Public Document Pack

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

www.plymouth.gov.uk/democracy

Date 01/06/10 Telephone Enquiries 01752 304469 Fax 01752 304819

Please ask for Ross Jago, Democratic Support Officer e-mail ross.jago@plymouth.gov.uk

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

DATE: WEDNESDAY 9 JUNE 2010
TIME: 3.00 PM
PLACE: COUNCIL HOUSE (NEXT TO THE CIVIC CENTRE) PLYMOUTH

Committee Members–
Councillors Bowie, Coker, Delbridge, Gordon, Dr. Mahony, Mrs Nicholson, Ricketts, Dr. Salter and Viney

Co-opted Representatives (subject to confirmation)-
Chris Boote, Local Involvement Network (LINk).
Margaret Schwarz, Plymouth Hospitals NHS Trust.

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.

Members and Officers are requested to sign the attendance list at the meeting.

BARRY KEEL
CHIEF EXECUTIVE

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

PART I (PUBLIC PANEL)

AGENDA

1. APPOINTMENT OF CHAIR AND VICE-CHAIR

The panel will appoint the Chair and Vice-Chair for the municipal year 2010/11.

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 - 12)

The panel will be asked to confirm the minutes of the meetings held on 31 March and 14 April, 2010.

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. TERMS OF REFERENCE (Pages 13 - 14)

The panel will note the Terms of Reference for the Health and Adult Social Care Overview and Scrutiny Panel.

6. TRACKING RESOLUTIONS AND FEEDBACK FROM THE OVERVIEW AND SCRUTINY MANAGEMENT BOARD (Pages 15 - 20)

The panel will monitor the progress of previous resolutions and receive any relevant feedback from the Overview and Scrutiny Management Board.

7. APPOINTMENT OF CO-OPTED REPRESENTATIVES

The panel will consider the appointment of co-opted representatives and/or confirm existing co-opted representatives.

8. OVERVIEW OF PRIORITIES FOR COMMUNITY SERVICES (ADULT SOCIAL CARE)

The panel will receive an overview of the priorities for Community Services, with a focus on Adult Social Care.

9. NHS PLYMOUTH - QUALITY ACCOUNTS BRIEFING (Pages 21 - 30)

NHS Plymouth will submit a briefing regarding the Quality Accounts process for action by the panel.

10. NHS PLYMOUTH - GREENFIELDS CONSULTATION (Pages 31 - 42)

NHS Plymouth will submit for the panel's consideration and comment its consultation proposals in respect of Greenfields.

11. SUBSTANTIVE VARIATION PROPOSALS (Pages 43 - 44)

The panel will consider the draft process for dealing with service development proposals as submitted by NHS Plymouth.

12. NHS PLYMOUTH - GP-LED HEALTH CENTRE (Pages 45 - 48)

NHS Plymouth will provide an update on the performance of the GP-Led Health Centre at Mount Gould following its opening in April 2009.

13. DRAFT WORK PROGRAMME 2010/11 (Pages 49 - 50)

The panel will consider its draft work programme for 2010/11.

14. FUTURE DATES AND TIMES OF MEETINGS

The panel is asked to note the dates of future meetings for the municipal year 2011. All meetings will commence at 3.00 p.m. –

Wednesday 9 June, 2010
Wednesday 7 July, 2010
Wednesday 1 September, 2010
Wednesday 13 October, 2010 (Provisional)
Wednesday 10 November, 2010
Wednesday 12 January, 2011
Wednesday 2 March, 2011
Wednesday 30 March, 2011 (Provisional)

This page is intentionally left blank

Agenda Item 3

Health and Adult Social Care Overview and Scrutiny Panel

Wednesday 31 March, 2010

PRESENT:

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

Co-opted Representative: Mr. Boote (LINk).

Apologies for absence: Councillor Mrs. Aspinall and Ms. Schwarz (PHT).

The meeting started at 10.00 a.m. and finished at 12.30 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.

71. **APPOINTMENT OF VICE-CHAIR**

In the absence of the Vice-Chair, Councillor Gordon, having been proposed by the Chair and seconded by Councillor Delbridge, was appointed Vice-Chair for the purposes of this meeting only.

72. **DECLARATIONS OF INTEREST**

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

73. **MINUTES**

Resolved that the minutes of the meetings held on 27 January and 23 February, 2010, be confirmed, subject to the amendment of Minute 68(6) to reflect the fact that a briefing paper be circulated to panel members in the first instance and that only in the event of concerns being raised would a report be presented to a future meeting of the panel.

CHAIR'S URGENT BUSINESS

74. **Scrutiny of Health Commissioning**

The Chair advised that the panel had been invited to submit comments on a draft scrutiny guide which had been prepared by the Centre for Public Scrutiny. The purpose of the guide was to raise awareness of the opportunities for health scrutiny panels to get involved in the scrutiny of health commissioning and particularly to focus on health inequalities.

Resolved that –

(1) panel members submit comments on the draft guide to the Democratic Support Officer by 6 April, 2010;

(2) authority to respond on the panel's behalf be delegated to the Democratic Support Officer, in consultation with the Chair and Vice-Chair.

75. **Lead Officer**

The Chair updated the panel on the latest position with regard to its Lead Officer following the departure of Christina Smale. Members were advised that Ian Gallin, Assistant Chief Executive, had been proposed to take over the role but the Chair had met with him and raised concerns about –

- whether it was appropriate for him to support the conflicting roles of both cabinet and scrutiny
- whether he had the capacity to take on such a significant role, given his already demanding workload

As a result, an alternative Lead Officer was being considered but could not yet be confirmed.

(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).

76. **SOUTH WESTERN AMBULANCE SERVICES NHS TRUST - FOUNDATION TRUST CONSULTATION RESPONSE**

The panel noted the report from South Western Ambulance Service NHS Trust which provided details of the consultation undertaken as part of its move toward becoming a Foundation Trust.

77. **MODERNISATION OF BROADMOOR HOSPITAL**

The panel noted the briefing paper from the NHS South West Specialised Commissioning Group regarding the planned modernisation of Broadmoor Hospital. Members were advised that the proposals would have minimal affect on Plymouth citizens.

78. **INFECTION CONTROL BRIEFING**

The panel received a report from the Plymouth Hospitals NHS Trust updating them on infection control measures and performance at Derriford Hospital. In attendance to present the report was Dr. Peter Jenks, Director of Infection Prevention and Control. The report provided statistics relating to the Trust's performance in respect of –

- Clinical cases of Meticillin-Resistant Staphylococcus Aureus (MRSA)
- MRSA bacteraemias
- Clostridium difficile
- Hand Hygiene
- Surgical site infection rates

In response to questions raised, the panel were further advised that –

(i) infection audits were carried out regularly on all wards on a three-monthly cycle. Each ward undertook its own audit for two months of the cycle and during the third month the Infection Control Team would make an unannounced visit;

(ii) the year-on-year improvements in infection control standards had been achieved for a number of reasons, including –

- investment in the Infection Control Team
- raising awareness of the importance of hand wash
- isolation of patients
- MRSA screening

These changes had been fully supported by the Trust Board and were now embedded throughout the Hospital;

(iii) all patients were screened prior to admission for surgery. Anyone identified as having an infection was given a five day course of treatment comprising application of a nasal cream two days prior to admission and three days after surgery;

(iv) educating the public was an identified area for improvement and work had already begun in this regard, including –

- poster competition in schools
- development of a questionnaire to establish how much/or little people actually knew
- establishment of a focus group to look at how the Trust could engage better

(v) membership of the focus group comprised hospital staff whilst the engagement project was being scoped but, once completed, this would be widened to include other interested parties;

(vi) Members' assistance in helping the Trust to engage with the public was welcomed and Dr. Jenks would come back with suggestions once he had taken time to give more thought to the matter.

The panel congratulated the Trust on its performance in regard to infection control and thanked Dr. Jenks for his attendance.

