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COUNCIL OF THE YEAR

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Date: 1 November 2011

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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

Date: Wednesday 9 November 2011
Time: 10 am
Venue: Warspite Room, Council House

Members:
Councillor Mrs Bowyer, Chair
Councillor McDonald, Vice Chair
Councillors Mrs Aspinall, Mrs Bragg, Browne, Casey, Drean, Gordon, Dr. Mahony, Mrs Nicholson, Dr. Salter and Tuffin.

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.

Please note that unless the chair of the meeting agrees, mobile phones should be switched off and speech, video and photographic equipment should not be used in meetings.

Barry Keel
Chief Executive

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

AGENDA

PART I – PUBLIC MEETING

1. APOLOGIES

To receive apologies for non-attendance by panel members.

2. DECLARATIONS OF INTEREST

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

3. 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 - 6)

The panel will be asked to confirm the minutes of the meeting of 14 September 2011.

5. TRACKING RESOLUTIONS AND FEEDBACK FROM THE OVERVIEW AND SCRUTINY MANAGEMENT BOARD (Pages 7 - 16)

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

6. SOFT TISSUE SARCOMA - NHS PLYMOUTH (Pages 17 - 24)

The panel will receive a service improvement proposal with regard to soft tissue sarcoma services.

7. DEMENTIA STRATEGY UPDATE - NHS PLYMOUTH / PLYMOUTH CITY COUNCIL (Pages 25 - 36)

To receive an update on the Dementia Strategy and action plan with reference to the following panel recommendations made on the 30 March 2011 –

Agreed that-

(1) the membership of the partnership board should be reviewed;

(2) service user feedback is provided by PIPs and the LINks to the partnership board to review the development of the strategy.

8. OLDER PEOPLES MENTAL HEALTH - PLYMOUTH COMMUNITY HEALTHCARE (Pages 37 - 52)

To receive a report from Plymouth Community Healthcare on changes to older people's mental health services.

9. PARKING PROPOSALS - PLYMOUTH NHS HOSPITALS TRUST (Pages 53 - 56)

The panel will receive a report on proposed changes to parking provision at Derriford Hospital.

10. BIANNUAL REPORT (Pages 57 - 62)

The panel will consider its biannual report to the Overview and Scrutiny Management Board.

11. WORK PROGRAMME (Pages 63 - 76)

The panel will consider adding items to its work programme.

Briefing reports on the 111 non-emergency number and proposed changes to stroke care are attached to this agenda item for consideration for addition to the work programme.

12. EXEMPT BUSINESS

To consider passing a resolution under Section 100A (4) of the Local Government Act 1972 to exclude the press and public from the meeting for the following item(s) of business on the grounds that it (they) involve(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 MEETING)

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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Health and Adult Social Care Overview and Scrutiny Panel

Wednesday 14 September 2011

PRESENT:

Councillor Mrs Bowyer, in the Chair.
Councillor McDonald, Vice Chair.
Councillors Mrs Aspinall, Mrs Bragg, Browne, Casey, Drean, Gordon, Dr. Mahony, Mrs Nicholson, Dr. Salter and Tuffin.

Co-opted Representatives: Chris Boote and Margaret Schwarz

Also in attendance: Nikki Thomas (Nurse Director, Peninsula Cancer Network (PCN)), Fiona Phelps, (Assistant Director of Commissioning, NHS Plymouth), Lucy Beckwith, (Contracts Manager, NHS Plymouth), Pam Marsden (Assistant Director for Adult Health and Social Care, Plymouth City Council (PCC)), Jo Yelland (Programme Lead for Putting People First and Integration PCC), Councillor Grant Monahan (Cabinet Member for Adult Health and Social Care PCC) Russell Moody, (Stop Smoking Service Manager, Department for Public Health) Vicky Shipway, (Host Manager Plymouth LINk), Giles Perritt (Lead Officer, PCC), Ross Jago (Democratic Support Officer, PCC).

The meeting started at 10.00 am and finished at 12.40 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.

25. DECLARATIONS OF INTEREST

Name	Minute No. and Subject	Reason	Interest
Councillor Mrs Bowyer	35. Work Programme Safeguarding vulnerable adults.	Care home manager.	Personal
Councillor Dr Mahony	33. Health and wellbeing boards – Status Update	General Practitioner.	Personal

26. CHAIR'S URGENT BUSINESS

There were no items of Chair's urgent business.

27. **MINUTES**

Agreed that the minutes of the meeting held on the 20 July 2011 were approved as a correct record.

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

Agreed that the panel's tracking resolutions were noted.

29. **GYNAECOLOGICAL CANCER SURGERY**

Nikki Thomas of the Peninsula Cancer Network (PCN) introduced a report on the shaping of patient and public involvement in cancer services. In response to questions from members of the panel it was reported that -

(a) the petitioners who had presented their petition to the panel had been contacted and a representative identified. They would be working closely with the PCN on the engagement of patients with regard to gynaecological cancer surgery;

(b) the approach to building engagement with patients, carers and key stakeholders would involve a prioritisation process, gynaecological cancer surgery would be within that process but it was not appropriate to assume the newly formed working group would choose it as a high priority;

(c) there would be further news on proposed service reconfigurations over the coming weeks;

(d) although a great deal of consultation had been taking place via the internet there were also telephone support lines, support groups and leaflets available.

Members of the panel expressed their disappointment at the apparent lack of process in addressing the concerns of Plymouth patients.

Agreed that -

1. a position paper outlining the approach of the working group after their first meeting would be presented to a future meeting of the panel;

2. information regarding the decision making process and proposals regarding the reconfiguration of Gynaecological Cancer Services would be made available to the panel as soon as possible.

30. **WINTER PRESSURE AND REABLEMENT FUND UPDATE**

The Assistant Director for Adult Social Care introduced a report on the winter pressure and reablement fund. The report set out arrangements for investment into social care services for 2010/11 and set out further investment plans over 2011/12 – 12/13.

It was reported that joint working had been productive and successful. The funding was in addition to current social care spend and had allowed for investment in small changes in provision which would result in long term benefit.

As a result of the winter pressures funding, Managed Care Appropriateness (MCAP) software had been purchased and was currently on trial. It was anticipated that the software would highlight the ways in which care quality and pathways could be improved, which could lead to more efficient service structures and save clinical costs.

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

(a) the funding was not intended for major adaptations such as ramps and extensions. The service were intending to use some of the funding to pump prime sustainable projects such as time banks where people link locally to share their time and skills. There could be some discrete funding available for the smaller adaptations or an equipment bank;

(b) direct discharge to residential care had been increasing over the last 18 months. The Local Authority was seeking alternatives to discharge to residential care with NHS Plymouth and NHS Plymouth Hospitals Trust. Discharge to residential care often reduced the confidence of patients and could present difficulties in reablement.

31. **A DRAFT TOBACCO ACTION PLAN FOR PLYMOUTH**

The Cabinet Member for Adult Health and Social Care introduced Russell Moody, Stop Smoking Service Manager, who presented the action plan for comment. In response to questions from members of the panel it was reported that –

(a) the Plymouth Smoke-free Team would drive the action plan and would include key stakeholders;

(b) smoking prevention, with a particular focus on children, was a high priority. The baseline data for the prevalence of smoking amongst 15 years olds was very high and it was likely this was not a true reflection of the situation in Plymouth. The smoke free team would be working with Routeways to improve the types of questions used to gather the data from young people;

(c) when Public Health migrate into the local authority there would be increased opportunities to become involved in the wider determinants of health which would help the smoke free team to become more holistic in their approach;

(d) the action plan is focused on social marketing, understanding the causes of smoking, health and lifestyle issues which would link to issues such as obesity and alcohol misuse.

Comments from members of the panel included–

(e) the Smoke-free Team should include ethnic minority groups, Her Majesty's Revenues and Customs and Trading Standards;

(f) accepting that the document was an early draft for consultation it required further proof reading and translation into plain English so that it was accessible to a range of people;

(g) the smoke free team should recommend that health visitors and midwives be allotted sufficient time to be able to speak to people regarding smoking cessation.

32. HEALTHWATCH PATHFINDER - STATUS UPDATE

Vicky Shipway, Local Involvement Network (LINk) host manager provided an update to the panel on the recent work of the LINk and development of Healthwatch. It was reported that -

(a) membership of the LINk had grown to around 2,500 members;

(b) the LINk were developing a number of work streams including a project with gypsies and travellers, the LINk manager was in contact with the Democratic Support Officer for the panel to ascertain whether a joint approach to this piece of work was appropriate;

(c) the LINk had recently provided recommendations to Derriford Hospital around access and discharge from hospital;

(d) the LINk had also undertaken an access to primary care survey and reported its results to NHS Plymouth;

(e) LINk would, over the next 18 months, develop into Healthwatch. In addition to the functions currently carried out by the LINk a number of other functions would be part of Local Healthwatch. Functions would include representing the views of patients on the Health and Wellbeing Board and providing access to independent complaints and advocacy services;

(f) it was anticipated that Local Healthwatch would be in place by October 2012 and new arrangements for advocacy would take effect from March 2013.

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

(g) the LINk worked hard to be representative and input to as many meetings and consultations as possible, the stewardship group made the decisions on where the limited resources would be applied;

(h) the LINk had no regular contact with individual general practices in the city; however they had excellent working relationships with General Practitioners via the Sentinel Clinical Commissioning Executive and the NHS Plymouth Primary Care Team.

Some panel members expressed disappointment at the lack of success of LINk both at a local and national level.

Agreed that the panel would take part in the tendering process and make recommendations to the Cabinet with regard to Local Healthwatch.

33. **HEALTH AND WELLBEING BOARDS - STATUS UPDATE**

The panel's lead officer introduced a paper on the development of a Health and Wellbeing Board for Plymouth. It was reported that -

(a) there was no requirement for early implementers to have a formally constituted Shadow Health and Wellbeing Board in place;

(b) Plymouth would be taking a different approach to many of the early implementers across the country and would have Health and Wellbeing Development Group. It was anticipated that this approach would allow lessons to be learned from those who had set up Shadow Boards and encountered difficulties;

(c) a development group had been formed and would meet initially in November 2011. The group would include the statutory membership outlined in the most recent version of the Health and Social Care Bill and would also include members of scrutiny.

Members of the panel noted the report and commented that whilst it was appropriate that scrutiny is active on the development group there were concerns raised as to the appropriateness of members of scrutiny having seats on future Health and Wellbeing Board.

Agreed that the panel would have a number of provisional meeting dates added to the calendar over the next 18 months to allow for scrutiny of Healthwatch and Health and Wellbeing Board development.

34. **ANNUAL OVERVIEW AND SCRUTINY REPORT**

Agreed that the Annual Overview and Scrutiny report was noted but required the addition of the co-opted members of the panel.

35. **PROJECT INITIATION DOCUMENT**

Agreed that the project initiation document, regarding the safeguarding of vulnerable adults, be commended to the Overview and Scrutiny Management Board for approval subject to the following amendments -

1. That the methodology should include evidence gathering by councillors through ward work;

2. That the following are added to the document as objectives –

a. To review and assess the adequacy of policies regarding whistle blowing;

b. To review and assess the adequacy of polices regarding unannounced visits to care settings.

Councillor Mrs Bowyer declared a personal interest and withdrew from debate on this item.

36. **WORK PROGRAMME**

Agreed that the panel's work programme was noted.

37. **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
14/09/11 (1)	a position paper outlining the approach of the working group after their first meeting would be presented to a future meeting of the panel;	This is in reference to the engagement working group (for cancer services) who met following the September meeting of the Panel.		A position statement is attached as an appendix.	9 November 2011
14/09/11 (2(	information regarding the decision making process and proposals regarding the reconfiguration of Gynaecological Cancer Services would be made available to the panel as soon as possible.	A position statement is attached as an appendix. All panel members were invited to a briefing to discuss the proposals with the Director of the Peninsula Cancer Network on the 27 September 2011.		Complete	27 September 2011
14/09/11 32	Agreed that the panel would take part in the tendering process and make recommendations to the Cabinet with regard to Local Healthwatch.			The democratic support officer will be in contact with the commissioner of the future service and will report back to the panel.	25 January 2012

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
14/09/11 33	Agreed that the panel would have a number of provisional meeting dates added to the calendar over the next 18 months to allow for scrutiny of Healthwatch and Health and Wellbeing Board development.				9 November 2011

Grey = Completed (once completed resolutions have been noted by the panel they will be removed from this document)
Red = Urgent – item not considered at last meeting or requires an urgent response

Peninsula Cancer Network NHS
Devon and Cornwall

Closer working between gynaecological cancer staff at Plymouth and Truro

Briefing – September 2011

1 Improving cancer services

At its meeting in September 2010, the Peninsula Cancer Network (PCN), which works on behalf of the NHS across Devon, Cornwall and the Isles of Scilly, revised its approach to improving cancer services.

This means that, as a matter of good practice, process is now aligned with the four 'key tests' issued by the Department of Health in July 2010. These tests are designed to demonstrate:

1. Support from GP commissioners
2. Strengthened public and patient engagement
3. Clarity on the clinical evidence base, *and*
4. Consistency with current and prospective patient choice

The emphasis of the PCN's revised process is on making the greatest improvements possible along the entire patient 'pathway', from diagnosis, through treatment to aftercare.

