Public Document Pack

**Tracey Lee**
Chief Executive

Plymouth City Council
Civic Centre
Plymouth PL1 2AA

Please ask for Ross Jago, Democratic Support.
T 01752 304469
E ross.jago@plymouth.gov.uk
www.plymouth.gov.uk/democracy
19 February 2013

# HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

Thursday 28 February 2013
2 pm
Warspite Room, Council House (Next to the Civic Centre), Plymouth

**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.

**Tracey Lee**
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 - 4)

The panel will be asked to confirm the minutes of the meetings held on 24 January 2013.

### 5. TRACKING RESOLUTIONS AND FEEDBACK FROM THE OVERVIEW AND SCRUTINY MANAGEMENT BOARD (Pages 5 - 8)

The panel will consider previous resolutions and feedback from the Overview and Scrutiny Management Board.

### 6. JOINT HEALTH AND WELLBEING STRATEGY (JHWBS) (Pages 9 - 18)

The panel will consider the consultation on the Joint Health and Wellbeing Strategy.

### 7. NEW DEVON COMMISSIONING INTENTIONS (Pages 19 - 42)

The panel will consider the NEW Devon Clinical Commissioning Group's commissioning intentions.

### 8. JOINT COMMISSIONING PARTNERSHIP COMMISSIONING INTENTIONS (Pages 43 - 48)

The panel will consider the Joint Commissioning Partnership's commissioning intentions.

**9. FRANCIS REPORT RECOMMENDATIONS AND LEGISLATIVE UPDATE** **(Pages 49 - 54)**

The panel will consider the Francis Report recommendations on Local Authority Health Scrutiny following the inquiry into Mid-Staffordshire NHS Foundation Trust and the publication of regulations governing Local Authority Health Scrutiny.

**10. WORK PROGRAMME** **(Pages 55 - 56)**

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.

This page is intentionally left blank

# Health and Adult Social Care Overview and Scrutiny Panel

**Thursday 24 January 2013**

PRESENT:

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

Apologies for absence: Councillors Dr. Mahony and Sue Kelley, Local Involvement Network.

Also in attendance: Sue Stock, Head of Midwifery Plymouth Hospitals NHS Trust (PHNT) Imogen Montague, Consultant Obstetrician and Gynaecologist (PHNT), Amanda Nash, Head of Communications (PHNT), Mrs Kerry Dungay, acupuncture service user, Mrs Sarah Budd, retired founder of the Acupuncture Midwifery service, Dr Adrian White, Researcher and Acupuncture practitioner, Nick Pahl, The British Acupuncture Council, Karen Kay, Designate Head of Western Locality Commissioning NEW Devon Clinical Commissioning Group (CCG), Candice Sainsbury, Lead Officer Plymouth City Council (PCC) and Ross Jago, Democratic Support Officer (PCC)

The meeting started at 2.00 pm and finished at 4.05 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.*

## 48. 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 Mrs Aspinall | Plymouth Hospitals NHS Trust - Maternity Acupuncture Service | Retired Midwife and member of the Royal College of Midwives. | Personal |
| Councillor J Taylor | Clinical Commissioning Group Authorisation Update | Clinical Commissioning Group Employee | Personal |

49. **CHAIR'S URGENT BUSINESS**

There were no items of Chair's urgent business.

50. **MINUTES**

Agreed to approve the minutes of the 22 November 2012.

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

The panel noted the tracking resolutions.

52. **PLYMOUTH HOSPITALS NHS TRUST - MATERNITY ACUPUNCTURE SERVICE**

Following a resolution on the 22 November 2012 the panel considered the closure of the Maternity Acupuncture Service at Derriford Hospital.

Sue Stock, Head of Midwifery and Imogen Montague, Consultant Obstetrician and Gynaecologist representing Plymouth Hospitals NHS Trust reported that -

(a) like many of the hospital's services, the maternity service had been undergoing a period of change due to reducing budgets;

(b) the maternity acupuncture service had been challenged for a number of years and a recent inspection by the National Institute for Clinical Excellence (NICE) had also challenged the validity and continuation of the service;

(c) the service was unable to guarantee one to one care with every woman in the acute setting and as such all available resource had to be redirected into the acute care setting;

(d) the research and trials available on the benefits of this kind of acupuncture was poor, inconclusive and did not show benefits over and above a placebo treatment. It was not felt that there was enough evidence to support continued acupuncture service provision in this area;

(e) commissioners had confirmed that the hospital would not receive a payment over and above the tariff to fund the service.

Mrs Kerry Dungay, previous service user, Mrs Sarah Budd, former acupuncture midwife, Dr Adrian White, Researcher and Acupuncture practitioner and Nick Pahl, Chief Executive of the British Acupuncture Council attending the meeting to speak in support of the closed service. It was reported that –

(f) the maternity acupuncture service was set up in 1988 initially to deal with pain relief in labor and later developed to deal with serious antenatal problems;

(g) an online petition had received1400 signatures and two previous service users had said they would be unable to deal with another pregnancy without the acupuncture service;

(h) the trust figures on the numbers of service users were misleading and inaccurate;

(i) the closure of the service was purely a cost saving exercise which would have a significant impact on the care of pregnant women in Plymouth;

(j) there were many areas of routine care which were not evidence based;

(k) NICE guidance was retrospective and there was high quality evidence available to support the service;

(l) acupuncture reduced the pharmaceutical costs for the NHS;

(m) acupuncture is a main stream provision in health services and is provided in various settings, there were upward of 4.5 million acupuncture treatments per year.

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

(n) the numbers stated in the Trust's report related to first appointments rather than total sessions;

(o) there was a large number of signatures from patients on the petition but also signatures from people across the country;

(p) many members of the public would be unable to afford the level of acupuncture required to deal with Hyperemesis Gravidarum;

(q) although it was stated that acupuncture was cost effective the evidence base was not strong and needed time to be developed;

(r) the service cost £180 per appointment;

(s) the Chair of the Maternity Service Liaison Committee had used the service;

(t) there was £1800 left in the charity account of the acupuncture service and there had not been any income from patients for the service.

<u>Agreed</u> –

(1) that the NEW Devon CCG Western Locality are requested to consider options for providing Acupuncture Services for women suffering with Hyperemesis Gravidarum in the community or Primary Care settings;

(2) in the context of the transformation of services, that the panel plans a future review into maternity services provided from Derriford Hospital. The panel will investigate actions which could be taken to enhance antenatal and postnatal service choices which could be provided in other community settings.

## 53. CLINICAL COMMISSIONING GROUP AUTHORISATION UPDATE

Karen Kay, Designate Head of Western Locality Commissioning, NEW Devon Clinical Commissioning Group (CCG) provided the panel with a presentation on the authorisation process and possible commissioning intentions.

The panel Agreed to note the presentation and request that the Western Locality Operating Plan is made available to a future meeting of the panel.

*(This agenda item was moved to facilitate better management of the meeting.)*

## 54. HEALTH AND WELLBEING BOARD AND STRATEGY UPDATE

Ross Jago, Democratic Support Officer introduced a briefing paper updating members of the panel on the development of the Health and Wellbeing board and joint health and wellbeing Strategy.

The panel agreed to –

(1) note the report;

(2) request that the draft health and wellbeing strategy is presented at a future meeting of the panel;

(3) recommend to the Shadow Health and Wellbeing Board that the Devon and Somerset Fire and Rescue Service is invited to become a member.

## 55. WORK PROGRAMME

Agreed to delegate to the Lead Officer, in consultation with the Chair and Vice Chair, the preparation of a new work programme which better reflects the panel's place in the new health system, ensuring that joint working between health and social care services and commissioning for prevention is adequately scrutinised.

## 56. EXEMPT BUSINESS

There were no items of Chair's urgent business.

**TRACKING RESOLUTIONS**
**Health and Adult Social Care Overview and Scrutiny Panel**

| Date / Minute number | Resolution | Explanation / Minute | Action | Progress | Target date |
|---|---|---|---|---|---|
| 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. | A comprehensive update will be available for the panel on at its meeting in April 2012. | Ongoing | April 2013 |
| 13/09/12 28 (2) | a report on bed occupancy rates is provided to the panel in April; | This recommendation relates to capital investment in the Glenbourne Acute Psychiatric Unit. | | Ongoing | April 2013 |
| 22/11/2013 44 (2) | That the trust provide a written report in January on days lost through sickness absence. The report would include details of targets, indicators and possible savings. | This recommendation relates to the debate on Regional Pay. | Forwarded to the Trust. | Note distributed via email. | February 2013 |
| 22/11/2013 45 (1) | That the trust provide a briefing note on the safety and quality governance structure within the trust. | This recommendation relates to the debate on Never Events. | Forwarded to the Trust. | Note distributed via email. | February 2013 |
| 22/11/2013 45 (2) | That performance reports and advanced scorecards, including incident reporting rates and level of harm, are distributed to the panel. | This recommendation relates to the debate on Never Events. | Forwarded to the Trust. | Note distributed via email. | February 2013 |

| Date / Minute number | Resolution | Explanation / Minute | Action | Progress | Target date |
|---|---|---|---|---|---|
| 24/01/2013 52 (1) | That the NEW Devon CCG Western Locality are requested to consider options for providing Acupuncture Services for women suffering with Hyperemesis Gravidarum in the community or Primary Care settings; | This recommendation relates to the debate on the closure of the Maternity Acupuncture Service. | Forwarded to the NEW Devon CCG. | Update expected in April. | April 11 2013 |
| 24/01/2013 52 (1) | In the context of the transformation of services, that the panel plans a future review into maternity services provided from Derriford Hospital. The panel will investigate actions which could be taken to enhance antenatal and postnatal service choices which could be provided in other community settings. | This recommendation relates to the debate on the closure of the Maternity Acupuncture Service. | Forwarded to the NEW Devon CCG. | Officers are currently exploring the possibilities or a Peninsula review of current maternity provision. | May / June 2013 |
| 24/01/2013 52 | The panel Agreed to note the presentation and request that the Western Locality Operating Plan is made available to a future meeting of the panel. | This recommendation relates to the debate on the CCG Commissioning Intentions. | Forwarded to the NEW Devon CCG. | Complete | April 2013 |

| Date / Minute number | Resolution | Explanation / Minute | Action | Progress | Target date |
|---|---|---|---|---|---|
| 24/01/2013 54 (2) | Request that the draft health and wellbeing strategy is presented at a future meeting of the panel; | This recommendation relates to the debate on the developing Health and Wellbeing Board. | | Complete – Consultation Document is available. | February 2012 |
| 24/01/2013 54 (3) | Recommend to the Shadow Health and Wellbeing Board that the Devon and Somerset Fire and Rescue Service is invited to become a member. | This recommendation relates to the debate on the developing Health and Wellbeing Board. | Recommendation to the Chair of the health and Wellbeing Board development group. | Complete – membership arrangements are yet to be confirmed by the Council. | |

**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

# Plymouth's Health and Wellbeing Strategy

FOR CONSULTATION

Plymouth's Shadow Health and Wellbeing Board brings together key organisations to promote the health and wellbeing of all the people of Plymouth and deliver three main statutory tasks.

