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HEALTH AND WELLBEING BOARD

Thursday 12 June 2014
10.00 am
Warspite Room, Council House

Members:
Councillor Sue McDonald (Chair)
Councillors Ian Tuffin and Dr John Mahony.

Statutory Co-opted Members: Strategic Director for People, NEW Devon Clinical Commissioning Group representative, Director for Public Health, Healthwatch representative, NHS England, Devon, Cornwall and Isles of Scilly representative.

Non-Statutory Co-opted Members: Representatives of Plymouth Community Homes, Plymouth Community Healthcare, Plymouth NHS Hospitals Trust, Devon Local Pharmaceutical Committee, University of Plymouth, Devon and Cornwall Police, Devon and Cornwall Police and Crime Commissioner and the Voluntary and Community Sector.

Members are invited to attend the above meeting to consider the items of business overleaf.

This meeting will be broadcast live to the internet and will be capable of subsequent repeated viewing. By entering the Warspite Room and during the course of the meeting, members are consenting to being filmed and to the use of those recordings for webcasting.

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Tracey Lee
Chief Executive

HEALTH AND WELLBEING BOARD

PART I (PUBLIC COMMITTEE)

1. CONFIRMATION OF CHAIR AND VICE CHAIR

The Board will confirm the appointment of the Chair and elect a Vice-Chair.

2. APPOINTMENT OF CO-OPTED REPRESENTATIVES

The Board will confirm the appointment of the co-opted representatives.

3. APOLOGIES

To receive apologies for non-attendance by Health and Wellbeing Board Members.

4. DECLARATIONS OF INTEREST

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

5. CHAIR'S URGENT BUSINESS

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

6. MINUTES (Pages 1 - 8)

To confirm the minutes of the meeting held on 27 March 2014.

7. FAIRNESS COMMISSION RECOMMENDATIONS (Pages 9 - 14)

The Board to consider the Fairness Commission recommendations.

8. CO-COMMISSIONING OF PRIMARY CARE SERVICES (Pages 15 - 34)

The Board to receive a joint presentation on the future of co-commissioning of Primary Care services.

9. INTEGRATED, PERSONAL AND SUSTAINABLE COMMUNITY SERVICES (Pages 35 - 56)

The Board to receive a report on Sustainable Community Services.

10. UPDATE ON INTEGRATED HEALTH AND WELLBEING TRANSFORMATION PROGRAMME

The Board to receive a verbal update on the Integrated Health and Wellbeing Transformation Programme.

11. PLEDGE 90 - MENTAL HEALTH REVIEW REPORT (Pages 57 - 126)

The Board to receive the Pledge 90 – Mental Health Review report.

12. EXEMPT BUSINESS

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

PART II (PRIVATE COMMITTEE)

AGENDA

MEMBERS OF THE PUBLIC TO NOTE

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

NIL.

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Health and Wellbeing Board

Thursday 27 March 2014

PRESENT:

Councillor McDonald, in the Chair.
Professor Richard Stephenson, Vice Chair.

David Bearman, Andy Boulting, Carole Burgoyne, Jerry Clough, Amanda Fisk, Tony Hogg, Stephen Horsley, Sue Kelley, Councillor Dr. Mahony, Vicky Shipway (for Debbie Roach), Nick Thomas (for Ann James), Steve Waite and Councillor Nicky Williams.

Apologies for absence: Ann James, Debbie Roach and Clive Turner.

Also in attendance: Craig McArdle, Craig Williams, George Plenderleith, Julie Frier, Giles Perritt and Amelia Boulter.

The meeting started at 10.00 am and finished at 12.50 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.

37. DECLARATIONS OF INTEREST

There were no declarations of interest.

38. CHAIR'S URGENT BUSINESS

The Chair gave thanks to Stephen Horsley, Interim Director of Public Health for taking the helm and providing leadership in public health and his campaign for a better public health settlement for Plymouth.

The Chair also reported on the recent press on the children and adolescent mental health service. The Chair stated that on behalf of the Health and Wellbeing Board she looked forward to receiving the recommendations from the Caring Plymouth Panel which monitored a review of mental health services across the city. With a whole systems approach no single organisation by itself fails or succeeds.

39. MINUTES

Agreed that the minutes of 13 February 2014 were correct subject to the following amendment –

Minute 33c – should read as 'comprises' and not compromises.

40. BETTER CARE FUND

Craig McArdle, Head of Co-operative Commissioning, Jerry Clough, Chief Operating Officer, NEW Devon CCG and Craig Williams, Interim Programme Manager (Integrated Health and Wellbeing) provided the Board with an update on the Better Care Fund (BCF) on the feedback received from the Local Area Team (LAT).

Members were advised that -

(a) changes were made since the last submission to the Board and the document had been shaped by feedback received from the LAT which highlighted a number of areas for development;

(b) the outcome measures needed to be more ambitious around delays on transfers of care which was also highlighted by the Board. This metric had been revised to be more challenging with the aim to achieve the national average by 2015;

(c) the metrics relating to the patient user experience was still currently blank this was because they were waiting for the national guidance. The Dementia metric was technically robust and were still in line with what was originally planned.

