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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

DATE: WEDNESDAY 13 OCTOBER 2010
TIME: 3.00 PM
PLACE: WARSPITE ROOM, COUNCIL HOUSE

Committee Members–

Councillor Ricketts, Chair
Councillors Bowie, Delbridge, Gordon, Dr. Mahony, McDonald, Mrs Nicholson, Dr. Salter and Viney

Co-opted Representatives- Chris Boote (LINks), Margaret Schwarz (NHS Plymouth Hospitals 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 COMMITTEE)

1. APPOINTMENT OF VICE CHAIR

To appoint the Vice Chair of the Panel following the resignation of Councillor Coker.

2. APOLOGIES

To receive apologies for non-attendance by panel members.

3. DECLARATIONS OF INTEREST

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

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. MINUTES (Pages 1 - 14)

The panel will be asked to confirm the minutes of the meetings held on 1 September 2010 and 16 September 2010.

6. TRACKING RESOLUTIONS AND FEEDBACK FROM THE OVERVIEW AND SCRUTINY MANAGEMENT BOARD (Pages 15 - 16)

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

7. PETITION - GYNAECOLOGICAL SURGICAL CANCER UNIT (Pages 17 - 24)

The panel will receive a petition regarding the transfer of the Gynaecological Surgical Cancer Unit from Derriford Hospital in Plymouth to Treliske Hospital in Truro, Cornwall.

8. NHS PLYMOUTH - QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION PROGRAMME

The panel will receive information on the Quality, Innovation, Productivity and Prevention programme.

9. NHS PLYMOUTH TRANSFORMING COMMUNITY SERVICES **(Pages 25 - 30)**

The Panel will receive information on the transfer of NHS Plymouth's community services.

10. WORK PROGRAMME **(Pages 31 - 32)**

The panel will consider its work programme.

11. 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(s) 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 COMMITTEE)

AGENDA

MEMBERS OF THE PUBLIC TO NOTE
that under the law, the Panel 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 5

Health and Adult Social Care Overview and Scrutiny Panel

Wednesday 1 September 2010

PRESENT:

Councillor Ricketts, in the Chair.
Councillor Coker, Vice Chair.
Councillors Bowie, Delbridge, Gordon, Dr. Mahony, Mrs Nicholson, Dr. Salter and Viney.

Co-opted Representatives: Chris Boote – Plymouth LINk

Apologies for absence: Margaret Schwarz - Plymouth Hospitals NHS Trust

Also in attendance: Councillor Grant Monahan – Cabinet Member Adult Social Care, Carole Burgoyne – Director for Community Services, Pam Marsden – Assistant Director for Adult Social Care, Deb Lapthorne - Director for Public Health, Giles Perritt – Lead Officer.

The meeting started at 3.00 pm and finished at 4.20 pm.

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.

30. **DECLARATIONS OF INTEREST**

There were no declarations of interest in accordance with the code of conduct.

31. **MINUTES**

Agreed the minutes of the 20 July 2010 be approved as a correct record.

32. **CHAIR'S URGENT BUSINESS**

The Chair confirmed a special meeting of the panel would take place on the 16 September to consider issues arising from the White Paper “Equity and Excellence, Liberating the NHS”.

33. **TRACKING RESOLUTIONS**

The Democratic Support Officer updated Councillors on progress against tracking resolutions, it was reported that-

a. although recommendations on the centralisation of Gynaecological Cancer Surgery had been submitted it was unlikely that feedback would be available until the new Coalition Government outlined plans

for cancer treatment;

b. the action plan for the Carers Strategy would be available after the initial meeting of the Carers Strategic Partnership Board;

c. a number of briefings had been circulated by email and the relevant resolutions would be removed from the tracking document.

Agreed that-

1. the centralisation of Gynaecological Cancer Surgery would be removed from the tracking resolutions and if required would return to the panel when feedback was available;

2. the tracking resolutions were noted.

34. **ADULT SOCIAL CARE DELIVERY PLANS AND PERFORMANCE MONITORING REPORT**

The Cabinet Member for Adult Health and Social Care introduced the quarterly performance and budget report. It was reported that-

a. there were comprehensive delivery plans in place and these were progressing well;

b. the Cabinet member met with the Adult Social Care senior management team on a weekly basis to monitor progress against delivery plans;

c. changes in the National Health Service and the impact of Adult Social Care services would be closely monitored.

The Assistant Director for Adult Social Care provided the panel with a progress report against 2010/11 delivery plans. It was reported that-

d. a review of administration had taken place across the department and the projected savings had been realised;

e. there had been a review of specialist teams and occupational therapy services, savings had been made by changing management structures;

f. nil inflation had been awarded to service providers for 2010/11. The savings realised from this action were likely to exceed the £1m stated in the report;

g. there had been a review of residential care contracts. In-house services had been improved which had led to a number of efficiencies;

h. there had been a redevelopment of in-house domiciliary care services. Savings had been made on short respite care following the change of

focus to providing an enabling service;

i. the move to personalisation resource allocation system would result in savings but until the completion of pilot schemes it was unclear whether the savings would be at the level stated in the report;

j. following a review of day care services, differences were found in costs across individual 'spot' contracts. The department had developed a new commissioning framework which would ensure consistent unit costs;

k. all requests for care funding were reviewed through a panel to ensure management oversight. This approach was implemented to combat the "gift mentality" and prevented staff over prescribing in peoples homes;

It was reported by the Director for Community Services that-

l. there was a delivery board in place to realise savings outlined at budget scrutiny, delivery plans were progressing well;

m. the department had a estimated net overspend in the current year of £1.635m, further plans would be provided to the delivery board to address this overspend;

n. the delivery board provided high level scrutiny of delivery plans ensuring they are managed correctly and a high level of performance is maintained.