Resolved that a further update be presented to panel in 12 months' time, the next report to include the actual number of incidents recorded in addition to percentages.

79. **CARERS CHAMPIONS**

This item was deferred for consideration at the meeting on 14 April, 2010.

80. **PROJECT INITIATION DOCUMENT - CARERS**

The panel received for its consideration a copy of the project initiation document (PID) prepared with a view to undertaking a task and finish group to look at carers. Members were advised that, subject to panel approval, the PID would be submitted to the Overview and Scrutiny Management Board's meeting that afternoon.

Recommended that the Overview and Scrutiny Management Board be requested to approve the panel's proposal to undertake a task and finish group in respect of Carers.

81. **LINk UPDATE**

The panel's co-opted representative presented an update on the work being undertaken by the Plymouth LINk. Members were advised that –

(i) questions which could not be answered would be responded to in writing after the meeting;

(ii) Plymouth's Primary Care Trust (PCT) was still not meeting the Government's target of 65 per cent with regarding to providing access to an NHS dentist. The LINk was working with the Trust to ensure that this would significantly improve over the next 12 months;

(iii) relations between the PCT and care homes had not been very good, particularly around patient discharge. One of the problems identified by the LINk had been the lack of attendance of a suitable PCT representative at the Care Homes Forum. This had since been resolved via the attendance of the Deputy Director of Primary Care;

(iv) the LINk was working with two specialist nurses to develop process and procedures aimed at improving the treatment of people with learning disabilities whilst in hospital;

(v) the LINk had been invited to form part of –

- an inspection team looking at cleanliness at Derriford Hospital to monitor performance of the Serco contract
- a review team tasked with assessing whether or not Derriford Hospital should be designated as a Burns Centre as part of the specialised commissioning process
- a review team tasked with reviewing access to social services

(vi) the success of the City Centre Health Day would determine whether or not it became an annual event;

(vii) copies of the LINk promotional leaflet would be made available to Councillors to pass on to constituents should they express an interest in becoming a member.

Written responses would be provided to the panel in respect of –

- the problems associated with patient discharge
- whether the cleanliness inspection at Derriford Hospital had been planned or a spot check
- the status of the LINk representative on the PHT Board
- the current membership of the LINk and the number of active members

82. **CORPORATE IMPROVEMENT PRIORITIES (CIPs)**

The Committee considered the briefing paper which provided an update on performance against the Council's Corporate Improvement Priorities, CIP3 and CIP4. In the absence of a presenting officer for this item, it was suggested that a written response to any questions asked would be provided in writing to members after the meeting. With this in mind, the following questions were noted for response -

(i) why was the Council failing to achieve the target set against NI 135 and what remedial action was being taken to address the situation?

(ii) was the Council comparing like for like in terms of benchmarking, could details of the comparatives used be provided?

(iii) in regard to NI 141, could a definition of vulnerable be provided?

(iv) the table in section 5 of the report was incomplete, could a more detailed overview of the milestones be provided?

Resolved that –

(1) with regard to (i)-(iv) above, the Assistant Director for Adult Health and Social Care be requested to provide a written

response to the Democratic Support Officer for onward dissemination to panel members;

(2) the statistics provided in future reports to include numbers as well as percentages;

(3) a copy of the action plan to reduce health inequalities, identified as a key area of under performance in the Council's Comprehensive Area Assessment, be presented to a future meeting of panel.

83. **QUARTERLY REPORT**

The panel received for its information a copy of the quarterly report.

Members noted the report with interest and sought assurance that the panel's remaining budget of £905.42 would be carried forward to 2010/11. The Chair reported that, as far as she was aware, the money would be ring-fenced. However, clarification would be sought from the Overview and Scrutiny Management Board which was meeting that afternoon.

84. **TRACKING RESOLUTIONS**

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

(i) Minute 56 – the Chair reported that she had met with the Chief Executive and the Director for Community Services and been advised that the Director for Public Health already attended all of the strategic meetings necessary and had regular dialogue with the Assistant Chief Executive. The panel's recommendation was not therefore required;

(ii) with regard to Minute 61(2) – the Chair advised that she would be speaking to the Assistant Chief Executive to identify a way forward;

(iii) with regard to Minute 68(3) – the Democratic Support Officer would make enquiries of the Assistant Director for Adult Health and Social Care as to when the results of the survey would be available;

(iv) with regard to Minute 69(2) - the Chair advised that she would be speaking to the Assistant Chief Executive to identify a way forward.

85. **WORK PROGRAMMES 2009/10 AND 2010/11**

The panel noted its work programme for 2009/10 and its draft work programme for 2010/11. The Chair reported that she would be working

closely with the Chair of the Healthy Theme Group during 2010/11 to ensure that the work programmes were more closely aligned with a particular focus on tackling inequalities.

86. **EXEMPT BUSINESS**

There were no items of exempt business.

This page is intentionally left blank

Health and Adult Social Care Overview and Scrutiny Panel

Wednesday 14 April, 2010

PRESENT:

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

Co-opted Representatives: Mr. Boote (LINk) and Ms. Schwarz (PHT).

Apologies for absence: Councillors Gordon and Mrs. Nicholson.

The meeting started at 10.00 a.m. and finished at 11.40 a.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.

87. **WELCOME**

The Chair welcomed Giles Perritt, Head of Performance, Policy and Partnerships, to his first meeting of the panel as Lead Officer.

88. **DECLARATIONS OF INTEREST**

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

89. **CHAIR'S URGENT BUSINESS**

There were no items of Chair's urgent business.

90. **MATERNITY SERVICES**

The panel considered a report on Maternity Services as submitted by the Plymouth Hospitals NHS Trust. In attendance to present the report were the Trust's Acting Director of Finance and the Acting Head of Midwifery who advised that the report had been prepared to respond to a number of specific concerns raised by the Chair and Vice-Chair.

Following presentation of the report, and in response to supplementary questions, Members heard that –

(i) in addition to the support for breastfeeding provided by midwives and health visitors, peer group supporters were available to work alongside new mums both at home and in hospital;

(ii) the Trust was applying for Baby Friendly Initiative certification and, as such, would be assessed at the end of the year;

(iii) breastfeeding remained a cultural challenge which needed to be addressed nationally as well as locally. Whilst businesses in the City were encouraged to sign up to the Baby Friendly Initiative and be 'kite' marked, the only facilities provided in many establishments were the ladies toilets;

(iv) Derriford's Maternity Unit dealt with approximately 5,000 births per annum;

(v) the National Institute for Health and Clinical Excellence (NICE) did not offer any guidance on the recommended length of stay for mothers who had delivered their babies by caesarean section. Provided there was no medical reason for mothers to be in hospital, they could go home;

(vi) up to 28 days following discharge from hospital, women were able to choose whether they saw a midwife, healthcare advisor or health visitor;

(vii) a copy of the Maternity Satisfaction Survey was included in the pack of information given to every woman who had delivered a baby at the hospital. In addition, 'comments boxes' were provided on all wards for patients to leave feedback about their care and stay;

(viii) sickness levels within the Maternity Unit were comparable to the rest of the Trust. The monitoring system in place flagged up areas where sickness absence rates were higher than 5.25% per month and appropriate action was taken when necessary;

(ix) allowance for absence was built in when planning duty rosters and, when necessary, part-time staff could be called to work extra hours or the NHS nurse bank could be utilized;

(x) the hospital did not undertake staff stress surveys, however, the recent NHS staff survey had included a number of questions around stress and emotional wellbeing;

(xi) turnover of staff was generally low. However, it was acknowledged that there were problems with the Trust's recruitment processes and work was under way to make it more streamlined. There were currently 3 vacancies within the Maternity Services Unit and, historically, the Trust received at least 3 applications for every vacancy;

(xii) the majority of midwives opted to work a 12-hour shift with a one-hour break entitlement and staff were encouraged to take their break off-ward as often as possible;

(xiii) all nurses, including midwives, were required to complete five study days a year as part of the continuing professional development programme. They were also required to submit an 'intention to practice' form;

(xiv) Birthrate Plus would be visiting the Hospital next week to evaluate the Trust as part of an independent external benchmarking process;

(xv) visiting hours within the hospital were, on the whole, very generous when compared to others in the south west. Whilst dads were encouraged to visit within the stated times, exceptions would be made for the fathers of babies delivered late in the day where adherence to those times would preclude them from having any or little time to spend with the new arrival and mother;

(xvi) a business case on establishment of a midwifery-led unit had been put together for presentation to the Trust's Board. Plans had been developed concerning the physical layout of the proposal but costs had yet to be finalized. It was, however, envisaged that there would be provision in the 2010/11 budget to take the proposal forward.