It has also been developed to reflect the report of the Independent Reconfiguration Panel, published in July 2010. In particular, this called for the PCN to “review how the experiences of patients will be captured and used to design and deliver better cancer services”.

Considerable effort has since been invested in developing a robust framework for patient and carer involvement, as outlined in a paper to Overview and Scrutiny Committees (OSCs) this summer. The main results have been a document called 'User Involvement Principles and Strategic Framework' and, following a series of involvement events, the creation of a Patient and Carer Working Group.

This group, bringing together members from each of the five established local patient groups in the Peninsula, became fully established in July 2011.

The PCN is now in a position to put the revised process into practice for gynaecological cancer services.

2 Gynaecological cancer services - background

Cancer networks across the NHS are expected to ensure the quality of local services by complying with national Improving Outcomes Guidance.

Under the IOG for gynaecological cancer (1999), the Royal Devon & Exeter Hospital was designated in 2004 as the sole Specialist Gynaecological Cancer Centre within Devon and Cornwall. Royal Cornwall Hospitals (Truro) and Plymouth Hospitals are both Local Gynaecological Cancer Units, with non-surgical treatment of patients with gynaecological cancers being provided

in all five acute trusts, including South Devon Healthcare (Torbay) and Northern Devon Healthcare (Barnstaple).

Ultimately, interpretation of compliance with the IOG lies in the hands of the National Cancer Action Team (NCAT).

NCAT agreed in 2007 that, while the IOG suggested the population of the Peninsula would support only one gynaecological cancer centre, its geography meant a second centre – in addition to Exeter – would be acceptable. An alternative proposal from RCHT, PHT and the PCN, involving the continuation of surgery at both Truro and Plymouth, was rejected.

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

This had two distinct components:

1. To review the Plymouth and Truro units with a view to providing a clinical assessment as to which hospital would be the preferred site for a second gynaecological cancer centre.
2. As the service in Exeter was already operating as a designated centre for this service and this status was not in question, to provide assurance that the patient pathways ensured that all complex gynaecological cancer cases, including ovarian, were appropriately referred into the centre.

The reviewers' report, published in December 2009, concluded that:

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

A series of meetings were arranged with existing gynaecological cancer patients in the Derriford catchment area, so the review and its implications could be discussed.

The clinical review was also discussed with OSCs in early 2010, with Plymouth adopting the following resolution:

> “Members welcomed the principle of developing centres of excellence but recognised that patients had other outcomes to consider such as emotional and financial wellbeing. Given that Plymouth was a city with pockets of deprivation, the panel sought assurances that the needs of patients having to travel would be met and supported, along with those of their families.
>
> “Recommended that the findings of the independent clinical review could not be supported because the report fails to provide the assurances the panel would need in respect of -
>
> 1. evidence to demonstrate that a second centre at Truro would make a significant difference to clinical outcomes for patients from Plymouth;
> 2. addressing the issue of individual choice for women over where their surgery should take place.”

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

Further engagement was then put on hold pending publication of the Independent Reconfiguration Panel report and details of the Department of Health's four key tests, which led in turn to the PCN's revised process and development of the Patient and Carer Working Group.

3 Gynaecological cancer services - current position

The NHS Operating Framework for 2011/12 recommends that cancer networks continue working to ensure full implementation of IOGs. In the Peninsula, gynaecological cancer has yet to comply with the guidance.

At present, staff at both Royal Cornwall Hospitals NHS Trust (RCHT) and Plymouth Hospitals NHS Trust (PHT) continue work as separate specialist Multi-disciplinary Teams (MDTs). The national quality-assurance programme known as peer review highlighted early in 2011 that this way of working did not meet its criteria and needed to be addressed.

In summer 2011, RCHT, PHT and the PCN therefore agreed that their own staff should work more closely together. Technically, this means the creation of a single specialist MDT for gynaecological oncology, spanning the two trusts.

As a result, patients will be able to have their treatment planned by a fuller range of specialists, who share their expertise but otherwise continue to work as now at their own hospitals. Final decisions on treatment will be taken by the women and their own consultants, as now.

Clinical leadership will be provided by Mr Tito Lopes, Consultant Gynaecological Oncologist at RCHT.

In June 2011, NCAT also said that a single MDT working across two sites might be acceptable for gynaecological cancers. Mike Richards, National Clinical Director for Cancer, said in a letter to Nigel Acheson, PCN Medical Director:

> “Taking into account the geography and location of services in the Peninsula you asked if NCAT would find it acceptable to receive a plan from the Cancer Network which included a single specialist MDT operating between Truro and Plymouth with surgical services being provided on both sites.
>
> “The geography in the Peninsula certainly justifies special consideration and in respect of gynaecology specifically we felt that it could be possible to secure the services necessary to deliver IOG compliance in this way with some careful planning.”

The letter also recommended that the PCN consider quality-assurance arrangements covering gynaecological cancer surgery in Bristol/Bath, where a similar solution has been agreed.

In parallel, and in line with the key tests and the revised PCN approach, the PCN Medical Director has concluded that evidence is very limited on whether centralisation for gynaecological cancer surgery would improve outcomes further for patients, given the improvements that have been made at RCHT and PHT since IOG publication in 1999. The Bristol/Bath case highlights the lack of consensus among clinicians on the validity of the evidence as the basis for centralisation.

The independent clinical review of 2009 did not differentiate between RCHT and PHT in respect of the evidence of improved clinical outcomes, stating: “Both units reported outcomes as good as, if not better than, available national data. As discussed in the introduction, these data are crude and not adjusted and subject to selection bias (in surgical terms). However, the visitors could not determine any obvious or major differences in outcome performance and are confident that whichever unit were to be accorded centre status would be able to produce continued improvements in long-term survival that would be at least equivalent to currently available outcomes from elsewhere.”

4 Gynaecological cancer services – the future

The future for gynaecological cancer services can be divided into two:

1. Creation of the single MDT, with closer working between staff at the two hospitals, as an essential precursor to...
2. Development of proposals to improve patient experience and outcomes along the entire pathway. While this is designed to include plans for IOG compliance in the West that are acceptable to NCAT, it will also help provide equity with the East, and enable experiences and good practice to be shared.

The first element is largely technical, involving issues such as the alignment of work plans at the two trusts, so MDT members can 'meet' each other via teleconference on a weekly basis to discuss the management of individual patients. This is essential to ensure that patients' care is planned with the benefit of consideration from the combined experience and skills of the single MDT. It also meets the requirements of peer review, but has no wider implications for patients in terms of travel, for example.

The second element is where there are real opportunities to improve services along the entire pathway, from the point at which the patient first becomes involved with the NHS, through treatment such as chemotherapy, radiotherapy and surgery, to follow-up appointments and aftercare.

Although the pathways in the East of the Peninsula, focused on Exeter, are fully compliant with IOG, this is nevertheless an opportunity to consider the patient experience and share good practice, putting East and West on an equal footing.

Clinicians will work therefore with GP commissioners, recent patients, carers and other stakeholders to:

- Understand the good and less-good aspects of current services
- Understand current and future demand for services
- Understand what improvements could and should be made
- Understand how these improvements could be put into practice
- Understand how improvements and attendant changes would fit within commissioning and provider trust strategies
- Develop proposals for the West that will be acceptable to NCAT

Patients and carers will be drawn from those with recent experience of gynaecological cancer. The way in which they are involved will be in line with the views of the PCN's Patient and Carer Working Group.

OSCs, GP commissioners and other stakeholders will also be asked how they would like to be involved in, or updated on, the process.

The overall aim is to arrive at plans for improving gynaeological cancer services that have been developed openly and by consensus, that will secure agreement from NCAT as being in line with IOG, and that will bring real improvements along the full patient pathways across the Peninsula.

As indicated by NCAT, in the West this should enable gynaecological cancer surgery to continue at both sites, as long as suitable safeguards are built in.

This development process may take time, especially as it is the first occasion on which the PCN's new process for service improvement has been put into practice.

Nevertheless, the intention is to secure NCAT approval for the West by summer 2012.

Peninsula Cancer Network NHS
Devon and Cornwall

Brief report of a meeting of the Network Patient and Carer Working Group

Tuesday 20th September 2011

Introduction

The Peninsula Cancer Network is working in partnership with patients, carers, the public and key stakeholders to design the right approach to engagement, and ensure that all voices are heard. Following a number of engagement events, the Network Patient and Carer Working Group (PCWG) held its first meeting on the 7th June 2011.

This report summarises the discussion, agreed actions and recommendations of the latest PCWG meeting held on 20th September 2011.

WORK PLAN PRIORITIES

There are some clear priorities in terms of developing the work programme for the PCWG. Actions agreed from the meeting are to:

Develop two pilots to explore use of methods and networks identified

- **Early diagnosis and breast screening –** using the information obtained from sources identified, plan how local involvement work should be undertaken
- **Improving the quality of care in gynaecology services –** a Network wide project to evaluate access and quality of care from a patient and carer perspective utilising successful methods for engagement.

Identify issues for future activities using information and feedback

- **Summary report from the National Cancer Survey –** the Group to look at the summary to identify issues for future work

Next Meeting: 22nd November 2011

A full report of the meeting will be available on the network website from 7th November 2011 @ www.peninsulacancernetwork.org.uk

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Appendix 3

Suggested dates for extraordinary panel meetings to consider Health and Wellbeing Board and Healthwatch Development.

These dates are provisional and will be activated only if the above items need to be considered outside of the agreed business meeting cycle.

7	December	2011
22	February	2012
4	April	2012

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NHS South West Specialised Commissioning Group

NHS Plymouth

Service Development for Soft Tissue Sarcoma Services for Adults
Stage 2 OSC Briefing: For Information

PCT Sponsoring Director/s:	Ann James, PCT Cluster CEO Rebecca Harriott, PCT Cluster Director of Commissioning Neil Kemsley, PCT Cluster Director of Finance
Specialised Commissioning Team:	Ann Jarvis, Director of Specialised Commissioning (South West) Barbara Gregory, Director of Finance & Performance Rod Walsh, Senior Commissioner for Soft Tissue Sarcoma

1 Purpose of the Report

1.1 To update Plymouth Health and Adults Overview and Scrutiny Committee on the outcome of the designation of soft tissue sarcoma services within the Peninsula. This briefing confirms the agreed arrangements for the Peninsula, which have the support of the National Cancer Action Team and the Peninsula Cancer Network as well as local hospital clinicians, GP Consortia and PCT commissioners.

2 Background

2.1 You may recall that the region's Overview and Scrutiny Committees supported the Specialised Commissioning Group's proposal to commence work to designate two specialised centres for Soft Tissue Sarcoma services for adults (one in the North of the South West, and one in the South) in August 2009.

2.2 Sarcomas are a rare and diverse group of cancers. Soft tissue sarcomas account for about 1% of all malignant tumours, and can occur anywhere in the soft tissues of the body (please see incidence figures overleaf). Signs and symptoms can vary greatly depending on the site of the tumour, as do treatment options and prognoses. Consequently, it is difficult for General Practitioners (GPs) to make a diagnosis and referral of soft tissue sarcoma as the disease presents in a number of different ways and is often initially thought to be another of a number of more common conditions. The rarity of soft tissue sarcoma also means that most GPs will not suspect it from an initial clinical examination – they may only see one or two patients with soft tissue sarcomas in their entire working life. Hence, many sarcomas are discovered following a hospital biopsy or during investigative general surgery, when effective surgery for sarcoma involves a more specific approach. The patient is only then referred on to a specialist centre, if indicated, for specialist surgery.

Incidence of Sarcoma (ICD-10 C48 or C49) 2007-09
Adults (18 years or older at diagnosis)

Area	PCTs	Cancer Network	Adult Population (2008)	Incidence (2007-09)
West of England	South Gloucestershire Bristol Teaching North Somerset Bath and North East Somerset Somerset Wiltshire (excl South Wiltshire)	Avon Somerset and Wiltshire	1,530,265	399
Peninsula	Cornwall and Isles of Scilly Plymouth Teaching Torbay Devon	Peninsula	1,340,641	344
Dorset	Dorset Bournemouth & Poole	Dorset	573,060	147
Swindon	Swindon	Thames Valley (part)	91,723	42
Gloucestershire	Gloucestershire	3 Counties (part)	462,411	116
Total for South West SHA (excluding Southern Wiltshire)			3,998,100	1,048
Total for South West Specialised Commissioning Group adult soft tissue sarcoma service planning (excludes Gloucestershire, Swindon, Dorset and Bournemouth & Poole and the South of Wiltshire (Salisbury))			2,870,907	743

2.3 Although the above table shows the number of people aged 18 and over that were diagnosed with a sarcoma in the three years between 2007-2009 to reflect national definitions of an 'adult', the Improving Outcomes Guidance that relates to this Soft Tissue Sarcoma service states that the service should be tailored to 24+ year olds. This is because teenagers and young adults (TYA) aged 16 to 24 years with sarcoma will be able to access a specialised service at various hospitals across the region that has recently been established specifically for TYA patients. Children up to (and including)

15 years old will receive the specialised aspects of their care from paediatric services (at the Bristol Royal Hospital for Children).

