprague, LETB Director South West</u>

"Health Education South West (HESW) fully endorse this joint application for Demonstrator status. A South West Integrated Personal Commissioning Network will support the development of the best possible programme solution and it is the intention of HESW to be a partner in supporting the programme through education and workforce development initiatives."

South West Academic Health Science Network (SWAHSN)

<u>Dr Renny Leach, Managing Director</u>

"The SW AHSN fully supports the collaborative approach to developing capacity and capability in delivering more personalized care across the south west. This approach aims to accelerate the learning and mainstreaming of best practice and to deliver sustainable change at pace. Bringing a collaborative approach is an exciting opportunity and one where we are very keen to contribute our expertise."

West of England Academic Health Science Network (WEAHSN)

<u>Anna Burhouse, Director of Quality</u>

"The West of England Academic Health Science Network is keen to work in collaboration to support the success of the Integrate Personal Commissioning Programme, supporting its aims and vision by helping to provide quality improvement consultation and support."

South West Commissioning Support Unit

<u>Jan Hull, Managing Director</u>

"South West Commissioning Support Unit (SWCSU) is very pleased to support the regional bid for the accelerated roll out of the Integrated Personal Commissioning programme across the whole South West Region. The SWCSU recognises the potential for transforming individual lives by delivering person centred integrated care to everyone who needs it. Through our existing connections within each locality across the region (for example, through the Patients in Control, Patient Voice, and procurement programmes) and our core support to individual CCGs, we are keen to support the programme to make system change a reality at an individual level, and ensure its sustainability for the long term."

Bath, Gloucester, Swindon and Wiltshire Area Team

<u>Dr Elizabeth A Mearns FRCGP, Medical Director</u>

"This initiative and a network approach looks to be a good way forward."

Peninsula and BNSSSG Area Team Joint Executive Group (JEG)

Minutes and briefing note:

Extract from Monday 3 November JEG meeting minutes:

Frances Tippett attended this session and presented the paper on this issue and programme. It was noted that there is work to be done on building the network particularly in Banes and Glos and therefore this paper will be sent to Ian Biggs.

After discussion, the JEG agreed to:

1. Endorse the approach set out in the paper,
2. AnF will discuss and agree with Ian Biggs who should be the sponsor
3. It was suggested that Lou Farbus may be able to progress participation

Appendix 2

Clinical commissioning groups and Local Authorities in the South West Region Current position

Clinical Commissioning Group	Current PHB's in situ	Local Authority Personal Budgets
NHS Kernow	9	We are currently mapping with our Local Authorities the number of Personal Budget/ Direct Payments which may be eligible for the Integrated Personal Commissioning in the future
NHS New Devon and Plymouth City	40 (50 in pipeline)	
NHS South Devon and Torbay	47	
NHS Bristol	7	
NHS North Somerset	7	
NHS Somerset	53	
NHS South Gloucestershire	4	
NHS Bath and North East Somerset	8	
NHS Gloucestershire	10	
NHS Swindon	10	
NHS Wiltshire	3 (15 being processed)	

Appendix 3

Clinical commissioning groups in the South West Region Proposed development

Clinical Commissioning Group	Children and young people with complex needs	People with multiple long term conditions	People with a learning disability with high levels of support needs	People with significant mental health needs
NHS Kernow	Phase 1	Phase 2	Phase 4	Phase 1
NHS New Devon and Plymouth City	Phase 1	Phase 2	Phase 3	Phase 4
NHS South Devon and Torbay	Phase 2	Phase 1	Phase 2	Phase 4
NHS Bristol	Phase 1	Phase 1	Phase 3	Phase 4
NHS North Somerset	Phase 1	Phase1	Phase 3	Phase 3
NHS Somerset	Phase 1	Phase 1	Phase 4	Phase 4
NHS South Gloucestershire	Phase 2	Phase 3	Phase 2	Phase 3
NHS Bath and North East Somerset	Phase 1	Phase 2	Phase 1	Phase 4
NHS Gloucestershire	Phase 2	Phase 3	Phase 3	Phase 3
NHS Swindon	TBC	TBC	TBC	TBC
NHS Wiltshire	Phase 4	Phase 4	Phase 4	Phase 4
Current position on sites reported to date	4	3	0	4

Appendix 4

Key Resources identified.