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

(d) the template had been revised and would be submitted to NHS England. With regard to Delayed Transfers of Care the aim was to achieve 308.5 and this was a national indicator. The Dementia rate was 47.8 with the aim to achieve 54.5 and was confirmed diagnosis.

It was further reported that -

(e) the LAT feedback reported the need to flesh out some of the schemes to take forward in 2015/16. The feedback received in relation to 2014/15 was very positive;

(f) there were a number of developments planned for 2015/16 grouped around a number of themes –
- promoting independence;
- minimising delayed transfers in care;
- reablement, rehabilitation and recovery;
- quality improvement;

(g) this was the start of the BCF process and recognise the need to further develop the schemes and monitor the outcomes. The priorities of the Transformation Programme and the BCF sits within a wider piece of work of the integration of health and social care and that has to be the priority for the next 2 years;

(h) the need to ensure robust governance arrangements for delivery and further work on Section 75 for 2015/16 was to be put in place and how services transform around 7 day working and the transformation of integrated of health and social care across the city would be developed.

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

(i) with regard to end of life care this was a return to the national average and was an ambition for the next 2 years. There was a need to look across the whole system at all the indicators to give a balanced overview and recognise the need to up skill the workforce around end of life care and the importance of meeting people's wishes and needs;

(j) feedback received from the LAT was helpful and feedback received from the Health and Wellbeing Board had been incorporated. They were working with 2 Health and Wellbeing Boards and have external support to make sure everything was pulled together to ensure consistency;

(k) the hospital was committed to working across the whole health system and ensuring pathways to care were correct. Taking money out of the system meant designing a system which delivered the right outcomes for patients;

(l) the BCF was largely silent on the issues of children and young people who were an important factor. Children and Young people were reflected in the Transformation Programme and the BCF template did not allow the story of the wider work the Board had been undertaking.

Agreed that the Health and Wellbeing Board endorses the changes made to the Better Care Fund template and its submission to NHS England. The Board would continue to monitor the implementation of the Better Care Fund.

41. BETTER OUTCOMES FOR CHILDREN AND YOUNG PEOPLE

Councillor Nicky Williams provided the Board with a report on better health outcomes for children and young people.

Members were advised that –

(a) in January 2012, the Government set up the Children and Young People's Health Outcomes Forum to look at health issues and better outcomes for children and young people;

(b) in February 2013, the Government set out its official response to the forum and signed up to the Better Health Outcomes Pledge and Health and Wellbeing Boards were invited to sign up to this;

(c) there were 5 shared ambitions and 5 key aims which resonate well with the strategic approaches of the Board and the Marmot approach to give children and young people the best start in life.

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

(d) this was the first step in taking the pledge forward. The next step was to look at how to implement the pledge locally and make it right for Plymouth. Further discussions took place on whether there was a need to have an additional recommendation on the importance of working with partners. It was felt that bullet point two of the recommendations covered this;

The Board received feedback from the community and voluntary sector on the support for adopting the pledge. It was reported that –

(e) funding and service cuts would impact significantly on this area of work. A suggestion was put forward on whether a solution shop would be an avenue for developing and adapting the local version of the pledge. This would allow a wider group of organisations to come together to feed into the development of the pledge;

(f) Cabinet recently agreed a recommendation that covers the issues raised and looks at the commissioning framework for children and young people. The recommendation took into account the whole care pathway and as this develops it could run alongside this work to be captured in one place with the Board having oversight.

Agreed that –

1. the Health and Wellbeing Board would sign up to the principles of the Better Outcomes for Children and Young People Pledge subject to the completion of next steps to include -

   - agreement on where oversight, accountability and responsibility for delivery should sit;
   - adaption of the Pledge in line with local need and priority areas;
   - a system of monitoring progress against the key ambitions and aims of the Pledge to be developed, cross referencing with relevant plans and performance already in place;
   - further work to be undertaken to identify the resource and financial implications of delivering the Pledge within the local context.

2. the Board have oversight of plan prior to going to the Children and Young People Partnership.

42. STRATEGIC ALCOHOL PLAN FOR PLYMOUTH 2013-2018

Stephen Horsley, Interim Director for Public Health provided the Board with the Strategic Alcohol Plan for Plymouth 2013 – 2018. It was reported that –

(a) alcohol was an issue in Plymouth with an estimated 60,000 people drinking at hazardous levels;

(b) the Health and Wellbeing Board was identified as providing the governance for implementation of the plan which has now been in place for 6 months. The delivery plans shows the progress so far;

(c) one meeting of the stakeholder group had taken place to ensure the issues relating to alcohol had been taken on Board. The implementation plan needs wider support from a number of agencies;

(d) the Evening and Night Time Economy (ENTE) was very important to Plymouth and probably needs more involvement with Economic Development. Further engagement with Economic Development and partners to possibly fund an ENTE Manager;

(e) the number of alcohol related admissions had risen at Emergency Departments and there was a need to look at additional support from NEW Devon CCG in relation with the Alcohol Liaison Service;

(f) the sale of super strength alcohol of 6.5% which are sold very cheaply and potentially cause a lot of problems. The Police and Crime Commissioner had also highlighted this as an issue and working in partnership would develop the best solution for Plymouth;

(g) there was a requirement for people to drink responsibly and this strategy would support people to do this.

