BEST ACHIEVING
COUNCIL OF THE YEAR

Barry Keel
Chief Executive

Plymouth City Council
Civic Centre
Plymouth PL1 2AA

www.plymouth.gov.uk/democracy

Date: 4 January 2012

Please ask for: Ross Jago, Democratic Support Officer
T: 01752 304469 E: ross.jago@plymouth.gov.uk

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

Date: Wednesday 25 January 2012
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 - 8)

The panel will consider the minutes of the meeting of the 9 November 2011.

5. TRACKING RESOLUTIONS AND FEEDBACK FROM THE OVERVIEW AND SCRUTINY MANAGEMENT BOARD (Pages 9 - 12)

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

6. DRAFT BUDGET SCRUTINY RECOMMENDATIONS (Pages 13 - 28)

The panel will receive extracts from budget scrutiny papers regarding Health and Adult Social Care which was presented to the Overview and Scrutiny Management Board on the 11 January 2012. Draft recommendations will follow after the 18January 2012.

7. NHS 111 URGENT CARE TELEPHONE NUMBER (Pages 29 - 34)

The panel will receive a report on the NHS 111 urgent care telephone number.

8. STROKE SERVICE REDESIGN (Pages 35 - 42)

The panel will consider a report on proposals for stroke service redesign.

9. PLYMOUTH HOSPITALS NHS TRUST - FOUNDATION TRUST CONSULTATION (Pages 43 - 72)

The will consider a response to the consultation of Plymouth Hospitals NHS Trust Foundation Trust business plan.

10. WORK PROGRAMME (Pages 73 - 74)

To receive the panels work programme.

11. EXEMPT BUSINESS

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

PART II (PRIVATE 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.

This page is intentionally left blank

Health and Adult Social Care Overview and Scrutiny Panel

Wednesday 9 November 2011

PRESENT:

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

Co-opted Representatives: Chris Boote (Plymouth Local Involvement Network)

Apologies for absence: Councillors Drean and Margaret Schwarz

Also in attendance: Paul O'Sullivan, Joint Commissioning Manager (NHS Plymouth), Debbie Butcher, Commissioning Manager (Plymouth City Council (PCC)), Lucy Beckwith, Commissioning Manager (NHS Plymouth), Sara Mitchell, Locality Manager (Plymouth Community Healthcare (PCH)) Dr. John O'Donovan, Consultant Psychiatrist (PCH), Kate Anderson, Head of Community Memory Service (PCH), Michelle Thomas, Director of Operations (PCH), Andrew Davies, Head of Environmental Services, (Plymouth Hospitals NHS Trust (PHNT)), Lesley Darke, Chief Operating Officer (PHNT) Amanda Nash, Communications Manager, (PHNT) Giles Perritt, Lead Officer (PCC), Councillor Grant Monahan, cabinet member for Health and Adult Social Care (PCC) and Ross Jago, Democratic Support Officer (PCC).

The meeting started at 10.05 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.

38. DECLARATIONS OF INTEREST

The following declarations of interest were made in accordance with the code of conduct –

Name	Minute No. and Subject	Reason	Interest
Councillor Mrs Bowyer	43. Dementia Strategy Update 44. Older People's Mental Health Service Redesign	Care home manager.	Personal
Councillor Dr Mahony	43. Dementia Strategy Update	General Practitioner.	Personal
Councillor Mrs Aspinall	43. Dementia Strategy Update	Chair of Plymouth Dementia Action Alliance.	Personal
Councillor Mrs Aspinall	45. Parking Proposals	Member of Disabled Users Forum	Prejudicial
Councillor Dr Salter	42. Soft Tissue Sarcoma 45. Parking Proposals	Governor in waiting Plymouth NHS Hospitals Trust.	Personal
Councillor Casey	43. Dementia Strategy Update 44. Older People's Mental Health Service Redesign	MENCAP employee.	Personal

CHAIR'S URGENT BUSINESS

39. **MEMBERSHIP OF TASK AND FINISH GROUP**

Membership of the Safeguarding Task and Finish Group was confirmed as follows –

Councillor McDonald (Chair)
Councillor Bragg
Councillor Browne
Councillor Penberthy
Councillor Dr Salter
Councillor Tuffin

40. **MINUTES**

Agreed that the minutes of the meeting held on the 14 September were approved as a correct record subject to the following addition at minute 32 (h)-

It was reported that the LINk had achieved progress and success in many areas and compared favourable both in the south west and nationally. Targets set by the local authority had been surpassed and service improvements in areas significant to local people had been achieved.

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

Agreed that the panel's tracking resolutions were noted.

42. **SOFT TISSUE SARCOMA - NHS PLYMOUTH**

Ann James, Chief Executive of the NHS Devon Cluster introduced a report on service development for soft tissue sarcoma services for adults. It was confirmed that –

(a) a single multidisciplinary team would operate for patients within the peninsula across Plymouth Hospitals and Royal Devon and Exeter sites;

(b) the multidisciplinary team would be responsible for agreeing an appropriate treatment regime for individual patients which would include decisions on which hospital site would be appropriate for surgery if required;

(c) sarcoma diagnosis and treatment will continue to be provided by clinicians who specialise in soft tissue sarcoma.

The panel welcomed the service development and the focus on providing improved cancer services.

Agreed that –

(1) the results of the programme of public and patient engagement would be shared with members of the panel;

(2) the panel noted the proposed approach to providing soft tissue sarcoma services;

(3) the panel noted the involvement of patients, clinicians and the public in the process;

(4) the panel noted the improved quality and safety of the service that the model would deliver over time.

43. **DEMENTIA STRATEGY UPDATE - NHS PLYMOUTH / PLYMOUTH CITY COUNCIL**

Lucy Beckwith (NHS Plymouth) and Debbie Butcher (PCC) introduced an update on the dementia strategy action plan. It was reported that a joint commissioning group had been established with NHS Plymouth as the lead agency for the delivery of the dementia strategy. Details of specific actions delegated to each member of the project group were detailed in the attached report.

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

(a) the dementia quality mark was an accreditation for care homes in the city. To qualify care homes had to satisfy clear standards. Following an application process a panel visited the homes to ensure the information provided was correct. The mark was highlighted on the online directory and would be reviewed the annually. Plymouth University had been approached to evaluate the project and their report would be shared at a future meeting of the panel;

(b) the focus on the reduction in the prescription of anti psychotic drugs was the result of a national focus;

(c) through master classes General Practitioners would be supported to correctly assess and report dementia patients, this issue was part of the work stream on early diagnosis;

(d) carer and service user representation on the board would be considered and would be actioned in consultation with the Plymouth LINk.

Agreed that –

(1) following a proposed review of the hospital discharge process for patients suffering from dementia the panel is updated on findings and proposals for changes at a future panel meeting;

(2) the ambition to be the south west leader in dementia support would be added to the dementia strategy;

(3) progress on the appointment of a service or user representative to the core group would be reported to a future meeting of the panel.

44. **OLDER PEOPLES MENTAL HEALTH - PLYMOUTH COMMUNITY HEALTHCARE**

Paul O'Sullivan (NHS Plymouth) introduced the report on proposed changes to older people's mental health services provided by Plymouth Community Healthcare. It was reported that –

(a) a review of the evidence relating to older people's mental health was undertaken in the summer of 2011. The review highlighted the significant and

increasing issues in older people's mental health, including dementia, and commissioners had requested that providers confirm how they would redirect resources to reflect increasing demand;

(b) there would be a reduction in bed numbers which would be supported by work to stop people being admitted unnecessarily and improvements to discharge. The inpatient units at Plympton would relocate onto a single site at Mount Gould alongside community staff. Initially there would be a reduction in beds from 18 beds per ward to 15 beds per ward;

(c) the changes to inpatient services would be supported by two clear functional and dementia pathways involving inpatients and community teams working in an improved model of service delivery;

(d) a lean and efficient Memory Service would be further developed including a reduction in waiting time and caseload. The service would move towards a time limited period of assessment, diagnosis, treatment and post diagnostic support. There would be a six month follow up appointment for patients prior to discharge back to GP. Difficulties encountered by patients and carers would be assessed by support from the dementia community team and the patient reintegrated into active mental health care at a level appropriate to care need. It was believed that this would reduce the current caseload by approximately 33 per cent.

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

(e) following an extensive review it was found that 18 inpatient beds were no longer required and the reduction in beds would be supported by robust community teams across localities;

(f) Edgcumbe ward at Mount Gould Hospital would be redesigned to accommodate the dementia group. Equipment such as sensory mattresses would be procured and directives on single sex accommodation would be adhered to;

(g) the Memory Service would assess a patient within four weeks following referral. The Memory Service carried out assessments in the patient's own home and could make further referrals to social care. There was currently an 18 week wait for a consultant review.

(h) sensory mattresses were being procured as cot sides were not appropriate for dementia patients;

(i) there were three substantive consultant posts which were filled and making good progress against targets;

(j) there was a developing problem of alcohol related dementia, plans to tackle the problem would be developed through partners and work was ongoing.

Agreed that –

(1) the city council and partners would develop an approach to communicating key dementia support messages to their staff and a progress report would be provided at a future meeting of the panel;

(2) the cross agency work on alcohol related dementia was to be welcomed and the outcome of the work was expected to be reflected in the development of the mental health strategy and services;

(3) the older peoples mental health service redesign was supported by the panel.

45. **PARKING PROPOSALS - PLYMOUTH NHS HOSPITALS TRUST**

Lesley Darke (PHNT) introduced a report on the proposed changes to parking at Derriford hospital. It was reported that –

(a) the current car park contract had been in place for 15 years. PHNT had been in the process of renegotiating the contract and making changes to address issues that had been highlighted by consultees including the Plymouth LINk;

(b) as a result of changes to the contract there would be a net increase in spaces and disabled bays with a more robust approach to car park management including changes to signage, permits and access control;

(c) to support the changes the trust planned to increase the use of staff park and ride schemes;

(d) parking proposals included a visible parking officer, increased advertising of concessionary rates and pay on foot where visitors to the hospital would make payments on exit. In order to achieve this there would be an increased number of automatic barriers in the car parks.

(e) the new contract would commence on the 1 January 2012 and would last seven to ten years. The new multi-storey car park would form part of the car parking solution at Derriford;

(f) the trust had been working hard to bring improvements whilst keeping car parking charges at current levels. To achieve this the current period of 45 minutes of free drop off time would be reduced to 15 minutes;

(g) the trust had consulted the disabled users forum on whether charges for disabled parking would be acceptable, in response the forum had stated that it would not object to charges for disabled users if the charges reflected increased and appropriate provision for disabled visitors.

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

(h) the free drop off period was not intended to be used as a period of free parking for all visitors to the hospital and had been heavily abused. The trust

were balancing costs and the reduction in the free drop off period would ensure that fund were not diverted to parking from frontline service provision;

(i) the changes to the lay out of the car park, along with greater access control and pick up / set down points at key access points to the hospital would ensure that the collection / drop off of patients would be possible in the 15 minute timescale

(j) the new contract included clauses which ensure issues around performance and changes would be tackled in partnership between the trust and the successful bidder;

(k) the multi-storey car park would be completed in 2013.

Members of the panel accepted that changes were required at Derriford to ensure parking provision was fit for purpose, however some members remained concerned that 15 minutes was not long enough to collect or drop off patients at the hospital.

Agreed that –

(1) the panel recommends to the cabinet member for transport that the facilities at the Derriford Hospital bus interchange are upgraded to include an increased number of shelters and benches;

(2) the panel recommends to the cabinet member for transport increased marketing and advertising activity is undertaken with regard to the George park and ride;

(3) PHNT provides real time public transport information in the hospital foyer/reception;

(4) PHNT are requested to ensure that car parking concessions are clearly publicised throughout the Derriford hospital site;

(5) further work is carried out by PHNT on the discharge process for patients to ensure that collection is possible in 15 minutes.

46. BIANNUAL REPORT

Agreed to note the panel's biannual report.

47. WORK PROGRAMME

Agreed to note the work programme and the addition of stroke service redesign and a report on the NHS 111 urgent care telephone number.

48. EXEMPT BUSINESS

There were no items of exempt business.