Clinical Commissioning Group	Key Resources:		
NHS Kernow	**Children and Young People:** Project manager linked to multi agency EHC planning,	**Long Term Conditions:** Program manager & Program Lead (limited time)	**Mental health:** Program manager and program lead (Limited time)

	Community paediatrician SEND Pathfinder ECH being trialled Multi Agency resource panel established Task and finish group established Local Offer reflects PHB'S Process for paying PHB's aligned with adult CHC PHB process	Penwith Pioneer , Project plan drafted Four target groups identified Potential budget identified Review of payment methodology underway	Participation in MH PHB Webinars Project plan drafted.
NHS New Devon and Plymouth City	**Long Term Conditions:** Identification of small roll out team for PHB's and IPC programme, Support from IATC Programme to assist with project management.	**People with a Learning Disability:** Identification of small roll out team for PHB's and IPC programme, Support from IATC Programme to assist with project management.	**Mental health:** Identification of small roll out team for PHB's and IPC programme, Support from IATC Programme to assist with project management.
NHS South Devon and Torbay	**Long term Conditions:** Project lead Integrated team between CCG. and Local Authority	**Children with complex needs:** Project Lead Integrated team between CCG. and Local Authority	**People with a Learning disability:** Key resources to be identified
NHS Bristol	**Children with Complex needs:** Programme manager CHC Programme support manager West of England centre for inclusive living	**Long Term Conditions:** Programme manager CHC Programme support manager Locality system for identifying priority patients West of England centre for inclusive living	**People with a learning disability:** Key Resources to be identified West of England centre for inclusive living
NHS North Somerset	**Long Term Conditions:** Integrated working relationship with local authority Budget sharing protocol in situ Good local authority process in situ for people with LTC that can be adapted	**Children with Complex needs:** Integrated working relationship with local authority Budget sharing protocol in situ Commitment to SEND roll out ongoing Multi-agency transitions group	
NHS Somerset	**Long Term Conditions:** Commissioning Office Strategic commissioning lead Existing support services	**Children with Complex needs:** Commissioning Office Strategic commissioning lead Existing support services	

	Up to 1200 LA personal budget holders have been identified some of whom may be eligible for an integrated Personal Budget.			
NHS South Gloucestershire	**Eclectic approach is being developed for all groups based on a risk stratification criteria:** PHB Project management board GP lead for LTC Director of partnerships and joint commissioning GP clusters working on risk stratification			
NHS Bath and North East Somerset	**Eclectic approach is being developed for all groups with no specific target group with initial focus on Children and People with a learning disability.** Remodelling of existing social care pathway is underway, Project manager and lead nurse funding in situ			
NHS Gloucestershire	**Children and Young People:** Project lead Children's PHB Lead Joint Commissioner for Children Executive support from Director of Finance Gloucestershire County Council, Education department, Health Watch	**Long Term Conditions:** Long term conditions team Gloucestershire County Council Health Watch	**Learning Disability:** LD Clinical Case Manager LD team Gloucestershire County Council Health Watch	**Mental Health:** Gloucestershire County Council Health Watch
NHS Swindon	2 workers identified to support the role out of this programme			
NHS Wiltshire	Eclectic approach is being developed in Wiltshire to be prioritised on risk stratification criteria Commissioning leads and clinical leads in place for people with long term conditions Integrated Community Teams programme currently delivering - 3 demonstrator sites will be up and running before end Dec14 delivering integrated health and community services, further 17 sites established across Wiltshire Current focus on delivering personalised care planning			

Key Partners engaged and committed.

