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BARRY KEEL
Chief Executive
Floor 1 - Civic Centre
Plymouth
PL1 2AA

www.plymouth.gov.uk/democracy

Date 20/10/09 Telephone Enquiries 01752 307815 Fax 01752 304819

Please ask for Katey Johns, Democratic Support Officer e-mail katey.johns@plymouth.gov.uk

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

DATE: WEDNESDAY 28 OCTOBER, 2009
TIME: 10.00 A.M.
PLACE: COUNCIL HOUSE, ARMADA WAY, PLYMOUTH

Committee Members–
Councillor Mrs. Watkins, Chair.
Councillor Mrs. Aspinall, Vice-Chair.
Councillors Berrow, Browne, Delbridge, Gordon, Kerswell, Mrs. Nicholson and Stark.

Co-opted Representative-
Chris Boote, Local Involvement Network (LINk).

Substitutes–
Any Member other than a Member of the Cabinet may act as a substitute member provided that they do not have a personal and prejudicial interest in the matter under review.

Members are invited to attend the above meeting to consider the items of business overleaf.

BARRY KEEL
CHIEF EXECUTIVE

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

PART I (PUBLIC MEETING)

AGENDA

1. APOLOGIES

To receive apologies for non-attendance submitted by panel members.

2. DECLARATIONS OF INTEREST

Members will be asked to make any declarations of interest in respect of items on this agenda.

3. MINUTES (Pages 1 - 8)

The panel will be asked to confirm the minutes of the meeting held on 23 September, 2009.

4. CHAIR'S URGENT BUSINESS

To receive reports on business which, in the opinion of the Chair, should be brought forward for urgent consideration.

5. ADULT SOCIAL CARE SERVICE PERFORMANCE UPDATE (To Follow)

The Director for Community Services' Business Manager will provide a performance update in respect of Adult Social Care.

6. ADULT SOCIAL CARE - INTEGRATED SERVICES (Pages 9 - 18)

The Assistant Director for Community Services (Adult Social Care) and the Chief Executive of NHS Plymouth will update the panel on progress with provision of integrated services. A copy of the report which was submitted to Cabinet on 11 August, 2009, is attached for Members' information.

7. NHS PLYMOUTH STRATEGIC PLAN

The Chief Executive of NHS Plymouth will attend to update panel on progress with its Strategic Plan.

8. PANDEMIC INFLUENZA PLAN

The Chief Executive of NHS Plymouth will report on the Pandemic Influenza Plan.

COMFORT BREAK - THERE WILL BE A 10-MINUTE ADJOURNMENT FOLLOWING CONSIDERATION OF THE ABOVE ITEM.

9. RESIDENTIAL CARE: UPDATE OF MODERNISATION OF OLDER PEOPLE SERVICES 2005-2015 - CONSULTATION RESULTS **(Pages 19 - 56)**

The Head of Modernisation Adult Social Care will submit a report providing feedback on the consultation which took place about respite provision in the City and the future of Whitleigh Residential Respite Home.

10. HYPERBARIC MEDICAL CENTRE **(Pages 57 - 66)**

The panel will receive a presentation on the facilities available at the Hyperbaric Medical Centre. A copy of the presentation handout is attached.

11. PLYMOUTH HOSPITALS TRUST STRATEGY REVIEW 2009 **(Pages 67 - 74)**

The Chief Executive of Plymouth Hospital's Trust will present details of the Trust's Strategy Review. A copy of the presentation handout is attached.

12. EXEMPT BUSINESS

To consider passing a resolution under Section 100A(4) of the Local Government Act 1972 to exclude the press and public from the meeting for the following item(s) of business on the grounds that it (they) involve the likely disclosure of exempt information as defined in paragraph(s) of Part 1 of Schedule 12A of the Act, as amended by the Freedom of Information Act 2000.

PART II (PRIVATE MEETING)

AGENDA

MEMBERS OF THE PUBLIC TO NOTE
that, under the law, the committee is entitled to consider certain items in private. Members of the public will be asked to leave the meeting when such items are discussed.

NIL.

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Agenda Item 3

Health and Adult Social Care Overview and Scrutiny Panel

Wednesday 23 September, 2009

PRESENT:

Councillor Mrs. Watkins, in the Chair.
Councillor Mrs. Aspinall, Vice-Chair.
Councillors Berrow, Browne, Delbridge, Gordon, Mrs. Nicholson and Stark.

Co-opted Representative: Vacancy

Apology for absence: Councillor Kerswell.

The meeting started at 10.00 a.m. and finished at 1.15 p.m.

Note: At a future meeting, the committee will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

11. **DECLARATIONS OF INTEREST**

There were no declarations of interest made in accordance with the Code of Conduct.

12. **MINUTES**

Resolved that the minutes of the meeting held on 29 July, 2009, be confirmed as a correct record.

13. **Co-options**

The Chair –

(i) sought the panel's opinion on co-opting non-executive board members from the Primary Care Trust and Plymouth Hospital NHS Trust;

(ii) reported that Barry Lucas, LINk representative, had stepped down from his role on the panel for health reasons and, as an interim measure, Vicky Shipway from Colebrook Housing would be attending meetings in order to keep Members informed of the LINk's progress.

In regard to (ii) above, Vicky Shipway advised that the Chair of the LINk's Stewardship Group, Chris Boot, had agreed to take on the role and would be attending future meetings of the panel.

Resolved that –

(1) letters be sent to the Primary Care Trust and Plymouth Hospital NHS Trust inviting each of them to nominate a non-executive board member to serve as a co-opted representative on the panel;

(2) the LINk's replacement Co-opted Representative nomination be noted and referred to the Overview and Scrutiny Management Board for approval.

14. **Nomination of Substitute for Management Board**

The panel was advised of the need to appoint a substitute member to attend meetings of the Overview and Scrutiny Management Board, as per the Management Board's terms of reference. The rationale behind this was to ensure that each scrutiny panel was represented

at every meeting of the Management Board. The substitute member must have received the required finance training and be from the same political party as the member for whom they were substituting.

Resolved that Councillor Stark be the nominated substitute from the Health and Adult Social Overview and Scrutiny Panel.

15. **Quarterly Scrutiny Report**

The panel was advised that the Overview and Scrutiny Management Board would be receiving quarterly scrutiny reports at its 4 November meeting. As not all panels were meeting in October, it would be necessary to consider delegating approval of the scrutiny reports to the Lead Officer, in consultation with the Chair and Vice-Chair, prior to their submission to Management Board.

Resolved that delegated authority be given to the Lead Officer of the panel, in consultation with the Chair and Vice-Chair, to approve the panel's quarterly scrutiny report prior to it being forwarded to the Overview and Scrutiny Management Board meeting on 4 November, 2009.

(In accordance with Section 100(B)(4)(b) of the Local Government Act, 1972, the Chair brought forward the above item of business because of the need to consult Members).

16. **SOFT TISSUE SARCOMA**

The panel considered a report by the South West Specialised Commissioning Group regarding service development proposals for the treatment of soft tissue sarcoma in adults. The report –

(i) indicated that, currently, patients from the Peninsula Cancer Network (Cornwall and the Isles of Scilly, Plymouth, Torbay and Devon) were treated by Royal Devon and Exeter NHS Foundation Trust or Plymouth Hospitals NHS Trust;

(ii) advised that there had been 279 incidence within the Peninsula in the last 3 years;

(iii) proposed that two centres be provided in the north and south of the region to serve the Avon, Somerset and Wiltshire and Peninsula populations.

In response to questions raised, the panel heard –

(iv) that the South West Specialised Commissioning Group was responsible for putting together the proposal as far as surgery and any associated treatments were concerned. However, behind this proposal, and any other service changes, there would be a need for a health and social care framework to be put in place to support it;

(v) that following the initial round of consultations with the Peninsula health scrutiny panels, the next stage would be a competitive procurement process to select a provider for each network. Once this had been completed, the South West Specialised Commissioning Group would return to the scrutiny panels with its final recommendations for approval;

(vi) with an increasing ageing population, it was anticipated that there would also be an increase in incidences of sarcoma;

(vii) that part of the preliminary specification for this service change proposal would include training for GPs around diagnosis then, as knowledge and diagnosis improved, referrals would be able to be made direct to the specialist centre;

(viii) that the views of the other scrutiny panels would be circulated to panel members for their information.

The panel welcomed the comprehensive report, particularly the inclusion of the glossary which had been most helpful, and thanked the representatives from the South West Specialised Commissioning Group for their attendance. Although the principle of developing centres of excellence was welcomed, Members recognised that patients had other outcomes to consider besides medical, such as emotional and financial wellbeing. They, therefore, asked that steps be taken to ensure the needs of patients having to travel and requiring overnight stays be met and supported along with those of their families.

Resolved that -

(1) the proposed approach to providing soft tissue sarcoma services for residents be noted;

(2) the improved quality and safety of the service that residents would receive be noted;

(3) the involvement of patients, clinicians and the public in the process to date be noted;

(4) the proposed approach, including the intention to designate two soft tissue sarcoma centres in the South West region, ready for service delivery in Spring 2010 be supported.

17. **SOUTH WEST AMBULANCE SERVICES NHS TRUST - FOUNDATION TRUST CONSULTATION**

The panel welcomed Lynne Paramor, Associate Director of Strategic Communication and Public Relations, who was in attendance to present and consult upon the Trust's proposals for achieving Foundation Trust status. Members were advised that this was the start of the statutory 12-week consultation period and the aim of the presentation was to seek their views on the Trust's –

- Mission, vision and values
- Journey so far and future priorities
- Thoughts about the benefits of becoming an NHS Foundation Trust
- Proposed membership plans
- Proposed Governance and Council of Governors
- Plans for what happened next

In response to questions raised, the panel heard that –

(i) charges were applied for ambulance call-outs in certain circumstances. The nature of those circumstances, together with details of the amount charged would be provided to the panel members in writing;

(ii) the Fire Authorities were aware of the Trust's proposals through discussions held at Chief Executive level;

(iii) over 144 consultation events, including 5 all-day events, had been scheduled along with relevant press and media coverage. One of the all-day events would take place at Plymouth Guildhall on Monday 5 October, 2009, and panel Members would be most welcome to attend

(iv) membership of the Council of Governors would be split geographically and per capita.

The Chair congratulated the Trust on being the best performing ambulance trust in the Country and welcomed the fact that the citizens of Plymouth benefitted from such an excellent service.

Resolved that the –

(1) Trust's application for Foundation Trust status be supported;

(2) panel makes a formal response to the consultation.

18. **LINk UPDATE**

The panel welcomed Vicky Shipway, LINk/PAPOP Support Team Manager, who was in attendance to provide an update on the work of the LINk. Members heard –

- how the LINk had been establishing itself in its first year of operation and was continuing to develop and build new relations
- that as a result of successful promotion across the City it now had over 1,000 members
- that it had been training its Visiting Team in preparation for undertaking unannounced inspections
- that it had looking at ways of working with scrutiny and had produced a draft protocol
- that it had been identifying priorities for inclusion in its work programme and these had now been agreed as –

    - GPs – focus on promotion of extended opening hours
    - Dentists – lack of access
    - Mental Health Services – focus on promotion of what is available
    - Derriford Hospital – waiting times
    - Carers' Support – promotion of availability

In response to a question raised, the panel heard that NHS Plymouth was responsible for putting together and publicising the list of available NHS dentists in the City and this was available on its website.