2.4 Both adult and paediatric cancer services will have a TYA service element to them to cater for young people. Long term patients would have had discussions as early as possible to prepare them for the transition into adult services and will be given the choice on their 19th birthday about whether they would like to transition to the adult service or remain a TYA patient.

2.5 When the designation process began adult patients from the Peninsula Cancer Network area (Cornwall and the Isles of Scilly, Plymouth, Torbay and Devon) were usually treated by Royal Devon & Exeter NHS Foundation Trust or Plymouth Hospitals NHS Trust. Patients from the Avon, Somerset & Wiltshire Cancer Network area (South Gloucestershire, Bristol, North Somerset, Bath and North East Somerset, Somerset and Wiltshire) were receiving their treatment from a combined service at North Bristol NHS Trust and University Hospitals Bristol NHS Foundation Trust. There was some informal communication and sharing of clinical ideas across the South West and with clinical teams in other areas, but no formal agreement or protocol for working together.

2.6 Designation of Sarcoma services was initially undertaken with the anticipation of designating one surgical centre within the Peninsula. This was based upon an agreement on responding to the requirements of the Improving Outcomes Guidance (IOG) and advice from the National Cancer Action Team (NCAT). However, since then the National Institute for Health and Clinical Excellence (NICE) has issued a set of peer review standards for sarcoma, which reinforces the role of the multidisciplinary team (MDT) and the importance of pathologists and surgeons with specialist skills and experience in sarcoma overseeing the care pathways of patients with soft tissue sarcoma. This has put considerably less emphasis on the need for fewer, larger surgical centres. Discussions with local commissioners and clinicians have also supported the SCG to consider whether a two centre 'partnership' option might be possible in the Peninsula, retaining the service on more than one site. We are delighted that this has now been achieved in the designation decision reached.

3 Outcome of the designation

3.1 In agreement with National Cancer Action Team, the South West Specialised Commissioning Group Board, local Primary Care Trusts (PCTs) and GP Consortia, we are now able to confirm the following:

- A single Multi-Disciplinary Team (MDT) will operate for patients within the Peninsula, across both Plymouth Hospitals and Royal Devon & Exeter sites. This arrangement will initially be led by Plymouth Hospitals NHS Trust. The lead Trust agreement will be kept under review, and leadership may move to the Royal Devon and Exeter NHS Foundation Trust in the future by mutual agreement.

- The joint MDT will be responsible for agreeing the appropriate treatment regime for individual patients, including the most appropriate hospital site for surgery, where appropriate.
- The two Trusts will jointly develop, and work to, shared clinical protocols, together with supporting clinical audit arrangements. This will ensure that sarcoma diagnosis and treatment continues to be provided by clinicians who specialise in soft tissue sarcoma.

3.2 In line with the Improving Outcomes Guidance, NICE peer review standards and the results of an extensive programme of public and patient engagement that was completed early in the designation process (see http://www.swscg.nhs.uk/consultation for a summary report), a shared-care model will be encouraged for follow-up care and routine common treatment regimens (for example, chemotherapy). The preferred model was chosen because it will establish a formal care and treatment pathway, managed by a multi-disciplinary team able to ensure that patients receive the best possible treatment from a dedicated team that are experts in soft tissue sarcoma.

3.3 As well as the functions of the MDT in dealing with individual patients, there are overall tumour site-specific co-ordinating functions needed by the sarcoma service across the whole South West Specialised Commissioning Group (SWSCG) area. As such, the MDT will be affiliated to the Sarcoma Advisory Group (SAG) that has been developed for the Peninsula. This means that parts of patients' care pathways can be received at other hospitals, potentially closer to where they live, whilst ensuring all aspects of their care are co-ordinated and overseen by a team that has met the necessary clinical standards. In terms of accountability and governance arrangements however, the MDT's relationship with the Peninsula SAG is crucial, as the SAG will be responsible in terms of peer review.

3.4 At the same time, we are developing a properly structured network across the South West that can provide training and advice to GPs, pathologists and general surgical hospital doctors. We would consequently expect increased awareness, more consistent treatment pathways and earlier diagnosis of soft tissue sarcoma. In this way we expect to achieve the following without reducing access to, nor moving the location of, specialised soft tissue sarcoma services in the Peninsula:

- Ensure the quality of clinical services
- Increase early detection and accurate diagnosis of sarcoma
- Ensure patients receive the highest quality sarcoma treatment delivered through multidisciplinary team co-ordination
- Improve clinical outcomes and survival rates over time
- Improve the patient experience through a stronger and clearer care pathway

3.5 This model of care has been received and endorsed by the National Cancer Action Team, the Peninsula Cancer Network and local clinicians, GP Consortia and commissioners.

4 Decisions/Actions Requested

4.1 Plymouth Health and Adults Overview and Scrutiny Committee is asked to:

- Note the proposed approach to providing soft tissue sarcoma services
- Note the involvement of patients, clinicians and the public in the process
- Note the improved quality and safety of service that the model will deliver over time

5 Glossary

Cancer Network	A group of professionals that help cancer services and organisations in the area to work together to reduce cancer rates and improve experiences and outcomes for patients.
Chemotherapy	Chemotherapy is a treatment used for some types of cancer. There are over 200 different types of cancer and over 50 chemotherapy drugs, which can be given in various ways.
Designation	Designation is a way of commissioning that involves commissioners working closely with local clinicians, patients, carers and members of the public to ensure designated providers meet recommended safety and quality standards. In this sense, designation is a quality assurance marker. Designation also prevents unsafe or wasteful duplication of specialised services, by formally designating an appropriate number of service providers to serve a Specialised Commissioning Group (SCG) population, that are best placed to provide high quality and best value services.
Improving Outcomes Guidance	The Improving Outcomes series of guidance was started by the Department of Health under the auspices of the NHS Executive in 1996 and handed over to the National Institute for Health & Clinical Excellence (NICE) in 2000. Each set of guidance sets out ways for improving the treatment that patients of a particular service receive.
Multi-Disciplinary Team	Group of experts from many different specialities working together to deliver a package of care.
National Cancer Action Team (NCAT)	A multidisciplinary team working with the Department of Health as part of the Cancer Reform Strategy's drive to improve cancer services and reduce inequalities in the provision of cancer care.

NICE	NICE (National Institute for Clinical Excellence) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.
Pathologist	Pathologists are scientists that study and diagnose disease, often through examining tissue samples.
Peer Review Standards	Peer review is a process of self-regulation by a profession or a process of evaluation involving qualified individuals within the relevant field. Peer review methods are employed to maintain standards, improve performance and provide credibility.
Peninsula	The Peninsula refers to the geographical area served by Devon, Cornwall & Isles of Scilly, Torbay and Plymouth Primary Care Trusts.
Prognoses	Predictions about how a disease is likely to progress or respond to treatment.
Public & Patient Engagement	As part of the commissioning/designation commissioners will seek the views of patients, carers and members of the public to develop service specifications and commissioning plans that help the health sector meet future challenges.
SCG	Specialised Commissioning Group (SCG) is comprised of all the Primary Care Trusts in a given geographical area that come together to commission specific group of services that have been defined as specialised. Currently, there are 10 SCGs in England, all with the same boundaries as the Strategic Health Authorities that oversee their work.
Shared Care	The responsibility for appropriate long-term medical care must be shared by cancer survivors, their families, the oncology team, and primary care providers.
Soft Tissue Sarcoma	A cancer that begins in the muscle, fat, fibrous tissue, blood vessels or other supporting tissue of the body. It is a rare cancer that accounts for

	about 1% of all malignant tumours. The cause of most cases of soft tissue sarcoma is not known. However there are certain risk factors for the development of soft tissue sarcomas.
Specialised Services	Specialised services generally involve complex procedures or require very specialised workforce and or treatment/ care for conditions that are rarer than those treated in local hospital. Consequently, specialised services often serve a wider population catchment than do local services and are not available in every hospital.
Stakeholders	Stakeholders refer to any person who has a stake and interest in the services that commissioners plan, designate and procure. Stakeholders can be professionals, patients, carers, members of the public, volunteers.
Treatment Regimen	Systematic course of therapy.

Plymouth Local Action Plan – Dementia 2011/12

Who is involved in our action plan:

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

- Consultant, Care of the Elderly, Plymouth Hospitals NHS Trust
- Consultant Psychologist, Plymouth Community Healthcare
- Mental Health Commissioner NHS Plymouth
- Director of Nursing, Plymouth Hospitals NHS Trust
- GP Lead (Dementia)
- Commissioning Manager – Adult Social Care, Plymouth City Council
- Assistant Director for Older Person's Mental Health, Plymouth Community Healthcare
- Head of Continuing Health Care, NHS Plymouth
- Director of Mental Health Services, Plymouth Community Healthcare
- Representatives from Community and Voluntary Sector

How the plan is being delivered and overseen:

A Joint Commissioning Group 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.

What we are doing.

Government's key priorities.
Improving hospital care What we have done and achieved so far: • Range of information has been developed regarding improvement of

clients experience on acute wards
- Redevelopment / redesign of Plymouth Liaison to enhance quality care in acute provision

What we plan to achieve in the next twelve months:

- Complete national hospital audit and develop action plan for both Plymouth Hospitals NHS Trust and Local Care Centre wards run by NHS Plymouth.
- Commissioning of Red Cross service to provide low level support to people and their families on discharge from hospital

Improving earlier diagnosis

What we have done and achieved so far:

- The Community Memory Service has achieved a national accreditation award and we have commissioned a nurse prescriber to support the service.
- Increased the number of people accessing the memory service.

What we plan to achieve in the next twelve months:

- Health and social care services will be redesigned through the TCS agenda to address the required anticipated growing need

Improving care in care homes

What we have done and achieved so far:

- The Dignity in Care Forum has continued to be developed. It achieved a national award for its' support for care homes.
- Plymouth City Council has commissioned the 'My Home Life' project to work with care home leaders to celebrate best practice and enhance quality of care.
- My home life commissioned to carry out 'Big Event', an appreciative enquiry event into improving the interface between hospitals and care homes. This will inform specifications for providers.

What we plan to achieve in the next twelve months:

- We will be leading the development of the Dementia Quality Mark for the South West. This involves establishing a local accreditation scheme with care homes with the aim of improving the quality of care provided.

- Increase joint work between health and social care around quality assurance and performance monitoring of care home provision
- Commission a care quality improvement team to support commissioned services with a focus on care homes

Reducing the use of antipsychotics

What we have done and achieved so far:

- Audit of prescribing anti psychotics and benzodiazepines in primary, secondary and nursing home care for those with dementia has been undertaken

What we plan to achieve in the next twelve months:

- Using the findings of the audit to develop an action plan to ensure patients mediation is regularly reviewed when prescribed anti-psychotics.

Raising awareness

What we have done and achieved so far:

- 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
- Living well with dementia conference held in Plymouth with representatives across, health, social care, education, voluntary sector, service users and carers

What we plan to achieve in the next twelve months:

- A range of information being developed for providers including primary care
- A Care Pathway for patients and carers is under development and will be launched later this year and will describe how people access services.
- Advise and information service to be recommissioned jointly across health and social care as part of the early intervention and prevention agenda (Putting People First).

Providing support in the community

What we have done and achieved so far:

- We developed the domiciliary care brokerage service to be delivered jointly across health and social care
- Adult Social Care launched Plymouth Online Directory
- Patients with dementia now have access to our Supported Discharge service when being discharged from general hospital
- Six Extra Care housing schemes opened, one of which specialises in dementia

What we plan to achieve in the next twelve months:

- There will be a review of the acute model of care to focus more support into the community enabling people to remain at home longer.
- Develop domiciliary care provision to better meet the needs of people with dementia, ensuring the workforce have appropriate training
- Enhance social care support through the NHS funds for social care (E.g. befriending, equipment)
- Ensure all intermediate care services are specified to be able to meet the needs of people with dementia

Supporting carers

What we have done and achieved so far:

- Developed an out of hours, flexible service for carers to access in a crisis
- Joint carers strategy in place
- Commissioned enhanced memory cafe services through Alzheimer's society

What we plan to achieve in the next twelve months:

- Committing additional resource to expand access to existing services for carers support and improve links to the memory service through the community and voluntary sector
- Increase access to short breaks

Training our workforce

What we have done and achieved so far:

- Professionals accessed dementia care mapping training.
- Delivered masterclasses for GPs.

- Workforce development group set up which includes representatives from University of Plymouth, City College and other training providers
- Adult health and social care dementia workforce strategy published to address the needs of all individuals working with people with or at risk of developing dementia.
- Commissioned Jackie Pool Associates to deliver awareness training to 250 care workers
- Plymouth Dementia Action Alliance launched

What we plan to achieve in the next twelve months:

- Widen GP masterclass programme
- Commission Jackie Pool Associates to implement leadership skills training across dementia suppliers

Other NDS objectives in our local plan.