In response to questions from members of the panel it was reported that-

o. the estimated savings in delivery plan six were linked to personal budgets and direct payments, savings were expected in this area but it was unlikely that they would total £0.87m;

p. there was a review underway to see where efficiencies could be made in the current system to address the in-year over spend, the figures in the report were from month three and were forecasts, and it was possible improvements would be made in coming months;

q. the service was not aware of any cross subsidy of residential care places from self funding clients following the nil inflation award to residential care service providers;

r. there was not a reduction in funding for residential care;

s. risks to consider included the growth of demographic requiring care packages, along with the changes in the NHS and the impact that it would have on the social care system;

t. there were forecasted overspends in some service areas, delivery plans were being developed to address these forecasted overspends and would be presented to scrutiny in the future;

u. Adult Social Care did not hold a funding reserve for abnormally cold winters although NHS services in Plymouth had started winter planning, building additional capacity in services;

v. corporate resources were developing a different way of buying goods, the savings that could be available to Adult Social Care have not yet been identified;

w. an action plan was in place to improve data collection around supporting adults with learning disabilities into accommodation and employment;

x. demand for dementia services would be managed through existing budgets and the service would work closely with NHS Plymouth to manage services.

Agreed -

1. that the Assistant Director for Adult Social Care investigate any disparity between fees charged to the local authority and self-funding clients for residential care and whether or not there is a risk of cross subsidy;

2. that following the comprehensive spending review a report is provided to the panel on whether there is a structural deficit affecting the NHS in Plymouth and if so what are the implications to the Local Authority?

3. to ensure that the implications of continuing under spend in the provision of domiciliary care are covered in future performance and finance reports if applicable.

35. **QUARTERLY REPORT**

Agreed to commend the panel's quarterly report to the Overview and Scrutiny Management Board.

36. **WORK PROGRAMME**

The Chair had met with Paul Roberts, Chief Executive NHS Plymouth Hospitals Trust, who advised that a number of future substantial variations would require scrutiny by the panel. The Lead Officer and Democratic Support Officer would ensure there would be sufficient flexibility in the work programme to ensure substantial variations would receive adequate scrutiny.

Agreed to –

1. add the special meeting on the 16 September 2010 to the panel's work programme;

2. that further provisional dates would be identified and added to the panels calendar to allow for scrutiny of possible substantial variations within NHS services in Plymouth;

3. note the panel's work programme.

37. **EXEMPT BUSINESS**

There were no items of exempt business.

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Health and Adult Social Care Overview and Scrutiny Panel

Thursday 16 September 2010

PRESENT:

Councillor Ricketts, in the Chair.
Councillor Coker, Vice Chair.
Councillors Delbridge, Dr. Mahony, Mrs Nicholson, Dr. Salter, Viney and Wildy (Substitute Cllr Bowie).

Co-opted Representatives: Chris Boote (LINk)

Apologies for absence: Councillors Gordon and Margaret Schwarz (NHS Plymouth Hospitals Trust)

Also in attendance: John Richards (Chief Executive, NHS Plymouth), Nick Thomas (Director of Planning and Information NHS Plymouth Hospitals Trust), Carole Burgoyne (Director of Community Services, Plymouth City Council), Claire Cordory (Children's Trust), Giles Perritt (Lead Officer), Lisa Woodman (Business Manager, Plymouth City Council)

The meeting started at 3.00 pm and finished at 5.10 pm.

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.

38. **DECLARATIONS OF INTEREST**

There were no declarations of interest in accordance with the code of conduct.

39. **CHAIR'S URGENT BUSINESS**

The Chair advised the panel that a petition had been received from members of the public concerning the move of the Gynaecological Cancer Surgery Unit from Derriford Hospital in Plymouth to Treliske Hospital in Truro. As the petition held more then 3,000 signatures the provisional meeting scheduled for the 13 October 2010 would be activated to consider the petition and an appropriate representative from NHS Plymouth would be requested to attend the panel.

The Chair informed the Panel that he had visited a consultation event on White Paper proposals around HealthWatch along with the Vice-Chair. It was reported that it was a very useful event which provided an opportunity for a full debate on the future direction of public involvement in health.

