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Date: 4 September 2012

Please ask for: Ross Jago, Democratic Support Officer
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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

Date: Thursday 13 September 2012
Time: 2 pm
Venue: Warspite Room, Council House

Members:
Councillor Mrs Aspinall, Chair
Councillor Monahan, Vice Chair
Councillors Mrs Bowyer, Fox, Gordon, James, Dr. Mahony, Mrs Nicholson, Parker, Jon Taylor 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.

Bob Coomber
Interim 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. MINUTES (Pages 1 - 6)

The panel will be asked to confirm the minutes of the meeting on 19 July 2012.

4. CHAIR'S URGENT BUSINESS

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

5. TRACKING RESOLUTIONS AND FEEDBACK FROM THE OVERVIEW AND SCRUTINY MANAGEMENT BOARD (Pages 7 - 24)

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

6. MENTAL HEALTH SERVICES - CAPITAL INVESTMENT IN THE GLENBOURNE UNIT (Pages 25 - 34)

The panel will receive a report on Plymouth Community Healthcare's capital investment plans regarding the Glenbourne Unit.

7. PUBLIC HEALTH TRANSITION (Pages 35 - 42)

The panel will receive an update on public health transition.

8. HEALTH AND WELLBEING

To receive an update on the development of the Health and Wellbeing Board, Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

9. SPECIAL MEETING - REGIONAL PAY

The panel will consider its membership for a special meeting on the South West pay, terms and conditions consortium.

10. WORK PROGRAMME (Pages 43 - 44)

The panel will consider its work programme.

11. EXEMPT BUSINESS

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

PART II (PRIVATE MEETING)

AGENDA

MEMBERS OF THE PUBLIC TO NOTE
that under the law, the Panel is entitled to consider certain items in private. Members of the public will be asked to leave the meeting when such items are discussed.

NIL.

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Health and Adult Social Care Overview and Scrutiny Panel

Thursday 19 July 2012

PRESENT:

Councillor Mrs Aspinall, in the Chair.
Councillor Monahan, Vice Chair.
Councillors Mrs Bowyer, Gordon, James, Dr. Mahony, Mrs Nicholson, Parker, Jon Taylor and Tuffin.

Apologies for absence: Councillor Fox

Also in attendance: Superintendent Keith Perkins (Devon and Cornwall Police), Carole Burgoyne - Director of People (Plymouth City Council(PCC)), Debbie Butcher - Commissioning Manager (PCC), Craig McArdle - Commissioning Manager (PCC) Cllr Sue McDonald, Cabinet Member for Public Health and Adult Social Care (PCC), Nicky Bray Joint Commissioning Manger, (NHS Plymouth, Devon and Torbay), Claire Hodgkins - Supporting People Project Officer (PCC), Giles Perritt – Lead Officer and Ross Jago – Democratic Support Officer (PCC).

The meeting started at 2.00 pm and finished at 5.15 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.

14. DECLARATIONS OF INTEREST

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

Name	Minute Number and Issue	Reason	Interest
Councillor Dr Mahony	All agenda items	Locum General Practitioner	Personal
Councillor Mrs Aspinall	Dementia Strategy	Member of the Plymouth Dementia Action Alliance	Personal

15. MINUTES

Agreed the minutes of the meeting held on the 21 June 2012 subject to the addition of apologies from Councillor Sue McDonald, Cabinet Member for public health and adult social care.

16. CHAIR'S URGENT BUSINESS

The Chair referred to the current consultation on scrutiny regulations following the Health and Social Care Act receiving royal assent.

Agreed to delegate the preparation of a response to the Lead Officer in consultation with Councillors Jon Taylor, Mrs Aspinall, Parker and Mrs Bowyer.

17. TRACKING RESOLUTIONS AND FEEDBACK FROM THE OVERVIEW AND SCRUTINY MANAGEMENT BOARD

The panel were advised that a letter regarding the demerger of the Peninsula College of Medicine and Dentistry had been drafted and would be sent to the Secretary of State for Business, Innovation and Skills as a matter of priority.

Agreed to note progress against the Panel's tracking resolutions.

18. RECOVERY PATHWAYS (MENTAL HEALTH SERVICES)

The panel received a report on proposed changes to Mental Health Recovery Pathways. David Macaulay, Mental Health Services Manager PCH introduced the consultation document, it was reported that –

(a) the paper set out proposals to redesign recovery services in the city in order to deliver improved outcomes and efficiencies through a programme of investment in community alternatives and inpatient treatment;

(b) Plymouth had significantly more Recovery in-patient beds when benchmarked against comparable Mental Health Providers;

(c) a programme of re-distribution of resources and service re-design would improve the quality of service and release resources for further investment;

(d) the proposal was aligned with the national direction of travel and national best practice;

(e) through developing community alternatives to in-patient care and strengthening working arrangements with Supporting People colleagues, 3,000 bed days could avoided;

(f) the total number of current delayed discharges equated to the capacity of either The Gables or Syrena in-patient units and marginal improvements in the period of time patients spend within these units would yield a significant reduction in the need for in-patient beds;

(g) the redesign would enhance the ability to meet the complex needs of people within the community;

(h) it was hoped that the redesign would achieve the following outcomes –

- A reduction in the need for out of area placements through a more effective model of service delivery and without compromising the ability to meet existing local demands.
- The delivery of services closer to people's homes and communities.
- Services developed in response to identified individual needs.
- A model developed in collaboration with people who use services and carers as well as with clinical involvement and input.
- The provision of better clinical outcomes for people.
- The delivery of significant efficiencies and an opportunity to re-invest in areas that are known deficiencies.

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

(i) community services would be enhanced to provide support people administering their own medication;

(j) the patients who would be affected by the redesign were not deemed high risk and were on the pathway to independent living;

(k) efficiencies savings made as part of the process would be reinvested into mental health services and there was no risk of money leaving the sector;

(l) changes in the welfare system could lead to increased levels of stress amongst the population, although these issues had been considered the client group affected by the redesign were different as they had a diagnosis of psychosis;

(m) the Primary Care Trust was aware that agencies required help with dealing with instances of severe depression within the population and the demand for swift action for those with that need, commissioners continued to carefully balance the system ensuring that specialist areas were adequately resourced;

(n) there were a range of services available to help those with learning disabilities and mental health needs gain meaningful employment. Services included 'Steps' and some services provided by Plymouth Community Healthcare. There was a wide range of responses that agencies had available;

(o) with the client group affected by the proposal there was a high risk of suicide, each individual user had a risk assessment to mitigate risk and there had not been a suicide for a number of years. The transfer from in-patient unit into community was high risk and the transition took place if appropriate with a focus on the individual.

(p) support would be provided to General Practitioners ensuring a development of knowledge and skill base in relation to this client group;

(q) the development of a model which would retain the single sex facilities is a high priority and providers were optimistic that this model could be achieved;

(r) there was capacity in the system for beds to be used during transition.

Agreed that –

(1) the panel receive a progress report in three months which would include a focus on the Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis, Skills analysis and single sex facilities;

(2) a project plan would be circulated to members.