19. **MATERNITY SERVICES - MONITORING PROVISION/ACTION PLAN**

The panel welcomed the Chief Executive of Plymouth Hospitals NHS Trust, together with the Acting Heads of Midwifery, who were in attendance to report on the provision of maternity services at Derriford Hospital. The presentation updated Members on progress being made on the following –

- Healthcare Commission Action Plan
- National Maternity Drivers
- Maternity and Newborn Care Programme
- Maternity and Newborn Strategy

In response to questions raised, Members were advised that –

(i) representatives from the Midwifery Service were on the working group that had been set up to look at teenage pregnancies and repeat conceptions;

(ii) the patient survey (which was anonymous) had been split into 3 categories to specifically target post-natal care and encourage a higher response rate all round, however, an overall return of 54% had established that this had not been the case and the next patient survey would be reverting to its former format;

(iii) over 30% of pregnant women using Derriford's maternity services were classified low-level risk and did not need to be in a hospital environment. A

national driver, and one of the Trust's strategic health targets, was to provide an alternative place of birth and, to this end, a business plan had been put together for providing a purpose-built midwifery unit. The proposal would be considered by the Trust's Capital Strategy Group next month;

(iv) the length of stay in hospital was dependent upon the type and nature of delivery. However, the results of the patient survey indicated that the majority of women felt their length of stay had been appropriate;

(v) women were given access to 6 sessions of pre-natal care, one of which focussed on breastfeeding. These sessions were generally provided at community health or children's centres;

(vi) the Hospital's Trust and Plymouth City Council were working very closely together toward achieving Baby Friendly status for the City. The first stage of the assessment had been completed and the assessment for the second stage was expected by the end of the year;

(vii) there were a total of 202 midwives employed by the Trust. Those working in the Hospital provided care for women from as far a field as South East Cornwall, West Devon and the South Hams. Those working in the community provided care to women, not only in Plymouth, but from parts of the South Hams, West Devon and down to South East Cornwall;

(viii) the quarterly report on smoking cessation was currently awaited, however, there had been a definite improvement in take-up since the Smoking Cessation Service had been making contact direct in addition to communicating through the Community Midwives.

The Chair noted with interest that the Midwifery Service was represented on the teenage pregnancy working group and suggested that they may wish to participate in the joint task and finish group which was being set up to look at sexual health (minute 23(2) refers).

The panel welcomed the presentation and thanked the representatives from Plymouth Hospitals NHS Trust for their attendance.

Resolved that a copy of the Maternity Strategy be presented to the panel when available.

20. **FOUNDATION TRUST STATUS AND HYGIENE CODE UPDATE**

The panel welcomed the Chief Executive of Plymouth Hospitals NHS Trust and the Director of Nursing and Midwifery/Nurse Consultant in Critical Care, who were in attendance to report on cleanliness at Derriford Hospital and update Members on the Trust's application for Foundation Trust status.

With regard to improving cleanliness, Members were advised that –

(i) following an unannounced visit by the Healthcare Commission in June 2008, the Trust was found to have been in breach of two of the three Hygiene Code standards;

(ii) the Trust had immediately drawn up an action plan to address the concerns raised and a cleanliness action group now met on a fortnightly basis. In addition, the following four work streams had been developed to help the Trust improve the situation and maintain consistently higher standards -

- Developing a culture of ownership
- Standardising and improving the process
- Enhancing the environment
- Increasing user involvement and public confidence

(iii) the Care Quality Commission had undertaken a conditions review visit in July, 2009, and had been satisfied with the 5 wards inspected. As a result, the Condition imposed in June 2008 had been lifted with effect from August 2009;

(iv) unannounced yearly inspections by the Care Quality Commission would continue to take place.

In response to questions raised, Members were advised that –

(v) every cleaner working at the hospital had met with the new contract provider to discuss the new working arrangements;

(vi) that the service level agreement would be monitored, in the first instance, at ward level. This would be backed up by a series of inspections from which a database would be compiled and any trends quickly identified dealt with;

(vii) visitors were not permitted to sit on patients' beds;

(viii) staff leaving the hospital in their uniform were only supposed to do so if they were going directly home, otherwise it should be removed before leaving work.

The Chair commented that she had been most encouraged on her last visit to Derriford and was confident that the new contract provider would be a vast improvement. This feeling was reiterated by other panel Members who had recently visited the hospital, along with positive comments about the improvements to lighting and signage.

With regard to Foundation Trust status, Members were advised that the Trust had taken the decision not to pursue its application until next year when they would have to start the process all over again. They would be focussing on delivering good healthcare instead and if this was achieved, Foundation Trust status would follow.

The panel welcomed the presentation and thanked the representatives from Plymouth Hospitals NHS Trust for their attendance.

Resolved that number of extra staff employed as a result of the change in service provider be forwarded to the Democratic Support Officer for onward dissemination to panel Members.

21. **LOCAL STRATEGIC PARTNERSHIP - HEALTHY THEME GROUP MINUTES**

The panel received for its information a copy of the Local Strategic Partnership's Healthy Theme Group minutes of the meeting held on 18 May, 2009.

Resolved that –

(1) the minutes be noted;

(2) a copy of the Health Poverty Index 2007 be circulated to panel members for their information.

22. **TRACKING RESOLUTIONS**

The panel received for its information a copy of the tracking resolutions schedule. With regard to –

(i) Minute 7 – Dementia Strategy

since the agenda had been published several members had expressed an interest in the proposed memory clinic visit and arrangements would now be

put in place for this to proceed. Councillor Gordon asked that his name be added to the list;

(ii) Minute 8 – Tracking Resolutions (Use of Sunbeds)

the view of the Mayflower Trust Board remained unchanged and the sun bed would be kept in-situ until the Mayflower Centre was replaced by the Life Centre. The Chair would write again to the Cabinet Member providing him with the supporting evidence from the World Health Organisation and seeking an assurance that sun beds would not be installed in the Life Centre.

23. **WORK PROGRAMME**

The panel considered its work programme for 2009/10, as presented in its new format. The Chair also reported on progress being made on the health projects awareness-raising day which would provide an opportunity for community groups to showcase their work and inform Members of the additional services that were available locally to help support communities live healthier lives. The event would be held at the Jan Cutting Healthy Living Centre at a date to be advised. Finally, nominations were sought for a representative of the panel to serve as a member of the Plymouth Hospitals NHS Trust multi-storey car park working group.

Resolved that –

(1) the new format work programme be noted;

(2) the three nominations requested for the joint task and finish group with the Children and Young People's Overview and Scrutiny Panel be confirmed as –

- Councillor Mrs. Watkins
- Councillor Mrs. Aspinall
- Councillor Delbridge

(3) Councillor Stark be appointed as the panel's representative to the Plymouth Hospitals NHS Trust's multi-storey car parking working group.

24. **EXEMPT BUSINESS**

There were no items of exempt business.

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CITY OF PLYMOUTH

Subject:	Establishing Health and Social Care Integration Board
Committee:	Cabinet
Date:	11 August 2009
Cabinet Member:	Councillor Dr. Salter
CMT Member:	Director for Community Services
Author:	Carole Burgoyne, Director for Community Services
Contact:	Tel: (01752) (30)7525 e-mail: ann.haley@plymouth.gov.uk
Ref:	
Part:	I

Executive Summary:

This report seeks Cabinet's support to end the shadow status of the Health and Social Care Integration Board and establish it formally in accordance with the attached report.

It proposes the underlying principles, scope and priorities that both organisations will adopt as a framework to secure an integrated approach to improving the health and wellbeing of the people of Plymouth.

There have been a number of key collaborations and experiments, the learning from which underpins the content of this report: they include an Integrated Care Commission at the most senior level, a pilot integrated team in Devonport, collaborative projects to enhance out-of-hospital care, joint approaches to commissioning, and, not least, the establishment of a shadow Board to provide overall accountability and governance. This has created a platform of understanding and increased trust on which it is proposed we will now build a set of more formally integrated organisational arrangements.

Corporate Plan 2009-2012:

Establishing an Adult Health and Social Care Integration Board will contribute to the delivery of Corporate Improvement Priority 3 which is 'Helping people to live independently'. It is aiming to provide joint working arrangements between health and social care and make it easier for service users to access advice, help and assessment processes.

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land

There are no immediate financial implications from the establishment of the Board, but as work progresses there will be opportunities for efficiencies in facilities and IT through co-location of staff across Health and Adult Social Care.

Other Implications: e.g. Section 17 Community Safety, Health and Safety, Risk Management, Equalities Impact Assessment, etc.

These areas will be addressed as the programme is developed and implemented.

Recommendations & Reasons for recommended action:

1. That Cabinet agree the proposal and formally approve the establishment of the Health and Social Care Integration Board, and
2. That the Cabinet Member for Adult Health & Social Care is delegated responsibility to sign a formal Memorandum of Understanding on behalf of both partner organisations at the next meeting of the Board.

Alternative options considered and reasons for recommended action:

No alternative options have been considered at this stage.

Background papers:
Direction of Travel of Adult Social Care and Health Services – Cabinet report 16 December 2008
Draft Proposals for Partnership (Version 1.3) July 2009

Sign off:

Fin	CoSF AC910 001 (JB)	Leg	LT1039	HR		Corp Prop		IT		Strat Proc	
Originating SMT Member Carole Burgoyne											

1.0 Context

A paper was presented to Cabinet in December 2008 setting out the direction of travel for Plymouth Adult Social Care and Health Services. It sought support to set up a shadow Partnership Board to improve joint working and integration with the NHS Plymouth.

The report described how the Government White Paper, 'Our health, our care, our say', which had been published in January 2006, had set out a new direction for the whole health and social care system. This was alongside a number of other government papers, which had placed a greater emphasis on the personalisation agenda and transforming the way in which services are delivered.

1.1 Our overall approach for the city is consistent with national policy requirements, including the *Putting People First* concordat, the drive for "world class" commissioning in the NHS, and the personalisation of health and social care. We will also seek to realise the seven outcomes specified in *Our Health, Our Care, Our Say* and we will monitor our own performance against these.

The emerging evidence (local, national and international) suggests strongly that fully integrated services, readily accessible at local level and linked to Primary Health Care, are a key component in producing these overall outcomes. This will be the central theme of future commissioning. As a consequence, our approach to the NHS policy of *Transforming Community Services* is to seek to bring together the Provider services of NHS Plymouth and the Council's Adult Social Care. This can be a strong foundation for the personalised care which we are both expected to provide, maximising opportunities for individuals to commission their own care and support.

1.2 The Cabinet member for Adult Health and Social Care has been chairing the Shadow Board since it was established and it has met on a regular basis. At the shadow Health and Social Care Integration Board meeting in July 2009 a draft proposal was presented by the Director of Community Services and the Chief Executive of NHS Plymouth to end the shadow arrangements and establish the Board formally in accordance with the report. The shadow Board supported the proposals and tasked the lead officers to take the proposal to the City Council Cabinet and to the NHS Executive Board for approval. The draft proposal is attached.

1.3 It is recommended that this proposal is accepted and the report should become the basis of a formal Memorandum of Understanding to be signed on behalf of both partner organisations following approval from Cabinet and NHS Plymouth Board.

1.4 It is important that this work is developed in conjunction with work being undertaken through the Children's Trust and the Directors for Community Services and Children's Services will be required to ensure appropriate links are made in areas that impact on both service areas.

1.5 This work will also need to link together the support services across the two organisations and there is a proposal that work is undertaken to establish a Public Sector Board across the Local Strategic Partnership to progress more efficient working and use of buildings, ICT and other support services. This will be subject to a separate report when further work has been undertaken.

Draft Proposals for Partnership (Version 1.3) July 2009

Report of the Director of Community Services, Plymouth City Council and the Chief Executive of NHS Plymouth

An integrated approach to health and wellbeing will require a step change in the relationship between local NHS organisations, local government, other relevant statutory services, employers, third sector and independent sector providers. We want to ensure synergy between the development of vibrant primary and community care services and the 'Putting People First' transformation programme led by local government. We will provide support to those organisations that wish to go further in integrating health and social care services.

(NHS Next Steps Review, 2008)

Outcomes for Joe;

Easier access,
Quicker responses,
Simpler to get decisions
Fewer errors,

Joe in control.

Recommendations:

1. **This final draft Report should be considered and approved subject to any amendments**
2. **The Health and Social Care Integration Board should now end its "shadow" status and be established formally in accordance with this report**
3. **This report should become the basis of a formal Memorandum of Understanding to be signed on behalf of both partner organisations at the next meeting of the Board.**

Introduction – the journey so far

This report proposes the underlying principles, scope and priorities that both organisations will adopt as a framework to secure an integrated approach to improving the health and wellbeing of the people of Plymouth. Both partners recognise their obligation to cooperate in the most effective way to overcome the historical fragmentation of policy and provision, which has resulted in services which are currently: fragmented and inequitable; duplicated across health and social care; and difficult to access and navigate.