WHITE PAPER CONSULTATION

40. **White Paper Presentation**

The Director of Public Health gave a presentation outlining the major proposals contained within the Health White Paper and associated consultation documents with particular emphasis on the Local Democratic Legitimacy in Health consultation paper. It was reported that-

a. the White Paper proposals outlined the most significant changes to the NHS since its creation and contained several key principles including –

- Involvement of clinicians in service configuration and commissioning,
- Provision of patient centric services,
- Development of the Health Market;

b. key issues to affect local authorities would include-

- leading Joint Strategic Needs Assessments (JSNA) to ensure coherent and coordinated commissioning strategies,
- supporting local voice, and the exercise of patient choice,
- promoting joined up commissioning of local NHS services, social care and health improvement,
- leading on local health improvement and prevention activity;

c. local Health and Wellbeing Boards would be created, with statutory scrutiny functions being moved to the new body. The new board would have four main functions-

- to assess the needs of the local population and lead the JSNA;
- to promote integration and partnership across areas, including through promoting joined up commissioning plans across the NHS, social care and public health;
- to support joint commissioning and pooled budget arrangements, where all parties agree this makes sense; and to undertake a scrutiny role in relation to major service redesign;
- to undertake a scrutiny role in relation to major service redesign.

In response to questions from the panel it was reported that funding allocations for commissioning would be made to GP consortia, although it was unclear how and with what formula allocations would be made.

41. **Feedback on proposals from NHS Plymouth**

John Richards, Chief Executive NHS Primary Teaching Trust, provided comments on the white paper for consideration by the panel. It was reported that-

a. the vision within the paper was a clear, broad ranging and good vision.

It built on “High Quality Health Care for All” and proposals formed a bridge from the previous Government’s health care strategy;

b. many of the proposals would require changes to primary and secondary legislation. It would be reasonable to assume that many proposals may be amended or discarded through the legislative process;

c. nationally there had been a challenge to the Department of Health approach. Unions were challenging the White Paper on the basis that many of the proposals were not included within Party Manifestos or the Coalition programme for Government;

d. Plymouth was well placed to implement some of the changes proposed in the white paper with a proven track record of partnership working;

e. the Sentinel organisation had expressed an interest in being developed as the GP consortium for the City;

f. in terms of Health and Adult Social Care integration there had been arrangements made across the city, the NHS and Local Authority already had a memorandum of understanding and continue to work very closely together;

g. if reforms were to be implemented in isolation from the NHS Quality, Improvement, Productivity and Prevention programme they could fail;

h. the short proposed timescale and possible loss of capacity within NHS Plymouth over this period posed significant risks;

i. there was a large number of statutory services that the NHS Plymouth provided. The services would still be required although the White Paper did not suggest how they may be delivered;

j. by moving responsibility for Public Health into the local authority there was a risk that the health services could lose focus on the public health agenda, any health organisations formed in the future would need to work closely with local authorities so that issues of public health are embedded within all organisations.

In response to questions from members of the panel it was reported that-

k. it was not clear how the JSNA would link to GP Consortia or other providers and how or where the Health and Wellbeing Board would have an overview, the critical test would be how commissioners take the JSNA into account;

l. there were gaps in the white paper with regard to how broad the role of GP consortia would be in commissioning services;

m. the White Paper allowed for further development of existing arrangements within the city, provided there was no loss of expertise from within the system the good working arrangements could continue;

n. it was unlikely that an organisation such as Sentinel would go unchallenged as the GP consortium for Plymouth and it was possible that the City could have several consortia, however, the process for authorising GP consortia had not been outlined and the timescales within the white paper were very short;

o. the theme of localism was present throughout the white paper.

42. **Feedback on proposals from NHS Plymouth Hospitals Trust**

Nick Thomas, Director of Planning and Information, outlined the trusts view of the White Paper, it was reported that-

a. a number of the key proposals were welcomed by the Trust;

b. the renewed energy and focus on the Foundation Trust agenda was a positive step;

c. the hospital would be required to be a flexible organisation in the future;

d. a concern for the trust was the scale of the changes, particularly within the present financial climate;

e. the focus on quality outcomes and standards was welcomed;

f. transformation of services was important and proposals should not only on a transfer into a new organisation.

In response to questions from members of the panel, it was reported that-

g. the Trust would become increasingly accountable to patients through the proposals in the White Paper;

h. the Trust had no strong views on the membership or constitution of the proposed Health and Wellbeing Boards;

i. there were plans to save 43% of management costs through the abolition of the Primary Care Trusts, Strategic Health Authorities and other arms length bodies;

j. GP consortia were expected to be in place by 2013;

k. there would be a risk that GPs would not be willing to develop consortia.

43. **Feedback on proposals from General Practioners**

General Practitioners were not represented at the meeting.

44. **Feedback on proposals from Plymouth Adult Social Care**

Carol Burgoyne, Director for Community Services, highlighted the principles of joined up services and a patient centric wraparound service as principles supported by the Local Authority. The Local Authority welcomed the opportunity to have a stronger influence on health outcomes and take on Public Health responsibilities. Arrangements around the JSNA were already in place and would be developed. It was further reported that-

a. there had been integration with Adult Social Care and Health, including services for people with mental health problems and learning disabilities. The Local Authority also co-locates with health services across several sites in Plymouth;

b. Adult Social Care hopes to further develop joint commissioning;

c. many of the suggestions and proposals within the white paper are already being carried out within Plymouth.

In response to questions from members of the panel, it was reported that more clarity was required from the Government around the role of the Health and Wellbeing Board.

45. **Feedback on proposals from UNISON**

UNISON were not represented at the meeting.