Improve end of life care for people with dementia

What we have done and achieved so far:

- Launch end of life coordination centre to deliver one point of contact for professionals and the public for patient's receiving end of life care.
- Commissioned 'Facing the Sunset' conference in Plymouth where professionals, service providers, service users and families come together to share and learn about end of life care for people with dementia

What we plan to achieve in the next twelve months:

- Implement end of life register
- Work in partnership to ensure delivery of end of life training programme

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NHS Plymouth and Plymouth City Council

Plymouth Dementia Joint Strategic Commissioning Group

Terms of Reference

1. ROLE

1.1. The Plymouth Dementia Strategy Joint Strategic Commissioning Group (PD JSCG) will ensure that this strategy will be delivered in accordance with national and local policy frameworks such as: Transforming Community Services, New Horizons, Living Well with Dementia (National Strategy) and the South West SHA Dementia Review and Plymouth Joint Dementia Commissioning Strategy.

1.2. The Group will ensure that services commissioned in Plymouth meet the needs of the local population, anticipate future demand, and are flexible and accessible to all.

1.3. The Group will work towards the achievement of the five strategic Dementia priorities identified in the Plymouth Dementia Strategy:

- Increasing and improving awareness
- Early diagnosis and intervention
- Support for service users and cares
- Improved quality of care
- Improved dementia pathway

1.4. The Group will review and update the Plymouth Dementia Strategy as necessary so that it reflects the objectives of NHS Plymouth and Plymouth City Council.

1.5. The Group will ensure that the health and social care community responds to national dementia guidance in a coherent and integrated manner by reviewing new guidance whenever it is published and incorporating changes into the Plymouth Dementia Strategy.

2. MEMBERSHIP

2.1. Core Group

Chair – (to be appointed)

NHS Plymouth Commissioner

Head of Strategic Commissioning Plymouth City Council

1 Head of Continuing Care Commissioning

1 Plymouth Community Healthcare Executive

1 Plymouth Hospitals NHS Trust Executive

1 representative from Adult Social Care provider

1 Representative of independent and voluntary sector providers

Expert advisors;

Clinical Psychology

Consultant Psychiatrist

General Practitioner

Academia

Public Health

LINK representation

Administrative support to be provided by NHS Plymouth

Other providers and commissioners will be co opted as required e.g. those who have responsibility for community physical care and acute inpatient liaison.

3. QUORUM

3.1 Meetings will be quadrate when attended by the Chair PCT Commissioner/PCC Head of Strategic Commissioning /Head of CHC Commissioning.

4. WORK STREAMS

The PD JSCG will identify the respective works stream in accordance with the available Work/Action plan nominating the respective leads and timescales for deliver. It is important to note that compliance with this way of working will ensure speedy improvement in dementia services and ultimately be of benefit to the user, carer and member of staff working in this area

5. ACCOUNTABILITY

5.1 The Joint Strategic Commissioning Group reports to the Sentinel Clinical Commissioning Executive and is accountable to NHS Plymouth and Plymouth City Council through the Trust Board and Cabinet.

5.2 The Group will provide regular reports to the Sentinel Clinical Commissioning Executive on the progress of the strategy and will escalate any unresolved issues or blockages to them.

5.3 NHS Plymouth will ensure that minutes of the meetings are kept and ensure that minutes, and agendas are issued within 14 days of the meeting.

5.4 Safety and risk issues will be reported to the respective Commissioning Governance Committees

5.5 Members of the PDJCSG will have a duty to :-

5.6 Contribute to the development of the respective works streams

5.7 Communicate the key priorities and recommendations arising from the PDJSCG to their PCT Directorate or partner organisation

5.8 Communicate the views of their PCT Directorate or partner organisations to the PDJSCG

5.9 Commit their PCT Directorate or partner organisation to deliver their part of the agreed development plan

5.10 Take action to improve performance where necessary

6.0 STAKEHOLDER ENGAGEMENT

6.1 To date there has been significant stakeholder involvement however this will continue using the recognised process available i.e. contracted groups and Local Involvement Networks (LINKS,) workshops and respective websites. A dementia nework will be established to ensure that there is a conduit to the dementia commissioning group

7.0 TRAINING AND DEVELOPMENT

7.1 Those with identified needs for training/development will be offered and supported with such. Existing mechanisms will be used

8.0 REVIEW

8.1 The above Terms of Reference, membership and length of term will be reviewed on a 6 monthly basis.

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Plymouth Dementia Action Plan

V3 29.09.2011

Ref	Task	Lead	Start Date	Finish Date	Status update	Key Milestone	When we aim to have…
1.0	**Improving hospital care**						
1.1	Delivery of PHT action plan	KG	01 July 2011	31 March 2012	Action plan in place. SHA peer review 30/09/2011	November	Report from peer review
1.2	Delivery of Plymouth Community Health action plan	KE	01 July 2011	31 March 2012	No update received from KE.		
2.0	**Improving earlier diagnosis**						
2.1	Review of memory servi ce capacity	KA	01 June 2011	30 November 2011	Plans agreed to implement short term capacity	November	Short term capacity in place
2.2	Refresh of memory service specification	LB	01 September 2011	30 September 2011	Specification drafted	October	Specification signed off within PCH contract
2.3	Develop information pathway to improve GP recognition of diagnosis	OR/JN	01 September 2011	31st December 2011	KA undertaking various work with OR-to clarify this workstream at next meeting.		
3.0	**Improving care in care homes**						
3.1	Dementia Quality Mark for care homes	DB	01 April 2011	31 December 2011		December	Evaluation of pilot and reccomendations of way forward.
3.2	Care Home quality team	DB/CG	01 September 2011	31 March 2012	Business case going to SCCE in October	January	Implementation plan.
4.0	**Reducing the use of antipsychotics**						
4.1	Refresh of prescribing project	LB	01 October 2012	30 March 2012	Meeting in October to plan future work	October	Plan of future work
5.00	**Providing support in the community**						
5.10	Redesign of rapid response team delivered.	FP/JY	27 June 2011	31 March 2012	Specification includes dementia requirements. Commissioner/Provider meeting 29/09/2011	October	Agreed model with Implications for OPMH and social care support. Implementation plan.
5.20	Increase in reablement capacity	FP/JY	27 June 2011	31 March 2012	LTC into independent sector but expected support people with Dementia. Will have 1500 hours of social care reablement and selected 4 domiciliary care providers.	December	All appropraite clients moved to providers and reablement capacity released.
5.30	Development of dementia specialism in dom care market	DB	01 April 2011	31 January 2012	Training commissioned.	December	Providers staff trained and able to take clients with dementia.
5.40	Negotiate opening of new DE nursing homes	DB/CG/LB	01 January 2011	29 February 2012	One home opened with 60 beds. Second home to open in 2012-regular meetings with provider	February	Second home open to admissions.
5.50	OPMH redesign	SM	01 September 2011	31 March 2012	Redesign paper written to go through approval process.	October	Update
5.60	Implement locality-based support	SM	01 September 2011	31 March 2012	Dementia included within locality specification. OPMH confirmed approach.	October	Update
5.70	Insert Dementia Quality standards into contracts	LB	01 September 2011	31 March 2012	Dementia standards included within localities and rapid response specification	March	Dementia to be included within acute trust and LCC contract. Refresh dementia CQUIN.
6.00	**Supporting carers**						
6.10	Delivery of increased provision through NHS support for carers	EF & DB	01 April 2011	31 March 2012	DB has agreed plan and will circulate. £123,000 to locality authority to enhance carers contracts and looks at adding support for carers and enhancement of Alzheimer's contract.	October	Update on all services that support people with dementia.
7.00	**Training our workforce**						
7.10	Refresh of GP training	LB	01 September 2011	31 March 2012	GP training programme started.	March	Completed GP training
7.20	Dementia workforce programme	NW	01 April 2011	Ongoing	Workforce strategy agreed and number of actions in place.	December then annual review of strategy.	Action plan in place. Then refreshed strategy.

Grey	Schedule for proposed action
Pale Green	All progressing to plan
Yellow hatch	Some difficulties encountered but should be resolved and not affect overall schedule
Red	Significant problem encountered. Progress stalled.
	Task closed/completed

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Plymouth Community Healthcare

Older People's Mental Health Redesign Strategy

Summary:

A document which outlines plans to redesign the current service to ensure that it remains congruent with the aims of locality working, local and national commissioning drivers and the determination by Plymouth Community Healthcare to deliver high quality specialist mental health services.

It details the rationale for change, what changes will be made and how these will be delivered.

It is a document that sets the scene for mental health service delivery for the older person or those that need our specialist skills for the next 3 years and has been developed and written with collaboration and consultation at its core.

Recommendation:

It is recommended Overview and Scrutiny Committee support the OPMH redesign strategy.

Authors:

Sara Mitchell, Locality Manager
Dr. John O'Donovan. Consultant Psychiatrist
Kate Anderson, Head of Community Memory Service
Claire Journeaux, Community Services Manager

Plymouth Community Healthcare

Older Peoples Mental Health Redesign Strategy 2011-2013

1. Purpose of the paper.

This paper proposes a way forward and redesign for Older People's Mental Health Services (OPMHS) including Inpatient units, Community teams and the Memory Service which recognises the specialty and identifies the need for locality working.

Approval and engagement will be sought from the relevant fora, including Sentinel (SCCE), Plymouth City Council Overview and Scrutiny Panel and JCCN to support the reshaping and realignment of the service.

Approval has been sought to date from Plymouth Community Healthcare Provider Executive Team (PET), NHS Plymouth and Plymouth City Council Commissioners, Plymouth Joint Dementia Commissioning group and Plymouth Mental Health Local Implementation Team.

2. Background.

Older People's Mental Health Services have a long history of providing specialist mental health services for the older population of Plymouth aged 65years plus. Since 2003 these services have been provided on 2 sites, Mount Gould and Plympton Hospital and in the community. Over the course of the past 8 years these services have had to become more responsive to a number of national drivers and local joint commissioning initiatives. This has been achieved through internal service reconstruction and change as opportunities have arisen, and in 2009, using internal resources and no external investment, OPMH services were divided into 2 main care pathways:

1. Functional disorders for non cognitive impairment e.g. late onset psychosis, depression and or anxiety
2. The Memory/dementia service e.g. Alzheimer's disease and other dementias.

However the service is now in a position where it must be responsive to the demands of differing agendas e.g. Transforming Community Services (TCS),Quality Innovation Productivity and Prevention (QIPP), Plymouth Dementia Strategy, Commissioning for Quality and Innovation (CQUIN) and, as a Social Enterprise offer high quality services that are efficient and productive but keep the needs of the individual at the centre of care. Both epidemiological and

demographic changes and growth of the proportion of the elderly (65 yrs plus) and very elderly (85 yrs plus) mean that for services to be delivered accurately and in keeping with 'Safe and Well and at Home' there needs to be a whole systems approach to service improvement including the following:

- Transforming Community Services to support and encourage more care provision out of hospital and prevent and reduce hospital admissions. Inpatient bed numbers will be reduced, but patient care improved by maintaining existing staff thus increasing staff ratios and **linking** community staff more closely with the wards with a model of co-working.

- The delivery of an integrated pathway that meets the aspirations on the National and Plymouth Dementia Strategy of early diagnosis, support and treatment of dementia and the development of services to better meet changing needs. This pathway will include the Community Memory Service, Dementia community teams and the Pinewood Inpatient unit.

- The delivery of an integrated care pathway that reflects **best practice** in the care of functional illness in the elderly.

- OPMHS will continue to provide specialist services for patients with a dementia and functional illness but age will be used as a guide and **access will be defined on clinical need.** Clear access protocols will be designed and agreed by senior clinical staff in consultation with Primary Care and commissioning colleagues. Thus the **ageless agenda** will be implemented locally so that specialist services are maintained and **access broadened**.

- To **increase the quality of the Inpatient provision** and experience for the individual and their carers. Bed numbers will be reduced and staffing levels maintained thereby increasing staff time and skills for patients. Staff will be trained in dementia skills via levels 1-9 of the national learning platform.

- To meet QIPP agendas, reinvest monies into increased community provision enabling services to be sustainable to meet increasing demand.

- The Community Memory Service needs to reduce the waits for Consultant diagnostic appointment in keeping with Referral to Treatment targets.

- To increase efficiencies within the service through agreed and innovative lean and structured working as outlined in the paper.

2.1 Key targets.

There are 3 main elements to the proposal;

- Reduction in bed numbers - stop people being admitted unnecessarily and their discharge home being delayed once they are ready. Reduce number of admissions to be in line with the top quartile for comparator PCTs

- Two clear functional and dementia pathways involving inpatients and community teams working in an improved model of service delivery.

- A lean and efficient Memory Service including reduction in waiting time and caseload.

If the strategy is agreed a 12 week consultation and engagement period with patients carers and key stakeholders will follow. This will include patients/service users, carers, key stakeholders and 3rd sector colleagues e.g. Alzheimer's society. Further details are outlined later in the document.

3. Proposed changes.

The following changes to services are anticipated which fall into 2 main stages:

Stage 1: Relocation of the inpatient units onto a single site alongside community staff with an initial reduction of beds from 18 to 15 for each ward.

Stage 2: A remodelling of service provision in the community to ensure congruence with joint commissioning agendas.

These stages will be followed by:

- a medium term strategy scrutinising how locality support working and changes in the Community Memory Service have influenced the productivity of the pathway.