19. **ALCOHOL PLAN**

The panel received the Strategic Alcohol Plan, introduced by Dave Schwartz and supported by Carole Burgoyne, Superintendent Keith Perkins and Paula McGinnis. It was reported that –

(a) there were increasing numbers of people admitted to hospital for alcohol related reasons, there was a 71 per cent increase between 2002/3 and 2009/10;

(b) there were not enough specialist treatment and support services available for those who really needed them;

(c) there had been a historical under-investment in adult treatment and intervention services;

(d) there were clear relationships linking some types of crime to alcohol use. In Plymouth, 70 per cent of all alcohol related crime was violent. It had also consistently been a recorded feature in more than 40 per cent of domestic abuse incidents;

(e) the cost of alcohol related harm within Plymouth was estimated at approximately £80 million a year;

(f) nationally the alcohol industry contributes £28.6 billion in GDP to the UK economy;

(g) alcohol was a complex issue, deeply embedded within British culture and a coherent and shared response by all key partners in the City was required in order to ‘promote responsibility and minimise harm’;

(h) Alcohol was a long term challenge and the aims in the Plan would be delivered over ten years in two phases. Phase 2 would be developed following a major review and refresh conducted in year 5 and build on the progress and learning achieved;

(i) An Operational Plan would be produced setting out how strategic aims would be developed;

(j) The Plan‘s key aims would -

- provide a strong, shared City response which would reduce alcohol related harm
- change knowledge, skills and attitudes towards alcohol
- provide support for children, young people and parents in need
- support individual need
- create safer drinking environments

Agreed that a Project Initiation Document (PID) would be drafted and submitted to a meeting of the Overview and Scrutiny Management Board for approval, the PID would focus on assisting the further development of the strategic and operational plan. The task and finish group would focus on balancing impact of Alcohol on health and maintaining a vibrant night time economy.

20. DEMENTIA STRATEGY

Debbie Butcher and Nicky Bray introduced a report and Dementia Action Plan. It was reported that –

(a) central government and the Prime Minster had highlighted dementia care as a highly important policy area and had launched a challenge on dementia which had four key aims –

- Boost to dementia research
- Address quality of dementia care
- Increase public understanding of dementia
- Make communities more dementia friendly

(b) the Department of Health would establish 12 National Dementia Clinical Networks aimed at spreading clinical expertise;

(c) NHS South of England Dementia Challenge Fund provided an opportunity for local areas to respond to the Prime Minister's Dementia Challenge. £10 million of funding had been made available to Clinical Commissioning Groups through a formal bidding process.

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

(d) key areas of the Dementia Challenge included the potential for extra funding which would allow Adult Social Care to accelerate on-going programmes. A bid was being developed and could be shared with the panel at a future meeting;

(e) Plymouth had maintained had a good track record for caring for those with dementia;

(f) a workforce development plan to provide training for those in care settings was in place. The package of training would include signposting, ensuring appropriate services introduced at points on through the pathway.

Agreed to receive a further update on the progress of the plan at a future meeting of the panel.

21. WORK PROGRAMME

Agreed the following additions to the panel's work programme –

(1) Community Mental Health Care Services, to include a three month update on the recovery pathway consultation;

(2) a review of the Dementia Strategy Action Plan in 12 months.

22. EXEMPT BUSINESS

Agreed that under Section 100(A)(4) of the Local Government Act, 1972, the press and public are excluded from the meeting for the following items of business on the grounds that it involves the likely disclosure of exempt information as defined in paragraph 3 of Part I of Schedule 12A of the Act, as amended by the Freedom of Information Act 2000.

23. HEALTHWATCH SPECIFICATION (E3)

Craig McArdle and Claire Hodgkins introduced a report on the specification for Local Healthwatch, a consumer champion for health services which was required by the recent Health and Social Care Act (2012). It was reported that –

(a) there had been concerns regarding Local Involvement Network arrangements. It was felt that the powers could have been used more effectively and that there had been a structural problem with too much focus on governance;

(b) a robust service specification had been developed for Local Healthwatch. There had been a wide ranging consultation including with the current LINk to ensure that the Local Healthwatch service will be fit for purpose.

(c) the Local Healthwatch service would be commissioned directly with an organisation rather than via a host which had in the past blurred lines of accountability.

Agreed that a quarterly monitoring report would be presented to the panel when the service was commissioned.

TRACKING RESOLUTIONS
Health and Adult Social Care Overview and Scrutiny Panel

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
29/07/12 16	Agreed to delegate the preparation of a response to the Lead Officer in consultation with Councillors Jon Taylor, Mrs Aspinall, Parker and Mrs Bowyer.	This recommendation relates to a consultation on future scrutiny regulations.	Working group to prepare response on behalf of the panel.	Complete	7 September 2012
29/07/12 18 (1)	Agreed that the panel receive a progress report in three months which would include a focus on the Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis, Skills analysis and single sex facilities;	This recommendation relates to proposed changes to Mental Health Recovery Pathways.	Request information from Plymouth Community Healthcare		22 November 2012
29/07/12 18 (2)	Agreed that a project plan would be circulated to members.	This recommendation relates to proposed changes to Mental Health Recovery Pathways.	Request information from Plymouth Community Healthcare		22 November 2012

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
29/07/12 19	Agreed that a Project Initiation Document (PID) would be drafted and submitted to a meeting of the Overview and Scrutiny Management Board for approval, the PID would focus on assisting the further development of the strategic and operational plan. The task and finish group would focus on balancing impact of Alcohol on health and maintaining a vibrant night time economy.	This recommendation relates to the Strategic Alcohol Plan.	Prepare PID and submit to the Overview and Scrutiny Management Board.	Ongoing	OSMB October 2012
29/07/12	Agreed to receive a further update on the progress of the plan at a future meeting of the panel.	This recommendation relates to the updated Dementia Action Plan.	Further update would be provided to the panel at the January meeting of the panel.	Ongoing	January 2012
04/04/12 Minute 74 (1)	there is an immediate pause in the process of demerging the Peninsula College of Medicine and Dentistry;				

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
04/04/12 Minute 74 (2)	a 12 week consultation exercise is undertaken, in line with the Government's published code of practice for consultation;	These resolutions refer to the special meeting of the panel held on the 4 April 2012 when the panel considered the demerging of the Peninsula College of Medicine and Dentistry.	The panel's recommendations were forwarded to a meeting of the Full Council where they received unanimous support.		21 June 2012
04/04/12 Minute 74 (3)	an options appraisal detailing alternatives to the demerging of PCMD is made available during the consultation period;				
04/04/12 Minute 74 (4)	no further action is taken until the outcomes of the consultation process are known.				

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

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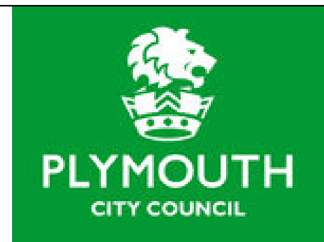
Response to the proposals on Local Authority Health Scrutiny

September 2012



Introduction

Following the passing into law of the Health and Social Care Act 2012, the Department of Health is finalising the supporting regulations and guidance. As part of this process the Department has sought feedback from local authorities regarding the role of health scrutiny.

This document sets out responses from the Plymouth City Council's Health and Adult Social Care Overview and Scrutiny Panel to the Department of Health's consultation relating to Local Authority Health Scrutiny. It has been produced following liaison with the Members of the Health and Adults Overview and Scrutiny Committee and the Cabinet Member for Public Health and Adult Social Care.

The final response has been signed off by the Chair and Vice-Chair of the Health and Adult Social Care Overview and Scrutiny Panel.

The eleven consultation questions have been set out below, along with the panel's responses. The response was forwarded to the department of Health on the 7th September 2012.

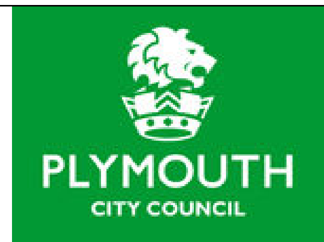
Q1 Do you consider that it would be helpful for regulations to place a requirement on the NHS and local authorities to publish clear timescales? [when substantial variation proposals are made]

Yes. The publication of timescales with relation to reconfiguration proposals would allow local health scrutiny committees to adequately plan for the consideration of such proposals. This would involve the scrutiny of development proposals prior to, as well as during and subsequent to the consultation process which would allow for a view of how proposals may / may not have changed following consultation with key stakeholders. Timescales would allow adequate time for joint committees to be formed, particularly when reconfiguration will affect large Acute Trusts delivering services across local authority boundaries.