In the two years of preliminary work which have led to this proposal, we have been driven by the desire to focus any change on the overarching objective of improving care for the individual. We have invented "Joe" to embody this, and have settled some simple common-sense outcomes to convey the core vision (see front cover). We believe that these can only become a reality, and only be sustained, through integrating appropriate functions of our organisations at every level: corporate, strategic, operational, and practice.

There have been several key collaborations and experiments, the learning from which underpins the content of this report: they include an Integrated Care Commission at the most senior level, a pilot integrated team in Devonport, collaborative projects to enhance out-of-hospital care, joint approaches to commissioning, and, not least, the establishment of a shadow Board to provide overall accountability and governance. This has created a platform of understanding and increased trust which on which we will now build a set of more formally integrated organisational arrangements.

The framework proposed here primarily aims to ensure that everyone can now understand the necessary changes, and focus on implementing them. However, detailed Agreements will be necessary along the way. These Agreements will be made under s75 of the National Health Service Act 2006, ie using the "flexibilities" created originally under s31 of the Health Act 1999, and will include *inter alia* all matters pertaining to finance, and to the efficiency savings we expect to achieve from the start.

Vision

Integrated Care means advanced arrangements for joint working between health and social care, and any integrated service should therefore:

- be easy for service users to access for advice and help
- offer the maximum opportunity for self-determination, choice and control for individuals
- have the simplest processes for assessment and decision making
- enable the swiftest delivery of whatever help is needed, with no needless delays and buck passing
- have the least risk of errors and the highest quality clinical and personal outcomes
- be cost effective

A key element of the future vision is decentralisation of service delivery to the six localities of the city designated by the Local Strategic Partnership. This is where public engagement can be made a reality, and key stakeholders from all services and sectors (inc Primary Health Care) can inter-relate more readily and respond to community needs more directly. This defines for us a *principle of subsidiarity*: services and developments should be made accessible locally unless it is impractical or inefficient to do so

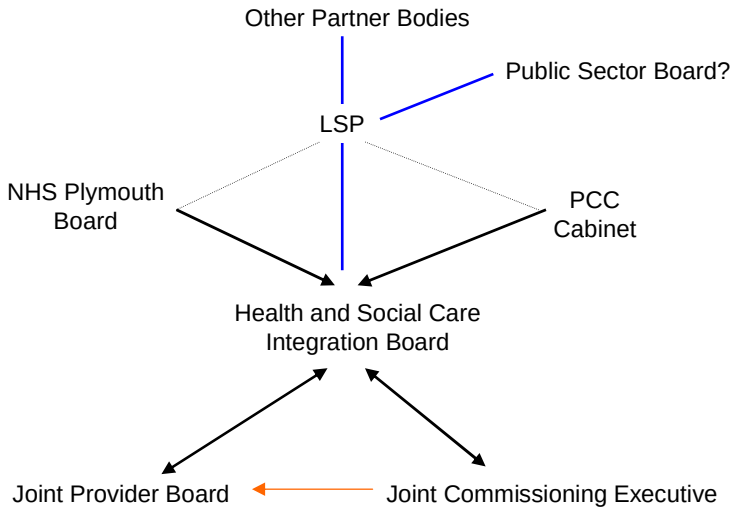
Our overall approach for the city is consistent with national policy requirements, including the *Putting People First* concordat, the drive for "world class" commissioning in the NHS, and the personalisation of health and social care. We will also seek to realise the seven outcomes specified in *Our Health, Our Care, Our Say* and we will monitor our own performance against these:

1. Improved Health & Wellbeing
2. Improved quality of Life
3. Making a Positive Contribution
4. Increased Choice & Control
5. Freedom from Discrimination & Harassment
6. Economic Wellbeing
7. Maintaining Dignity & Self Respect

To oversee and ensure this, we will now formally establish Governance arrangements in the form of a joint ***Health and Social Care Integration Board***, *which will operate under powers delegated by the two statutory partners*, who retain ultimate accountability individually. This will replace the shadow Board which was formed in December 2008. A constitution and terms of reference will need to be agreed forthwith. This will include responsibility to establish a separate Board which will be accountable for the governance of integrated health and social care Provision, and relationships with primary health care services.

The Health & Social Care Integration Board will make links with, and be influenced by, the Local Strategic Partnership. In due course it is expected that a "Public Sector Board" also linked to the LSP will come into existence, through which we also expect to achieve efficiencies for health and social care in the joint use of land and buildings, information technology, and support services generally.

In outline, the new Governance framework will be:



Shaping the future of care together

NHS Plymouth and the City Council each have a core responsibility to identify the needs of the city and to use available resources to address them effectively. We must also undertake a regular Joint Strategic Needs Assessment.

Building on experiences over the last few years, which have included a number of joint appointments and informal coordination of plans, we will now commit ourselves formally:

- to unite around the outcomes we are jointly seeking,
- to approve all strategic plans jointly,
- to set collective annual priorities and goals, and
- to pool resources where appropriate when commissioning services to meet the needs identified.

Under the direction of the Integration Board, we will establish a ***Joint Commissioning Executive***, led jointly by the council's Director of Community Services and the Chief Executive of NHS Plymouth. This is to replace the Integrated Care Commission. It will be responsible initially for implementing our overall approach, including the development of integrated commissioning, and then for securing the agreed outcomes in the longer term.

At the strategic level, commissioning is the process by which together we will ensure better health and well-being, better care and best value for the citizens of Plymouth. Our commitment is to:

- develop plans that are based on good evidence of needs and effectiveness, with a focus on reducing health inequalities and improving health outcomes
- engage service users, health and social care staff and other stakeholders in forming plans that meet local needs and priorities
- stimulate the market to ensure that services are available to meet demands and achieve good outcomes

- invest our collective resources to increase choice, drive continuous improvement and innovation, and secure gains in health and well-being

- evaluate critically the impact of our investment decisions

The emerging evidence (local, national and international) suggests strongly that fully integrated services, readily accessible at local level and linked to Primary Health Care, are a key component in producing these overall outcomes. This will be the central theme of future commissioning. As a consequence, our approach to the NHS policy of *Transforming Community Services* is to seek to bring together the Provider services of NHS Plymouth and the Council's Adult Social Care. This can be a strong foundation for the personalised care which we are both expected to provide, maximising opportunities for individuals to commission their own care and support.

We recognise that a change of this magnitude will require an early investment: we will commission a time-limited Integrated Care Transformation Team which will have the skills, resources and credibility to drive forward the delivery of our vision.

Governance of integrated Provider Services

The vision being developed for *Transforming Community Services* entails:

- city-wide, universal advice and information services, also able to commission simple services directly – a one-stop shop
- a new integrated personal and proactive service for people with more complex care needs in six localities, each with a single jointly appointed Manager and linked to local primary healthcare services, which will provide high quality, seamless and tailor-made care and services in people's homes and in the local community
- some additional specialist provision to support the six localities, and to facilitate hospital discharges

Providers will be required to embed key principles into services. They must:

- eradicate needless delay;
- deliver evidence-based, high quality clinical and professional care, providing cost effective outcomes for individuals and the tax payer;
- be proactive in supporting self determination and independence – for example through the use of individual budgets, direct payments, self care, and self directed support,
- work in partnership with the independent and community organisations to facilitate access to community based services to support individual's well-being - reducing dependence on statutory services, and
- be free from discrimination;

.

Commissioners will test all provision for quality and efficiency through a formal "contestability framework" which, over time, may reshape the pattern of provision. Initially, an ***Integrated Provider Service*** is envisaged, covering all community services for adults and older people - including Mental Health and Learning Disability, which have for some years been provided on a joint basis. ***A Joint Provider Board*** will be put in place as soon as possible, with equal representation from the city council members and non-executive directors of NHS Plymouth, and representation from primary health care. As the Board's constitution and terms of reference are considered, arrangements will have to comply with NHS guidance, and also ensure proper accountability for the city council and its staff. However, in due course, the Board may wish to consider options for a more radical or more independent form of organisation. These would need to be ratified by the two partner organisations.

We are clear that we must start with a new top management appointment, accountable to the new Board, to lead this integrated service through a single management structure. This will involve a series of new joint appointments or secondments to cement a leadership team for the service; and common policies will operate. Commissioners will expect the service to co-locate staff in shortest possible timescale into the six localities; and to bring IT systems together to create a single integrated information system in due course.

Integrating care services in the localities

Whilst the idea of six localities suggests a strictly geographical approach, we expect the first line of cooperation to be based on team work around GP surgeries, ie the individual's GP registration will determine how locality services will be accessed. For the public, their GP is most commonly the first point of call with health and care problems, and is generally available on a neighbourhood basis: it therefore makes best sense to build community support from this established foundation. This is expected to work readily for most people within most of the localities. But it is acknowledged that for a small proportion of people who live at a distance from their GP it will be impractical, and individual alternative arrangements for care and support will be made, ie by the Locality Team nearest to where they live.

The core underlying principles are that services should:

- Be simple to access
- Eradicate needless delay
- Be delivered close to people's homes
- Deliver evidence based, safe, high quality professional and clinical care

It should be noted, however, that we do not need to integrate all services: this would be disproportionate to the care most people need. There are many people who have straight forward needs for care or treatment that will continue to be provided by, for example, locally based community nursing services, primary care, or adult social care without the need for a multi-disciplinary approach. A system of triage will determine this. We know nevertheless that 80% of health and social care is consumed by 20% of the population: the purpose of integration is to make the services needed by the 20% of people with complex needs more effective via a joined up and co-ordinated response to their needs from local professionals. Approval has been given to develop proposals to pilot the approach in two of the localities, Plympton and Plymstock. We have already tested multi-disciplinary working in a pilot Integrated Team in Devonport which is being formally evaluated, and its experiences are being built into the plans for the pilot of the mainstream integrated service in Plympton and Plymstock. With further monitoring and evaluation during the next pilot phase, lessons will be learned which will underpin implementation across the city.

Locality services will be principally required to improve outcomes for the public, and performance will be monitored against key national and local targets which will be set annually by the Joint Commissioning Executive and be binding on all Providers, including the new Integrated Provider Board.

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CITY OF PLYMOUTH

Subject:	Residential Care: Update on Modernisation of Older Peoples' Services 2005-2015
Committee:	Health and Adult Social Care Scrutiny/Cabinet
Date:	28TH October 2009/10th November 2009
Cabinet Member:	Councillor Dr Salter
CMT Member:	Carole Burgoyne
Author:	Julia Penfound
Contact:	Tel: (01752 (30) 7344 e-mail: Julia.penfound@plymouth.gov.uk
Ref:	Your ref.
Part:	1

Executive Summary:

In accordance with the recommendations within the Cabinet Paper dated 14th July (Appendix 1), this report is to provide feedback to Cabinet in relation to the consultation initiative that has taken place about respite provision in the City, and the future of Whitleigh Residential Respite Home.

The consultation process took place over a twelve week period. A variety of approaches were adopted to ensure that users and their carers were afforded opportunities to provide feedback.

This report provides a summary of the outcomes of the consultations.

Although 135 people who were users of Whitleigh were invited, only a small number of people chose to attend the consultation events themselves. Of the questionnaires distributed 60% were returned and the majority of the remainder were contacted by telephone. A number of individual appointments were also offered.

All appeared to appreciate the time given to air their views and to receive confirmation of the Council's continued investment in carers' services. Whilst many expressed a desire for Whitleigh to remain open, it was apparent from the feedback received that the concern about the future of Whitleigh was intimately connected to a need for information around alternatives and a reassurance that there would be no overall reduction in respite provision.

The consultation provided an opportunity to ensure that service users and carers were more familiar with the choices available to them and the range of services on offer and to give further reassurance that we would continue to purchase and provide good quality respite services.

