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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

DATE: WEDNESDAY 10 NOVEMBER 2010
TIME: 3.00 PM
PLACE: WARSPITE ROOM, COUNCIL HOUSE

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

Co-opted Representatives – Chris Boote (LINk), Margaret Schwarz (Plymouth NHS 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. APOLOGIES

To receive apologies for non-attendance by panel members.

2. DECLARATIONS OF INTEREST

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

3. CHAIR'S URGENT BUSINESS

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

4. MINUTES (Pages 1 - 8)

The panel will consider minutes of the 13 October 2010.

5. TRACKING RESOLUTIONS AND FEEDBACK FROM THE OVERVIEW AND SCRUTINY MANAGEMENT BOARD (Pages 9 - 14)

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

6. DEMENTIA STRATEGY (Pages 15 - 18)

The panel will consider the updated action plan and briefing in relation Dementia Strategy (as seen in January 2010).

7. TRANSFORMING COMMUNITY SERVICES (Pages 19 - 74)

The panel will consider the business plan for the Transforming Community Services Programme.

8. GREENFIELDS UNIT CONSULTATION RESULTS (Pages 75 - 94)

NHS Plymouth will provide results of the consultation process on the Greenfields Unit.

9. MONITORING ADAPTATIONS BUDGET AND PERFORMANCE **(Pages 95 - 98)**

The panel will receive a written update on the Adaptations Budget and Performance.

10. WORK PROGRAMME **(Pages 99 - 100)**

To receive the panels 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 4

Health and Adult Social Care Overview and Scrutiny Panel

Wednesday 13 October 2010

PRESENT:

Councillor Ricketts, in the Chair.
Councillors Bowie, Gordon, McDonald, Mrs Nicholson, Dr. Salter and Viney.

Co-opted Representatives: Chris Boote (LINk)

Apologies for absence: Councillors Delbridge and Dr. Mahony, Margaret Schwarz (PHNT)

Also in attendance: Wendy Tonks (Petitioner), Marilyn Goves (Petitioner), Sarah Peonides (Petitioner), Councillor Grant Monahan (Cabinet Member for Adult Social Care), John Richards (Chief Executive, NHS Plymouth), Dr Simon Rule (Clinical Director, Peninsula Cancer Network), Lesley Darke (Chief Operating Officer, PHNT), Paul O'Sullivan (Joint Commisioning Manager, NHS Plymouth), Steve Waite (Chief Operating Officer, NHS Plymouth), Giles Perrit (Head of Policy, Performance and Partnerships, 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.

50. **APPOINTMENT OF VICE CHAIR**

The Chair announced the resignation of Councillor Coker and thanked him for his contribution to the work of the panel since the beginning of the municipal year.

The Chair welcomed Councillor McDonald to the panel.

Agreed that Councillor McDonald, having been proposed by Councillor Ricketts and seconded by Councillor Viney, was confirmed as Vice-Chair of the panel.

51. **DECLARATIONS OF INTEREST**

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

CHAIR'S URGENT BUSINESS

52. **CHAIR'S URGENT BUSINESS**

The Chair advised the panel that the Task and Finish Group had completed their review on the Modernisation of Adult Social Care. The report was being prepared and would be forwarded to the Overview and Scrutiny Management Board on the 27 October 2010. Additional information received from the consultation process which closes on the 19 October 2010 would be presented to the Overview and Scrutiny Management Board at this point.

The report of the Task and Finish Group would be added to the next agenda of the Panel for information.

53. **RESPONSE TO THE WHITE PAPER - EQUITY AND EXCELLENCE: LIBERATING THE NHS**

The Chair advised the panel that following the meeting of the 16 September 2010 a response had been prepared with regard to the consultation document "Liberating the NHS: Local Democratic Legitimacy in Health". The response had been forwarded to the Department of Health on the 11 October 2010.

54. **PANEL MEETING DATES**

The Chair advised the panel that due to budget scrutiny taking place in January the panel's scheduled meeting for the 12 January 2010 would need to be re-scheduled. The Democratic Support Officer would circulate alternative dates when they had been identified.

55. **MINUTES**

Agreed that the minutes of the 1 September 2010 and the 16 September 2010 be approved subject to the following amendments –

1. Regarding Minutes No. 43 and 45 of the 16 September 2010, General Practioners and UNISON were invited to the meeting but representatives did not attend;

2. Regarding the meeting of the 16 September 2010, Councillor Grant Monahan, Cabinet Member for Adult Social Care was present at the meeting.

56. **TRACKING RESOLUTIONS AND FEEDBACK FROM THE OVERVIEW AND SCRUTINY MANAGEMENT BOARD**

Agreed that the panel noted the tracking resolutions.

57. **PETITION - GYNAECOLOGICAL SURGICAL CANCER UNIT**

The panel considered a petition submitted to the Council against the proposals for a Designated Specialist Gynaecological Cancer Surgery Unit in Treliske Hospital, Truro. Three petition organisers introduced the petition. It was reported that –

a. the petition was started at the end of 2009 when the proposals were first made; the petition was closed on the number10.gov.uk petition website in April due to the general election. The petition contained in excess of 3,000 signatures and it was felt by petitioners that there would have been further signatories had the petition not had to close;

b. the petition highlighted the strength of feeling against proposals for a Designated Specialist Centre based in Cornwall. This could lead to women in Plymouth having to travel for their care. It was felt that the travel distance was excessive and too far from family and friends which could cause additional stress at a difficult time;

c. continuity of care was extremely important for women undergoing complex surgery. When undergoing this sort of surgery it was important to build up trust with the surgical team, this trust could not be built if surgery took place in one hospital and follow up care in another;

d. first class care was already available at Derriford Hospital with reported outcomes among the best in the country, people should not be made to travel when excellent care was already provided in Plymouth;

e. the proposals had not been widely publicised to members of the public or former patients of Derriford Hospital's Gynaecological Cancer unit. The Petitioners' felt that former patients and the wider general public needed to be engaged and have the opportunity for their concerns and opinions to be listened to;

f. clinical aspects of recovery were extremely important but recovery was also aided by personal aspects such as the ability of friends and family to visit a patient and continuity of care.

Representatives from NHS Plymouth Primary Care Trust (PCT) and the Peninsula Cancer Network (PCN) attended the meeting to respond to the petition. John Richards, Chief Executive of the PCT reported that –

g. the PCT and PCN appreciated the opportunity to attend and respond to the petition. The issue was taken very seriously and the PCT valued and respected the views of the petitioners;

h. the PCT had not carried out adequate consultation on the proposals and were open to suggestions on how to consult better in the future;

i. the situation since the 27 January 2010 when the panel first considered

the proposals had changed significantly. The criteria against which the process for service change of this kind is tested has now been set out by the government and took into account patient choice and impact of choice;

j. no decision had yet been taken and the Peninsula PCTs and PCN were currently working in collaboration to identify a new way forward.

Dr Simon Rule, Clinical Director for the Peninsula Cancer Network (PCN), in response to the petition reported that-

k. some cancer treatments benefit from centralisation and improved outcomes could be identified. No decision had yet been made on Gynaecological Cancer treatment in Plymouth;

l. the PCN was charged with achieving the best outcomes for patients and with providing those outcomes as locally as possible. However, whilst looking to achieve better outcomes for patients a certain degree of service change could be required;

m. the specialist Gynaecological Cancer Centre at the Royal Devon and Exeter Hospital was working well and achieving good outcomes, whilst looking for a similar configuration in the west of the Peninsula clinicians proposed that services continue to be provided over the two sites, the proposal was not acceptable to the Government of the day;

n. clinicians were being asked by PCN to suggest changes in the way that services were provided in the west of the Peninsula and provide clinical evidence to support proposals;

o. with regard to patient engagement there were improvements to be made, although there were difficulties in approaching former patients because of data protection concerns.

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

p. there were no new models for Gyneacological Cancer Surgery in the Peninsula proposed. Patient choice was paramount but the service could improve;

q. any proposal would need to demonstrate a clear clinical case for change, the new criteria had moved from an inflexible centralisation model to flexible model based on outcomes and patients' views;

r. key areas where care services were delivered would be identified in an attempt to engage with patients and public;

s. there were benefits that could be gained from centralisation, Devon and Cornwall were very fortunate in that Radiography Services were available in four of the five hospitals in the Peninsula;

t. there was a balance to be achieved between treating less complex cases locally and the possibility of the centralisation of specialist treatments, but no decisions had been made;

u. patient and public engagement did need to be improved and the PCN would be meeting with the lay member of the Independent Reconfiguration Panel to discuss how this could be improved.

In summing up the petitioners expressed satisfaction that they had been afforded the opportunity to provide the panel, representatives of NHS Plymouth and the Peninsula Cancer Network with their concerns and worries. If better outcomes could be achieved then this needed to be backed with robust evidence. The petitioners reiterated that the care package offered at Derriford Hospital was excellent and provided very good outcomes for women during an extremely difficult and stressful time of their lives.

The Chair closed the debate and the panel considered the following recommendations-

Agreed that-

1. that a timetable for considering proposals and an option appraisal for service reconfiguration is made available to the panel at the earliest opportunity;

2. a detailed consultation plan for patients and the wider public with regard to the formation of service reconfiguration proposals is made available to the panel at the earliest opportunity;

3. where possible NHS Plymouth and the Peninsula Cancer Network engage current and former patients in the service reconfiguration proposals and take advice on consultation from partner agencies.

58. **NHS PLYMOUTH - QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION PROGRAMME**

Sharon Palser, NHS Plymouth Director of Development reported on the Quality, Innovation, Productivity and Prevention programme (QIPP). It was reported that-

a. the magnitude of the changes was very large and the pace of change was very quick;

b. it was possible to make efficiency savings in service reconfiguration, by changing the way in which services were delivered could prevent services being cut;

c. there were increasing expectations on the Health Service in general

and the inflation in NHS costs was much higher than experienced in the rest of the economy;

d. there were services that were being provided by the NHS which were ineffective and which had led to more effective services being unaffordable;

e. there was a reliance on in-patient mental health care but community mental health care had been shown to produce better outcomes. There were many services which could be better provided in the community away from primary care settings;

f. there would be a public engagement event on the 9 November 2010 and meetings with patient's groups had been arranged. Public messages would be distributed through newspapers and would be in plain English, the public would be invited to engage;

g. NHS Plymouth would be happy to provide updates on a regular basis.

John Richards added that although the QIPP programme was high level and unspecific at this stage, NHS Plymouth wanted to provide the panel with an overview of the key points of the programme. The economic outlook for the country was poor and the NHS was not immune from this despite a ring-fenced budget. The end of the growth trend that the NHS has experienced over a number of years would be very difficult to deal with. The QIPP programme would highlight savings available in a range of NHS services and the 50 delivery plans which underpin the programme would help NHS Plymouth deal with budgetary constraints. Over the course of the next month financial information would be made available to the general public.

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

h. the PCT would be abolished by 2013 under current government plans but cuts would begin next year so work had to start now. The PCT were discussing the plans with clinical colleagues and involving Sentinel;

i. there was no intention to increase the number of staff to increase efficiency. It was not accepted by NHS Plymouth that more staff would be needed as many staff were caring for patients who did not need to be admitted to hospital;

j. extensive cuts to services was not an option and the QIPP programme was a credible alternative;

k. each delivery plan underpinning the QIPP programme would be assigned a project manager and a clinician;

l. there was a good basis on which to take this programme forward in the city and evidence was available to support this view.

Agreed that NHS Plymouth would continue to provide regular updates on the QIPP programme and any substantial service variation that resulted from it. The updates would be added to the panel's work programme.

59. **NHS PLYMOUTH TRANSFORMING COMMUNITY SERVICES**

Paul O' Sullivan, Joint Commissioning Manager NHS Plymouth introduced the Transforming Community Services Programme to the panel. It was reported that-

a. the programme was a continuation of NHS policy to move provider services away from the PCT which commissioned the services;

b. there would be an increase in alternative community services which would sit between primary and social care;

c. a number of options were available to the PCT in considering how to transfer the provider arm. Tendering for services was ruled out due to a lack of capacity in the private sector across the Peninsula; transferring the services to Sentinel was also ruled out due to procurement rules. There was no capacity with current providers to deliver the community services so an employee owned model had been identified as the way forward;

d. the PCT would continue to work with the City Council on localities and integrated locality teams and the Transforming Community Service business plan would require scrutiny.

Councillors felt there was not enough time left within the meeting to consider further the details of the Transforming Community Services programme. Councillors considered a substantial service variation of this scale required greater scrutiny and would need to be added to the agenda of a future meeting.

Agreed that the Transforming Community Services programme would be added for the panel's November meeting along with the initial business plan for the programme.

60. **WORK PROGRAMME**

The panel noted the work programme and noted that a number of items could be required to move in order to consider substantial service changes.

Agreed that-

1. the QIPP programme update is added to the work programme for January's meeting;

2. the Transforming Community Services programme and initial business

plan is added to the work programme;

3. an update on the timetable for proposals and consultation around Gynaecological Cancer Surgery is added to the work programme.

61. **EXEMPT BUSINESS**

There were no items of exempt business.

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

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
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
13/10/10 57 (1)	that a timetable for considering proposals and an option appraisal for service reconfiguration is made available to the panel at the earliest opportunity;	PETITION - GYNAECOLOGICAL SURGICAL CANCER UNIT	Added to Work Programme	Complete	10 November 2010

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
13/10/10 57 (2)	a detailed consultation plan for patients and the wider public with regard to the formation of service reconfiguration proposals is made available to the panel at the earliest opportunity;	PETITION - GYNAECOLOGICAL SURGICAL CANCER UNIT	Added to Work Programme	Complete	10 Novenber 2010
13/10/10 57 (3)	where possible NHS Plymouth and the Peninsula Cancer Network engage current and former patients in the service reconfiguration proposals and take advice on consultation from partner agencies.	PETITION - GYNAECOLOGICAL SURGICAL CANCER UNIT			
13/10/10 58	that NHS Plymouth would continue to provide regular updates on the QIPP programme and any substantial service variation that resulted from it. The updates would be added to the panel's work programme.	NHS PLYMOUTH - QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION PROGRAMME		Complete	10 Novenber 2010

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
13/10/1059	that the Transforming Community Services programme would be added to a future agenda of the panel along with the initial business plan for the programme.	NHS PLYMOUTH TRANSFORMING COMMUNITY SERVICES		Complete	10 November 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

Plymouth Report Summary

General observation

9 The growth agenda makes Plymouth distinct and touches all aspects of partnership activity, which is not surprising given its scale. For example, it inter-weaves with health as both a vehicle for planning healthy communities, with better quality housing, services and improved access to specialist facilities, which can help reduce inequalities and prevent poor health; and, is a means of attracting more high value jobs and companies to the city, with the development of the medical sciences, hospital and university. It can, therefore, be the thread that binds a range of activities together in a highly focused way.

The city and its customer

10 Although residents feel positive about Plymouth as a place, the city is near the average across a number of service satisfaction areas. There is no shared single contact point or customer management strategy across agencies evident. Some services, like health care, are provided to a single customer in many different settings by many organisations. The city is perceived as being comparatively isolated and lacking in a dynamic image, despite its discovery heritage, though these are issues that are being addressed. Visitors within its catchment area have a reasonably good view of the city and there is scope to build on the existing visitor base.

Wealth

11 The city is successfully implementing a spatial framework and developing the infrastructure to meet its very ambitious vision of becoming one of Europe's major waterfront cities. Many major schemes and investments are already delivered or in progress and the changes to the city are visible. There are clear strategies in place around the economy, health, housing, transport and culture. Annual monitoring of the Local Development Framework shows that it is progressing strongly and it is seen as a national exemplar. However, the city's current profile does not meet that level of ambition, as the population is in the main not yet sufficiently entrepreneurial or skilled in the right areas. For instance, self-employment is significantly lower than the regional and national average; occupationally the city is under represented in managerial, senior official, professional and associate occupations, as well as in the finance, IT and other business industrial classification; there is an over-representation in public sector employment, while

Key challenges

- The growth agenda is what makes Plymouth distinct and it can be the thread that binds a range of activities together.
- The city is successfully implementing a spatial framework and developing the infrastructure to meet its very ambitious vision, but its current profile does not match that ambition as in the main it is not sufficiently entrepreneurial or skilled in the right areas.
- Health is improving but health inequalities are wide and are linked to a range of other inequalities that tend to converge around the western edge of the city.
- Educational attainment is improving well, but entry to higher education is relatively low when compared to other cities and performance around vocational qualifications could be better.
- The voluntary and community sector in Plymouth is not as large as in comparable cities at a time when there is likely to be increasing demands made on it.
- The same customers are often dealt with by many agencies in many places, but there is no shared contact point and customer management strategy across agencies.
- There is currently no resource plan for the LSP covering people, finance and assets, while there is growing pressure on how more limited resources can be used across the partnership and risks and impacts assessed

recent employment growth has been in part-time work; whilst not lacking skills, relatively low numbers of people are skilled to Level 4 and above; it does comparatively poorly for young people going onto higher education and has a comparatively low gross value added score - which is a means of measuring the output of the local economy and productivity. It is not certain that the city will achieve its desired population increase to time, though estimates that have just come out show a rise, and a lot will depend on the composition of that increase if it is to be the dynamic, vibrant waterfront city with cutting edge industries and a strong cultural offer.