Resolved that –

(1) the Director for Public Health be requested to explore the possibility of including a number of key midwifery-related questions in the annual Health Visitor Survey;

(2) the City Development Company be asked what it was doing to encourage businesses to participate in the Baby Friendly Initiative and become kite marked;

(3) the results of the Maternity Satisfaction Survey, Maternity Care Patient Survey and the Maternity Unit Audit of Practice be forwarded to panel members, along with an analysis of trends and benchmarking;

(4) a copy of the results of the annual maternity survey be forwarded to panel members when available;

(5) a letter be sent to the National Institute of Health and Clinical Excellence (NICE) requesting that it considered including within its guidance a recommended length of postnatal stay for women who had delivered their babies by caesarean section.

91. **EXEMPT BUSINESS**

There were no items of exempt business.

This page is intentionally left blank

Health and Adult Social Care Overview and Scrutiny Panel

Terms of Reference

- To review new and existing policies and consider how they may be improved and developed;
- To monitor the budget and performance of the Cabinet Member, Department and partners to ensure that the priorities for the area are being delivered upon;
- To monitor performance against the relevant Corporate Improvement Priorities;
- To review Policies within the Budget and Policy Framework;
- To consider Equality Impact Assessments against new and existing policies;
- To investigate local issues to find out how the council and its partners can improve to meet the needs of local people;
- To make recommendations about service delivery to the Cabinet (via the Board)
- To review and scrutinise the performance of partner organisations
- To set up Ad-Hoc Working Groups as and when required;
- To produce quarterly progress reports to go to the management board

Policy Areas

- Adult Social Care
- Partner Organisations – PCT etc

Cabinet Members

- Adult Health and Social Care

Directorate

- Public Health
- Community Services

Corporate Improvement Priorities (CIPs)

- Independent Living (CIP 3)
- Reducing Inequalities (CIP 4)

LSP Link

- Healthy

Membership

The Chair of the Panel shall serve on the Overview and Scrutiny Management Board. The Health and Adult Social Care Overview and Scrutiny Panel will be chaired by a Member of the majority political group with the vice-chair from the opposition political group. All Members of the panel will adhere to the general rules of overview and scrutiny.

This page is intentionally left blank

TRACKING RESOLUTIONS

Health and Adult Social Care Overview and Scrutiny Panel

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
27/01/10 54 (1) (2)	**Service Improvement Proposal – Centralisation of Gynaecological Cancer Surgery** Recommended that the findings of the independent clinical review could not be supported because the report fails to provide the assurances the panel would need in respect of – evidence to demonstrate that a second centre at Truro would make a significant difference to clinical outcomes for patients from Plymouth; addressing the issue of individual choice for women over where their surgery should take place.	Consideration of proposals to centralise gynaecological cancer surgery with a view to establishing two specialist centres at Exeter and Royal Cornwall Hospital, Truro.	NHS Plymouth	Recommendations passed on to NHS Plymouth. Further report to come back to panel.	June/ July 2010
60 (2) (3)	**Alcohol Harm** Recommended that - the Assistant Director for Governance and Democracy be asked to look at whether licensing legislation allows for the impact on a neighbourhood's health to be taken into account when considering licence applications; the Alcohol Strategy be presented to the Licensing Committee for information;	Discussion on progress with production of an Alcohol Strategy for the City and alcohol-related problems in the City. (See also minute 69 below).		Recommendations submitted to the Overview and Scrutiny Management Board on 03/02/10 – not considered. Re-submitted to Overview and Scrutiny Management Board on 31/03/10 – deferred for consideration at next meeting pending appointment of a Lead Officer. To be submitted to OSM on 30 June, 2010.	

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
(4)	the Director for Community Services be requested to consider notifying ward councillors on receipt of licensing applications, similar to what is already in place for planning applications.				
61	**Smoking – Performance Against LAA Stretch Targets** Recommended that - the City Council lobbies the City's three MPs to support progress of the 2009 Health Bill – Tobacco Control - through Parliament.	Panel received a presentation providing an overview of the work of the Smoking Cessation Service in Plymouth, including details of how it was performing against the LAA stretch targets.		Submitted to Overview and Scrutiny Management Board on 31/03/10 – deferred for consideration at next meeting pending appointment of a Lead Officer. To be submitted to OSM on 30 June, 2010.	
23/02/10 68 (3)	**Annual Performance Assessment of Adult Social Care 2008/09 – Report from Care Quality Commission** Resolved that – the results of the Adult Social Care User Satisfaction Survey be emailed to panel members on completion;	Panel received an update on how the Adult Social Care Service had performed following assessment by the Care Quality Commission	AD for Adult Health and Social Care / DSO	Results of survey awaited.	
69 (2)	**Alcohol Strategy** Recommended that - if a Night Time Economy Manager is appointed, with responsibility for the whole of the city and not just to city centre trade, this post would ideally be funded in the majority by Statutory Partners with a contribution from the trade.	Further to minute 60, the Panel received an update on progress with production of the Alcohol Strategy. Discussion took place on the role of the Night Time Economy Manager and whether this should be expanded to cover the whole of the City rather than just the City Centre.		Submitted to Overview and Scrutiny Management Board on 31/03/10 – deferred for consideration at next meeting pending appointment of a Lead Officer. To be submitted to OSM on 30 June, 2010.	

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
31/03/10 73	**Minutes** Resolved that the minutes of the meetings held on 27 January and 23 February 2010 be confirmed, subject to the amendment of Minute 68(6) to reflect the fact that a briefing paper be circulated to panel members in the first instance and that only in the event of concerns being raised would a report be presented to a future meeting of the panel.	Report to panel not required in first instance so minute amended accordingly.		Awaiting briefing paper.	
74	**Scrutiny of Health Commissioning** Resolved that – Panel members submit comments on the draft guide to the Democratic Support Officer by 6 April, 2010; Authority to respond on the panel's behalf be delegated to the Democratic Support Officer, in consultation with the Chair and Vice-Chair.	Comments invited on draft scrutiny guide produced by Centre for Public Scrutiny. Tight deadline for response hence need to delegate.	DSO / Chair and Vice-Chair	No further comments received from panel members. Chair and Vice met with DSO and response sent on 12 April, 2010.	
78	**Infection Control Briefing** Resolved that a further update be presented to panel in 12 months' time, the next report to include the actual number of incidents recorded in addition to percentages.		Plymouth Hospitals NHS Trust	Included in panel's work programme to monitor in 12 months' time.	

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
80	**Project Initiation Document – Carers** Recommended that the Overview and Scrutiny Management Board be requested to approve the panel's proposal to undertake a task and finish group in respect of Carers.	Panel to look at carers and cared for people's experience of engaging in the policy-making process, including looking at the Carers Strategy.		Approved by Overview and Scrutiny Management Board on 31 March, 2010. Added to work programme.	
82 (1) (2) (3)	**Corporate Improvement Priorities (CIPs)** Resolved that – with regard to (i)-(iv) above, the Assistant Director for Adult Health and Social Care be requested to provide a written response to the Democratic Support Officer for onward dissemination to panel members; the statistics provided in future reports to include numbers as well as percentages; a copy of the action plan to reduce health inequalities, identified as a key area of under performance in the Council's Comprehensive Area Assessment, be presented to a future meeting of panel.	The panel considered an update on performance against CIP3 and CIP4. In the absence of a Lead Officer questions raised had to be noted for written response.	AD for Adult Health and Social Care	Response to be included in next CIP report to be considered by panel in July. Added to work programme.	
14/04/10 90 (1)	**Maternity Services** Resolved that – the Director for Public Health be requested to explore the possibility of including a number of key midwifery-related questions in the annual Health Visitor Survey;	Panel considered report on maternity services responding to specific concerns raised through the Chair and Vice-Chair.	Plymouth Hospitals NHS Trust	Recommendation forwarded to the Director for Public Health. Response awaited.	