This page is intentionally left blank

TRACKING RESOLUTIONS
Health and Adult Social Care Overview and Scrutiny Panel

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
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.				25 January 2012
9/11/11 42 (1)	Agreed that the results of the programme of public and patient engagement would be shared with members of the panel	This tracking resolution refers to the report of Soft Tissue Sarcoma Service Change.		The information has been circulated to members via email.	Complete
9/11/11 43 (1)	Agreed following a proposed review of the hospital discharge process for patients suffering from dementia the panel is updated on findings and proposals for changes at a future panel meeting	Dementia Strategy Update	Hospital discharge process added to work programme.		7 March 2012
9/11/11 43 (3)	Agreed progress on the appointment of a service or user representative to the core group would be reported to a future meeting of the panel.	Dementia Strategy Update		Information provided to members via email.	Complete

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
9/11/11 44 (1)	Agreed the city council and partners would develop an approach to communicating key dementia support messages to their staff and a progress report would be provided at a future meeting of the panel;	Dementia Strategy Update			7 March 2012
9/11/11 45 (1)	Agreed that the panel recommends to the cabinet member for transport that the facilities at the Derriford Hospital bus interchange are upgraded to include an increased number of shelters and benches	Parking Proposals - Plymouth NHS Hospitals Trust	Resolution provided to Management Board for recommendation to the portfolio holder for transport.		25 January 2012
9/11/11 45 (2)	Agreed that the panel recommends to the cabinet member for transport increased marketing and advertising activity is undertaken with regard to the George park and ride;	Parking Proposals - Plymouth NHS Hospitals Trust	Resolution provided to Management Board for recommendation to the portfolio holder for transport.		25 January 2012
9/11/11 45 (3)	Agreed that PHNT provides real time public transport information in the hospital foyer/reception;	Parking Proposals - Plymouth NHS Hospitals Trust	Resolutions forwarded to PHNT for inclusion in the new parking scheme.		7 March 2012

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
9/11/11 45 (4)	Agreed that PHNT are requested to ensure that car parking concessions are clearly publicised throughout the Derriford hospital site	Parking Proposals - Plymouth NHS Hospitals Trust	Resolutions forwarded to PHNT for inclusion in the new parking scheme.		7 March 2012
9/11/11 45 (5)	Agreed that further work is carried out by PHNT on the discharge process for patients to ensure that collection is possible in 15 minutes.	Parking Proposals - Plymouth NHS Hospitals Trust	Hospital discharge process added to work programme.		Hospital discharge process added to work programme. 7 March 2012

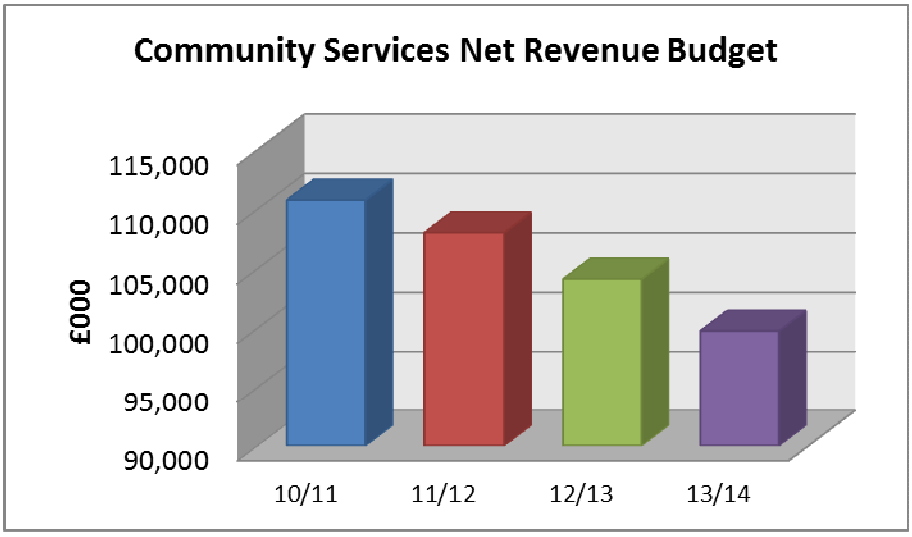
Grey = Completed (once completed resolutions have been noted by the panel they will be removed from this document)
Red = Urgent – item not considered at last meeting or requires an urgent response

This page is intentionally left blank

Extract from 2012/2013 Indicative Budget and Delivery Plans Presented to Overview and Scrutiny Management Board on the 11 January 2012

Community Services

	Net Revenue Budget £000
10/11	110,777
11/12	108,018
12/13	104,118
13/14	99,756



Departmental context

Community Services covers four customer facing departments:

- Adult Social Care
- Environmental Services
- Culture, Sport and Leisure
- Safer Communities

All of these services face a range of challenges in the current economic situation and all face significant policy changes and demands.

Adult Social Care

Major government changes are now reforming the system of social care. It is moving to a service that is more personalised, more preventative and more focused on delivering the best outcomes for those who use them.

We have jointly established a Health and Wellbeing Development Group, reflecting the anticipated role of the Council in ensuring better integration of health and social care as proposed in the Health and Social Care Bill, improving health and wellbeing outcomes for the people of Plymouth.

Nationally, Adult Social Care is facing increasing pressures due to the growth in relevant demographics and increasing levels of long term care needs for high dependency service users. We are projecting a 17% (6,800) increase of over 65s and 12% (700) increase of over 85s by 2015.

The Personalisation Agenda has again been given extra pace this year with targets around direct payments and personal budgets. This has changed both our commissioning activity and service delivery going forward.

Current year

The current year has again been challenging in order to deal with the continued pressure within Adult Social Care and also the rising costs of providing front line services within Environmental Services. Services are continually reviewed to deliver within budget whilst maintaining the level of service expected by our customers.

As a result of continuing cost pressure in Adult Social Care, a cross departmental Programme Board has been in place since 2009/10. The department is rolling out significant change in a managed and phased way which will result in a total transformation of the service by the end of the current financial year.

Delivery Plans 2011/12 – 2013/14

DIRECTORATE	2011/12 Total Delivery Plans	2012/13 Additional Delivery Plans	2013/14 Additional Delivery Plans
COMMUNITY SERVICES	**4,686**	**3,900**	**4,362**

The target in 2011/12 of £4.7m included the stretching challenge to Adult Social Care to reduce costs by £2.3m, with the directorate challenge increasing by a further £3.9m in 2012/13, and another £4.4m in 2013/14.

Community Services is largely on track to deliver the £4.6m delivery plans for the 2011/12 budget. The main challenge has been to deliver a wide programme of modernisation within Adult Social Care which has been very resource intensive; some notable successes around decommissioning, re-provision of services and our contributions policy have come about due to some excellent consultation with service users

The September monitoring shows £0.730m of Delivery Plans with a status of not achieved. Although the department will continue to work hard to offset these plans, there is still a risk of non-delivery. The plans concern the proposed transfer of assets to the community, public toilets for example, and savings associated with the Leisure Management contract.

The target savings increase for 2012/13 by a further £3.900m.This is made up of

- Adult Social Care £2.500m;
- Culture Sport & Leisure £0.230m;
- Cross-cutting targets £1.170m.

Adult Social Care plans going forward are around better commissioning and procurement, and ensuring value for money and a more targeted approach through the use of category

management. We also want to look at integrating commissioning activity within the Council and rebalancing spend across all user groups through personal budgets. We are developing much leaner business processes.

There are also a number of plans linked to reducing back office support within the department and ensuring a more consistent and standardised approach is in place in support areas.

This page is intentionally left blank

Community Services November - 2011/12

Community Services

The financial position for Community Services is currently projecting a year end overspend of £1.219m. We are no longer expecting to achieve the self directed support/direct payments target at year end but, we are expecting to improve on last years outturn position of 31%. Serious acquisitive crime is a concern. Domestic burglary has increased by 21% (129 more crimes) compared to same period last year.

Adult Social Care

The Department is projecting a year end overspend of 0.914m. This is due largely to increased costs of social care where the complexity of the service requires risk management on an on-going basis across all client groups reflected in recent increases in supported living packages of care with some continuing health care funded cases becoming the Councils responsibility. The service continues to focus on scrutinising all spend and managing down expensive packages of care, in particular targeting the Learning Disability Service. Progress is scrutinised and challenged through the Adult Social Care Programme Board. We are no longer expecting to achieve the self directed support/direct payments target at year end but, we are expecting to improve on last years outturn position of 31%. We are rolling out significant change in the Adult Social Care Service in a managed and phased way. This approach will have longer term benefits and has prepared the way for the total transformation of the service by April 2012. Performance has been affected in the short term, as it requires significant culture change and not all staff have received the necessary induction and training to operate in a personalised way. However, we are confident in achieving 100% of service users in receipt of DPs/Personal Budgets by March 2013.

Safer Communities

Serious acquisitive crime is a concern. Domestic burglary has increased by 21% (129 more crimes) compared to same period last year. Theft from vehicle is steady but is also showing an increase of 23% (141 more crimes). Despite this, we are performing well when compared to similar cities. Council crime reduction staff and partners, continue to work on tackling these issues focusing on enforcement and crime prevention.

Culture,Sport & Leisure

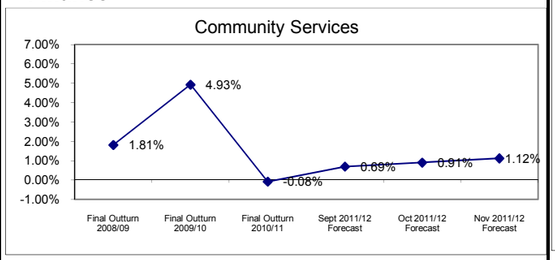
The majority of the performance indicators for Culture Sport and Leisure are expected to meet their end of year target. However, the museum indicator has been affected by the numbers attending touring exhibitions, though visits to the museum itself have increased.

Environmental Services

Environmental Services is projecting a year end overspend as it has not been possible to deliver the Community Asset transfers. There remains an element of financial risk within the budget which the Director and DMT continue to monitor and mitigate. The amount of waste sent for landfill per household (NI 191) has continued to decline during November with performance at 51.45kg against a target of 54kg.This is 15kg per household better than at the same point last year. Work has continued to promote recycling and waste minimisation during this period, including community talks and monitoring of new recycling facilities. There has also been an increased interest in using real nappies which has necessitated the recruitment of a second 'Real Nappy Campaigner', this has doubled the amount of events we can hold in the city. The overall percentage of waste diverted from landfill (NI192) this month has increased to 34.73%, in part due to continuing the garden waste scheme throughout November. The cumulative amount diverted from landfill to date this year is 34.2%

against a 33% target.