- Undertake a Joint Strategic Needs Assessment ( JSNA )and agree joint priorities
- Produce a Joint Health and Wellbeing Strategy ( JHWS ) using the evidence from the JSNA, and
- Promote integrated working between the NHS and Local Government ( including the approval of commissioning plans to ensure alignment with the JSNA and JHWS

VISION

*Happy Healthy Aspiring Communities*

PURPOSE

*To promote the Health and Wellbeing of all people in the City of Plymouth*

#LetsTalkHealth #LetsTalkPlym

The Board has developed a clear vision of what it wants to see for all the people of Plymouth, supported and framed by its own definition of health and wellbeing. The board's vision is to see "Happy Healthy Aspiring Communities" throughout Plymouth. By working toward this vision over the coming years the work of the board's will also underpin the Plymouth Plan.

The vision and purpose of the work of the board is for all, and so addressing inequalities will be both a necessity and a consequence of the board's work.

The partners on the board also recognise that that every individual will think of their own health and wellbeing in different ways. However the board is a publically accountable committee of the Local Authority and as such the partners on the board want to be clear about what they see as health and wellbeing. By doing so the board believes it will be able to help individuals, families and communities in Plymouth understand how the plans in the JHWS are linked to efforts to promote their health and wellbeing.

FOR CONSULTATION

## Our Vision

The partners on the board have already been working together as a development group for the last 18 months, and as part of this work have developed a vision that represents what the board is going to work together to achieve.

The vision is to see **"Happy Healthy Aspiring Communities"** throughout the City of Plymouth.

The board felt this was both respectful of the different communities that exist within the city, and yet that it was a vision for all its citizens. As such, at the heart of this vision, is the desire to address the inequalities that exist across the City of Plymouth.

The journey to achieve this vision stretches ahead of us and this Joint Health and Wellbeing Strategy describes our approach and the delivery plans over the coming years that we believe will deliver this vision.

## Our Approach

Over the years many attempts have been taken to address the inequalities that exist across our city. Whilst these have seen some success, inequalities still persist. What this tells us is that we must work differently as a board of partners and leaders if we truly want to achieve our vision, which has at its heart the inequality agenda.

We simply cannot go on doing what we have always done if we want to see different results for the people we serve.

As a result of this insight the board members have been working through a series of development workshops to change the way they think and work together as leaders.

We have thought about the health and social care system and considered why it is that previous attempts to collaborate effectively have not been as successful as we would have liked to have seen.

The results of that thinking have led to the development of 3 core strategic approaches that the board will oversee and hold each other accountable for as partners on a journey to the delivery of a common vision.

In addition the delivery plans of the Joint Health and Wellbeing Strategy will also need to evidence alignment with these core approaches in order to constantly ensure we are pulling resources toward prevention and hence the promotion of health and wellbeing.

In effect these 3 core strategic approaches will:

- Frame the way the board works as a group of partners
- Become key tests for the delivery plans that this Joint Health and Wellbeing Strategy encompass

FOR CONSULTATION

## Ensure shared ownership of the sustainability agenda

The first core strategic approach is to ensure that all partners on the board work together, with the public they serve, to take joint ownership of the sustainability agenda. This is a fundamentally different approach and will see individuals, families and communities being engaged in way not been done before.

This approach recognises that the solutions to how we will continue to provide high quality sustainable services on the backdrop of decreasing funds and the increasing service use are not going to be found by a small number of leaders, no matter how expert they are, in a darkroom somewhere. The solutions cannot be provided from on high.

We need to work differently with our public, whom we serve, and ask them how they think we should tackle the challenge of sustainability.

This will be challenging for all. Leaders may feel their authority is undermined and the public may feel their leaders should know the answers. However if the latter were true then we would have tackled the very inequalities we are seeking to address.

The solutions lie in the dialogue we can create, with the public we serve. To frame these new dialogues leaders can provide the technical knowledge and the understanding of the way the health and social care system works, whilst the public can provide their insight of service use and thoughts on how to really meet their needs.

The two together can find the sustainable solutions we all want.

### Ensure we develop and use systems and processes that make the best use of resources, every time

The second core strategic approach is to ensure that all partner organisations develop systems, processes and ways of working that make the best use of their collective and increasingly limited resources, every time. These are both monetary and human resources.

This approach asks the partners to find the synergies that exists between them on behalf of the public they serve, and to reduce the waste that is created by not doing so. So for example, some of the public sector partners could work together and share the administrative services that support their organisations or work on plans that deliver win-wins for each participating organisation and the public they serve.

Equally collaboration between a public sector partners and the community and a voluntary sector partner could create synergies and reduce wasteful duplication of time, effort and resources.

The essence to this approach is to focus on reducing waste and creating opportunities to release resources through collaborative advantage.

FOR CONSULTATION

## Move the focus of our work to the promotion of health and wellbeing

The third core strategic approach is to ensure partner organisations move the focus of their work away from "treating" the problems they face to preventing them occurring in the first place. As the adage goes, "prevention is better than cure".

What this means is that the partners will be asked to evidence how they are moving more and more resources into the prevention agenda over the course of the coming years.

So for partners on the board working in the health sector the challenge will be to spend less on treating illness and more on preventing illness, and thus there will be a need to focus on promoting health and wellbeing.

For other partners the same will apply. So for Police partners the challenge will be to prevent crime and when 70% is related to drug and alcohol misuse it is not hard to see where there are synergistic opportunities to work with health partners and create win-wins.

These 3 strategic approaches are themselves synergistic and add value to each other, such that working differently with the public we serve, will enable partners to make better use of their limited resources and these two together will allow them to release existing resources to deliver plans that promote health and wellbeing for all those they serve and move us closer to delivering our common vision.

## What do we mean by Health and Wellbeing?

There are many definitions of "Health and Wellbeing", some old, some new. Every individual also thinks differently about what this means for themselves.

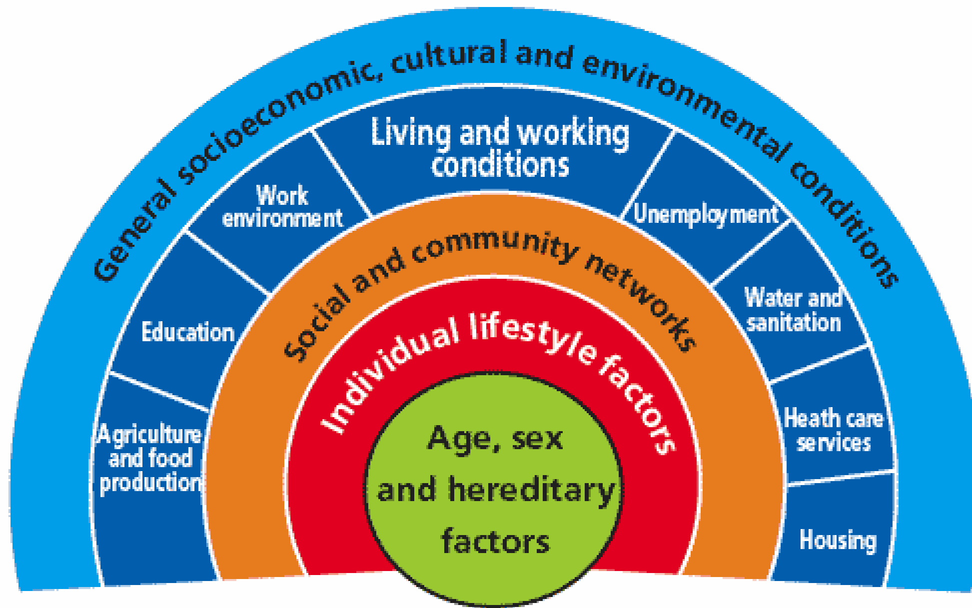
However the partners on the Plymouth Health and wellbeing Board felt it was important to be clear with the public they serve about what it is they felt represented true health and wellbeing.

This is so that the public , to whom the board is accountable, can better understand the board's intent and hold the board to account if the delivery plans in this Joint Health and Wellbeing Strategy fail to promote health and wellbeing as defined in this way.

As well as providing a definition of health and wellbeing it is important to understand the factors that influence health outcomes, so that as we work to promote health and wellbeing through our Joint Health and Wellbeing Strategy's delivery plans, we also address health determinants and the inherent inequalities that persist.

FOR CONSULTATION

Factors that Influence Our Health Outcomes




Defining Health and wellbeing

History, literature and religious texts  have described over many, many years 4 basic "ingredients" to humankind and it is upon these that Plymouth's Health and Wellbeing Board have built its definition of health and wellbeing.

Humankind's four basic ingredients are:

Our Body
Our Mind
Our Heart
Our Spirit

The balance between these ingredients is central to an individual's health and wellbeing and act as the four health and wellbeing cornerstones as illustrated in the following picture.

FOR CONSULTATION

Getting Around

Housing

Health & Care

Economic Diversity

- Physical Health and Wellbeing
- TO BE FIT AND HEALTHY
- TO BE ECONOMICALLY SUCCESFUL
- TO PROSPER

- Mental Health and Wellbeing
- TO BE HAPPY & HAVE FUN
- TO GROW AND DEVELOP
- TO LEARN

Education & Learning

Arts & Culture

The Body

The Mind

YOU

The Spirit

The Heart

City Pride & Vision

Greener Plymouth

- Spiritual Health & Wellbeing
- TO HAVE A SENSE OF COMMUNITY
- TO HAVE MEANING IN ONES LIFE
- TO CONTRIBUTE
- TO LEAVE A LEGACY

- Social health and wellbeing
- TO ASPIRE
- TO HAVE FRIENDSHIP
- TO LOVE
- TO ENGAGE

Local Community

***HAPPY HEALTHY ASPIRING COMMUNITIES***

These four health and wellbeing cornerstones connect to the 4 natures present in all of us. Combined with our understanding of the needs of the individuals and communities we serve they will define the delivery plans of this Joint Health and Wellbeing Strategy and will form part of the Plymouth Plan.