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

(h) Tony Hogg was respectful of the local position and that the impact of alcohol was enormous in terms of families, children, hospital admissions, policing etc and the hidden costs. Tony would be looking at this for Devon, Cornwall, Isles of Scilly and Torbay and would work in line with Plymouth's views.

Agreed that -

1. The current Year 1 Implementation Plan is reviewed to include specific timescales, metrics and -

    a. the Plan is represented to the Health and Wellbeing Board at its next meeting;

    b. a formal projects review is carried out and is reviewed at the Health and Wellbeing Board in the Autumn 2014.

2. a. The Stakeholder Group (Alcohol Programme Board) lead the delivery of the Plan through development and implementation of annual Delivery Plans;

b. Accountable Leads, as identified within the Implementation Plan, provide assurance of delivery for their specific domain areas. Annual statement of progress is provided to the Health and Wellbeing Board;

c. a review to take place on the membership of the Stakeholder Group (Alcohol Programme Board) to ensure the right people are on this board to deliver the plan.

3. The Chair of the Health and Wellbeing Board will meet with the Chair of the Growth Board to ensure alignment of strategic positioning and ownership of the plan;

4. The NEW Devon CCG considers how best the plan can be supported across health agencies and Public Health and reports back to the Board how this might be reflected through its commissioning infrastructure;

5. The Police and Crime Commissioner's current work to engage the alcohol retail sector is aligned to the city's work to reduce the availability of super strength alcohol products.

43. AGEING BETTER PLYMOUTH

George Plenderleith, Chief Executive, Plymouth Guild provided the Board with a presentation on Ageing Better Plymouth. The presentation highlighted that –

(a) Plymouth was one of 34 local authorities competing for up to £6m to spend over the next 3 to 4 years to reduce social isolation for older people;

(b) Ageing Better outcomes-
- older people are less isolated;
- older people are actively involved in their communities with their views and participation valued more highly;
- older people are more engaged in the design and delivery of services that help reduce their isolation;
- services that help to reduce isolation are better planned, co-ordinated and delivered;
- better evidence is available to influence the services that help reduce isolation for older people in the future;

(c) Highlights from the survey –
- whilst health restrictions, lack of transport and cost were given as reasons for not taking part in activities outside the home, lack of information was the biggest barrier;
- majority of respondents do not think that they are able to have say about the type of local services and activities available to them;
- half of those responded to the survey were over 70 years olds and the majority were woman.

A discussion took place that the Health and Wellbeing Board was not a commissioning Board and to request the Joint Commissioning Partnership to look at some of the recommendations. The Board felt that the Ageing Better Plymouth presentation was thought provoking with really important messages that should be built in our planning.

Agreed that –

1. the Health and Wellbeing Board endorses the initiative and the bid by the Guild which has clear links to the board's visions and strategy.

2. the needs of the socially isolated are reflected in the strategic commissioning plans.

3. the Joint Commissioning Partnership -
   - ensures strategic alignment of the various initiatives to provide services to socially isolated older people through engagement from the partner organisations on the Health and Wellbeing Board.
   - develops an alignment with Joint Strategic Commissioning for older people who are socially isolated with or without lottery funding.
   - considers new models of commissioning with the Ageing Better Social Enterprise.

44. NEW DEVON CCG 5 YEAR STRATEGIC PLAN

Jerry Clough, Chief Operating Officer, NEW Devon CCG provided the Board with an update on the New Devon CCG 5 Year Strategic Plan. It was reported that -

(a) a draft of the NEW Devon CCG 5-Year Strategic Plan would be submitted by 4 April and final draft submitted by 20 June. During that period there would be plenty of time for engagement and further refinement of the plan;

(b) Devon had been designated as a financially challenged health economy which means that Devon would be receiving intensive external support from 1 March to 20 June to support the 5 year plan;

(c) 5 key strategic priorities identified that resonate throughout the plan and are critical pieces of work -
   - Partnerships to deliver improved health outcomes;
   - Personalisation and integration;
   - General Practice registered populations as the organising units of care;
   - A regulated system of elective care that delivers efficient and effective care for patients;
   - A safe and efficient urgent care system.

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

(d) there were national drivers to make General Practice more available, open and responsive and that in itself was a tension, however, if merged and federated at scale, patients could have access to urgent care services not from a named GP but they would receive the care when needed;

(e) the 'Green family' had created a lot of interest and whether the statements were ambitious enough was questioned. The default of taking someone to hospital too quickly was still in place when there could be other options;

(f) areas that have significant issues around health inequalities were party due to low uptake and the engagement of people with their own healthcare. This was an issue nationally and spend was higher in communities where health inequalities were not a big issue. There was a need to be open and transparent and CCG had applied allocation formula to each of their localities;

Agreed that the Health and Wellbeing Board note the update at the first meeting in the new municipal year would consider the final plan.

45. **EXEMPT BUSINESS**

There were no items of exempt business.