Finance

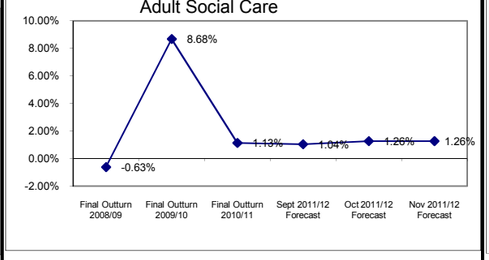


Directorate Budget

£108,613,000

Budget Forecast

1.12%	£1,219,000

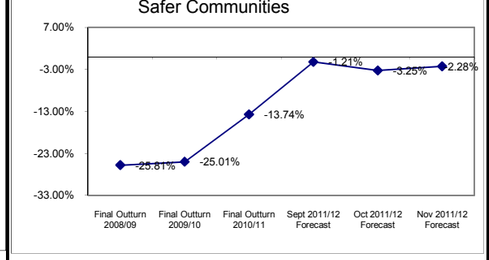


Departmental Budget

£72,406,000

Budget Forecast

1.26%	£914,000

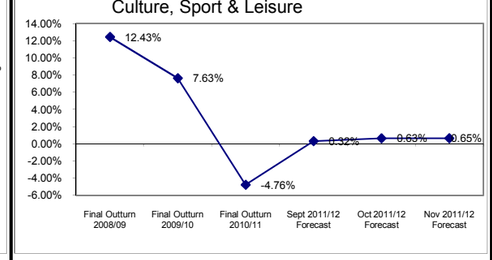


Departmental Budget

£2,495,000

Budget Forecast

-2.28%	-£57,000

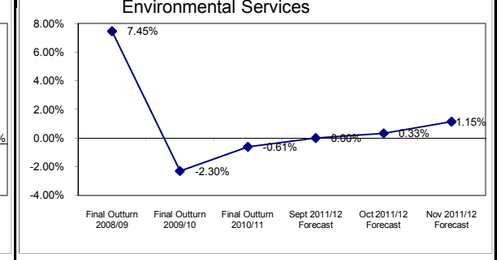


Departmental Budget

£10,004,000

Budget Forecast

0.65%	£65,000



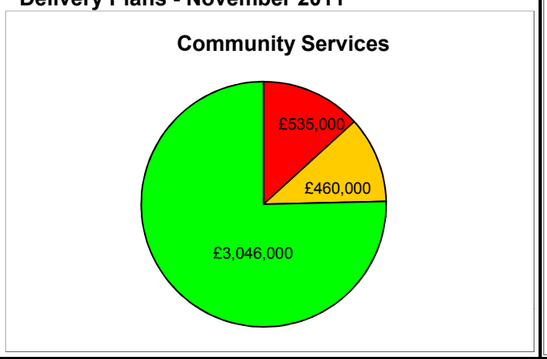
Departmental Budget

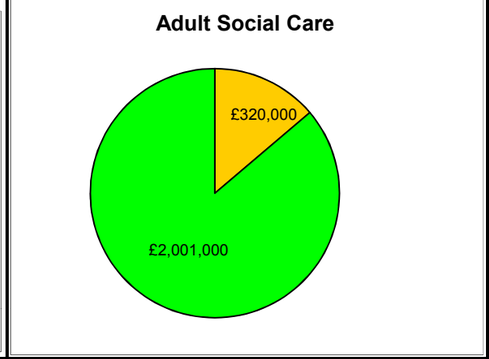
£25,853,000

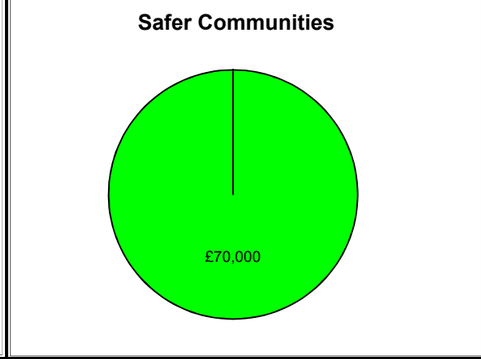
Budget Forecast

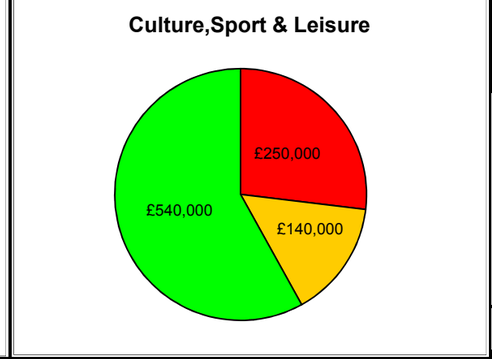
1.15%	£297,000

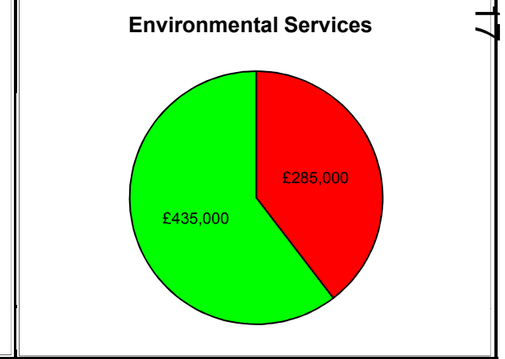
Delivery Plans - November 2011



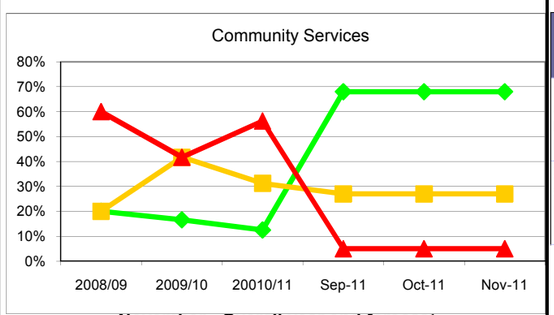








Performance



November - Overall year end forecast

5%	27%	68%

Indicator Definition	November	11/12 Target/ Forecast
1C (ex NI 130) Proportion of people using social care who receive Self Directed Support, those receiving Direct Payments	29.20%	60.00%
2A (ex 1ADF) Permanent admissions to residential and nursing care homes per 100,000 population	107.20	107.71

November - Overall year end forecast

40%

Indicator Definition	November	11/12 Target/Forecast
Rate per 1000 population for Acquisitive Crime	7.36	9.93

November - Overall year end forecast

57%

Indicator Definition	November	11/12 Target/Forecast
Number of Visitors to Museums and Archive Services	110,898	241,000

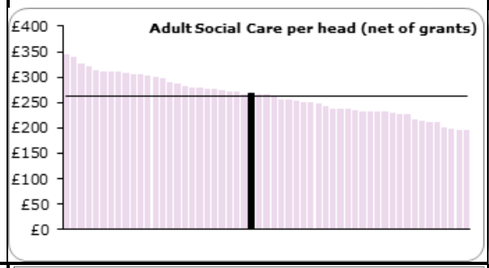
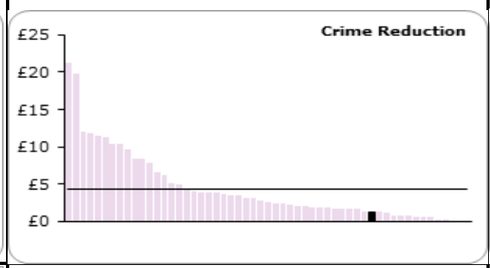
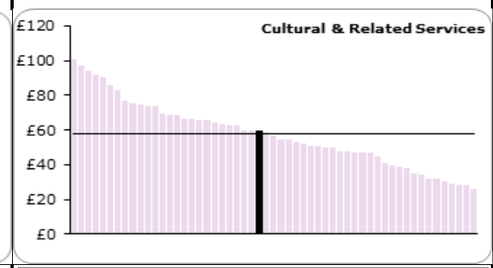
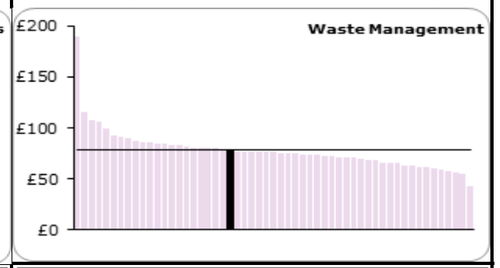
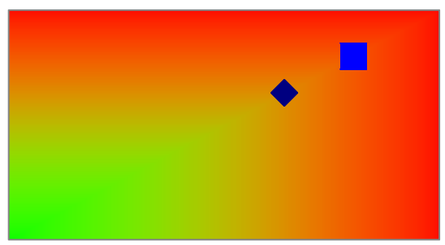
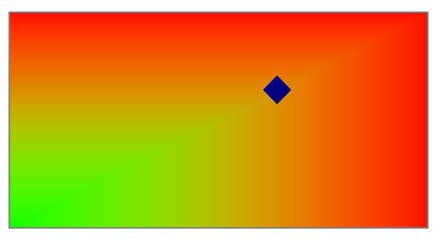
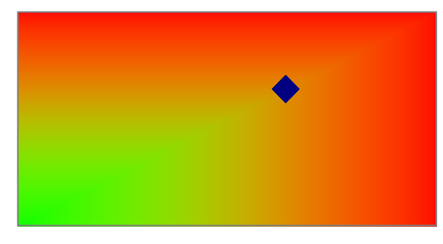
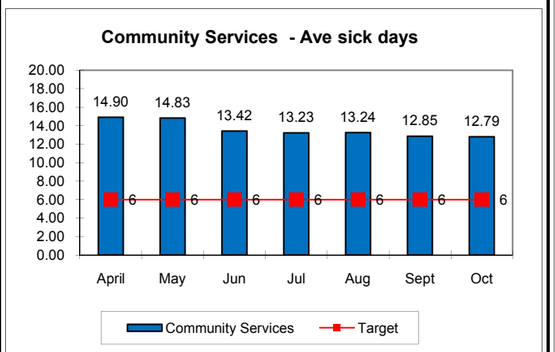
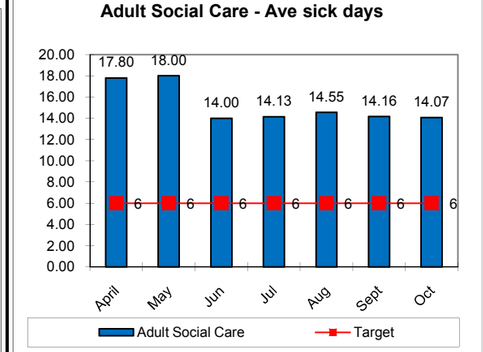
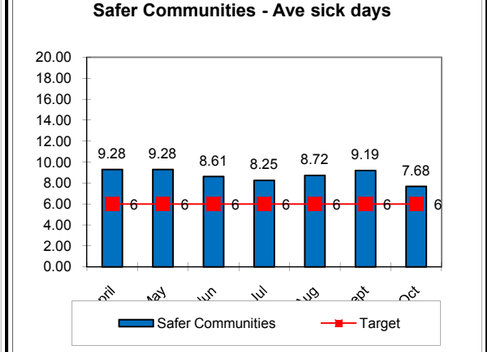
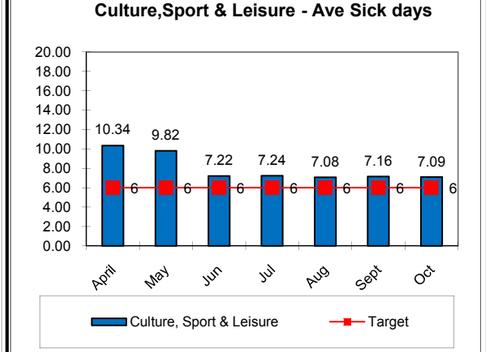
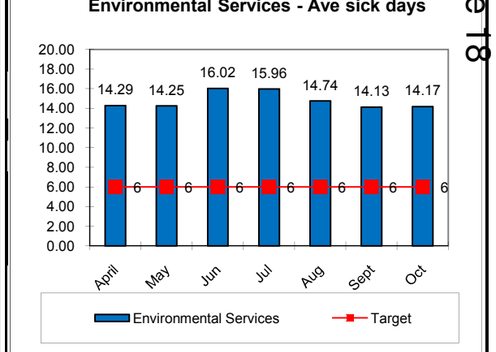
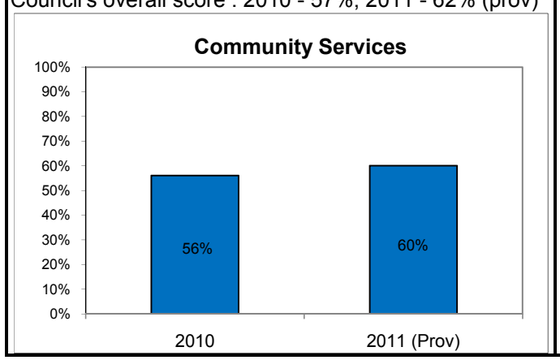
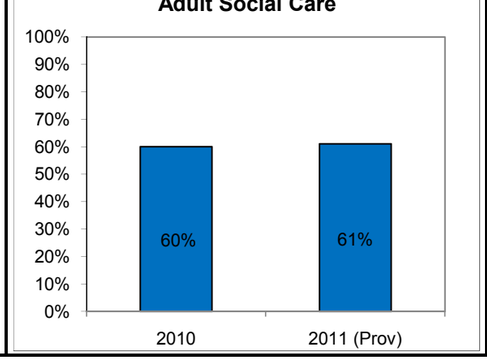
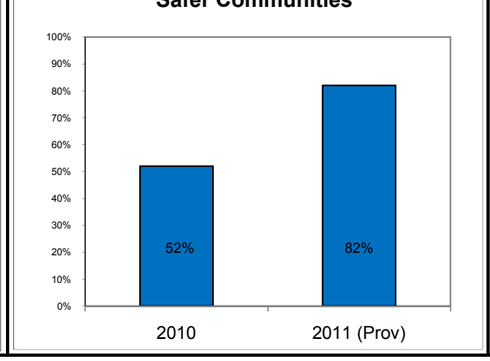
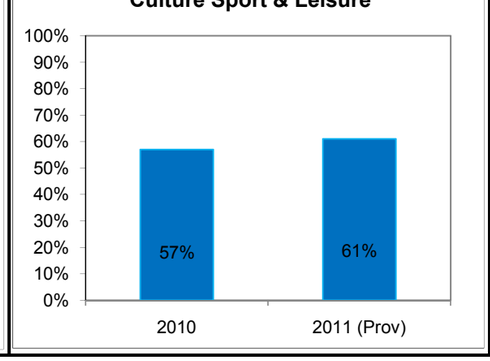
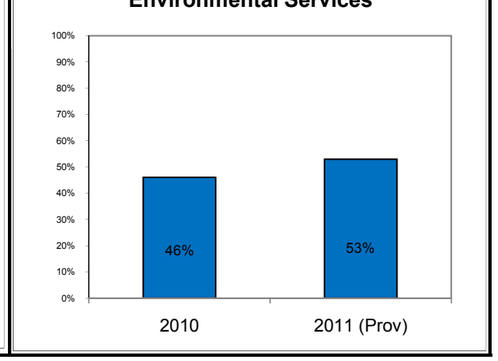
November - Overall year end forecast

75%

No RED indicators

November - Overall year end forecast

100%

Community Services	Adult Social Care	Safer Communities	Culture Sport & Leisure	Environmental Services
	Value for Money (Cost per head compared to all Unitary)	Value for Money (Cost per head compared to all Unitary)	Value for Money (Cost per head compared to all Unitary)	Value for Money (Cost per head compared to all Unitary)
				