In addition these four cornerstones frame the recommendations of the Marmott Report 2010 *Fair Society Healthy Lives* and our vision ***Happy, Healthy, Aspiring Communities***.

Marmott Report Recommendations:

- Giving every child the best start in life
- Enabling all children, young people and adults to maximize their capabilities and have control over their lives
- Creating fair employment and good work for all
- Ensuring a healthy standard of living for all
- Creating and developing sustainable places and communities
- Strengthening the role and impact of ill-health prevention

FOR CONSU

#LetsTalkHealth #LetsTalkPlym

## Our Engagement

For the partners at the Shadow Health and Wellbeing Board a healthy individual has a healthy mind, body, spirit and heart. It is only by addressing these four cornerstones that we can really create "Happy, Healthy, Aspiring Communities".

Plymouth's Shadow Health and Wellbeing Board will shortly launch a public consultation about how best to improve health and wellbeing across the City. We will not be consulting on the full strategy but want to talk to our City about health and wellbeing.

**Do you agree with the Board's definition of health and wellbeing?**

#LetsTalkHealth #LetsTalkPlym

**Do you know what things affect your health and wellbeing?**

**Do you have ideas that might improve health and wellbeing and what can you do differently?**

We want to develop a deal between the Health and Wellbeing Board and the People of Plymouth, we want to talk about the things we can do but also what you can do and also recognise that some things are beyond control.

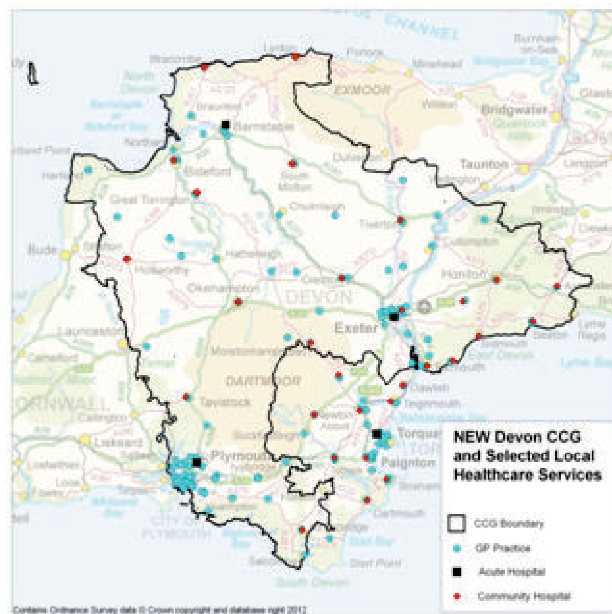
We will spend 12 weeks listening to health and social care professionals, community partners, service users, carers and the public before finalising plans in the summer. We think it's the right time to start a public debate about what we as individuals need to do, how communities can get involved and how local organisations can provide support for our vision.

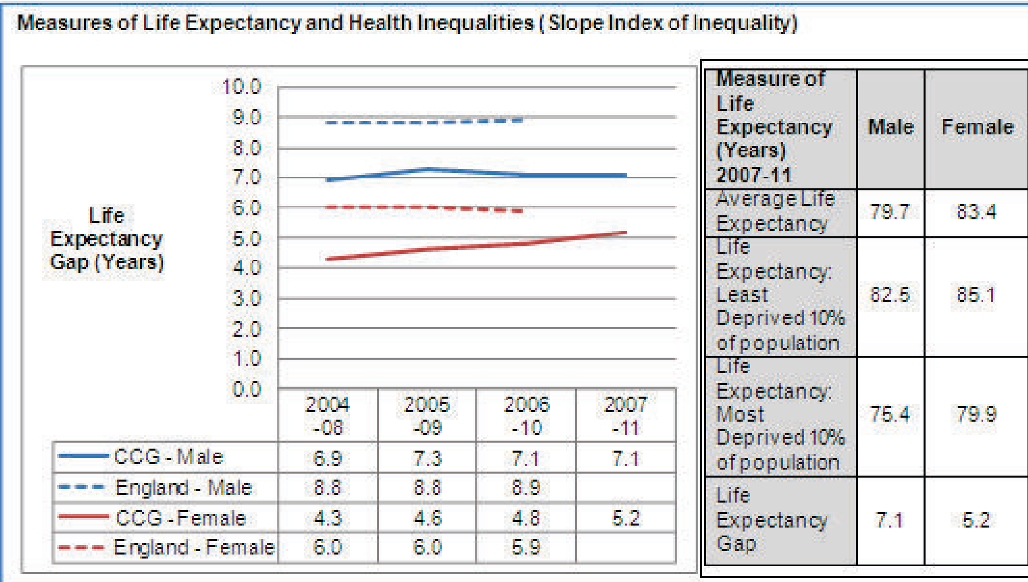
FOR CONSULTATION

This page is intentionally left blank

## Appendix 1 NEW Devon Profiles

# NEW Devon Clinical Commissioning Group Health Profile 2012



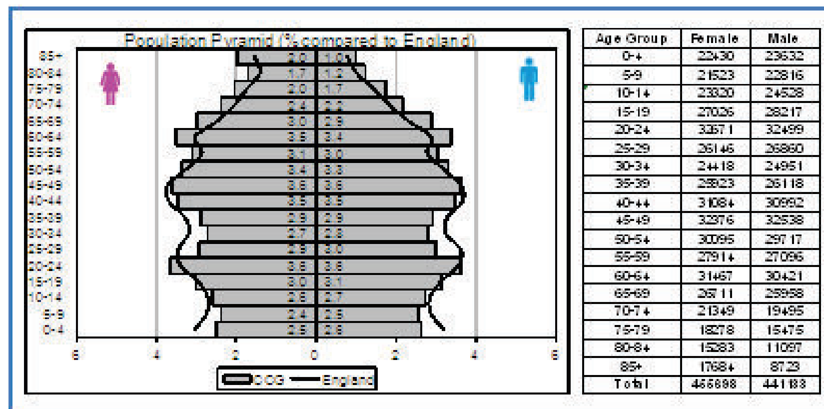



Measures of Life Expectancy and Health Inequalities (Slope Index of Inequality)



| | 2004-08 | 2005-09 | 2006-10 | 2007-11 |
|---|---|---|---|---|
| CCG - Male | 6.9 | 7.3 | 7.1 | 7.1 |
| England - Male | 8.8 | 8.8 | 8.9 | |
| CCG - Female | 4.3 | 4.6 | 4.8 | 5.2 |
| England - Female | 6.0 | 6.0 | 5.9 | |

| Measure of Life Expectancy (Years) 2007-11 | Male | Female |
|---|---|---|
| Average Life Expectancy | 79.7 | 83.4 |
| Life Expectancy: Least Deprived 10% of population | 82.5 | 85.1 |
| Life Expectancy: Most Deprived 10% of population | 75.4 | 79.9 |
| Life Expectancy Gap | 7.1 | 5.2 |

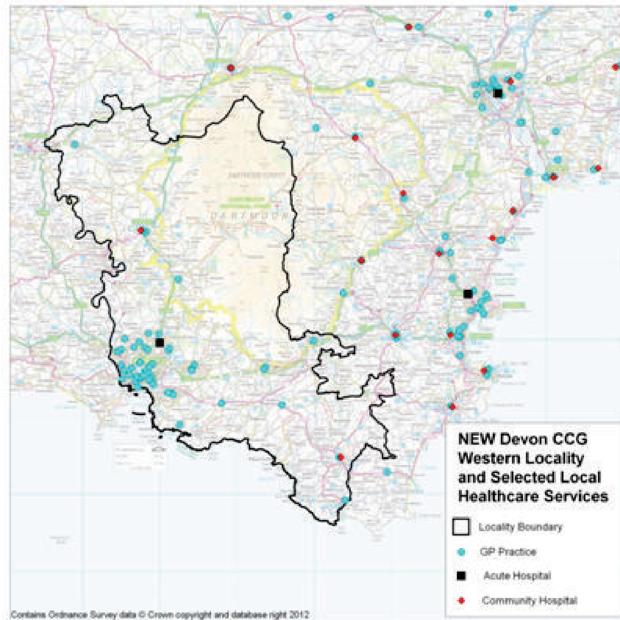


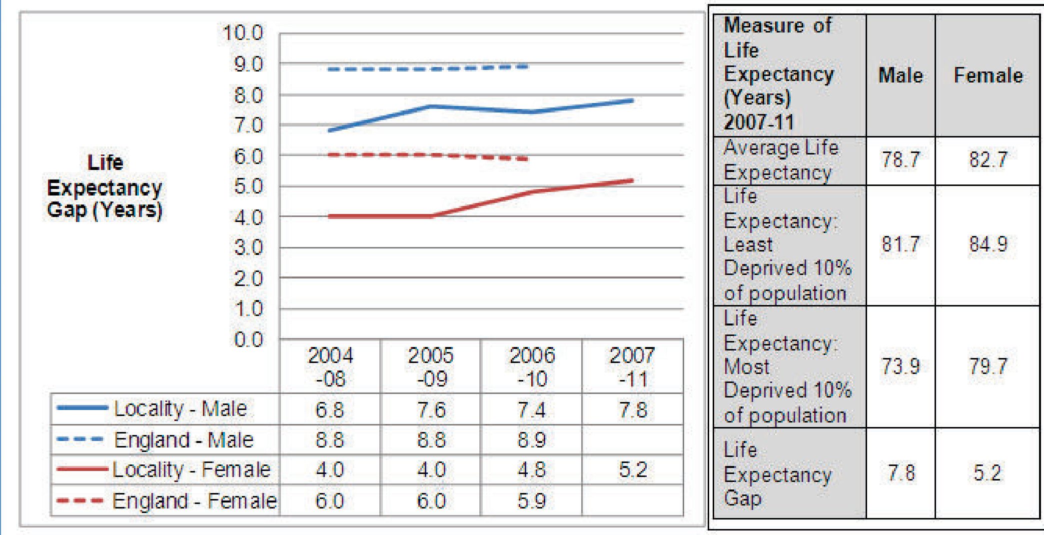

| Age Group | Female | Male |
|---|---|---|
| 0-4 | 22430 | 23632 |
| 5-9 | 21523 | 22816 |
| 10-14 | 23320 | 24528 |
| 15-19 | 27026 | 28217 |
| 20-24 | 32671 | 32499 |
| 25-29 | 26146 | 26860 |
| 30-34 | 24418 | 24951 |
| 35-39 | 25923 | 26118 |
| 40-44 | 31084 | 30992 |
| 45-49 | 32376 | 32538 |
| 50-54 | 30095 | 29717 |
| 55-59 | 27914 | 27096 |
| 60-64 | 31467 | 30421 |
| 65-69 | 26711 | 25958 |
| 70-74 | 21349 | 19495 |
| 75-79 | 18278 | 15475 |
| 80-84 | 15283 | 11097 |
| 85+ | 17684 | 8723 |
| Total | 466698 | 441183 |