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
(2)	the City Centre Company be asked what it was doing to encourage businesses to participate in the Baby Friendly Initiative and become kite marked;			Recommendation forwarded to City Centre Company. Response awaited.	
(3)	the results of the Maternity Satisfaction Survey, Maternity Care Patient Survey and the Maternity Unit Audit of Practice be forwarded to panel members, along with an analysis of trends and benchmarking;			Analysis of survey results awaited.	
(4)	a copy of the results of the annual maternity survey be forwarded to panel members when available;			Results of Annual Maternity Survey awaited.	
(5)	a letter be sent to the National Institute of Health and Clinical Excellence (NICE) requesting that it considers including within its guidance a recommended length of postnatal stay for women who had delivered their babies by caesarean section.			Letter sent to NICE 24/05/10 with panel's recommendation. Response awaited.	

Overview and Scrutiny Management Board

Date/min number	Resolution / Recommendation	Explanation / Minute	Response	Explanation

Grey = Completed (once completed resolutions have been noted by the panel they will be removed from this document)

Red = Urgent – item not considered at last meeting or requires an urgent response

This page is intentionally left blank

BRIEFING NOTE ON THE QUALITY ACCOUNT PROCESS, 2010-2011.

Summary.

1. It is an annual report for public consumption.

2. The aim is to enhance public accountability and engage the organisations leaders in their quality improvement agenda.

3. Account has to be completed and placed on the NHS Choices web-site by close of play 30th June 2010.

4. The period covered by the account is 2009-10.

5. The account will only need to cover mental health services for 2009-10.

6. The account consists of 3 parts- Part 1 is a statement by the Chief Executive, Part 2 identifies priorities for improvement and statements relating to the quality of NHS services provided, and Part 3 reviews quality performance, explains who has been involved in the process and contains statements from the commissioning PCT, LINkS and OSC.

7. Community health and primary care services are exempt until 2010-2011.

8. All relevant information relating to the process can be found in the Quality Account Toolkit on the following site:

   www.dh.gov.uk/en/Healthcare/Highqualitycareforall/Qualityaccounts

Introduction

"….the primary purpose of Quality Accounts is to encourage boards to assess quality across the totality of services they offer, with an eye on continuous quality improvement. If designed well, the Accounts should assure commissioners, patients and the public that trust boards are regularly scrutinising each and every one of their services."

Professor Sir Bruce Keogh, Quality Accounts Toolkit 2010.

The above quote encapsulates the purpose of Quality Accounts.

Content

A Quality Account needs to be determined locally, and should present an honest picture of what the Trust delivers and what its improvement plans are. However, in order to provide some consistency between provider reports, and to provide assurance that the Trust is meeting essential standards and is involved in cross-cutting initiatives that aim to drive up quality improvement, a series of statements from the board are required as part of the regulations.

The content of a Quality Account cannot be decided by the board (or equivalent), and therefore the information presented and the decisions taken on improvement as a result, needs to be decided by involving all interested parties; for example, patients and their carers, including those from equality target groups; staff and clinical teams; commissioners and regulators.

A Quality Account therefore, must include:

- a statement from the board (or equivalent) of your organisation summarising the quality of NHS services provided:

"Part 1, containing a statement summarising the provider's view of the quality of NHS services provided or sub-contracted by the provider during the reporting period,

and

The relevant document must include a written statement, at the end of Part 1, signed by the responsible person for the provider that to the best of that person's knowledge the information in the document is accurate."

- your organisation's priorities for quality improvement for the coming financial year;
- a series of statements from the board for which the format and information required is set out in regulations:

"The relevant document must include, in Part 2, a description of the areas for improvement in the quality of NHS services that the provider intends to provide or sub-contract for the 12 months following the end of the reporting period.

The description must include:

- at least three priorities for improvement;
- how progress to achieve the priorities identified in paragraph (a) will be monitored and measured by the provider; and
- how progress to achieve the priorities identified in paragraph (a) will be reported by the provider. "

and a review of the quality of services in your organisation. You might like to think about expressing this in terms of the three domains of quality: patient safety, clinical effectiveness and patient experience:

"This section is where you will find information relating to the quality of services that your organisation provides. It should therefore should reflect the type of organisation you are (for instance, acute or specialist services, mental health, ambulance etc.), and show data relevant to specific services and specialities as well as what patients and the public say matters most to them."

Sections in green text above indicate quotes from the toolkit.

Included in the above will be involvement in clinical audit, research, information on data quality, CQC registration status and Commissioning for Quality and Innovation (CQUIN) involvement.

Collaboration

It will be clear from the above that the production of a Quality Account is a collaborative venture. Some of the organisations involved could include:

- LINkS
- Oversight and Scrutiny Committee (OSC),
- Local Strategic Partnership (LSP),
- Lead commissioner,
- Patient and carer groups
- Staff,
- Other stakeholders, such as police, probation, housing and transport services
- Third sector, such as MIND, Alzheimers Disease Association, Age Concern, housing associations etc.
- Local groups representing diversity of race gender and spirituality etc,

The Department of Health's publication *A Dialogue of Equals* (2008) sets out a process for how NHS organisations can engage effectively with seldom-heard-from, marginalised groups. It contains worked-through examples of good practice.

Sources of useful information.

The following are useful sites for information or examples that will contribute to the production of the Quality Account:

- www.dh.gov.uk/en/Healthcare/Highqualitycareforall/Qualityaccounts - DoH main QA website
- http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_105714.pdf - Kings Lynn Quality Report
- http://www.opsi.gov.uk/si/si2010/uksi_20100279_en_1 - NHS (Quality Accounts) Regulations, 2010
- http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_111113 - role of Commissioners, LINkS and OSC
- http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_097598 - Sunnyview Quality Report
- http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_112359 - Quality Accounts toolkit

May 2010.

==========

BRIEFING NOTE ON THE QUALITY ACCOUNT (QA) PROCESS, 2010-2011.

Presented by Steve Waite, Liz Cooney and Nigel Pluckrose.

Summary

- It is an annual report for public consumption.
- The aim is to engage effectively with the public and ensure the organisations leaders are more accountable for their quality improvement agenda.
- The QA has to be completed and placed on the NHS Choices web-site by close of play 30th June 2010.
- The period covered by the account is 2009-10.
- The account will only need to cover mental health acute/in patient services for 2009-10.

Purpose of QA

- “….the primary purpose of Quality Accounts is to encourage boards to assess quality across the totality of services they offer, with an eye on continuous quality improvement. If designed well, the Accounts should assure commissioners, patients and the public that trust boards are regularly scrutinising each and every one of their services.”
- Professor Sir Bruce Keogh, Quality Accounts Toolkit 2010.

Content

- **A Quality Account must include** a **statement from the board**, *and*
- must include **a written statement**, signed **by the responsible person for the provider** that to the best of that person's knowledge the information in the document is accurate.
- the **organisation's priorities for quality improvement for the coming financial year.**
- **A description of the areas for improvement** in the quality of NHS services that the provider intends to provide or even sub-contract for the 12 months following the end of the reporting period.
- The description must include **at least three priorities for improvement** *and*
- **how progress to achieve these priorities will be monitored, measured and reported,**
- **a review of the quality of services** in your organisation, possibly expressed as the three domains of quality: **patient safety, clinical effectiveness and patient experience,**
- **How clinical audit, research, information on data quality, CQC registration status and Commissioning for Quality and Innovation (CQUIN) will be involved,**
- How other local organisations will collaborate in the QA production.