Risks **Adult Social Care** - Social Care - Client Management IT Systems (Carefirst) (Strategic Aug 11) (20) **Adult Social Care** - Significant pressure on Adult Social Care budget (Strategic Aug 11) (16) **Culture, Sport and Leisure** - Loss of public records due to failure to meet BS5454 standards (16) **Culture, Sport and Leisure** - Coastal erosion at Mt Edgcumbe (16) **Culture, Sport and Leisure** - Poor conditions of buildings and facilities in relation to Schools Library Service (16) **Environmental Services** - Failure to meet PI targets om recycling and composting targets (16)	 1. Social Care - Client Management IT Systems (Carefirst) (Strategic Aug 11) (20) 2. Significant pressure on Adult Social Care budget (Strategic Aug 11) (16)		 1. Loss of public records due to failure to meet BS5454 standards (16) 2. Coastal erosion at Mt Edgcumbe (16) 3. Poor conditions of buildings and facilities in relation to Schools Library Service (16)	 1. Failure to meet PI targets on recycling and composting targets. (16)
HR 				
Employee Engagement Index Scores Council's overall score : 2010 - 57%, 2011 - 62% (prov)				
				

Delivery Plans

Balancing the budget : Areas for savings, efficiency gains or increase income	Lead Officer	Service	2012/13	2013/14	2014/15	Narrative	Revised 12/13
			£000	£000	£000		R/A/G
Theme 1 Domiciliary Care Services: maximisation of block contracts and standardisation of unit rates, efficiencies across in house and externally provided services	Pam Marsden	Adult Social Care	300	1,100	1,100	Plans continue to be updated and progressed through the Adult Social Care Programme Board	G
Theme 2 Supported Living: remodelling of services and standardisation of unit	Pam Marsden	Adult Social Care	423	623	623	Plans continue to be updated and progressed through the Adult Social Care Programme Board	G
Theme 3 Care Management Services: reviewing of high cost packages and alternative service provision	Pam Marsden	Adult Social Care	200	850	850	Plans continue to be updated and progressed through the Adult Social Care Programme Board	A
Theme 4 Day Care: remodelling of services and standardisation of unit rates	Pam Marsden	Adult Social Care	34	234	234	Plans continue to be updated and progressed through the Adult Social Care Programme Board	G
Theme 5 Enabling and Floating Support: remodelling of services and standardisation of unit rates	Pam Marsden	Adult Social Care	278	278	278	Plans continue to be updated and progressed through the Adult Social Care Programme Board	A
Theme 6 Residential Care - under 65: remodelling of services and standardisation of unit rates	Pam Marsden	Adult Social Care	212	262	262	Progress against the individual projects within this theme continues with incremental savings being captured during the year	A
Theme 7 Workforce re-modelling: linked to CareFirst 6 and Charteris Business process Re-design for the operating model	Pam Marsden	Adult Social Care	950	950	950	Consultation completed. Structures to be delivered for April, subject to Accommodation and ICT timelines. Service operations to be modelled to establish potential level of savings from provision of care	G
Environment Service Programme. Service reprovision and efficiency initiatives	Jayne Donovan	Environment Service	560	560	560	Environment Service programme board working through a range of options	R
Events, grants and other funds initiatives	James Coulton	Culture Sport & Leisure	170	290	290	The suite of delivery plans continue to be worked through to achieve the required savings	A
Transfer of assets: transfer of assets / facilities to local community ownership.	James Coulton	Culture Sport & Leisure	80	80	80	Research into the options has taken place during 2011/12	A
COMMUNITY SERVICES DIRECT TOTAL:			**3,207**	**5,227**	**5,227**		

Publicly Cross-Cutting: Savings delivered on behalf of, or reliant on, other departments							R/A/G
Performance and Intelligence: rationalise performance management, completion of government returns and data analysis across the council. 1/3rd of total planned savings applied to Community Services at this early stage of development	Giles Perritt	Chief Executive	180	180	180	Achieved in 11/12. Residual Target for 12/13 and beyond. Budgets and Delivery Plan to transfer to the Chief Executive as part of the organisational restructure	A
Business Support Review: Rationalise Business Support across the council.	Tim Howes	Other	tbc	tbc	tbc	Community Services engaged in project proposals. Paper proposing delivery plan savings and implementation in progress	G
Leisure Management Contract	James Coulton	Culture, Sport & Leisure	0	250	250	The Leisure Management contract has now been awarded and will commence in February 2012, savings will accrue in future years.	G

COMMUNITY SERVICES INDIRECT TOTAL:	**180**	**430**	**430**

TOTAL DELIVERY PLANS COMMUNITY SERVICES:	**3,387**	**5,657**	**5,657**
2011/12 PLANS ABSORBED IN THE BASE	**3,545**	**3,735**	**3,735**
TOTAL SAVINGS TARGET COMMUNITY SERVICES:	**6,972**	**11,234**	**11,234**
SURPLUS/(SHORTFALL) IF ALL PLANS DELIVERED:	**(40)**	**(1,842)**	**(1,842)**

This page is intentionally left blank

Overview and Scrutiny Board.

P2020 Partnership budget challenge session - January 2012.

NHS Plymouth - overview of budget and priorities for 2012/13.

Introduction.

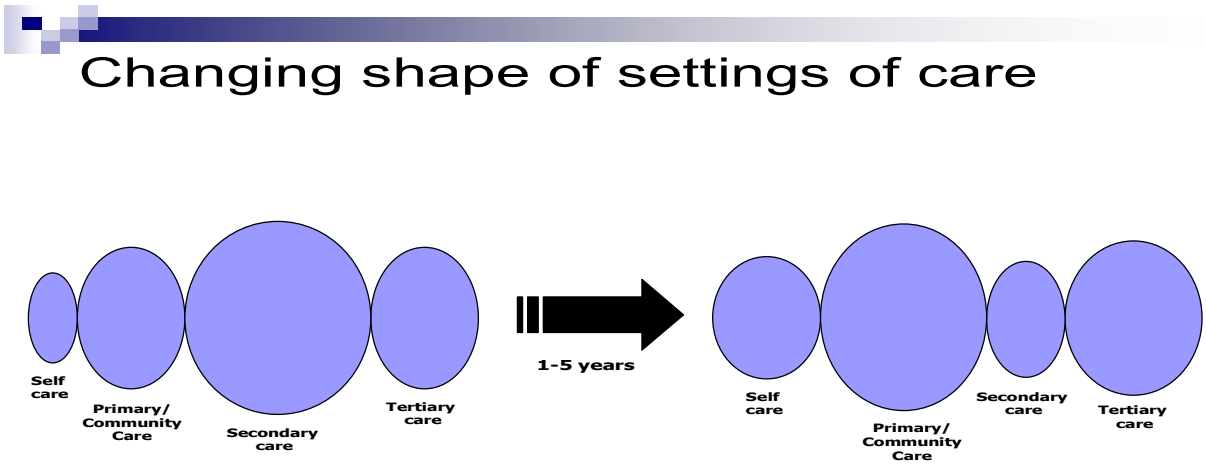
NHS Plymouth is the local branch of the NHS. It is the Primary Care Trust (PCT) responsible for commissioning healthcare from providers for the people of Plymouth.

Our vision is of 'Healthy people leading healthy lives in healthy communities'.

Locally in Plymouth we are working towards a 'Healthy System' which will result in improved outcomes, productivity and allocation of resources. This includes:

- A shift away from unplanned treatments, and towards planned care, planned interventions and personalised care
- An increase in prevention and maintenance, funded by reinvesting costs and capacity released through a reduction in treating preventable illnesses and admissions
- Further reduced waiting times
- An increase in efficiency and a more sustainable cost base through:
    - A significantly increased level of collaborative clinical working to bridge the gap across clinical teams and organisations
    - A focus on reducing the net cost of care, rather than the cost to individual teams and organisations
    - A focus on reducing transaction costs across organisations
    - A focus on equity of care and equity of access, ensuring that funding is targeted at patients with greater health needs and interventions and treatments that are proven to be of greater clinical value
    - Getting the pathway right for patients

The diagram below reflects the resulting expected change in the shape of the Plymouth Health community over the next 5 years. More care is expected to be provided in the community and advances in technology and healthcare mean that patients are often able to leave hospital more quickly after surgery or treatment resulting in the need for a smaller acute hospital.



Financial context

There has been a substantial increase in investment over recent years in the NHS which has significantly improved the overall quality of services, increased access, reduced waiting times, and improved the buildings, wards and clinics in which care is delivered, maintaining the NHS as a universal service, free at the point of delivery.

However, although there are no plans to reduce the level of investment in the NHS over the next few years, the previous year on year increases will almost cease and the cost of delivering care is growing at a rate that is not sustainable. This is mainly due to our increasing ability to treat illness and extend life through the availability of new drugs, treatments and technology and changes to the age profile and lifestyles of the population.

NHS Plymouth's Medium Term Financial Plan (MTFP) for 2012/13 onwards will set out how resources are to be deployed to invest in meeting demand, improving quality and tackling national and local priorities whilst maintaining or continuing to improve day to day standards of performance.

The MTFP is based on assumptions included within the national NHS Operating Framework for 2011/12 and published 2011/12 PCT allocations. A local analysis of the recently published NHS Operating Framework for 2012/13 will be completed during December in order to inform the next revision of the MTFP and the panel will receive a verbal update if this significantly alters any of the messages within this briefing paper.

Allocations received on the 14th December 2011, confirm that NHS Plymouth will receive growth of 2.8% (£11.9m), increasing the allocation from £423.4m in 2011/12 to £435.3m in 2012/13. The NHS and South West Operating Frameworks require NHS Plymouth to set aside:

- Headroom of 2.0% of recurrent baseline or £8.7m
- A minimum level of surplus at 1.0% of recurrent baseline or £4.4m
- PCT Contingency anticipated to be 0.5% of baseline or £2.2m

The NHS Operating Framework also sets out a number of areas (totalling £3.3m locally) in which the PCT is required to plan to invest including Re-ablement, Health Visitors, Carers and the Dementia Strategy.

There are existing commitments to local priorities for 2012/13 totalling £1.9m. This includes investment in the Major Trauma Centre at Plymouth Hospitals NHS Trust, and Primary Care Premises.

Therefore, based on these assumptions NHS Plymouth is planning around £20m of efficiency savings in 2012/13 to invest in meeting demand, improving quality and tackling national and local priorities, some of which will come from the full year effect of initiatives which started in 2011/12 and some from initiatives due to start in 2012/13.

In addition major providers from whom the PCT commissions services will also be required to make efficiencies of 4% in line with the national Operating Framework.

Process and timescales for setting budgets.

The first draft MTFP was submitted to the Strategic Health Authority in mid-December. This will continue to be developed and amended as necessary to reflect the requirements of the NHS Operating Framework for 2012/13 and to reflect contract discussions with providers

until the final MTFP and budgets are agreed and signed off by the Board for the Devon, Plymouth and Torbay PCT Cluster at the end of March 2012.

Addressing local priorities and the challenge of QIPP (Quality, Innovation, Productivity and Prevention.)

Maintaining strong day-to-day performance remains the over-riding priority of the NHS. Alongside that we will continue the delivery of a significant programme of change (called 'Quality Care Best Value') to make sustainable improvements in quality and productivity, further increase the focus on prevention of ill health and encourage innovation across the whole care system and are planning very carefully with partners to tackle this challenge transparently together to ensure we secure the best value for the community.

We can already see encouraging early signs that this year's change programme is delivering the sustainable changes needed to deliver the QIPP challenge. If we compare the mid-point of 2011/12 with the same point in time last year we see that referral rates have reduced quite significantly, emergency attendances have stabilised and non-elective admission rates have reduced.[1] NHS Plymouth Board performance report November 2011is available on the website and provides more detail.

This section of the report is not an exhaustive list but sets out key examples of major service changes planned, any significant changes in levels of investment and NHS Plymouth's contribution to local partnership priorities:

Public health:

Primary prevention and early detection and intervention are key strands of the vision for a healthy system described earlier in this report and, whilst to some extent subject to the same need to demonstrate efficiency as in other service areas, the current level of service offer in relation to health promotion and health inequalities is expected to be maintained during 2012/13 especially where it is targeting P2020 partnership priorities.

Structural changes to public health and national determination of the allocation of funding for public health in future presents the potential risk that the allocation of funding for Plymouth may be subject to change.

Changing settings of care:

In September 2011 the Plymouth health community embarked upon a process of studying whether patients in the health system were being treated in the most appropriate setting of care. Reflecting one of the key principles of the healthy system, the first piece of work was a study of patients in PHNT which found that for a significant number of patients there could have been a more appropriate, less acute setting of care to meet their needs. This information further supports the direction of travel for the changing shape of Plymouth's health community set out above.

There is now a programme of work underway to analyse what changes need to be made across the care system to support the move away from unnecessary admission or an unnecessarily long stay in an acute setting. This is likely to result in a fundamental evidence based re-shaping of service models over a number of years rather than a simple transfer of services and resources from one setting to another.

[1] Based on performance reported to in NHS Plymouth Board Performance Report, November 2011, page 60.

Health and social care commissioners and providers are working in partnership to develop a way forward.