In respect of the long stay resident a social worker and an advocate were linked with the family and the resident to ascertain her views and reassess her care needs. The resident has viewed a new dual registered home in the independent sector and moved there recently for a trial period with a member of Whitleigh staff accompanying her for support.

Corporate Plan 2009-2012:

This report links directly to the Council's Corporate objectives outlined in Corporate Improvement Priority 3 (Helping People to Live Independently) and Corporate Improvement Priority 14 (Providing Better Value for Money)

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land

The proposals around Whitleigh will lead directly to budget savings whilst ensuring no decrease in the amount of respite available. We estimate that the full year financial saving will be approximately £350K.

Other Implications: e.g. Section 17 Community Safety, Health and Safety, Risk Management, Equalities Impact Assessment, etc.

None for the purposes of this report.

Recommendations & Reasons for recommended action:

1. It is recommended that Cabinet agrees to the reprovision of Whitleigh Residential Respite Home and the reinvestment into alternative respite services.

Alternative options considered and reasons for recommended action:

To maintain our residential homes without significant future investment will not meet Care Quality Commission (formerly CSCI) minimum standards. Providing alternative respite arrangements promotes choice and control for individuals.

Background papers:

Cabinet Paper 29th November 2005 (Ref: C 61 05/06) – "Residential Care: Proposals to Modernise Older Peoples' Services 2005-2015"

Cabinet Paper 14th July 2009 – "Residential Care: Update on Modernisation of Older Peoples' Services 2005-2015"

Sign off: comment must be sought from those whose area of responsibility may be affected by the decision, as follows (insert initials of Finance and Legal reps, and of HR, Corporate Property, IT and Strat. Proc. as appropriate):

Fin	JB (CoSFAC0910002)	Leg	RW 1057	HR		Corp Prop	CJT /037 /151009	IT		Strat Proc	
Originating SMT Member: CB											

RESIDENTIAL CARE: UPDATE ON MODERNISATION OF OLDER PEOPLES' SERVICES (2005-2015)

In accordance with the recommendations within the Cabinet Paper dated 14th July (Appendix 1), this report is to provide feedback to Cabinet in relation to the consultation initiative that has taken place about respite provision in the City, and the future of Whitleigh Residential Respite Home.

1. Background

On 14th July 2009 Cabinet received a paper updating on the progress that has been made in relation to the modernisation of Older Peoples' Services as outlined in the strategy agreed in November 2005.

Cabinet approved the proposed direction of travel outlined in the 14th July paper:

- Changing the use of Stirling and Frank Cowl Residential Homes from long to short-stay occupancy (gradually to reduce the numbers of people who are permanent within the homes over the next 2-3 years – noting the new Extra Care Schemes coming on stream - The next Extra Care Housing Scheme to be completed will be in Devonport with handover expected January 2011

- Consult users/carers about alternatives to the current respite facility (Whitleigh) – noting that there has been a trend of under-occupancy within the unit as carers are already choosing alternative respite services.

2. Whitleigh Consultation Process

2.1. A 12-week consultation period was initiated following Cabinet's decision.

The methodology encompassed a range of initiatives to gather feedback:

- Consultation events
- Questionnaires
- Feedback through the Council's website
- 1:1 visits
- Advocacy support

2.2. **Consultation Events**

All those people who had used Whitleigh in the last 12 months were contacted and sent a questionnaire; they were also invited to consultation events.

On the 28th and 29th September 2009 Adult Social Care ran two events inviting service users and their carers to discuss how the potential reprovision of Whitleigh may affect them should such a decision be taken. These events also explored how the Council intended to develop alternative provision to extend the range of options already available to carers.

135 people were invited – in total only 13 people attended both events.

Event 1: held on Monday, 28th September 2009 10.00 -12.00 pm at the Pavilions, Plymouth

Attended by:	Four service users and six carers
Supported by:	PCC Commissioning Manager
	Independent Consultant
	Unit Manager, Whitleigh Respite Care Home
	Unit Manager, Stirling House Residential Care Home

Event 2: held on Tuesday, 29th September 2009, 4.00- 6.00 pm at Elspeth Sitters House, The Barbican

Attended by:	Three carers and Carer's Champions representative
Supported by:	As above

The feedback from these events along with any written responses received by the Council has been collated.

A summary of the key questions and issues raised by service users and carers at the events is detailed below:

What would be the refurbishment cost to raise Whitleigh to the required standard? Is this an option?
Rooms at Whitleigh are not large enough to build en suite facilities and the building is outdated.

In order to raise occupancy levels in Whitleigh, couldn't beds be used for step-down care from hospital?
As the occupancy rates have fallen the rooms have been used to support hospital discharge and emergency placements but there has still not been sufficient demand for the unit.

If Whitleigh were to close, would this reduce the access to respite beds?
No – the council would ensure that respite beds would be available to meet identified need.

Could Stirling, as a Plymouth Council home and an alternative respite provider, accommodate the current level of respite at Whitleigh?
There are currently 4 respite beds in Stirling and as beds become available it was confirmed that they could be used for carer respite if this is needed.

When discussing respite beds across the sector, the group felt that what was most important was to ensure all respite services had staff trained to the same standard and would treat people with dignity and respect.

Carers expressed concern about accessing other independent care homes for respite. Perceptions of the independent sector were varied and based on anecdotal evidence

It was confirmed by the Commissioning Manager that a small number of homes would be identified with a good rating where respite beds would be commissioned as alternatives.

2.3. **Questionnaires**

Out of the 135 number of questionnaires distributed, 60% have been returned and the majority of the remainder of people have been contacted by telephone to ensure that their comments have been taken into account.

2.4. **Website**

The Councils website has been refreshed with a page for people to email their comments .All stakeholders have been emailed and informed. Their comments have been taken into account.

2.5. **1:1 Visits**

All Service Users and their carers who had stayed at Whitleigh in the past year were invited to the consultation events and provided with a questionnaire to complete. People who utilised Whitleigh more than 4 times in the same period were offered additional support from the manager of Whitleigh. This resulted in a number of individual appointments to discuss with carers and service users on a personal basis and gain their views on the future of Whitleigh.

2.6**. Advocacy**

An Advocacy Service has been offered to everyone involved in the consultation through Plymouth Age Concern.

2.7. **Long Stay Resident**

There is one long-stay resident still residing at Whitleigh. A social worker and an advocate were linked with the family and the resident to ascertain her views and reassess her care needs.

The resident has viewed a new dual registered home in the independent sector and moved there recently for a trial period with a member of Whitleigh staff accompanying her for support. It was made clear to the family and resident that we would not want to put any undue pressure on them and that this decision had to be one of personal choice. We are confident that the family and the resident are happy with this outcome.

2.8. **Summary from consultation**

All appeared to appreciate the time given to air their views and to receive confirmation of the Council's continued investment in carers' services. It was apparent from the feedback received that the concern about the future of Whitleigh was intimately connected to a lack of information around alternatives. However the consultation provided an opportunity to ensure that service users and carers were more familiar with the choices available to them and the range of services on offer, and to reiterate that this was not about an overall reduction in respite provision in the City. There was also some reassurance felt about the Council's commitment to purchase quality care from the independent sector as an alternative.

The small number of service users and carers who attended the events expressed a desire for Whitleigh to remain open.

3. Staff Consultation

Managers have met with the staff employed at Whitleigh and explained the decision by Cabinet and the arrangements for consultation. Staff were encouraged to feedback their views in a number of ways as described above (Questionnaire, website etc.)

The Unions have also been informed. Clearly at this stage no decision has been taken and therefore the Council is not formally consulting with them about their future employment.

4. Recommendations

Taking into account the results of the consultation events and the feedback from the questionnaires. I am recommending that:

4.1. Cabinet agrees to the reprovision of Whitleigh Residential Respite Home and the reinvestment into alternative respite services.

Appendix 1

CITY OF PLYMOUTH

Subject:	Residential Care: Update on Modernisation of Older Peoples' Services 2005-2015
Committee:	Cabinet
Date:	14 July 2009
Cabinet Member:	Councillor Dr Salter
CMT Member:	Director for Community Services
Author:	Julia Penfound
Contact:	Tel: (01752 (30) 7344 e-mail: Julia.penfound@plymouth.gov.uk
Ref:	Your ref.
Part:	**1**

Executive Summary:

In November 2005 Cabinet approved a new strategic direction to modernise older people's services over a 10 year period. Modern high quality extra care accommodation would be built in the immediate vicinity of our residential homes wherever possible.

Several of our older people residential homes were in outdated buildings that did not meet current day expectations. There are also no en-suite facilities in any of the remaining units.

This paper both updates on our progress to date and outlines the proposed continued direction of travel to achieve the 2005-2015 ambitions taking into consideration new national and local expectations.

Since 2005 we have achieved significant progress against the strategy set out in the Cabinet paper – specifically:

- Peirson was de-commissioned with the transfer of skilled staff into the Local Care Centre at Mount Gould
- Three new extra care facilities (Torridge Way, St Pauls and Astor Court) have been built and Paternoster de-commissioned.

The Council has remained committed to its policy that no older person currently residing in a Plymouth City Council residential home will have to move. However, they will be offered first choice of the extra care accommodation available and built in the same neighbourhood.

Plymouth City Council are recognised as regional leaders in the successful delivery of extra care schemes. The next phase of our delivery plans proposes to continue to develop extra care accommodation, and to develop alternative forms of respite provision in consultation with users and carers, to support both older people themselves and their carers in having choices about the preferred type of service.

We currently have three long-stay residential homes for older people: Frank Cowl, Stirling and Lakeside.

- There are 22 beds in Frank Cowl Residential Home in Devonport. Currently there are 11 long stay placements and 11 used for interim care (short stay). Work has commenced on a new scheme in Devonport which will be completed in 2011 and is part of the regeneration of this area. There will be 40 extra care units of accommodation in this scheme. It is recommended that we offer residents of Frank Cowl first choice of the extra care accommodation developed in Devonport.

- There are 28 beds in Stirling Residential Home in Honicknowle and currently 24 of these have long term placements and 4 are used for interim care (short stay). We are currently exploring the possibility of securing land in Honicknowle and work is ongoing to acquire this to develop an extra care scheme.

- Lakeside is a specialist dementia care facility and at present we have no plans to move to extra care given the increase in demand for residential support for people with dementia. However, the building is outdated and there may be opportunities to develop partnerships to re-provide services in the independent sector.

This report recommends that we change the use of Stirling and Frank Cowl from long to short stay and gradually reduce the numbers of people who are permanent within these units over the next 2 to 3 years i.e. when a long-term bed becomes available it will revert to short-term care. For each scheme those residing at these homes who wish to move to the new accommodation with the same levels of care and support will be able to do so.

We have one predominately short-stay residential unit - Whitleigh

- There are 23 beds at Whitleigh Residential Home - with 1 long stay placement and 22 used for respite care to support users and their carers. Occupancy levels for respite has been at increasingly lower levels as carers are already choosing alternative respite services.

Given the outdated nature of the facilities at Whitleigh and the relatively low useage we believe this is an appropriate time to consider de-commissioning. Therefore there is a further recommendation that we consult with service users/carers about respite provision in the City and the use of Whitleigh for

this purpose, and that views are taken into account in relation to decisions regarding de-commissioning. This is not about reducing the amount of respite provision, but offering a wider choice of alternatives which could range from residential independent sector provision to direct payments to enable users and carers a greater level of control over how they are supported.

This is in line with the new national strategies for both Carers and Putting people First. These strategies emphasise the drive to significantly increase opportunities for people to have greater choice and control over their lives including introducing individual budgets and expanding direct payments.

Corporate Plan 2009-2012:

This report links directly to the Council's Corporate objectives outlined in Corporate Improvement Priority 3 (Helping People to Live Independently) and Corporate Improvement Priority 14 (Providing Better Value for Money)

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land

The proposals around Whitleigh will lead directly to budget savings whilst ensuring no decrease in the amount of respite available. We estimate that the full year financial saving will be approximately £350K.

There is no financial impact from the change from long-stay to short-stay at Stirling and Frank Cowl.