Health

12 Health has improved across the population with life expectancy increasing and now standing at 81.9 years for women and 76.8 years for men, which is a slight widening of the gender gap and just above the national average for women (81.8yrs) and a below that for men (77.7yrs). Health inequalities feature strongly in Plymouth and together with crime, educational attainment, housing quality and deprivation levels generally converge around the western boundary of the city, with multiple demands on multiple services. At the extreme there is a 12 year gap between neighbourhoods at the top and bottom end of the spectrum. When comparing the bottom and top 20% of areas the gap is 7 years for men and nearly 3 years for women. Health in the city is significantly worse than the national average in

17 of the 32 comparative health categories. For example, estimated rates for smoking, healthy eating and obesity in adults are worse than average; physical activity is similar, as is childhood obesity. Teenage pregnancy and hospital stays for alcohol related harm are both higher than average. Early deaths from cancer, heart disease and stroke are falling, though new cases of malignant melanoma are amongst the highest in England. The proportion of the population that is elderly is below average, but is growing numerically and there are consequently rising demands for care packages.

Safe/strong

13 Plymouth is a comparatively safe city when compared to other urban conurbations, with falling overall crime, particularly acquisitive crime, such as theft of and from vehicles, domestic burglary and robbery. Offending linked to the night time economy and alcohol remains problematic for the city with drunkenness, alcohol related violence and offences such as sexual assaults and domestic abuse main issues. Violence against the person has reduced over the past few years, though the city still performs poorly against its national comparative group for assault related crimes. Whilst violence and drunkenness impact on the economy and health, there is currently no shared city-wide approach to addressing it or joint commissioning in place. There is a strong focus on safeguarding children and adults and supporting the most vulnerable in communities. There are excellent examples of partnership working in relation to emergencies and critically sensitive events, where the city received a green flag under the former CAA inspection. Safeguarding will always be a concern, particularly at a time of public sector cutbacks, and there are large numbers of children and young people in care or with child protection plans. The environment is relatively clean and the city has undergone a major change in the collection of waste. Satisfaction results for waste compare well with other public services in Plymouth, though not so well with some national figures. Success has been achieved around social cohesion and the city has been officially classed as 'low' for tension for some years, though it is recognised that the city's expansion will need to be managed in a cohesive way. The voluntary and community sector, though making good progress from the mid-nineties, is not as developed as in comparable cities according to the local Whitfield study and National Study of the Third Sector. This needs to be seen in the context of the national drive for a bigger role for the sector.

Wise

14 The city has a cultural strategy and is trying to improve its cultural and sporting offer through the development of initiatives like the Life Centre, World Cup bid and major events like the Pilgrim 400 anniversary and British Art Show. The creative industries sector is one of the six priority growth sectors. Both the University of Plymouth and City College are focused outwards on business and skills. There is a strong focus on educational attainment and improving learning environments, though progress with the schools building programme is affected by current national cutbacks. Attainment, together with safeguarding, is going to be a priority for the new coalition government. Progress with educational attainment has been good and needs to be maintained. The Early Years Foundation Stage, Key Stage 1 and 4 have all continued to improve; the city does better than nationally for getting 5 GCSEs A*-C, but is below the national average when English and Maths are included. Although the geographic attainment gap has been narrowed, it is still significant; while girls consistently out perform boys. Comparatively low number of young people are going into higher education when contrasted with other cities and keeping or attracting those who already have such qualifications is recognised as necessary. The city could also think how it compares internationally on attainment and other matters, given its ambitions and desire to raise aspirations.

Capacity

15 Although performance is generally good and finances managed well it should be noted that the resource management element of the 2009 Use of Resources assessment only met minimum requirements across each of the partners inspected – i.e. Primary Care Trust (PCT), Council, Police and Fire and Rescue Service. In the current climate there is likely to be a sharper focus on the need for further enhancing joint commissioning activity, shared service provision and support functions, as a means of more effective delivery, improved value for money and cost savings. The first draft of an investment plan for the city has been completed, though there is no LSP resource plan as such that would include the strategic use of resources like people, assets and finance across the partnership. There is a wealth of data, numerous needs analysis and multiple strategies and plans across the agencies. They are, however, not always aligned in their scheduling, can contain contradictory data and do not always demonstrate shared high level objectives. Staff survey data from some public agencies, though containing many positive findings, shows that staff do not feel they are being sufficiently involved in the improvement agenda. This should be seen in the context of partners needing to do more with less available resources, with innovation increasingly likely to be valued.■

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Plymouths Dementia Strategy – update

Plymouth City Council Adult Social Care Services and NHS Plymouth have been working together to deliver the Joint Dementia Strategy for Plymouth.

In Plymouth Services currently provided by specialist and non-specialist staff for people diagnosed with dementia are of excellent quality but it is acknowledged nationally and locally that there is a significant number of older people living in our communities with dementia who have not had the benefit of a specialist assessment and, therefore, have not had their care needs identified, or met. In addition, as people live longer, we can expect the number of people with dementia to rise which will place an additional burden on local services. There is no option, or desire, to stand still.

The joint strategy Adult Social Care and NHS Plymouth in conjunction with the SHA have undertaken a baseline review of current services which identified gaps in provision and areas for improvement. There is clearly need to be a redesigning of specialist services to ensure they are fit for purpose, able to meet the growing demand and that people with dementia in Plymouth will be able to access the highest quality care available.

This strategy advocates provision of:

- A robust analysis of the needs of older people with dementia in Plymouth to inform commissioning.
- A whole health and social care system focus for service improvement
- A commissioning framework for Plymouth City Council and NHS Plymouth
- Coherence with other related health and social care commissioning strategies - All our Futures Strategy
- for people over 50, Extra Care Housing Strategy, Carers' Strategy and the End of Life Care Strategy

The overarching commissioning aims of the strategy include:

1. For Plymouth to be a regional or national leader in dementia care service provision.
2. To secure services and support that deliver holistic, person-centred health and care and low level support which address mental, as well as physical health needs and which provide dignity and respect.
3. To secure services that are flexible and able to change in line with people's unique circumstances, enabling independence and choice.
4. To secure a comprehensive Community Memory Service as part of a fully integrated pathway of care.
5. To promote equity of access to services and support based on individual and population needs.
6. To ensure that treatment, care and support is based on the best available evidence of effectiveness.
7. To ensure that wide ranging resources and services in the community are supported to be alert and responsive to the needs of people, particularly those in the early stages of dementia.

Joint Dementia Programme Board

A Joint Programme Board has been established with NHS Plymouth as the lead agency for the delivery of the Dementia Strategy and there are specific actions against each member of the project group:

- Dr Andrew Stone – Consultant Derriford Hospital
- Dr Kate Anderson – Consultant Psychologist
- Julie Wilson – Mental Health Commissioner NHS Plymouth (Dementia / Autism)
- Karen Grimshaw – Director of Nursing Derriford Hospital
- Dr Tamsin Ousey – GP Lead (Dementia)
- Debbie Butcher Commissioning Manager – Adult Social Care
- Jennifer Jones – NHS Plymouth
- Carol Green – Head of Continuing Health Care
- Representatives from Community and Voluntary Sector
- Representatives from Care Home Sector

Where other people are required for specific task and finish areas they are invited to the programme board.

Progress against Action Plan

Progress to date includes the following:

In respect of the National Strategy which advocates the following 3 key areas:

1. Information, Education, Signposting
2. Early Intervention / Detection
3. Improving Quality of Nursing Homes .

1. **Information, Education, Signposting**

Through the joint programme given the following has been achieved

- Lead GP identified to support primary care education, training and awareness
- Dementia Lead Consultant appointed to enhance development of service provision and development of care pathway
- A range of information being developed for providers including primary care
- The commissioned research to inform the development of care pathway in conjunction with University Plymouth and the Alzheimer's Society
- Launch of Dementia Strategy in early December in conjunction with Plymouth University Dementia Research Team.
- A Care Pathway for patients and carers is under development and will be launched later this year and will describe how people access services.
- Master classes for GPs being are being delivered.

2. **Early Intervention / Detection**

- Health and social care services will be redesigned through the TCS agenda to address the required anticipated growing need i.e. addition of specialist mental health staff to RITA / District Nursing Services)

- The Community Memory Service has achieved a national accreditation award .and we have commissioned a nurse prescriber to support the service.
- Monitoring of Strategic Health Authority key performance indicators demonstrating assurance of delivery and outcome

3. **Quality**

- We have representatives who are key members of the Joint Programme Board supporting SHA to shape requirement of care pathway across the Peninsula, key performance indicators, improvement in acute care developments
- Range of information has been developed regarding improvement of clients experience on acute wards
- We will be working with Care Quality Commission to develop a "quality mark "for homes that care for people with dementia.
- There is a review of acute provision to focus more support into the community enabling people to remain at home longer.
- Redevelopment / redesign of Plymouth Liaison to enhance quality care in acute provision
- Audit of prescribing anti psychotics and benzodiazepines in primary, secondary and nursing home care for those with dementia with a view to reduce and utilize new and more effective medication
- The Dignity in Care Forum achieved a national award to support care homes.

In January 2011 the Strategic Health Authority will be undergoing a validation exercise which will evaluate Plymouths joint progress in delivering the Dementia Strategy. The report will be presented back to Health and Social Care Overview and Scrutiny Panel.

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Transforming Community Services

Commissioner Case for Change – NHS Plymouth

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.

Table of Contents

1. Chapter One: The Strategic Case

1.1 Introduction and Purpose

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.

1.2 Clinical Case for Change

The health needs of the population of Plymouth are described in the findings from the Joint Strategic Needs Assessment and the recommendations arising are encapsulated in the Healthy Plymouth Strategy. From these documents, and in consultation with our partners, NHS Plymouth has identified a number of key challenges that must be faced if the vision for health, social care and well-being for the people of Plymouth is to be realised.

A full analysis of the health needs of the population of Plymouth, as defined by the Joint Strategic Needs Assessment, is available in the Healthy Plymouth Strategy; however the figure below provides a brief overview of the needs of the city's population.

Figure 1 - Overview of Plymouth's population

• Though life expectancy is similar to national rates, there is a 13 year difference in life expectancy between the 'best' and 'worst' neighbourhood • A higher percentage of Plymouth's population describes themselves as suffering from a long-term illness, or as permanently sick and unable to work than the national average, especially men under 65 • Although emergency hospital admissions are reducing overall, more people than expected are admitted to hospital as an emergency from the deprived	• Alcohol misuse is on the rise and is causing increased health problems • Teenage pregnancy rates are decreasing but remain above national rates and the gap between deprivation groups is widening • There are important links between risky sexual behaviour, drugs and alcohol • 20.1% of the working age population in Plymouth is workless – there is a five-fold variation across the neighbourhoods • There is a growing trend in

neighbourhoods • There is likely to be large number of people (up to 16% of adults) suffering from a common mental health problem, especially in deprived areas • Smoking rates remain high in women and in those living in deprived areas and rates amongst pregnant women are a particular cause of concern • Obesity rates continue to rise and are a significant challenge • Breast feeding rates are particularly low in Plymouth • Physical activity rates are low compared to the south west region and country, and addressing this requires a partnership approach	incapacity benefit claims which currently make up 11.6% of the working age population. This costs the public purse over £75 million a year • There appear to be specific barriers for people with a learning disability who wish to access employment • There are high levels of non-decent housing in both the public and private sectors • More information on local health priorities and initiatives is in the Annual Report of the Director of Public Health and in the Joint Strategic Needs Assessment

The inequalities present in Plymouth and the impact of economic, environmental and social determinants on the health of Plymouth's population is critical to our understanding if further improvements in outcomes are to be realised. This is equally the case for understanding patterns of access to planned and unscheduled health and social care and the need for further change in order for services to become both more effective and efficient in future.

The QIPP Plan (Quality, Innovation, Productivity & Prevention) of July 2010 sets out the initial plan for the Plymouth health and social care community to deliver services and financial sustainability for 2011/12 to 2013/14. This plan builds upon the strategic direction of the local community and is dependent upon a successful Transforming Community Services process. As such the focus of the work is on making better use of the available funding and healthcare resources by:

- Increasing personalised care and personalisation, and reducing preventable illness;
- Improving the way in which we organise and deliver healthcare services; and
- An increased focus on those patients with greater health needs, and a reduced spend on those treatments of proven lower effectiveness and value for money.

We are committed to transforming the present health care delivery system into an integrated, easy to access, personalised care model, with a focus on prevention and involved and committed clinical leadership. NHS Plymouth has NHS leadership responsibility as well as a real determination to address the root causes of ill health and to measurably improve the life chances for people living in the city's more deprived communities.

NHS Plymouth's vision for the delivery of health and social care services is encapsulated in the 'story of services for Joe', a person typical of many people living in the community with multiple needs, whose life is affected by many factors and who is therefore in receipt of a variety of services from each agency. The aim is that 'Joe' is able to gain easy access to advice and help which will offer him the maximum opportunity for self determination, choice and control. Joe will have the simplest processes for assessment and decision making, enabling the swiftest delivery of whatever help is required to meet Joe's individual needs, with no needless delay, having the least risk of errors and the highest quality outcomes.

The vision is to deliver an effective, whole system approach to the care and support of people and will embed key principles into service delivery. It will:

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

Our plans and priorities have taken into account national, regional and local objectives and reflect clinically selected outcomes and measures. The latest joint strategic needs assessment, incorporated into our Healthy Plymouth Local Strategic Partnership plan, has also been influential in shaping our system-wide approach. This formed the basis of the Strategic Framework for Improving Health in Plymouth, and has been the starting point and reference point for the Transforming Community Services agenda.

1.3 High Level Description of the Preferred Options

Given the description of need above Plymouth is looking to create a care delivery system that has the following characteristics:

I. The provision of 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.

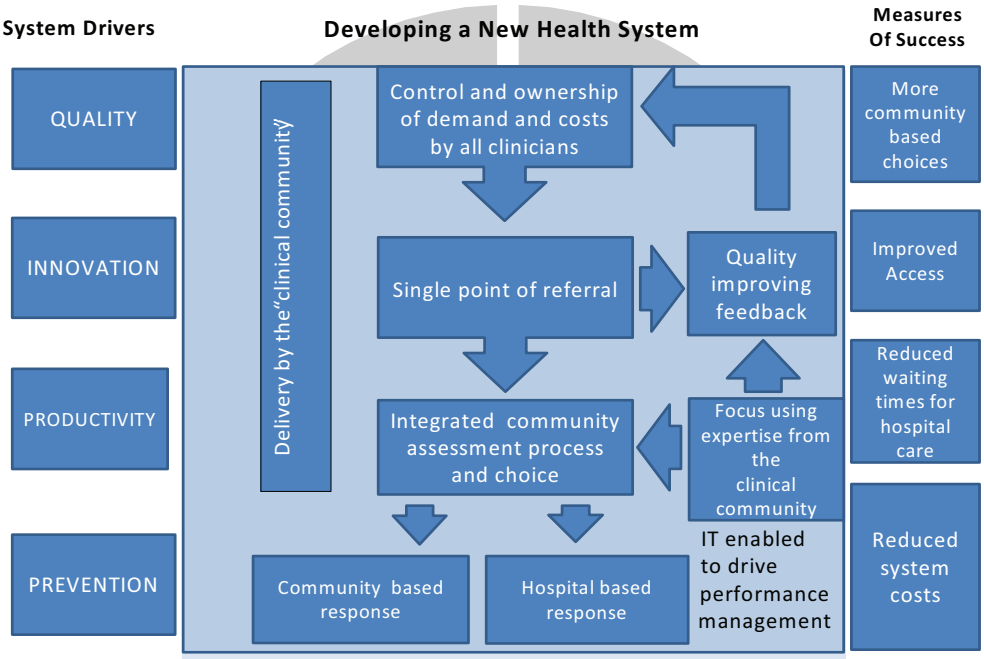
III. Close collaboration across primary, community and secondary healthcare alongside social care minimising duplication and hand-off's between teams / departments so as to improve the patient experience.
IV. This increase in efficiency to be mirrored by an increase in productivity and a reduction in 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.

NHS Plymouth currently provides a broad spectrum of services in each of the main population groups reflected by the three directorates in the current provider arm, that range from specialist inpatient services to those with a community and public health focus. The vision and characteristics described in the sections above have underpinned consideration of the potential organisational options available. Plymouth's preferred option is one that can best promote an integrated delivery model, indeed displays the features of an integrated care organisation for its users and minimises the risk of fragmentation between each of the providers.

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. This will allow the provider services to respond to the current engagement taking place with staff and partners and to develop options for the Integrated Business Plan. 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.

Set out below is an illustration of the system in which future providers will operate to focus the flow of patient activity through a single point of referral and integrate the assessment and response.

Figure 2 – the Health Delivery System



The principle features of the future care delivery system:

- It will operate as a healthy system
- Patients will be supported in choice of place, time and treatment options
- It will be characterised by improved outcomes, productivity and allocation of resources.

The new health system will derive some productivity savings through the alterations in infrastructure, but significantly more savings as the service delivery vehicle for realising many of the QIPP schemes. NHS Plymouth has employed the learning from Sentinel CIC in their management of planned care in achieving the principle of 'right first time' and this underpins the service delivery model for the whole system.

1.4 Whole System Fit

Early discussions in Plymouth recognised the huge potential of integration across health and social care community services to deliver better outcomes for service users. These developments have been largely 'organic', deriving from the innovative ideas of front-line staff, the inspiration of examples elsewhere, especially Torbay, and the creation by system leaders of a supportive environment in which these developments can flourish. It is important to recognise the progress that has been made and to maintain a sense of continuity with this, but all parties recognise the need for increased pace and delivery within a clearer organisational framework.

In order to determine the way forward for Plymouth, the approach taken has been in line with the methodology adopted in 2009 and outlined in the Transforming Community Services Commissioning Framework – July 2009. This has involved:

- Service line analysis to determine the best option for each service, including an assessment of clinical and business risk, service quality and scope for improved efficiency.

- Overview for coherence – grouping together those services that are interdependent and best managed by a long term strategic partner as part of the fabric of local services and identifying those service lines that are 'commodities' and lend themselves to considerations of alternative models of provision; for example, certain functions may be best managed by a specialist trust or independent sector provider.