Estimated number of people with selected health conditions, aged 65 years and over

| Health Problem | 2012 | 2015 | 2020 | 2025 | 2030 |
|---|---|---|---|---|---|
| Depression | 16,065 | 17,195 | 18,648 | 20,299 | 22,334 |
| Severe Depression | 5,128 | 5,481 | 5,953 | 6,697 | 7,353 |
| Dementia | 13,524 | 14,387 | 16,457 | 19,062 | 22,273 |
| Longstanding health condition caused by heart attack | 9,096 | 9,771 | 10,654 | 11,666 | 12,810 |
| Longstanding health condition caused by stroke | 4,282 | 4,614 | 5,081 | 5,623 | 6,178 |
| Longstanding health condition caused by bronchitis/emphysema | 3,125 | 3,365 | 3,661 | 3,981 | 4,373 |
| Fall in last 12 months | 49,824 | 53,354 | 58,824 | 64,850 | 72,780 |
| Regular continence problems | 30,665 | 32,852 | 36,088 | 39,931 | 44,235 |
| Moderate or severe visual impairment | 16,399 | 17,512 | 19,405 | 21,930 | 24,054 |
| Moderate or severe hearing impairment | 79,692 | 84,879 | 95,200 | 109,432 | 121,518 |
| Learning Disability | 3,831 | 4,132 | 4,516 | 4,889 | 5,367 |

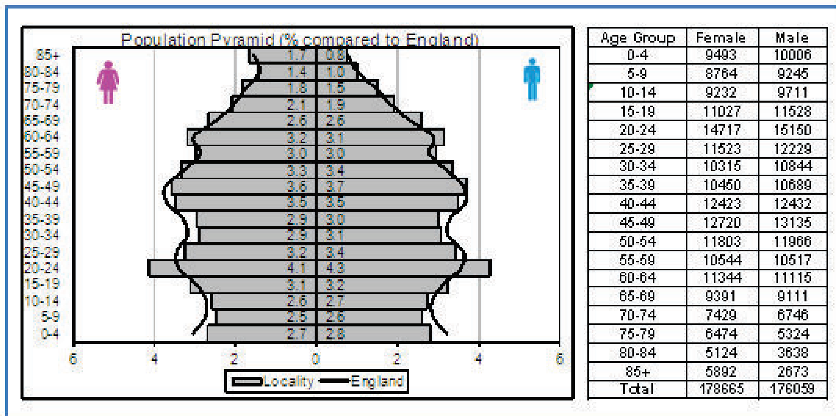
# NEW Devon CCG Western Locality Health Profile 2012




| | 2004-08 | 2005-09 | 2006-10 | 2007-11 |
|---|---|---|---|---|
| Locality - Male | 6.8 | 7.6 | 7.4 | 7.8 |
| England - Male | 8.8 | 8.8 | 8.9 | |
| Locality - Female | 4.0 | 4.0 | 4.8 | 5.2 |
| England - Female | 6.0 | 6.0 | 5.9 | |

| Measure of Life Expectancy (Years) 2007-11 | Male | Female |
|---|---|---|
| Average Life Expectancy | 78.7 | 82.7 |
| Life Expectancy: Least Deprived 10% of population | 81.7 | 84.9 |
| Life Expectancy: Most Deprived 10% of population | 73.9 | 79.7 |
| Life Expectancy Gap | 7.8 | 5.2 |




| Age Group | Female | Male |
|---|---|---|
| 0-4 | 9493 | 10006 |
| 5-9 | 8764 | 9245 |
| 10-14 | 9232 | 9711 |
| 15-19 | 11027 | 11528 |
| 20-24 | 14717 | 15150 |
| 25-29 | 11523 | 12229 |
| 30-34 | 10315 | 10844 |
| 35-39 | 10450 | 10689 |
| 40-44 | 12423 | 12432 |
| 45-49 | 12720 | 13135 |
| 50-54 | 11803 | 11966 |
| 55-59 | 10544 | 10517 |
| 60-64 | 11344 | 11115 |
| 65-69 | 9391 | 9111 |
| 70-74 | 7429 | 6746 |
| 75-79 | 6474 | 5324 |
| 80-84 | 5124 | 3638 |
| 85+ | 5892 | 2673 |
| Total | 178665 | 176059 |

**Estimated number of people with selected health conditions, aged 65 years and over**

| Health Problem | 2012 | 2015 | 2020 | 2025 | 2030 |
|---|---|---|---|---|---|
| Depression | 5,440 | 5,816 | 6,202 | 6,745 | 7,328 |
| Severe Depression | 1,729 | 1,829 | 1,975 | 2,209 | 2,394 |
| Dementia | 4,462 | 4,784 | 5,389 | 6,223 | 7,147 |
| Longstanding health condition caused by heart attack | 3,059 | 3,279 | 3,518 | 3,849 | 4,165 |
| Longstanding health condition caused by stroke | 1,435 | 1,543 | 1,671 | 1,847 | 2,001 |
| Longstanding health condition caused by bronchitis/emphysema | 1,051 | 1,128 | 1,208 | 1,313 | 1,422 |
| Fall in last 12 months | 16,735 | 17,931 | 19,480 | 21,401 | 23,696 |
| Regular continence problems | 10,300 | 11,033 | 11,929 | 13,181 | 14,394 |
| Moderate or severe visual impairment | 5,521 | 5,839 | 6,426 | 7,208 | 7,816 |
| Moderate or severe hearing impairment | 26,566 | 28,429 | 31,299 | 35,877 | 39,230 |
| Learning Disability | 1,299 | 1,384 | 1,503 | 1,619 | 1,758 |

## Appendix 2 NEW Devon Provider and Commissioner Performance

### Provider performance: year to date at June 2012

| Key Measure | Target | NDHT | PHT | RD&E | SDHT |
|---|---|---|---|---|---|
| 18 weeks Referral to treatment waiting times (admitted) (YTD Aug) | 90% | 95.4% | 92.2% | 86.1% | 92.2% |
| 18 weeks Referral to treatment waiting times (non-admitted) (YTD Aug) | 95% | 99.6% | 96.1% | 98.6% | 97.1% |
| A&E four hour waits (YTD Sept) | 95% | 95.8% | 95.2% | 94.9% | 96.3% |
| Cancer 14-day urgent referral (YTD Aug) | 93% | 97.3% | 94.0% | 97.3% | 96.6% |
| Cancer 14-day breast symptoms (YTD Aug) | 93% | 96.4% | 91.7% | 99.5% | 97.8% |
| Cancer 31-day first treatment (YTD Aug) | 96% | 98% | 98.3% | 96.8% | 97.8% |
| Cancer 31-day subsequent drug treatment (YTD Aug) | 98% | 100% | 99.8% | 99.7% | 99.7% |
| Cancer 31-day subsequent surgical (YTD Aug) | 94% | 97.7% | 97.1% | 98.1% | 99.4% |
| Cancer 31-day subsequent radiotherapy (YTD Aug) | 94% | N/A | 96% | 98.6% | 97.9% |
| Cancer 62-day standard (YTD Aug) | 85% | 87.9% | 83.2% | 84.7% | 88.5% |
| Cancer 62-day screening (YTD Aug) | 90% | 71.4% | 93% | 94.4% | 97.7% |
| Cancer 62-day consultant upgrade(YTD Aug) | 85% | 100% | 96.6% | 92.1% | 88.9% |
| Infection control: MRSA cases (YTD Sept) | Actual/Target | 0/1 | 0/3 | 0/2 | 1/1 |
| Infection control: C.difficile cases (YTD Sept) | Actual/Target | 3/8 | 18/25 | 25/34 | 13/10 |
| Diagnostics – 6 week breaches (YTD Aug) | 1% | 0.1% | 1.6% | 1.5% | 0.8% |
| Mixed sex accommodation breaches (YTD Aug) | No breaches | 24 | 6 | 0 | 0 |
| Delayed transfers of care (YTD Aug) | 3.5% | 1.7% | 3% | 4.1% | 0.4% |
| Stroke services – patients spend 90% of time spent on a stroke unit (YTD Aug) | 80% | 69% | 73.8% | 75.1% | 79% |

## Commissioner performance - year to date at June 2012

| Key Measure | Target | Devon | Plymouth | Torbay |
|---|---|---|---|---|
| **Maternity services:<br>Women who have seen a midwife by 12 weeks and 6 days of pregnancy (YTD Jun)** | 90% | 100% | 99.8% | 89.3% |
| **Maternity services:<br>Breastfeeding at 6-8 weeks (YTD Jun)** | 52%/39%/37% | 50.6% | 33.2% | 33.6% |
| **Ambulance services:<br>Category A response within 8 minutes (YTD Sep)** | 75% | 73.6% | 87.2% | 90.2% |
| **Ambulance services:<br>Category A response within 19 minutes (YTD Sep)** | 95% | 92.8% | 99.6% | 99.6% |
| **Mental health:<br>Home treatment episodes from crisis resolution teams (YTD Aug)** | 100% of plan | 127% | 117.4% | 108% |
| **Mental health:<br>Newly confirmed early intervention cases (YTD Aug)** | 100% of plan | 118% | 325%* | 117% |
| **Mental health:<br>People receiving psychological treatment following referral (YTD Jun)** | | 76.2% | 52.2% | 69.7% |
| **Choose & Book (Sept 2012 position)** | 90% | 80% | 112% | 83% |