Other Implications: e.g. Section 17 Community Safety, Health and Safety, Risk Management, Equalities Impact Assessment, etc.

None for the purposes of this report.

Recommendations & Reasons for recommended action:

1. It is recommended that we consult with users and carers (using advocacy services where appropriate) and dedicated social work professionals about respite provision in the City and the use of Whitleigh for this purpose, and that views are taken into account regarding decisions to de-commission.

2. It is recommended that we consult with staff

3. This report recommends that we change the use of Stirling and Frank Cowl from long to short stay and gradually reduce the numbers of people who are permanent within these units over the next 2 to 3 years i.e. when a long-term bed becomes available it will revert to short-term care. It is recommended that we offer residents of Frank Cowl first choice of the extra care accommodation developed in Devonport.

4. Work with all users/carers and the single long-stay resident of Whitleigh on an individual basis to listen to their views and ensure that appropriate service provision is in place to meet their needs.

5. It is recommended that the results of consultations are reviewed at Health & Wellbeing Overview & Scrutiny Panel

Alternative options considered and reasons for recommended action:

To maintain our residential homes without significant future investment will not meet Care Quality Commission (formerly CSCI) minimum standards. Promoting Extra Care Housing as an alternative ensures accommodation of the highest quality and promotes independent living as outlined in 'Our Health, Our Care, Our Say' national strategy. Providing alternative respite arrangements promotes choice and control for individuals.

Background papers:

Cabinet Paper 29th November 2005 (Ref: C 61 05/06) – "Residential Care: Proposals to Modernise Older Peoples' Services 2005-2015" (Appendix 1)

Sign off: comment must be sought from those whose area of responsibility may be affected by the decision, as follows (insert initials of Finance and Legal reps, and of HR, Corporate Property, IT and Strat. Proc. as appropriate):

Fin	MC 160 609.	Leg	LT1 017	HR		Corp Prop	CJT /032 /120 609	IT		Strat Proc	
Originating SMT Member: CB											

RESIDENTIAL CARE: UPDATE ON MODERNISATION OF OLDER PEOPLES' SERVICES (2005-2015)

1. Vision

Plymouth City Council is committed to supporting Older People to remain independent whenever possible within the community of their choice.

2. Strategy 2005 -2015

The strategy agreed at Cabinet in November 2005, set out a strategic direction for increased development of Extra Care facilities and the future of our residential homes (Attached as Appendix 1). At the time of the 2005 Cabinet Paper there were 1,715 people permanently living in residential/nursing facilities across the City funded by the City Council, and by March 2009 this number had reduced to 1,111.

We currently have 5 Extra Care Schemes in the City providing 158 independent apartments.

3. Context for Change

A number of national strategies have emphasised the need to maximise independence, offer a wide range of alternatives to support users and carers promoting choice and control.

This report seeks to confirm agreement to the continued direction of travel.

4. Current In-House Residential Service Provision

4.1. Plymouth City Council currently provides residential facilities for Older People in the following facilities.

Residential Home	Beds available	Occupancy 2008/09
Whitleigh	1 long stay 22 Respite short stay	70%
Frank Cowl	11 Long stay 11 Short stay	87%
Stirling	24 Long stay 4 Short stay	87%
Lakeside – specialist support for Dementia	29 long stay 1 Short stay	92%

5. Extra-Care Facilities Planned:

5.1. The current plans for further Extra Care facilities in the City are:

- Thomas Pocklington Trust has recently opened a new scheme (May 2009). This offers 75 units of accommodation with onsite care and support commissioned by Adult Social Care.
- Work has started on a new extra care scheme in Devonport – this will be a 40 unit scheme, expected to complete in 2011. This scheme is located near Frank Cowl Residential Home.
- We are currently exploring the possibility of securing land in Honicknowle and work is ongoing to acquire this to develop an extra care scheme.

6. PROPOSALS FOR MODERNISING OLDER PEOPLES SERVICES 2009 - 2015

Plymouth City Council is committed to supporting older people to remain independent whenever possible within the community of their choice. The proposals below outline the next phase in our ambitions to deliver on the 2005-2015 strategy but also reflect the national context as set out above.

6.1. Frank Cowl Residential Home

It is proposed to change the registered use of this unit from long stay to short stay and gradually reduce the numbers of people who are permanent within the unit over the next 2-3 years. When a long-term care bed becomes vacant this will revert to short-term care. It is anticipated that with the development of the Devonport Extra Care Scheme those who wish to move from Frank Cowl into this new unit with the same level of care and support will be able to do so.

However, no long term resident will be forced to move as a result of this proposal.

The Devonport Extra Care Scheme scheduled for completion in 2011 will have 40 extra care units.

It is recommended that we offer residents of Frank Cowl first choice of the extra care accommodation developed in Devonport.

6.2. Stirling Residential Home

It is proposed to change the registered use from long stay to short stay and gradually reduce the numbers of people who are permanent within the unit over the next 2-3 years. When a long-term care bed becomes vacant this will revert to short-term care. Once again, no long term resident will be forced to move as a result of this proposal.

We are currently exploring the possibility of securing land in Honicknowle with a view to developing an extra care scheme. If successful we would look to progress this scheme and engage with residents in the same way as with Frank Cowl.

6.3. Lakeside Residential Home

Lakeside is a specialist dementia care facility and at present we have no plans to move to extra care given the increase in demand for residential support for people with dementia. However the building is outdated and there may be opportunities to develop partnerships to re-provide services in the independent sector in the future.

6.4. Whitleigh Respite Care Home

It is proposed that users and carers are consulted about alternative respite provision. Useage of Whitleigh has gradually declined and we would like to develop and deliver more innovative solutions to support carers in their crucial role. Over the last 4 years we have been developing key partnerships with independent sector care providers and housing strategy to deliver this objective.

There is capacity in the independent sector to provide short respite breaks. In addition, as part of our strategy to promote choice and control a range of options for short respite breaks is already being explored – for example, we have already developed a Carer's Voucher Scheme whereby Carers can be issued with vouchers to enable them to choose directly their preferred provision.

Given the outdated nature of the facilities at Whitleigh and the relatively low useage we believe this is an appropriate time to consider de-commissioning. Therefore there is a further recommendation that we consult with service users/carers about respite provision in the City and the use of Whitleigh for this purpose, and that views are taken into account in relation to decisions regarding de-commissioning. This is not about reducing the amount of respite provision, but offering a wider choice of alternatives which could range from residential independent sector provision to direct payments to enable users and carers a greater level of control over how they are supported.

6.4.1. Budget

The total budget for Whitleigh is £855,942. Within the budget for 2009/10 savings have been identified to be achieved by alternative commissioning of respite services. It is anticipated that the full year savings would be approximately £350k.

6.4.2. Impact on budget availability for alternative provision

Note that if the proposal is not accepted the savings of £350k will still need to be identified from other areas within the Adult Social Care budget.

6.4.3. General Information on Whitleigh respite care home

Whitleigh residential home is a 23-bed unit which predominately provides accommodation for respite breaks for individuals and their carers. This

respite can be both planned and unplanned. Whitleigh also has one long-stay resident.

The unit employs 35 staff (22.3 Full time equivalent) across a range of roles including Domestics, Kitchen Assistants, Care Assistants, Assistant and Unit Managers

In previous years, a core group of regular users would choose Whitleigh as their preferred location for respite. However, recent years have seen a significant reduction in the number of people selecting Whitleigh for respite and occupancy levels through 2008/2009 have been low, averaging at 70% occupied (significantly lower than occupancy levels in all other in-house residential units – see table in section 4.1 above).

We believe this partly reflects our progress on ensuring people have more choice and control over where and how their services are delivered and that people are now either choosing alternative residential locations for their respite or are opting to manage this in different ways e.g. through Direct Payments.

The Whitleigh building itself offers small single rooms and has a number of shared lounges and kitchen areas available to all users and would not now meet the new CQC (formerly CSCI) standards when opening a new residential service.

6.4.4. Users of the Service

Consultation with all users and carers would be undertaken and supported by both our Social Work team and Care Staff and will be conducted in a sensitive and supportive way.

Consultation would include:

a) Discussion with the one long-stay resident and their family regarding the future of Whitleigh and the options that are available. These options will include support to identify a new residential facility or should the resident not wish to move, advice and support on how we will continue to provide support and accommodation at Whitleigh.

b) Consultation with all users/carers and their families who are currently occupying or scheduled to use Whitleigh for their respite care in 2009. This will include support and assistance in identifying alternative solutions for respite.

c) Offers of support to any potential users who may contact us following this news being made public that may have been considering Whitleigh as a location for future respite care.

6.4.5. Staff

A comprehensive HR process and plan is available and will be agreed with all relevant unions prior to any formal announcement to staff. This plan sets out

in detail each step of the process, the timeframes involved and all the support and information staff will receive during the process.

Our intentions are to support our staff through the proposed de-commissioning and work towards finding suitable alternative employment (through the redundancy avoidance policy) with the Council. However, it is anticipated that not all staff will be successful in finding alternative roles and that some redundancies will be unavoidable.

6.4.6. Future of the Whitleigh building and site

An options appraisal has been undertaken on the building to consider its potential for future use:

- For Extra Care Housing
  The costs of converting the premises for extra care housing would be prohibitive. Work continues with the Council's Housing Strategy Unit to look at expansion of extra care provision in the City for Older People.

- For community use
  The building is not suitable for community use without investment to support conversion. This has not been budgeted for at present and would require a financially viable business case.

- For disposal
  Any receipt from potential disposal has not been accounted for in the Council's planned disposals over the next five years. Therefore in the event Whitleigh is de-commissioned the Council would need to consider options for the building/site under the Council's surplus property disposal scheme.

7. Recommendations

- To consult with users and carers (using advocacy services where appropriate) and dedicated social work professionals about respite provision in the City and the use of Whitleigh for this purpose, and that views are taken into account regarding decisions to de-commission.
- Consult with staff
- Change the use of Stirling and Frank Cowl from long to short stay and gradually reduce the numbers of people who are permanent within these units over the next 2 to 3 years i.e. when a long-term bed becomes available it will revert to short-term care. It is recommended that we offer residents of Frank Cowl first choice of the extra care accommodation developed in Devonport.
- Work with all users/carers and the single long-stay resident of Whitleigh on an individual basis to listen to their views and ensure that appropriate service provision is in place to meet their needs
- It is recommended that the results of consultations are reviewed at Health & Wellbeing Overview & Scrutiny Panel.

Appendix 1

CITY OF PLYMOUTH

Subject:	**Residential Care: Proposals to Modernise Older Peoples Services 2005-2015**
Committee:	Cabinet
Date:	29th November 2005
Cabinet Member:	Councillor Camp
CMT Member:	Director for Community Services
Author:	Pam Marsden
Contact:	Tel: (01752 (307344) e-mail: Pamela.Marsden@plymouth.gov.uk
Ref:	C 61 05/06
Part:	I

Executive Summary:

The proposals set out in the Green Paper: *Independence Well being and Choice* if fully implemented will mean a shift in the provision of current services to those which promote community living and provide alternative solutions such as Extra Care housing.

Several of our older people residential homes are in outdated buildings that do not meet current day expectations. When new CSCI minimum standards relating to room sizes (projected start 2008) come into force most of the rooms in these units will fail this standard. There are also no en-suite facilities in any of the units.

The report recommends that we modernise our services to older people over a 10 year period. Modern, high quality extra care accommodation will be built in the immediate vicinity of our residential homes.

No older person currently residing in a Plymouth City Council residential home will have to move however they will be offered first choice of the extra care accommodation built in the same neighbourhood.

The Torridge Way Extra Care scheme will be completed in November 2007 and is part of the regeneration of the Heart of Efford. There will be 40 units of accommodation in the new scheme, which will have the capacity to house 65 people due to the high ratio of 2 bedroom apartments.

There are 32 beds in Paternoster Residential Care Home, Efford. Currently there are 20 long-stay placements and 12 used for interim care (short-stay).