46. **Feedback on proposals from the Local Involvement Network**

Chris Boote, Chair of the Plymouth Local Involvement Network (LINk) advised the panel on the work of the LINk in relation to the white paper. It was reported that-

a. LINk was considering approaching the public to gather views on the proposals set out in the White Paper;

b. the LINk supported the proposals for Local and National HealthWatch which would be the natural next step for LINks;

c. the proposals would allow for a national brand, voice and opportunity to tackle national issues;

d. the LINk would continue to carry out current activities with proposed new activities complementing the work already carried out;

e. the future role of the LINk was dependent on funding and how Local Authorities commission a HealthWatch service.

In response to questions from members of the panel it was reported that-

f. LINk would carry out consultation work on the 9th October 2010;

g. LINk have carried out work to increase the public profile of the organisation. The establishment of National HealthWatch would increase the profile of local groups;

h. Plymouth LINk fully supports the proposals for HealthWatch.

47. **Feedback on proposals from the Children's Trust**

Claire Cordory, representing the Children's trust reported that –

a. the Children's Trust had jointly planned and delivered services across the city;

b. the children's trust would encourage a response to the White Paper consultation which would recognise and preserve current arrangements particularly with regard to the duty to cooperate;

c. the children's trust would develop links with new bodies and GP consortia when established.

48. **PANELS RECOMMENDATIONS FOR RESPONSE**

The Chair thanked officers who attended for the valuable information provided to the panel. It was commented by members of the panel that-

a. HealthWatch was a good initiative which would strengthen patient involvement in health services. National HealthWatch would strengthen public awareness of local patient involvement. HealthWatch should be set minimum standards in order for benchmarking with similar services in other Local Authority areas. A general set of principles or framework should be developed in order for local authorities to assess local HealthWatch outcomes;

b. there were severe doubts over the democratic legitimacy of the Health and Wellbeing board, it was felt by panel members that there was a muddle of executive and scrutiny functions on the board. It would be led by elected councillors but the proposed largely unelected membership could lead to a democratic deficit on the board. Although the ability to design governance arrangements locally was welcome, many of the proposals within the paper were seen as vague and potentially difficult to implement;

c. it was felt by Councillors that a health scrutiny function would still need to exist within the Local Authority to scrutinise the work of the Health and Wellbeing board along with Adult Social Care, it was also suggested a redesign of the scrutiny function should be undertaken to reflect changes proposed not only by the NHS White Paper but also other legislative changes proposed by the coalition government;

d. a health premium, similar to the pupil premium announced by the coalition government, would be a welcome addition to the white paper proposals;

e. governance arrangements would need to be locally designed to allow the Local Authority and Health Services to deliver the best outcomes for the residents of Plymouth.

Agreed that a response to the consultation would be drawn from the comments made by Councillors during the debate with delegation for approval to the Head of Policy, Performance and Partnerships in consultation with Chair and Vice Chair.

49. **EXEMPT BUSINESS**

There were no items of exempt business.

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TRACKING RESOLUTIONS

Health and Adult Social Care Overview and Scrutiny Panel

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
14/04/10 (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.	10 November 2010
20/07/10 24 (1)	a copy of the action plan implementing recommendations in appendix one and the 'What we aim to do' sections of the strategy is considered by the panel following the initial meeting of the Carer's Strategic Partnership Board in September			Resolution will be progressed following the first meeting of the partnership board.	10th November 2010
01/09/10 34 (1)	that the Assistant Director for Adult Social Care investigate any disparity between fees charged to the local authority and self-funding clients for residential care and whether or not there is a risk of cross subsidy		Assistant Director for Adult Social Care	Investigation underway.	10th November 2010
01/09/10 34 (2)	that following the comprehensive spending review a report is provided to the panel on whether there is a structural deficit affecting the NHS in Plymouth and if so what are the implications to the Local Authority				Will be identified post CSR

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
16/09/10 48 (1)	that a response to the consultation would be drawn from the comments made by Councillors during the debate with delegation for approval to the Head of Policy, Performance and Partnerships in consultation with Chair and Vice Chair.	A response to the consultation document "Local democratic legitimacy in the NHS" would be prepared by the Head of Policy, Performance and Partnerships in consultation with Chair and Vice.		Completed	11th October 2010

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

Peninsula Cancer Network NHS
Devon and Cornwall

Improving Outcomes Guidance – the way forward

Revised approach to improving cancer services

Board direction 24 September 2010

The previous approach to achieving compliance with Improving Outcomes Guidance (IOGs) for gynaecological and head & neck cancers has been overtaken by changes in emphasis on service reconfiguration. These changes called for a reappraisal of our approach to improving services for patients across the Peninsula. The revised approach was approved by the Peninsula Cancer Network board on 24 September 2010.

1 Introduction

Two recent developments suggested that a shift was needed in the approach of the NHS in Plymouth, Devon, Torbay and Cornwall and Isles of Scilly to service reconfigurations. Firstly the Department of Health issued four key tests for any service reconfiguration. Secondly, the report of the Independent Reconfiguration Panel on upper gastro-intestinal centralisation pointed to the need to revise processes, with particular emphasis on wide engagement from the start, and certainly before any solutions are proposed.