Key:
Green: Performing
Orange: Slightly below target
Red: Underperforming

Authorisation sub

## Appendix 3 Medium term Financial Plan

| | Total Planned Spend 2012/13 | Recurrent Spend | Non Recurrent Spend | % Change |
|---|---|---|---|---|
| | £000 | £000 | £000 | |
| **Spend Area** | | | | |
| **Primary Care Commissioning** | | | | |
| Enhanced Services | **8,625** | 8,625 | 0 | 0.00% |
| GP Out of Hours | **8,546** | 8,546 | 0 | 0.00% |
| Other Primary Care | **738** | 738 | 0 | 0.00% |
| Primary Care Prescribing | **145,198** | 145,198 | 0 | 3.50% |
| **Total Primary Care** | **163,107** | **163,107** | **0** | **3.10%** |
| **Purchase of Secondary Healthcare** | | | | 0.00% |
| Plymouth Hospitals NHS Trust | **175,709** | 175,709 | 0 | 2.50% |
| Royal Devon and Exeter Foundation Trust | **217,699** | 217,699 | 0 | 1.20% |
| South Devon Healthcare Foundation Trust | **4,608** | 4,608 | 0 | 1.50% |
| Northern Devon Healthcare NHS Trust (North Devon Element) | **113,936** | 113,936 | 0 | 0.95% |
| Other Acute Providers | **29,044** | 29,044 | 0 | 0.50% |
| Devon Partnerships NHS Trust | **70,138** | 70,138 | 0 | 3.45% |
| Plymouth Community Services | **62,452** | 62,452 | 0 | 0.50% |
| Torbay Care Trust | **11,993** | 11,993 | 0 | 1.00% |
| Northern Devon Healthcare NHS Trust (East Devon Community) | **57,486** | 57,486 | 0 | 0.95% |
| Devon Children's Services | **11,559** | 11,559 | 0 | 0.50% |
| South West Ambulance Foundation Trust | **30,004** | 30,004 | 0 | 3.65% |
| Other Non Acute Services | **33,782** | 33,782 | 0 | 3.98% |
| **Total Secondary HealthCare** | **818,411** | **818,411** | **0** | **1.72%** |
| **Specialist Services Commissioning** | **0** | **0** | 0 | **0.00%** |
| **Complex Care Commissioning (CHC, IPP, etc)** | **92,114** | **92,114** | 0 | **6.00%** |
| **Other Healthcare Purchasing** | | | | 0.00% |
| Social Care Transfer | **12,375** | 0 | 12,375 | 0.00% |
| Reablement | **4,875** | 4,875 | 0 | 0.00% |
| **Total Other Purchase of Healthcare** | **17,250** | **4,875** | **12,375** | **253.84%** |
| **Total Purchase of Healthcare** | **1,090,882** | **1,078,507** | **12,375** | **3.45%** |
| **Non Healthcare Purchase** | | | | 0.00% |
| HQ Running Costs | **19,855** | 19,855 | 0 | 0.00% |
| **Total Non Healthcare Purchase** | **19,855** | **19,855** | **0** | **0.00%** |
| **Reserves and Contingencies** | | | | 0.00% |
| Contingency | **15,976** | 15,976 | 0 | 4.73% |
| Headroom | **22,588** | 22,588 | 0 | 0.00% |
| Investment Reserves - National and Regional Requirements | **17,724** | 17,724 | 0 | 35.58% |
| Investment Reserves - Local Commitments | **4,090** | 4,090 | 0 | 0.00% |
| Unidentified QIPP Requirement | **1** | 1 | 0 | 148.95% |
| **Total Reserves and Contingencies** | **60,379** | **60,379** | **0** | **9.77%** |
| **Total Planned Spend** | **1,171,116** | **1,158,741** | **12,375** | **3.70%** |
| | | | | 0.00% |
| **Revenue Resource Limit** | **1,176,190** | 1,158,740 | 17,449 | 4.15% |
| | | | | 0.00% |
| **Under Spend Against Revenue Resource Limit** | **5,074** | **(0)** | **5,075** | **0.00%** |

Authorisation submission

## Appendix 4 NEW Devon Commissioning Intentions 2013/14

| Draft Version 5 | NEW Devon CCG Commissioning Intentions 2013/14 | Eastern /Northern /Western Locality/Partnerships |
|---|---|---|

The purpose is to reach a position to fully describe commissioning and contracting intentions to providers, and prior to this to have the high level information ready, in preparation for authorisation and issues that might arise.

**Alignment of commissioning intentions to the CCG strategic approach and medium term strategic priorities**

Commissioning and contracting intentions will be aligned to the three core strategies described within the strategic approach of the Clinical Commissioning Group. These are listed below and the CS1/CS2/CS3 references used against each commissioning intention in the core strategy column on the spreadsheet.

**CS1. Ensure the clinical community and the public take joint ownership of the sustainability agenda (*Joint clinical and public ownership*)**

**CS2. Ensure systems and processes are developed that make best use of limited resources every time (*Best use of limited resources every time*)**

**CS3. Move the focus of commissioning away from treatment and towards a prevention and maintenance approach (*Towards prevention and maintenance*)**

In addition the commissioning intentions must reflect the strategic priorities of the clinical commissioning group: Strengthening prevention, self care and maintenance; Optimising elective, or planned care pathways; Optimising urgent care pathways; Improving care of frail older people, Improving mental health services (including older people); Improving care for people with learning disabilities; Medicines optimisation; and Improving primary and community services. These priority headings are on the drop down box of the spreadsheet

**Link to QIPP, Performance, and workforce**

The commissioning intentions will also be aligned to the QIPP prescriptions and as this information becomes available it is being added to the spreadsheet to enable cross referencing to QIPP and including quarterly milestones. Similarly the connection to outcomes and workforce will be incorporated into the final spreadsheet, although not included at this stage.

Aut

| Strategic Priority | Core Strategy | Subject | Commissioning intentions | QIPP ref | Resource implications | | Outcome |
|---|---|---|---|---|---|---|---|
| | | | | | Invest | Save | |
| Elective pathways | CS1 | Surgery | We will commission an improved adherence of the surgical safety checklist | N/A | N/A | N/A | To be confirmed |
| Other | CS1 | Risk management | All providers will improve risk management and incident reporting including seeking to reduce the number of patient safety incidents resulting in harm | N/A | N/A | N/A | To be confirmed |
| Other | CS1 | Patient experience | All providers should demonstrate improved patient experience including improved mechanisms to capture and report patient experience | N/A | N/A | N/A | To be confirmed |
| Elective pathways | CS1 | Follow-up | We will work with providers to reduce the number of follow-up outpatient appointments in 2013/14. This will focus on those appointments that are of a limited clinical benefit | TBC | 0 | 425k | 2% reduction in follow up appointments (4600 appointments) |
| Primary & community | CS1 | Long-term conditions | Increase the proportion of people feeling supported to manage their conditions (NHS outcomes framework). Increase the employment rate for people with long-term conditions so that it is comparable to the population as a whole | TBC | TBC | 1121k | Reduction of 560 non-elective admissions. Increase by 1% the percentage of people with a LTC in employment (NHS outcomes framework) |

| Primary & community | CS1 | Long-term conditions | We will pilot of Single Accountable Provider for patients with respiratory conditions and diabetes. Including:-<br>- Improve the under 75 mortality rate from respiratory disease to the average for the Southwest (NHS outcomes framework).<br>- Reduce the number of emergency hospital admissions for respiratory conditions (including children) (NHS outcomes framework).<br>- Reduce unplanned hospital admissions for diabetes (NHS outcomes framework)<br>- Ensure sustainability in service model | TBC | TBC | 407k | Reduce annual cost growth to zero in respiratory and diabetes services.<br>- Respiratory services; 2.6% reduction in inpatient admissions<br>- Diabetic medicine; 7% reduction in 1st outpatient attendances and 12% reduction in inpatient admissions |
|---|---|---|---|---|---|---|---|
| Frail older people | CS2 | Patient flow | Reduce delayed transfers of care to a minimal level including ensuring the health community work together to reduce length of stay across all main providers | TBC | TBC (part of S256) | 339k | 16% reduction in the number of days delayed across Plymouth (both acute and non acute providers) |
| Frail older people | CS2 | End of life care | To increase number of patients able to die in their own home. Including improving the experience of care for people at the end of their lives (NHS outcomes framework) | TBC | TBC | 152k | 4.5% increase in the proportion of patients who are able to die at home which is equivalent to the best performing |
| Elective pathways | CS2 | Orthopaedic | We will commission a reduction in orthopaedic non trauma activity (specifically hips, knees, shoulders and carpal tunnel) so that it is comparable to the national average for Plymouth patients (measured using SARs). Improve the patient reported outcomes measures for hip and knee replacements (NHS outcomes framework) | TBC | 0 | 800k | The followingchanges in activity would be included:-<br>- Hips: reduction of 58<br>- Knees: reduction of 35<br>- Shoulders: reduction of 27<br>- Carpal tunnel: reduction of 171 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Elective pathways | CS2 | Cancer | A minimum of 85% of cancer patients following GP referral will commence treatment within 62 days from April 2013 | N/A | N/A | N/A | A minimum of 85% of cancer patients following GP referral will commence treatment within 62 days from April 2013 |
| Elective pathways | CS2 | RTT | All providers will achieve and sustain 18 week referral to treatment (RTT). This will include delivery at a specialty level from April 2013 | N/A | TBC | TBC | All providers will achieve and sustain 18 week RTT. This will include delivery at a specialty level from April 2013 |
| Elective pathways | CS2 | Cancelled operations | We expect a reduction in the number of operations cancelled on the day of admission or later for non-clinical reasons. Where a patients operation was cancelled all can expect to be treated within 28 days of the cancellation | N/A | N/A | N/A | Reduction to 0.8% of the total elective activity |
| Other | CS2 | Stroke | We will commission an improvement of the stroke pathway. This will include:-<br>- increasing the proportion of inpatient care spent on a stroke unit<br>- Improve early supported discharge leading to a reduction in overall LOS for stroke patients<br>- Improved efficiency of the TIA pathway.<br>- Improved recovery rate from stroke (NHS outcomes framework) | TBC | TBC | 215k (high risk as limited achieveme nt to date) | 80% of stroke patients will spend 90% of their time on a stroke unit from April 2013.<br>9.5% reduction in total length of stay for stroke patients |
| Other | CS2 | Readmission s | We will reduce the number of emergency readmissions within 30 days of discharge from hospital (NHS outcomes framework) through increased investment in rapid response and reablement services | TBC | TBC (part of S256) | 200k | Reducion in readmissions within 30 days of 2.6% |