The report recommends that we change the use from long stay to short stay and gradually reduce the numbers of people who are permanent within the unit over the next 2 years. When a long-term care bed becomes vacant this will revert to short-term care. It is anticipated that with the development of the Torridge Way Extra Care Scheme those who wish to move from Paternoster into this new unit with the same level of care and support will be able to do so.

There is a further recommendation that Peirson be decommissioned once the Local Care Centre opens in Autumn 2006. The anticipated number of bed days required (based on 2004-2005 admission statistics) in the new Local Care Centre, are 231. Adult Services will contribute to the LCC to secure these bed days to continue to provide intermediate care.

Corporate Plan 2004-2007:

This report leads directly to the Corporate Objectives of looking after vulnerable adults and using the Council Tax efficiently.

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land

These proposals around Peirson and Paternoster will lead to a budget saving. We have estimated that in the financial year 2006/07 there would be an overall saving of approximately £139k and £358k in 2007/08, leading to approximately £488k in 2008/09. Some of this saving however will be dependent upon residents choosing to move from Paternoster, which would enable us to decommission the building.

Other Implications: e.g. Section 17 Community Safety, Health and Safety, Risk Management, etc.

None for the purpose of this report.

Recommendations & Reasons for recommended action:

1. It is recommended that we decommission Peirson once the Local Care Centre opens in Autumn 2006.
2. It is recommended that we offer residents of Paternoster first choice of the extra care accommodation developed in Torridge Way in 2007.

Alternative options considered and reasons for recommended action:

To maintain our residential homes without significant future investment will not meet CSCI minimum standards (projected start date 2008). Promoting Extra Care Housing as an alternative ensures accommodation of the highest quality and promotes independent living, as outlined in the Green Paper, Independence Well-Being & Choice.

Background papers:

Green Paper: Independence Well-Being & Choice: 'www.dh.gov.uk'
Housing Strategy: PCC website, 'Housing Strategy'.
Supporting People Strategy : PCC website, 'Supporting People Strategy'.

Sign off:

Fin	AB	Leg	DS	Head of HR	GM	Head of AM	N/a	Head of IT	N/a
Originating CMF Member									

RESIDENTIAL CARE: PROPOSALS TO MODERNISE OLDER PEOPLES SERVICES 2005-2015

Vision

Plymouth City Council is committed to supporting older people to remain independent whenever possible within the community of their choice.

Strategy 2005-2015

It is proposed that we modernise our services to older people over a 10 year period. Modern, high quality extra care accommodation will be built in the immediate vicinity of our residential homes.

- No older person currently residing in a Plymouth City Council residential home will have to move however they will be offered first choice of the extra care accommodation built in the same neighbourhood.
- The accommodation will be of the highest quality. All the facilities will be disability designed with en-suite bathrooms.
- The 24 hour care will be delivered by the same staff who currently care for residents in our Homes whenever possible.

Context for Change

1. The proposals set out in the Green Paper: *Independence Well being and Choice* if fully implemented will mean a shift in the provision of current services to those which promote community living and provide alternative solutions such as Extra Care housing.

2. Several of our older people residential homes are in outdated buildings that do not meet current day expectations. When new CSCI minimum standards relating to room sizes (projected start 2008) come into force most of the rooms in these units will fail this standard. There are also no en-suite facilities in any of the units.

Where we are now?

In relation to extra care, housing partnership working and strategic planning is well established in Plymouth. We successfully bid for Department of Health Extra Care funding of £1.37m in 2003-04 to help achieve our current planned provision and have been successful in the second bidding round 2004/05 for £1.6 m both with the Housing Corporation match funding.

Work has been undertaken through strategy and planning to identify sites, which would be suited to developing extra care housing. (See appended information extra care schemes in planning and in operation.)

Timeframes

Pierson Community Resource Centre:

This home provides an intermediate care facility of up to 6 weeks for 25 service users. The Local Care Centre at Mount Gould will be completed in Autumn 2006 and this will offer 60 intermediate care beds.

Proposal

Peirson to be decommissioned once the Local Care Centre opens in Autumn 2006.
The anticipated number of bed days required (based on 2004-2005 admission statistics) in the new Local Care Centre, are 231. Adult Services contribute to the LCC to secure these bed days to continue to provide intermediate care.

Paternoster Residential Care Home Efford:

There are 32 beds in this unit. Currently there are 20 long stay placements and 12 used for interim care (Short Stay). The Torridge Way Extra Care scheme will be completed in November 2007 and is part of the regeneration of the Heart of Efford. There will be 40 units of accommodation in the new scheme, which will have the capacity to house 65 people due to the high ratio of 2 bedroom apartments.

Proposal

Change use from long stay to short stay and gradually reduce the numbers of people who are permanent within the unit over the next 2 years. When a long-term care bed becomes vacant this will revert to short-term care. It is anticipated that with the development of the Torridge Way Extra Care Scheme those who wish to move from Paternoster into this new unit with the same level of care and support will be able to do so.

How will these changes affect users and carers?

- Services should be designed to meet planned and urgent need. Supporting carers through the availability of short breaks is recognised as a key factor in enabling them to continue in their caring role.
- With the exception of Paternoster and Pierson these proposals, if approved, will be carried out over a 10-year period, which will give sufficient time to plan for the care of individual service users.
- We will seek to provide extra care housing wherever possible close to existing units to prevent unnecessary loss of community connections for the current residents.

How will these changes affect staff?

- PCC redundancy avoidance policy and procedure will apply to all employees whose posts may be at risk as a result of these proposals.
- This process will include 3 months formal consultation with employees and trade unions with a view to reaching agreement on the avoidance of any compulsory redundancies. Voluntary and wider expressions of interest for redundancies will be considered.
- Every effort will be made to find employees suitable alternative employment and an agreed HR process will be followed. This will include an appropriate vacancy freeze, ring-fence arrangements, preference exercise, and corporate redeployment.
- Employees whose place of work is compulsorily changed, and who incur extra travel expenses, will receive compensatory payment in accordance with the Single Status Agreement.

Recommendations

- Consult with users and carers using advocacy services where appropriate and dedicated social work professionals.
- Consult with staff.
- Intermediate care services to be integrated into the Local Care Centre in Autumn 2006 and Pierson closed.
- Cease admissions of long stay placements into Paternoster.
- Work with all residents currently living in Paternoster on an individual basis to listen to their views and to ensure that an appropriate service provision is in place to meet their needs.
- Review the job descriptions and train the care staff within Paternoster so that the same staff group could continue to work with the same residents if and when these residents transfer into the new build extra care units.
- Gain agreement for a programme of development and partnership with housing strategy, which will increase the capacity of extra care housing units within the city to meet future demand. Seek to develop extra care housing in the same part of the city as our current residential home wherever possible.

Appendix 1

What is Extra Care Housing?

Extra Care Housing provides a housing setting for the provision of care and support to older and disabled people. Tenants have control over their finance and they have security of tenure. Domiciliary care is provided within schemes

tailored to meet individual need. The domiciliary care into the current extra care schemes is provided by an independent agency.

Plymouth has held an Extra Care Seminar to raise the profile of this resource and to ensure joint planning of future developments. However more detailed analysis of need and demand will be undertaken to allow for demographic changes and review of current provision. The table shows the difference between residential care and extra care housing.

Although units are owned and managed by housing associations the eligibility criteria and nominations agreements agreed by Plymouths legal services ensures that people admitted to the scheme are those that are at a significant risk of admission into care.

The first extra care-housing scheme was built approximately 5 years ago Hanover Housing Association manages it. The scheme has 24 hour care team commissioned by social services through the independent sector. This scheme has been commended by the housing corporation both in terms of the service it provides, the partnership working between the Plymouth City Council officers involved in meeting the objectives of offering choice and independent living.

The second scheme opened in May 2005. It is owned and managed by Sarsen Housing Association. This scheme has 24 hour care and which is commissioned separately by social services and design features to help people with dementia.

The opportunity in 2003-04 to bid for a new Extra Care Housing Fund through the Department of Health led to the success of Plymouths first bid which is funding the Signpost development in the East End. This is part of the regeneration of the area.

Plymouth has been successful a second time in 2004-05 in a bid for funding to develop a scheme near to Paternoster at the heart of Efford. Total funding including match funding from the Housing Corporation £3.365 million.

Appendix 2: Focus on Extra Care - How does extra care differ from residential care?

Dependency Level	Low		Medium	Medium		High
Provision Type	'Category 1' sheltered housing	'Category 2' sheltered housing	Residential Home	Extra Care Housing	Nursing Home	Hospital/Hospice
Features	Independent Flats or bungalows. Baths or showers Fully fitted kitchens. Communal facilities (sometimes): Residents' lounge Laundry (residents' use) Guest room	Independent flats Baths or showers Fully fitted kitchens Communal facilities: Residents' lounge Laundry (resident's use) Guest room Assisted bathroom (sometimes)	Bedrooms 11sq m En Suite washing/toilet facilities (sometimes) Communal facilities: Residents' lounge Laundry/sluice Assisted bathroom Dining room Visiting hairdresser	Independent flats 50sq m Level access Showers in all flats to disability standard Fully fitted kitchens, Wheelchair accessible. Communal facilities: Residents' lounge Laundry (residents' use) Laundry/sluice Guest suite Assisted bathroom Restaurant Hairdressing salon Bar Shop Activities room	Bedrooms Wash hand basins Ensuite sometimes Communal facilities: Residents' lounge Laundry/ sluice Assisted bathroom Dining room Visiting hairdresser	Bedspaces or bedrooms (sometimes) Communal facilities: Day room Laundry/sluice Assisted bathroom

Nature of Support	Warden/Estate Manager (sometimes) Individual support packages from external providers	Warden/Estate Manager Individual support packages from external providers	Manager/Matron 24-hour in house care team Disposable Income £18.80 pw	Estate Manager 24-hour in-house care team Disposable Income Up to £140 pw (inc. attendance allowance & pension)	Matron 24 hour nursing care	Medical/Nursing Staff 24-hour nursing care
Independence Rating	High	High	Low	Low	Low	Low

Appendix 3: Provision of Extra Care Housing operational and in planning

Provider	Type of provision	No. of units in the scheme	Total annual cost of contract revenue for care and support	No. of clients	Operational /In Planning
Runneymeade Court Hanover Housing Association	Extra Care housing for older people .24 hour care team on site	33 x 1 bedroom 5 x 2 bedroom	Supporting People £ Care Contract £139,256	Min 38 Max 43	Operational
St Barnabas Court Sarsen Housing Association	Extra Care Housing for older people including people with dementia 24 hour care team on site	15 x 2 bedroom 17 x1 bedroom	Supporting People £60,000 Care contract £ 190.000	Min 32 Max 47	Operational
Signpost Extra Care Scheme Cattedown	Extra care Scheme for people over 55 years old 24 hour care on site 2-4 interim beds	25 x 1 bedroom 5 x 2 bedroom	Supporting People £ 35K* Care contract £ 190,000*	Min 30 Max 35	Opens November 06
Torridge Way Sarsen Housing association	Extra care Scheme for people over 60 years old 24 hour care on site 2-4 interim beds	25 x 2 bedroom 15 x 1 bedroom	Supporting People £35K Care Contract £190,000	Min 40 Max 65	In planning Completion November 2007

These are projected costs based on the schemes currently in operation with annual uplift.

Appendix 4: Financial Information-Residential Units

PCC Scheme	**Start Date for Implemented Savings**	**PCC Revenue**	**PCC Capital Costs upgrades**	**Number of Beds**
Peirson	The work stream will transfer to the Local Care Centre Autumn 06	£865,488 per annum		6 RITA beds 20 Rehab Beds
Paternoster	As each long stay bed becomes vacant it will transfer to short term. Remaining residents will be offered a placement at the extra care scheme Nov 07	£637,426 per annum		20 long stay 12 short stay interim placements

APPENDIX 5

RESIDENTIAL CARE AND EXTRA CARE HOUSING
(ALL SAVINGS AT 2006/07 PRICES)

Overall Strategy
To respond to the recommendations from the inspection of service to older people by reducing the number of residential care places purchased and investing in additional extra care housing.