Q2 Would you welcome indicative timescales being provided in guidance? What would be the likely benefits and disadvantages in this?

Yes. Guidance around indicative timescales, to be locally interpreted, would be useful. This would allow for negotiation with service providers on the development of proposals. Committee cycles differ across local government and non-statutory guidance would be useful in this area, particularly when large geographical areas and non-coterminous local government boundaries are considered.

Response to the proposals on Local Authority Health Scrutiny
September 2012



Q3 Do you consider it appropriate that financial considerations should form part of local authority referrals? Please give reasons for your views.

Yes. Tough financial decisions will be made across the statutory sector in coming years and it is essential that there potential impact on city priorities is considered as part of this process.

Financial considerations often form part of the Scrutiny Panel considerations when scrutinising a possible reconfiguration of services. However, financial information provided to the panel is often opaque and the panel cannot be assured how funding will stay within the health system.

Regulations enabling health scrutiny to require financial information to be provided by NHS Bodies and relevant service providers would be welcomed, health scrutiny should be able to consider this information in an open and transparent way and the department, when making regulations, must consider how commercially sensitive information, particularly from 'any qualified providers' should be considered by health scrutiny.

Whilst health scrutiny should be able to provide suggested alternatives within the same financial envelope to a provider proposing reconfiguration, this should not be a pre-requisite to support any subsequent referral.

Q4 Given the new system landscape and the proposed role of the NHS commissioning board, do you consider it helpful that there should be a first referral stage to the NHS Commissioning Board?

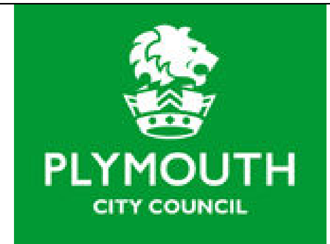
No. Health scrutiny would initially engage with the Health and Wellbeing Board to resolve disputes locally. The NHS Commissioning Board is an unelected independent body which sits at arm's length from government. The Board will authorise, support and develop the network of clinical commissioning groups across the country. It will also contribute to the setting of national tariffs and directly commission not only local primary care services but also regional specialist services.

It is not appropriate that a democratically elected body should refer any reconfiguration to the NHS Commissioning Board, not only does this damage the potency of any such approach, but the NHS CB would also not be seen to retain its independence and could have a conflict of interest.

Additional stages in the referral process will significantly slow the process and whether or not a referral was successful more resource would be required in dealing with any such referral.

Response to the proposals on Local Authority Health Scrutiny

September 2012



Q5 Would there be any additional benefits or drawbacks in establishing this intermediate referral?

Yes. Informal engagement with the NHS CB would be of benefit to the local authority if local disputes were to occur over reconfiguration proposals, however health scrutiny would initially engage with the health and wellbeing board to resolve disputes locally.

Q6 In what other ways might the referral process be made to more accurately reflect the autonomy in the new commissioning system and emphasise the local resolution of disputes?

The risk of referrals would be mitigated by the publication of timetables regarding service reconfiguration proposals as suggested in the consultation document. This panel feels that the current referral process works well and further changes are not required.

Q7 Do you consider it would be helpful for referrals to have to be made by the full council? Please give reasons for your view.

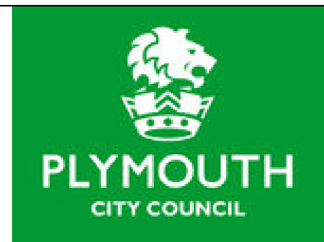
No. Full Council does not provide a forum for complex health issues to be fully explored. Health scrutiny in Plymouth is politically proportional and as such the collective voice of full council is represented in its membership. Lodging this power with the full council would slow the referral process.

Q8 Do you agree that the formation of Joint Overview and Scrutiny arrangements should be incorporated into regulations for substantial service developments or variations where more than one local authority is consulted? If not why not?

No. Guidance issued by the Department of Health in relation to statutory instrument No. 3048 (2002) provides sufficient local flexibility for authorities to establish Joint Committees. The guidance and current regulations allow authorities who have non-conterminous boundaries with Clinical Commissioning Groups, Acute Trusts and other providers to adequately establish Joint Committees with specific objectives.

Response to the proposals on Local Authority Health Scrutiny

September 2012



Q9 Are there additional equalities issues with these proposals that we have not identified? Will any groups be at a disadvantage?

No. The panel agrees with the equalities analysis accompanying this consultation which states proposals are largely technical changes required to implement secondary legislation in line with the Health and Social Care Act 2012. The panel is not aware of any evidence which shows any direct impact on particular equality groups.

Q10 For each of the proposals can you provide any additional reasons that support the proposed approach or reasons that support the current position? Have you suggestions for an alternative approach, with reasons?

The proposals in the 2010 white paper with respect to scrutiny sought to strengthen democratic legitimacy within health services and increase accountability. The removal of the power of referral to the secretary of state is one which has not yet been used by Health Scrutiny in Plymouth; local resolution of disputes will always be the first priority. However the removal of the ability for a democratically elected body to refer changes to a democratically elected minister in effect waters down health scrutiny's current powers and could diminish the potency of recommendations health scrutiny could make.

Q11 What other issues relevant to the proposals we have set out should we be considering as part of this consultation? Is there anything that should be included which is not?

In order to consider the wider issues of Health and Wellbeing, consideration must be given to widening the scope of those required to appear before health scrutiny (Section 244 of the Health Act 2006). Section 104 of the Local Government and Public Involvement in Health Act 2007 provides a list of partner authorities which have an impact on the Health and Wellbeing of the population, this should be extended further to include registered social landlords.

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4 September 2012

Dear Secretary of State

Demerger of the Peninsula College of Medicine and Dentistry

I am writing to you following a resolution made by Plymouth City Council to request a review of the above. Despite concerns raised by a large number of stakeholders, the decision of the universities of Plymouth and Exeter to demerge the Peninsula Medical School is being implemented. Attached is correspondence with the Higher Education Funding Council and the General Medical Council which sets out the detail of our concerns.

Whilst respecting the autonomy of higher education institutions in matters such as these, we believe that the universities failed to engage in proper dialogue with strategic partners prior to making this decision which has importance to the whole peninsula. We have therefore requested that in future any decision of this nature must be taken following a period of consultation in line with the government compact.

The Council and stakeholders also remain deeply concerned about the longer term sustainability of the new Plymouth University Peninsula Schools of Medicine and Dentistry, with reduced student numbers, fewer economies of scale as a result of the demerger.

In the light of the above, the Council would like -

- your views to whether the process as described in the attached correspondence provided a sufficient degree of engagement over such a decision and if not your proposals to address this in the future;
- to formally place on record with you our concerns about the sustainability of the School in Plymouth, which the Council will revisit should they prove true.

I look forward to hearing from you in due course

Yours faithfully

Bob Coomber
Interim Chief Executive
Plymouth City Council

cc Secretary of State for Health
Sir Alan Langlands, Chief Executive, Higher Education Funding Council.
Niall Dickson, Chief Executive, General Medical Council.
Professor Wendy Purcell, Vice-Chancellor and Chief Executive, University of Plymouth.
Professor Sir Steve Smith, Vice-Chancellor and Chief Executive, University of Exeter.

BEST ACHIEVING
COUNCIL OF THE YEAR 2010

Mr Niall Dickson
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23 April 2012

Dear Mr Dickson

Peninsula College of Medicine and Dentistry

You will be aware of the announcement in January 2012 by the Universities of Exeter and Plymouth that the Peninsula College of Medicine and Dentistry is to demerge. I am writing to you to request the support of the General Medical Council in helping to address significant failings in the way that this decision was made, and in ensuring that future medical school arrangements for the region are both sustainable and in the best interests of medical students and other major stakeholders.