Using this approach it has been possible to distinguish between those services that can best be commissioned from a new local community provider to support the delivery of integrated care and those services where efficiencies may be realised by seeking alternative commissioning arrangements. However, given the geography of the peninsula and an assessment of the current provider market, it is recognised that there is a need for significant input to develop the maturity of the current supplier market community and a need to encourage market entry in to the Plymouth area. It is recognised that this will need to be done jointly with the local authority and with other commissioners across the peninsula and interim arrangements may therefore be required.

Sentinel CIC are the preferred GP commissioning consortium for the City of Plymouth (and subject to consultation and agreement with NHS Devon and NHS Cornwall & Isles of Scilly) to cover the catchment population for Plymouth Hospitals NHS Trust. Sentinel CIC are committed to the development and delivery of the bio-psycho-social approach as an essential component of the Healthy System model, and in their developing commissioning role will be a key partner in driving delivery, rather than in a direct integrated relationship with the social enterprise.

1.1 Stakeholder Engagement

Stakeholder engagement has been on ongoing process through a development path that has led to the Transforming Community Services proposals. This can be seen in the production of Plymouth's JSNA and Healthy Plymouth Strategy, NHS Plymouth's Strategic Framework, the Memorandum of Understanding with Plymouth City Council and establishment of Health and Social Care Integration Board supported by Joint Provider and Joint Commissioning committees. More recently the development of the QIPP plans has involved extensive collaboration between all partner agencies in the health and social care community.

Under the leadership of the Joint Provider management, staff directly involved in the provision of services have been working together to develop more integrated service delivery between primary, community and social care. Pilots have been created to enable learning from practice. As the proposed service delivery model has matured there has been a process of iteration with the health and social care commissioners via the Joint Commissioning Executive with significant input from the Joint Provider Executive, leading to the development of joint service models and in turn emerging specifications that can be used to contract for community services in future.

A key role in stakeholder engagement will be effective communication and involvement of the staff. There have already been a number of events involving staff across the statutory partners in discussing and designing the integrated team concept.

Sentinel have played a role in developing the service delivery model and in organisational form assessment – in their role as GP commissioners representing all GP practices across the city.

There has been input from other organisations – on 29th July a Joint Health and Social Care commissioner day invited Mental Health Providers to attend and discuss the emerging model. Representatives from NHS Plymouth mental health provider service and from Cornwall Foundation Trust attended. Following this event, a questionnaire has been sent to a number of providers requesting completion of the advantages and disadvantages of organisational form by directorate. This has helped with the option appraisal of preferred form – the final preferred option remaining the responsibility of NHS Plymouth.

Stakeholder mapping has taken place and a joint communication and engagement plan is being developed between the key statutory partners.

1.2 Current Service Delivery Arrangements

The local health community in Plymouth is dominated by a single acute provider and NHS Plymouth's own community provider services. On the one hand, this restricts competition and provides a challenge to the delivery of reform through market stimulation. However, it has allowed us to build up strong relationships with providers through alignment of strategic objectives and collaboration, which should also lead to improved quality of care.

The following are our main providers:

Plymouth Hospitals NHS Trust (PHNT)
NHS Plymouth's main hospital provider is Plymouth Hospitals NHS Trust, which is also a provider of tertiary services for the peninsula, and a leader in teaching and research.

Peninsula NHS Treatment Centre
This was amongst the first cohort of Independent Sector Treatment Centres,

commissioned to support the capacity required for elective orthopaedic services. Following a competitive tender process, the Treatment Centre has recently changed management to UK Specialist Hospitals – a sole Treatment Centre provider with units at Shepton Mallet in Somerset, Emersons Green in Bristol, Cirencester and Devizes.

Nuffield Hospital Plymouth
The Nuffield is Plymouth's private sector hospital and takes part in the Extended Choice Network – a national initiative giving access to NHS funded procedures in a range of elective specialties.

NHS Plymouth Provider arm
The NHS Plymouth Provider arm provides services in three directorates:

- Health Services for Children and Families
- Community and Rehabilitation
- Adult Mental Health and Learning Disabilities

Primary Care Medical Services
There are 42 GP practices and one GP-led health centre contracted to NHS Plymouth, providing primary medical services to registered and non-registered patients. Access is good and improving, with good uptake of 'extended opening' in practices, but further improved access remains a key priority.

Primary Care Dental Services
In the last three years NHS Plymouth has considerably increased NHS dental provision across the city. There remains a need to continue this expansion in service provision with a target of providing access for 65% of the population.

Community Pharmacy Services
50 community pharmacies provide patients with good access to pharmacy and medicines management services, both locally and nationally commissioned. NHS Plymouth is working to build on the strength of community pharmacy in line with the recommendations of the Pharmacy White Paper and 'World Class Commissioning – Improving Pharmaceutical Services' guidance.

General Optical Services
Across NHS Plymouth there is good access to Optometric practices in Plymouth with a choice of providers. Through the Local Eyecare Forum (a clinician to clinician group) NHS Plymouth has developed services through local opticians for areas such as diabetic retinopathy. The development of further local services for areas such as glaucoma and acute eye care conditions is being further developed.

Sentinel Clinical Assessment and Treatment Service (CATS)
NHS Plymouth commissions a Clinical Advice and Information Service and a Clinical Assessment and Treatment Service from Sentinel Healthcare South West. Sentinel is a Community Interest Company (CIC) which is owned and led by local GPs and practice managers. CATS manages the referral process within the health services in Plymouth. It aims to ensure that patients in

Plymouth receive the right care, at the right time and in the right place for every referral.

DevonDocs
Devon Doctors Limited is a Social Enterprise. Trading as Devon Doctors on Call they provide Out of Hours primary medical service for NHS Plymouth and recently won the tender to provider the GP Health Centre.

Third Sector providers
The 'Third Sector' is defined by Government as: 'Non-governmental organisations that are value driven and that principally reinvest their surpluses to further social, environmental or cultural objectives'. The Third Sector is composed of a wide variety of organisations, categorised most simply as: voluntary and community organisations (VCO's), social enterprises and cooperatives and mutuals. Closer working with the Third Sector is vital to NHS Plymouth and forms part of our commitment to improve health and well-being for the broader population and to tackle health inequalities. Plymouth has a large number of small VCS organisations (as oppose to consisting only of the large national organisations) who have established effective collaborative working arrangements over recent years. Consequently this sector is well placed and is actively involved in many aspects of service delivery. NHS Plymouth is signed up to the Plymouth Compact, which is a vital tool for improving relationships between organisations in the public sector and those in the Third Sector, providing a framework whereby this Sector has time and opportunity to respond to opportunities that emerge through our commissioning decisions for the future and/or continued delivery of services.

Private Sector Care Home providers
There are approximately 1,800 mainly frail elderly people in a range of residential or care homes in Plymouth funded through continuing health care and funded nursing care resources. Working closely with Adult Social care, an integrated review team and a Dignity in Care forum has been established whose purpose is to identify standards and improve these standards of care across the sector.

Whilst all efforts are made for care for people locally, a number of such will require care further afield. NHS Plymouth funds and commissions beds with the intention to repatriate at the earliest, appropriate opportunity.

1.3 Strategic Benefits

There are five main strategic benefits sought from the change in organisational form which will be used as the key delivery vehicle for the transformation of community services.

- A contribution to delivery of the PCT's stated strategic ambitions;
- A contribution to defined priority outcomes;
- A contribution to achieving 'A Healthy System';
- A contribution to delivery of QIPP cash-releasing savings; and

- A contribution to the three critical areas set out in the national TCS guidance.

The degree to which a successful change in organisational form and the transformation of community services is expected to contribute each of the strategic benefits is summarised in the table below.

Strategic Benefit Area	Benefit Contribution Sought	Anticipated Impact				
		1 Negative impact	3 No significant impact	5 Some +ve impact	7 Significant +ve impact	9 V significant +ve impact
1. Strategic Ambitions	1.1 Reduce health inequalities					
	1.2 Prevent ill-health					
	1.3 Commission modern and innovative services					
	1.4 Ensure value for money					
	1.5 Improving quality*					
	1.6 More control					
	1.7 Wider choice*					
	1.8 Easier access					
2. Ten Priority Outcomes	2.1 Reduce health inequalities for males and females					
	2.2 Increase life expectancy for males and females					
	2.3 Reduce the number of women smoking at the time of delivery					
	2.4 Increase the number of infants breastfed					
	2.5 Reduce hospital admissions for alcohol-related harm					
	2.6 Reduce hospital admissions caused by unintended and deliberate injuries					
	2.7 Improve coronary heart disease mortality rates					
	2.8 Reduce teenage conception rates					
	2.9 Reduce the number of acute delayed transfers per hospital bed*					
	2.10 Improve the self-reported experience of patients*					
3. A Healthy System	3.1 Works with the PCT commissioned 'system integrator' (Sentinel CIC) to support delivery of a healthy system					

Strategic Benefit Area	Benefit Contribution Sought	Anticipated Impact				
		1 Negative impact	3 No significant impact	5 Some +ve impact	7 Significant +ve impact	9 V significant +ve impact
	3.2 Patients will be supported in choice of place, time and treatment options*					
	3.3 It will be characterised by improved outcomes, productivity and allocation of resources*					
	3.4 There will be a net reduction in cost and capacity					
4. QIPP Areas	4.1 Shifting settings of care and optimising urgent care					
	4.2 Optimising elective care pathways					
	4.3 Adopting best-practice care pathways for LTCs*					
	4.4 Improving prescribing					
	4.5 Improving primary and community care*					
	4.6 Improving mental health*					
	4.7 Improving learning disabilities*					
	4.8 Improving non-clinical productivity					
5. TCS Critical Benefits	5.1 Improve quality*					
	5.2 Increased efficiency of solution					
	5.3 Sustainability of solution					

The source and background to each of these five main benefit areas is described in the Strategic Framework for Improving Health in Plymouth 2010/11 – 2014/15.

In developing the medium term strategic plan to support the strategic framework, NHS Plymouth also identified the scale of the financial challenge for the local health economy with a most likely scenario of £20m gap per year for a forthcoming five year period. This sum is at the bottom end of the value being used by the PCT and NHS South West for QIPP planning – that is £63 to £93m over the three year period, and the latter is now judged to be a more likely prudent estimate of the requirement for cash releasing efficiency gains given the context of likely broader public sector budget reductions and the current financial position of the main acute hospital provider (Plymouth Hospitals).

From May to July this year the PCT worked with local partners in health and social care to develop plans to ensure service and financial sustainability using the work done by NHS South West as the start point i.e. QIPP. A summary of the efficiencies being planned for by QIPP area for NHS Plymouth is shown in the table below.

Estimated implications for spend by NHS Plymouth

	Provider	2010/11 Baseline	"Do Nothing" Growth	QIPP Impact	Net Effect
		£ms	£ms	£ms	
1	Plymouth Hospitals NHS Trust	146.0	21.5	33.0	134.5
2	NHS Plymouth Provider (incl MH, LD, Childrens)	75.0	11.0	13.0	73.0
3	Primary Care (incl GP, Dental, Pharmacy, Optom)	54.0	7.9	3.0	58.9
4	Non NHS (incl IS, ISTC, CHC, IPP)	47.0	6.9	5.0	48.9
5	Primary Care Prescribing	40.0	5.9	2.7	43.2
6	Specialised Services	25.0	3.7	4.8	23.9
7	Other	63.0	9.3	4.7	67.6
	TOTAL	450.0	66.2	66.2	450.0

| 29

In relation to QIPP, the clear expectation of the transformation of community services, supported by a new organisational form and operating as both a service provider and partner is that there will be a very significant positive impact on:

- Value for money and productivity, releasing cash for reinvestment in the host organisation or elsewhere in line with the benefits realisation plan for QIPP and the PCT's commissioning intentions

- The delivery of streamlined and personalised care for patients with long term conditions, mental health, learning disabilities and those requiring general rehabilitation services

- Innovation in the design and delivery of services, sourcing and adopting these as part of day-to-day good practice; the continued development of clinical collaborative working between primary, community and secondary care clinicians will support both dialogue and innovation

The new organisational provider is expected to play an active role in the continued development and refinement of QIPP initiatives and the overall QIPP programme, to ensure that the maximum available benefits are achieved for the local health and social care system.

1.7.1 Three Critical Areas for Benefit

The national TCS guidance summarises how a statutory separation of provision from PCTs, and a change to a new organisational host and form is expected to make a contribution to three critical benefit areas. Whilst there is overlap with local expected benefits, the PCT believes that it is important to clearly identify these as anticipated benefits and incorporate them into the overall benefits realisation plan.

Critical Benefit Area	Test
Improve quality	• Improve outcomes • Improve quality • Improve service integration • Stakeholder engagement
Increased efficiency of solution	• Efficiency improvements • Infrastructure utilisation
Sustainability of solution	• Sustainability • Whole system fit

1.7.2 Key Strategic Benefits to Patients

The key strategic areas where there is expected to be a significant or very significant additional benefits to patients are:

- Quality
- Choice
- Delayed transfers of care
- Self-reported experience
- Outcomes

These will be in long term conditions, mental health, learning disabilities and general community services.

1.8 Strategic risks

NHS Plymouth recognises the need for an Assurance Framework that captures all of the risks and delivers a comprehensive assurance framework during this period of transformational change. It is recognised that there is a need to cover:

- Commissioning capacity & capability;
- Provider workforce, capacity and capability;
- Market development & provider sustainability;
- Stakeholder relations;
- Clinical capacity and capability.
- Cost control and risk sharing.

Given that the QIPP agenda was developed jointly across the Health and Social Care community, it is recognised that the Assurance Framework will

also need to be developed and assured through the commissioning partnership of the PCT, Plymouth Hospitals NHS Trust, Sentinel CIC as the emerging GP consortium and the Local Authority. The governance architecture developed to support this partnership in the delivery of QIPP, and specifically the Executive Programme Board, provides a forum for monitoring and responding to the emergence of any risks to collaboration or delivery of QIPP plans.

Appendix 6.5 sets out the Commissioning Assurance Framework 2010/11.

2. Chapter Two: The Economic Case

2.1 Critical Success Factors – what will constitute success?

This initiative is about 'transforming' community services, not solely 'transferring' community services. As such, the approach is captured within our QIPP agenda. Productivity savings are at the heart of the agenda.

In addition, the following principles are at the heart of our approach:

- Integration - It has been clear for some time that there is a need to incorporate our community services work with social services delivery. However, the TCS work highlights the increasing need for this to be a tri partied approach including Primary care services to offer a complete care approach.
- Single points of contact - We need to provide a more holistic approach to the patients and, where possible, provide a single point of contact.
- Coordination – the need to improve coordination between services, and reduce fragmentation and the duplication of activities that this causes.

2.2 Options appraisal

2.2.1 Options Appraisal for Service Delivery Model

Various options have been suggested for the organisational form the provider arm should take. In order to come to a conclusion about the best solution to deliver against, NHS Plymouth has undertaken the following analysis.

Stage 1
Initial analysis of the Organisational forms to establish those of more detailed consideration. In addition, a segmentation of the provider services by directorate as an appreciation that there may be more than one outcome by care group.

Stage 2
PEST analysis (**P**olitical, **E**conomic, **S**ocial, and **T**echnological analysis) to establish the conditions applying to the decision.

Stage 3
More detailed SWOT analysis (**S**trengths, **W**eaknesses, **O**pportunities, **T**hreats) of the options against the PCT's needs and issues identified in the PEST analysis.

Stage 4
Analysis of service lines to establish which areas are core and non core. Service lines are examined against paired parameters to gain an understanding of the areas that are key to retain in a linked core provider.

Also areas that would deliver greater opportunities for efficiency and effectiveness gains in different organisational entities are identified.

Stage 5
Consider the associations and interdependencies of the service lines to ensure appropriate groupings of core and non core areas are coherent and synergies are maintained / developed. The groupings are then considered for scale to clarify whether there is scope for locality team provision or whether the service scale requires a broader city scope or broader geographic capability, to maximise long term efficiency and effectiveness.

In line with the White Paper – Equity and Excellence; Liberating the NHS, issued in July 2010 in which it states that local health improvement will transfer to local authorities, who will employ the Director of Public Health, it is assumed that the Public Health function of NHS Plymouth will be part of Plymouth City Council – this would include the Health Promotion service, Stop Smoking service and Screening roles. Further clarity will be set out in the programme for public health in a White Paper later this year, when this decision may be reviewed.

2.2.2 Options Appraisal for Organisational Form

The approach undertaken was engagement with potential providers for their assessment of the preferred organisational form, and discussions with commissioning colleagues in Adult Social Services, Childrens Services, and Sentinel CIC as our preferred GP Consortium solution. However it was clearly communicated to all stakeholders that the final decision would rest with NHS Plymouth commissioners.