| Other | CS2 | Unscheduled care | We will commission the continued roll out of the ambulatory care centre in PHNT<br>- Reduce the number of emergency admissions for acute conditions that should not usually require hospital admission (NHS outcomes framework) | TBC | TBC | 618k | To be confirmed |
|---|---|---|---|---|---|---|---|
| Other | CS2 | Unscheduled care | We expect providers to reduce the number of ambulance handovers that are over 30 mins | N/A | TBC | TBC | % of ambulance handovers that are over 30mins |
| Other | CS2 | Unscheduled care | We expect all provider to ensure that a minimum of 95% of patients spend 4 hours or less in A&E throughout 2013/14 | N/A | 0 | 0 | More than 95% of patients spend less than 4 hours in A&E |
| Mental health | CS2 | Dementia | We will commission improved hospital care for people with dementia | N/A | TBC | TBC | To be confirmed |
| Mental health | CS2 | Mental Health | We will continue to develop and implement the Mental Health QIPP programme | TBC | TBC | TBC | To be confirmed |
| Mental health | CS2 | Mental Health | Realise the benefits of current (12/13) Mental Health service redesign | TBC | TBC | TBC | To be confirmed |
| Mental health | CS2 | Mental Health | We will commission improved Mental health liaison services | N/A | TBC | TBC | To be confirmed |
| Mental health | CS2 | Mental Health | Productivity and efficiency gains including medical and professional staffing | N/A | TBC | TBC | To be confirmed |
| Frail older people | CS3 | Quality | We will commission reduced incidence of pressure sores | N/A | TBC | TBC | To be confirmed |
| Prevention | CS3 | Prevention | We will commission an improvement in rehabilitation and secondary preventation | TBC | TBC (part of S256) | 230k | To be confirmed |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Frail older people | CS3 | Falls | We will commission an improvement in fractured neck of femur pathways to achieve increases in fractures operated on within required timescales and improve outcomes for patients including reducing the length of time for surgery; improving recovery rates for fragility fractures(NHS Outcomes Framework) and mortality rates. | TBC | TBC | 65k | Increase the number of hip fractures operated on within 36 hours to 70% from April 2013<br>Improve the recovery rate from fragility fractures<br>Improve the mortality rate from fractured neck of femur to the national average |
| Primary & community | CS3 | Intermediate care | We will commission an increase the number of people accessing intermediate care services (NHS outcomes framework) to increase the proportion of older people who remain in their own homes after discharge from hospital into reablement /rehabilitation services. | TBC | TBC (part of S256) | 1516k | We expect an increase the proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services.<br>Reduce average length of stay in PHNT and PCH |
| Frail older people | CS3 | Falls | Development of the elderly fragility model | N/A | N/A | N/A | To be confirmed |
| Primary & community | CS3 | Telehealth | We will complete to evaluation of telehealth pilot and decide on the potential roll out by March 2013 | TBC | TBC | TBC | To be confirmed |
| Mental health | CS3 | Dementia | We will commision an improved care in care homes for people with dementia | N/A | N/A | N/A | To be confirmed |
| Mental health | CS3 | Dementia | We expect to increase dementia diagnosis rate | N/A | N/A | N/A | To be confirmed |
| Mental health | CS3 | Dementia | We will commission increased support in the community for people with dementia | TBC | TBC | TBC | To be confirmed |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Mental health | CS3 | IAPT | We will commission an increase the number of people entering psychological therapies to 15% of the estimated population with depression/ anxiety disorders. This will include increasing the recovery rate, reducing waiting times and extending access to include older people, children and young people and adults with physical long-term conditions or medically unexplained symptoms | TBC | TBC | 115k | The results will be an: increase in the recovery rate to 50%; reduction in the number of people waiting more than 28 days; and extended access to psychological therapies. |
| Mental health | CS3 | CAMHS | We will commission improved access to CAMHS services | N/A | TBC | TBC | To be confirmed |
| Mental health | CS3 | Mental health | We will increase joint working between primary care and community mental health teams to support people with stable, enduring mental health problems in primary care | TBC | TBC | TBC | To be confirmed |
| Elective pathways | CS3 | Alcohol | We will commission a reduction in alcohol related hospital admissions through the development of a sustainable hospital alcohol liaison service | TBC | 128k (TBC) | 406k (TBC) | 5% reduction in alcohol related hospital admissions (ie reduce annual groath to zero) |

| Strategic Priority | Core Strategy | Subject | Commissioning intentions | QIPP ref | Resource implications Invest | Save | Performance |
|---|---|---|---|---|---|---|---|
| Mental health | CS2 | Urgent care | Review and redesign models of urgent inpatient and community mental health services to improve transition between primary and secondary care and build on liaison, pathways and responsiveness to promote better outcomes for those people experiencing mental health problems. | | | | Clear pathway through primary care; greater responsiveness to needs; smoother transition; focus on early interevention, accurate formulation, evidence based treatment and recovery; collaboration with carers and families and care centred on home; enable people to maintain |
| Mental health | CS2 | Dual diagnosis | Support and monitor the implementation of the dual diagnosis strategy to bring current provision to nationally recommended standards. | | | | Patients receive the highest standard of interventions relevant to their care pathway; a joint approach to care between drug and alcohol and adult mental |
| Mental health | CS2 | ASC/ADHD | A revised service specification for ASC/ADHD to support providers in developing services to meet needs of this client group. This will include a wide range of interventions including pharmacological as well as psycho social aims, and will pay close attention to the mechanics of the shared care arrangement. | | | | Right interventions in the right place at the right time. |
| Mental health | CS2 | Offender health | A wider care pathway to ensure that delivery of specialised, evidence based intervention is both timely and equitable. | | | | More streamlined service with Offender Health and Probation services; development of Gateway worker; enhanced identification of mental |