- a systematic review of the workforce and skill mix.

- an exploration of work in conjunction with the University of Plymouth to explore the implementation of models of service delivery.

- Long term strategy of further reduction of beds and expansion of increased support in the community.

3.1 Inpatient Services

The 2 wards on the Plympton site (Pinewood and Oakdale) will relocate to the Mount Gould site and reduce, initially, from 18 beds per ward to 15 beds per ward. Edgecumbe has been assessed as being suitable for the Pinewood patient group and Cotehele for 'functional patients'. Consultant Old Age Psychiatrists will also relocate with secretarial staff to the Mount Gould site where all OPMHS staff will then be based. This will result in more efficient team working, better medical cover and heightened productivity.

Both of these wards will be compliant with other current national agendas e.g. single sex accommodation.

The table below demonstrates the spread of admissions across the city and provide data which will help formulate OPMH staffing needs within the localities.

From 31-8-09 to 31-8-11 301 patients were admitted to OPMH inpatient beds. The breakdown of admissions by postcode across the city and areas covered by Devon Partnership NHS Trust are as follows:

Number of Admissions per Postcode

PL	1	2	3	4	5	6	7	8	9	12	13	15	19	20	21	Others
Oakdale																
1.9.09 - 31.8.10	9	4	16	5	4	16	13	4	10	2	2	3	6	8	1	9
1.9.10- 31.8.11	10	6	16	9	19	13	17	4	10	0	2	0	3	0	4	6
Pinewood																
1.9.09 - 31.8.10	11	1	16	6	20	19	25	0	18	8	0	3	1	3	4	4
1.9.10- 31.8.11	9	3	21	6	12	15	25	0	12	1	0	5	7	3	4	4

The aim of the restructure is to ensure that Inpatient acute assessment services are better **focussed** and that community teams, through co-location and working with the wards, are **responsive** to both ward and locality requirements. A link nurse role from within the ward staff team will be developed to work creatively and efficiently with community teams with the aim of preventing admissions where possible and speeding discharge. The result will be an enhanced patient and carer experience through a seamless OPMH service and a more **productive** working style with greater systemic **clarity of purpose** and **pathway** working.

Such changes are in keeping with QIPP and national strategy and will be achieved through:

- A focussed model for admissions
- Refreshment of service specifications
- Close work with the commissioning team regarding alternative suitable accommodation
- A review of staffing resource.
- Staff who will be trained appropriately and possess relevant key skills.

The proposed move of the Inpatient units will offer the following:

- an enhanced patient and carer experience and increased **quality of care.**
- **reduction of stigma** and isolation of the older person with mental health difficulties by placing services closer to mainstream provision.
- **Better access to** medical cover and **Out of Hours general medical cover.**
- **Improved access** to medical care and **nursing support** including OOH medical cover by situating the OPMH wards on the Mount Gould site. In addition the relocation creates the possibility of far greater **synergy**, co working and mutual support between medical staff and those in training. e.g. **easier development of joint clinics** with Old Age physicians for those people presenting with **complex multiple pathology.**
- Stop people being admitted unnecessarily and their discharge home being delayed once they are ready.
- Reduce number of admissions to be in line with the top quartile for comparator PCTs
- Enable people to live at home longer, reducing admissions to care homes
- Easier access for patients and carers due to Mount Gould's more central site and transport links.
- Increased access and support from medical staff to the OPMH community teams and **encourage a pathway approach** to care.
- **Transform** care into a whole system rather than team care.
- Greater support and integration of community and ward staff and promote staff rotation through the pathway to develop increasing skill set and enhance career development.
- It is anticipated that Devon Partnership will continue to access 5 beds.

3.2 Dementia Pathway

The Dementia pathway will be comprised of the Dementia Community Team (Locality Support Working and High Intensity Support) and the Community Memory Service (CMS).

3.2.1 *Dementia Community Team.*
(Previously known as Complex Care Team/High Intensity team)

The current community team will be co working and located with the wards and will have 2 strands of work:

- a focus on an acute care model of highly skilled and intense, time limited intervention designed to avoid admission and speed earlier discharge.

- support of the localities by **named** link Dementia Community team members who have dementia knowledge and expertise who will support and liaise with locality health hubs (Locality Support Working) and who will work across localities as required. The team will **support** moves towards an integrated Rapid Response Service to ensure that all OPMH clients have access to the service. This will be achieved through the appointment of a Band 6 OPMH Nurse who will provide active liaison, support and care between OPMH and RITA/Reablement.

3.2.2 Locality Support Working (LSW) - <u>functional **and** memory pathway</u>

In both pathways there will be **named** link staff that will be the first point of contact with the locality and will work with the localities under the 3R's rubric:
Respect
Reciprocity
Responsibility.

Respect: LSW will bring to the localities specialist knowledge of how mental health presents in old age and will work with locality team members in contributing to high quality holistic assessments and recommendations. There will be the expectation of the development of strong and trusting relationships to be built up both within the locality team and with relevant residential and nursing establishments in that locality. LSW will **support** and **contribute** where cognition and behaviour are relevant factors on the Continuing health Care (CHC) Decision Support Tool (DST).

Reciprocity: ensuring that older people with functional and memory problems have the **same access** to the same physical health support available in the locality.

Where it is evident that more specialist assessment or intervention is required the Locality Support link worker will screen and seek more active intervention from the more specialist/high intensity element of the pathways.

Responsibility: LSW will support specialist mental health care through timely and seamless onward referral to access high intensity/highly specialist mental health resources e.g. Memory Service, neuropsychological assessment, management of behaviour where placement or maintenance of residence is at risk and facilitate return to locality support.

It is anticipated that that there will be an allocated worker from each of the pathways in the locality who will be expected to cover for each other in periods of absence

The aim of LSW is to ensure that throughout an episode of care the person and their supporters receive the 'right care, by the right person at the right time' and to keep the person "Safe and Well and at Home" wherever this is appropriate. The care required and the people providing it will change throughout an episode but

the person receiving that care will always feel confident that they are in safe and supportive system that puts their needs first.

All individuals will continue to be assessed for CHC Funding and Section 17 Aftercare .Closely integrated work with Joint Commissioning of services will continue to ensure that services available enhance options for care.

With the support and agreement of commissioners It is anticipated that a proportion of any savings made in the restructure through QIPP will be invested in the overall OPMH pathway and particularly the Dementia Care team working at high intensity who will have a brief to support those people with a dementia combined with high and challenging needs to enable them to remain in a place with which they are familiar. The team will draw on the 'Newcastle Model' of management of Behavioural and Psychiatric Symptoms of Dementia (BPSD) where appropriate.

Through the development of new and innovative community resources it is anticipated that beds will be used only by those who present as having complex need (Cluster 20+) and those under the Mental Health Act.

The management of the Community Dementia team/wards will emerge as the service transforms into the new structure.

3.2.3 Community Memory Service.

Referrals to the Community memory Service have increased

Apr 2004 – 2005	28
Apr 2005 – 2006	144
Apr 2006 – 2007	183
Apr 2007 – 2008	187
Apr 2008 – 2009	381
Apr 2009 – 2010	508
Apr 2010 – 2011	560

Current referral rate is 60 per month.

The level of referrals to the service has risen year on year and the demographic trend suggest that this will continue.

The level of referrals and the number of potential New Patient (NP) appointments for consultant diagnostic clinic (12 per week) mean that there is always a shortfall and there is currently a waiting list that has meant the service has been unable meet waiting time targets.

To address the waiting times a number of initiatives and actions are proposed:

- The Community Memory Service will move towards a **time limited** period of assessment, diagnosis, treatment and post diagnostic support and **6 month Follow Up appointment** prior to discharge back to primary care. There will

be guaranteed easy return to the CMS/High Intensity Support from the Dementia Community Team if circumstances or presentation change. Difficulties encountered by patients and carers would be assessed by staff locality support working from the Dementia Community team and the person reintegrated into active mental health care at a level appropriate to care need. This will reduce the current caseload by approximately 33%.

- The short term solution of extra paid consultant time (2 weeks AL) funded through short term funding from OPMH underspend as reviewed at the end of August to reduce waiting times.

- Tighter service specification with the Commissioning team to meet the requirements of the Department of Health National Commissioning Pack for Dementia.

- Increased use of shared care agreements after titration of ACI medication as agreed with GPs and medicines management team once stability of medication and appropriate support is in place.

- Involvement and feedback form GPs regarding their expectations of a Memory Service and ongoing care. GP engagement and education/training sessions begin on 14-9-11 with 4 subsequent 'Master Classes' arranged with the support of Primary Care Commissioning.

- Did Not Attend and/or cancellation of 2 offered appointments leading to discharge to be rigorously applied.

- Longer term solutions of 2 extra medical clinic sessions will be sought from reinvestment of CQUIN monies once the waiting lists have reduced.

The overall impact of the changes across the memory pathway is to ensure that, in the arc of a long illness during which many people and professions are likely to be involved, the patient and their carers are treated and supported by pathway teams with shared values and an ethos of 'individual first'. The aim of the pathway teams will be to ensure that the frailest and the most vulnerable in the community experience health care of the highest calibre wherever they are in the progression of their illness.

The Dementia pathway will give us the opportunity to provide seamless care for people with memory problems, a diagnosed dementia and those requiring admission to admission through to End Of Life. This will not be appropriate for all people referred and some will be discharged from the pathway to primary care with the option of easy return to the pathway if required.

The dementia pathway will follow the person from initial referral through to CHC providing the appropriate level of care with primary care colleagues at each stage of the illness.

3.3 Functional Pathway

The Functional pathway will be comprised of the Functional Community Team (Locality Support Working and High Intensity Support).

It is anticipated that the Functional team will remain within OPMH management and will mirror the memory/organic pathway through developing **strong outward looking links with the locality health team hubs**. The OPMH functional specialists would be expected to support people clustering at 3+ across the mental health spectrum and work creatively with ward and medical staff to **minimise admissions** and proactively and energetically **support early and active discharge** and on occasions may call upon the wider AMH resources e.g. Home Treatment and Psychological Therapies. The team will form one pathway with the ward and develop a strong LSW model.

The workforce plan will be reviewed to ensure that the skill mix is optimal for the provision of care.

This plan has the wholehearted multidisciplinary support of the service and is viewed as a 'win-win' scenario.

3.4 Staff training and support

The expertise and skills of the OPMH memory pathway staff group will be supported by the expectation of **all** staff members participating in an appropriate Dementia Learning Platform provided by Learning4health. This activity will be a part of subsequent Personal Development Plans and be addressed in line management.

Staff team members in the functional team will be encouraged to explore and access appropriate sites and training with relevant managers and training department. It is suggested that the team will also access agreed dementia training to ensure skills are interchangeable within the team.

4. Commissioning context

There are a variety of investments taking place across health and social care in Plymouth to improve community services for Older People with a mental health condition and support implementation of the Plymouth Dementia Strategy. The development of these services will increase people's ability to stay independent at home for longer and reduce their need to access specialist services. Whilst some of this investment is time-limited it will enable evaluation of which interventions are successful and enable an increased focus on community provision.

NHS Plymouth invested £359,000 in 2010/11 and £4.25 million in 2011/12 in social care services to support health and reablement services. This level of investment is expected to continue into 2012/13. Of this NHS Plymouth has specified the expectation that this resource and redesign will ensure rapid response and reablement services meet the needs of older people with a mental health diagnosis through the development of a liaison post between RITA/Reablement and OPMH. Key outcomes will include a reduction in admissions to acute and psychiatric beds and care homes. Reablement services will increase in capacity and be accessible to people with dementia. Key

outcomes will include reducing hospital admissions to Derriford, preventing deterioration and delaying dependency. The remainder of the resource will be utilised to improve Information advice and advocacy, Practical Support at Home and using technology to support people.

The Strategic Health Authority has made available £20,000 for enhancing early intervention and diagnosis for people with dementia, with particular focus on engaging GPs. This aims to increase the proportion of people who receive an early diagnosis and are able to access successful interventions to enable them to remain independent for longer. Training is being delivered with the support of Primary Care Governance with no extra investment.

NHS Plymouth has invested an additional £123,000 in 2011/12 into services to carers alongside Plymouth City Council's existing commitment. Some of these services are generic to carers of people with a variety of diagnoses and some specific to people with dementia. Examples include developing Alzheimer's Society contract to provide befriending services and enhance their links to the memory service.

Plymouth City Council in partnership with NHS Plymouth has obtained additional investment to lead the development of the Dementia Quality Mark for care homes. This project is intended to increase the quality of care for people with dementia in care homes.

Plymouth City Council has invested in a workforce strategy and training for staff across the city to increase awareness and the quality of care provided. Domiciliary Care agencies are undertaking training with Jackie Pool Associates to develop their knowledge to work with people with dementia.

NHS Plymouth will continue to explore the potential to pilot the dementia advisor role working with the memory service.