These new factors called for a re-assessment of the previous approach to gynaecological and head & neck cancers. This new approach will be incorporated into a wider framework for quality improvement in cancer care in the Peninsula. The whole pathway must be taken into account, surgery being one – albeit important – element.

Given clinical advances since IOGs were first produced, there remains the possibility of conflict between the demands for IOG compliance and the need to demonstrate the clinical case for change. Existing clinical reviews in head & neck and gynaecology cancer services need to be set against the new tests to see how well they satisfy the requirements.

2 IOGs – the position in the South West Peninsula

There has been considerable work to ensure that gynaecological and head & neck cancer services comply with their IOGs, with the emphasis on surgical care.

Gynaecology

In Devon and Cornwall, the Royal Devon & Exeter Hospital was designated in 2004 as the sole Specialist Gynaecological Cancer Centre. Royal Cornwall Hospitals (Truro) and Plymouth Hospitals are both Local Gynaecological Cancer Units, with non-surgical treatment of all gynaecological cancers being provided in all five acute trusts, including South Devon Healthcare (Torbay) and Northern Devon Healthcare (Barnstaple).

However, analysis by the lead gynaecological surgeons from all five trusts suggests that far more vulval, cervical and ovarian cancers should be managed by the Specialist Gynaecological Centre than previously indicated by clinicians. They estimate that this would result in around 300 additional patients from Plymouth and Cornwall being managed by Exeter, rather than the 32 previously suggested.

Analysis of the current distribution of surgical activity, undertaken by the South West Public Health Observatory and the Cancer Registry, has confirmed that the majority of services in Devon, Plymouth, Torbay and Cornwall need further work to comply fully with the IOG. In particular patients with ovarian cancer were still being treated at trusts other than the designated Specialist Gynaecological Cancer Centre at the RD&E.

The Peninsula Cancer Network, the four primary care trusts serving Devon and Cornwall and the five acute trusts therefore agreed that a second Specialist Gynaecological Cancer Centre should be created. The National Cancer Action Team has also agreed with the principle, given the number of additional patients identified.

The route to the Specialist Centre(s) would continue to be through local hospitals, which would also continue to carry out pre-assessments and follow-up care.

An independent clinical review by leading UK specialists, supported by all four PCTs and the local acute trusts, was commissioned by the Peninsula Cancer Network to provide an objective appraisal of the services.

The reviewers' report, published on 1 December 2009, concluded that:

1. The Royal Devon & Exeter (RD&E) service, which serves patients from Torbay to North Devon, was “exemplary”
2. The second specialist centre should be created at Truro, with Plymouth retaining its current status as a cancer unit

A series of meetings were arranged with existing gynaecological cancer patients in the Derriford catchment area, so the review and its implications could be discussed. The outcomes from this engagement are available separately.

Head & neck

In Devon, Plymouth, Torbay and Cornwall, there are currently three multi-disciplinary teams (MDTs) that treat patients with head and neck cancers, based at:

- Derriford Hospital, Plymouth
- Royal Cornwall Hospital, Truro
- Royal Devon and Exeter Hospital, Exeter/Torbay Hospital, Torquay/North Devon District Hospital, Barnstaple

The National Cancer Action Team has agreed to two centres for Devon, Plymouth, Torbay and Cornwall.

The team in the east has agreed referral criteria for those cases which travel to the RD&E for their surgery. Torbay patients have been treated at Exeter since April 2008, in accordance with the implementation plan agreed in 2007.

However, in the west, agreement has yet to be reached on the referral criteria for patients between the two Trusts in Truro and Plymouth.

A clinical review by leading UK specialists, supported by all four PCTs and the local acute Trusts, was commissioned by the Peninsula Cancer Network to provide an objective appraisal of services. The review had two distinct components:

- To review the Plymouth and Truro head & neck teams with a view to providing a clinical assessment as to which hospital would be the preferred site for a second head & neck cancer centre.
- As the service in Exeter is acting as the specialist centre for the service and this status is not in question, to provide assurance that the current patient pathways ensure that all complex head and neck cancer cases are appropriately referred into the centre.

The review was designed to provide an objective independent opinion of the current service provision and to help inform the Network board of the future shape of these services in order to provide IOG compliance. The review visits took place from 30 November 2009 to 2 December 2009.

The review report did not follow the terms of reference, leaving the outcome inconclusive. However, having already agreed to the approach in the peninsula, the NCAT subsequently reaffirmed that a solution based on two centres – one at Exeter and one in the west - remained acceptable in meeting the IOG.