Additional Information

- **Sources of useful information.**
- The following are useful sites for information or examples that will contribute to the production of the Quality Account:
- www.dh.gov.uk/en/Healthcare/Highqualitycareforall/Qualityaccounts - DoH main QA website
- http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_105714.pdf - Kings Lynn Quality Report
- http://www.opsi.gov.uk/si/si2010/uksi_20100279_en_1 - NHS (Quality Accounts) Regulations, 2010
- http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_111113 - role of Commissioners, LINkS and OSC
- http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_097598 - Sunnyview Quality Report
- http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_112359 - Quality Accounts toolkit

- David Ockelford, 14th May 2010.

Greenfield's Option Appraisal Proposals
A Consultation Paper

Introduction

Following the Health Care Commission (HCC) Review of the Willows in October 2008 a detailed implementation plan was agreed and operationalised in regard to the main points that were identified. This demonstrated however that despite best efforts to address the key issues, it has become apparent that there are some fundamental service design and quality issues that compromise the ability of the unit to fully meet the needs of individuals with a learning disability and the complex range of needs often presented.

It has been agreed at NHS Plymouths Provider Governance Committee and Trust Board that the current service model is unsustainable and as a result, NHS Plymouth's Trust Board agreed in March 2010 that a three month consultation period would commence on the future direction of the in-patient service. NHS Plymouth's Provider Mental Health Management Team have been asked to facilitate the consultation process and will feedback the outcomes of this to Commissioners, so that an informed decision can be made about what is the best model for Plymouth's service users and carers for the future.

The aim of this paper is to inform the consultation process and put forward proposals that mental health and learning disability providers have reviewed and feel are the most viable options for the future of the service. The objective of this exercise is that NHS Plymouth and Plymouth City Council (PCC) should be in a position to deliver a quality service meeting the range of needs of the local population in an environment that promotes dignity and respect, underpinned by a service model that is flexible, adaptable, therapeutic and focuses on the long term ability of service users to live as independent and full

life as possible. This paper has been developed through discussion with senior clinicians and managers, as well as contributions from frontline clinical staff within the learning disability and mental health service.

Local Need and Case Studies

People with learning disabilities in Plymouth (current population of 1,300) have significantly higher need for health care services than the general population. The principles outlined within the service specification agreed with Commissioners in 2009/2010 articulate the need for an inpatient unit providing care and treatment to those with particularly complex needs (see appendix 4). A very small number (between 2 & 3%) of those with the most complex needs require expert/specialist inpatient assessment, treatment and crisis resolution facilities, when assisted care alternatives at home or in other health and social care settings have been exhausted. Greenfield's has provided this service to the majority of those requiring it.

Having reviewed the current service specification, it has been concluded that in essence there is a fine balance between developing a service with a clear role and criteria that is focussed enough to meet the needs of a defined group of the population without compromising quality and risk, against developing a service specification that is too restrictive and misses groups of service users who have a need that can potentially be met within the service.
It has been concluded that the inpatient unit, as it is currently configured is not resourced or able to meet the needs of the local population in the way described within the service specification. It is this issue therefore that will become the focus of this paper and process and will underpin the options that are being presented. Furthermore as part of the review process, specifications for other similar units have been reviewed. What is noticeable is that it has not been possible to identify a specification for a unit that is any more defined or detailed than the one currently available at Greenfield's. What is of note however is that other services and units provide a far broader range of therapeutic interventions and activities for service users.
The following recent referrals provide an illustrative case example of this:

1. Mr A is a 21 year old gentleman, with a severe learning disability, complicated by epilepsy (full range), communication impairment on the autism spectrum, and a history of brain trauma. Mr A is well built, ambulant gentleman, and can move quickly.
Mr A has presented with assaultative behaviour towards others over some years. Behaviour includes scratches, grabs/digging nails, bites/attempted bites to others, hair-pull, and pulling. The Challenging Behaviour Service (CBS) worked with Greenfi eld's staff and clarified the "functionality" of some behaviours i.e. Known triggers include noise, crowds, confusion, and unsolicited proximity. The resulting care plan necessitated 2:1 support whilst Mr. A. was an inpatient. Given the fact that the unit is commissioned to provide only 3 nurses per shift, this posed a significant and un-funded challenge. Medication change (epilepsy related) reduced apparent sedation, but was associated with an increase in rate of assaults on peers and staff, and a Safeguarding plan advised relocation to manage risk.
Some of Mr As behaviour seemed non-functional, (i.e. neither triggered by identifiable environmental events nor apparently reinforced by consequences, and more related to intrinsic factors). Mr A's complex needs have contributed to risks associated with his unpredictable behaviour being a challenge to manage, even with staffing enhancement, in open plan communal settings.
Mr A. has now been successfully discharged. The cost of his community placement is £169K per year. This includes a minimum of 1:1 staffing within an environment that is of low stimulation and able to accommodate his needs.

2. Miss B was referred to Greenfield's following a breakdown in her supported living placement and it was felt that Miss B, who had breached her probation order, would be requested to be admitted to hospital for assessment when she appeared in court. There were concerns at the time that Miss B was hearing voices and was responding to them. She was diagnosed with negative schizophrenia. Medication changes were made which resulted in an increase in seizures. Behaviours were difficult to manage at times but there were known triggers to this - loud music, not responding, isolating herself. The discharge plan for Miss B was moving to a supported living package. A

provider was identified and introduced to Miss B to build a relationship with her whilst she stayed at Greenfield's. The provider however withdrew from the case when Miss B displayed several behavioural outbursts and it was felt that she would not be safe within a flat with only 1 member of staff. The discharge plan was reviewed and supported living was felt to be appropriate for Miss B. A flat was found and she was about to be discharged with a company that was very experienced in working with challenging behaviour, when Miss B attacked a member of Greenfield's staff. This was a week before discharge from hospital. The attack was severe and Miss B was removed to The Gables Mental Health Recovery unit as she was a serious risk to the other clients as well as staff. The severity of the attack caused the 2nd support team to withdraw their offer of supporting Miss B in the community.
The Gables, which was not experienced in Learning Disabilities, tried to work with Miss B but despite some staff training, an increase number of staff supporting her with dedicated 1:1 during the day (again unfunded). Miss B continued with her aggressive outbursts and she assaulted both staff and clients on the unit. Numerous Adult Safeguarding meetings were held and following several re-assessments, Miss B was admitted to St Andrews Hospital (as they have a Women's Learning Disability Behavioural unit) to help her manage her anger and aggression. There were no local facilities that could accommodate Miss B due to the amount of aggression she displayed and the risk she was posing to both staff and other service users. The annual cost of her out of area placement is currently £325K per year.

Having compared the Greenfield's Unit to similar facilities in other parts of the country; as well as our own local analysis, it has become very apparent that there are some obvious gaps. In particular the range of therapeutic interventions available to service users on the Unit and actual dedicated psychology time is extremely limited. It would be considered the norm for a unit the size of Greenfield's to have a dedicated half time Psychologist allocated to the core ongoing psychological treatment of service user's resident on the Unit, not to mention the wider systemic role in terms of supervision and support. As well as this, there is an obvious gap in regard to core occupational activities and interventions available to service users.

Having again compared the Unit to other similar facilities, it is suggested that a dedicated whole time Occupational Therapist would be required to address this gap.

Currently the unit is staffed to only provide a maximum of three members of nursing staff on duty both during the day and overnight. This does not enable the team to be able to engage individually with service users, particularly those with complex needs and behaviours that challenge with the benefit in reducing the need for physical interventions should service users become distressed.

With all the required skills and staff embedded within the service, it would be able to offer a full core multi disciplinary team approach to the delivery of the whole range of presenting needs of service users.

A review of the needs of recently referred service users in the context of the service specification suggests that the type of service user could be summarised as those requiring “time limited/short term (less than 12 months) specialist inpatient health care interventions for people with complex needs and whose level of risk require around the clock nursing and medical supervision”.