SUMMARY OF RECOMMENDATIONS

Principles of fairness

Local recommendation

1. That the Plymouth Fairness Commission's Principles of Fairness are agreed by all public bodies in Plymouth, with consideration of how they are included in decision making.

A new approach to leadership

Local Recommendations

2. That all public bodies in Plymouth learn about the Systems Leadership approach.

3. That a similar approach is part of the induction and training process for all staff in Plymouth's public sector.

4. That measurable objectives on implementing this type of approach are included in the performance objectives of senior staff in all Plymouth's public sector bodies.

5. That all bodies cited against recommendations in the Plymouth Fairness Commission's report agree a Systems Leadership approach to the way they implement them.

Strengthening Local Communities

Local Recommendations

6. That all public sector agencies in Plymouth review the way they currently engage with communities and agree an approach which ensures benefits are shared across communities.

7. That public sector agencies fully explore ways of engaging with communities of interest and identity in a way that works for the individual members of those communities.

8. That local councillors review their current ways of working as elected representatives of local communities.

9. That an external, independent civil society expert undertakes a critical review of Plymouth's voluntary and community sector and provides recommendations to strengthen it.

10. The urgent resolution of issues preventing the provision of professional indemnity insurance is needed to widen the availability of free specialist legal advice.

Individual and Family Wellbeing

National Recommendations

11. That a fair, needs based and long-term funding settlement for local government and other sectors should be urgently developed by central Government.

12. That Plymouth City Council's current grant allocation for public health is urgently reviewed by the Department for Health.

13. That the National Institute for Clinical Excellence's recommendation of a national minimum price per unit of alcohol is implemented.

14. That the Local Government Associations proposals for reforming the current licensing system for alcohol is implemented to limit 24-hour licensing in areas where alcohol causes harm.

15. That the current provision of universal free school meals to Year 1 and 2 pupils in infant schools due to come into effect in September 2014, be extended to all primary school children.

16. That the Department for Work and Pensions urgently addresses the delays in benefit payments when individual circumstances change, and the inappropriate use of benefit sanctions.

Local Recommendations

17. That all parts of the public sector jointly quantify Plymouth's 'Missing Millions' to make the case to Government for fairer funding for the city.

18. That a review of primary care provision across Plymouth is undertaken to ensure equitable access to primary care based on identified local needs.

19. The development of an agreed comprehensive response to Plymouth's mental health needs, and the publication of resourced commissioning plans.

20. That a joint review is completed to agree appropriate crisis responses for those presenting with a mental health need.

21. The development, resourcing and implementation of an evidence-based and coordinated approach to reduce the sale of cheap vodka and 'super strength' beer and cider, as per Plymouth's Strategic Alcohol Plan.

22. That confirmation is given that systems and funding to deliver the Commissioning Plan for the Plymouth Domestic Abuse Partnership 2012-2019 will be adequate and sufficiently resourced to meet the scale of the problem.

23. That cross-sector funding for Domestic Abuse services is protected and, where appropriate, increased to ensure sufficient services and support to meet rising demand.

24. That all primary school children in Plymouth are offered a free school meal.

25. That a pilot is undertaken to assess the potential take-up, costs and benefits of providing a free daily meal to disadvantaged pupils outside term-time.

26. That all schools providing meals in Plymouth should meet the National School Food Standards.

27. That Plymouth City Council's Public Health remit on healthy weight be expanded to include food poverty, with responsibility for co-ordinating food poverty initiatives across the city.

28. That Plymouth City Council amend its spatial planning policy to enable the restriction of fast food outlets within 400 metres or less from a school, youth facility or park.

29. That Plymouth City Council work with the organisers of Plymouth's main events, such as the Fireworks Championships, to reduce the provision of low nutritional value food and improve the food offer.

30. That current food initiatives are better coordinated to ensure they reach Plymouth's food deserts.

Young People and Young Adults

National recommendation

31. That the Department for Education takes active steps to ensure collaboration and sharing best practice is demonstrated by new types of schools, e.g. academies through formal policy and practice.

Local Recommendations

32. That extending the implementation of the Plymouth Primary Teaching School Alliance's collaborative model to Plymouth's secondary schools is made a priority.

33. That a specific review is held to understand and address the factors that prevent young people taking up apprenticeships, and concrete steps agreed to address them.

34. That a 'Virtual Sixth Form' is developed, providing city-wide timetable of courses available from Plymouth's education institutions is made available online to support 16 – 18 year olds.

35. That a consistent set of Information, Advice and Guidance (IAG) protocols, covering all providers is developed for young people choosing their post-16 options.

36. That all primary and secondary schools develop an alumni programme.

37. That all Plymouth's secondary schools and other learning institutions develop relationships with local and regional employers to encourage presentations, workshops and placements and help pupils become 'work ready'.

38. That a formal system is brokered linking schools and businesses so all young people have fair access to internships, work placements and youth enterprise schemes.

39. That a 'Positive Youth' approach to the commissioning of services for young people in the city is developed.

40. That every young person in the city should be able to access free recreational and cultural activities within one bus ride.