Plymouth City Council welcomed the report and recommendations of the LGA Health Commission that you chaired in 2008 prior to taking up your role at the GMC. We have built strong health partnerships in the city, based on transparency and engagement that are delivering significant outcomes for our citizens, both within the city and the sub region. It is especially important therefore, that we are supported in holding the universities to account for a decision making process that does not demonstrate local accountability. As you point out in your report, 'if providers are not held to account, then the system is not accountable'.

The Council's Adult Health and Social Care Overview and Scrutiny Panel met on the 4 April to discuss the demerger plans. The Vice Chancellors of both universities were present, as was the Dean of the College, the Interim Chief Executive of Plymouth Hospitals NHS Trust and myself. The panel had requested specific assurances that:

- There had been sufficient dialogue with key stakeholders prior to the decision being taken to demerge the College
- The long term viability of two separate schools of medicine in such close proximity could be assured
- The reputational value of the existing College amongst potential students would be maintained under proposed new arrangements
- The proposed demerger best fulfils the regional and national ambitions of the city

With respect to the first point, it was clear that no meaningful consultation had taken place with key stakeholders prior to the announcement that the demerger was to take place. The panel heard that

the Acute Trust, the Local Medical Council, the city's Shadow Health and Wellbeing Board, Members of Parliament for both Plymouth and Exeter and both Cornwall and Plymouth Councils had all been presented with a 'fait accompli' by the universities that the demerger was to take place, without a request for views or concerns to be taken into account. Indeed, the Vice Chancellor of Exeter University stated at the Panel meeting that the demerger was 'a done deal' as far as he was concerned. All the above stakeholders have since raised reservations about the wisdom of the proposal. Particularly importantly, the Chair of the panel has since heard from the student body of the College, thanking her for raising the issue and expressing disappointment at the lack of engagement by the universities with students over the issue. Of 600 students surveyed on the issue, 91% had expressed opposition to the demerger.

We have yet to hear convincing evidence about the long term viability of two separate schools of medicine within such close proximity. With public resources for higher education at a growing premium, it seems unlikely that funding assurances can be given with respect to two schools to match our sub regional planning horizons to 2026.

Both Vice Chancellors agreed that the existing college enjoys a first class reputation among former and current students, and is of national and international standing. Unsurprisingly, neither was able to give categorical assurances that the new arrangements would do anything other than divide and dissipate that reputation.

You will be aware that Plymouth, as the fifteenth largest city in the UK is a key driver for both economic growth and improved health outcomes in the region. It is not clear whether any of the demographic, employment or public health implications relating to this decision were considered, much less shared or debated with any key stakeholders prior to it being made. Whilst respecting the autonomy of higher education institutions, I believe that it is not becoming of the universities to fail to engage in proper dialogue with strategic partners prior to making decisions of strategic importance to the peninsula.

At a meeting of the full City Council on 16 April, the following recommendation was made to the Vice Chancellors of the University of Exeter and Plymouth University: that

- There is an immediate pause in the process of demerging the Peninsula College of Medicine and Dentistry
- A 12 week consultation exercise is undertaken, in line with the Government's published code of practice for consultation
- An options appraisal detailing alternatives to the demerging of PCMD is made available during the consultation period

In addition, I have been mandated, as Chief Executive of the Council to raise the matter with the Secretary of State for Health and the Secretary of State for Business, Innovation and Skills for review in the event of the recommendation not being actioned.

You will see from the above that there is an overwhelming desire by a significant number of key stakeholders to be properly and meaningfully engaged in the decision making process concerning the PCMD. I am formally and respectfully requesting that the General Medical Council acknowledge the requirement that consultation as set out above should take place and is properly considered before any approval is given to demerged schools of medicine at the two universities.

I am happy to discuss the above, or provide further details of our deliberations if you would find that helpful, but in any case look forward to your urgent response to my request.

Yours sincerely

B A Keel
Chief Executive

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BEST ACHIEVING
COUNCIL OF THE YEAR 2010

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18 April 2012

Dear Sir Alan

Peninsula College of Medicine and Dentistry

Since my letter to Sir Ian Carruthers of 29 March concerning the above, a copy of which I forwarded to you and which is also attached, there have been further developments. I am writing to inform you of these, and to formally request your support in ensuring that decisions regarding the future of the Peninsula College of Medicine and Dentistry are properly and transparently made.

The Council's Adult Health and Social Care Overview and Scrutiny Panel met on the 4 April to discuss the demerger plans announced by the University of Exeter and Plymouth University in January 2012. The Vice Chancellors of both universities were present, as was the Dean of the College, the Interim Chief Executive of Plymouth Hospitals NHS Trust and myself. The panel had requested specific assurances that:

- There had been sufficient dialogue with key stakeholders prior to the decision being taken to demerge the College
- The long term viability of two separate schools of medicine in such close proximity could be assured
- The reputational value of the existing College amongst potential students would be maintained under proposed new arrangements
- The proposed demerger best fulfils the regional and national ambitions of the city

With respect to the first point, it was clear that no meaningful consultation had taken place with key stakeholders prior to the announcement that the demerger was to take place. The panel heard that the Acute Trust, the Local Medical Council, the city's Shadow Health and Wellbeing Board, Members of Parliament for both Plymouth and Exeter and both Cornwall and Plymouth Councils had all been presented with a 'fait accompli' by the universities that the demerger was to take place, without a request for views or concerns to be taken into account. (Indeed at the Scrutiny Panel the Vice Chancellor of Exeter University stated that "It was a Done Deal" as far as he was concerned). All

have since raised reservations about the wisdom of the proposal. Particularly importantly, the Chair of the panel has since heard from the student body of the College, thanking her for raising the issue and expressing disappointment at the lack of engagement by the universities with students over the issue. Of 600 students surveyed on the issue, 91% had expressed opposition to the demerger. I mention this specifically, noting your observation to the Annual Dearing Conference in February 2011 that 'the new arrangements for higher education funding mean that the active involvement of students at all levels of university development and decision making will become even more important'.

Both Vice Chancellors agreed that the existing college enjoys a first class reputation among former and current students, and is of national and international standing. Unsurprisingly, neither was able to give categorical assurances that the new arrangements would do anything other than divide and dissipate that reputation.

We have yet to hear convincing evidence about the long term viability of two separate schools of medicine within such close proximity. With public resources for higher education at a growing premium, it seems unlikely that funding assurances can be given with respect to two schools to match our sub regional planning horizons to 2026.

You will be aware that Plymouth, as the fifteenth largest city in the UK is a key driver for both economic growth and improved health outcomes in the region. It is not clear whether any of the demographic, employment or public health implications relating to this decision were considered, much less shared or debated with any key stakeholders prior to it being made. Whilst respecting the autonomy of higher education institutions, I believe that it is not becoming of the universities to fail to engage in proper dialogue with strategic partners prior to making decisions of strategic importance to the peninsula.

At a meeting of the full City Council on 16 April, the following recommendation was made to the Vice Chancellors of the University of Exeter and Plymouth University: that

- There is an immediate pause in the process of demerging the Peninsula College of Medicine and Dentistry
- A 12 week consultation exercise is undertaken, in line with the Government's published code of practice for consultation
- An options appraisal detailing alternatives to the demerging of PCMD is made available during the consultation period

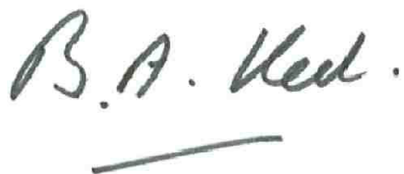
With regard to the point relating to a full options appraisal, it is still not clear if this has even been undertaken. If this has not been done then this is a very surprising omission.

In addition to the above recommendations, I have been mandated, as Chief Executive of the Council to raise the matter with the Secretary of State for Health and the Secretary of State for Business, Innovation and Skills for review in the event of the recommendation not being actioned.