Future Options for Greenfield’s

Two potential options are presented. There remains however, an element of ambiguity as a role for any intensive support service needs to fit into the wider context and commissioning framework.

Option 1

The first option proposes that there is further investment into the service to enable it to meet the needs of those service users with a learning disability and a range of complex needs, ensuring consistency with the service specification. In keeping with the principles of valuing people (2008) it is suggested and proposed that a minimum of four nursing staff are resourced to be on duty during the day and at night.

The cost & workforce implications of resourcing the core team within the unit to this level are described in figures 1 below.

Fig 1

Roles	Band	Funded	Additional requirements	Cost	Total
Psychologist	7		0.5	£21.162	£21.162
Ward Manager	7	1		£42.524	£42.524
Clinical Team Leader	6	1		£35.444	£35.444
Deputy Ward Manager	6	1		£35.444	£35.444
OT	6		1	£35.444	£35.444
Staff Nurses	5	6	5	£28.713	£172.278
STR	4		1	£23.978	£23.978
Support Worker/STR	3	10	1	£20.538	£205.380
Secretary	2	1		£18,058	£18,058
Housekeeping	2	2		£36,117	£36,117

NB – The total cost of staff is currently £545,245. This excludes non pay costs and capital charges but includes on costs. Total additional investment required in terms of staffing is £244,687. This excludes medical support for the unit, which is currently provided from within the LD Partnership. Speech and Language Therapy and other individually required therapies are also excluded but would require individually tailored sessional input at Band 6. One session per week would have an annual cost of £3.5K.

The aim of this investment would enable a reduction in the use of out of area placements and the ability to manage service users closer to their home thus promoting continued ties with family and carers and the avoidance of breakdown of placements.

Furthermore, 8 beds could be used to develop a Peninsula specialist inpatient unit. A bid to the Strategic Health Authority (SHA) for pump priming investment could be considered in order to mitigate short term financial risks for NHS Plymouth.

Referral to the service

To ensure the success of this option it is essential that there is a "robust" process of referral to the service. This should include a full multi-disciplinary team discussion prior to any admission to ensure that:

1. The admission is necessary and appropriate options to meet the person's needs are considered as an alternative to an in-patient admission
2. That there are clear reasons for the admission with an expected outcome and an initial formulation of interventions and necessary treatments are agreed.
3. A Care Co-ordinator is allocated
4. Clear accountabilities for discharge planning are agreed

Changes would be required within the LD community team to ensure this process can be followed and are able to fully support the decision making process and any community based interventions that may be recommended. Due to the wide range of needs of people that may require admission to Greenfield's, it is important that the environment is configured to ensure that all service users and staff are safe. The environment needs to be flexible to allow for individualised care when required - this will result in management of people with different needs to be supported in the same unit and not require placements away from Plymouth.

Option 2

Option two is the providers preferred option and works on the premise that the current Greenfield's Unit is decommissioned as it is currently provided. The resource would be used to develop the skills and expertise to provide a peripatetic community support team ("Community Treatment/Support Service") or service, to enable service users to remain in their current environments or placements with intensive treatment and support. The detail in terms of roles, skills and numbers would need further consideration. The service however would be envisaged to work flexibly in terms of hours of operation (based on service user and carer needs) over 7 days and be funded from within the current allocated resource at Greenfield's. The service could either be a stand alone team, or be embedded within existing teams and services, in keeping with the principles of Greenlight. Alternatives to hospital admission would be considered as part of an enhanced community package of care e.g. intensive home support, respite care, review of medication etc….. Other resources currently available within the community, such as residential

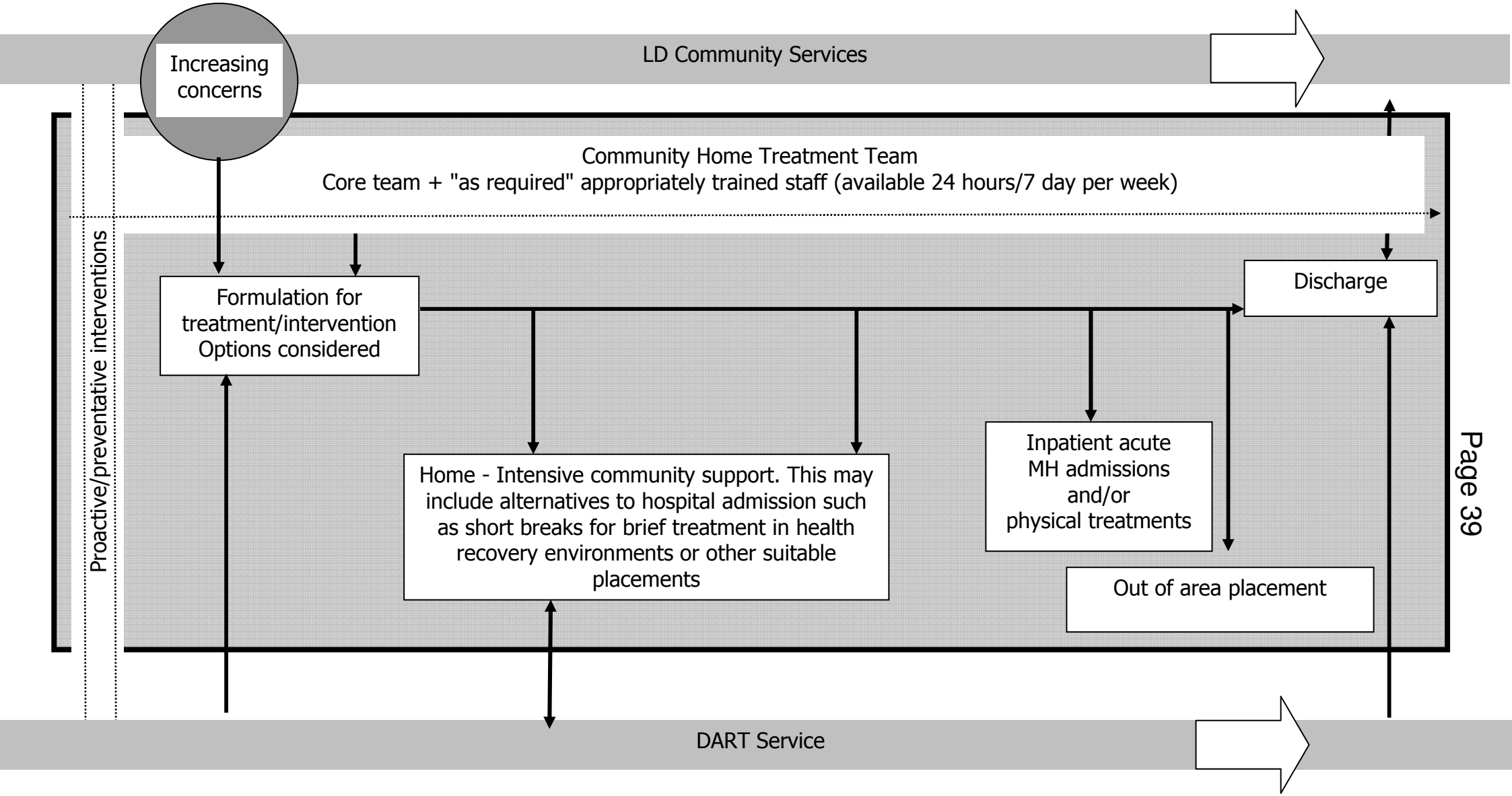
services, supported living placements and local authority short break (respite) services could be included in the range of alternatives to admission. Where community treatment, support and accommodation options have been exhausted due to level of need, there would need to be appropriate environments available to support service users who are detained under the Mental Health Act. Those with a severe learning disability would require suitable specialist or self-contained accommodation utilising the Mental Capacity Act and Best Interests framework to arrange their care, treatment and support.