For consideration.

a) The bed reductions are predicated upon the reduction of inappropriate admissions and delayed discharges.

b) It is anticipated that Devon Partnership will continue to purchase 5 of the overall complement of 30 beds.

c) There is a need for a specialist OPMH service for both pathways in order to deliver the quality and skilled care.

d) Development of services needs to be informed and driven by **accurate epidemiology** of dementia and other psychiatric illnesses in the frail elderly, notably the Data Bank used by the commissioners. There will need to be an ongoing consideration of the care provided and analysis of resources available. Current Royal College of Psychiatry guidelines suggest 4 Old Age substantive consultant posts for the Plymouth population (not including an Old Age Liaison Psychiatrist).

Work is under way with Public Health to strengthen the data used for forward planning.

e) Both pathways will work actively with Adult Social Care to offer a quality service and will support, wherever appropriate the personalisation agenda.

5. Public involvement and consultation

- There will be a formal period of consultation with service users and carers, IP units and community teams after agreement in principle from the Sentinel Clinical Commissioning Group. There will be discussions with staff about how the needs of patients and carers are best met and will include open meetings with patients, their carers and staff at appropriate times and will include the offer of meetings at weekends and evenings.

- Plymouth Community Healthcare's Joint Committee for Consultation and Negotiation have been involved with the process to date and their views will continue to be sought through appropriate staff consultation. The proposed changes have the overwhelming support of clinical staff.

- With the eventual relinquishing of OPMH wards on the Plympton site administrative, secretarial and hotel services staff will transfer to the Mount Gould site through the current redeployment policy as agreed with Human resources.

- Edgecumbe ward patients and staff will be part of an in-house consultation regarding the move of ward. Initial, exploratory discussions with staff have raised no significant issues and there is a willingness and enthusiasm on their part for the potential move. Estates have been involved and view the move as helpful within the Mount Gould site.

- A longer term review of overall staffing is part of the Plympton Steering Group.

- The service will seek the support of the University of Plymouth research team to evaluate the changes in keeping with national best practice OPMH community and inpatient models

- The Southwest Dementia Partnership (SWDP) is undertaking a peer review of Memory Services/diagnostic pathways which is likely to comment on the wider access to services after diagnosis. We view this as a helpful addition in ensuring that services are delivered to the appropriate standard.

5.1 Proposed time scales for consultation:

External consultation.
The paper has been seen by:

Plymouth Community Healthcare Provider Executive Team	15-9-11
NHS Plymouth and Plymouth City Council Commissioners (QIPP Transformation meeting)	20-9-11

Plymouth Joint Dementia Commissioning Group	26-9-11
NHS Plymouth and Plymouth City Council Commissioners	26-9-11
Plymouth Community Healthcare Board	27-9-11

and will be discussed by:

Plymouth Community Healthcare Joint Trade Union Forum (JTUF)	7-11-11
Plymouth Community Healthcare Joint Committee for Consultation and Negotiation (JCCN)	16-11-11
Cllr Monahan to visit Community Memory Service	4-11-11
Sentinel Clinical Commissioning Executive	9-11-11
Health and Social Care Overview and Scrutiny Panel	9-11-11

5.2 Proposed action plan time scales: see attached sheet for details

- **Internal consultation**. Consultation period of 12 weeks with patients carers and staff will start following agreement by OSR and SCCE. This will include weekend and evening sessions to ensure the widest constituency of engagement and involvement. Consultation dates for patients, carers, and staff are attached. The consultation will include Edgcumbe Ward. (Appendix 1)
- Bed numbers reduced and wards moved by 31-3-12 or following consultation period whichever is soonest.
- Edgecumbe ward to move to Greenfields December/January.
- Memory Service waits to be reducing by 31.1.12 in preparation for SWDP Peer Review in December'11/January 2012, MSNAP review in February 2012 and cleared by 31-3-11.
- Action plan and time scales are attached.

Sara Mitchell, Locality Manager
Dr. John O'Donovan. Consultant Psychiatrist
Kate Anderson, Head of Community Memory Service
Claire Journeaux, Community Services Manager

October 2011

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OPMH Redesign Strategy 2011-2013
Action Plan

Action	Time	Responsible	R	A	G
The proposal will be presented to: **Plymouth Community Healthcare PET**	15. 9.11	Sara Mitchell Kate Anderson			G
NHS Plymouth and Plymouth City Council Commissioners (QIPP Transformation meeting)	20.9.11	Steve Waite Michelle Thomas			G
Plymouth Joint Dementia Commissioning Group	26.09.11	Sara Mitchell Kate Anderson			G
Plymouth Community Healthcare Provider Board	27.9.11	Steve Waite Michelle Thomas			G
Plymouth Mental Health Local Implementation Team (with representatives from LINKS and PIPS)	13.10.11	Sara Mitchell			G
Sentinel (SCCE)	9.11.11	Sara Mitchell Kate Anderson			
Health and Social Care Overview and Scrutiny Panel	9.11.11	Sara Mitchell Kate Anderson			
Plymouth Community Healthcare Joint Trade Union Forum (JTUF)	3.10.11	Sara Mitchell Kate Anderson			
Plymouth Community Healthcare Joint Committee for Consultation and Negotiation (JCCN)	19.10.11	Sara Mitchell Kate Anderson			
Consultation period for Oakdale and Pinewood.	1.10.11 – 31.12.11 10.11.11	Sara Mitchell Mandy Rolfe Kate Anderson Claire Louise Journeaux			
In-patient Staff Consultation -2 daytime - 2 weekend - 2 evenings	 16.11.11 – day 1.12.11 – day 1.12.11 – night staff To be confirmed	Sara Mitchell Mandy Rolfe Kate Anderson Claire Louise Journeaux			
In-patient Patient/Service User Consultation Edgecumbe Inpatient consultation	15.11.11 5.12.12 To be confirmed	Sara Mitchell Mandy Rolfe Kate Anderson Claire Louise Journeaux			
In-patient Carer Consultation - 2 sessions	To be confirmed	Sara Mitchell Mandy Rolfe Kate Anderson Claire Louise Journeaux SM/CLJ			
Community Staff - 1 Session	To be confirmed	Sara Mitchell Mandy Rolfe Kate Anderson Claire Louise Journeaux			
Edgecumbe move to Greenfield	Oct/Nov in agreement with S. Adams, Estates by 31.12.11	SA/Edgecumbe Staff mgr Claire Louise Journeaux			

Plympton General Office/Admin Staff/ Medical Secretaries/Support Staff eg Porters and Hotel Services - 1 Session	By 30.11.11	Sharon Veitch et al			
Period of minor refurbishment	Nov 11 – Jan 12	Suzanne Adams Estates			
Pinewood → Edgecumbe	By 31.1.12 to be confirmed with estates	Mandy Rolfe Estates Suzanne Adams			
Oakdale → Cotehele	As soon as possible after the Pinewood move is completed by 28.2.12	Mandy Rolfe Estates Suzanne Adams			
OPMH to vacate the Plympton site by 30.3.11					

Plymouth Hospitals NHS
NHS Trust

Report for:	Plymouth Health and Adults Overview and Scrutiny Committee
Report Topic:	Car Parking Improvements at Derriford Hospital
Report date:	For 9 November 2011

1. Introduction

Car parking is a fundamental part of the patient and public's care pathway. Difficulty in parking and finding the entrance to the hospital is stressful for patients and members of the public and can have a profoundly negative effect on their experience at the start of their visit.

Feedback from our patients and LINk (Appendix A) tells us that they find it difficult to find somewhere to park on the Derriford site. We are determined to change the way car parking is managed to make it easier and better for our patients, members of the public and visitors to the Derriford site. At the same time, we have to meet the needs of our staff.

Since March 2011, we have been working with expert external car parking contractors to design and implement plans to make these improvements. A member or members of this Committee were invited to join this process in February 2011.

Through this competitive process, we are looking to radically improve and change the way the traffic and car parking is managed on the site. The proposed solution will have evolved through many hours of discussion, involving members of staff from across the organisation, the public and patient representatives including LINk.

At the time of writing, the final solution has not yet been determined but there are some key principles and enhancements that will form part of the final solution, regardless of the chosen contractor. The preferred solution and expert contractor will be decided in November 2011, following a final evaluation process in which members of staff, patients, the public and governors will be involved before being presented to the Trust Board. The new contract will start in January 2012 and the improvements will begin to happen.

2. Current Situation

The current system is not working because:

- Patients tell us that the signage is not good enough
- Patients tell us there are not enough spaces for the public, particularly at peak times
- Patients tells us having to pay before they go into the hospital is stressful and they don't always have the right money on them
- Accessing change for paying or help when needed is not easy for patients
- Parking attendants are not visible
- There are not enough disabled parking bays of adequate size.

- The public have to drive in a 'route' to find a parking space (through A to B through B to C) as they are not signposted to an appropriate car park with spaces. This is not acceptable
- The site is very congested and parking is not controlled
- There are safety issues with cars (mainly staff) parked across loading bays and within areas that should be kept free for deliveries
- The 45 minutes free parking, introduced in good faith to aid with drop-offs and pick-ups, is being heavily abused. This is borne out by an average of £10,786 reduction in income per month since this was introduced. This is a total of £129,432 per annum at a time when activity and visitors to the site have increased.
- A significant number of staff are parking in spaces which are designated for patients and the public

3. Changes to Improve Parking for Patients and the Public

- Our car parking charges, that mirror the City Council rates, will not increase but will be held at the current rates for the next few years.
- Changes to the traffic flows on entering Derriford Hospital site and accessing car parks will result in improved quality of service. It will be easier to get to a car park as not all the traffic will be going in the same direction.
- Our patients and members of the public will be directed to a car park with spaces upon entering the Derriford Hospital site. The use of visible and electronic signage indicating where spaces are available will mean less time spent driving around looking for spaces.
- Improved entrances, exit and traffic flows around most of the car parks will make it quicker and easier to find a parking space and safer as there will be less crossing of traffic flows.
- Some car parking areas on site will be re-designated as public to give more parking spaces for patients, closer to the services they are going to visit.
- Staff will be prevented from parking in public car parks which will release at least an additional 120 spaces for patient use.
- Increased use of Trust owned park and ride sites by staff, including the allocated spaces at the George Junction Park and Ride site, ensuring more on site spaces reserved for patient use. This will also enable the Trust to meet its Green Travel Plan commitments by reducing the number of single occupancy car journeys made to the Hospital and reduce on site traffic congestion.
- An increase in the number of disabled spaces will mean all blue badge holders will be able to access disabled spaces in the future. An increase in the size of disabled parking bays will mean that there will be enough room to ensure disabled members of staff, patients and members of the public are able to get out of their car and into the hospital safely.
- The introduction of new barriers and pay on exit within public car parks will help to provide a less stressful experience for patients and the public as they will not need to think about payment until they are leaving. They will not need to think about having the correct change for payment on them and it will also make it quicker for patients and the public to get to wherever they need to go within the hospital.

- Visible car parking office and access to immediate assistance, if required.
- Newly painted white lines and road markings will ensure that patients and the public are safe whilst accessing our services.
- Not having cars parked in access, loading or delivery areas will make for a safer site.
- Improved drop off areas will mean that less people will need to use the car parks for a very short stay.
- A reduction in the free parking period, to allow drop off and pick up, from 45 minutes to 15 minutes will enable improvements to be made and public and staff car parking charges to be frozen at their current rate.

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PLYMOUTH CITY COUNCIL

Subject:	Health and Adult Social Care Overview and Scrutiny Panel Biannual Report
Committee:	Health and Adult Social Care Overview and Scrutiny Panel
Date:	9 November 2011
CMT Member:	Carole Burgoyne (Director for Community Services)
Author:	Ross Jago (Democratic Support Officer)
Contact:	ross.jago@plymouth.gov.uk
Ref:	
Part:	Part I

Executive Summary:
This report sets out a review of the Health & Adult Social Care Overview and Scrutiny Panel incorporating the meetings of 8 June 2011 – 14 September 2011.

Corporate Plan 2010-2013:
The Health & Social Care Overview and Scrutiny Panel provides strategic scrutiny of the following Corporate Improvement Priorities and key areas:

- Corporate Priority - Delivering Value For Communities
- Corporate Priority - Reducing inequalities
- Health performance
- Adult Social Care performance
- Commissioning
- Health and Adult Social Care Integration

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land
Adult social care is one of the Council's largest areas of revenue spend, so effective scrutiny of Health delivery plans is a key element of corporate performance management arrangements.

Other Implications: e.g. Section 17 Community Safety, Health and Safety, Risk Management, Equalities Impact Assessment, etc
None

Recommendations & Reasons for recommended action:
That the report is noted

Alternative options considered and reasons for recommended action:
N/A

Background papers:
Health & Adult Social Care Overview and Scrutiny minutes and forward plan

Sign off: N/A

PLYMOUTH CITY COUNCIL

Health and Adult Social Care Overview and Scrutiny Panel Biannual Report

1. Introduction

This report sets out a review of the Health and Adult Social Care Overview and Scrutiny Panel, incorporating the meetings of 8 June 2011 – 14 September 2011.

2. Scope of the Overview and Scrutiny Panel

2.1 The Health and Adult Social Care Overview and Scrutiny Panel is primarily concerned with the strategic scrutiny of the following Corporate Priorities and key areas:

- Corporate Priority - Delivering Value For Communities
- Corporate Priority - Reducing inequalities
- Health performance
- Adult Social Care performance
- Commissioning
- Health & Adult Social Care Integration

The terms of reference have recently been revised to reflect the statutory functions of the panel and have been approved by full council. The detailed terms of reference for the panel are contained in Appendix 1.