41. That the touchpoints of contact for Plymouth's young carers are identified and actively targeted to ensure more young carers contact and benefit from Youth Services.

Discrimination

Local Recommendation

42. That organisations from all sectors in the city generate leadership on tackling discrimination in all its forms, against specific actions.

Escalating Cost of Living

National Recommendations

43. That the Government leads in encouraging employers to pay the recommended Living Wage and requires all Government Departments to pay their employees at this level, as a minimum.

44. That the Local Government Association's demands for changes to the existing planning and licensing laws in relation to new betting premises are actioned.

Local Recommendations

45. That all public sector bodies in Plymouth should commit to pay their staff, and those of the employees of agencies that work for them, the Living Wage.

46. That Plymouth City Council and other public sector agencies engage with subcontractors to ensure that they in turn pay 100% of their workers a Living Wage within two years.

47. That all private sector employers in Plymouth aim to implement the Living Wage for all their employees to ensure Plymouth becomes a Living Wage City across all sectors.

48. That an annual 'Fair Pay in Plymouth' report is published in the Plymouth Herald, including an explanation of executive pay, with top to median pay ratios and all taxable earnings.

49. That the use of zero hours contracts across the city should be monitored annually.

50. That exclusive zero hours contracts are not advertised by job centres or recruitment agencies in Plymouth.

51. That all public sector agencies review their current use of subcontractors and commissioned services that use exclusive zero hours contracts and pledge to commission only from services that do not restrict their employees to exclusive zero hours contracts.

52. That Plymouth City Council demonstrates it is maximising its planning restrictions, within the current legal framework, to control the number of betting shops, fixed odds betting terminals and payday lenders in the city.

53. That the Plymouth universities partner with schools and youth organisations to provide peer mentoring to train young people to become confident in budgeting and managing money.

54. That Plymouth City Council works with partners to develop robust visible campaigns against the use of payday loans and illegal loan sharks.

55. That Plymouth City Council, housing associations and other agencies work together to consolidate customers' debts, offer payment plans and signpost to expert sources of help and advice.

56. That every point of access with public agencies should provide clear and accessible links to specialist debt advice, benefit maximisation and sources of affordable credit, readily and prominently on their websites.

57. That Plymouth credit unions and their partners take greater responsibility for ensuring that they offer a broad range of services that benefit the city, against a number of specific steps. If this is unachievable, Plymouth City Council should step in to take action.

58. That a baseline of current need for, and availability of, affordable credit is developed to ensure city-wide access and availability to individuals and enterprises.

59. That an annual pre-Christmas campaign is held which brings together debt and money advice services, banks, trade unions, credit unions and relevant Council departments to raise awareness of their services and provide opportunities for action.

60. The development of an annual, city-wide 'Fair Money' awards dinner, sponsored by the large high–street banks, with award categories against which the people of Plymouth can vote.

Strengthening the Local Economy

National Recommendations

61. That the Department for Transport and the Treasury review funding allocations in the UK with a view to creating more equitable funding in the South West.

62. That the Department of Transport and the Treasury urgently address Plymouth's need for a fast and resilient rail line to connecting the South West to the rest of the UK.

Local Recommendations

63. That a 'Buy Local, Give Local' trademark scheme is developed for local traders, producers, public bodies and the voluntary sector to help customers and producers identify local providers.

64. That Plymouth City Council should review all the charitable trusts for which it is a corporate trustee and explore methods of amalgamating them and transferring the management of their assets to a Plymouth community-based charity.

65. That all public sector and all large private organisations in Plymouth develop a social value/sustainability statement with clear social value outcomes and measures.

66. That all public sector agencies fully explore the steps they could take towards meeting best practice, beyond the requirements of the Public Services (Social Value) Act 2012, to ensure the inclusion of social value in all contracts for goods and services.

67. That the City Deal clarifies both how it will deliver social value and how this delivery will be measured and evaluated.

68. That baseline data on current public spending with local businesses is established, to enable public bodies in Plymouth to create clear targets for their spending with local businesses, and report on them as part of their annual reporting mechanisms.

69. That work is undertaken with the South West Investors Group and other community finance organisations to increase the amount of capital available for microfinance and small business lending in Plymouth.

70. That a thorough review of the current Sell2Plymouth portal and associated procurement systems of public sector agencies is completed, and recommendations made for changes to ensure there is an efficient link-up of public sector commissioners with private sector suppliers.

71. That the Growth Board reviews the way in which Micro businesses and SMEs contribute to governance, consultations and decisions, and makes recommendations to deliver greater transparency in their involvement and engagement.

Housing

National Recommendations

72. That a National Register of Landlords is established.

73. That local Councils are given the ability to issue fixed penalty notices both to reduce enforcement costs and allow prompt action for breaches of legislation.

74. That new standards for housing are developed to make it easier for both landlords and tenants to know if standards are being met.

75. That the currently expensive, complex and bureaucratic Compulsory Purchase legislation available to councils should be simplified, as recommended by the Local Government Association.

Local Recommendations

76. That Plymouth City Council develops a comprehensive, and resourced, response to raising standards in the private rented housing sector.