You will see from the above that there is an overwhelming desire by a significant number of key stakeholders to be properly and meaningfully engaged in the decision making process concerning the PCMD. Indeed there is great concern whether the decision is a good one for Plymouth City or the whole of the peninsula. I am therefore formally and respectfully requesting that the Higher Education Funding Council for England acknowledge the requirement that consultation as set out above should take place and is properly considered before any approval is given to providing funding to demerged schools of medicine at the two universities.

I am of course, very happy to discuss the above, or provide further details of our deliberations if you would find that helpful, but in any case I look forward to your urgent response to my request.

Yours sincerely



B A Keel
Chief Executive

Enc

cc Gary Streeter MP
Councillor Vivien Pengelly, Leader, Plymouth City Council
Professor Wendy Purcell, Vice Chancellor and Chief Executive, University of Plymouth
Professor Sir Steve Smith, Vice Chancellor and Chief Executive, University of Exter

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Plymouth Community Healthcare

Acute Care Pathway

Glenbourne Redesign

Consultation Document

Version Control

Issue	Date	Author	Reason
Version1	August 2012	David McAuley	Consultation Process

Distribution List

Name	Date
Plymouth Community Healthcare Executive Team	13th Sept 2012
Western Locality Strategic Leadership Team	
QIPP Transformation Board	18th Sept 2012
Mental Health QIPP Group	17th Sep 2012
Acute Care Pathway Group	1st Oct 2012
JCCN	
Health Overview and Scrutiny Committee	13th Sept 2012

1. Executive Summary

Acute Psychiatric Beds for Plymouth and the surrounding are based at the Glenbourne Unit which is located on the periphery of the Derriford Hospital site.

The Unit was built in the 1970s and since that time has had little capital investment.

Glenbourne was originally constructed to house three wards, Dunsford .Bridford and Harford. Over the years however the approach to Acute Psychiatric Medicine has changed and best practice is now directed to achieving shorter acute stays augmented with strong community and well integrated multi agency support.

As a consequence Dunsford Ward has not been operational for a number of years with 44 available beds based on Bridford and Harford. Wards. Over the past two financial years the average number of occupied beds has been 33.

Due the age of the building, facilities are not now seen as meeting required patient standards in privacy and dignity. These are now directed to single sex wards, individual rooms and en suite facilities.

Additionally it is considered that overall service provision for patients would be better achieved through bringing together a number of Teams at Glenbourne who are currently largely located off site.

There is also a need to have facilities on site which will enable the management of patients during their more challenging psychotic episodes and help avoid referral to out of area facilities.

Finally it is planned to re-locate and re-operationalise "Place of Safety" arrangements for patients who are assessed under S135 and S136 of the Mental Health Act. These assessments are currently being undertaken at Charles Cross Police Station and this situation is felt to be both unsatisfactory and inappropriate. This will also enable the Unit to have an "extra care" nursing area, to help manage those in the most acute need, who require a low stimulus environment.

In order to achieve these improvements it is intended to progress a building redesign for Glenbourne. It is envisaged that this will entail a reduction in the number of currently available beds from 44 to 36. This reduction will not impact the number of staff and it is planned that these will be increased to allow for the Place of Safety to be re-operationalised and for the local management of patients who would otherwise be referred for Out of Area treatment.

There will also be additional investment in Community Infrastructure.

In summary it is intended that the building re-design will result in:-

- Significant enhancement to the environment within which Acute Mental Health services are delivered

- The achievement of standards required relating to privacy and dignity
- The integration on site of Teams directed to the overall management of patient care
- Place of Safety arrangements
- Enhanced Community Service Provision
- The local management of patients who would otherwise be treated out of area

2. The Glenbourne Unit

The Glenbourne Unit is currently a 44 bed Acute Psychiatric admissions Unit serving the Plymouth, South Hams and Tavistock.area.

The Unit is located on the periphery of the Derriford Hospital site. This adjacency is helpful in facilitating the linkage that exists between Glenbourne and the Accident and Emergency Unit within the main hospital where patients with a Mental Health issue often present. There is currently a Psychiatric Liaison Team dedicated to the management of these patients and ensuring that they are directed to the most appropriate psychiatric service area which may include admittance to Glenbourne

Within the Glenbourne Unit there are currently two operational wards these being Bridford and Harford.

The Unit was built in the 1970s and at that had had three operational wards the two which are operational today plus Dunsford.

Best practice in Psychiatric care is now directed to achieving shorter acute stays augmented with strong community and well integrated multi agency support. As a result the number of beds needed to support the local population has reduced and since 2006 has been used for other purposes including Psychiatric Medical Staff Training and Administration.

The layout of the area, as a former ward, does not lend itself to the best use of space and is in need of adaptation and improvement.

Over the years standards have changed and there is an expectation that accommodation will be largely based on single room accommodation which enjoy either en-suite or hand wash facilities. The majority of accommodation at Glenbourne is based around “bays” and therefore does not meet the expected standards associated with privacy and dignity.

Current ward areas are directed to mixed sex accommodation. There is now a requirement to develop single sex accommodation.

The Mechanical and Electrical Infrastructure at the Unit has had little investment over the years and is now in need of significant upgrade.

3. The Service Model

Psychiatric acute care is now directed to ensuring that the length of acute psychiatric stay is appropriate for individual patients but that this is minimised. This trend has been evidenced in reduced average length of stays and bed use. A table setting out average monthly occupied beds is set out in Appendix 1

This shows that in 2011/12 the monthly average occupied bed total was contained within the 36 level which is now proposed.

In order to achieve this objective is essential to have in place robust inter-agency support infrastructure which, apart from Community Services support, includes for areas such as housing, education, employment and primary care.

In Plymouth these arrangements are generally perceived to work well and this has enabled the reduction in beds numbers at Glenbourne which has been seen over the years. There is however an aspiration of continued improvement and the proposed structural changes to the Glenbourne Unit are seen as a catalyst to ensuring that the patient pathway is geared, where appropriate, to the management of patients within a community setting.

At the same time there are a number of patients at the more challenging end of the management spectrum who are currently sent out of area to Psychiatric Intensive Care Units (PICU). It is considered that given the correct nursing environment, known as extra care, a number of these patients could be managed locally to the benefit of the patients themselves as well as family and friends.

4. Integrated Management and Staff Location

There are a number of Teams currently supporting the Acute Patient Pathway including the Home Treatment Team, the Out of Hours Team and Community Mental Health Team. These are currently largely located off site.

Consideration is currently being given to the merit of bringing these Teams under unified management structure. A corollary of this approach would be for appropriate staff to be co-located and the optimum location is considered to be the Glenbourne Unit.

This arrangement would also allow for the Unit to be used for appropriate outpatient sessions and the dispensing of necessary medication to community patients within a controlled environment.

5. Place of Safety

Where a patient is suspected of having a Mental Health problem and is need of immediate care and control, the police can use Sections 135 and 136 of the 1983 Mental Health Act to take the person to a “Place of Safety” (POS) for up to 72 hrs.

In 2009 a dedicated “Place of Safety” suite was physically established in the Glenbourne Unit at the end of the former Dunsford ward. The staffing of the suite was however never funded and was dependent on staff leaving the wards to support the assessment process. Additionally the POS was located away from the wards and therefore staff were potentially vulnerable, on those occasions, when they were in one to one contact with the patient.

Due to a combination of staff having to leave the wards and the location of the suite, the POS has not been operational since February 2012 and in consequence all assessments have been undertaken at Charles Cross police station.

This situation is unsatisfactory and the redesign process will be directed to ensuring that the POS is appropriately located within the Unit which ensures staff security.

6. Proposals for Building Re-configuration

In order to address the current shortfall in service provision set out above it is intended to progress building adaptation and re-configuration which will result in the following:-

6.1 Lower Ground Floor

It is intended to create two eighteen bedded units arranged over Dunsford and Harford wards.