2.2 At the meetings of the 8 June and 14 September 2011, the panel consisted of the following members and officers -

Title	Name	Attendances (3 meetings)
Councillor (Chair)	Mrs. Bowyer	2
Councillor (Vice Chair)	McDonald	3
Councillor	Dr Salter	3
Councillor	Mrs Beer	1
Councillor	Dr Mahony	3
Councillor	Gordon	2
Councillor	Mrs Bragg	3
Councillor	Tuffin	3
Councillor	Mrs Nicholson	3
Councillor	Mrs Aspinall	3
Councillor	Drean	3
Councillor	Casey	2
Councillor	Browne	2
Lead Officer	Giles Perritt	3
Democratic Support	Ross Jago	3
Co-opted Representative – Local Involvement Network (LINk)	Chris Boote	3
Co-opted Representative PHT Non-Exec Board Member	Margaret Schwarz	2

2.3 The Panel, through effective strategic and operational scrutiny, supported the following cabinet members and CMT officers -

Title	**Name**
Cabinet Member (Adult Health & Social Care) 2011/12	Cllr Monahan
Director for Community Services	Carole Burgoyne

3. Key achievements to date

3.1 The panel has met on three occasions since the last quarterly report was presented to the Overview and Scrutiny Management Board. Meetings have been well structured, managed efficiently and well attended by panel members. A positive contribution has been made to support an effective strategic and operational overview; in particular the following achievements have been made -

- Following a petition presented last year, the panel scrutinised the proposed move of gynaecological cancer surgery services to Truro away from Plymouth. As a result of recommendations made to the Peninsula Cancer Network by the panel the Plymouth service will remain in Derriford Hospital and will provide patients with an appropriate care experience.

- Quality accounts of NHS Plymouth were amended following scrutiny to include information on the formation of Plymouth Community Healthcare.

- A non-executive Board member from Plymouth Hospitals NHS Trust has been reconfirmed as a co-opted member to the Panel, along with the representative from Plymouth LINk

- Recommendation has been made to the Public Health Development unit on the Tobacco Action Plan for Plymouth. The panel challenged several aspects of the plan and will receive a revised version in the near future.

- The panel continues to keep the approach to dementia care under review and will receive further information at future meetings.

- Following a series of "never events" at Derriford Hospital the panel had requested that the Hospital return to the panel should further events occur. The panel received a further report of a "never event" in July 2011.

4. On the Horizon

4.1 The panel has a programme planned over the coming months which include –

- A review of urgent care in plymouth.

- The initial business plan for foundation trust status from Plymouth Hospitals Trust.

- The Dementia Strategy

- The Plymouth Hospitals NHS Trust Infection Control Update

- NHS Plymouth, Plymouth Hospitals Trust and Plymouth City Council Joint Finance and Performance Monitoring, including performance monitoring.

- A report of the work towards alcohol and tobacco harm reduction.

4.3 A Project Initiation Document (PID) has been approved to undertake a task and finish group on Safeguarding Vulnerable Adults, amongst other things–

- To review and assess the adequacy of policies relating to the protection of whistleblowers.
- To review and asses the adequacy of the current unannounced
- To consider guidance and procedures and to be assured that care services are protecting vulnerable adults in a range of care settings.
- To understand the triggers for raising an alert
- To examine multi-agency alerting procedures for reporting alleged cases.

4.4 The Health and Adult Social Care Overview and Scrutiny Panel looks forward to a challenging year which will focus on the changes being experienced in the Health sector and the impact on social care services. Public health transition into the local authority will also feature on the panels agenda along with the development of the Health and Wellbeing Board and Healthwatch. The panel will consider these strategic issues alongside service changes proposed by adult social care and health services and continue to monitor the performance of services for the people of Plymouth.

5. Recommendation

That the progress of the Health and Adult Social Care Overview and Scrutiny panel is noted by the Overview and Scrutiny Management Board.

Health and Adult Social Care Overview and Scrutiny Panel
Terms of Reference

1. To scrutinise matters relating to health, adult social care and public health. To hear the views of local residents, with a view to improving health services, reducing health inequalities and improving the health of local residents.

2. To respond to consultations by local health trusts and by the Department of Health.

3. To consider whether changes proposed by local health trusts amount to a substantial variation or development and, if so, to take appropriate action including appointing members to any joint committee where the proposals cover more than one local authority's area, including undertaking all the statutory functions in accordance with Section 244, of the National Health Act 2006, regulations and guidance under that section.

4. To assist the council in the management of its contractual arrangements relating to LINks under section 221 (1) of the Local Government and public involvement in health act and statutory instrument 2008 No. 528.

5. To scrutinise the impact of the Council's own services and of key partnerships on the health of its population.

In performing the above duties the Panel will scrutinise:-

- Arrangements made by local NHS bodies to secure hospital and community health services for the residents of Plymouth;

- The provision of family health services, personal medical services, personal dental services, pharmacy and NHS ophthalmic services;

- the public health arrangements in the area, e.g. arrangements by NHS bodies for the surveillance of, and response to, outbreaks of communicable disease or the provision of specialist health promotion services;

- the planning of health services by NHS bodies, including plans made in co-operation with local authorities, setting out a strategy for improving both the health of the local population, and the provision of health care to that population;

- The arrangements made by NHS bodies for consulting and involving patients and the public under the duty placed on them by Section 11 of the Health & Social Care Act 2001;

- Any matter referred to the Committee by a patients' forum under the NHS Reform And Health Care Professions Act 2001;

- Social care services and other related services delivered by the authority.

Policy Areas

- Adult Social Care
- Partner Organisations NHS Plymouth, NHS Plymouth Hospitals Trust, South West Ambulance Service, LINk, Strategic Health Authority and the Department of Health.

Cabinet Members

- Adult Health and Social Care

Directorate

- Public Health
- Community Services

Plymouth Priorities

Monitor performance against the relevant corporate priorities.

Membership

The Chair of the Panel shall serve on the Overview and Scrutiny Management Board. The Health and Adult Social Care Overview and Scrutiny Panel will be chaired by a Member of the majority political group with the vice-chair from the opposition political group. The panel can consider inviting non-voting co-opted members to join the panel, subject to the approval of management board. All Members of the panel will adhere to the general rules of overview and scrutiny.

Health and Adult Social Care Overview and Scrutiny Panel

Work Programme 2010/11

Topics	J	J	A	S	O	N	D	J	F	M	
Health and Social Care Bill											
Healthwatch				**14**							
Health and Wellbeing Boards				**14**							
Public Health											
Alcohol Harm Reduction & Tobacco Control Strategy						**9**					
NHS Plymouth Primary Care Trust Services											
Gynaecological Cancer Surgery Service Change Update				**14**							
NHS Plymouth - Quality Improvement Productivity and Prevention (QIPP) Update		**20**									
Review of Urgent Care Services						**9**					
Plymouth NHS Hospitals Trust											
Plymouth Hospitals NHS Trust – Infection Control Update										**7**	
Never events post inspection update		**20**									
Plymouth City Council – Adult Social Care											
Winter pressure and reablement fund Update				**14**							
Safeguarding Adults						**9**					
Dementia Strategy Update						**9**					
Task and Finish Groups											
Safeguarding Adults (TBC)											

Topics	J	J	A	S	O	N	D	J	F	M	
Performance Monitoring											
Quality Accounts										**7**	
NHS Plymouth, Plymouth Hospitals Trust and PCC Joint Finance and Performance Monitoring, including LAA Performance Monitoring.								**25**			

Key:

* = New addition to Work Programme

NHS South of England

South West Strategic Health Authority

Briefing for Overview and Scrutiny Committees

Introduction of NHS 111 in the South West

1. Purpose of the report

1.1 The aim of this paper is to provide Overview and Scrutiny Committees with information about plans to introduce NHS 111 services across the seven Primary Care Trust clusters within NHS South West.

1.2 Overview and Scrutiny Chairs and chief Officers and Local Involvement Network leads have previously received a verbal briefing on these proposals from the Head of Engagement and Stakeholder Relations at the South West Strategic Health Authority.

2. Decisions/actions requested

2.1 Overview and Scrutiny Committees are asked to:

- receive and note proposals for the introduction of NHS 111 within the South West;
- note the opportunities to comment on the development of the new services.

3. Background

3.1 NHS 111 is a new national NHS service. It is a telephone advice line and signposting service for patients with unscheduled health problems which require assessment but which are not so serious as to require a 999 call.

3.2 NHS 111 is a free to call number available 24 hours a day, 365 days a year to respond to people's healthcare needs when:

- they need medical help fast, but do not believe it is a 999 emergency;
- they do not know who to call for medical help, for example they do not have a general practitioner to call or are away from home;
- they think they need to go to Accident and Emergency or another NHS urgent care service;
- they require health information, signposting, or reassurance about what to do next.

3.3 The service is intended to provide consistent clinical assessment at the first point of contact and route customers to the right NHS service first time, without the need for the caller to repeat information. The service provider will have a call

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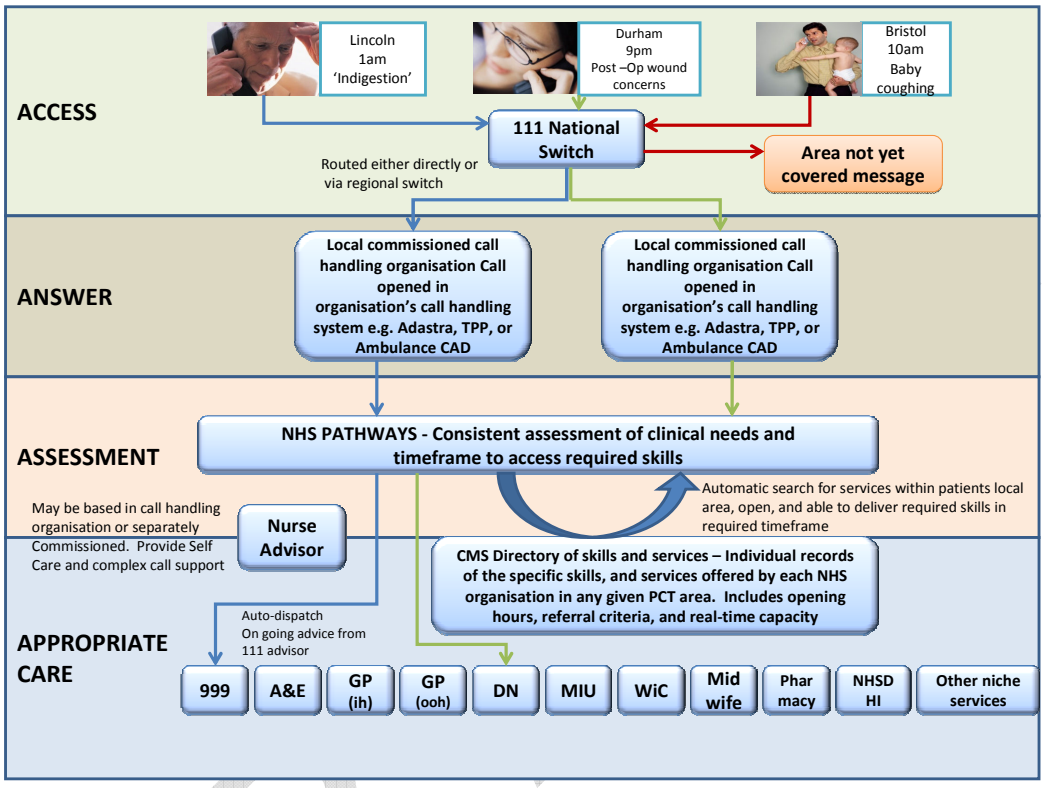
handling system with support software, which links automatically into a comprehensive local directory of service.

3.4 A flowchart showing the service model is below in Table 1.

Table 1: NHS 111 – service model



3.5 NHS 111 was introduced in four national pilot sites in 2010. These are in County Durham and Darlington, Nottingham City, Lincolnshire and Luton.

3.6 The Department of Health has committed to ensuring that NHS 111 is available in all localities by April 2013. Each Strategic Health Authority, in conjunction with Primary Care Trust Clusters and Clinical Commissioning Groups, has been asked to put plans in place to deliver this.

3.7 National research in 2009 found that 38% of those questioned were not sure of the care options available for non-emergencies outside general practitioner surgery hours.

3.8 The Strategic Framework for Improving Health in the South West similarly identified a need to simplify public access to urgent care, with the current system leaving many people unclear which number to call. NHS 111 is intended to address that need directly.

4. Current service arrangements – what happens now?

4.1 Currently, people with urgent care needs have a number of choices. They may request an urgent appointment with their general practitioner, ring their out of

hours provider, call NHS Direct, attend a minor injury unit, urgent care centre, Accident and Emergency department or other local service.

4.2 In a significant proportion of cases the first destination may not be the most appropriate for that patient, and there is no opportunity for them to be signposted elsewhere early on.

4.3 Callers to current services also frequently need to wait to be called back by an advisor, and to repeat their name, details and other information each time they speak to a new advisor.