3 What has changed?

New tests for service reconfiguration
On 29 July 2010, David Nicholson set out in detail the tests that must be applied to “all future proposals for substantial service change”, saying:

> *The goal of any change to services must be to ensure patients get the best care possible, delivered to the highest standards in the most effective, efficient and personalised way.*
>
> *It is vital that the NHS continues to modernise and improve, and to meet the challenges of QIPP, but this must go hand-in-hand with an NHS where improvements are driven by local clinicians, patients and their representatives from the ground up. These tests are designed to ensure this will happen. The recent history of service reconfiguration demonstrates that where change is well planned and well managed, better decisions are made and implementation is more effective.*
>
> *I am also determined that the new tests do not become overly bureaucratic, and that we avoid a ‘one size fits all’ approach. The Secretary of State has also made it very clear that GP commissioners will lead local change in the future. With that in mind, I am asking local GP commissioners, in conjunction with PCTs, to lead this process locally and assure themselves, and their SHAs, that proposals pass each of the tests.*

This means proposed reconfigurations must demonstrate:

- Support from GP commissioners
- Strengthened public and patient engagement
- Clarity on the clinical evidence base, and

- Consistency with current and prospective patient choice

At the same time, commissioners will be expected to apply a 'test of reasonableness' covering the balance of evidence and stakeholder views, while stakeholders will need to provide “valid and robust evidence to support their position”, to avoid “potentially-vexatious objections”.

On the issue of clinical evidence, the Nicholson letter says that “local commissioners will need to consider both the strength of the clinical evidence and the support from senior clinicians whose services will be affected by the reconfiguration. It will be for commissioners and their provider partners to determine the specific composition of the clinical body to engage, though this should include representatives from across the patient pathway and from different relevant clinical specialties. It is recommended that clinicians should lead in gathering this evidence, considering current services and how they fit with the latest developments in clinical practice, and current and future needs of patients.”

On the issue of patient choice, it says: “Services should be locally accessible wherever possible and centralised where necessary. Patient choice and contestability are powerful drivers for improving quality and efficiency in the provision of services. In this context, local commissioners will need to consider how the proposed service reconfiguration affects choice of provider, setting and intervention; and the choice this presents the patient compared with the current model of provision.”

Independent Reconfiguration Panel
On 15 February 2010, Andy Burnham informed Cornwall OSC that the Independent Reconfiguration had recommended a full review of the transfer of upper GI services to Plymouth.

The new Secretary of State, Andrew Lansley, published the outcomes on 22 July 2010, endorsing the IRP's position that “the [upper GI] changes that have been implemented are in the best interests of patients and will provide safe, sustainable and accessible services for the population”.

He also accepted all eight of the IRP's recommendations. While the first three were tied to upper GI cancers, the remaining five all have relevance to proposals for other cancers:

4. The organisation and cost of travel and subsistence should not be a source of unnecessary anxiety to patients and carers at a very difficult time. Cornwall and Isles of Scilly PCT must use the feedback of patients and carers to ensure that any potential issues are avoided with the right practical support from the specialist cancer nurses and others.

5. Cornwall and Isles of Scilly PCT must engage patients and carers in a programme of work to identify and implement improvements to patient transport and subsistence arrangements within six months. This programme should include consideration of best practice elsewhere, options for dedicated transport between NHS facilities, a common policy and contract for the provision of patient transport services, and an inequalities impact assessment.

6. Cornwall and Isles of Scilly PCT should continue to engage the public and the Royal Cornwall Hospitals NHS Trust in implementing its strategic plan A Healthy Future for All, including the future role of the Royal Cornwall Hospital, West Cornwall Hospital and St Michael’s Hospital. The PCT and Trust must within six months produce a clear plan showing how facilities and capacity for delivering more services closer to the patient’s home will be taken forward.

7. The Peninsula Cancer Network must complete the process of re-establishing an effective, functioning Partnership Group and review how the experiences of patients will be captured and used to design and deliver better cancer services. This process should be the subject

of external assurance and changes made to meet national guidance and best practice. Changes should be made within six months.

8. Cornwall and Isles of Scilly PCT, the Cornwall Health & Adults Overview Scrutiny Committee and local NHS organisations should together consider the lessons learnt from this experience and take action to ensure all service change proposals are developed in an environment in which there is an open and constructive relationship aimed at delivering improved services and better health outcomes for the people of Cornwall.

Unless the new process follows these avenues, there will be a risk that they too are referred to the IRP, with attendant delays.

Overview and Scrutiny Committees
The independent clinical review of gynaecological cancer services was discussed with OSCs in early 2010. Cornwall and Isles of Scilly OSCs both noted the recommendations of the independent clinical review, Plymouth adopted the following resolution:

1. Members welcomed the principle of developing centres of excellence but recognised that patients had other outcomes to consider such as emotional and financial wellbeing. Given that Plymouth was a city with pockets of deprivation, the panel sought assurances that the needs of patients having to travel would be met and supported, along with those of their families.
2. 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.

The issues raised by the OSC broadly reflected those arising from the local patient engagement events in the Derriford catchment.

Both OSC and patient voices further underline the need to develop processes that are closely in line with the four new key tests and with the guidance set out by the IRP.

4 The PCN approach

The PCN aims to help improve the quality of care and of the patient's experience with all types of cancer in the Peninsula, from the beginning to the end of each pathway. The approach is therefore designed to prioritise areas for improvement, given limitations on resource, develop potential solutions and support improvements where these system-wide rather than purely local.