Primary care:

Healthy Living Pharmacies will be launched in Plymouth early in 2012 to increase the role that community pharmacy can play in delivering high quality health and wellbeing services. The pilot in Portsmouth shows that people there are now enjoying better access to health and wellbeing services including stop smoking, alcohol interventions, emergency hormonal contraception, Chlamydia screening, NHS health checks and targeted respiratory Medicine Use Reviews.

Primary Medical Services review - the PCT has reviewed the spread of investment in GP contracts across the city in order to reduce variation in core funding for individual practices. The shift in investment (in the region of £0.5million) will be paced to take place during the period January 2012 to April 2014. An indicative figure of 50% of these released funds will be redistributed to the lowest funded practices to achieve the aim of reduced variation and the remaining 50% will be invested into enhanced services developed to support identified local need.

GP-led health centre – a decision to re-commission or otherwise will now be made in January 2012 based on an analysis of outcomes and value for money. The outreach service for homeless people is part of this commissioning exercise but, although the outcome cannot be pre-empted, early indications are that it is highly likely that this service will be re-commissioned.

Out of hospital / non-acute services:

There has been a significant focus by both health and social care commissioners and providers in 2011/12 on the development of effective models of care across the health and social care community that are aligned with the strategic direction outlined in this report and the plans for changing settings of care. This will continue in 2012/13 and beyond.

The PCT will need to work together with the local authority to agree jointly on commissioning priorities, plans and outcomes for a number of services and specifically around investment of funding allocated in the national Operating Framework for ‘investment in social care to benefit health and to improve overall health gain’ and the monies allocated by the NHS for re-ablement in 2012/13 (which could include things like telecare, falls prevention, support for the National Dementia Strategy, tackling delayed transfers of care).

The NHS funding allocated in the national Operating Framework for ‘investment in social care to benefit health and to improve overall health gain’ will be transferred to the local authority via an agreement made under Section 256 of the NHS Act 2006 for spending on those jointly agreed priorities and plans which are expected to be agreed by the end of the current financial year.

It is essential that this allocation is used to make significant improvements in the care system that are sustainable in the long term, which will involve partners being very clear about the arrangements and recurrent cost implications for these services beyond the term of this specific allocation. (The Operating Framework for 2012/13 does indicate that ‘financial support from the health system for social care will continue in 2013/14 and 2014/15’ but does not specify the form or value of that support and makes no commitment beyond 2014/15)

In the light of the updated Department of Health mental health policy (No Health Without Mental Health, DH 2011) NHS Plymouth is embarking on an ambitious programme to

modernise mental health services in three key areas (acute care services, mental health recovery services and talking therapy services) that will improve efficiency, create greater integration of services and an increased focus on treatment and recovery.

Example of planned service change:

Locality based service model – this service will provide low level community intervention and prevention. We are currently working with Plymouth Community Healthcare to embed this model of working into the contract for 2012/13. This will result in closer integration of mental and physical health and primary, community and secondary care through a multidisciplinary team focused on addressing the holistic needs of the patient. Community Matrons (previously known as Long Term Condition Managers) will be part of these teams and the capacity of this team has already been increased in recognition of the crucial role they play in enabling people to feel supported in their own home.

Rapid response and re-ablement services – these services complement the locality based model (for low level community intervention and prevention) by providing enhanced provision in times of crisis and supporting timely discharge. Plans are at various stages of development for delivery in 2012/13.

Health visiting - increased investment is planned by NHS Plymouth which will directly contribute to the Children and Young People Plan priority i.e. best start to life.

Recovery pathway - for particularly mental health users is being redesigned to move towards a community support model in which Supporting People is an essential aspect in being able to continue to enable vulnerable people to live independently and find work, have choice, reduce the number of residential placements etc.

Improving access to psychological therapies – there are plans for expansion of the IAPT service to meet unmet demand for psychological support & to reflect anticipated growth in demand. There is a particular focus in expanding towards those with severe mental health problems, those with Long Term Conditions and the treatment of medically unexplained symptoms. The PCT is working closely with the Job Centre to ensure the contribution of this service to the growth agenda in supporting people to gain or sustain employment.

Dementia services – there is increasing demographic pressure on all dementia services but joint working is well underway. The Overview and Scrutiny panel have previously received reports on the development of a joint dementia strategy and will continue to receive updates at appropriate points in the process.

Learning disability –both NHS Plymouth and Plymouth City Council plan to make changes to improve outcomes, efficiency and value for money of services used by people with a learning disability. It is critical that partners work together to ensure that plans for change are joined up and coherent.

Acute services:

Urgent Care – plans to improve the model of urgent care are in the early stages of development. The vision is for simpler, more streamlined access to urgent care of all kinds and potentially reduced confusion for patients by bringing demand to a single point which is expected in turn to improve efficiency.

Major Trauma – the expected designation of Plymouth Hospitals NHS Trust (PHNT) as the Major Trauma Centre for the Peninsula will improve the quality of services and outcomes for

patients across the area as well as safeguarding some of the highly specialised skills locally in PHNT.

Non-clinical or 'back office'

The programme of change relating to improved efficiency in non-clinical or back office functions has particular implications for the P2020 partnership focus on the growth of the city and its economy for example:

Care provider market development – the transfer of community based health services to a newly created social enterprise in 2011 will be followed by the implementation of 'Any Qualified Provider' in 2012/13, a mandatory requirement for Primary Care Trusts, which creates the potential for new organisations to enter the market in the specified areas of business.

Outsourcing of Family Health Services (FHS) to SBS: FHS provides a number of administrative functions related to primary care, including patient registration, records management and contractor payments. The service for Plymouth patients is currently provided by NHS Devon and there will continue to be a local presence in Exeter maximising opportunities for staff retention.

Co-location of teams from Plymouth City Council and NHS Plymouth – progress is being made towards the co-location of a number of teams at Windsor House. There will be obvious benefits of closer working, between health and social care teams for example, and although indications are that the costs will be broadly similar to current costs this will potentially release land for alternative use. In order not to lose momentum this is continuing throughout the current period of change in the NHS although this does present some challenges in relation to longer term planning.

Digital City: PCT can confirm its commitment and contribution to this joint initiative to improving the connectivity of Plymouth.

P2020 Partnership priorities for 2012/13

Overview - NHS Plymouth proposes that the current economic environment poses a potential risk to our ability as a partnership to make progress on agreed priorities for children and young people and that active consideration of how to minimise that risk is essential. For example there may be a direct impact on the number of children and young people not in education, employment or training (NEET) and the number of apprenticeships the public sector may be able to offer in the future; but also potential for less direct impact where loss of employment and/ or financial pressure for families may begin to impact upon on levels of child poverty and the overall psychological welfare of families and children.

Key service areas - With respect to the key service risk areas below that were highlighted in the Budget Challenge paper last year as a general principle the PCT has provisionally set aside continued funding for each but, along with partners, has also identified the need to examine the outcomes achieved from each service and to ensure that the funds invested are focussed appropriately:

Domestic Abuse services - the PCT has identified potential funding, along with other partners, to address the shortfall in Domestic Abuse Funding however clarity is required about the outcomes that this service will provide.

Sexual Assault Referral Centre (SARC) – Partners have confirmed their intention to extend the current contract for a further year for 2012/13 (The PCT has provisionally set

aside £60k to reflect its on-going commitment to SARC) however there is a remaining funding gap for 2012/13 and further examination is needed to ensure that current activity in SARC is in line with its original purpose. Paul O'Sullivan (NHS Plymouth) is leading discussions with partners to address this.

Support for enhancing the capacity of the voluntary &community sector – It is expected that there to be an increased range of opportunities in the coming year for third sector organisations to provide services, for example around re-ablement. In addition the PCT will provide continued support for infrastructure in 2012/13 at same level as 2011/12 subject to a clearly specified outcome based contract. However the PCT is unable to fulfil the P2020 partnership commitment to a three year contract for infrastructure as it is unable to commit beyond March 2013, the point at which the emergent Clinical Commissioning Group will take responsibility for commissioning healthcare.

Youth Offending Team – the PCT has provisionally set aside continued funding. As with other services the YOT will be expected to provide a proposal for running costs which will inform the allocation of an appropriate level of funding by all partners.

Locality working – the PCT remains committed to the principle of locality working and is currently in the process of embedding this within the contract with Plymouth Community Health Services to service the 6 locality areas.

Early intervention and family support services – these will be even more essential in the light of the identified challenge posed by the economic environment to ensure that families are supported effectively and therefore to prevent any unnecessary escalation of issues into acute or more specialist services than would otherwise be required. The PCT for its part can confirm its commitment to maintain the Family Nurse Partnership at current levels and would be keen to see a similar commitment in relation to other services of this nature e.g. Family Intervention Services.

Karen Kay.
Assistant Director of Corporate Planning and Performance.
NHS Plymouth.
14th December 2011.

This page is intentionally left blank

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:

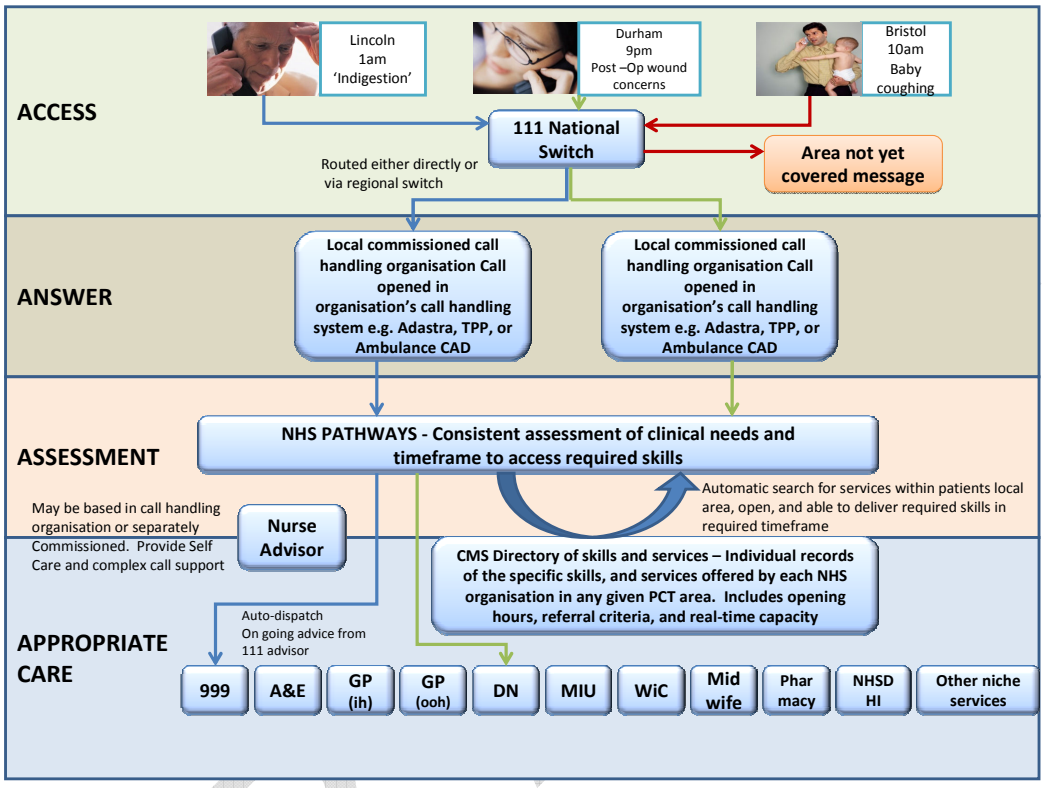
- they need medical help fast, but do not believe it is a 999 emergency;
- they do not know who to call for medical help, for example they do not have a general practitioner to call or are away from home;
- they think they need to go to Accident and Emergency or another NHS urgent care service;
- they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

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.

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;

- 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.

This page is intentionally left blank

16 January 2012

NHS Devon
NHS Plymouth
Torbay Care Trust

Plymouth Teaching PCT
Building 2
Derriford Business Park
Plymouth Hospitals PL6 5QZ

Telephone: 01752 437027
k

Councillor Lynda Bowyer
Chair
Health Overview and Scrutiny Committee
Plymouth City Council

Dear Cllr Bowyer

Update on bed capacity for stroke services for Health Overview and Scrutiny Committee

The attached document was provided for OSC in October 2011 to signal a piece of work being undertaken in Plymouth in relation to stroke services. The outcomes at this stage are unclear but, as it was anticipated that there could be a significant service change, it was important to raise the issue with the HOSC.
The document is self-explanatory.
The timescale for completion was expected to be January/February 2012, but this was going to be largely influenced by our need to engage with the public about the suggested options. This summary describes progress to date.

Current status
The work is not yet completed as it has taken longer than expected to explore the impact and implications from a clinical perspective. If there was evidence available that would suggest an integrated unit was not clinically safe, or has as a minimum the same clinical outcomes as separate units we would not proceed. It therefore didn't seem sensible to proceed with public involvement until there was this level of clarity.

Clinical evidence for either option has proved sparse, so more work has needed to be undertaken with actual clinical teams (locally and nationally) exploring the data we have.