The *Mansell Report* (1993 and revision 2007) sets out a number of key factors for success for services (known as a 'Developers Model') that support people with complex and challenging needs, they include competent commissioning, organisations and management, well supported and trained workforce, appropriate occupation and engagement and crucially suitable environments in which to provide treatment, support and care.

Most individuals would be supported at home, however, in some instances there would be additional costs associated with this model such as the spot purchasing of potential residential or supported beds as a short term placement for individuals in crisis. The cost of these placements could fall to Plymouth City Council or NHS continuing health care requirements.

Evidence within mental health would suggest that there is potential for efficiencies however its application with learning disability service users is unclear locally at this point in time.

Fig 2 below describes the referral pathway.


LD Community Services
Increasing concerns
Community Home Treatment Team
Core team + "as required" appropriately trained staff (available 24 hours/7 day per week)
Proactive/preventative interventions
Formulation for treatment/intervention Options considered
Discharge
Home - Intensive community support. This may include alternatives to hospital admission such as short breaks for brief treatment in health recovery environments or other suitable placements
Inpatient acute MH admissions and/or physical treatments
Out of area placement
DART Service

Notes:

The dark grey shaded box represents the role of the "Home Treatment Team" - this overlaps with existing community teams and the DART service that all have a focus on early intervention and prevention - this work would be enhanced by the development of the Home Treatment Team.

The circle represents a point in time that concerns are expressed about the continuing deterioration in health which triggers a team discussion - facilitated by the Home Treatment team - and includes people supporting the person and community based staff currently involved. From this point onwards the Home Treatment Team takes responsibility for the person working closely with others as required, e.g. social care specific therapies etc.

Whilst the Home Treatment Team will provide 24 hour/7day a week treatment (when required) the environments that this happens in will depend upon the person's needs and circumstances - a number of options are shown in the diagram. (These resources are necessary to ensure the success of this model). DART, therapy and other services have an on-going involvement as agreed through MDT discussion.

When the person is stable the Home Treatment Team would discharge the person but community services - including DART - may continue to be involved.

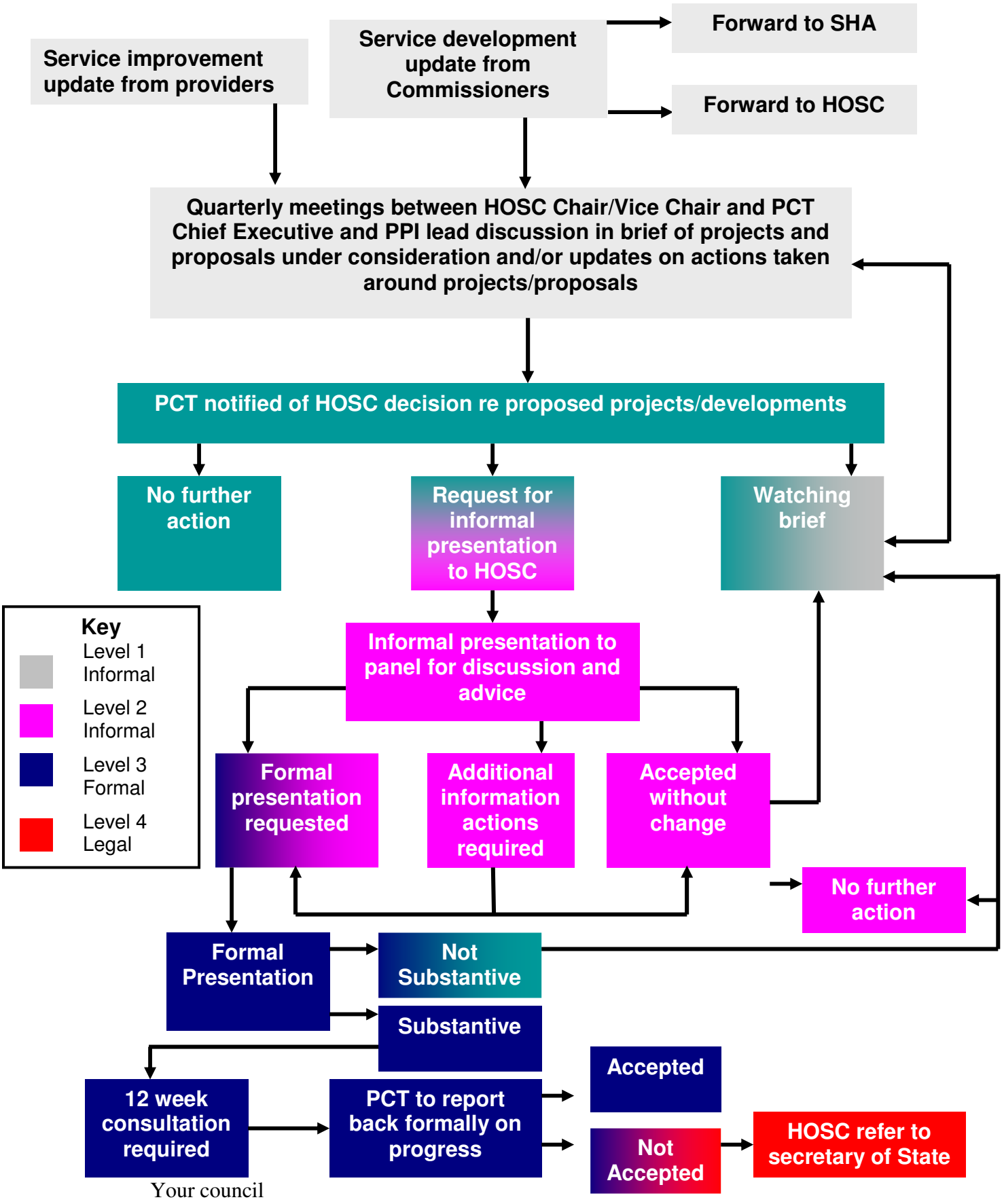
Conclusion

As the service is currently configured, it is not sustainable and/or able to meet the requirements of the service specification, particularly given the level of complexity of service users that present and the model and resource currently available to the Greenfield's Unit. It is therefore concluded that there must be fundamental change with regard on how the service is delivered to meet the needs of the local population.

This paper has described what is felt to be the most viable options locally and we offer the proposals to key stake holders for consideration and discussion in regard to the future development of the learning disability service in Plymouth.

This page is intentionally left blank

Draft PCT /HOSC process



This page is intentionally left blank

Plymouth NHS
Teaching Primary Care Trust

DELIVERING EQUITABLE ACCESS IN PRIMARY MEDICAL CARE

INFORMATION UPDATE FOR THE OVERVIEW AND SCRUTINY COMMITTEE ON THE PLYMOUTH GP HEALTH CENTRE

1. INTRODUCTION

1.1 This briefing provides an update for the Overview and Scrutiny Committee on the Equitable Access in Primary Medical Care Programme in Plymouth, specifically the Plymouth GP Health Centre service which opened 1st April 2009. The Committee has previously received information during the development and implementation phases of this service. The aim of the briefing is to inform members of how the service has developed during its first 12 months and how it aligns with the wider context of offering increased access and choice to patients from primary medical care services across the city.

2. BACKGROUND

2.1 The NHS Next Stage Review Interim Report (October 2007) carried out by Lord Darzi, reported that, despite sustained investment and improvement in the NHS over the past ten years, access to primary medical care services and the quality of those services, continues to vary significantly across the country. Many of the poorest communities nationally experience the worst health outcomes and major inequalities exist within England in life expectancy, infant mortality and cancer mortality. Further, the gap in life expectancy between the most deprived and least deprived areas has widened, despite improvements in life expectancy in the most deprived areas.

2.2 The focus of the Equitable Access in Primary Medical Care programme was on achieving an accessible, fair and personalised NHS (whilst upholding the values of safe and effective primary care services). All Primary Care Trusts (PCTs) were required to undertake a national procurement process to set up a GP led health centre service in each area to support this initiative. The procurement was open to all suitable qualified and experienced healthcare providers. The Plymouth contract was awarded in December 2008 to a social enterprise organisation, Devon Health Limited.