This means working with patients, clinicians, GP commissioners and other stakeholders to:

- Understand the good and less-good aspects of current services
- Understand current and future demand for services
- Understand what improvements could and should be made (the case for change)
- Understand how these improvements could be put into practice
- Understand how improvements and attendant changes would fit within commissioning and provider trust strategies
- Implement changes

The groups involved throughout this process will be:

- Clinicians involved in cancer care
- GP consortia and other clinicians (eg public health)
- Patients
- OSCs
- Other stakeholders (eg LINKs, social care, MPs, charitable & support groups)
- Wider public

The same stakeholders will also need to be involved in shaping the process itself, so a robust system emerges for the longer term and for other services.

The identification of current strengths and shortcomings will also draw on:

- Peer review – national (assessing compliance with IOGs)
- Peer review – local
- Outcome measures (such as the National Lung Cancer Audit (LUCADA) and DAHNO for Head and Neck, as well as more local audits)
- Regular analysis of the quality of patient outcomes
- Patient experience including observational visits, surveys and other engagement
- Independent clinical reviews
- The existing independent clinical reviews for gynae and for head & neck

All these elements will take time, given the number of services involved.

Clinical involvement in evidence and development

Network Site Specific Groups (NSSGs) will be the fulcrum for specialist clinical input to the process. They will be responsible for:

- Advising on whether the existing independent clinical reviews provide evidence of compliance with the four new key tests for reconfiguration
- Advising on standards, including clinical outcome and patient experience standards
- Advising the PCN on the current strengths and shortcomings of services their own pathway
- Collating clinical evidence to inform potential ways forward
- Developing proposals
- Mapping associated governance, accountability and reporting arrangements
- Appraising options

Support from GP commissioners

The PCN will approach GP consortia to see how best they would like to be engaged in the process of developing proposals for cancers, ensuring ownership. The picture is complicated by the different stages of development of consortia across the Peninsula, so a variety of approaches may be necessary.

Public and patient engagement

The PCN is currently working on a Patient, Carer and Public Involvement Strategy, 2010-2014. As the IRP suggests, this will ensure that “the experiences of patients will be captured and used to design and deliver better cancer services”.

The strategy will cover reconstitution of the Partnership Group, and supporting arrangements.

Involvement must be comprehensive. Assessment of the quality of current services – both clinical and non-clinical aspects – will need to include survey work and the direct participation of patients. They will then need to be involved in developing solutions, appraising options and implementing change.

Patient choice
Any proposal will need to be tested against the ideal of sustaining, if not enhancing, patient choice. The balance between choice and quality might be explored further with patients, but the work commissioned in the Peninsula from Ipsos MORI shows clearly that people are happy with the principle of travelling further for the best treatment.

Overview and Scrutiny Committees
The IRP's final recommendation, that “all service change proposals [be] developed in an environment in which there is open and constructive relationship” with OSCs, also suggests involvement at an early stage. This will be based on a common approach and shared information around the Peninsula.

Strategic fit and affordability
As well as meeting the Nicholson criteria, the PCN, PCTs, GP commissioners and acute trusts need a shared vision of how developments in cancer care fit within local strategies. This means both PCT strategies for better health and trusts' service strategies, taking into account affordability. Individual developments, such as gynaecological or head & neck, should not be seen in isolation.

This calls for compatibility of strategies with each other in terms of key issues, such as the balance between local access and centralisation of specialist care.

5 Making it happen

Given the vast array of services, for all cancer patients and from the beginning to the end of each pathway, it will take time to construct a comprehensive improvement programme for the Peninsula. The process will also need to be refined in the light of experience.

A developmental approach will enable the NHS in the Peninsula to focus on selected services where some work has already been carried out, while refining the model for the future.

Given the uncertainty created by the reviews of gynaecological and head & neck cancers, the new approach will be adopted for these services. Independent reviews have been carried out, expectations have been raised and, in the case of gynaecological services, clinicians, OSCs and patients have been engaged.

Initial meetings have already been arranged to bring together the acute clinicians involved in gynaecological and head & neck services, to discuss the way forward. In line with the new approach, these will consider process as well as clinical issues.

The various NSSGs will also need to consider the framework and its implications.

In all cases, wider engagement work with other groups identified in section 4 (above) will be needed to bring new perspectives on the potential framework for improving cancer care

A steering group will oversee:
- Development of the wider process for handling all future developments, as outlined above
- All stages of the work on the priority services

Membership: To be defined

Sitting below the steering group will be one sub-group per service to drive day-to-day progress.

Membership: To be defined

NHS Plymouth

Transforming Community Services

Commissioner Case for Change – NHS Plymouth

Executive Summary

September 2010

Executive Summary

This paper sets out the response from NHS Plymouth to the Revision of the NHS Operating Framework 2010/11, published 21st June 2010, in respect of the requirement for a separation of commissioning from provision by April 2011. NHS Plymouth is clear that if it is to achieve the ambitious challenges set out in its QIPP plan then this will require a 'transformation' of community services rather than simply a 'transfer' of the existing provider services. This in turn will create the appropriate vehicles through which to deliver the improvements described in QIPP plans for both the health of the local population and for the delivery of healthcare. The project therefore has two areas of focus:

- the Commissioning Intention for the service delivery model; and
- the preferred organisational form.

Plymouth is looking to create a care delivery system that has the following characteristics:

I. The provision services close to home wherever clinically appropriate including within sub localities in Plymouth, differentiating services in accordance with the specific requirements of individual communities in order to both improve access and to address factors that can prevent future ill health.