In addition, the work exposed some challenges in the partnership between the two health providers and the way they work together to provide a seamless service for the patient and their family.

Whilst making a decision about the future model of bed capacity for stroke patients, it is now part of a larger piece of work, and whilst still a priority, there are a number of other issues which need to be resolved first.

The PCT as a commissioner has therefore engaged the two main providers in a programme of work, the outcomes of which will be available in March, identifying the priority for service improvement and also resolving issues about leadership and responsibility for the pathway. The decision regarding the possible reconfiguration of the beds will be incorporated into the wider plan which will also dictate timescales. The PCT would be willing to return to OSC with further information at a later date and describe the wider plans if felt to be helpful to you, and will of course share the outcome of the recommendation regarding future bed location.

Yours sincerely

Elaine Fitzsimmons
Assistant Director of Commissioning
NHS Plymouth

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

This page is intentionally left blank

Plymouth Hospitals NHS
NHS Trust

Report for:	Plymouth Health and Adult Social Care Overview and Scrutiny Panel
Report Topic:	Foundation Trust Application
Report date:	09.01.2012
For presentation by:	Joe Teape, Director of Finance Plymouth Hospitals NHS Trust

---

1. Purpose of Report

Plymouth Hospitals NHS Trust is seeking the views of the Committee on its plans for the future as an NHS Foundation Trust. These plans include strategic intentions, a proposed new name and arrangements for governance in the shape of membership and the make-up of the Council of Governors.

Committee members are asked to give their views, either during the meeting or using the consultation forms provided or both, and consider signing up as individual members

2. Recommendation

Committee members are being asked to give their views to help shape the future for patients. Members are asked to support the proposals being presented or, if appropriate, indicate where they would like to see changes made.

All feedback will be carefully considered and a response given at the end of the consultation period in March 2012.

This page is intentionally left blank

Plymouth Hospitals NHS
NHS Trust

Join Us – Together we can make a difference

NHS Foundation Trust Consultation Document

January - March 2012

Contents

> "I believe being a Foundation Trust will mean more local accountability over services and finances through the participation of local people who mostly benefit from the services offered by the Trust. It should mean more flexibility in the type and scope of services to reinforce the good progress made in cancer and heart patients' treatment" **- Judi Thorne, Member**

Introduction

We are seeking to become an NHS Foundation Trust by the end of February 2013. This document sets out our plans to become an NHS Foundation Trust. It describes

- who we are
- what an NHS Foundation Trust is
- why we want to become one
- our plans for the future
- how we will govern ourselves

Most importantly, this document asks for your views and asks you to consider joining us as a member. As a patient, a carer, a member of staff, one of our partners or a member of our local community, what you think matters and we want to hear from you.

We hope you find this information interesting and informative. There is a feedback form for you to give us your views on page 13 and a membership form if you would like to join us on page 15. Or you can:

- visit our website at www.plymouthhospitals.nhs.uk
- phone 0845 155 8207

Our consultation runs until Tuesday 27 March 2012. Please let us know what you think before then so we can ensure your views help us shape the way forward. Thank you for your time.

Please join us – together we can make a difference.

This document can also be provided inother formats including large print, audio and the following languages: Polish, Bengali, Cantonese, French, Kurdish, Arabic and Farsi. If you would like an alternative format please contact 0845 155 8207, email pressoffice.phnt@nhs.net or write to:

Foundation Trust c/o Communications Office
Level 7
Derriford Hospital
PL6 8DH

About us

Who we Care for
Our Trust provides comprehensive hospital and specialist healthcare to people in the South West Peninsula. We offer a full range of general hospital services to around 450,000 people in Plymouth, North and East Cornwall and South and West Devon. These include emergency and trauma services, maternity services, paediatrics and a full range of diagnostic, medical and surgical sub-specialties.

We also work within a network of other hospitals to offer a range of specialist services. These are provided to a population of between 700,000 and two million depending on the type of care needed:

- Kidney transplant
- Pancreatic cancer surgery
- Neurosurgery
- Cardiothoracic surgery
- Bone marrow transplant
- Upper Gastro-intestinal surgery
- Hepatobiliary surgery
- Neonatal intensive care and high risk obstetrics
- Plastic surgery
- Liver transplant evaluation
- Stereotactic radiosurgery

As a Trust, we have 907 beds, around 5,200 whole-time equivalent staff and a planned turnover of £383m for 2011/12.

Your Regional Specialist Teaching Hospital Trust
We also provide comprehensive training and education for a wide range of healthcare professionals. The Trust is developing rapidly as a centre for research in partnership with the Peninsula College of Medicine and Dentistry, which is one of the top achieving medical schools in the country in a number of areas and has its headquarters on the Derriford campus.

The Trust works in partnership with the Universities of Plymouth and Exeter to assist in the delivery of courses for the Faculty of Health and Social Work. With university campuses in Plymouth, Exeter, Truro and Taunton, along with teaching facilities in Bristol, the Faculty of Health and Social Work is one of the largest providers of nursing, midwifery, social work and health professional education and training in the South West.

> "I became a member because I want to influence policy and development for the benefit of hard-to-reach groups and hold the Board to account for their decisions"
> **– Krzystof Vere-Bujnowski**

Our Plymouth 'Spirit of Discovery'
Every treatment we deliver is based on research and the only way we will improve outcomes for patients is by doing more research. This is why we believe research is so important.

In 2009 the National Institute for Health Research set a target of doubling the number of patients recruited to portfolio studies in a five year period. As a Trust, we have already exceeded this target, with the number of patients recruited into studies up from 2,048 in 2008/09 to 4,679 in 2010/11.

We almost doubled the number of patients (1,414) recruited into interventional studies in 2010/11. Plymouth Hospitals' recruitment into these complex studies is exceptionally high compared with other Trusts.

We are a successful partner in the Peninsula Collaboration in Applied Health Research and Care (PenCLAHRC). The fundamental objective of PenCLAHRC is to improve health outcomes for patients and the public through the translation of patient-focused research.

Working Hand in Hand with the Military
We have a longstanding and excellent relationship with the Ministry of Defence. Around 240 trained and trainee personnel work alongside NHS colleagues helping care for patients in our hospitals and units. These military personnel are drawn from all three services in the Defence Medical Service. Many of them bring unique experiences and knowledge from their deployments and this, in turn, benefits Plymouth Hospitals NHS Trust and our patients.

Our Hospitals and Centres
We provide services for patients at the following main sites as well as through clinics at other local hospitals and care centres:

Derriford Hospital
We offer the widest range of hospital based services in the Peninsula. What sets our Trust apart from the majority of acute hospital trusts is both the scope and scale of the services we offer on one site.

Derriford has a high volume outpatient department with almost 470,000 attendances planned for 2011/12 and a busy emergency department, with around 91,000 patients expected during 2011/12. More than 48,000 people pass through the main entrance of Derriford in a week.

- **The Royal Eye Infirmary (REI)**
  The REI provides a full range of diagnostic facilities incorporating orthoptics and optometry. The building is 108 years old and no longer ideal as an eye hospital. The Trust currently leases this building and has started to transfer services to Derriford Hospital. In October 2010, urgent eye care outside of normal working hours and care for patients needing overnight stays moved to Derriford. Plans are being drawn up for all ophthalmology to be moved to Derriford Hospital during 2012.

- **Child Development Centre**
  Developmental services for young children are provided at the Child Development Centre, Scott Business Park.

- **The Plymouth Dialysis Unit**
  Patients needing treatment for renal failure are now cared for in state-of-the-art, purpose-built facilities that they helped design. Easily accessible and offering significantly more space, especially around each of the 29 treatment stations, the new unit is based in Eaton Business Park and replaces the hub haemodialysis unit previously located within Derriford Hospital.

- The Trust also manages community midwifery services and a Radiology Academy.

Reasons to be Proud

The dedication and commitment of our staff to giving high quality patient care means that we already have much to be proud of.

We are in the best 10% nationally for low mortality rates, according to Dr Foster, an independently run health information specialist.

Our patients are very satisfied. In the National Inpatient Survey 2010, commissioned by the Care Quality Commission, 91% of patients rated their treatment and care as 'excellent', 'very good' or 'good', and 98% of patients said they were treated with respect and dignity while they were in hospital.

Independent inspectors from the Care Quality Commission reported that we treat our patients with dignity and respect when they visited us in the spring and summer of 2011.

We are an exemplar site for:
Venous Thromboembolism (VTE) - the collective name for deep vein thrombosis and pulmonary embolism.

Diabetes care in which we are a national exemplar for helping to prepare people with diabetes for surgery so that it can safely be carried out as a day case procedure, without needing admission.

The use of standardised theatre safety checklists, sharing our knowledge and expertise with hospitals around the country.

We are award-winning
Our Infection Control Team won a Patient Safety Award for their work to prevent surgical site infections in 2011.

Our Information and Communications Technology team won a 2011 E-Health Award for their innovative work to develop a new Risk of Admission Patient Alert system.

We are nationally recognised as delivering excellence in Oesophago-Gastric Surgical Cancer Services.

We are among the best performing hospital Trusts in the country for the number of patients we are able to treat as day cases, avoiding them having to stay overnight if they don't need to.

Our consultants are among national leaders, including one who is President of the Royal College of Obstetricians and Gynaecologists and another who is President of the Society of British Neurological Surgeons.

We are one of the best hospital Trusts in the country for the number of patients who attend their appointments, with a low rate of patients who Did Not Attend (DNA).

What is an NHS Foundation Trust?

In July 2010, the NHS White paper, Equity and excellence: Liberating the NHS, set out the Government's intention to support all NHS Trusts to become NHS Foundation Trusts.

NHS Foundation Trusts are based on the same fundamental values as other NHS hospitals, bound by the NHS Constitution, offering care for all, freely available where people need it.

Part of the NHS family – what stays the same:

- Maintaining the NHS principle of care for all free at the point of need – this will be their core function
- Continuing to employ NHS staff
- Treating NHS patients, free of charge
- Bound to the same quality standards as other NHS organisations
- Subject to independent inspections, e.g. by the Care Quality Commission

What's different about an NHS Foundation Trust hospital?

- They are public benefit corporations involving the public in the way they are run.
- They have members who are local people who decide they want to play a part in the future of the NHS Foundation Trust.
- They have a Council of Governors, made up of patients, staff, local people who are elected by members, as well as Governors appointed by partners and stakeholders.
- NHS Foundation Trusts have financial freedoms which means they can borrow and use surplus cash to reinvest in new services, equipment and innovations.
- They are not subject to central Government management – instead there is an independent regulator, Monitor, to ensure compliance with strict governance and financial rules.

> "The Trust must be shown to be "owned" by its members. Ownership can be in many forms: input with policy; feedback from members on the services provided; an outlet for grievances and concerns. But above all, the Trust must be a significant part of the community" **– Leonard McCoy, Member**

Summary of differences between NHS Trusts and NHS Foundation Trusts

NHS Trusts (as we are now)	NHS Foundation Trusts (FTs) (as we want to be)
Employ NHS staff treating NHS patients on the basis of clinical need, free of charge.	Same, but with more freedom to introduce changes, ability to make decisions faster, more control over finances.
Must meet all national NHS targets; method of achieving them sometimes dictated.	Must meet all national NHS targets but more flexibility on best approach.
Regulated by the Care Quality Commission for clinical quality and safety and subject to inspection.	Exactly the same.
Managed by NHS South of England, a clustering of three Strategic Health Authorities: South West, South Central and South East Coast.	Regulated by Monitor, the independent regulator of foundation trusts which ensures FTs are legal, run well and financially sound.
Standardised user involvement.	Patients, former patients, members of the local community, staff and other stakeholders have more direct input into the Trust's strategy and direction via the Council of Governors, which has statutory powers.
Plans for major new projects can take some time to be agreed.	Monitor can approve plans more quickly if it agrees plans are sound financially; others can be decided by the FT itself.
Any financial surplus can only be spent subject to wider NHS approvals.	FTs have greater financial independence and our Board can decide on how to invest any surpluses for the benefit of patients.
Board make-up: Non-executive directors appointed centrally. They are part-time directors who oversee the management team and challenge where necessary in the broader public interest.	The Board remains. Patients, former patients, members of the local community, staff and other stakeholders have more direct input into this appointment process through the Council of Governors which is elected by members.
Staff involvement.	Staff have direct influence through their elected representatives on the Council of Governors, supplementing other means of engagement.

Why do we want to become an NHS Foundation Trust?

We want to become an NHS Foundation Trust, so that we can:

Develop even better ways to work with our patients, our staff and our supporters
By becoming a membership organisation, we will be involving more people in the way we work and our plans for the future. Our members will vote for the Governors they want to represent them on the Council of Governors. The Council of Governors will have a real say, thereby helping us better involve patients, families, staff and other partners much more closely.