2.3 PCTs in areas of greatest need were also required to set up new GP Practices. Plymouth is not an under-doctored area and did not meet the criteria for this initiative. The national MORI patient survey reports consistently good results for Plymouth's primary medical services, with positive feedback on the 42 practices providing in-hours services and the out-of-hours urgent care service. Over 70% of local GP Practices provide extended hours access to their patients, during an evening and/or on a Saturday morning. There are approximately 272,000 patients registered with the GP practices at present and the average practice list size is 6,500 patients.

3. PLYMOUTH GP HEALTH CENTRE 2009-10

3.1 The GP Health Centre is located at the Mount Gould Primary Health Care Centre, adjacent to the Local Care Centre. It opened on 1st April 2009 and will register patients from any part of the city. The service works closely with the Mount Gould practice to ensure effective use of resources including premises.

3.2 In line with the Department of Health's service specification guidance, the following core services are offered to patients:

- Provision of core GP services from an accessible location
- Open from 8.00am to 8.00pm, 7 days a week, all year round
- Provision of GP-led services to both registered and non-registered patients (ie "non-registered patients" are those people who are already registered with other GP Practices or who may not have a GP)
- Bookable appointments and a walk-in service
- Integrated services, including community based services

3.3 NHS Plymouth also developed the service specification to reflect local needs, particularly "harder to reach groups" who may not find it easy to access traditional primary medical services. The following services are now offered:

- Outreach health clinics have been established for people who are homeless, in liaison with local voluntary organisations and statutory services
- Outreach clinics for offenders, in liaison with the Probation Office and offenders' own registered GP practices
- Opportunities for closer liaison with the organisations and staff providing services for young people, such as the Zone.
- More convenient access and choice for people who commute, either coming in to Plymouth from other areas or those people who do not work locally, tourists, and working parents with children
- Liaison with the Accident and Emergency Department to signpost patients who attend that department but do not have a local registered GP practice
- Services aimed at prevention and improving health such as smoking cessation, alcohol screening and contraception can also be offered to non-registered patients

3.4 During its first year the service has grown from having no registered patients to 786 registered patients as at 31st March 2010. There has been steady growth and the service has the capacity to register more new patients. A key quality standard of the service is to ensure continuity of care to patients, particularly those people with long term health conditions, and non-registered patients who attend more than twice are asked if they wish to register with the service. Feedback from both local and national patient surveys has been positive. Homeless people without a local GP are also encouraged to register with the service.

3.5 Attendances by non-registered patients have increased over the year with an average of 14 patients per day being seen in April, rising to 25 patients per day in March. Main reasons for patients choosing to use the service include more convenient choice about access times and ability to be seen on the day, especially during the evening and at weekends. Demand can fluctuate, which can present the service with additional pressure to ensure all patients are seen during opening hours. Non-registered patients are encouraged to book appointments by telephone whenever possible to enable the service to allocate its resources appropriately. Feedback from patients' surveys has been very positive, with one complaint being received during the year.

3.6 The Outreach Clinics have been attended by over 60 people, with a number being able to attend on a regular basis to receive on-going care and support for physical, mental health and substance misuse problems. A review of the first year of these new services is being undertaken and commissioners will liaise with the Local Authority to ensure outcomes are identified and contribute to the overall strategies for these groups of people. Wherever possible homeless people are encouraged to register with the service to ensure continuity of care and facilitate referrals to other services.

3.7 During 2009/10 the service provider and primary care commissioners have liaised with groups such as the Primary Care Clinical Governance Forum, Local Medical Committee, Medicines Management Team, and the PCT's Provider Arm Human Resources Department and IM and T support to ensure safe and clear operational practices and constructive and co-ordinated working relationships. There is also close liaison with the PCT's Patient Advice and Liaison Service (PALS) and, more recently, closer communication with the LINKs network.

3.8 Performance management of the five year Alternative Provider of Medical Services (APMS) contract is structured through monthly meetings and formal joint quarterly reviews. The Commissioning Team includes primary care, finance and information managers. Devon Health Limited has ensured focused implementation and operational support from experienced practice managers, nominated clinical leads, and dedicated implementation manager time.

3.9 There have been a number of updates sent to other primary care service providers, including GP practices, community pharmacies, optometrists, dentists, community services and NHS direct to advise them of the GP Health Centre's services and to try and ensure timely and effective co-ordination and signposting of patients to the appropriate services. NHS Plymouth wanted to ensure that the role of this new service is understood as well as possible by both patients and other service providers. For instance the GP Health Centre does not provide a minor injury service – this would be through the Minor Injuries Unit at the Cumberland Hospital or the Accident and Emergency Department.

3.10 The GP Health Centre has developed its website to provide more information about its services and access times. Further information about the service can be found on www.plymouthgphealthcentre.nhs.uk

4. WORK PROGRAMME FOR 2010/11

4.1 Key areas of work for 2010/11 will be:

- Increasing the numbers of registered patients in order to provide an essential basis for core activity and financial stability.
- Reviewing capacity and skill-mix to use resources to meet demand from walk-in patients. This includes planned recruitment of a nurse practitioner and additional receptionist time.
- Consolidating the outreach clinic work, including on-going provision of computerised information systems in liaison with the IM and T department and the Local Authority
- On-going development of services aimed at prevention and improved health
- Continuing to clarify the role of the service and how it fits in with other local primary and community services and plans
- Accreditation as a medical training practice during 2011
- Completing the preparation for registering with the Care Quality Commission from April 2012

5. SUMMARY

- Members are invited to comment on the progress that has been made during on the development of primary medical services to improve choice and access for patients in Plymouth.

- Members are also invited to comment on the planned priority intentions for 2010/11

Pauline Macdonald

Primary Care Commissioning Team

26th May 2010

Agenda Item 13

Health and Adult Social Care Overview and Scrutiny Panel

Work Programme 2010/11

Topics	J	J	A	S	O	N	D	J	F	M	A
Specialised Commissioning – Proposed Service Changes -											
• Gynaecological	9										
• Head and Neck											
NHS Plymouth – Finance and Performance Monitoring	9										
Plymouth Hospitals Trust – Finance and Performance Monitoring	9										
GP-Led Health Centre – 12 month Update	9										
Substantive Variation Protocols	9										
LINk Update	9										
Dementia Strategy and Action Plan – Performance Monitoring		7									
Joint Strategic Needs Assessment – Progress		7									
Reducing Inequalities between Communities – Action Plan (Min. 82(3) refers)		7									
Quarterly Scrutiny Report		7									
Carers Strategy		7									
CIP Report		7									
Alcohol Strategy		7									
Monitoring Adaptations Budget and Performance		7									
All Our Futures				1							
Adult Social Care CQC Judgement and ASC Action Plan (Performance Monitoring)				1				12			

Topics	J	J	A	S	O	N	D	J	F	M	A
Update on work plan to review and improve Intermediate Care (Min. 68(1) refers)				1							
Briefing on Quality Checkers Service (Min. No. 68(4) refers)				1							
NHS Plymouth – Mental Health Commission Annual Report 2010						10					
Smoking – Monitoring Performance against LAA stretch targets											
PCC Joint Finance and Performance Monitoring, including LAA Performance Monitoring (subject to referral from Management Board)											
Plymouth Hospitals NHS Trust – Infection Control Update										2	
Monitoring Implementation of the National Dual Diagnosis Strategy											
End of Life Care Pathway											
Barriers to Access											
Tobacco Control Initiatives (Min. 61 refers)											
Participation Rates in Sports (to include details of progress with the free swimming programme for the over 60's)											
Fuel Poverty											
Visits to – • Memory Clinic • Heartswell Centre • Learning Disability Extra Care Centre											

Reviews / Task & Finish Groups	J	J	A	S	O	N	D	J	F	M	A
Safeguarding Adults Review											
Carers Task and Finish Group											