77. That Plymouth undertakes a pilot to investigate the viability of a voluntary licensing and accreditation scheme for private sector landlords.

78. That the possibility of property-specific penalties for non-compliant Private Rented Sector homes is investigated, including whether non-compliant PRS homes could be earmarked as "not Housing Benefit eligible".

79. That a comprehensive, measured and monitored Empty Homes Strategy for Plymouth is consulted upon, recommendations provided and action taken.

80. That a virtual Plymouth Private Tenants Forum is created, advising private tenants of their rights, offering an online space to exchange experiences, publicise consultations and offer contact details on further public sources of support.

81. That a full examination is carried out into the coverage of specialist housing provision in Plymouth, comparing what is available against known demographics of groups in need and including a full gap analysis.

The Implications of an Ageing Population

Local Recommendations

82. That an 'All Ages City' Taskforce is created to co-ordinate both the social and non-social care aspects of Plymouth living for older people, as part of the Plymouth Plan process.

83. That the Plymouth Joint Dementia Strategy is given the highest priority to ensure its recommendations are actively delivered across the city.

84. As part of this strategy, that additional consideration be given to ensure that people with dementia who require, and can demonstrate they meet the eligibility criteria are encouraged to apply for the blue badge scheme using the discretionary powers of the Local Authority.

85. That a pack signposting sources of dementia support, information and advice is made freely available in all primary care settings and provided for dementia patients and their carers.

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Northern, Eastern and Western Devon
Clinical Commissioning Group

Co-commissioning of Primary Care Services

Report for Plymouth Health and Wellbeing Board Meeting: June 2014

Recommendation
The Board is invited to engage and contribute views in relation to the potential new arrangements for co-commissioning of primary care services.

NHS England has asked CCGs to submit expressions of interest to develop new arrangements for co-commissioning of primary care services.

The Expressions of Interest should include information on the following areas:

- At individual CCG or group of CCGs level
- Intended Benefits and Realisation
- Scope
- Nature of co-commissioning
- Governance
- Monitoring and evaluation
- Engaging Member Practices and Stakeholders

To complete the Expression of Interest NEW Devon CCG would like to include the views of member practices, patient groups, provider organisations and local authority colleagues.

Report of NHS Northern, Eastern and Western Devon CCG/June 2014

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NHS England

Publications Gateway Ref. Number 01599

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9 May 2014

To: CCG Clinical Leads

Area Directors, NHS England

Copy: CCG Chief Officers

Co-commissioning of primary care services

We are writing to set out:

- how CCGs can submit expressions of interest to develop new arrangements for co-commissioning of primary care services, following Simon Stevens' announcement on 1 May (see annex A);
- the work proposed to be done through the NHS Commissioning Assembly to support CCGs and area teams in developing co-commissioning arrangements.

We are inviting CCGs to submit expressions of interest by 20 June. We would encourage CCGs to work with area teams in developing proposals.

Expressions of interest should include at least this information:

A. CCG(s) involved

Proposals may be submitted by an individual CCG or by a group of CCGs that wishes to propose co-commissioning arrangements to cover their combined localities.

B. Intended benefits and benefits realisation

Expressions of interest should set out how the proposals fit with five-year strategic plans and, in particular, how they will help:

- achieve greater integration of health and care services, in particular more cohesive systems of out-of-hospital care that bring together general practice,

community health services, mental health services and social care to provide more joined-up services and improve outcomes;

- raise standards of quality (clinical effectiveness, patient experience and patient safety) within general practice services, reduce unwarranted variations in quality, and, where appropriate, provide targeted improvement support for practices;
- enhance patient and public involvement in developing services, for instance through asset-based community development;
- tackle health inequalities, in particular by improving quality of primary care in more deprived areas and for groups such as people with mental health problems or learning disabilities.

C. Scope

Commissioning of primary care encompasses a wide spectrum of activity, including:

- working with patients and the public and with Health and Wellbeing Boards to assess needs and decide strategic priorities;
- designing and negotiating local contracts (e.g. PMS, APMS, any enhanced services commissioned by NHS England);
- approving 'discretionary' payments, e.g. for premises reimbursement;
- managing financial resources and ensuring that expenditure does not exceed the resources available;
- monitoring contractual performance;
- applying any contractual sanctions;
- deciding in what circumstances to bring in new providers and managing associated procurements and making decisions on practice mergers.

The expression of interest should indicate which aspects of commissioning fall within the scope of the proposed arrangements. CCGs may wish to propose that they take on delegated or joint responsibilities for some aspects, whilst NHS England continues to discharge other responsibilities directly.

We envisage that arrangements for managing the Performers List, revalidation and appraisal would fall outside the scope of any co-commissioning arrangements.

NHS England cannot delegate responsibility for commissioning of community pharmacy services or dental services. CCGs may wish to make proposals for how better to align decisions made by area teams in commissioning of community pharmacy services with CCGs' strategic objectives, provided that NHS England retains its statutory decision-making responsibilities and that there is appropriate involvement of local professional networks.

NHS England could in principle delegate responsibility for commissioning of primary eye care services, but the main services commissioned by NHS England (NHS sight tests) are essentially a demand-led service governed by national regulations.