Clinical Commissioning Group	Key Resources:		
NHS Kernow	Long Term Conditions: Cornwall County Council Primary Resource Age UK Cornwall and isles of Scilly, Volunteer Cornwall Disability Cornwall Many other smaller local organisations Cornwall Health and Wellbeing Board Isles of Scilly Health and Wellbeing Board	Children and Young People: Cornwall County Council Parent Carer Council Hear Our Voice (young People Cornwall) Cornwall Health and Wellbeing Board Isles of Scilly Health and Wellbeing Board	Mental Health: Cornwall County Council Voluntary sector provider forum (12 organisations)
NHS New Devon and Plymouth City	**Long Term Conditions:** Project Board (including existing budget holders) Devon County Council Plymouth City Council Project board Enham Trust Living Options	**People with Learning Disability:** Project Board Devon County Council Plymouth City Council Project board Enham Trust Living Options	**Mental health:** Project Board Devon County Council Plymouth City Council Project board Enham Trust Living Options
NHS South Devon and Torbay	**Long term Conditions:** Devon County Council Torbay Council South Devon Healthcare Foundation Trust Torbay and Southern Devon Health and Care Trust Torbay Community Development trust Newton Abbot Frailty Hub (Numerous local support groups)	**Children with complex needs:** Devon County Council Torbay Council South Devon Healthcare Foundation Trust Torbay and Southern Devon Health and Care Trust Torbay Community Development trust	**People with a Learning disability:** Devon County Council Torbay Council South Devon Healthcare Foundation Trust Torbay and Southern Devon Health and Care Trust Torbay Community Development trust
NHS Bristol	**Children with Complex needs:** Bristol City Council Education department Health and Wellbeing board	**Long Term Conditions:** Bristol City Council Health and Wellbeing board West of England centre for inclusive	**People with a learning disability** Bristol City Council Health and Wellbeing board West of England centre for inclusive

<table>
<tr><td></td><td>West of England centre for inclusive living,
Healthwatch
Accelerated development programme</td><td colspan="2">living,
Healthwatch
Have identified over 700 LA budget holders some of which will be eligible for a PHB</td><td>living,
Healthwatch
Proportion of 700 identified personal budget holders will have a Learning Disability</td></tr>
<tr><td>NHS North Somerset</td><td colspan="2">Long Term Conditions:
Local Authority
1 in 4 (mental health charity)
People First (learning disability user lead organisation)
Age Concern
Healthwatch
Identified over 300 adults with a personal budget of which some may be eligible for a PHB</td><td colspan="2">Children with Complex needs:
Local Authority
Multi Agency working group
Healthwatch
Identified up to 130 children for SEND program some of which may have PHB eligibility.</td></tr>
<tr><td>NHS Somerset</td><td colspan="2">Long Term Conditions:
Commissioning Support Unit
Somerset County Council
Compass Disability (Brokerage and support)
NDTI training
Developing e-market
Developing peer support systems</td><td colspan="2">Children with Complex needs:
Commissioning Support Unit
Somerset County Council
Compass Disability (Brokerage and support)
NDTI training
Developing e-market
Developing peer support systems</td></tr>
<tr><td>NHS South Gloucestershire</td><td colspan="4">All Groups:
South Gloucestershire Council
Health and Wellbeing Board
The care forum (South Gloucestershire voluntary sector)
West of England Centre for Integrated Living (Wecil)</td></tr>
<tr><td>NHS Bath and North East Somerset</td><td colspan="4">All groups:
Bath and North East Somerset Council
Integrated health and social care organisations
Peer network
5 Year plan
Direct payment support and advice in situ
Bath HDI</td></tr>
</table>

<table>
<tr><td></td><td colspan="4">PheoniX
Age UK Banes
Compass Disability</td></tr>
<tr><td>NHS Gloucestershire</td><td>Children and Young People:
Gloucestershire County Council,
Education department,
Health Watch</td><td>Long Term Conditions:
Gloucestershire County Council
Health Watch</td><td>Learning Disability:
Gloucestershire County Council
Health Watch</td><td>Mental Health:
Gloucestershire County Council
Health Watch</td></tr>
<tr><td>NHS Swindon</td><td colspan="4">TBC</td></tr>
<tr><td>NHS Wiltshire</td><td colspan="4">TBC</td></tr>
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