Through the analysis that has been undertaken, there are key areas of consideration:

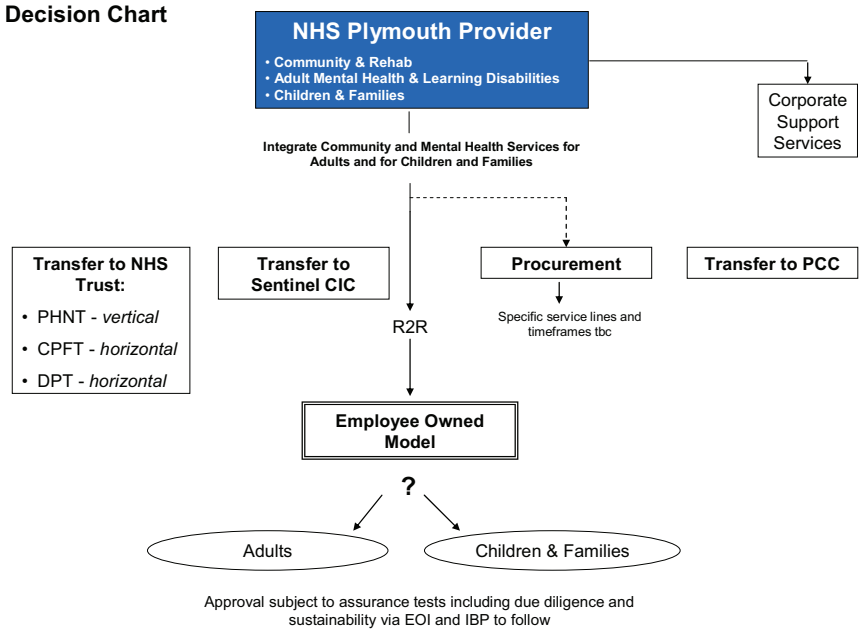
- **Quality Improvement** – in terms of improving outcomes, improving quality, service integration and stakeholder engagement.
- **Increased Efficiency of Solution** – in terms of efficiency improvements and infrastructure utilisation.
- **Sustainability** – in terms of clinical and financial sustainability,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

	Adult Community & Rehabilitation	**MH & LD**	**Children & Families**
Vertical Integration with PHNT	Discounted due to: 1. Risk of monopoly supply. 2. Current financial challenges facing PHNT with the	Discounted due to: 1. Current financial challenges facing PHNT with the additional management of community	Discounted due to: 1. Current financial challenges facing PHNT with the additional management of community

	additional management of community services potentially a distraction from resolving financial issues and limiting capacity to achieve transformation.	services potentially a distraction from resolving financial issues and limiting capacity to achieve transformation. 2. Not appropriate for provision of MH and LD services. 3. Separation of community from mental health services resulting in potential organisational barrier to delivery integrated service model.	services potentially a distraction from resolving financial issues and limiting capacity to achieve transformation. 2. Not appropriate for provision of MH and LD services for children & young people. 3. Separation of community from mental health services resulting in potential organisational barrier to delivery integrated service model.
Vertical Integration with existing NHS Mental Health Provider	N/ A	Discounted due to: 1. Limited provider options to achieve VFM and requirement for market development preferably via sw peninsula commissioner approach. 2. Separation of community from mental health services resulting in potential organisational barrier to delivery integrated service model.	Discounted due to: 1. N/A for community services leading to separation of community from mental health services resulting in potential organisational barrier to delivery integrated service model.
Integration with another community-based provider	No existing NHS provider. Transfer to existing Community Interest Company discounted due to inconsistent with procurement and competition guidance.	No existing NHS provider. Transfer to existing Community Interest Company discounted due to inconsistent with procurement and competition guidance.	No existing NHS provider. Transfer to existing Community Interest Company discounted due to inconsistent with procurement and competition guidance.

Integration with Local Authority	Discounted due to a move towards a commissioning only approach misalignment of staff T&Cs and potential problems in governance provision.	Discounted due to a move towards a commissioning only approach misalignment of staff T&Cs and potential problems in governance provision.	Discounted due to a move towards a commissioning only approach misalignment of staff T&Cs and potential problems in governance provision.
Social Enterprise / Employee Owned Model	Preferred Option	Preferred Option	Preferred Option

Figure 3 Decision Chart for Organisational Form



The preferred option is to support the establishment of an employee owned organisation to provide a vehicle for transforming the community services in Plymouth, under the Right to Request scheme. 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, through the assessment process of IBPs.

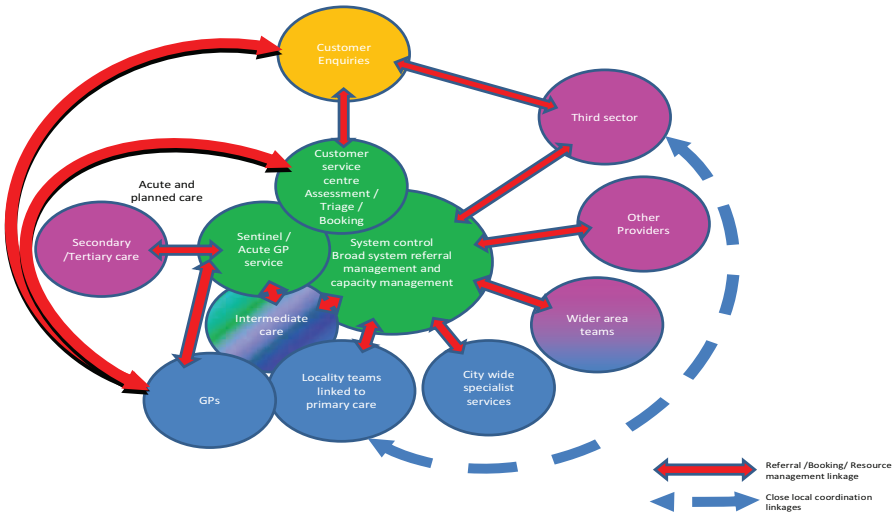
The social enterprise model(s) will have clearly stipulated Key Performance Indicators (KPI) which must be met. These would include a staged reduction in overall contract value, in line with the QIPP productivity requirements set out in the financial case for change section. Other performance indicators would assure the commissioners of improved quality outcomes. The Commissioners will also clearly communicate the service lines that will be subject to competitive tender and the timeframes for this. In the event of a single social enterprise, the commissioner will require 'open book

transparency' as an assurance that each of the three directorates is financially sustainable and to allow for further opportunities for service integration.

2.3 Description of preferred options for Service Delivery Model

- The focus of the system control element of this model should be to maximise the efficiency and effectiveness of the system through driving productivity by managing patient flow and providing the relevant information for system redesign. This is a fundamentally different focus from delivery functions where we wish the prime drive to be delivering a quality service.
- There is an opportunity to utilise the change to bring together the primary care clinicians with the community provider services this will potentially drive service improvement.
- Key focus of the commissioning team will be on the system control as this is likely to be the fulcrum in delivering QIPP.

Figure 4: Overview of the System Model



2.3.1 Single Point of Access and System Control

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 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.

The potentially increased complexity of the model may require greater navigation. It is therefore important to:

- Provide clarity for the public for access to health and social care non emergency activity;
- Provide customer contact in the most cost effective manner. The private sector recognise that a contact centre that can triage contacts and escalate as required is the most effective way of handing this;
- Provide an effective single interface for the public;
- Provide instant responses to the public and healthcare professionals on service availability and booking;
- Examine the opportunity of links to other contact centre providers.

Due to the potential booking requirement and inbound / outbound capability, it would be logical to align this element with the system control capability.

This suggests that alignment of these areas is required in terms of organisation, technology, information, process and behaviours to focus on system resource maximisation if we are to deliver the best outcomes for patients.

In addition currently we replicate services for different patient cohorts - mental health, the elderly, those with learning disabilities, for example. This leads to duplication of capability and inefficiency. If we manage all care through this system, regardless of diagnosis or label, we can take any differences into account when allocating service provision. This will ensure any specialist requirements are accounted for. There are key service areas that drive the flow through the pathways and these should be collectively managed in systems control.

2.3.2 Adults Community and Rehabilitation

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. These services include community nurses such as district nurses, health visitors, & tissue viability nurses; end of life care teams; long term conditions management such as falls team and day therapy; and care co-ordination such as onward care. The team would provide services to all of the population regardless of whether the individual lived in their own home, or in a Care

Home. The localities may have differential resource allocation, due to the strategic ambition of reducing health inequalities, to target services where the need is greatest. This service delivery model approach focuses on supporting and enabling people to maintain their optimum level of independence with the lowest appropriate level of support and care.

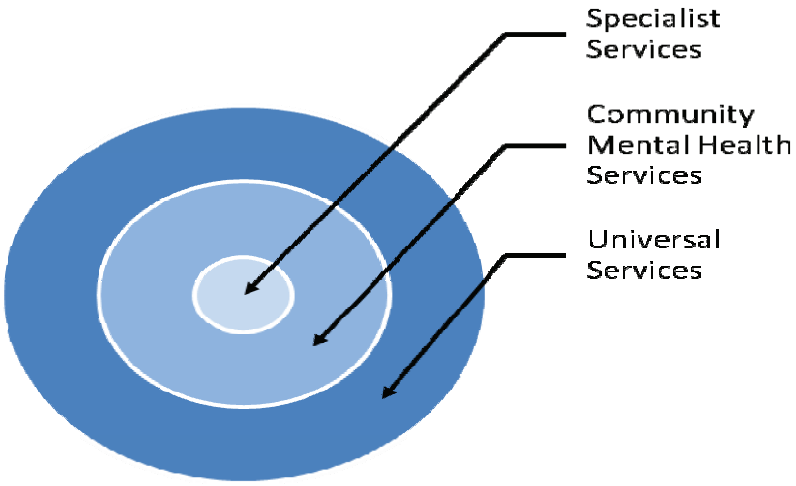
In addition, there will need to be city wide resources, for services where it would not be operationally effective to devolve down to localities – such as community cardiology services and Local Care Centre beds - which would be an available resource for locality teams to draw down support for individuals, as and when necessary. Referral within the locality team can be achieved in two ways – either through direct contact with another member of the team, or via the System Control function; either methodology will be overseen by the System Control function, who will be able to view individuals' available appointment slots and thereby monitor demand and capacity.

The function of intermediate care is defined locally as 'to meet the health and social care needs of individuals to prevent unnecessary admission, expedite hospital discharge and to avoid long term admission to care homes'. The aim of intermediate care is to use timely and focussed intensive support so that people can maximise their long term independence. This approach focuses on enabling people within their homes, so that they achieve optimum level of independence with the lowest appropriate level of ongoing support and care. Accordingly, on the basis of subsidiary, it has been agreed appropriate for many of the intermediate care services to be provided from the locality teams or the city wide team. However, there is an element of intermediate care services that are more aligned to commissioning and system control, and these will be brought within the system control function.

2.3.3 Mental Health & Learning Disability Services

2.3.3.1 Mental Health Services

Based on national guidance and adapted from the work of the local Mental Health Atlas the following framework for services is proposed:



The focus of the outer circle is on mental health promotion and building resilience. This builds upon a key theme in New Horizons that mental health is everyone's business. This develops the notion of a public mental health approach that is the prevention of mental ill health and the promotion of mental health. This outer circle covers a range of service areas including employment, housing, leisure, transport, money advice and benefits, and safer communities. Because of its breadth it requires agencies across the City working in a coordinated way. Whilst many of these service areas may be outside of the direct responsibility of any future provider of mental healthcare services, the provider will be expected to understand the co-dependency of these factors and the relationship between these services and the provision of healthcare. In turn the provider will be expected to contribute toward the development of related strategies, initiatives or service plans that assist the maintenance or recovery of good mental health at a city wide or local level.

The middle circle centres on community based mental health provision and on the principles of recovery and inclusion. The services within this area are wide ranging and include day service provision, accommodation based support, community mental health teams, employment and volunteering as well as IAPT and Assertive Outreach Services. These services will support users when they are moving from the inner circle on their journey to recovery and inclusion by supporting them to access and utilise mainstream universal services in the outer circle. The same group of services may also have a preventative role with a part of their remit to stop users from accessing acute services. It is proposed that these services are incorporated in to the locality team delivery model working alongside primary care (as described in the section on Adult Community and Rehabilitation above) whilst at the same time maintaining a specific mental health professional contribution and skill set. The mental health atlas produced by the public health development unit in Plymouth provides a basis for planning service provision and differentiating delivery where necessary to improve the take up of services. In addition Plymouth has indicated an intention to reduce admissions and length of stay in inpatient services both in and outside of Plymouth through its QIPP plans. Therefore the role and development of mental services in this area is critical to maintaining independence in community settings through early intervention and provision of specialist mental healthcare.

Finally the inner circle consists of acute, mostly inpatient provision. This is not a uniform provision and further work is required to segment this market by patient group and service line. It will continue to be essential to offer timely access to safe, high quality inpatient services for any patient that requires such a service. However, as indicated above, the commissioner will also seek outcomes that focus on supporting timely return to community living and the avoidance of readmission. NHS Plymouth currently commissions a range of services, such as PICU and specialist assessment or treatment placements outside of the NHS Plymouth provider. The commissioner will be seeking innovative solutions from any future provider that minimises the requirement for placements outside of Plymouth and, where these do occur, ensures a proactive shared care arrangement that reduces the length of stay.

Mental Health services could be commissioned from one mental health provider, working in an integrated manner for the locality provision, with either the same provider or a different provider focusing upon the more specialist acute service provision. The intention is to undertake a competitive process, ideally next financial year, for the more specialist service provision to ensure best value is achieved. It is recognised that a degree of market development is required prior to the competitive process, and that there may be opportunities for a peninsula commissioner approach.

2.3.3.2 Learning Disability Services

NHS Plymouth intends to commission learning disability services in three key areas, which will address the priority requirements for people with learning disabilities. The key areas for action are:

- Challenging Behaviour Services - It is vital that this service operates in tandem with existing mental health services, especially for out of hours services. The key tasks for the service are to assess individuals, plan in detail for their needs, prepare for potential crises and the team must be able to intervene at short notice with effective pre-planned interventions. It is proposed that this service is subject to market review.

- Liaison in Specialist Health Services - A key priority for modern learning disability services is to ensure that people with a learning disability access mainstream health services for all their health requirements. Priority areas include mental health, epilepsy services and dementia services but the principle applies to all health services. It is recognised that people with a learning disability will require extra support to access services and to ensure they achieve equal outcomes in comparison to people without a learning disability. It is therefore proposed that this service is provided within the integrated locality teams.

- Liaison in Primary Care - Since the publication of Valuing People Now (DH 2009) and Healthcare for All (DH 2008) there has been a significant emphasis on improving the health and well-being of people with learning disabilities. Within primary care there is already a Direct Enhanced Scheme to support GPs to undertake annual health checks but in order to maximise the benefit of this programme there will be a team of liaison nurses who can offer support.

2.3.4 Health Services for Children and Families

The recent external inspection of children's services in Plymouth by OFSTED and CQC has reported how agencies are now effectively working together to safeguard and improve the well being of children and young people in Plymouth under the leadership of the Children & Young People's Trust.

Notably Plymouth is judged to be outstanding in the way it listens to and engages children, young people and parents, creating positive opportunities for them to inform agencies about service provision. As a result of this information has already been gathered as part of the Children and Young People's Plan about the nature and characteristics of services that children, young people and families would like to see in the city.

Overall Plymouth has seen improved performance against the 5 outcomes for children and associated national performance indicators compared to previous years. There are many examples of good practice that have been recognised as leading to improvement in service provision as a result of increased cooperation between partner organisations, for example in Child & Adolescent mental health Services, services for children with disabilities and children in care.

The Children and Young People's Plan has provided a focus for the shared strategic development of joint priorities and alignment of resources across the individual partner organisations. Where appropriate this has been supported through shared resources, for example section 75 pooled fund for CAMHS as well as shared budgets for safeguarding and Youth Offending Services. Equally Plymouth has made significant progress in implementing the standards of the National Service Framework for Children, Young People and Maternity Services and thereby improving the quality of service provision.

Nevertheless there continue to be significant health needs in Plymouth and variation in health and access to patterns of healthcare associated with inequalities. Ongoing needs include:

- Promoting the health of parents and ensuring that young children receive a healthy start to life as measured for example in reduced rates of smoking in pregnancy, increased rates of breastfeeding and reduction in obesity.
- Reducing risk taking behaviour in young people as indicated by levels of alcohol and substance misuse, smoking and unprotected sex with consequent levels of STI's and under 18 conceptions.
- Increased care co-ordination for children with long term conditions, multiple and complex needs and children with disabilities as well as increased quality and choice in palliative care.
- Dental health is a persistent problem and is an area of significant inequality.
- A reduction in the high numbers of children and young people accessing unscheduled secondary care at hospital for both medical reasons and accidents including a reduction in the variation between different localities in the city.
- Promoting good mental health and reducing stigma.
- Improving the transition to adult services.

A detailed description of need is included in the needs analysis that has been developed by all partners in support of the latest iteration of the Children & Young People's Plan. This needs analysis also shows a significant increase in

the numbers of children who are subject to child protection plans whilst at the same time thresholds for social care child protection services have been assessed as being appropriate and safeguarding children training for staff has increased across all agencies. In looking to transform community services, not only will any new provider need to continue to meet the statutory requirements to safeguard and promote the welfare of children, but also to provide services at an early stage in conjunction with partners that are effective in reducing vulnerability and escalation of risk.

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. In addition to the generic characteristics and features described in the sections above, it is expected that any future provider will ensure that:

- Children, young people and families continue to be involved in evaluating services and informing delivery in order that they remain child and family focussed.
- There is continued progress on developing a workforce with the necessary skills for meeting the specific needs of children, young people and families including safeguarding and promoting welfare.
- Services are delivered in an integrated way with professionals from partner agencies at both a locality team level as well as in city wide services, and a key requirement to involve primary care teams.
- Services are enhanced or targeted toward specific groups where there is increased vulnerability or reduced levels of access to healthcare. Providers to identify and address inequality within their service delivery and contribute towards a reduction in health inequality.
- There is access to services in dedicated facilities, provided by dedicated staff supported by a quality assurance process such as implementation of the You’re Welcome standard or local variant.

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 explore further potential arrangements for integrated configuration of provider services in future under the umbrella of the children’s trust arrangements. Improvements have been made in safety and quality through existing collaborative arrangements and these should continue to be supported through the proposed organisational arrangements. In order for these gains to be sustainable in future further progress needs to be achieved in efficiency in delivery along agreed pathways of care. This may best be realised through the development of a single integrated care organisation in future and

opportunities or options will be considered by partners during the contract period 2011 – 2014. Proposals via the Integrated Business Plan (IBP) for a new provider in 2011 will need to provide a basis for further integration of provider services in due course.