Accommodation will be based on single sex requirements but with multi use recreational areas. These Units will enjoy adjacency to the garden areas avoiding the need for patients to be escorted downstairs from Bridford Ward located on the ground floor.

Bedrooms will be for single use and enjoy either full en suite or individual washing facilities. It is proposed to create a level of facility which will enable the appropriate management of Bariatric patients.

It is envisaged that a Conservatory will be created in the garden area providing a pleasant and tranquil environment throughout the year.

The area between the wards will be given over to creating a multi function suite which will provide an appropriate location for a Place of Safety Suite and the Extra Care nursing area referred to above.

It is planned to provide additional dedicated staffing to support the POS and Extra Care areas. These resources will be made available from the currently planned re-configuration of Recovery Services.

As set out above it is envisaged that the provision of Extra Care nursing will allow for the local management of patients who would otherwise be sent to PICU facilities outside of the area.

6.2 Ground Floor

The Ground floor provides the base for those peripatetic staffing groups supporting the overall patient pathway and other essential support staff.

It will also provide an outpatient hub for Psychiatric Services.

Electro Convulsive Therapy ECT) is currently administered at the Unit. Options for the future location of this service are currently being considered including part of the ground floor area at Glenbourne.

7. Community Services

It is planned to direct additional resource to the development of Community Services in support of facilitated discharge and the management of patients, where appropriate, in the Community who would otherwise be admitted to Glenbourne.

Arrangements are also being taken forward to develop the key worker concept of working with Primary Care colleagues in the management of patients during a Psychiatric episode.

8. Mechanical and Electrical Infrastructure

As part of the overall re-configuration of Glenbourne the opportunity will be taken to upgrade the Mechanical and Electrical Building infrastructure including Boiler replacement and ensuring that the unit is engineered to modern standards.

9. Process and Timescale

Designs for the revised accommodation are currently being developed by a Multi Disciplinary Clinical Team supported by appropriate Technical and other advice.

It is planned to complete the design stage by the end of September 2012.

Subject to a satisfactory consultation process, and the appropriate finance being in place, it is proposed to Commence Phase 1 of the adaptations in January 2013.

These would be undertaken in three phases up to March 2014 allowing for the service to remain operational during the adaptation process.

The maintenance of high quality patient care within a safe and stress free environment will remain paramount during this period.

Details costs have yet to be determined however it is envisaged that a potential capital receipt from sale of the recently vacated former Plympton Hospital site could be re-invested in the Glenbourne Unit.

10. Summary

It is proposed to undertake a programme of building adaptation and re-design at the Glenbourne Psychiatric Unit. This programme will enhance patient care through the provision of:-

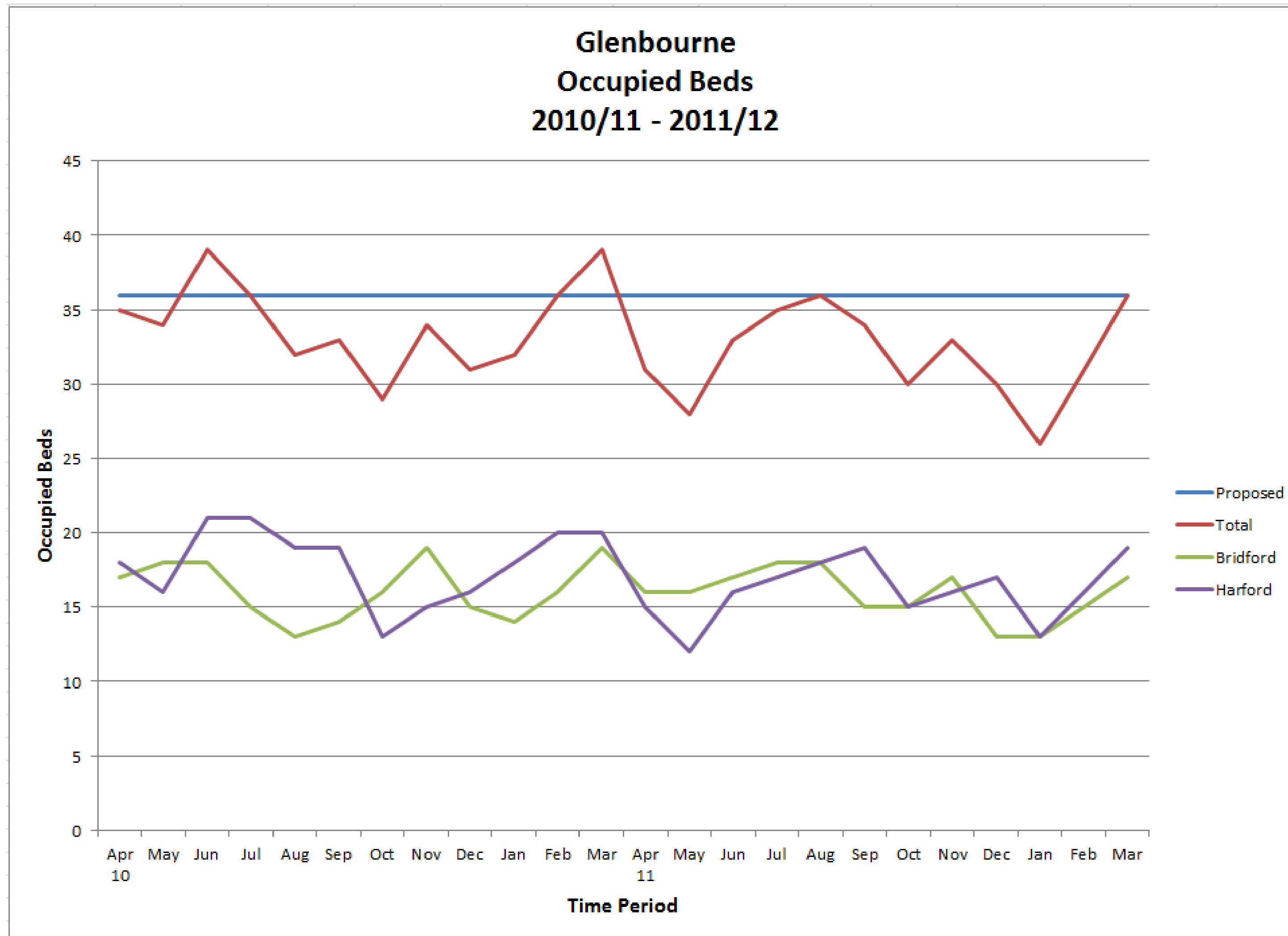
- Individual Bedroom Accommodation allowing for the achievement of appropriate standards of dignity and privacy.
- En suite or hand wash facilities for each room with a level of bariatric provision.
- Single Sex wards enabling Department of Health requirements to be met.
- Multi function areas including the development of a conservatory.
- The location of appropriate Community and other staff within Glenbourne in support of an integrated management structure.
- An appropriately located Place of Safety Suite which will allow for the majority of assessments to be undertaken in Glenbourne rather than the Charles Cross Police Station.
- The development of Extra Care Nursing facilities allowing for the local management of a number of patients who would otherwise need to be treated "out of area."
- The development of improved outpatient and other facilities.
- An upgrade of mechanical and electrical services within the Building

It is envisaged that the re-design will result in a reduction in overall available beds from 44 to 36. This reduction is in keeping with the service model of maintaining appropriate patients within a community setting and facilitated discharge.

The reduction will be supported by an enhancement to Community Staffing levels.

The programme of works will be subject to careful planning and management recognising the paramount need to maintain high quality patient care within a sensitive environment.