Home	Current Service Provision	2006/07 £'000	2007/08 £'000	2008/09 £'000	2009/10 £'000	2010/11 £'000	Change in Service Provision
Peirson Paternoster	4 x long stay plus 26 intermediate care 20 x long stay + 12 x short stay	-179 40	-358 0	-358 -130	-358 -130	-358 -130	30 intermediate care placements 16 short stay placements plus 16 extra care placements.
TOTAL	**Net savings**	**-139**	**-358**	**-488**	**-488**	**-488**	

Assumptions:-
Estimated 20% natural loss of long stay residential placements
Estimated 30% of long stay placements requiring alternative long stay provision
Estimated 50% of long stay placements choosing extra care housing provision
Financial provision made for extra staffing in homes to meet additional short stay placements during interim term
Cost of purchasing placements from the independent sector based on the average unit fee paid for current commitments
Client contribution based on the average contribution paid by current commitments.

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Appendix 2 - Equality Impact Assessment - Standard Assessment Template

Section A: Assessment

Policy	Officer conducting this assessment with Contact Details	Date
Consultation with service users, carers, staff and interested parties in respect of possible de-commissioning of Whitleigh Respite Care Home	**Debbie Butcher – Commissioning Manager, Adult Social Care**	**4th September 2009**

1. The Policy

Is this a new or existing policy?	**Existing:** This EIA is being conducted in relation to the above mentioned consultation and is not a policy.
What is the purpose of the policy?	In response to the Cabinet Report – Residential Care: Update on Modernisation considered 14th July 2009 – a consultation exercise has been commissioned to obtain the views of service users, carers, staff and other interested parties in respect of the possible de-commissioning of Whitleigh Care Home.
How do the aims of the policy fit in with corporate priorities i.e. Corporate Plan	CIP 2 Informing and involving residents: this consultation exercise seeks the views of service users, carers, staff and other interested parties Whitleigh Care Home. Their views and comments will be taken into consideration as part of the decision making process for the future of the Home. CIP 3 Helping people to live independently: modernised services that promote individual choice and control, minimise risk and

	enhance people's quality of life by supporting them to live independently. CIP 14 Providing better value for money: useage of Whitleigh Care Home has gradually declined and its facilities have become outdated. Within the budget for 2009/10, savings have been identified to be achieved by alternative commissioning of respite services to approximately £350k per year.
Who will benefit from the policy?	Users and their carers of Whitleigh Care Home will benefit from a wider choice of alternatives in their care which could range fro residential independent sector provision to direct payments. This would give them a greater level of control over how they are supported.
What outcomes are wanted from this policy?	Improved quality of life and independence for vulnerable adults and their carers, provision of modernised services for users/carers, effective use of resources and meaningful dialogue with this community group.
Are there any factors that might prevent outcomes being achieved?	Willingness of some service users and carers to embrace the modernisation agenda.

2. Data Collection

What qualitative data do you have about the policy relating to equalities groups (e.g. monitoring data on proportions of service users compared to proportions in the population)?	• Putting People First • Our Health, Our Care, Our Say • National Frameworks such as Healthy Plymouth and Joint Strategic Needs Assessment • National Carers Strategy • Statement of Community Involvement/Plymouth Compact
What quantitative data do you have on the different groups[1] (e.g. findings from discussion groups, information from comparator authorities)?	• Self Assessment Survey 2008 • RAP Return 2008 • PSSEX1 Return 2008 • Reducing occupancy number at Whitleigh since initial

[1] Age, (young/old) disability, Gender (Male, Female), Race, Faith and Belief, Sexual Orientation (Lesbian, Gay, Bi-sexual, Trans

	Cabinet Report in 2005
Please indicate the source of the data gathered? (e.g. Service/Department/Team)	Performance & Business Support Team
What gaps in data have you identified? (Have to put actions to address this in your action plan?)	None identified

3. Impact

Please complete the following tables using ticks.

Consider the information gathered in section 2 of this assessment form, comparing monitoring information with census data as appropriate[2] and considering any earlier research or consultation. You should also look at the guidance in appendix 1[3]

Equalities Issue	Positive impact	Negative impact	None	Reasons for decision
Age	**X**			The modernisation agenda is committed to improving and positively enhancing the health and well being of those people who are aged 50+ currently receiving respite and long term services via Local Authority Residential/Respite Units and their carers, regardless of age, disability, faith, gender, race or sexual orientation.
Disability	**X**			
Faith	**X**			
Gender	**X**			
Race	**X**			
Sexual Orientation	**X**			

3.1 Do you think that the policy impacts on people because of their age? [4]

[2] www.ons.gov.uk (Office National Statistics website)
[3] See SIU equalities legislation paper for additional guidance (inclusion@plymouth.gov.uk)
[4] For demographic data see www.plymouth-informed.gov.uk or www.ons.gov.uk

Age[5]	Positive	Negative	None	Reasons for your decision
Young (Children and young people, up to 18)	**x**			Our target group are vulnerable people and carers aged 18+, nevertheless the modernisation could also positively impact of young members of their families.
Older (Working age, and above)	**x**			Whitleigh Care Home provides services for adults aged 18+. Their views are sought along with their carers and staff working at the home as part of the consultation exercise.

3.2 Do you think that the policy impacts on people with a disability? [6]

Disability	Positive	Negative	None	Reasons for your decision
Visual impairment	**x**			The modernisation is committed to positively enhance people's quality of life and independence irrespective of any visual / hearing impairment, or physical disability. Whitleigh Care Home provides services for adults who may have a visual or hearing impairment, or may be physically disabled. Their views along with their carers will be sought as part of the consultation exercise. If they have special requirements to enable them to participate in the consultation such as Braille documents, audio tapes , mobility aids or representation, this will be provided as appropriate and when requested.
Hearing impairment	**x**			
Physically disabled	**x**			
Learning disability			**x**	Whitleigh Care Home does not provide services to clients with Learning Disabilities or Mental Health related illnesses.
Mental health			**x**	
Other (HIV positive, multiple sclerosis,	**x**			Whitleigh Care Home does not provide long term care terminally ill clients. They do however, provide respite and short term care for clients and carers

[5] Individual services should look at how the above age criteria best relates to them, and make clear reference to it in deciding on any impact
[6] Disability is defined as an impairment, which has a substantial, long-term adverse effect on a person's ability to carry out normal day-to-day activities.

cancer, diabetes, epilepsy)				irrespective of any long term chronic illnesses.

3.3 Do you think that the policy impacts on people because of their faith/belief? [7]

	Positive	Negative	None	Reasons for your decision
Faith and Belief	**x**			Services are designed to meet the needs of those with a faith background and therefore during the course of the consultation, any issues relating to this area will be addressed (including requests for Translate Plymouth).

3.4 Do you think that the policy affects men and women in different ways?

Gender	Positive	Negative	None	Reasons for your decision
Male	**x**			The modernisation agenda aims to improve the quality of life for the individual around assessed needs irrespective of their gender. Whitleigh Care Home provides services for both male and female clients and carers. Their views will be sought irrespective of gender as part of this consultation exercise.
Female	**x**			

3.5 Do you think that the policy impacts on people on the grounds of their race? [8]

[7] Religious groups cover a wide range of groupings the most of which are Buddhist, Christians, Hindus, Jews, Muslims, and Sikhs. Consider these categories individually and collectively when considering impacts

[8] Under the Race Relations Act, it is unlawful to discriminate against anyone on grounds of race, colour, nationality (including citizenship or ethnic or national origin). Includes Gypsy and Traveller Communities.

Race	Positive	Negative	None	Reasons for your decision
Promoting equality of opportunity	**x**			The modernisation agenda and this consultation exercise will be expected to operate within the requirements of the Race Relations Amendment Act 2000. Any specific requirements such as translators or translated documents will be provided as appropriate and when requested. Use of services such as Translate Plymouth will considered in these situations.
Promoting good race relations	**x**			As above
Eliminating unlawful discrimination	**x**			As above

3.6 Do you think that the policy impacts on people because of their sexual orientation?

Sexual Orientation	Positive	Negative	None	Reasons for your decision
Gay Men	**x**			Whilst no specific focus has been made in response to peoples sexual orientation, all services including this consultation exercise are expected to promote equality of opportunity and operate within the requirements of the Equality Act of Sexual Orientation Regulation 2007.
Lesbians	**x**			
Bi-sexual	**x**			
Trans communities (i.e. Trans-gender, trans-sexual and transvestite and gender reassignment)[9]	**x**			

[9] Transgender/transsexual person: a person whose perception of their own gender (gender identity) differs from the sex they were assigned at birth.
A Transvestite will dress as a member of the opposite sex but doesn't have feelings of belonging to the opposite sex or alienation from their own bodies. Source: www.herts.ac.uk/services/counselling/understanding_gender_dysphoria.pdf
Gender reassignment: the process of transitioning from the gender assigned at birth to the gender the person identifies with. This may involve medical and surgical procedures.

4. Summary

Which equality groups have positive or negative impacts been identified for (i.e. differential impact). [10]	NONE: Learning Disability and Mental Health (see 3.2) All other areas are identified as POSITIVE.
Is the policy directly or indirectly discriminatory under the equalities legislation? [11]	The consultation exercise is neither directly or indirectly discriminatory under Equalities legislation.
If the policy is indirectly discriminatory can it be justified under the relevant legislation? [12]	N/A

[10] Differential Impact suggests that a particular group has been affected differently by a policy, in either a positive, or negative way.
[11] Direct discrimination is treating people less favourable than others, e.g. on the grounds of age, disability, gender, race, relation and belief, sexual orientation.
Indirect discrimination is applying a provision, criterion or practice that disadvantages people, e.g. on the grounds of age, disability, gender, race, religion and belief, sexual orientation and that can't be justified as a proportionate mean of achieving a legitimate aim.
(If needed please seek advice from Legal Ser vices and/or your manager)

Appendix 3

Plymouth City Council
Delegated Decision - Equalities Impact Assessment Template

Policy	**Date**
Data used in conducting this assessment	**Officer conducting this assessment with contact details**

Equalities Issue	**Positive impact**	**Negative impact**	**None**	**Reasons for decision**
Age				
Disability				
Faith				
Gender				
Race				
Sexual Orientation				

.

The guidance on undertaking a standard EIA (see appendix 1) is also applicable to a basic assessment.
This EIA template is suitable for small-scale assessments of delegated decisions

Section B: Action

5. Please complete your action plan below. Issues you are likely to need to address include

- What **consultation** needs to take place with equality groups (bearing in mind any relevant consultation already done and planned corporate consultation exercises)
- What **monitoring**/evaluation will be required to further assess the impact of any changes on equality target groups

Equalities Impact Assessment Implementation Action Plan

Issue to be addressed	Responsible Officer	Action Required	Timescale for completion	Action Taken	Comments
No issues	Debbie Butcher	EIA to be reviewed	End of October 2009		

6. Report and publication

Please record details of the report or file note which records the outcome of the EIA together with any actions / recommendations being pursued (date, type of report etc)	Review to be undertaken as above.
Please record details of where and when EIA results will be published	Adult Social Care pages of Plymouth City Council website.