Authorisation submission

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Mental health | CS2 | DART/TRAC | Develop and roll out of the expansion of DART and Trac to support introduction of all adult and older peoples mental health referrals across all localities managed by new Devon and South Devon and Torbay CCGs | | | | |
| Mental health | CS3 | Veterans | Improve understanding, among primary health care and social professionals, of the culture of the armed forces, the particular pressures veterans may be under and the risk of veterans developing mental health problems | | | | |
| Mental health | CS1 | Veterans | Increase involvement of veterans in awareness training for health and social care professionals who come into regular contact with veterans. | | | | |
| Mental health | CS3 | Veterans | To encourage local mental health promotion initiatives could usefully include veterans as a specific target audience. This should be a component part of outreach initiatives | | | | |
| Mental health | CS3 | QIPP | Admission and discharge transition process. This will include a focus on the Younger people In Transition (YPIT) mechanism, to ensure proactive, safe and appropriate planning of care. The key drivers are prevention, early intervention, access and life chances. The intention is to involve the commissioners of younger people's services to promote a partnership process to provide direction across the pathway. | | | | |
| Mental health | CS3 | QIPP | An increased focus on alternative to inpatient stays to include the development of more robust Home Treatment services. | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Mental health | CS2 | QIPP | Access to treatment. A focus on assessment to treatment times will be taken and a QIPP plan set up to develop treatment packages aligned to appropriate pathways. | | | | |
| Mental health | CS1 | QIPP | Development of the "virtual team" approach between primary care teams and the specialist mental health service | | | | |
| Mental health | CS2 | QIPP | Reduction of PICU usage, down to zero for out of area and significantly lower in the contracted service (Harvest). | | | | |
| Mental health | CS2 | QIPP | Development of an effective secure and forensic mental health pathway with adequate treatment capacity and senior clinical leadership. | | | | |
| Mental health | CS2 | QIPP | Further enhancement of the personality disorder care pathway, especially regarding early intervention. | | | | |
| Mental health | CS1 | Development | Commence the development of longer term strategic objectives including prevention and early intervention; personal health budgets; AQP; closure of recovery beds and community services development; acute care pathway enhancement; community treatment; consultant psychiatry and leadership roles; eating disorder pathway; increased personality disorder therapy; iapt; place of safety. | | | | |
| Learning disabilities | CS2 | Winterbourne | A Clear Pathway for people who challenge services, supported by contract specifications and quality monitoring for outcomes: | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Learning disabilities | CS2 | Winterbourne | Support and expertise in the community to maintain people in the community, care management and provide crises intervention minimising the need and length of inpatient admissions. | | | | Feedback from people who use services and family carers re the quality of services. |
| Learning disabilities | CS3 | Winterbourne | Inpatient and Assessment services. Ensure equality of access and improved health outcomes for people with LD to primary and secondary including wider primary care services and screening programmes. / Health Checks making sure people have health action plans/ Obesity | | | | High performer in terms of numbers but need to ensure quality of the health checks/ health action plans |
| Learning disabilities | CS2 | Winterbourne | Meeting the needs of people with PMLD in the community Support Acute provision to make reasonable adjustments in service | | | | |
| Learning disabilities | CS3 | Winterbourne | Widen access for people with learning disability and dementia to universal services | | | | |
| Other | CS2 | | Working with Social Care to drive reduction in dependency on a bed-based model of care, with the aim of improving co-ordinated case management in a holistic multi-disciplinary methodology. Delivery will be locality based and the service models may vary. | | | | |
| Children & Young People | CS2 | Place of Safety | Working in conjunction with DCC colleagues to commission a robust care pathway for Devon & Torbay for children requiring a Place of Safety. This will ensure all C&YP up to the age of 18 yrs meeting the criteria are held in a C&YP friendly environment | N/A | tbc | | No C&YP inappropriately placed in a Police Station for a place of safety. 100% of C&YP meet the demands of the care pathway and placed in a child friendly environment. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Children & Young People | CS2 | Development of a robust Community Consultant Paediatrician function | Work to continue and progress with colleagues from DCC, ICS and Paediatric Consultants at the RD&E to agree core elements of a robust community paediatric function that meets the needs of C&YP and supports the developing community agenda. The overall aim to develop this to ensure a robust paediatric function across Devon to optimise skills / function to ensure best use of resources. | N/A | possible reallocation of finances in the longer term. | | Clear focus regarding the role of community paediatrics. Prevention of unnecessary hospital admissions. Consistent participation within care pathways, i.e. ASC and ADHD. |
| Children & Young People (CAMHS) | CS2 CS3 | Perinatal Infant & Maternal Mental Health | To support and monitor the implementation of the new Perinatal Infant & Maternal Mental Health Service across Devon ensuring families receive an evidence based service ranging from early intervention to specialist treatment. | N/A | Business case supported | | Early intervention for women. Improved quality of service. Prevention of hospital admission. Provision of infant mental health service. |
| Children & Young People (CAMHS) | CS2 | ADHD | To commission a service for children with ADHD that is in line with the developing Neurological Pathway currently progressing the ASD Pathway. To both support and make the outcomes re efficiency, waiting times and effectiveness. | N/A | | | Improved Access to a consistent community based pathway of care in line with NICE guidance. Reduction of waiting times. |
| Children & Young People | CS3 | ASC | To commission the revised ASC Pathway ensuring compliance with the SEND Pathfinder process ensuring all children have access to an efficient robust evidence based provision. This will form the basis of an agreed Neurological Pathway supported by the appropriate involvement of GPs and acute paediatric consultants. | | Additional investsment already made to support ASC pathway | | Improved Access to a consistent community based pathway of care in line with NICE guidance. Reduction of waiting times. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Children & Young People | CS2 | C&YP Community Nursing Service Review | To review existing Community Nursing arrangements across Devon, Plymouth and Torbay with a view to establishing a consistant service provision with the aim of preventing hospital admission, reducing LOS and maintaining children within their own homes when appropriate to do so. | N/A | | | Provision of a consistent community children's nursing service aimed at maintaining children within their own home wherever appropriate thereby reducing hospital admission and supporting reduced length of stays |
| Children & Young People | CS2 | Children in Care | To review Devon Children in Care service with DCC colleagues. To ensure there are effective efficient processes in place. To consider the role of the medical provision in order to ensure National and Local Performance Indicators are met. | N/A | It is anticipated this review will have some cost implications | | Development of a care pathway in line with National and Local performance indicators. |
| Children & Young People (CAMHS) | CS2 | IAPT | To ensure the successful implementation of the IAPT Bid from Devon, Torbay and Plymouth with the overall aim of service transformation in order to meet the service specification for Devon, ensuring the best and consistent use of resources across our three | N/A | Successful Bid for funding achieved. | | A CAMHS workforce appropriately trained to take forward transformation of the CAMHS service in line with the National Directives regarding psychological therapies. Early intervention/ prevention of hospital admission and referrals to psychiatric servi |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Children & Young People | CS2 | Therapy Services/ Learning Disabilities | To work with ICS to ensure the revision of both OT, Learning Disabilities and S&L Services facilitate revised efficient work practices to ensure the priorities agreed within the service specification are met. To ensure compliance with the Performance Indicators | N/A | | | To agree criteria for access to the services in view of the current service pressures regarding waiting times to ensure most effective use of service provision. |
| Children & Young People | CS1 CS2 CS3 | Special Educational Needs (SEND) | To work collaboratively to develop and support the implementation of the SEND Pathfinder project in Devon and to identify and take forward key commissioning actions for the ongoing service provision. | | | | To ensure Children with Additional Needs are cared to meet the needs of the Reform of Special Educational Needs National Directive, parents are offered improved parental involvement and choice. |
| Children & Young People | CS3 | Personal Held Budgets | Working in conjunction with DCC colleagues, clarifying guidance and arranging the development of personal held budgets for families with children with a Special Education Need is a core underpinning element of the SEND Pathfinder project. | N/A | There may be a need to acknowledge the impact this will have on heath service budgets, both commissioning and provider. | | To promote greater management/ control for parents and young people as to how they purchase their care. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Children & Young People (CAMHS) | CS2 | JCAT/ SAC | To review the JCAT and SAC service with a view to reconfiguring | N/A | | | To ensure optimum service provision with a view to improved integration with mainstream CAMHS. |
| Children & Young People (CAMHS) | CS2 | Out of Hours Service (OoH) | To commission a 24hr safe and accountable OoH service that includes CAMHS psychologists. | N/A | | | A save and sustainable Out of Hours service. |
| Children & Young People | CS2 | Complex Care | Establish purpose and pathways for Complex Care budget and link with community healthcare as per the draft service specification. | N/A | | | The development of an effective care pathway ensuring a robust process for the application of spend against the Complex Care budget to an agreed specification/ criteria. |
| Children & Young People (CAMHS) | CS2 | Assertive Outreach / Link to QUIPP | To aim to commission a CAMHS Assertive Outreach Service as described within the business case for Devon with the overall aim of providing early intervention for C&YP with an Eating Disorder providing a community based service, reducing costly out-of-area | Likely to be a QIPP proposa l | | | Provision of an evidence based community service for C&YP with an Eating Disorder providing early intervention specialist service and prevention of out-of-area placements. |
| Children & Young People | CS2 | Service Specifications | To review all ICS service specifications in conjunction with the new single Accountabler Provider to ensure optimum service provision, performance monitoring and completion of the agreed performance indicators and contract monitoring framework | N/A | | | Clear and robust service specifications indicating the service provision and performance indicators of the services expected to be commissioned from the new single accountable Provider. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Children & Young People | CS2 | Unscheduled care | Revision of unscheduled care pathways for children and young people through the introduction of a Paediatric Outreach Team (one year pilot covering Plymouth only during the pilot phase). | | | | Pilot for one year - testing assumptions on reduction of acute admissions and attendances for CYP. |
| Children & Young People | CS2 | Unscheduled care | Development of pathways and processes (across the multiagency partnership) to support reduction in length of stay and cumulative inpatient bed use. | | | | A reduction in inpatient stays for a defined patient population. Better management of children and young people outside of an acute hospital setting. |
| Children & Young People | CS3 | Mental Health | Delivery of the revised neurodevelopmental pathways for children and young people with suspected Austistic Spectrum Disorder or suspected Attention Deficit Hyperactivity Disorder. | | | | Improved access to assessment and diagnosis for children and young people. |
| Children & Young People | CS3 | Mental Health | Revision to the service model for the delivery of CAMHS, taking into account the recommendations of the external review of Plymouth CAMHS and the roll out of Children and Young People's IAPT (IAPT will be rolled out across Devon and Torbay as well). | | | | Improved access to services and improvements in demonstrating the outcomes for children and young people accessing CAMHS. |
| Children & Young People | CS2 | Scheduled care | Revision to the service model for the delivery of targeted and specialist Children and Young People's Speech and Language Therapy, following the recommendations of the speech, language and communication review undertaken in 12/13. | | | | |
| Children & Young People | | Mental Health | Development of the perinatal and infant mental health services in Plymouth, in line with pathway work already undertaken in Devon and Torbay. | | | | An improvement in the coordination and delivery of the perinatal mental health services available to women and their babies. |

| Children & Young People | CS2 | Early Intervention and Prevention | An increased emphasis on targeted intervention, working in partnership with other agencies and services to move towards a model of preventive 'early help' and away from specialist treatment and intervention. | | | | Delivery of the 'health strands' of the Early Intervention and Prevention Strategy, improving the ability of the multiagency partnership to r espond to the needs of children, young people and their families earlier and reducing escalation to specialist tr |
|---|---|---|---|---|---|---|---|
| Children & Young People | CS2 | Maternity | Review of the service model for the delivery of maternity services, taking into account the adoption of standard, intermediate and advanced care pathways (linked to the adoption of a linked national tariff). | | | | Improved choice and quality of care for women. |
| Children & Young People | CS3 | Primary Care | Development of primary care services to meet the needs of young people, taking into account feedback from a review of services carried out in 2012/13. | | | | Increased use of primary care by young people. A more responsive and young people friendly service. |

Autho

## Partnership Contracting intentions

| Strategic Priority | Core Strategy | Subject | Contracting intentions | Contracting notes |
|---|---|---|---|---|
| Mental health | | PBR | Roll out mental health PBR in 2013/14 and embed the use of the currencies as the basis on which contracts are agreed. | Particular emphasis will be placed on benchmarking local prices against published indicative (non mandatory) pricing per clustre period, agreeing a single cluster price per provider, the use of nationally mandated quality and outcome measures and improving the completeness of cluster data. We will also update the MOUs and consider the use of CQUIN to improve data quality |
| Mental health | | Extending choice | Recovery focused services that offer a greater choice for patients | Open up delivery to a wider range of organisations and move towards a more diverse landscape of providers including third |
| Learning disabilities | | Quality and safety | Rigorous about monitoring providers against MCA/ DOL's / | |

# INTEGRATED COMMISSIONING

JOINT COMMISSIONING PARTNERSHIP

In response to the Health and Social Care Bill senior commissioning leads from across Plymouth have established a single multi agency Joint Commissioning Partnership (JCP) which spans across a range of health and wellbeing services. This group is made up of representatives from Plymouth City Council (Adult Social Care, Children's Housing and Community Safety), Public Health, NHS Plymouth, Probation and the Police.

The JCP is responsible for ensuring that there is a coordinated and consistent approach to commissioning services on behalf of partner agencies in Plymouth. It aims to ensure a joined up approach to strategic planning and service delivery in order to maximise best use of public resources and deliver seamless services by working across organisational boundaries.

The Joint Commissioning Partnership covers a range of areas and is presently identifying opportunities for development of joint commissioning plans relating to:

- Provision of Information and Advice
- Housing and Related Support and Homelessness
- Community Safety including Domestic Violence
- Financial Inclusion
- Alcohol and Substance Misuse
- Libraries and Leisure
- Health Improvement
- Adult Social Care
- Carers
- Community Health Care
- Relevant Public Health functions (subject to proposed transitional arrangements being confirmed)
- Collaboration with Children and Young People's services undertaken via Children & Young People's Trust

Below this it is the intention to build an integrated commissioning hub. First stage has to been to pull adults and children commissioners into a single team. The team is also leading on the Public Health transfer, with the aim that Public Health commissioning is embedded into the team from April 2013. Supporting this discussions between senior officers in the NHS and the Local Authority have identified that in light of the changes brought about by the Health and Social Care Act 2012 there are potential opportunities to increase collaboration and joint commissioning between the partners. In response NHS commissioners are to be located in the same building early in 2013 with areas of lead commissioner already being discussed. These changes will provide an integrated commissioning response, able to commission around people not labels.