4.4 There is potential for both duplication and gaps in current provision of urgent care services.

5. Proposed service development – what will change?

5.1 The seven Primary Care clusters within the South West have been working with Clinical Commissioning Groups and the Strategic Health Authority to develop plans to implement NHS 111 by April 2013.

5.2 The NHS 111 service will provide a single, easy to remember number for people to call with any urgent care need. It will route them through to the right service for them, first time.

5.3 The aim of the South West service, in line with the national specification, is to simplify access to the urgent care system by:

- improving public access to urgent healthcare;
- helping people use the right service first time, including self-care;
- providing management information on usage of services to commissioners;
- enabling and supporting quality and productivity plans for urgent care.

5.4 The core principles that the new service will deliver are the ability, 24 hours a day, 365 days a year, to:

- dispatch an ambulance without delay where the call is an emergency;
- complete a clinical assessment on the first call without the need for call back;
- refer calls to other providers without re-triage;
- transfer clinical assessment information to other providers;
- book appointments where appropriate;
- signpost to another service, where outside the scope of 111;
- conform to national quality and clinical governance standards.

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5.5 These represent an improvement on the current system and will help people to navigate the urgent care system much more rapidly.

5.6 The new system also involves the development of a comprehensive directory of service. The directory of service lists and defines all local services with daily availability. When people ring NHS 111 the call handlers will have access to the local directory of service and be able to direct the caller to the service most appropriate to their needs.

5.7 Suitable providers for the call handling and clinical assessment services are being sought through a procurement process. There is a single collaborative procurement across the South West with local geographical lots based on the seven Primary Care Trust clusters:

- NHS Bath and North East Somerset and Wiltshire;
- NHS Bristol, North Somerset and South Gloucestershire;
- NHS Cornwall and Isles of Scilly;
- NHS Devon, Plymouth and Torbay;
- NHS Dorset, Bournemouth and Poole;
- NHS Gloucestershire and Swindon;
- NHS Somerset.

5.8 Potential suppliers may bid to provide a service for one or all lots.

5.9 Other elements of the service, including for example maintenance of an up to date local Directory of Service, will be provided in parallel but are not part of the procurement. Population of the Directory of Service is already underway in all cluster areas.

5.10 NHS 111 services will be organised at Primary Care Trust cluster level, with clinical governance arrangements managed locally.

5.11 The NHS Direct 0845 4647 number will be decommissioned in April 2013 when the NHS 111 service is available nationally.

5.12 The NHS 111 service in the South West will conform to a national service specification so that a consistent identity and quality of service is maintained across the country, but delivered locally by the NHS in a way that is most appropriate for each area.

6. Expected benefits from the proposed service development

6.1 The chief benefits anticipated are:

- for the public and patients:
    - streamlining access to urgent healthcare;

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- avoiding confusion about which service to call or visit;
- speedier route to diagnosis and treatment;

- for the NHS:
  - good information about usage and availability of services leading to improved commissioning and provision of urgent care to meet local needs;
  - increased public satisfaction with NHS services.

7. The engagement process

7.1 This briefing is being shared with all Overview and Scrutiny Committees within NHS South West. Each Primary Care Trust cluster will have an identified lead to link with the Overview and Scrutiny Committee who will be able to respond to questions and share details about local plans and timescales.

7.2 Presentations and discussions are being held with Local Involvement Network leads and groups.

7.3 It is intended that there should be an opportunity for engagement in the development of the specification for the NHS 111 service and in the criteria for assessment of potential providers. It is also intended that during the procurement there will be an opportunity to hear how potential suppliers propose involving service users in the delivery of NHS 111.

7.4 A further briefing will be provided following the conclusion of the procurement to update Overview and Scrutiny Committees on the outcome and to outline the next steps.

8. Current timescales

8.1 A Pre-Qualification Questionnaire will be published on 3 November 2011 inviting suppliers who have expressed an interest in the procurement to submit initial information. The full Invitation to Tender is scheduled to be published in January 2012 and the provider to be selected in June 2012.

8.2 There will be a substantial period for development and mobilisation of the service, to ensure that robust technical, service and clinical governance arrangements are in place. The planned date for the start of the NHS 111 services across the South West is March 2013.

9. Conclusion and Recommendations

9.1 Overview and Scrutiny Committees are asked to:

- receive and note proposals for the introduction of NHS 111 within the South West;
- note the opportunities to comment on the development of the services.

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NHS Plymouth

Service proposal for stroke care
For Information and Comment

Presented by: Elaine Fitzsimmons, Assistant Director of Commissioning

1 Purpose of the briefing

There are 2 distinct phases to the redesign of services for people who have experienced a stroke. The first phase is Plymouth Community Healthcare (PCH) proposing to relocate the existing inpatient beds from the Stroke Unit at Mount Gould Hospital to a dedicated part of Skylark Ward at the Local Care Centre and to develop an early supported discharge scheme. The second phase is a broader review of services across the acute and rehabilitation stages including the services and facilities provided throughout the Plymouth health community as described in this paper.

To bring to the attention of the panel a proposed review of the approach to providing stroke services in Plymouth. The purpose of this review is to develop a range of possible options on how the service might be provided and will include an option for no change. This review is a first step only and how we take the work forward after the review will depend on its outcome and a subsequent appraisal of the resulting options. We want to share these plans with the Health and Social Care OSC at this early stage so they are aware of our proposal and can have the opportunity to determine and advise us of the level of scrutiny they feel is needed.

2 Decisions/Actions requested of the OSC

Members of the panel are asked to:

- Note the proposed review
- Advise us on any requirements for future updating on the progress of the review

The following paper sets out why we feel a review is needed and how we plan to take this forward.

3 Background

In 2007 The Department of Health introduced a range of national key quality indicators for stroke care. These were further strengthened by the publication of NICE guidance in 2010. Locally, these were followed by a baseline review of services by the South West Strategic Health Authority (SHA). This review in 2009 highlighted areas in need of focus around a lack of professional cohesion; silo working and greater attention on supporting a patient-centered approach to service provision.

In response, the commissioners and providers entered an intense period of improvement led by a service line manager and a community clinical leader with support from the Peninsula Heart and Stroke Network and funding for education and data collection. This service line approach was agreed by the main providers with the commissioners.

To support this improvement work, the service line manager and clinical lead had authority vested in them to work across the providers, which allowed them to provide

cohesion around leadership, decision making and clinical challenges to practice. Each provider retained their own operational structures but these reported to the service line manager to whom they were accountable for their practice. The main providers of stroke care within Plymouth have worked hard to improve patient care and this approach has realised savings to the community and for providers and has significantly improved patient care. For example, in 2008 84% of patients spent only 19% of their inpatient time in a dedicated stroke unit. Now, 84% of all patients spend 90% of their time in dedicated stroke units.

In January 2011, the Care Quality Commission in their document "Supporting Life after Stroke" rated Plymouth health and social care as 'Best Performing' for stroke services in the country. Plymouth scored top marks in the category, *support for participation in community life* and scored very well for *community services including specialist rehabilitation services* and *outcomes for patients one year after their stroke*. The report also identified some areas requiring further focus such as:

- helping people to identify the early signs and symptoms of a stroke and so obtain urgent clinical advice,
- the provision of additional therapy time across all sectors
- looking at the lengths of stay in our community rehabilitation unit (which are significantly longer than comparable units), and
- developing early supported discharge services

In addition to the improvements recommended by the review; the National Tsar leading the review, Damien Jenkinson, challenged the NHS in Plymouth to consider if improvements in clinical outcomes, quality, productivity and financial position could be enhanced further by combining the acute and rehabilitation inpatients units. It is important to note this was not an absolute recommendation, as there is no evidence to suggest that one combined unit is better than two single and separate units in terms of outcomes for patients.

4 Current position

Stroke services in Plymouth are currently provided by Plymouth Hospitals NHS Trust (PHNT) and Plymouth Community Healthcare Community Interest Company (PCH CIC). PHNT provides the acute service and PCH CIC provides a bed-based rehabilitation service. The service and inpatient beds are therefore split across two sites, some six miles apart. The acute stroke unit is based at Derriford Hospital whilst the rehabilitation unit is based at Mount Gould Hospital.

It is recognised that despite all the improvements that have been made, further and continued improvement is needed and that there are still some gaps in the care pathway. For instance, the community based rehabilitation service does not have an early supported discharge service and there is also a need to increase the level of general therapy support for patients who have been discharged. In addition, there is a belief that current inpatient costs are greater than they need to be.

5 Proposal

The commissioner feels that, despite all the improvements that have been made and given the identified need for more improvement in stroke services, and the belief that the cost of providing an inpatient service is higher than it ought to be, that they should give the National Tsar's recommendation for combining the two units serious

consideration. However, the commissioner also recognises that there maybe other clinical or practical issues which should be considered before making this decision.

The proposed review is intended to provide an independent view of the best way forward and to look into all these issues and provide a recommendation about the future shape of stroke services in Plymouth. The rationale for proposing this review is the need to test a number of observations and answer a range of questions that have arisen around the provision of stroke services both as a result of the original SHA review and our own subsequent improvement work. In the process of doing this review, we hope to be able to provide the evidence required by the Nicholson four tests when any change is under discussion. That is, that any change has:

- The support of GP Commissioners
- Is based on a clear evidence base that is relevant to Plymouth
- Has involved patients and the public
- Enhances patient choice

The proposed review has already been discussed with the GP commissioners (SCCE) and has their support. Devon and Cornwall commissioners have been advised of the proposal, have given their approval and are currently working to engage their clinicians.

The commissioner is looking for a report that identifies a range of options that includes one integrated unit and another for two stand alone units but that does not presume that these may be the only options available. It is the purpose of the review to explore all possible options.

The review will need to consider the options from a range of different perspectives so that it helps the commissioner understand what the options are able to offer in terms of improving quality and costs. To do this, the review will require input from; clinical and communication and engagement teams across the cluster; patients, carers and members of the public, and key stakeholders such as LINks and OSCs.

6 Timetable

The Heart and Stroke Network are supporting this work by providing sample service specifications to NHS Plymouth. These will be in first draft by the end of November. It is hoped a recommendation could be presented to the Sentinel Clinical Commissioning Executive (SCCE) group in January or February.

7 Engagement to date

At this stage there has not been any specific engagement with patients but commissioners acknowledge the need for patient involvement in identifying the patient experience of the services as they are currently provided; the possible options and in assessing the impact of these on the patients and other users of the services that will inform the ultimate decision on the future model of stroke service provision.

Engagement plan

Aim

To ensure that all stakeholders:

- Are aware of the review, any options identified, any changes arising from the review and how they can be involved in the process of the review and beyond
- Inform the development of the options to be appraised
- Are involved in appraising the various options particularly in respect of the varying impacts on them
- Are involved in any redesign of the service model arising from this work

Stakeholder list

- Local stroke patient groups
- Local carers groups
- Local Involvement Network (LINks)
- OSCs
- Groups representing hard to reach communities
- Staff from both providers
- Clinicians
- Plymouth third sector consortium's health forum
- Social care colleagues

Methodology

Because these services are used by people from beyond the Plymouth area and take patients from both Devon and Cornwall, engagement needs to take place across that geographical area. The engagement work will supported by the communication and engagement leads from Devon and Cornwall and work with local communication and engagement staff where this is appropriate.

The draft engagement plan below sets out how we will engage with patients, carers and members of the public (service users) and reflects the diversity of the populations we want to engage with and adopts a range of activities that covers the provision of information (giving information), discussions with service users (gathering information), reference to the effects any decision will have on service users (participation) and the involvement of service user representatives in the decision making process (partnership). The plan sets out the different elements and the actions they will require.

Aim	Action	Support functions required	Target date for completion
To ensure that stakeholders are aware of the intended review of services	To inform stakeholders of the plan to review the service and seek their involvement using a range of communication methods.	Communications	TBC
To understand the experiences of users of the current services and other stakeholders	To examine sources of patient experience data to include: • Complaints, compliments and suggestions • PALS episodes • Patient Opinion • Feedback received	Business intelligence Patient Services departments Patient and public Involvement Leads	TBC

	from community and third sector organisations • Staff feedback		
	To canvass key stakeholder groups with regard to their experience of services as they are currently provided this to be done for: • Service users using only acute services • Service users using only rehabilitation services • Service users who have used both services • Provider and Social care staff	Patient and Public Involvement leads Project team members	TBC
Work with stakeholders to explore possible options regarding the future model of service provision	To hold an event(s) at which different options are floated	Patient and public Involvement Leads Project Team members	TBC
	Through these events to identify individuals who wish to be involved in impact assessing the various options.	N/A	TBC
To involve all stakeholders in impact assessing the various options identified	To establish a time limited patient reference group to assess the impact on service users of the various options.	Project team with support from PPI Lead for the project	TBC
	To canvass the views of the wider stakeholder population using a range of tools that might include: A survey Face to face discussions with specific stakeholder groups (e.g. Carers)	Project team with support from PPI Lead for the project	TBC
To ensure that stakeholders are kept informed of the progress of the review and any outcomes that arise	To inform stakeholders of progress and how they are informing it and have informed the final decision.	Communications	TBC

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