II. A bio-psycho-social approach that integrates provision across professions and partners that can best respond to the physical, mental and social needs of individuals in order to be most effective in improving outcomes.

III. Close collaboration across primary, community and secondary healthcare alongside social care minimising duplication and hand-off's between teams / departments so as to improve the patient experience.

IV. This increase in efficiency to be mirrored by an increase in productivity and a reduction in transactions between organisations.

V. A workforce that is motivated to improve the well being of patients and public, that has a focus on quality and safety and has the skills needed to deliver integrated care.

Early discussions in Plymouth recognised the huge potential of integration across health and social care community services to deliver better outcomes for service users. Equally, the proposed model builds upon the elective work

of Sentinel CIC and expands this model to cover the whole health system (and potentially the whole health and social care system) as a '***System Control'*** function.

A strong understanding of patient flow is essential to ensure the constituent elements are maximised in terms of productivity. In some instances this will allow resources to be flexed to reflect demand. This improved understanding of flow, improved quality of referrals, and booking capability, will also enable innovation. The system control element is fundamental to the effective running of the overall health system. As the market becomes more complicated, with a greater number of providers, the system control piece will be essential in ensuring a comprehensive choice offer is available for all patients. It is clear from the work of Sentinel CIC to date, that a stronger control of referral and management of patient flows improves our ability to "get it right first time" and gives us an opportunity to maximise productivity.

The aim is to establish ***locality teams*** working in an integrated multi-professional way, where a patient's clinical condition would benefit from this, to support people with short or long term needs, so that people can maximise their independence. The new integrated approach will ensure improved communications between health and social care professionals by using joint assessment and care planning processes and a shared IT system. The intention is that community mental health and learning disability services would be provided by the locality teams in a fully integrated manner.

In addition, there will need to be ***city wide resources***, for services where it would not be operationally effective to devolve down to localities.

A clear understanding has been developed about the co-dependency of determinants that affect successful outcomes for ***children and young people*** and a range of structures and strategies have been established to support the integrated delivery of services across partner agencies. The clear aspiration of both NHS Plymouth commissioner and its partners is that Transforming Community Services should continue to support the improvements that have already been made and increase the capability and capacity to address the ongoing needs. As a minimum, a new provider arrangement will need to enable delivery of an integrated care system. Given the current position of partner agencies, it is proposed that this can best be provided through the establishment of an employee owned organisation for services presently provided by NHS Plymouth provider. However it is the intention of these partner agencies to continue to explore further potential arrangements for an integrated provider organisation of a full range of children's services under the umbrella of the children's trust arrangements.

There are a number of services that either require greater scale to maximise productivity and ensure critical mass in driving best practice or have been highlighted as opportunities for further analysis and review. The Commissioner would embark on a process of market review across these services lines. This in turn could lead to a competitive procurement process. It is proposed to engage the provider market via the 'invitation to participate in dialogue' process (as set out in the 'Procurement Guide for Commissioners of NHS-funded services) in some areas.

In consideration of organisational form, the commissioner looked at the various options in terms of vertical integration, horizontal integration and the establishment of an employee owned organisation, using the consideration of the parameters of:

- **Quality Improvement** – in terms of improving outcomes, improving quality, service integration and stakeholder engagement.
- **Increased Efficiency of Solution** – in terms of efficiency improvements and infrastructure utilisation.
- **Sustainability** – in terms of clinical and financial sustainability, the necessary skills and knowledge base critical mass and whole system fit.

NHS Plymouth supports the establishment of an employee owned organisation to provide a vehicle for transforming the community services in Plymouth working collaboratively with strategic partner organisations for primary care, secondary health care and social care in order to create an integrated care delivery system. In accordance with the original proposals developed in March 2010 and approved by SHA and DH, NHS Plymouth will consider the option for the creation of a social enterprise for adult services and another for children and families where this can be shown to meet the requirements of the commissioner for improvement and achieve sustainability.

A final decision will be made by NHS Plymouth Board through appraisal of the Integrated Business Plan(s) in October using the assurance tests published by DH in February 2010.

However the existing provider landscape in Plymouth and the South West peninsula is limited. Therefore further provider and market development is needed over the forthcoming period, particularly in community services, to run concurrently with the implementation of QIPP plans. In turn the configuration of the social enterprise that is established for April 2011 is not expected to

remain the same beyond the initial contract period. Specifically it will be changed as a result of:

- Implementation of the QIPP programme and changes in both service delivery models and further changes in provider organisational arrangements that may be required to achieve revised pathways of care and increases in quality and efficiency. This may well involve organisational integration of services provided by existing provider organisations.

- A period of provider and market development, ideally involving cooperation between existing PCT's where appropriate.

- The development of the GP commissioning consortia and any changes to either commissioning intentions or footprint that occur as a result.

The above will provide opportunities for the new community provider as well as existing statutory providers and current community interest companies or VCS organisations. However new market entrants may also be encouraged where appropriate to develop services in accordance with "Plymouth's Healthy System" and revised service models derived through QIPP.

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Agenda Item 10

Health and Adult Social Care Overview and Scrutiny Panel

Work Programme 2010/11

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