Have more freedom to develop our services
We will gain financial freedom, including the ability to retain surpluses we make and the right to borrow if necessary. This increased financial flexibility will allow us to invest more in research, innovation and facilities so that we can achieve our aim of leading with excellence and caring with compassion.

Remain an independent standalone hospital, within the NHS family
Plymouth Hospitals NHS Trust is a large and successful healthcare provider and we believe it should remain so. Becoming an NHS Foundation Trust will ensure that Plymouth Hospitals NHS Trust remains an organisation in its own right and continues to deliver healthcare for the benefit of the people we serve as a local and specialist healthcare provider.

Our Foundation Trust Journey So Far
We are excited by the opportunity NHS Foundation Trust status gives us.
We are in a good position, not least because we are fortunate to have had the support of our governors and members-in-waiting since 2008. As part of our preparations for our previous NHS Foundation Trust application, elections to the Council of Governors took place. Although our 'governors' have no formal role, we have worked with them over the last three years to develop links with committees and groups to facilitate a voice for members in the day to day running of the Trust.

We have systematically engaged with our members and 'governors', working with them to ensure that the patient's voice is heard across a range of issues; from developing our Patient Promises to contributing to a longer term strategy for the Trust, and from interviewing candidates for the role of Chief Executive to helping to define our Quality Account.

We established a Members Forum to act as a focal point for membership; it has two prime functions: to act as a conduit for the provision of topical information to and from members and to give members the opportunity to question senior staff on issues of concern.

We believe that we will be an even better hospital Trust by involving people and being more responsive. But don't take our word for it. Here is what our 'governors in waiting' have to say:

" It is essential that we become an NHS Foundation Trust, as we are the largest Trust in the south west offering specialist services and we should be controlling our own destiny. Becoming a Foundation Trust will give us more autonomy to plan and invest in research and innovation, which undoubtedly improves patient care and outcomes." **'Governor in waiting' Consultant Thoracic and Oseophago-Gastric Surgeon Joe Rahamim**

"I have been actively involved as a 'shadow governor' for the past two years and thoroughly enjoyed being able to use my skills and talents within Derriford. As a 'governor in waiting', I listen to the views of the community and am able to feed them back in a meaningful way.

"I attend Board meetings and governor meetings, as well as sit on Committees such as the Charitable Funds and Hospital Transfusion, I have also taken part in senior staff appointments, which has allowed the members and local community to have a real voice in many areas.

"Foundation Trust status would allow us to continue to reflect the local interests and concerns of the Members; become more involved in guiding the strategic direction of the Trust, as well as taking responsibility for one of our primary roles as governors in waiting, that of holding the Board of Directors to account." **'Governor in waiting' Alison Malcolm**

"Since being elected as a 'governor in waiting' I have learnt an incredible amount and gained a greater understanding of the Trust as well as an appreciation of the day-to-day challenges. I have been involved in a number of activities including the recruitment of key senior management posts which has been extremely interesting. I believe that Foundation Trust status is within reach and will allow us greater freedom and flexibilities in terms of how we deliver and develop local healthcare." **'Governor in waiting' Carolyn Bruce-Spencer**

”Becoming a Foundation Trust will give the public rights and opportunities to have their views heard about the provision of hospital services. Foundation Trust status creates channels for exciting public participation, and ensures hospitals are accountable to the local population. Patient involvement creates patient-centred care, which is good for patients. As a ‘governor in waiting’ I have contributed ideas from the patient perspective, highlighting what is good and bad, to influence change. My deepening understanding of broader issues gives me a greater awareness of all aspects of future provision of hospital care. I have met many senior staff to learn about essential Trust functions, and shared in discussions about developments in care. I have seen changes happen and realise that the opinions of ‘governors’, members and patients are valued. I have been part of the ‘governors’ panel three times when the Trust has appointed Executive Directors.“ **‘Governor in waiting’ Vera Mitchell**

“This hospital is about to submit an application to become a Foundation Trust. This will enable all those with an interest to become involved in the way the hospital is run.

“Interested members of the public can enrol as members, who will receive information on activities within the Trust, they can also elect the Council Of Governors, or ultimately stand for election as Governors.

“The Council of Governors will have very wide reaching powers to hold the Trust to account. They will also act as a medium to relay views of members to the Trust.

“This ultimately means a Trust is run in accordance with the wishes of the members of the Foundation Trust. However the application will need your help; a three-pronged approach from the Trust Board, Governors and members will ensure a successful Foundation Trust. The outcome lies in all our hands and only by working together can it come to fruition.” **‘Governor in waiting’ Ivor Vaughan**

“I strongly believe Plymouth Hospitals should be a Foundation Trust to allow decisions to be made locally, influenced by the people who live here and use the services, as well as the staff who deliver them.

“As a ‘governor in waiting’, I have been able to gain an insight and receive training into the running of the hospital and the service it provides, as well understand the problems that need to be overcome. It has allowed us to begin to build a relationship and two way conversation between management and all the stakeholders involved. I hope we will have the opportunity to develop this further as a Foundation Trust to help provide the best service for everyone involved, one of which we can all be truly proud of.” **‘Governor in waiting’ Pam Redgwell**

Consultation Form

Please give us your views - together we can make a difference

Your view of our plans for the future

Please circle the answer you feel is the most appropriate

Question 1

Do you agree with our plans for the future?

Strongly agree Agree Neither agree or disagree Disagree Strongly disagree

Additional comments

.....

.....

.....

Question 2

Do you agree with our new name?

Strongly agree Agree Neither agree or disagree Disagree Strongly disagree

Additional comments

.....

.....

.....

Your view of our plans for membership

Please circle the answer you feel is the most appropriate

Question 3

Do you agree with our membership plans?

Strongly agree Agree Neither agree or disagree Disagree Strongly disagree

Additional comments

.....

.....

.....

Your view of our plans for how we will govern ourselves

Please circle the answer you feel is the most appropriate

Question 4

Do you agree with the make-up of our Council of Governors?

Strongly agree Agree Neither agree or disagree Disagree Strongly disagree

Additional comments

.....

.....

.....

Why do we want to know about you? The following information will help us to ensure that we have consulted with representative members of the public who we provide services for.

My postcode is .....

Gender ☐ male ☐ female

Date of birth ...../...../.....

Race, ethnicity and national group (please tick relevant category)

White	Dual Heritage	Asian or Asian British	Black or Black British	Chinese or other ethnic group
☐ White	☐ White and black caribbean	☐ Indian	☐ Caribbean	☐ Chinese
☐ Irish traveller	☐ White and black african	☐ Pakistani	☐ Somali	
☐ Roma gypsy/traveller	☐ White and asian	☐ Bangladeshi	☐ Other african	
☐ Any other white background (please write in)	☐ Any other mixed background (please write in)	☐ Any other asian background (please write in)	☐ Any other black background (please write in)	☐ Any other ethnic group (please write in)

Disability

Disabled ☐ Non-disabled ☐ I prefer not to say ☐

Thank you for taking the time to complete and return this questionnaire and for the support you have shown to this hospital trust.

Membership Form

Please complete this form if you would like to apply to be a Member or express your interest in becoming a Member of the new NHS Foundation Trust.

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other .....

First Name

Last Name

Address

Email address

Daytime telephone number

What is your preferred method for us to contact you?

☐ Email ☐ Post ☐ Telephone

☐ **I want to become a member**

☐ I'm interested in becoming a Member, but need more information, please contact me

For membership analysis

☐ Male ☐ Female Date of birth

Ethnicity

☐ White British
☐ White Irish
☐ Other White
☐ Black British-African
☐ Black British-Caribbean
☐ Other Black British
☐ Asian British-Indian
☐ Asian British Pakistani
☐ Asian British-Bangladeshi
☐ Other Asian-Britsh
☐ Mixed- White and Black Caribbean
☐ Mixed- White and Black African
☐ Mixed- White and Asian
☐ Chinese
☐ Other, please state .....

Do you live in

☐ Plymouth ☐ Cornwall and Isles of Scilly ☐ Devon (excluding Plymouth)

Do you consider yourself to have a disability?
Please note the legal definition of disability includes: Physical disability or impairment; Sensory impairment - eye sight, hearing or speech; Learning difficulty eg dyslexia; Mental health; Long term or progressive health conditions eg multiple sclerosis, arthritis, HIV, diabetes or cancer.

☐ Yes ☐ No

Have you been a patient of Plymouth Hospitals NHS Trust in the last three years?

☐ Yes ☐ No

Are you a member of any health related organisation or group?

☐ Yes please specify .....

☐ No

As a Member, would you be interested in:

☐ Receiving regular information

☐ Attending meetings or events

☐ Being involved in focus and planning groups

☐ Being sent information on how to stand for election on the Board of Governors

I am particularly interested in becoming involved in .....

I apply to be a member of the NHS Foundation Trust when it is formally established and be bound by the rules of the organisation and I give my consent to the processing of the information.

Signature .....

Date .....

☐ I do not want my name and constituency to be viewed through the public membership register.

This data will be used only to contact you about the NHS Foundation Trust status or other health issues, and will be stored in accordance with the Data Protection Act – full details available upon request. Your details will not be shared with any third parties.


NHS
NHS
Parents Guide to the
Breastfeeding Policy.

Our mission and goals

Our Vision and Strategy

Our Values, which we define the way we do things, are:

- Putting Patients First
- Taking Ownership
- Respecting Others
- Being Positive

Our Promises to our Patients

Our patients are at the heart of everything we do. As part of our Patient Experience Strategy, we have developed a set of patient promises in partnership with nearly 1,000 patients, our NHS Foundation Trust members and 'governors in waiting' and our staff who gave their view of what good quality patient care should look like.

The promises that every member of our staff has to make come alive are:

- I will … care for your compassionately and respectfully
- I will … give you clear information and involve you in your care
- I will … give you the best treatment I can when you need it
- I will … make sure you are treated in a clean and safe environment

Our High Standards

Safety and quality are at the heart of all the Trust's plans. We both want and need to set ambitious goals in terms of providing high quality patient care. As a Trust, we are already among the best performing hospitals for Hospital Standardised Mortality Ratios (HSMR), length of stay and rates for the number of patients who attend appointments and in the upper quartile for patients undergoing day surgery.

We have also received full Care Quality Commission compliance; positive dignity and nutrition reviews and very good patient survey results.

We aim to build on this and bring all of our services into top tier performance for safety, quality and productivity. We are committed to continuously improving the quality of our services by asking the following three questions:

- How good are our services?
- Are they improving?
- How do they compare?

> "I became a member because of my general interest in hospital services and patient care. Public views and input can often help to improve services or change practices" – **Eunice Davis, Member**

Our Vision

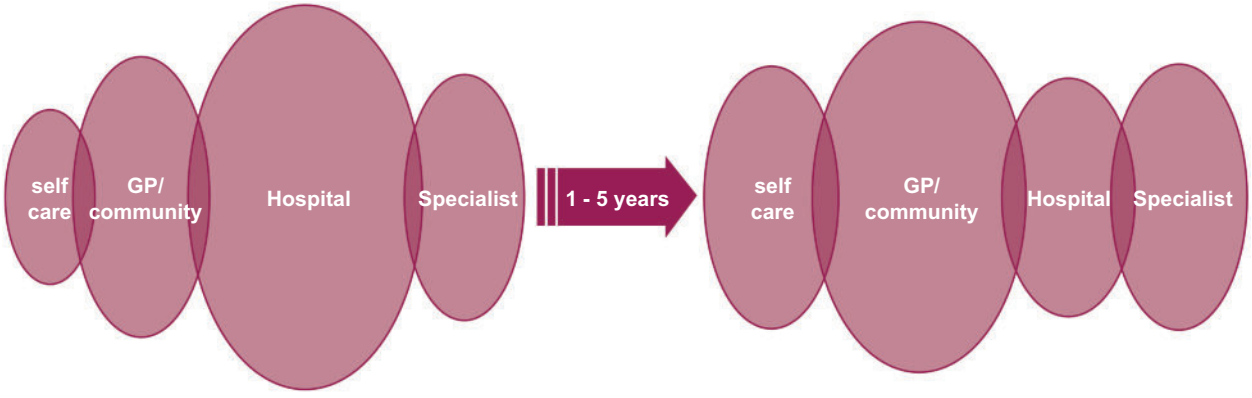
We want to provide healthcare services that patients and their families can trust and depend on. We want to be a major teaching hospital and healthcare provider, which is recognised as one of the best in the country. We will lead with excellence and care with compassion.

The most important principle is that patients are able to receive the right care, in the right place at the right time. Together with other health and social care providers in this area, we are working to ensure that only those patients who need to access specialist expertise and facilities, come to hospital.

We are working with GPs and professionals in the community to change the way patients receive care. It is expected that our hospital and other services will see a decrease in the proportion of outpatient attendances and emergency patient activity but an increase in specialist activity. In addition, the introduction of new models of care, including better supported discharge, the ability to treat more patients as day cases will significantly reduce the amount of time patients have to spend in hospital.