In addition there are a number of services where quality and value for money could best be realised by commissioning services over a larger population base. For example Plymouth has developed the provision of the inpatient adolescent mental health service for the South West peninsula with a purpose built unit scheduled to open at the end of 2010. Collegiate commissioning will continue to be required across commissioning organisations to secure relevant services, such as paediatric surgery, of an appropriate and safe standard whilst also facilitating access. The Children and Young People Needs Assessment is shown as Appendix 6.6 and a refresh can be found at: http://www.plymouth.gov.uk/homepage/socialcareandhealth/childrenssocialcare/pcypt/cypp.htm

2.3.5 Services for Initial Market Review

There are a number of services that have been identified 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 and therefore retains the right to test the market in these areas, to ensure quality of service and value for money.

- Defined Mental Health & LD Provision
- Community Dental Services
- Wheelchairs and Disability Services
- Weight Management Services
- Medium and low secure services
- Parkinson Disease Services
- Primary Care GP Services (PCTMS)
- Stroke inpatient rehabilitation
- Neurological inpatient rehabilitation

A clear decision has been made however, to market test a range of mental health and learning disability provision. This constitutes a significant part of the QIPP agenda and this process will lead to a revision of the service model. 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) and the commissioner anticipates that this process will commence during 2011/12.

2.4 Value for money

Delivery of Value for Money is one of the key strategic objectives for the PCT and wider Health Economy. As such the provider will be expected to identify plans to deliver efficiencies in line with tariff and QIPP requirements.

2.5 Benefits realisation plan

The benefits realisation plan will be used to track the delivery of benefits for this programme. Continuing the development of joint or collegiate commissioning the benefits, including appropriate measures and milestones, will where relevant be specified in conjunction with key partners who share an interest in the service delivery area. All areas of potential impact will be monitored to ensure that where there is an expectation of significant or very significant benefits these are being achieved with the timescales expected, and where there is some or no significant expected impact that there are no intended consequences.

Progress against the key actions, milestones and expected outcomes and benefits will be reviewed monthly through a programme board. Failure to achieve agreed progress will be subject to performance management under contractual arrangements to be established with the new provider.

The framework for the benefits realisation plan is set out below.

Figure 5: Benefits Realisation Plan - Framework

Strategic Benefit Area	Benefit Contribution Sought	Baseline Position (As at 31 March 2010)	Target Outcome (of community service activity)	Action Required (and by who)	Responsible for Action and Outcome	Key Milestones	Anticipated Impact				
							1 Negative impact	3 No significant impact	5 Some +ve impact	7 Significant +ve impact	9 V significant +ve impact
1. Strategic Ambitions	1.1 Reduce health inequalities										
	1.2 Prevent ill-health										
	1.3 Commission modern and innovative services										
	1.4 Ensure value for money										
	1.5 Improving quality*										
	1.6 More control										
	1.7 Wider choice*										
	1.8 Easier access										
2. Ten Priority Outcomes	2.1 Reduce health inequalities for males and females										
	2.2 Increase life expectancy for males and females										

Strategic Benefit Area	Benefit Contribution Sought	Baseline Position (As at 31 March 2010)	Target Outcome (of community service activity)	Action Required (and by who)	Responsible for Action and Outcome	Key Milestones	Anticipated Impact				
							1 Negative impact	3 No significant impact	5 Some +ve impact	7 Significant +ve impact	9 V significant +ve impact
	2.3 Reduce the number of women smoking at the time of delivery										
	2.4 Increase the number of infants breastfed										
	2.5 Reduce hospital admissions for alcohol-related harm										
	2.6 Reduce hospital admissions caused by unintended and deliberate injuries										
	2.7 Improve coronary heart disease mortality rates										
	2.8 Reduce teenage conception rates										
	2.9 Reduce the number of acute delayed transfers per hospital bed*										
	2.10 Improve the self-reported experience of patients*										

Strategic Benefit Area	Benefit Contribution Sought	Baseline Position (As at 31 March 2010)	Target Outcome (of community service activity)	Action Required (and by who)	Responsible for Action and Outcome	Key Milestones	Anticipated Impact				
							1 Negative impact	3 No significant impact	5 Some +ve impact	7 Significant +ve impact	9 V significant +ve impact
3. A Healthy System	3.1 Works with the PCT commissioned 'system integrator' (Sentinel CIC) to support delivery of a healthy system										
	3.2 Patients will be supported in choice of place, time and treatment options*										
	3.3 It will be characterised by improved outcomes, productivity and allocation of resources*										
	3.4 There will be a net reduction in cost and capacity										
4. QIPP Areas	4.1 Shifting settings of care and optimising urgent care										
	4.2 Optimising elective care pathways										
	4.3 Adopting best-practice care pathways for LTCs*										
	4.4 Improving prescribing										

Strategic Benefit Area	Benefit Contribution Sought	Baseline Position (As at 31 March 2010)	Target Outcome (of community service activity)	Action Required (and by who)	Responsible for Action and Outcome	Key Milestones	Anticipated Impact				
							1 Negative impact	3 No significant impact	5 Some +ve impact	7 Significant +ve impact	9 V significant +ve impact
	4.5 Improving primary and community care*										
	4.6 Improving mental health*										
	4.7 Improving learning disabilities*										
	4.8 Improving non-clinical productivity										
5. TCS Critical Benefits	5.1 Improve quality*										
	5.2 Increased efficiency of solution										
	5.3 Sustainability of solution										

** Main areas of expected benefit for patients*

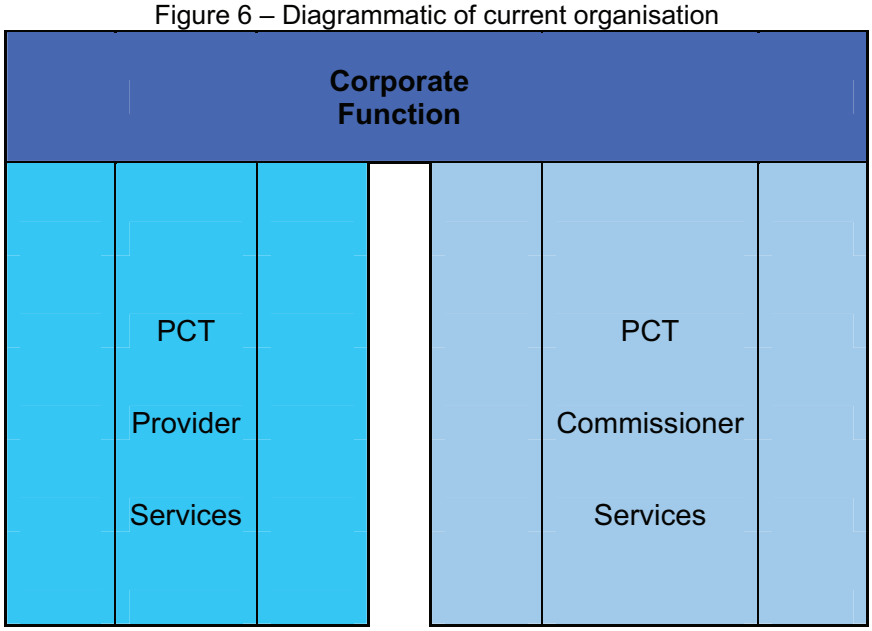
2.6 Impact on the PCT Commissioner Function

2.6.1 Corporate Function

NHS Plymouth understands its legal obligations as a statutory body and must act in accordance with the legislation enacted by Parliament. The PCT is the statutory body through which the National resource allocation is made and for which the Board is held to account. This will need to be retained in to the future, until such time as legislation changes.

The current organisational form of NHS Plymouth, as can be described as having three basic parts – these are set out in figure 6.

Figure 6 – Diagrammatic of current organisation



In workforce terms, there is over 2,000 whole time equivalent staff in the organisation and the current split between the three areas is as follows:

- Corporate Function 14%
- Provider Services 80%
- Commissioning Function 6%

Clearly, transferring the provider services to an alternative organisational form will have implications for the remaining organisation.

With the number of organisational elements across the city, there is the potential for duplication of support elements which could potentially increase the cost base. There are recognised and considerable benefits for support services to operate across a number of organisations. It is not intended for these services to form a separate organisation in their own right, but will need to be hosted in one organisation, using service level agreements.

There are a number of key steps:

- Identify which areas should remain with the commissioning function of the PCT, which should transfer with the provider services.
- How the support functions will be enabled to operate to continue to provide the essential inputs required to all parties.
- Develop an appropriate Service level Agreement and mechanism to ensure that all parties have appropriate levels of access to the support services.
- Assess how surplus asset is gained as a result of this transaction, and how this should be handled
- Consider any overhead implications and arms length costing model, to ensure provider meets fully the costs of any support.

There are a number of opportunities to work collaboratively across the wider peninsula. This is already happening to a degree in a number of areas including primary care, medicines management, public health and PHNT Acute commissioning. Discussions are ongoing on other opportunities to share resource and reduce duplication of effort.

2.6.2 GP Commissioning Consortia

The publication of the White Paper 'Liberating the NHS' sets out the vision for the future commissioning arrangements. In NHS Plymouth, the preferred lead clinical commissioning mechanism is with Sentinel Community Interest Company. The Board has held three developmental sessions with the Board of Sentinel and Sentinel have confirmed their willingness to take forward the development of a GP Commissioning Consortium for Plymouth. A joint programme of development is to be pursued over the coming months, which will focus on what will be involved in commissioning in the future and ensuring that NHS Plymouth plays its part in supporting the consortium to get off the ground and enable its authorisation by the NHS Commissioning Board in due course.

2.6.3 Estates and Infrastructure

With respect to the management of the estate, the intention is for the Commissioning body to retain ownership of all of the estate, and for the provider to operate as a tenant, under a lease agreement. This model is currently operating successfully for the Peninsula NHS Treatment Centre. Estates offer a huge opportunity for the PCT. Effective management of the estate requires expert management and an aggregation of asset bases across a broader geography to maximise the potential portfolio. This would allow investment in skilled labour to effectively manage the estate which has significant opportunities for value creation – more detail is covered in Chapter Four.

The decision to pursue this model of operation is made for a number of reasons, but largely as it is perceived that otherwise commissioning leverage would be weakened:

- A commissioner's ability to negotiate service improvements or reconfiguration is limited; and
- Concentration of key sites, assets and high cost equipment in the hands of a small number of providers could act as a barrier to new market entrants.

Facilities management will be aligned to the provider function in its operational management role of the estate.

2.6.4 Support Services

The principle of a collective support organisation that operates across a number of organisations is raised in section 2.6.1. Initial thoughts on the services that could potentially form part of this arrangement are:

- Human Resources – to cover the transactional element of HR.
- Finance & Information – the balance between management, financial accounting and information provision will vary dependent upon the organisation. However, the breadth of skills and productivity of these services would be enhanced by scale. The ownership of the financial accounts will need to remain an organisational accountability.

In addition, there are a number of currently purchased areas that could be functions of a centralised shared management capacity facility:

- Legal – currently employed on a bespoke basis. Potential for advantaged solutions either in contractual terms or through block employment.
- Energy – a significant and growing expenditure which can be significantly reduced through expert management.
- Travel – a reasonable spend that can be impacted by effective purchasing practice.

3. Chapter Three: The Commercial Case

3.1 Market management

We will apply our market development process in the areas we have scheduled for market testing.

The market review and development process is the way in which we formally review current market arrangements from the supplier base in delivering against the needs of the population in a defined area of requirement. This review process will consider a number of elements:

- The importance of the area, as described by public health information, patient and public feedback, political and economic factors;
- The disease and population characteristics;
- The ability to deliver person centred integrated care;
- The relationship type required to maximise the potential in this area;
- The alignment of the suppliers to the needs of the commissioners;
- The ability to deliver QIPP plans;
- The current market place and it's level of provision;
- Supplier performance;
- The ease of change; and
- The need for a strategic shift in provision.

From these characteristics, the priorities for change are established. NHS Plymouth will plan to drive the market to deliver improved outcomes identified through the work above - this may be through increased competition, but driving improvement through developmental approaches with providers is also an area where increased focus is being placed.

3.1.1 Driving Market Change

The breadth of available levers is indicated below:-

a) Strategic review process – The use of this approach will ensure the correct focus on areas to drive maximum benefit.

b) Engagement – With patients the public and clinicians. This will deliver a more detailed understanding of the patient need, and clinicians are far more involved in the development of the resulting services.

c) Supplier development - Monitoring of provider outcome performance will be utilised to drive continuous improvement in supplier performance. Where appropriate, the PCT may instigate improvement programmes where a performance issue exists.

d) Robust contracting processes – The contracting approaches are more robust as the PCT uses the standard documentation produced by the

Department of Health. Service specifications are focused on performance outcomes.

e) Integration – Through integration with social services, new ways of working will be adopted that will drive synergies towards our joint vision for health and care provision.

f) Collaboration – The potential of collaborating with other PCT areas.

g) Choice – The choice agenda is broadening the supply base and this in itself offers greater opportunity for market development.

h) Information – The increasing availability of robust information provides a stronger foundation for decision making in driving pathway and supplier development. This information requirement is one of the prime drives for the creation of a single point of access and system control element. It will also collect patient feedback to ensure services become more patient centred.

i) Reverse marketing – We will look not only at current market places but at associated areas where we may attract new providers into the market to benefit from their innovation and expertise.

j) Opportunity marketing - We will not only look for local solutions but attract the best suppliers of services to the area by indicating the opportunity available being aware of providers needs and ensuring as far as possible we are preferred customers within Value For Money constraints.

Contestability is therefore one of a set of options we will utilise to leverage the supply market in the areas we are considering for a market test and is not considered to be the only way to improve services.

Going forward we are designing an open approach to our contact and system control hub in terms of referral, booking and data management this is to enable a more open market approach in the future.

The goal will be to:

> "Drive our markets so that we are in an advantaged position to deliver future healthcare goals, we are treated as a preferred customer and we are served by a committed and productive supply base delivering value, quality outcomes and innovation."

3.1.4. Safeguarding

Key aspects of provision involved in monitoring and ensuring safety will be disentangled from the core provision to ensure that review occurs impartially across all providers. These areas include aspects of infection control and

safeguarding adults and children.. These along with clinical governance overview will be retained in the commissioning enterprise.

3.1.5 Local Market Development

At this stage 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. Consequently it is the view of NHS Plymouth that the configuration of the social enterprise that is established for April 2011 will not necessarily 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.

The Social Enterprise will have clear key performance indicators (KPIs) in their contract. These will have been developed and agreed by clinicians through PEC, Sentinel CIC and with key partners through joint commissioning arrangements. The commissioner will retain the right to market test areas where non-adherence to these indicators occurs. See section 2.5 for further detail.

3.2 Payment mechanisms

There is currently a NHS standard contract in place for Mental Health and Learning Disabilities and a separate NHS community services contract for Adults and Older People and Children's and Families services.

The contracts were agreed on a three year basis, commencing April 2010 so would be available to be rolled forward if required. However, they may need to be novated in order to reflect any changes in the organisations legal entity.

It is possible that any new provider organisation may be formed on a social enterprise basis. The guidance around Social Enterprises requires any new organisations to be contracted with for 3 to 5 years without the provided services being re-tendered. However, there is no guarantee regarding income levels, or continuation of services which can be varied in line with the standard NHS contracts requirements.

There is currently a 'quasi' activity based contract in place for the provision of services by the PCT's provider function. This will need to be extended in order to drive through the required service changes and demonstration of improvement in patient outcomes. Examples being:

- Introduction of Payment by Results (PbR) for mental health services, including the reporting of outcomes
- Development of the CQUIN methodology to enhance quality
- Improved patient experience demonstrated through surveys and other stakeholder feedback.

Tariff will be applied as required nationally, and where tariff does not apply, the agreement of local prices reflective of cost of delivery will be required.

Penalties and fines will be applied per national standard contract.

The contractual mechanism should be reflective of risk and reward, and be variable in nature wherever possible in order to ensure appropriate incentives are embedded to drive and reward delivery.

3.3 Commercial Risk Management

There will inevitably be a bedding in period, during which the legacy corporate organisation and new provider would need to understand and appropriately mitigate risks to delivery.

It is expected that the provider will be a key partner in the delivery of the Plymouth Health Community Transformation programme, and as such will form part of the programme governance. This will require participation in the Executive Programme Board, and the rules of engagement in the delivery of risk management wherever possible.

No financial guarantees can be assumed at this stage.

4. Chapter Four: The Financial Case

4.1 Impact of the proposed transaction

The provider will be expected to produce an Integrated Business Plan, incorporating the financial forecasting of its key statements over the next five years. This will be expected to include the impact of all of the following, including QIPP and any internal efficiencies required.

Financial Due Diligence will explore the past performance of the organisation through detailed analysis of Income and Expenditure, Cashflow, Balance Sheet, and Efficiency Programme delivery.

4.1.1 Corporate and Support Functions

The transaction will require the separation of the range of corporate services being provided to the current organisational entity. This will include:

- Finance and Financial Services
- Workforce Development and Payroll
- Estates (Strategic and Operational) and Facilities
- IM&T (already provided by a 3rd party)
- Governance
- PCT Board and Corporate Office

In most cases a definitive transfer of the relevant service would be most cost effective, with an inter-organisational service agreement being created between the host organisation and the customer.

Over the forthcoming period of development, the PCT retains the opportunity to seek further efficiencies by delivering support services jointly with other partners. The outcome of which may mean a short term holding position whilst options are explored and delivered. The provider will deliver non-clinical productivity efficiencies in line with QIPP, delivering its appropriate share of the total programme of £10.8m.