D. Nature of co-commissioning

There is a spectrum of potential forms that co-commissioning could take, for instance:

- greater CCG involvement in influencing commissioning decisions made by NHS England area teams;
- joint commissioning arrangements, whereby CCGs and area teams make decisions together, potentially supported by pooled funding arrangements;
- delegated commissioning arrangements, whereby CCGs carry out defined functions on behalf of NHS England and area teams hold CCGs to account for how effectively they carry out these functions.

Expressions of interest will need to indicate the form that CCGs would like co-commissioning to take and how they would like this to evolve, including the proposed relationship with any current or proposed joint commissioning with local authorities.

CCGs will be expected to ensure that their proposals take advantage of synergies with existing areas of CCG activity and enable functions to be discharged within existing CCG running costs as far as possible. Expressions of interest will need to indicate where proposals would rely upon area team staff working under the supervision of CCGs.

E. Timescales

Expressions of interest will need to indicate the proposed timescales for applying the new arrangements, including any proposals for phasing (e.g. where some elements of co-commissioning are introduced during 2014/15, followed by a more developed form of co-commissioning during 2015/16).

Any proposals that rely upon setting primary care budgets at a locality level (below that of an area team) would have to be implemented from 2015/16 onwards.

F. Governance

CCGs already have powers to commission services from general practice (or from other primary care providers) in their own right. Where commissioning services from general practice, or from any organisation in which their members or offers have a

material interest, CCGs have a statutory duty to manage conflicts of interest and to have regard to the statutory guidance on managing conflicts of interest published by NHS England[1]. CCGs would need equally to meet these duties and follow the statutory guidance in relation to any functions that they were to carry out jointly with, or on behalf of, NHS England.

Expressions of interest should set out any additional proposed safeguards for managing conflicts of interest.

G. Engaging member practices and local stakeholders

Expressions of interest should set out how CCGs have engaged their member practices in developing the proposals and any key issues raised by member practices, together with proposals for how they will further involve member practices.

Expressions of interest should provide any initial views of local stakeholders, together with proposals for engaging stakeholders more fully in developing the proposed arrangements more fully. This should, for instance, cover:

- patient groups;
- local authorities and Health and Wellbeing Boards;
- other local provider organisations, e.g. community, mental health, acute trusts.

H. Monitoring and evaluation

Expressions of interest should set out initial proposals for how to monitor and evaluate the impact and effectiveness of the proposed co-commissioning arrangements, in order to ensure that CCGs and area teams can adapt

NHS Commissioning Assembly project

The primary care working group of the NHS Commissioning Assembly will undertake a rapid piece of work to identify the key issues that will need to be resolved to support successful co-commissioning, with the aim of supporting area teams and CCGs in working together to refine the proposals that come from expressions of interest and to help spread innovative thinking.

This will include:

- identifying likely success factors for effective co-commissioning;

[1] http://www.england.nhs.uk/wp-content/uploads/2013/03/manage-con-int.pdf

- identifying the different forms that co-commissioning could take – and its potential scope – and the considerations that would need to be applied locally in choosing between them;
- developing a checklist that could guide CCGs and area teams through the steps involved in setting up new arrangements.

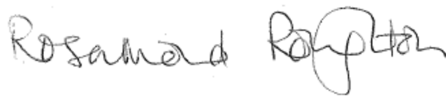
The project will also look, among other issues, at:

- how NHS England can assure itself that delegated functions are being discharged effectively and that any conflicts of interest are being managed appropriately;
- how associated financial resources would be allocated, managed and accounted for;
- any national decisions or approvals that would be needed in relation to information sharing;
- any implications for the public health offer to support primary care commissioning from Public Health England and local authorities.

Conclusion

CCGs are asked to submit expressions of interest, covering the factors set out above (paragraph 8), by 20 June. Please submit expressions of interest to england.co-commissioning@nhs.net.

The relevant Area Team will then discuss each proposal with the applicant CCG(s) and subsequently make a recommendation for approval through the Board governance of NHS England.



Rosamond Roughton
National Director: Commissioning Development

Dame Barbara Hakin
Chief Operating Officer

Annex A

NHS ENGLAND PRESS NOTICE (1 May 2014)

LOCAL HEALTH PROFESSIONALS TO GET MORE POWER TO IMPROVE NHS PRIMARY CARE

Stevens announces new option for local Clinical Commissioning Groups to co-commission primary care in partnership with NHS England

England's 211 clinically-led local Clinical Commissioning Groups will get new powers to improve local health services under a new commissioning initiative announced today by NHS England Chief Executive Simon Stevens.

Speaking to GPs and other NHS health professionals at the Annual Conference of NHS Clinical Commissioners in London, Simon Stevens said:

"England has now taken the bold step – unique in the western world – of putting two thirds of its health service funding under the control of local family doctors and clinicians.

"If we want to better integrate care outside hospitals, and properly resource primary, community and mental health services - at a time when overall funding is inevitably constrained - we need to make it easier for patients, local communities and local clinicians to exercise more clout over how services are developed.