We are working to ensure that our specialist doctors, nurses and therapists work beyond our hospitals or specialist facilities, closer to patients' homes, wherever possible. For example our diabetes team already help lead the care for diabetes patients in the community.

The changing shape of healthcare provision is illustrated in the following diagram:



It is expected that more care will be provided in the community and at home instead of in a traditional hospital setting. However, it is expected that very specialist hospital services will experience growth.

Our Five Year Plan

This is based around four key aims:

- Achieving excellent patient outcomes
- Employing excellent people
- Developing excellent partnerships
- Building on a reputation for excellent research and innovation

Excellent Patient Outcomes	
Maintain and improve the safety and quality of our core hospital services and deliver excellent specialist care	This will result in: • Patients being treated in a modern, safe and clean environment which complies with all the regulatory standards and has an excellent score by the Patient Environment Action Team (PEAT) • Maintaining our excellent survival rates and being among the best hospital Trusts nationally for safety, quality and productivity measures • Our ophthalmology services moving successfully to a newly-designed and designated area in Derriford • Offering our trauma and orthopaedic care to more patients • Being designated as a Major Trauma Centre by 2013 and performing as one of the best in the country • Improving our patient environment in the Birch Ward Isolation Unit for cancer patients • Continuing to be the specialist centre for the most premature and vulnerable babies (NICU level 3) • Helping provide better paediatric services in the peninsula
Deliver care in the most appropriate setting for the patient – right treatment, right time, right place	This will result in: • A better experience for all our patients • More care will be provided for patients outside of hospital • Successful working with other health and social care providers to ensure that services are available to meet the needs of older people • Minimising the number of people who are treated in hospital when they don't need to be • Fewer hospital beds are needed as more patients are treated as day cases and supported to go home as soon as they are well enough to
Develop healthcare services that are led by doctors, nurses and professional healthcare staff and well supported by good managers	This will result in: • Healthcare services which are designed around and for the patient • A good experience for patients, measured by good outcomes, high satisfaction levels and low numbers of complaints • Services which are high quality and cost-effective • Evidence of an entrepreneurial spirit which will ensure we are continually improving care for patients and leading in excellence

Excellent People

Review and change our workforce, where necessary, to ensure that we have the right people, in the right place at the right time to provide excellent patient care and support colleagues who do so	This will result in: • A good experience for patients, measured by good outcomes, high satisfaction levels and low numbers of complaints • All our groups of services (service lines) being of high quality and cost-effective • All staff having appraisals and personal development plans • Good, solid workforce and succession plans in place • High-levels of workforce productivity which compare favourably with national benchmarks • Through maintaining good relationships with educational establishments, the Trust will continue to play a key role in influencing and delivering excellent professional training for healthcare staff
Provide clear and consistent leadership to highly motivated staff who take a pride in delivering the best possible care with kindness and compassion	This will result in: • More than 90% of staff feeling confident in recommending this as a Trust to work at and be treated by • Staff survey results that place us in the top 25% of all Trusts nationally • Being able to attract, retain and develop talented people

Excellent Partnerships

Develop good relationships and robust contracting arrangements with those who purchase services on behalf of patients	This will result in: • A good experience and joined-up care for patients, measured by good outcomes, high satisfaction levels and low numbers of complaints • Complete ownership, clarity and certainty on which services we are expected to provide and to whom • Ensuring we can balance our books or deliver small surpluses to reinvest
Engage governors, members and future Healthwatch in shaping and improving the quality of services to our patients	This will result in: • Engagement from the Council of Governors and future Healthwatch which makes real change happen for the benefit of patients • Representative and active members who continue to want to be involved in making a difference for our patients

Excellent Innovation

Promote and expand our research and development activities	This results in: • Constantly finding new and better ways to treat patients • Increased research and development opportunities • More patients getting involved in clinical trials • Achieving a strong national reputation for research
Empower our staff to innovate and lead their services	This results in: • Services that are designed for and around the patient • The Trust is regarded as the provider of choice by patients

Our Challenges

The Trust is aiming to achieve a breakeven financial result for 2011/12 by delivering savings of £31.3 million (around 8% of the Trust's budget). This is being done through improved efficiency, changing how we care for patients, for example ensuring that patients are pre-assessed for surgery on the day it is decided they need an operation rather than asking them to come back to the hospital for another appointment; reducing our salary costs and negotiating better value for goods and services.

Becoming more efficient and finding ways to save money whilst continuing to deliver safe and high quality care will continue to be a challenge in the coming years.

Our 'excellent people' aim is founded on the principle of getting staff with the right skills in the right place and at the right time to care for patients or support those who do. This means that we will continue to review and change our staffing numbers and mix of different professionals as required to meet the needs of patients.

We are committed to developing healthcare services that are led by doctors, nurses and professional healthcare staff and well supported by good managers. We recognise that we can only achieve our aims if we have high quality staff who are able and encouraged to take ownership of the services they provide. Our challenge is to create an environment and culture where staff can do that; where they feel valued, can influence change, contribute to better patient care, reach their full potential and feel proud of being part of Plymouth Hospitals NHS Trust.

question 1 **Do you agree with our plans for the future?**

> "I became a member because although now retired as an ex-employee, I continue to be very interested in all things related to the NHS. It is important for the general public to know what is happening and be able to feed back constructive ideas/thoughts on how to help improve services" **– Margaret Hinchcliffe, Member**

Our New Name
We want to use this opportunity to change one very simple but important thing about our hospital Trust: our name.

We will change our name to include the words 'NHS Foundation Trust when we are authorised. We also want to include something else in our name: the word 'University'.

The Trust has developed and continues to develop as a centre for academic and research excellence, as well as our role in supporting high class multi-professional teaching and learning. We think this role is extremely important for the future.

Plymouth Hospitals NHS Trust is the largest hospital trust in the south west peninsula. It is a teaching trust in partnership with the Peninsula College of Medicine and Dentistry, the University of Plymouth and College of St Mark and St John who train health professionals.

We have strong links with these institutions. The headquarters of the Peninsula College of Medicine and Dentistry is named after our former chairman, John Bull, in recognition of the part he played in establishing the new medical school.

It is important that our role in education and research is reflected in our name.

We believe we should be called:

University Hospital Plymouth NHS Foundation Trust

question 2 **Do you agree with our new name?**

How we will be governed as an NHS Foundation Trust

Members

Public | **Patients** | **Staff** | **Those from our partner organisations**

Board of Directors

The Board is made up of Executive and Non-Executive Directors. The Board has to include:

- A chief executive
- A doctor
- A nurse
- A director of finance
- Non-executive directors

The Board of Directors is responsible for setting strategy, plans and budgets and running the organisation and its services.

The Chairman and non-executive members of the Board of Directors are appointed by the Council of Governors. The current Chairman and non executives directors are, by law, the first appointees to the new NHS Foundation Trust.

Chairman

The Chairman leads both the Board of Directors and the Council of Governors and is the key link between them. He or she is supported by the Senior Independent Director and lead Governor.

The Chairman will ensure that a co-operative and, when necessary, challenging relationship exists between the Council of Governors and the Board of Directors as well as between the executive and non-executive members of the Board.

Council of Governors

Governors can either be elected members or nominated representatives from other organisations that the Trust works in partnership with.

The Council of Governors' role is to encourage genuine community involvement in the work of the Trust. It must also make sure that the Board of Directors is accountable to the community.

It is the Governors' responsibility to help members make an active contribution. They should represent the views of members at the Council of Governors and to the Board of Directors.

Our Members
Six thousand members of the public signed up to become members when we previously pursued becoming an NHS Foundation Trust, back in 2007.

Our members are our patients, their families, our staff, patient support groups, our partners and those with a real interest in the services we provide.

We will ask all our existing members if they wish to continue to be members as we apply to become an NHS Foundation Trust again and we will invite others to join us.

We want our membership to continue to reflect all those who care about our services. There is no cost to join.

We believe that involving our staff gives them a greater say and a better chance to have a hand in our organisation's destiny. That's why we plan to make all our staff automatic members of our Foundation Trust unless they choose not to be and opt out.

Who can become a member?
We would like anyone over 16, with an interest in the healthcare services we provide, to become a member of our new NHS Foundation Trust.

We will, of course, continue to listen to and liaise with our young service users, as we have been doing through our children's forum.

We are recruiting members before the NHS Foundation Trust is formally established. If you would like to become a member, please complete the form on page 15.

Members will be registered with the NHS Foundation Trust and all members' personal details will be kept confidential according to data protection requirements.

Where are our members drawn from?
Members will be continue to be drawn from the three electoral areas made up of:
- Plymouth
- Cornwall and the Isles of Scilly
- Devon (excluding Plymouth)

Staff members will be drawn from the following staff groups:
- Admin and Clerical (A&C), Management, Hospital Chaplains and Estates
- Nursing and Midwifery Services
- Medical and Dental
- Health Professionals
- Volunteers
- Contracted Staff

> "I became a member because I wished to be involved with Derriford's progress and continue to have an opportunity to be a 'critical friend'. I think we should become a Foundation Trust because it should give a voice to those people who 'use' Derriford and it offers users the ability to scrutinise the Board in a very public way" **– Sue Addy**

What do members do?
They can stand as Governors, elect Governors, give community views to Governors, receive regular information, attend meetings and events and give their opinions.

Why would I want to join?

- You will be updated regularly on what is happening in the Trust
- You can become involved in activities, focus groups and plans
- You could positively influence plans for the development of the Trust and our services
- It's free to join
- You can stand for election to become a Governor or you can elect Governors to represent your views on the Council of Governors

Join us – together we can make a difference.

question 3 **Do you agree with our membership plans?**

Our Governors

Governors are members who are either elected to the Council of Governors or nominated to the council of governors if they are representatives from other organisations. Elections will be held as per our constitution, which will be available on our website. We expect that the Council of Governors will meet four times per year and that in between these full meetings, Governors will want to meet in smaller groups and with members.

Our Members and the Council of Governors

Constituency	Number of elected Governors
Public Constituencies (elected)	**14**
Plymouth	
Cornwall	
Devon	
Staff Constituencies (elected)	**6**
A&C, management, hospital chaplains and estates	
Nursing and midwifery services	
Medical and dental	
Health professionals	
Volunteers	
Contracted staff	
Primary Care Trusts (appointed)*	**3**
Sentinel	
Devon Comissioning Representative	
Cornwall Comissioning Representative	
Local Authorities (appointed)	**3**
Plymouth City Council	
Cornwall Council	
Devon County Council	
Partnership Organisations (appointed)	**3**
Derriford Hospital League of Friends	
University of Plymouth	
Ministry of Defence Hospital Unit	
Overall Total	**29**

* Primary Care Trusts will be replaced by clinical commissioning groups which will take over representation once formally established as statutory bodies.

question 4

Do you agree with the make-up of our Council of Governors?

Your voice, your choice

If you would like to help us, you can:

Give us your views
Please read through this information, or if you require it in a different format please let us know by calling 0845 155 8207, and then please complete the form on page 13 to tell us what you think.

What will you do with my feedback?
We will record and consider all the comments made to us. Your views and comments will help shape the future direction of our NHS Foundation Trust, because we will consider all your feedback and use it to help inform our plans.

A copy of the summary of responses and outcomes will be sent to every person and organisation that replies to our consultation. We will publish these on our website.

Join Us
Get involved in helping us improve our services for patients and speaking up for their many different and diverse needs. Become a member by filling out the form on page 15 and returning it to us in the prepaid envelope.

Or you can
• visit our website at www.plymouthhospitals.nhs.uk
• phone 0845 155 8207

Volunteer
We are always looking for people who can give a regular commitment for at least six months. To become a volunteer you will need to be reasonably fit and active, friendly, a good listener and committed to your voluntary role. In return you will find helping in your local hospital Trust services a very rewarding experience!
If you are interested, please contact Elizabeth Pollard, Volunteer Co-ordinator, level 5, Derriford Hospital, Plymouth PL6 8DH or email elizabeth.pollard@nhs.net

Support us through fundraising
Find out more by visiting our website and following the ‘Thinking about Giving’ link.

Please join us – together we can make a difference

Health and Adult Social Care Overview and Scrutiny Panel

Work Programme 2011/12

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**									
Stroke Service Redesign								**25**			
NHS 111 Urgent care telephone number								**25**			
Review of Urgent Care Services						**9**					
Plymouth NHS Hospitals Trust											
Plymouth Hospitals NHS Trust – Infection Control Update										**7**	
Trust Status Business Plan								**25**			
Hospital discharge process										**7**	
Never events post inspection update		**20**									
Plymouth City Council – Adult Social Care											

Topics	J	J	A	S	O	N	D	J	F	M	
Winter pressure and reablement fund Update				**14**							
Safeguarding Adults						**9**					
Dementia Strategy Update						**9**					
Task and Finish Groups											
Safeguarding Adults							**6**	**10**			
Performance Monitoring											
Quality Accounts										**7**	
NHS Plymouth and PCC Joint Finance and Performance Monitoring.								**25**			

Key:

* = New addition to Work Programme