4.1.2 Contractual Relationship with NHS Plymouth Commissioner

The development of the contractual relationship will need to be addressed in the Integrated Business Plan. This will need to set out the risks and mitigating actions to delivery of the Health Care system. The contract to date has remained only semi-activity based, and the development of the balance of service line contracting will need to be addressed. There are further risks to both clinical and financial sustainability that need to be addressed in Commissioner Case for Change and the Integrated Business Plan. The current year income and expenditure envelopes for the Provided services are set out in Table 1.

4.1.3 Income and Expenditure, Financial Balance

The Provider will plan to deliver at least financial balance between income and expenditure in each year. The Integrated Business Plan will evidence the

delivery of sustainable financial balance for the strategic period and on-going viability. The plan will include all source of income including from other NHS Commissioners, but also from Social Services and other sources. Significant convergence of income planning assumptions from commissioners and other sources of income will be required for the Integrated Business Plan. The management of upside and downside scenarios will be exemplified in the Integrated Business Plan, and will be assessed for strength in terms of planning assumptions and viability of response. The management of planned investments in capital assets, such as IM&T infrastructure will need to be managed through delivery of surpluses, cashflow management, and strength in the balance sheet.

4.1.4 Balance Sheet (Statement of Financial Position)

The Provider will exemplify the statement of financial position through the strategic past to include 2010/11. The Integrated Business Plan will exemplify plans for the sustainable strength of its balance sheet in the future. This will require disaggregation of the Balance Sheet across the legacy organisation.

4.1.5 Cashflow

The analysis of past cashflow, through extraction of actual balances and payments will be required to evidence past delivery of effective cash management. The Integrated Business Plan will identify best practice cash management processes, and plan to deliver sustainable cash balance in the future.

4.1.6 Assets and Estate

A significant element of the corporate organisation relates to the ownership and utilisation of the existing NHS estate. The Provider Integrated Business Plan will evidence delivery of the expectations laid out in the Commissioners Integrated Asset Management Strategy (CIAMS). This includes timescales for the strategic development and rationalisation of the estate, and will require planned and systematic withdrawal and /or maximisation of usage of the remaining estate. Strategic Asset Management responsibilities will remain with the NHS Commissioner, and are planned to be delivered through partnership or outsourcing arrangements. The provider will enter into fully repairing lease arrangements for each asset over the period of the contract (between 3 and 5 years) – although the exact requirement is subject to clarification at a national level to ensure a cost neutral position overall (i.e maintain status quo to the current status of the asset). The delivery of Operational Estates will be managed by the Provider. The impact of Capital Charges resultant from planned investment and maintenance in the properties will be reflected in variations to lease prices. Ownership of Information Technology assets, including all Personal Computers, Laptops, Printers, Patient Administration and other Clinical Systems, other software, and Infrastructure will be transferred to the Provider. On-going investment and development will be the responsibility of the Provider through financial security and planning.

4.1.7 Accountability
The Integrated Business Plan will be required to set out the financial governance and accountability framework, to include external and internal audit functions and responsibilities, together with the risk assurance framework.

4.1.8 LIFT and LIFTCO organisations
The legacy exclusivity agreement with Resound, the Primary Care Trust's LIFT partner will remain with the legacy NHS organisation, the commissioning PCT. The Provider will be required to sign up to the partnering agreement, and will be required to utilise LIFT as the preferred organisation for all significant estate development that it pursues outside of the leased estate arrangement from the commissioning PCT. The legacy leases for the currently operational estate and current developments (the Tier 4 Child and Adolescent Mental Health Services centre) will remain with the commissioning PCT. The agreed Lease Plus charge (including additional costs) will be the basis of the sub-lease to the provider, under the same arrangements as the LIFTCO leases, including Retail Price Indexed rental increases and decreases for the period of the lease.

4.1.9 .Other Services
Provided General Medical Services (PCTMS) and Dental Services (DAC) are currently provided by the PCT Provider function under separate Service Level Agreement from the core SLA. The new Provider will be expected to continue to provide these services under separate sections of an integrated Service Level Agreement, which will continue to maintain the equity of treatment with all independent contractor contracts. Uplifts are calculated in accordance with the Doctors and Dentists Remuneration Board (DDRB) agreements.

NHS Plymouth has the co-ordinating commissioner role for the Peninsula Dental School. This role will remain in place, ensuring equitable treatment and access across the peninsula commissioning PCT's. The individual running of buildings and services remains with the new provider, and is incorporated under a separate section of the Service Level Agreement. Income is dependent on Dental SIFT, HEFCE and other external sources of funding.

4.1.10 National Health Service Litigation Authority (NHSLA)
The Provider will be able to participate in the NHSLA scheme, and will examine the mechanics of the transaction through analysis of on-going liabilities (provisions and contingent liabilities), together with the on-going contributions to CNST. Disaggregation of commissioner elements as appropriate will be required.

4.1.11 Reference Costs
The current PCT Provider provides reference costs on an annual basis. The new provider will continue to provide reference costs in accordance with planned deadlines to ensure there is common understanding of the benchmarked efficiency of the PCT provider, which will inform local pricing structures where necessary. The new provider will set out plans to be at least 100 in benchmarking the costs of provision of its reference costed services.

Where prices are set by tariff the new Provider will be required to deliver within that price structure.

4.1.12 Management Costs

In line with the NHS White Paper, Equity and Excellence, Liberating the NHS, the reductions in management costs will be delivered by the Provider as planned. The provider will participate in the analysis and identification of on-going management cost targets across PCT commissioner and provider.

4.2 QIPP Contribution

The Provider will have a proven track record of delivery against its efficiency plans. The Integrated Business Plan will set out the last three years programmes including budgets and evidenced delivery, to include 2010/11 as planned. The new provider will set out its future efficiency plans within its Integrated Business Plan in order to respond to the commissioner's targets to deliver balance within the overall income envelope, including QIPP. Co-operation and participation in the Health Community Transformation Programme (to include QIPP) will be required, which will include sharing of all efficiency programmes ensuring synchronicity with other organisational and community goals and objectives. The planning assumptions to be used for the purposes of the Integrated Business Plan should be consistent with those set out in the Strategic Framework, Medium Term Financial Plan and QIPP submission and plans. Wherever possible, commissioner convergence will be expected to ensure the IBP delivers as planned. Commissioner convergence will be expected with all significant commissioners. Planning assumptions from the 2010/11 to 2013/14 Strategic Framework are included in Table 3.

Table 1 – NHS Plymouth Provider Services 2010/11 Budgets

Expenditure Budgets - 2010/11	Next Yr £'m	Total £'m	Pay £'m	Non Pay £'m	Income £'m
Adult Mental Health Services	26.9	28.6	26.5	3.4	-1.3
Adults and Older People	26.6	31.4	24.6	10.8	-4.0
of which:					
PCTMS					
Dental Access Centre					
Dental School					
Childrens and Family Services	7.7	8.2	10.7	1.1	-3.6
Medical Staffing	0.1	0.3	0.3	0.0	0.0
Total Service Provision	61.4	68.6	62.1	15.4	-8.9
Corporate	0.8	0.8	0.7	0.1	-
Workforce Development	1.7	1.8	1.5	0.4	-0.1
Finance	3.6	3.7	2.0	1.7	-0.0
Facilities	4.5	4.5	2.8	1.7	-0.1
Central Contracts	2.3	1.9	-	1.9	-
Capital Charges	3.7	3.7	-	3.7	-
Reserves	-	0.1	-	0.1	-
Total Support Services	16.6	16.5	7.0	9.6	-0.2
Total Services	77.9	85.0	69.1	25.0	-9.0
NHS Plymouth SLA	-69.0	-76.7	-	-	-76.7
NHS Cornwall SLA	-8.9	-8.3	-	-	-8.3
NHS Devon SLA	-	-	-	-	-
Total SLA Income	-78.0	-85.0	-	-	-85.0
Financial Balance	-0.0	0.0	69.1	25.0	-94.1

The process of due diligence will evidence the reconciliation of the Service Level Agreement, and inter Trust Agreement for the provision of support services with the Income and Expenditure budgets. It should also set out medium term plans for Service Line income and expenditure in the delivery of the QIPP Programme.

As a result the values in Table 1 may change.

Table 2 – NHS Plymouth Health Community QIPP Programme

NHS Plymouth QIPP Plans – 2011/12 to 2013/14	2013/14 £'m
Shifting the Settings of Care	16.5
Optimising Elective Care Pathways	17.2
Best Practice Care Pathway for Long Term Conditions	4.1
Improving Medicines Management	2.7
Improving Primary and Community Care	9.9
Improving Mental Health	6.0
Improving Learning Disabilities	5.1
Non Clinical Productivity / Other	4.7
Total Services	66.2

Table 3 – NHS Plymouth Strategic Framework Planning Assumptions

Planning Assumptions - Base	10/11 %	11/12 %	12/13 %	13/14 %
SIF Local Contingency	0.38%	0.41%	0.45%	0.45%
SIF Voluntary	0.36%	-	-	-
SIF Topslice	0.38%	0.41%	0.45%	0.45%
SIF Recurrent Headroom	0.75%	1.24%	1.65%	1.95%
SIF Surplus	1.00%	0.69%	0.45%	0.15%
CQUIN	0.65%	-	-	-
Public Health	0.10%	0.10%	0.10%	0.10%
Improving Access	0.30%	-	-	-
Quality Fund	0.10%	-	-	-
NHS VFM Savings	0.50%	-	-	-
Inflationary Assumptions				
Tariff Inflation	0.35%	0.25%	0.25%	0.25%
Tariff CRES	-0.35%	-0.45%	-0.45%	-0.45%
Prescribing	5.00%	5.00%	5.00%	5.00%
Primary Care	-			
Non NHS	1.00%	1.00%	1.00%	1.00%
Capacity Planning				
Elective Growth	2.00%	2.00%	2.00%	2.00%
Non Elective Growth	4.00%	4.00%	4.00%	4.00%
Other NHS	2.00%	2.00%	2.00%	2.00%
A&E / OP / ESS	1.00%	1.00%	1.00%	1.00%
PCT Provider	1.00%	1.00%	1.00%	1.00%
Continuing Healthcare	3.00%	1.00%	1.00%	1.00%
Efficiencies Requirements				
Minimum efficiencies over tariff	-4.87%	-0.57%	-0.43%	-0.31%

Planning Assumptions - Downside	10/11 %	11/12 %	12/13 %	13/14 %
Inflationary Assumptions				
Tariff CRES	-0.35%	-0.40%	-0.40%	-0.40%
Efficiencies Requirements				
Minimum efficiencies over tariff	-4.87%	-0.89%	-0.75%	-0.64%

Planning Assumptions - Upside	10/11 %	11/12 %	12/13 %	13/14 %
Base Case Scenario				
Baseline Growth	5.89%	2.50%	2.50%	2.50%
Inflationary Assumptions				
Tariff CRES	-0.35%	-0.35%	-0.35%	-0.35%
Efficiencies Requirements				
Minimum efficiencies over tariff	-4.87%	1.19%	1.38%	1.55%

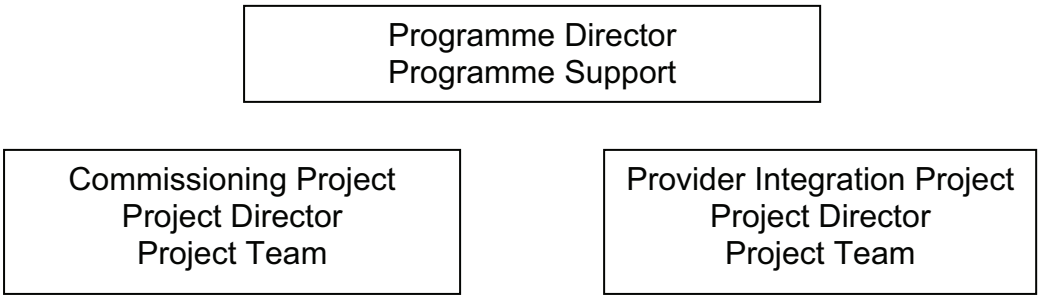
5. Chapter Five: The Management Case

5.1 Implementation capability

It is clear that the success of both the TCS Project and the QIPP programme are inextricably linked. The Executive Team meetings have taken on the role of Project Board for Transforming Community Services, with clearly nominated individuals. This needs to be driven by strong and focused leadership across the Health and Social Care Community and this is achieved via the Health and Social Care Integration Board.

A separate project team has been established for the Integration Project, reporting up through the Provider Executive Team to the Provider Board.

It is the intention to appoint a Programme Director, whose role will be to oversee both strands of work for NHS Plymouth, with dedicated project support.



The high level work programme was shared with the Strategic Health Authority for the end of July 2010. This workplan is being strengthened and consolidated as the emerging vision and direction is being finalised.

5.2 Project roles for the Primary Care Trust

This paper sets out the role for NHS Plymouth as 'Commissioner' in this process. However, it must be recognised that for the 'organisation' there are also key roles for the board in respect of the 'provision' role and for some individuals, it will be necessary to have dual roles in the overall process.

In terms of commissioning the project roles are as follows:

Project Role	Appointed Individual	Areas of Responsibility
Project Director	Paul O'Sullivan	Oversee the overall project from a commissioning perspective.
Project Manager	Fiona Phelps David Bearman	Support the Project Director in all aspects of the commissioning project.
Finance & Information	Ben Chilcott	Finance, Performance and Information workstream lead.
QIPP	Sharon Palser	Ensures integration with QIPP agenda, and also lead for Estates
Governance	Liz Cooney	
Communication	Corinne Shore	Develops Communications plan and lead for Stakeholder Engagement.

5.3 Business Continuity

NHS Plymouth and each of the Directorates within the Provider Organisation have existing Business Continuity Plans. It will be necessary to assure the Programme Director that the current Business Continuity Plans are fit for purpose, in light of the Transforming Community Services Programme.

The provider will need to demonstrate through the IBP that they have the necessary capacity and capability to achieve the transformational change or have made arrangements to secure that additional required capability.

It is the prime concern of all partners to ensure that on 1 April 2011 that a safe service for the public is available on transfer day.

5.4 Commissioner Strength

NHS Plymouth has a strong local vision and goals behind which major providers and stakeholders are aligned. WCC assessed the PCT as 'green' reflecting a vision which is firmly grounded in the PCT and national context, is underpinned by thorough analytical research into needs and priorities, is

ambitious and realistic and provides confidence that the PCT will deliver all of the local NSR vision, the national priorities and it's own top strategic priorities.[1]

The assessment in April 2010 also recognised that the PCT has made significant progress in strengthening its commissioning arrangements. when the PCT was assessed as improved in eight of the eleven competencies and further progress has continued to be made.

The PCTs ability to learn from feedback and rapidly improve and the strength in the following areas are reflected in the quotes below from the WCC assessment report and provide assurance of strong governance and the organisation's ability to lead and manage the transformation of community services, to address local priorities and national policy:

Formulating the vision for health and healthcare in Plymouth:
"Following last year's feedback the PCT has focused on getting its processes right, and has made important progress in detailing what the characteristics of the future health and social care in Plymouth will look like. The panel were able to sense the values and purpose that underlies the PCT's work."

Clinical leadership
"The panel was impressed by the degree of empowerment of clinicians that the PCT has achieved – for example, through the work with Sentinel CIC as well as with acute, mental health and social care professionals – and can see that the PCT is putting together the building blocks of the delivery system in Plymouth. The panel observed a process to improve the health of relationships across the local health and social care system, which is supporting changes in culture and behaviour."

Strategy
"The PCT vision of nine priorities references the PCT and national context, and addresses specific locality needs addressing pockets of deprivation based on a strong underpinning analytical research."

Finance
The PCT has a strong track record in financial management which was recognised in the WCC assessment of 'green' reflecting the fact that "Historically the PCT's financial performance has been in line with SHA expectations. The PCT is forecasting a surplus in each of the next 5 years in line with SHA expectations."

Board
The PCT's strength in governance was reflected in an assessment of 'green' in two key areas:
Organisation – reflecting clear and well defined organisational structures, roles and responsibilities, clarity about capacity and capability gaps and plans in place to address them.[2]

[1] WCC assurance handbook year 2 p86 -criteria to be met to achieve a green assessment for vision and goals

Delegation – reflecting that in joint, collaborative and specialised commissioning arrangements there are clear and delineated roles, responsibilities and accountabilities, evidence of robust processes for decision making and clarity about how these arrangements will support delivery of the strategy[3]

Organisational Development (OD) plan

The PCT has an existing plan for organisational development which is framed around the McKinsey model of organisational health. This is in the process of being refreshed to reflect the significant progress made towards the local model of clinical commissioning, the feedback from the WCC assessment and also to reflect the outcome of the capacity and capability gap analysis currently underway with partners across the health and social care community to support the delivery of the QIPP programme.

An OD plan will be developed to ensure appropriate skills and capacity are in place along with robust governance and management arrangements to implement the model of care for Plymouth and ensure the strength and sustainability of the new organisational model.

Contracts with the new provider or providers will specify requirements in relation to the integrated delivery of care across the health and social care system. It is also intended to establish a mechanism to allow flexibility to continue to develop the initial model during the first twelve months to ensure that progress in the integration of health and social care in particular can be accommodated.

[2] WCC assurance handbook year 2 p92 -criteria to be met to achieve a green assessment for organisation.

[3] WCC assurance handbook year 2 p94 -criteria to be met to achieve a green assessment for delegation

6. Chapter Six: Appendices

6.1 Option Appraisal of Organisational Form

6.2 QIPP Slide – Plymouth's future care delivery system

6.3 Service line analysis – methodology

6.4 Service line analysis – outcome

6.5 Commissioning Assurance Framework

6.6 CYPP Needs Assessment

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Service Development/Change
OSC Briefing: Greenfields - for information

Presented by: Gavin Thistlethwaite, Joint Commissioning Manager

1 Purpose of the report

To report to the Overview and Scrutiny Committee (OSC) that we have completed the consultation process relating to our proposal for the future of the service provided from the Greenfields site. The revised proposal outlined in this paper is the option that has been developed following consultation with local clinicians and GPs, patients and members of the public.