As a response to the national concerns about the quality of care in care home settings and the changing role of CQC Plymouth City Council and NHS Plymouth have jointly established a

strategy support care homes to improve and develop good quality care. The strategy focus is on 3 areas:

- *Market management*
- *Safeguarding*
- *Improving Quality*

We have established systems to support care homes in the following ways:

- Established a *Dignity in Care Homes Forum* .Approximately 70 care homes attend at each event. There are plans to roll this out across the Devon Clinical Commissioning locality.
- Set up a Quality Improvement Team for care homes using health funding for Social Care to support with improving care rather than regulating practice. Discussions are being held with NEW Devon CCG to roll this out across Devon
- Developed the Dementia Quality Mark for Care Homes – this is an accreditation mark and once the standard has been achieved care homes are flagged on Plymouth on line directory

**JOINT COMMISSIONING PARTNERSHIP WORK PROGRAMME 2013**
**Version Date-January 2013**

| TOPICS | Owner | 22nd Jan | 19th March | 21st May | 23rd July | 17th Sept | 19th Nov |
|---|---|---|---|---|---|---|---|
| **Governance** | | | | | | | |
| Review of Terms of Reference and Membership | Paul O'Sullivan | | | | | | |
| **Joint Commissioning Arrangements** | | | | | | | |
| PCC and NHS Commissioning Restructures/Integration Plans | Paul O'Sullivan/Pam Marsden | | | | | | |
| Role of Police and Crime Commissioner and Commissioning Arrangements | TBC | | | | | | |
| Health and Social Care 256 Funding | Paul O'Sullivan/Pam Marsden | | | | | | |
| PH Transition; Commissioning and Contracting Workstream | Craig McArdle | | | | | | |
| **Priority Area; Tackle poverty and the wider factors that affect health and wellbeing and health inequalities** | | | | | | | |
| Young Persons Accommodation Commissioning Plan | Craig McArdle | | | | | | |
| Supported temporary accommodation business case | Craig McArdle | | | | | | |
| Housing Services- Delivery Plans. | Stuart Palmer | | | | | | |
| Framework for peninsula placement services including residential, fostering and special school placements for children. | Fiona Fleming | | | | | | |

| Overview of the strategy for children 11-19 and the skills agenda including overview of contract with Careers South West and achievement of NEETS targets. | Judith Harwood (TBC) | | | | | | |
|---|---|---|---|---|---|---|---|
| Refugee support service | Craig McArdle | | | | | | |
| **Priority Area; Achieve the best start for children and young people** | | | | | | | |
| Early Years and Childrens Centers including BIG Lottery bid | Judith Harwood (TBC) | | | | | | |
| Short breaks Commissioning Plan for Disabled Children | Judith Harwood (TBC) | | | | | | |
| Early Intervention in Mental Health and overview of CAMHS | Fiona Fleming | | | | | | |
| Commissioning Intentions for Early Intervetion and Prevention Strategy including Families with a Future | Fiona Fleming | | | | | | |
| **Priority Area; Enable People to live healthy lives and make healthy choices** | | | | | | | |
| Alcohol Commissioning Strategy | Dave Schwartz | | | | | | |
| Health Improvement Commissioning Intentions | Sarah Lees | | | | | | |
| Teenage Pregnancy. Re-design of servcie delivery | Fiona Fleming | | | | | | |
| Sexual Health Services Commissioning Plan | Laura Juett | | | | | | |
| Substance Misuse Commissioning Plan | Gary Wallace | | | | | | |
| **Priority Area; Delay and reduce the need for care and support** | | | | | | | |
| Domiciliary Care and Reablement Business Case | Debbie Butcher | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Personal Health Budgets | Fiona Phelps | | | | | | |
| Sheltered Housing and low level support for Older People Business Case. | Craig McArdle | | | | | | |
| **Business Planning** | | | | | | | |
| Performance/Finance Monitoring | Patrick Hartop/Simon Arthurs | | | | | | |
| Quality and Safeguarding (Adults and Children) | TBC | | | | | | |
| JSNA & Evidence BankDevelopment | Rob Nelder | | | | | | |

This page is intentionally left blank

**PLYMOUTH CITY COUNCIL**

| | |
|---|---|
| **Subject:** | Francis Inquiry (into Mid-Staffordshire NHS Foundation Trust) Report and Legislative Update |
| **Committee:** | Health and Adult Social Care Overview and Scrutiny Panel |
| **Date:** | 28 February 2013 |
| **Cabinet Member:** | Councillor Peter Smith, Deputy Leader / Councillor Sue McDonald, |
| **CMT Member:** | Adam Broome, Director for Corporate Services / Carole Burgoyne, Director for People |
| **Author:** | Ross Jago, Democratic Support Officer |
| **Contact details** | Tel: 01752 304469<br>Email: ross.jago@plymouth.gov.uk |
| **Ref:** | N/A |
| **Key Decision:** | No |
| **Part:** | I |

**Purpose of the report:**

The purpose of the report is to update the panel on two recent publications which will have an impact on local authority health scrutiny.

Firstly recommendations made by Robert Francis QC following his inquiry into Mid-Staffordshire NHS Foundation Trust. His Inquiry followed concerns about standards of care at the Trust, and an investigation and report published by the Healthcare Commission in March 2009. The report contains 6 recommendations regarding the Health Scrutiny functions of local authorities.

Secondly, the publication of secondary legislation (The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013), following the Health and Social Care Bill 2012, which has a direct impact on Local Authority Health Scrutiny Function.

**Corporate Plan 2012-2015:**

Recommendations will support the -

- Clarification of Overview and Scrutiny’s engagement with changing delivery arrangements and ways of doing business, particularly in areas like health and crime;
- Make the commitment to Open Plymouth a reality through more open and transparent local government and public service delivery.

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

- None identified.

**Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management:**

- None identified.

**Equality and Diversity**

Has an Equality Impact Assessment been undertaken? No

**Recommendations and Reasons for recommended action:**

The panel is asked to –

1. Note the Francis Report's recommendations with regard to scrutiny and the actions which the panel has taken and could take in the future to support them.

2. Agree to recommend to council the delegation of all health scrutiny functions (other than referral of matters to the Secretary of State for Health) to a Health Scrutiny Panel.

**Alternative options considered and rejected:**

None

**Published work / information:**

Robert Francis Inquiry Report into Mid-Staffordshire NHS Foundation Trust –

(http://www.midstaffspublicinquiry.com/sites/default/files/report/Volume%203.pdf)

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 -

(http://www.legislation.gov.uk/uksi/2012/1021/contents/made)

**Background papers:**

N/A

**Sign off:**

| Fin | | Leg | | Mon Off | TH 00 90 | HR | | Assets | | IT | | Strat Proc | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Originating SMT Member | | | | | | | | | | | | | |
| Has the Cabinet Member(s) agreed the contents of the report? Yes / No* please delete as necessary | | | | | | | | | | | | | |

1 Robert Francis Inquiry Report into Mid-Staffordshire NHS Foundation Trust

1.1 The Inquiry was set up by the Rt Hon Andy Burnham MP, Secretary of State for Health, following a Healthcare Commission report into the trust published in March 2009. The period reviewed by the Inquiry was principally January 2005 to March 2009.

1.2 The Inquiry was urged to investigate the role of a number of external agencies in the failure to detect and act on the deficiencies revealed by the Health Care Commission investigation, but the terms of reference set did not permit it to do so. It has, however, received a considerable body of opinion on that issue.

1.3 Moving beyond the NHS to consider the health overview and scrutiny role of local authorities, evidence was received from a number of people about the perceived ineffectiveness of that system in this case. Many comments were about the lack of understanding and grip on the real local healthcare issues.

1.4 The inquiry received information and documentation from Staffordshire County Council highlighting that their Health Scrutiny agendas contained little evidence that a particularly aggressive or proactive approach was taken in the scrutiny of local NHS services. Apart from a standing item for ‘health trust updates’ at its monthly meetings, the committee considered just six specific agenda items about the Trust during 2005–08.

1.5 The following information highlights practical actions that the Plymouth City Council Health Scrutiny function has undertaken or could undertake in the future. The report’s recommendations to strengthen the health scrutiny function are useful, but members must be mindful that the Department of Health are yet to respond to the report and there may be further legislative or regulatory changes proposed.

1.6

| **Francis Report Recommendation** | **Plymouth Health and Adult Social Care Overview and Scrutiny Panel initial response** |
|---|---|
| 47 - *“The Care Quality Commission should expand its work with overview and scrutiny committees and foundation trust governors as a valuable information resource. For example, it should further develop its current ‘sounding board events’.”* | The panel will engage fully with the Care Quality Commission, members of the panel will meet with CQC Compliance Managers and Inspectors on the 6 March 2013 and agree how to work together in practical ways in the new Health landscape. |
| 119 - *“Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality.”* | The Lead officer to the panel will explore the potential for information sharing with local trusts. The panel will work with Local Healthwatch to develop this area and provide and opportunity for the new organisation to make regular reports to the panel on complaints received by local NHS services. |
| 147 - *“Guidance should be given to promote the coordination and cooperation between Local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees.”* | The lead officer to the panel will take an overview of guidance already produced regarding this relationship and will provide a briefing pack to panel members. |

| | |
|---|---|
| 149 - *"Scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks."* | The scrutiny function is currently undergoing evaluation. |
| 150 - *"Scrutiny committees should have powers to inspect providers, rather than relying on local patient involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate, rather than receiving reports without comment or suggestions for action."* | The panel will work with local structures to trigger and follow up inspections where appropriate. Local Healthwatch will continue to have powers enabling the inspection of Healthcare providers and the panel will support the use of those powers. |
| 246 - *"Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality accounts should be required to contain the observations of commissioners, overview and scrutiny committees, and Local Healthwatch. "* | The panel has received quality accounts on an annual basis and made comments to be included in the documents. The panel has consistently requested that providers work together to provide information in a consistent manner. |

2 The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

2.1 The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 were published on the 8 February 2013. The publication of these regulations enables the local authority to finalise local preparations for new health scrutiny arrangements.

2.2 The regulations in relation to health scrutiny make provision for local authorities to review and scrutinise matters relating to the planning, provision and operation of the health service in their area and replace the previous 2002 regulations on health scrutiny. Certain elements of the previous regulations have been preserved but there are new obligations on NHS bodies, relevant health service providers and local authorities around consultations on substantial developments or variations to services to aid transparency and local agreement on proposals.

2.3 Previous statute allowed for the referral of substantial variations in service (when deemed appropriate by the panel) direct from the panel to the Secretary of State for Health. This power now rests with full council and regulations make clear that this function is the only health scrutiny function which cannot be discharged by a committee, the has been achieved

by dis-applying Section 101 (a) of the Local Government Act 1972 in relation to this function. If health scrutiny functions are delegated to a scrutiny panel, that panel will need to make recommendations to full council in order to refer substantial variation to the Secretary of State.

This page is intentionally left blank

# 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 | 13 /14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Health Integration Programme** | | | | | | | | | | | | |
| Joint Health and Wellbeing Strategy (JHWBS) | | | | | | | | | 28 | | | |
| Public Health Transition / Director of Public Health Annual Report | | | | | | | | | | | 11 | |
| Dementia Strategy | | | | | | | | | | | 11 | |
| NEW Devon Commissioning Intentions | | | | | | | | | 28 | | | |
| Quality Accounts | | | | | | | | | | | 11 | |
| Hospital Discharge Process | | | | | | | | | | | | |
| Foundation Trust Business Case | | | | | | | | | | | | |
| Joint Commissioning Partnership Commissioning Intentions | | | | | | | | | 28 | | | |
| Update on Regional Pay | | | | | | | | | | | | |
| Mental Health Recovery Pathways / Capital Investment In the Glenbourne Unit | | | | | | | | | | | 11 | |

This page is intentionally left blank