Name of Officer completing __Debbie Butcher_____

Signed _____

Date: _____

Name of Senior Manager Authorising Assessment and Action Plan for publication _____

Signed: _____

Date: _____

The Hyperbaric Medical Centre

(Diving Diseases Research Centre)

Charity (DDRC) founded in 1980

www.ddrc.org

The Hyperbaric Medical Centre

The Hyperbaric Medical Centre

DDRC – Main Activities

Clinical	Research	Training
		

Plymouth Hospitals NHS

Department of Health

Nuffield Health

Spire Healthcare

CareQuality Commission

NHS

DDRC

DAN

PADI

The Hyperbaric Medical Centre

MAJOR PATIENT GROUPS TREATABLE WITH HBO

[There are 13 "accepted" indications]

1. Non-healing ulcers (diabetes)
2. Radiation Tissue Damage (post cancer)
3. Infections (diabetes; plastic surgery)
4. Carbon Monoxide poisoning (house fires; boilers)
5. Divers (recreational accidents)

The Hyperbaric Medical Centre

MAJOR PATIENT GROUPS TREATABLE WITH HBO

[There are 13 "accepted" indications]

1. **Non-healing ulcers (diabetes)**
2. Radiation Tissue Damage (post cancer)
3. Infections (diabetes; plastic surgery)
4. Carbon Monoxide poisoning (house fires; boilers)
5. Divers (recreational accidents)

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DIABETES - NATIONALLY

- The cost of care for diabetics is **10% of the NHS budget** (estimated at £1 million per hour)
- Of the UK population **>5% are diabetic**
- Lower extremity amputation is **15-20 times** more likely in diabetic patients than in the general population.
- There are **proven advantages** of using hyperbaric oxygen therapy (HBO) in difficult to heal diabetic foot and leg ulcers[1,2].

[1] Canadian Agency for Drugs and Technologies in Health. Technology Report March 2007 – a) Overview of Adjunctive HBO for Diabetic Foot Ulcers b) Adjunctive HBO for Diabetic Foot Ulcer: An Economic Analysis

[2] NHS Quality Improvement Scotland – Systematic Review 2008. The clinical and cost effectiveness of hyperbaric oxygen therapy

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DIABETES - IN PLYMOUTH

- In 2007/08 **9683 people aged 17 or over** were diagnosed with diabetes.
- There are estimated to be **>10 000 diabetics in Plymouth**
- Predicted rise in diabetes in Plymouth 2005 to 2025 will be from **4.3% to 6.2%**.
- Currently only **11% of diabetics attend educational events**.

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DIABETES - IN PLYMOUTH

- Most patients referred to DDRC are progressing towards amputation
  - Progression is expensive (dressings, nurse time etc etc)
  - Post amputation is expensive
  - ~70% of diabetic lower limb amputees will die within 5 years [1]

The alternative

At DDRC :

- ~ 50% of patients - healed
- ~ 30% of patients - partially healed / improving wound.

[1] Schofield, C.J. *et al.*, (2006) Diabetes Care 29(10):2252-2256

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DIABETES - IN PLYMOUTH

- The average cost of a course of HBO is £4,500 per patient
- The cost of surgical amputation is unknown but includes:
  - Wound and stump care,
  - Occupational therapy,
  - Physiotherapy, prostheses,
  - Higher intensity healthcare professional intervention,
  - Psychological impact on patient and family,
  - (In)capacity to work,

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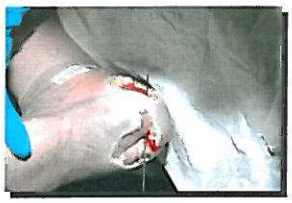

5 months
non-healing ulcer

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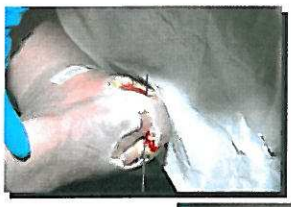

5 months
non-healing ulcer

5 months post presentation
for HBO

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MAJOR PATIENT GROUPS TREATABLE WITH HBO

1. Non-healing ulcers (diabetes)
2. **Radiation Tissue Damage (post cancer)**
3. Infections (diabetes; plastic surgery)
4. Carbon Monoxide poisoning (house fires; boilers)
5. Divers (recreational accidents)

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RADIATION TISSUE DAMAGE (1)

Prevention of Osteoradionecrosis

- Head and Neck Cancer survivors are at significant risk of jaw bone necrosis
- Marx (1985) - Dental work requires HBO pre- and post-operatively
- Significant savings in preventing the development of ORN
  - ORN requires protracted surgery, nutritional supplements, feeding tubes, pharmaceuticals, infection prevention etc
- Clinical trial (Cancer Research UK and the Liverpool Cancer Trials Unit) – multicentre RCT

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RADIATION TISSUE DAMAGE (2)

Pelvic Radiation Tissue Damage

- Survivors of cancers of the pelvic region (eg prostate, bladder, cervical, ...) are at risk of developing delayed tissue damage.
- Symptoms are debilitating - include bleeding, diarrhoea, pain, incontinence,..
- Significant costs associated with housebound lifestyle/blood transfusions etc
- Life changing successes achieved with patients treated at DDRC
- American clinical trial has shown significant efficacy of HBO – now standard care for this condition in the US
- RCT underway (Royal Marsden, CRUK) – results expected 2014

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MAJOR PATIENT GROUPS TREATABLE WITH HBO

1. Non-healing ulcers (diabetes)
2. Radiation Tissue Damage (post cancer)
3. **Infections (diabetes; plastic surgery)**
4. Carbon Monoxide poisoning (house fires, boilers)
5. Divers (recreational accidents)

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Other conditions treatable with HBO

Infections

Includes:

- Necrotising soft tissue infections
- Antibiotic Resistant Infections

Efficacy and potential not fully understood
Research required
Potential to save limbs and lives

Pre HBO

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Other conditions treatable with HBO

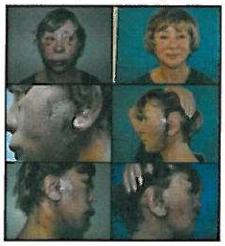
Infections

Includes:

- Necrotising soft tissue infections
- Antibiotic Resistant Infections

- Efficacy and potential not fully understood
- Research required
- Potential to save limbs and lives

Pre HBO 10 days later



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MAJOR PATIENT GROUPS TREATABLE WITH HBO

1. Non-healing ulcers (diabetes)
2. Radiation Tissue Damage (post cancer)
3. Infections (diabetes, plastic surgery)
4. **Carbon Monoxide poisoning (house fires; boilers)**
5. Divers (recreational accidents)

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Other conditions treatable with HBO

Carbon Monoxide Poisoning

Few referrals due to:

- Lack of A&E awareness
- Difficulties with ITU support for ventilated patients

Potential benefits of HBO treatment:

- Lifesaving in some instances
- Accelerated removal of CO from blood (reduced hospital stay)
- Prevention of delayed brain damage
- Prevention of downstream cardiac problems

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MAJOR PATIENT GROUPS TREATABLE WITH HBO

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Other conditions treatable with HBO

Decompression Illness

Recompression combined with hyperbaric oxygen therapy is the ONLY treatment for decompression illness

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IN PLYMOUTH

Are all the patients who could benefit being referred?

Diabetic Foot Ulcers – No

Radiation tissue damage (MaxFacs) – No

Radiation Tissue Damage (Pelvic) - No

Infections – No

CO exposure – No

Decompression Illness – Yes

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IN PLYMOUTH

Significant potential to reduce acute and downstream costs via:

- **Prevention of amputations** (diabetes; necrotising infections)
- **Prevention of ORN** (Maxillofacial cancer patients)
- **Healing of radiation-damaged tissue** (pelvic radiation, maxfacs)
- **Prevention of brain damage and cardiovascular damage** (CO exposure)
- **Improved healing times** (diabetes, antibiotic resistance)
- **Healing of ischaemic wounds and failing flaps** (plastic surgery)

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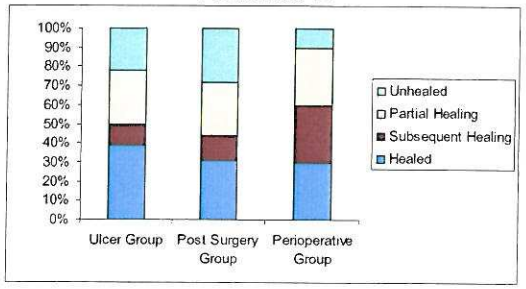
(Diving Diseases Research Centre) DDRC

We're here to help!!

Results 3



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13 Aug 2009 V11

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Strategy Review 2009

Strategy Review 2009

- What is our current strategy?
- Why are we reviewing it?
- What changes should we make? – Your chance to give your views
- Next steps

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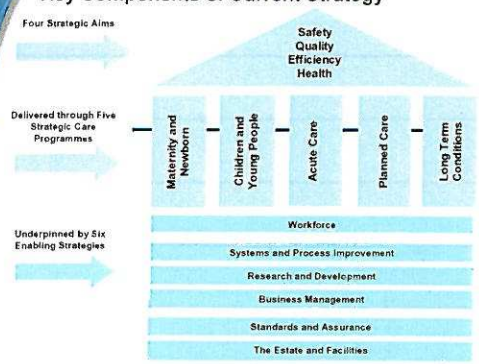
Key Components of Current Strategy



Why are we reviewing it?

- The current strategy is only eight months old, but there have been some significant changes in the strategic environment

External:

- Economic downturn
- Regulatory environment

- **Internal:**
  - Continuing Trust's overall performance volatility
  - Failed FT application

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The economic downturn

Economic Situation

- National debt approximately £1.5 trillion
- Expected increase in Public Sector spending of 0.7% in cash terms (including unemployment & Social Care)
- The *Institute for Fiscal Studies* suggest £45bn needs to be cut from public sector spending each year until debt reaches sustainable levels
- At least 3 comprehensive spending reviews (10 years) until we see growth in public sector funding

Impact on NHS

- 20% Real terms cuts over next five years equivalent to 1000 jobs
- 0% uplift on tariff –acute sector will bear the brunt of cuts
- Costs will continue to rise
  - tied into 3 year pay award
  - drug costs increasing
  - increasing fuel price

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What changes should we make…….

- To our clinical services?
- To our capital programme?
- To the way we do business?

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What changes should we make to our clinical services?

- **Models of care**
- **Care programmes**

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Models of care

- How will models of care need to change during the economic down-turn?
- Are there particular changes for:
  - Acute care
  - Planned care
  - Maternity and the newborn
  - Children and young people
  - Long-term conditions

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Care programmes

- What else is new that needs to be taken into account when developing strategies for:
  - Acute care?
  - Planned care?
  - Maternity and the newborn?
  - Children and young people?
  - Long-term conditions?

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What changes should we make to our capital programme?

- **What constraints will there be on the programme?**
- **Where should we prioritise our investment?**

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What constraints will there be on the Capital Programme?

- Sources of funding in the LTFM (five years):
  - Surpluses: £32m
  - Borrowing: £15m
  - Depreciation: £96m
- What is a more realistic capital budget?
- How hard are we prepared to work in order to invest?

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Where should we prioritise our capital investment?

Existing plans
- Gateway programme (*£14m)
- Children's hospital (*£18m)
- Ward refurbishment (*£13m)
- Emergency hub (*£14m)
- Re-provision of REI (tbc)
- Theatre refurbishment (*£15m)
- Medical equipment replacement (*£40m)

Other possible priorities
- Community based facilities
- Other children's facilities (instead of hospital)

*Approximate maximum costs

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What changes should we make to the way we do business?

- Enabling strategies
- Relationships with partner organisations
- Approach to "problem" services
- Organisational culture

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Enabling strategies

What should the main emphasis be in these enabling strategies:

- Workforce?
- Systems and process improvement?
- Standards and assurance?
- Business management?
- Estate and facilities?
- Research and development?

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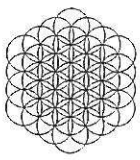
Relationships with partner organisations

Do our relationships with partner organisations need to change?

- Primary Care Trusts
  - Commissioners
  - Providers
- GPs
- SHA
- Other healthcare providers:
  - NHS
  - Independent sector
  - Local Government



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Approach to "problem" services

- What should the trust do about services that are not breaking even?
- What should services do that cannot meet regulatory standards? e.g.
  - Cleanliness
  - Training
  - Waiting times

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Organisational culture

- Should organisation/culture development be part of the strategy?
- If so, what should the organisation aim for:
  - More performance orientation and accountability?
  - More alignment between the staff and the Board?
  - Understanding the needs of Patients

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Next Steps

- ☑ Continued workshops with internal & external stakeholder
- ☑ Presentation of findings to Trust Board on 25 September 2009
- ☑ Presentation of findings to the Leadership Conference on 29 September 2009
- ☑ Revise Strategy in early October 2009

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THANK YOU
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