2 Decisions/Actions requested

The purpose of this paper is to inform the OSC about the process of consultation and its outcomes and our progress with our plans to improve the quality, safety and access to mental health services for people with learning disabilities.

Information about our plans was first brought to the OSC in June 2010 and this update takes account of the useful questions and suggestions raised by the panel at that time.

The Overview and Scrutiny Committee are asked to:

- Note the results of our options appraisal and consultation on the future of the Greenfields services
- Note the support from patients, users and health care professionals for improving mental health services for people with learning disabilities.
- Support the adoption of the proposed service model and associated service developments

3 Background

Greenfields was commissioned to deliver detailed health assessments of learning disabled people with complex presentations, often complicated by mental health issues, and to generate effective treatment interventions. Admissions are intended to be short term and focused on delivering treatment interventions that can be delivered both in an inpatient environment and then transferred to a community setting.

Despite substantial effort and commitment from services it has become increasingly apparent to the service provider and the commissioners that the service delivered from Greenfields is unable to meet the quality requirements of a modern inpatient facility and is struggling to deliver effective outcomes for service users. There is a particular concern about the length of stay on the unit.

An option appraisal was undertaken by the Mental Health Partnership and considered within the Provider Executive Team. The option appraisal considered four possible options:

- Invest in the unit in order to try and bring it up to the required standard;
- Do nothing, leave the unit operational and provide no extra investment;
- Close the unit and provide no replacement service;
- Close the unit and invest released funds from the unit into community based replacement services.

The option to invest in the Greenfields service was rejected on both financial and policy grounds. The estimated investment requirement was approximately £250,000, which is unachievable in the current climate. This should be seen in the context of a policy drive which moves away from NHS provision of learning disability inpatient services (Valuing People Now, DH 2009).

Maintaining the *status quo* in the service was also rejected on grounds of quality and risk.

The option to close the service and provide no replacement service was rejected on grounds of cost and quality, as it would inevitably lead to an increased use of out of area placements which have been demonstrated to deliver limited benefits to individuals and are frequently extremely expensive.

The final option to close the unit and take some the resources released from the unit to invest into community based services was identified as the most appropriate approach, delivering both an improvement in quality and a commitment to maintaining the mental health and well-being of learning disabled people in their local community.

The review and options appraisal were carried out in the context of:

- Our own Quality Innovation, Productivity and Prevention (QIPP) programme that places an emphasis on care that supports people to remain healthy, whilst maintaining the quality and required level of provision of inpatient care.
- Policy and advice from the Department of Health and guidance like the Mansell Report (DH – 2007, Rev. Ed.)

4 The Engagement process

We had conducted some of our consultation in advance of our previous presentation to the panel and it should be noted that this involved a range of stakeholders, including staff, carers and service users. Subsequently, we held two public engagement events, both open to all

partners and stakeholders including Service Users, Carers, General Practitioners, Trades Unions, the general public and anyone interested in informing the debate on the future of the service. Transcripts of the sessions and a DVD of the service user sessions facilitated by the 'Mirror Mirror' drama group are available for review.

Public and service users were made aware of the events through local media, the Learning Disability Partnership Board and articles on the local radio. Details of all the consultation meetings are included in the attached appendix 1.

5 Consultation findings

The consultation supported the closure of the Greenfields unit and the delivery of intensive community based services.

There were a varied set of responses in the consultation which can be summarised into 5 key points:

- A community based service is favoured
- Where inpatient admission is required, a unit with specialist skills should be used
- Service user choice and empowerment is fundamental to improving services
- Services should focus on crisis avoidance rather than crisis responses
- Close multi-disciplinary and multi-agency working is crucial

6 Revised Proposal

Following the consultation the proposal from the Commissioners and the Service Provider is to close the Greenfield site and instead to develop community based services for the group of patients most likely to be affected by the closure. The priority areas for development we identified as:

- Access to mainstream mental health inpatient service
- Investment in specialist learning disability inpatient staff
- Investment in out-of-hours support for people with learning disabilities
- Improved capacity for challenging behaviour service

The people we consulted indicated that flexibility, accessibility and specialist knowledge are crucial and that investment in the above areas will be needed to deliver the requirements they identified when consulted with. As a result, we will be:

Strengthening mainstream mental health services to ensure that they can provide the care needed by people with learning disabilities by:

- Having a specialist learning disability team within mainstream mental health services
- Introducing compulsory training for all inpatient staff around learning disability awareness
- Developing a detailed shared care planning process between mental health and learning disability specialists services
- Developing adapted environments that can support the care of learning disabled and vulnerable service users
- Detailed and robust discharge planning

Introducing an Out of hours service/Intensive intervention team

- A 7 day service operating into the evening and with the option to work 24 hours a day if required;
- A team of professionals who are skilled at assessing and managing risk as situations change in order to provide an effective response;
- Delivery of focused training to support providers;
- Skilled in the preparation of detailed crisis plans.

Strengthening the existing Challenging behaviour Service

- Invest in process of patient identification;
- Improve crisis planning with the out of hours service;
- Develop crisis avoidance strategies with support providers

This proposal has been approved by the Professional Executive Committee (PEC) of NHS Plymouth and the PCT Board.

7 Timescale for implementation

This proposal is part of the integrated programme of improvement for the whole learning disability service that is underway as part of NHS Plymouth's wider QIPP agenda. The timescale for the implementation of this full model of service for the learning disability provider is scheduled to be agreed by April 2011 and fully implemented by March 2014. In terms of the specific proposal presented here, we are, thanks to the consultative work described above, in a position to be able to have functional teams in place by April 2011.

8 Summary

- Greenfields has been shown to be an inadequate service and there is no available resource to invest in this service to improve it.

- At the time of the consultation there were only two patients on the ward and this reduced to zero during the process.
- The consultation supported the closure of the unit and for it to be replaced with a community based service that is accessible and flexible.
- When admission is required it should be as close to Plymouth as possible – for any kind of mental health presentation or detention under the Act this will be Glenbourne.
- An out of hours service needs to be developed to operate 7 days a week.
- Challenging behaviour services should be enhanced
- The HOSC are asked to note the consultation process and the approval by PEC and the PCT Board.

Appendices

Appendix 1 is the full report to PEC/PCT Board

Appendix 1

Title: **Proposal for the Development of Services Following the Consultation on the Future of Greenfields**

Author: **Gavin Thistlethwaite, Joint Commissioning Manager**

Date: **27th August 2010**

Background

Greenfields is commissioned to deliver detailed health assessments of learning disabled people with complex presentations, often complicated by mental health issues, and generate effective treatment interventions. Admissions are intended to be short term and focused on delivering treatment interventions that can be delivered both in an inpatient environment and then transferred to a community setting.

Despite substantial effort and commitment from services it has become increasingly apparent to the service provider and the commissioners that the service delivered from Greenfields is unable to meet the quality requirements of a modern inpatient facility and is struggling to deliver effective outcomes for service users. There is a particular concern about the length of stay on the unit.

Following an option appraisal undertaken by the provider, a proposal to close the unit and replace it with a community based service was made. This has been consulted upon with a variety of stakeholders and the outcome of that consultation has been used to amend and adapt the proposed service.

This paper will propose a structure of service that will address the requirements for a system that will replace the inpatient service and move towards a situation where admission to services out of area becomes a rarity and where service users are supported to stay in their own homes rather than being moved in the event of a crisis. This will then be place in the wider context of a potential service model for specialist services that will be driven by the QIPP programme. It should be noted that the QIPP programme is at the very earliest stages and there will be a need for much greater analysis and debate before finalising any new structure. The proposed service model to replace Greenfields is suggested in the context of policy and advice from the Department of Health and guidance like the Mansell Report (DH – 2007, Rev. Ed.)

Consultation

An extensive consultation process has been undertaken to discuss the proposed closure of Greenfields and to test the assumptions made in the proposal. **The consultation supported the closure of the Greenfields unit and the delivery of intensive community based services.** There were a

varied set of responses in the consultation which can be summarised into 5 key points:

- A community based service is favoured
- Where inpatient admission is required, a unit with specialist skills should be used
- Service user choice and empowerment is fundamental to improving services
- Services should focus on crisis avoidance rather than crisis responses
- Close multi-disciplinary and multi-agency working is crucial

It should be noted that the consultation involved a range of stakeholders, including staff, carers and service users. Transcripts of the sessions and a DVD of the service user sessions facilitated by the Mirror Mirror drama group are available for review. The full report is attached as appendix 1 of this document.

Revised Proposal

The key concerns about the proposal to close Greenfields centred on the alternatives to admission and the appropriateness of these options. The effective replacement of an inpatient service requires not just the delivery of an alternative service but also a change in the clinical culture of operation. In order to make a community based service work effectively the building blocks for alternatives to inpatient care need to be in place which include revised approaches to assessing, sharing and managing risk; improvements in the management, sharing and control of information; and significantly upgraded partnerships between agencies with a role in meeting the needs of this client group. The primary requirements for a replacement service are:

- A clear focus on assessment, treatment intervention and the planning of robust, achievable and shared crisis plans
- The ability to respond rapidly to crisis situations
- The ability to access up to date information
- The ability to call upon extra resources to support individuals or bolster packages of care
- In the event of an admission to hospital or moving to an alternative supported environment being required for those places to have skilled staff available who can address the issues for learning disabled patients effectively and with confidence
- To ensure that learning disabled people are treated wherever possible at home
- To ensure that providers of support are equipped to implement the intervention requirements of a treatment programme
- An integrated assessment and planning process with key partners but most importantly with Adult Social Care.

The absence of a dedicated unit was a concern to some and the proposed service will address this by ensuring that, in line with the Mansell Report (DH

2007 Rev. Ed.), there are a series of viable options for addressing the needs of learning disabled people who challenge services.

Enhanced Mental Health Service – "Green Light" Compliance

The primary task is to recognise that the majority of those requiring the services of an inpatient facility have mental health issues; indeed Greenfields was a function of mental health services for that reason. There are a range of views regarding the incidence of significant mental health problems for learning disabled people but the Foundation for People with Learning Disabilities (2003) has suggested that an incidence of between 25% – 40% is supported by the available evidence. This compares to an incidence of between 16% - 25% for the wider population.

Any admission for assessment and treatment for mental health issues must go via mainstream mental health services and those services must have both the staff capability and facilities to meet this need. This will require the following:

- A group of staff with specialist skills and experience of working with learning disabled people
- Compulsory training for all inpatient staff in learning disability awareness
- Detailed shared planning between mental health and learning disability specialist services
- Development of adapted environments that can enhance support and treatment of disabled or vulnerable service users
- Detailed and robust discharge planning pathways and shared care arrangements

These steps are a priority for completion and will ensure a suitable service for those with the greatest needs that will be provided by a specialist service that is part of the mainstream of mental health treatment.

The key features of the service should be:

- An adapted inpatient environment that is able to meet the needs of a range of vulnerable people, including learning disabled people, when required. Decisions about the use of this facility will be driven by need and not diagnosis
- A core team of LD professionals or mental health staff with enhanced training who co-ordinate, plan and review the treatment of people with a learning disability in an inpatient service
- A focus on short lengths of stay and supported discharge.

It is proposed that there should be a core team that consists of the following personnel:

Profession	Band	Number (wte)	Cost (£)

Nurse (team leader)	6	1	36,095
Nurse	5	3	105,285
OT	5	1	35,095
STR Worker	3	1	20,695
Total	**-**	**6**	**197,170**

Whilst the primary focus of this exercise is on those with a learning disability this service can also address the needs of a wider group of vulnerable adults who may be admitted to a mental health inpatient ward. One of their key roles will be to ensure that other colleagues are familiar with the issues that make people with a learning disability and other patients vulnerable and have some core skills that will help them address these issues.

Out of Hours Service/Intensive Intervention Team

The other fundamental issue that has lead to the need to admit, the failure of placements and the unchecked escalation of crises is the ability to respond rapidly 7 days a week, 24 hours a day. The LD Partnership currently does not have the capacity to respond out of hours and at weekends. These issues are handed over to duty services that are frequently ill equipped to respond effectively to crises when they develop.

A specialist LD service, as recommended by Professor Mansell (Mansell Report DH 2007 Rev. Ed.), needs to be able to respond effectively 24 hours a day, 7 days a week. It is a not inconsiderable cost to develop this kind of service and it is crucial to consider opportunities to integrate the task with other pre-existing services, of which the Mental Health Home Treatment team provides the greatest level of overlap and is a key part of the bed management and treatment functions of the inpatient service. The out of hours/intensive intervention function requires the following:

- Experienced and skilled professionals that are able to analyse complex situations and deliver interventions that will prevent admission, support providers/carers to manage crisis situations and ensure that service users can remain at home.
- An up to date understanding of the most complex and challenging patients in the community including known indicators of deterioration, planned responses for anticipated issues and previously effective interventions
- Robust relationships with inpatient teams
- An ability to work with support providers that recognises the limitations of these services and provides extra support to sustain support arrangements
- The ability to access detailed care plans and crisis plans that can direct suitable responses
- Clear daily relationships with the Challenging Behaviour Service and community mental health services, including the forensic service

This service should not be a caseload holding service but should be flexible enough to respond at short notice to crises for known service users, i.e. those engaged with the challenging behaviour service, as well as being the first responder to crises for those not previously known to the service or discharged from services.

Providing on-going maintenance interventions that are known to prevent or delay breakdown will be crucial for sustaining the riskier cases in the community, the necessary positive risk taking will require supervision and fine tuning at the early stages of any packages or following a change. All cases supported by the team should be care co-ordinated by either the Challenging Behaviour Service or community mental health services.

It is proposed that this out of hours intervention service would require the following personnel:

Profession	**Band**	**Number (wte)**	**Cost (£)**
Nurse (team leader)	7	1	53,000
Nurse	5	4	144,000
Total	**-**	**5**	**197,000**

At this stage, and in line with the Mansell Report (DH 2007, Rev Ed), it is suggested that integration with the existing mental health Home Treatment Service will provide a suitable infrastructure for the development of the service, allow for the development of robust team working, enhance shared care and bring the needs of learning disabled people into the mainstream. If an argument develops for a more substantial operation over time then separating into an independent team may be a more appropriate response but for the moment integration with an existing service provides significant efficiencies and an operating framework.

Challenging Behaviour Service

The most significant task is to ensure that the specialist LD Service is focused on those patients with the most challenging presentations. The discussions on the future of the specialist LD service are governed by the QIPP programme and the delivery of Transforming Community Services (TCS) agenda. These processes are currently unresolved and will require significant further consultation with key clinical stakeholders, commissioning partners, statutory bodies, providers and, crucially, service users and their families. The proposals below should be seen in the context of an on-going work programme but it should also be noted that they deliver the agenda set out in key policy and guidance documents. Any service model proposed will need to comply with the key tenets of these documents and be able to deliver the outcomes desired for this disadvantaged population.

The NHS has three key responsibilities towards people with learning disabilities:

- To annually check the health learning disabled people and plan for necessary interventions in a way that can be understood by the patient (Valuing People, DH 2001, Valuing People Now, DH 2009)
- To ensure mainstream health and mental health services are accessible to learning disabled people and can deliver equivalent health outcomes to the rest of the population (Healthcare for All, DH 2008)
- Provide detailed assessment, diagnosis and treatment services for people with challenging behaviours.

The final function is described in the Mansell Report (DH – 2007, Rev. Ed.) which places a particular emphasis on the need to ensure that people with challenging behaviours and complex needs are well known to the specialist service, have detailed plans that are regularly reviewed and updated, have plans for how to manage crises when they develop and the most important requirement is the ability to anticipate difficulties and intervene early to prevent crises from developing.

This service will consist of key professionals who will be required to deliver the following:

- Thorough assessments of needs that identify problem behaviours, the causes of these issues and the range of interventions that will mitigate them
- An effective range of treatment interventions that will, over time, deliver resolution to or mitigation of behaviours.
- The ability to respond directly to challenging behaviours and arrest or slow the onset of challenging presentations
- Develop, maintain and implement detailed plans for each person known to the service
- Work alongside mainstream care management teams and providers to ensure that networks and links are established to promote continuity of service provision
- Work closely with the out of hours service to ensure that all service users known to be a risk of breakdown are alerted to the out of hours service and have agreed crisis plans
- Work closely with inpatient services to ensure that they are supported to manage learning disabled people as inpatients and are able to effectively plan and implement effective discharges
- Work with all providers of support whether they are residential homes, domiciliary care providers, family and friends or other types of provider to ensure they understand the issues affecting an individual, understand their role in delivering effective interventions and are familiar with crisis plans.
- Provide individualised training to all stakeholders in meeting the needs of individual patients or groups of patients.
- Monitoring of specialist placements, especially those made out of area.

The LD Partnership can currently identify between 250 and 300 people that might be described as having challenging behaviours or complex needs. It is anticipated that there will be a working caseload of 150 people from this total figure for the team with the remaining patients as part of a “watching brief”. The team will be expected to have detailed knowledge of every patient accompanied by a plan that is accessible 24 hours a day and includes a functional crisis response.

Treatment is the primary responsibility of this service and the team will need to deliver a wide range of interventions from highly skilled professionals including psychologists, speech and language therapists, occupational therapists, nursing and medical staff. Treatment interventions will need to be supported by evidence of effectiveness and should tie into a pathway through the service that promotes independence and a move towards greater self directed care, personal control and a reduction on the reliance on paid support.

The vast majority of day to day support and contact for this group of people is delivered by commissioned service providers who will require significant support and development by the team so that they are able to support the delivery of the necessary interventions to individuals. This will be a key function of the Challenging Behaviour Service and all plans for treatment need to recognise the necessary development of skills and knowledge that will allow commissioned providers to implement appropriate support.