Appendix 1



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PLYMOUTH CITY COUNCIL

Subject:	Public Health Transition – Position Statement
Committee:	Health and Social Care Overview and Scrutiny
Date:	13 September 2012
Cabinet Member:	Councillor McDonald
CMT Member:	Carole Burgoyne, Director for People
Author:	Candice Sainsbury, Senior Policy, Performance and Partnerships Advisor and Kevin Elliston, Associate Director, NHS Public Health.
Contact:	Tel: 01752 307387 Email: candice.sainsbury@plymouth.gov.uk
Ref:	
Key Decision:	No
Part:	I

Purpose of the report:

This position statement aims to inform the panel about the status of the transfer arrangements of public health responsibilities to the Local Authority prior to the final report due at Cabinet in December 2012.

Public Health is about improving, promoting and protecting the health of everyone to the highest level possible and is concerned with physical, mental, and social well-being and not merely the absence of disease or infirmity. The transfer of public health responsibilities to the Local Authority signifies the step change required to improve and protect Plymouth's health and wellbeing, and to improve the health of the poorest fastest. This will enable the development of a comprehensive and sustainable public health system that can effectively tackle significant health inequalities across the city, including reducing the gap in life expectancy, tackling child poverty and reducing the premature mortality rates in men. Such improvements contribute to the delivery of the city's vision.

Key points outlined in this paper are as follows:
i. Responsibility for key public health functions will transfer from the National Health Service (NHS) to local authorities on 1 April 2013.
ii. A local joint transition plan is in place with key workstreams including Future Public Health Model, Commissioning and Finance, Human Resources, Communications, Risk Management, Intelligence, Core Offer, Health Improvement Team, and Emergency Planning.
iii. Key milestones include identification of NHS Public Health staff to transfer to Local Authority (December 2012) and the final funding formula (December 2012).

Corporate Plan 2012-2015:

The formal transfer of key public health responsibilities to the Local Authority is expected to contribute significantly to addressing long term outcome measures to reduce health inequalities. These include reducing the gap in life expectancy, tackling child poverty and reducing the premature mortality rates in men. This will be achieved in line with the development and delivery of the upcoming Health and Wellbeing Strategy as part of the overall Plymouth Plan.

The public health transition is also expected to impact on the other priorities by shaping and controlling local services which influence wider determinants of health for example transport, economic development, housing, culture and leisure, education, environment and public protection.

Implications for Medium Term Financial Plan and Resource Implications:
Including finance, human, IT and land

The final funding formula for public health is now not expected to be released until December 2012. The financial due diligence of the NHS Public Health transfer centres around the formal returns completed by the PCT which sets out the budgets and resources allocated to NHS Public Health locally in Plymouth. These formal returns will feed the resource allocations and the spending review by government departments.

Finance officers from PCC, NHS Public Health and the PCT (commissioner) have already worked on the 2010/11 baseline assessment which set out the spending for NHS Public Health. PCT colleagues are currently working on the latest baseline for 2012/13.

The PCT are currently in the process of also providing more comprehensive financial data for PCC to analyse in the context at building a shadow budget for a transferred public health service.

Other Implications: e.g. Child Poverty, Community Safety, Health and Safety, Risk Management and Equality, Diversity and Community Cohesion:

1. A local Equality Impact Assessment is currently being undertaken.

2. The new public health outcomes framework identifies two high-level outcomes to be achieved across the public health system as follows:

- increased healthy life expectancy
- reduced differences in life expectancy and healthy life expectancy between communities

These outcomes reflect a focus not only on how long people live but on how well they live at all stages of life. The second outcome focuses attention on reducing health inequalities between people, communities and areas. Both are essential to enable the city to effectively address areas of inequality, and in particular health inequalities. This has immediate cross overs with the child poverty agenda.

In general, there are significant opportunities to positively impact health inequalities through close alignment with delivery of the public health outcomes as integrated within the upcoming Health and Wellbeing Strategy.

3. A joint risk management register is being developed to identify the key areas of risk to be managed within and beyond the transition period. Significant risks identified continue to centre primarily on the final funding formula and implications of the final staff transfer arrangements.

Recommendations & Reasons for recommended action:

Recommendation for the panel to note the report.

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

Background papers:
N/A

Sign off:

Fin	DJN 1213.005	Leg	15314/ DVS	HR BS		Corp Prop		IT		Strat Proc	
Originating SMT Member: Giles Perritt											
Have you consulted the Cabinet Member(s) named on the report? Yes											

1. BACKGROUND

1.1 The Health and Social Care Act 2012 transfers the responsibility for some key public health functions from the National Health Service (NHS) to local authorities on 1 April 2013 (please see Appendix 1 for a full list of the transferring responsibilities). These focus on:

- promoting the health of the local population,
- ensuring robust plans are in place to protect the health of the local population, and
- providing advice to NHS Commissioners.

1.2 The new executive agency 'Public Health England', which brings together the Health Protection Agency, National Treatment Agency and others, will take a national role in protecting the nations health, provide leadership and guidance, and support development of a public health workforce.

1.3 The NHS will continue to have a role on improving the public's health at a national level through the NHS Commissioning Board responsibilities, and locally by working jointly with local authorities to focus the impact of services they commission and by making 'every contact count'.

1.4 Local authorities are considered to be in a strong position to take on new public health functions because they have a population focus (lead on the Joint Strategic Needs Assessment and Health and Wellbeing Board), shape and control local services which influence wider determinants of health (e.g. transport, housing, culture and leisure, education, environment, public protection), and are locally accountable.

1.5 Locally this move presents a real opportunity to create a comprehensive and sustainable public health system that builds on the existing links and synergies between NHS Plymouth and Plymouth City Council's work to improve the health of local communities. This opportunity must be embedded within the upcoming Health and Wellbeing Strategy if real improvements to reduce health inequalities are to be made. The transition of public health functions can assist this by putting health at the heart of the Plymouth City Council's policies and decisions, by building on its experience of engaging local communities, and by commissioning evidence based services.

1.6 Plymouth City Council will be allocated a ring fenced grant to help deliver against these new responsibilities, and will plan and deliver public health services against the Public Health Outcomes Framework. The ultimate aim of this Outcomes Framework is to improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest by:

- Improving the wider determinants of health
- Health improvement
- Health protection
- Healthcare public health and preventing premature mortality

1.7 A Joint Transition Management Steering Group led by Deb Lapthorne, Joint Director of Public Health and Carole Burgoyne, Director for People, Plymouth City Council (PCC) has been established to oversee the Transition Planning governance arrangements at local level. The local transition process is being overseen by the Cluster Transition Board.

1.8 A local transition plan has been developed and agreed with clear milestones to facilitate the transition to the new public health system and aims to be flexible enough to embrace guidance as and when it is released. Delivery of this plan is through a joint project team representing the NHS Public Health and Plymouth City Council.

1.9 A final report to Cabinet, outlined in the Forward Plan for December 2012, will confirm the transfer arrangements of public health responsibilities to the Local Authority.

2. TRANSITION WORK STREAMS

2.1 Future Public Health Model

2.1.1 A key question for the future of Public Health delivery is how it is integrated and mainstreamed into everyday Local Authority business. Guidance from the Local Government Association and the Department of Health suggests there are three broad categories for future public health delivery

- a distinct public health directorate in the local authority (often including additional local authority functions)
- a section of another directorate-generally the directorate with responsibility for adult social care or a chief executive/corporate directorate
- a “distributed” or “integrated” model in which public health responsibilities and staff work across directorates or functions but maintain identity and focus through being a “virtual team”, a “hub” or a “core and extended” team

2.1.2 Planning is underway to establish the best fit in order to deliver the maximum health improvements. A workshop will take place in early August 2012 to kick start this process, beginning with agreement of the vision, purpose and outcomes.

2.1.3 The way in which Plymouth City Council delivers its new public health functions will need to be closely aligned with the development and delivery of the upcoming Health and Wellbeing Strategy. While it is not a separate work stream within this project, working links have been established across the wider health integration programme.