In order to ensure that support provision is good quality, effective and value for money the partnership with social care service provision and commissioning is crucial. The way resources are allocated to packages of care has an impact on both health and social care budgets and it is important that this is seen to be fair, appropriate, allocated according to policy and delivering good value. It is in the interest of the whole community that this happens and is a key plank in the delivery of personalised care for learning disabled people, especially those with profound and complex disabilities (Raising Our Sights, DH 2010)

The development of this service will require a substantial redesign of the existing functions of the LD Partnership and as such is a key deliverable of the QIPP for learning disabilities. This service will require a substantial focus on treatment and all assessments and plans will be focused on interventions that will deliver measurable outcomes and demonstrable improvements in both presentation and quality of life for all patients.

In order to support the process of developing this function it is proposed that extra capacity is brought in to the challenging behaviour service in order to start the process of identifying priority patients and commence the development of working relationships with the new teams identified above. The staff required will be:

Profession	Band	Number (wte)	Cost (£)
Behavioural Advisor	6	1	36,095

Behavioural Advisor	5	1	30,095
Total	**-**	**2**	**66,190**

Commissioning Intentions

The commissioning and funding of these three services will occur via the closure programme for Greenfields and the QIPP and TCS processes.

The development of the enhanced mental health service and the out of hours/intensive intervention service will be funded by some of the released revenue from the closure of Greenfields. The cost of these services will be less than the existing ward budget and will deliver a cost saving.

The redesign of the wider LD service is part of the QIPP programme and is required to deliver efficiencies of £1 million over three years. This will mean a radical redesign of services and will necessitate the refocusing down to a core patient group of those with the most challenging and complex needs.

Additional Services

As part of the whole system for learning disabilities it will be necessary to take advantages of the other services that exist to support learning disabled people. Often the opportunity to intervene creatively will prevent the escalation of crises and can divert service users into appropriate alternative types of support. These options are not always accessible at the moment and a greater emphasis on exploiting them will need to be part of the service development programme for specialist learning disability services.

Some examples of this might be:

- **Housing**

  A great many learning disabled people in Plymouth receive support in residential care settings. Evidence has shown that given an informed choice learning disabled people will choose to live in their own home and it is well recognised that many incidents and difficulties experienced by learning disabled people are caused by sharing accommodation with other vulnerable people and having restrictions placed on their freedom to make life choices by the strictures of residential care settings.

  Enabling the opportunities to have their own home will help many learning disabled people manage or overcome the many difficulties they experience and greatly promote their independence. (Valuing People Now, DH 2009; Raising Our Sights, DH 2010)

- **Links with liaison services**

Ensuring learning disabled people have access to high quality healthcare is a key performance target for the PCT that has been set by the Department of Health and NHS South West. Issues with ill health, unrecognised mental health problems, pain and discomfort have all been linked to challenging behaviours and the development of crises. (Healthcare for All, DH 2008)

- **Access to Forensic interventions and services**

  The specialist skills and knowledge of the mental health forensic service should be readily accessible to work with the LD service to ensure that those with the highest risk behaviours are suitably engaged and can access specialist interventions. The model of the current sex offender treatment programme (SHEALD) provides a template for other similar work with risk groups.

  Consideration will be given to developing LD expertise within the forensic service that will act as an advisor to the LD service, specialist case manager and link to MAPPA. (Bradley Report, DH 2009)

- **Links to criminal justice agencies**

  The police, courts, probation and other agencies have a crucial role in dealing with small but high risk group of service users and effective links with these agencies will ensure a appropriate responses towards learning disabled people in the criminal justice system as well as highlighting the most appropriate ways to help learning disabled victims of crime. (Bradley Report, DH 2009)

- **Specialist hospital providers**

  There are occasionally circumstances when admission to specialist hospital facilities is indicated and in the best interest of the service user. Whilst this might be unusual ensuring that hospital service providers are effective and work well with our services is crucial in delivering high quality outcomes. (Mansell Report, DH 2007, Rev Ed)

Summary

Following a successful consultation exercise it is recommended that the inpatient facility at Greenfields is closed and that the service for people is redesigned to deliver:

- An enhanced mental health service
- An out of hours/intensive intervention service
- An enhanced challenging behaviour service

This redesign will address key weaknesses in existing services, will help address crises, prevent admissions and promote the provision of services in the home and community.

The proposal will deliver an immediate cost saving from the inpatient budget that can be used to support the development of more effective and efficient services.

Number of New Posts (wte)	Total Proposed Spend (£)	Current Spend (£)	Predicted Saving (£)
13	**460,360**	**661,000**	**200,640**

NHS Plymouth

CORPORATE SUMMARY REPORT **Item 5.4**

Name of meeting:	NHS Plymouth Trust Board Meeting
Date of meeting:	24 June 2010
Name of report:	An update on the Greenfield's Consultation Process
Authors:	David McAuley
Approved by:	Steve Waite
Presented by:	Steve Waite

Purpose of the report:	
To update the Board on progress.	
Recommendations:	
That the Board note the progress to date, identify any further actions needed and request a final report at the conclusion of the process.	
Please tick appropriate PCT objective:	
X	In partnership, lead and continuously improve individuals' health and well-being, based on patient and public involvement and encourage personal responsibility.
X	Reduce key health inequalities in the city by working in partnership to deliver the Plymouth health strategy by 2012.
X	Deliver sustainable financial balance and spend NHS Plymouth's money wisely, demonstrating value for money through accurate reporting and benchmarking.
X	Continually provide efficient care, closer to people's homes through an ongoing programme of workforce development and innovation.
X	Increase patient choice by extending the range, accessibility and quality of our integrated health and social care services.
X	Ensure that services are safe, effective and in accordance with best practice through compliance with health and social care regulations.
Please tick as appropriate:	
X	This paper provides assurance for the above objectives.
	This paper presents a risk to achieving the above objective.
If Assurance, what is the nature? Please tick appropriate box:	
X	Progress Report
	Action Plan
	Minutes/notes of meeting
	Strategy
	Protocols/policy/procedure
	Guidance
	Other:

Appendix 1

Care Quality Commission Outcomes[1]:						
1, 4, 5, 7, 12, 13, 16.						
Summary of Financial and Legal Implications:						
None.						
Equality and Diversity and Public & Patient Involvement Implications						
If this paper is a proposal to establish a new service or to change an existing service, or if it is a strategy, policy or procedure, an equality impact assessment (EIA)[2]) must be undertaken. Please indicate whether an EIA has been completed relating to this paper.	yes	X	no		n/a	

[1] Reference only, not full text of Standard. The Standards can be found at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086665

[2] The purpose of an EIA is to make sure that the PCT's activities and services do not discriminate and that, where possible, they promote equal opportunities.

AN UPDATE ON THE GREENFIELD'S CONSULTATION PROCESS

1 Introduction

1.1 This paper will describe progress in regard to the temporary closure and consultation on the future of the Greenfields Learning Disability in-patient unit and advise the Board of next steps in the process.

2. Progress to date

2.1 The Mental Health Management Team were informed of the Board's decision to agree a three month consultation period on 29 March 2010. A meeting was arranged with the Greenfields staff advising them of the decision and that the unit would temporarily close, pending the outcome of the consultation process, for 30 March 2010.

2.2 Individual meetings between managers, Human Resource (HR) colleagues, Union Representatives and all those affected by the changes were scheduled for 15 April 2010 and 20 April 2010 and short term redeployment into funded posts was found and agreed with each individual.

2.3 The final service user was discharged from the Greenfield's unit on 21 April and the Unit temporarily closed on 23 April 2010. The following week was used as an opportunity to provide the necessary training and development for the staff in order to prepare them for their redeployed posts. This took place between 26 April and 30 April 2010.

2.4 In order to formally begin the Consultation Process, an option appraisal paper was developed with Learning Disability colleagues, an Equality Impact Assessment (EIA) completed and an easy read version of the consultation papers produced. A briefing was produced for the Provider Executive Team (PET) on 6 May 2010.

2.5 A full presentation was made on 19 May 2010 to the Learning Disability Partnership Board.

2.6 On 20 May, formal letters inviting Greenfield's staff, union officers, LiNKS, the Joint Trade Union Forum (JTUF) and local General Practitioners were sent advising them of the consultation events that had been arranged for 3 June 2010, (staff and employees open forum), 30 June 2010 (public forum) and 12 July 2010 (public forum). This complimented and was in addition to earlier internal e-mails.

2.7 On 19 May 2010 a further briefing took place with the Greenfield's staff to keep them up to date with developments. These have been scheduled at fortnightly intervals throughout the consultation period.

2.8 On 21 May 2010 an article was written and made available to the local media. This was subsequently published in the Plymouth Herald, advising the public that a consultation process had begun in regard to the future of the Greenfield's Unit and making them aware of the open fora available to them should they wish to participate.

2.9 Consultation meetings were scheduled with the Learning Disability Consultant Clinical Psychologist and Head of Feelings Team on 21 May 2010 and the Consultant Psychiatrists Group on 23 May 2010.

2.10 The matter was tabled and discussed at the Joint Committee for Consultation and Negotiation (JCCN) on 26 May 2010.

2.11 Articles appeared in Trust Talk on 23 May and 3 June advising staff and others of the process. This was complimented by the same information being published on "Facebook" on 3 June 2010.

2.12 Further consultation took place with the Highbury Trust on 28 May 2010

2.13 The full open forum for staff employed by NHS Plymouth and Plymouth City Council took place on 3 June 2010. This was attended by 21 individuals. Feedback was collated.

2.14 Further letters were sent to all local independent sector providers inviting them to the public events. Easy read invitation letters were sent to former service users. These were sent on 3 June 2010.

2.15 It was decided that in order to maximise feedback from service users, carers and other stakeholders, external facilitators would be sought. After further consultation and advice from Learning Disability service users and clinicians, the Playback Theatre Company were approached and asked if they would be willing and able to facilitate the open public fora on 30 June and 12 July 2010. A full scoping meeting detailing and outlining the methodology and structure for the events was agreed on 3 June.

2.16 The Health and Adult Social Care Overview and Scrutiny Committee were approached and the Greenfield's Consultation Process was included on the Agenda for 9 June 2010. A full briefing was produced for this meeting. David McAuley and Steve Waite attended the meeting on behalf of NHS Plymouth to answer questions and queries Councillors had. This was followed up by an interview with David McAuley on the consultation process by Radio Plymouth.

3. Next Steps

3.1 The next step is to formally consult with the general public, service users and carers as well as local General Practitioners and other key

stakeholders at the events arranged for 30 June 2010 and 12 July 2010 at the Novotel Hotel in Plymouth.

3.2 Once these events have been concluded a full report, with a proposed preferred service model will be presented to Commissioners for discussion and agreement on the future provision of the service including the delivery model and contract value. It is envisaged that this will be concluded by 31 July 2010.

3.3 A recommendation will then be made to PEC and Board for approval to implement a permanent re-configuration of the service.

Health & Adult Social Care Overview & Scrutiny Panel

10 November 2010

Disabled Facilities Grants – progress report

1. Introduction:

1.1 A report on adaptations was last considered by Health & Adult Social Care Overview & Scrutiny Panel at its meeting on 27 January 2010. This report provides an update on the situation concerning Disabled Facilities Grants.

2. Disabled Facilities Grants

2.1 Since 1990, local housing authorities have been under a statutory duty to provide grant aid (DFG's) to disabled people for a range of adaptations to their homes, generally building works or modifying a dwelling but might also include relocation if this best meets the need. The maximum DFG available per application for eligible works is £30,000. DFG's are primarily received by private sector owner occupiers and tenants but housing association tenants are also eligible to apply.

2.2 Historically, the funding available for DFG work has been insufficient to meet the need and there has been a growing waiting list. This has been exacerbated by growing demand as a result of demographic changes, particularly associated with an ageing population.

3. The Current Situation

3.1 Table 1 below shows the latest 2010/11 budget, spend and commitment figures (as at 29 October 2010) for the DFG major adaptations programme.

Table 1: 2010/11 DFG budget, spend and commitment:

1	Total Available Budget	£1,498,000
2	Total Spend	£ 801,766
3	Registered Social Landlord spend	£xxxxxxxxx
4	Total commitment	£1,232,831
5	Amount still to commit	£ 265,169

N.B. The Registered Social Landlord spend relates to DFG applications submitted by Housing Association tenants

3.2 Table 2 below shows some key performance indicators (as at 29 October 2010).

Table 2. DFG Key Performance Indicators 2010/11.

1	Grants approved	179
2	Grants completed	113
3	Average Timescale - Critical	13 weeks
4	Average Timescale – Substantial	42 weeks
5	Average Timescale - All	28 weeks
6	Waiting list nos.	
	- DFG waiting list	39
	- Occupational Therapist / Community Care Worker assessment list	389 (of which an estimated 150 might require a DFG)
7	DFG Waiting list – Critical cases	0

3.3 The annual target for DFG completions is 175. 113 had been completed as at 29 October 2010 and it is anticipated that the target will be reached by the end of the year.

3.4 The average timescale (28 weeks) relates to the average length of time from referral to approval for all DFG's as at the end of Quarter 2. The annual target from referral to approval is 30 weeks. The average wait for a major adaptation from referral to DFG approval was 33.75 weeks in 2009/10, 34.4 weeks in 2008/09 and 34.6 weeks in 2007/08. Within the resources available, the aim is to address critical cases as soon as possible. There are currently no critical cases on the DFG waiting list. Whilst the end of quarter 2 average of 28 weeks is better than the target for the year (30 weeks), due to the scale of the waiting list it has not proved possible to address all substantial cases within the target timeframe.

4. Future Outlook

4.1 Every effort has been taken to maximize the funds available for DFG's during 2010/11. The DFG allocation from Government was £778,000 to which Private Sector Renewal Grant (PSR) has been added to bring this up to the total of £1,498,000. Use of PSR reduces the funding available for private sector housing improvements but is in recognition of the DFG need in Plymouth. The DFG allocation from Government is well below our 'calculated need' (this is as calculated by Government and across the SW region, Plymouth has received the lowest allocation as a % of calculated need over the last 5 years). This matter has been raised on many occasions with Government Office for the South West and we received the largest % increase for 2010/11, albeit still only 82% of our calculated need and still the equal lowest in the region.

4.2 As part of the 20 October Comprehensive Spending Review, the Coalition Government announced that DFG funding will increase with inflation. Assuming no further allowance for Plymouth's calculated need, this might result in an allocation of approx. £800,000 for 2011/12. However, it is understood that this funding will be 'un-ringfenced' and form part of the Council's Area Based Grant and as such might be open to local decision making and could therefore increase or decrease.

4.3 To date, there is no news about the PSR allocation but given the scale of cuts affecting the Communities and Local Government department, it is possible that the Council's PSR allocation will be considerably reduced. Again, this will be un-ringfenced and form part of the Area Based Grant. As such, there can be no certainty of the amount, if any, of PSR funding that can be used to top-up the DFG programme in 2011/12.

4.4 Enquiries to Adult Social Care (to assess fair access to care eligibility and carry out an occupational therapist / community care worker assessment) progressively increased in June, July and August (257, 272 and 282 respectively). It is currently projected that over 190 cases will come forward for a DFG during 2011/12 (16 per month). At current average costs (£7,000) then a minimum projected budget of £1,330,000 will be required in 2011/12 to keep up with fresh demand plus an estimated £200,000 from the current year, totalling £1.5m. The impact of any sizeable reduction in funding for DFG's in 2011/12, as compared with close to £1.5m in 2010/11, will be that there is less money to meet need resulting in a growing waiting list with fewer people supported to live independently in their own homes and consequent increases in care costs.

4.5 An initial 'Invest to Save' proposal has been considered by the Capital Programmes Board and may require re-visiting if the growing need for adaptations is to be managed. Work is also underway, as part of a Devon-wide RIEP funded project, to engage with Registered Social Landlords with a view to achieving greater consistency of delivery and to secure more funding support for adaptations for their tenants.

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Agenda Item 10

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
NHS Plymouth Primary Care Trust Services											
Specialised Commissioning – Proposed Service Changes - Gynaecological Cancer Surgery					**13**						
Gynaecological Cancer Surgery Service Change Timetable and Consultation								**12**			
Substantive Variation Protocols	**9**										
GP-Led Health Centre – 12 month Update	**9**										
NHS Plymouth - Quality Improvement Productivity and Prevention					**13**			**12**			
NHS Plymouth – Transforming Community Services					**13**	**10**					
NHS Plymouth – Mental Health Commission Annual Report 2010						**10**					
Greenfields Unit Consultation Results						**10**					
Plymouth NHS Hospitals Trust											
Plymouth Hospitals NHS Trust – Infection Control Update										**2**	
Plymouth City Council – Adult Social Care											
Carers Strategy		**20**				**10**					
Modernisation of older peoples services		**20**									
Fairer charging policy		**20**									
Short breaks for those with learning disabilities		**20**									
Monitoring Adaptations Budget and Performance						**10**					

Topics	J	J	A	S	O	N	D	J	F	M	A
All Our Futures								12			
Adult Social Care delivery plans and performance monitoring report.				1				12			
Monitoring Implementation of the National Dual Diagnosis Strategy											
Dementia Strategy						10					
Tobacco Control Strategy											
Plymouth Local Involvement Network (LINks)											
LINk update and performance monitoring								12			
Consultations											
Consultation response to White Paper – "Liberating the NHS"				16							
Task and Finish Groups											
Modernisation of Adult Social Care			24		4						
Performance Monitoring											
NHS Plymouth, Plymouth Hospitals Trust and PCC Joint Finance and Performance Monitoring, including LAA Performance Monitoring.				1							
Monitoring Implementation of the National Dual Diagnosis Strategy											

Key:

= New addition to Work Programme