2.2 Commissioning, Contracting and Financing

2.2.1 From April 2013, the Local Authority will take on the lead responsibility for commissioning Public Health Services. In order to take on this role it is necessary to understand the current scope of commissioning activity undertaken by Public Health and the wider NHS for services that support public health.

2.2.2 A detailed mapping of current activity relating to the anticipated public health functions transferring to PCC is nearly complete. Part of this mapping has been to collect information on the amount that NHS Public Health and PCT currently spend in related activity (both contracts and in house provision) so that PCC can start preparing for and understanding potential future financial liabilities. Once a full picture is understood then the reshaping of these contracts within the financial envelope can be undertaken.

2.2.3 The final funding formula for public health is now not expected to be released until December 2012. The financial due diligence of the NHS Public Health transfer centres around the formal returns completed by the PCT which sets out the budgets and resources allocated to NHS Public Health locally in Plymouth. These formal returns will feed the resource allocations and the spending review by government departments.

2.2.3 Finance officers from PCC, NHS Public Health and the PCT (commissioner) have already worked on the 2010/11 baseline assessment which set out the spending for NHS Public Health. PCT colleagues are currently working on the latest baseline for 2012/13.

2.2.4 The PCT are currently in the process of also providing more comprehensive financial data for PCC to analyse in the context at building a shadow budget for a transferred public health service.

2.3 Human Resources and Communication

2.3.1 This work stream is concentrated predominantly on the people management issues arising from the transfer in to PCC of NHS Public Health employees on 1 April 2013. A number of key documents have been published to assist with this aspect of the transfer[1].

2.3.2 PCC and NHS Human Resource professionals are working closely together on staffing matters both formally, via the Public Health Workforce Group and the Public Health Plymouth Transition Steering Group, and informally via regular updates by telephone and email as issues arise.

2.3.3 The transfer between the NHS ("sender organisation") and PCC ("receiver organisation") will be guided by the requirements of the Transfer of Undertakings (Protection of Employment) Regulations 2006 often referred to as TUPE.

2.3.4 Currently there is no confirmed final list of the roles and names of those transferring to PCC. This is now expected around December 2012. The process of identifying and confirming the final destination of current NHS employees is currently on-going by NHS management and their HR departments.

2.3.5 It has been agreed between trade unions, LGA and NHS employers, the Department of Health, Department for Communities and Local Government and HM Treasury that staff transferring on 1st April will stay on the NHS Pension Scheme. Decisions on the provision of pensions for new starters and for staff who move between posts after 1 April 2013 are still the subject of further discussions. An update will be given in further reports.

2.3.6 A joint communication plan is currently being developed to ensure that NHS Public Health and PCC employees are aware of the transfer and its implications. A detailed induction plan is also being scoped. Part of the communication plan will include press management timescales.

2.4 Health Improvement Team

2.4.1 Presently, NHS Public Health both commission and directly provide services through the Health Improvement Team (HIT). The type of services currently provided, include smoking cessation, chlamydia screening, and community health development.

2.4.2 Due to the strong clinical focus of some of these interventions, rather than transferring the Health Improvement Team over to the Local Authority, an in principle decision has been made to transfer the service to Plymouth Community Healthcare, under the Transforming Community Services framework. Planning is now under way for this to happen and a series of tests are being put in place to ensure the proposed provider is the most appropriate destination for the service.

2.5 Core Offer

2.5.1 One of the mandatory responsibilities that local authorities will be required to deliver from April 2013 is to provide specialist public health expertise and advice to NHS commissioners to support them in delivering their objectives to improve the health of the local population, this will be called the core offer.

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[1] Public Health Human Resources (HR) Concordat

This is seen as crucial in ensuring that accessible high quality healthcare services continue to be commissioned and delivered by the NHS to improve health and reduce health inequalities.
2.5.2 Guidance states that the offer will be limited to healthcare public health advice that genuinely requires specialist public health expertise, rather than what public health trained individuals might happen to do in a given area. The 'core offer' will be funded from the public health budget allocated to local authorities at no cost to CCGs.

2.5.3 There could be an opportunity for PCC to provide additional advice and support to CCG's over and above the free 'core offer'.

2.6 Public Health Intelligence

2.6.1 The Devon-wide Public Health Information and Intelligence working group oversees the transition of NHS Public Health Plymouth's information and intelligence responsibilities to PCC and, where appropriate to Health protection Agency and other related partner organisations and agencies.

2.6.2 A number of issues relating to the transition of the Public Health (intelligence) function will be addressed as part of the co-location to the Local Authority.

2.7 Emergency Planning

2.7.1 Consolidation of emergency planning responsibilities across both the NHS and Local Authority is currently underway. Recent guidance however suggests that Public Health England will provide an oversight role on behalf of the NHS, with additional responsibilities being passed to the NHS Commissioning Board Local Area Teams and the Local Authority.

2.8 Risk Management

2.8.1 A joint risk management register is being developed to identify the key areas of risk to be managed within and beyond the transition period. Significant risks identified continue to centre primarily on the final funding formula and implications of the staff transfer arrangements.

3. KEY MILESTONES

March 2012	Final Cluster plan to Strategic Health Authority submitted.
April 2012	Local Transition Plan agreed
July 2012	Local joint communications plan developed
August 2012	Vision and outcomes joint workshop
September 2012	Vision agreed linked with Health and Wellbeing Strategy outcomes
November 2012	Transitional model agreed
October 2012	Formal assessment of progress by Strategic Health Authority
November 2012	Negotiation of commissioning contracts to be transferred to Local Authority
December 2012	Final list of NHS Public Health staff to transfer to Local Authority
December 2012	Expected Health Improvement Team transfer to Plymouth Community Healthcare
December 2012	Final funding formula announced
January 2013	Co-location of NHS Public Health staff within the Local Authority
January 2013	Shadow arrangements in place
April 2013	Formal transfer of responsibilities/budget to Local Authorities

APPENDIX 1

Local Authority Commissioning Responsibilities from April 2013:

• tobacco control and smoking cessation services

• alcohol and drug misuse services

• public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)

• the National Child Measurement Programme

• interventions to tackle obesity such as community lifestyle and weight management services

• locally-led nutrition initiatives

• increasing levels of physical activity in the local population

• NHS Health Check assessments

• public mental health services

• dental public health services

• accidental injury prevention

• population level interventions to reduce and prevent birth defects

• behavioural and lifestyle campaigns to prevent cancer and long-term conditions

• local initiatives on workplace health

• supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes

• comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)

• local initiatives to reduce excess deaths as a result of seasonal mortality

• the local authority role in dealing with health protection incidents, outbreaks and emergencies

• public health aspects of promotion of community safety, violence prevention and response

• public health aspects of local initiatives to tackle social exclusion

• local initiatives that reduce public health impacts of environmental risks

Health and Adult Social Care Overview and Scrutiny Panel

Work Programme 2012/13

Topics	J	J	A	S	O	N	D	J	F	M	A
Health Integration Programme											
Health and Wellbeing Board / Joint Strategic Needs Assessment (JSNA) / Joint Health and Wellbeing Strategy (JHWBS)				**13**							
Government Policy Changes											
Public Health Transition				**13**							
Joint Priorities											
Alcohol Strategy (Task and Finish)											
Safeguarding Vulnerable People (review of recommendations)						**22**					
NHS Devon Cluster Primary Care Trust											
NEW Devon, Clinical Commissioning Group (Western Locality)											
Commissioning Intentions						**22**					
Plymouth NHS Hospitals Trust											
Hospital Discharge Process (TBC)											
Foundation Trust Business Case						**22**					
Plymouth City Council – Adult Social Care											
Social Care Transformation Programme								**24**			
Plymouth Community Healthcare											
Performance Monitoring											

Topics	J	J	A	S	O	N	D	J	F	M	A
Referred by Local Involvement Network											
Services for Gypsies and Travellers				**13**							

N.B – items will be automatically deleted from the work programme once they have been considered by the Panel.