"That means giving local CCGs greater influence over the way NHS funding is being invested for their local populations. As well as new models for primary care, we will be taking a hard look at how CCGs can have more impact on NHS England's specialised commissioning activities.

"So today I am inviting those CCGs that are interested in an expanded role in primary care to come forward and show how new powers would enable them to drive up the quality of care, cut health inequalities in primary care, and help put their local NHS on a sustainable path for the next five years and beyond.

"CCGs are still young organisations at different stages of development, and with different local needs. So rather than specifying a one-size-fits all solution, and having listened carefully to what CCGs have been saying, I'm keen to hear from CCGs themselves about what next steps they would like to explore."

Mr Stevens announced that NHS England will be writing next week to all CCGs in England with details of how to submit expressions of interest in taking on enhanced powers and responsibilities to co-commission primary care.

Applications will need to describe the additional powers and responsibilities the CCG would like to assume. They will need to meet a number of tests, including showing

they will help advance care integration, raise standards and cut health inequalities in primary care.

They will also need to show how they will ensure transparent and fair governance - with a continuing oversight role for NHS England to safeguard against conflicts of interest - all in the context of the CCG's five-year plan for its local NHS services.

NHS England will work with the NHS Commissioning Assembly, NHS Clinical Commissioners and other stakeholders to advance this agenda.

CCG expressions of interest should be developed by June 20, the same date that CCGs will complete their initial five-year 'Forward Views' for local NHS services.

Each proposal will be discussed by the applicant CCG and the local Area Team of NHS England, which will subsequently make a recommendation for approval by the Board of NHS England.

NOTES TO EDITORS

England's 211 CCGs are statutory bodies led by local GPs, alongside hospital doctors, nurses and other health professionals, managers, and independent lay members of the public.

NHS Clinical Commissioning Groups (CCGs) now control £67 billion of NHS funding – about two thirds of NHS spending in England.

Giving CCGs the ability to better influence and shape primary care services requires no further structural reorganisation, and the necessary enabling powers are already included in current legislation.

In accordance with national legislation, NHS England (and its Area Teams) will in all parts of the country continue directly to discharge specific primary care responsibilities, including in respect of community pharmacy, primary dental and ophthalmic services, as well as certain responsibilities in respect of primary medical services.

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Northern, Eastern and Western Devon
Clinical Commissioning Group

Commissioning of Primary Care Services

NEW Devon CCG

Dr Paul Hardy
Clinical Chair
Western Locality

Background

Northern, Eastern and Western Devon Clinical Commissioning Group

NHS England

The Health and Social Care Act has brought about considerable changes to the commissioning of Primary Care Services

During the first year of CCGs there has been a level of frustration due to this fragmentation and the inability of CCGs to commission across the whole care pathway

More recently there has been an increased emphasis on the Primary Care Commissioning agenda as outlined in;
A Call to Action Primary Care Report – Phase 1
CCG Expressions of Interest – Co-commissioning Primary Care

Primary Care Call to Action – Why does general practice need to change?

Northern, Eastern and Western Devon Clinical Commissioning Group

NHS England

- **Demographics**: The population is growing and people are living longer. Those with more than one long-term conditions will rise from 1.9 million in 2008 to 2.9 million in 2018.

- **The GP workforce** is also ageing and insufficient graduates have been choosing General Practice over recent years. Numbers of GP's has grown at only half the rate of other medical specialties and has not kept up with population growth. More GPs are also working part time.

- **Outcomes:** There are variations in the general practice services that patients currently receive that impact on their care. There are growing challenges in relation to patient experience of access to care.

- **Financial constraints:** The NHS funding gap of £30 billion by 2021/22. Primary care potentially has a key role in helping reduce this gap by providing more personalised, accessible community-based services for patients to reduce avoidable pressures on hospital resources.

Wider primary care, delivered at scale

NHS
Northern, Eastern and Western Devon
Clinical Commissioning Group

NHS
England

- General practice will likely need to operate **at greater scale and in greater collaboration** with other providers and professionals, and with patients, carers and local communities.
- At the same time general practice will also need to preserve and build on its traditional strengths of providing personal continuity of care and its strong links with local communities. We need to remember **90% of patient contacts are in Primary Care** local to where people live.
- GP Practice populations as units of planning for services in communities.
- This does not necessarily have to involve a change in organisational form. It can be achieved through practices coming together in networks, federations or super partnerships, or as part of a more integrated model of provision.
- Developing a modernised Primary Care aligns with CCG strategies for shift of services into the community and maintaining people at home.

Meeting our ambition

NHS Northern, Eastern and Western Devon Clinical Commissioning Group

NHS England

- General practice, at its best, has been described as the jewel in the crown. But without change and without support it will not be fit for purpose or sustainable for the next decade.

- To support locally-led transformations in primary care, there is a focus at national level on seven main areas :
  i. Empowering patients and the public
  ii. Empowering clinicians
  iii. Defining, measuring and publishing quality
  iv. Joint commissioning
  v. Supporting investment and redesigning incentives
  vi. Managing the provider landscape
  vii. Workforce, premises and IT

Northern, Eastern and Western Devon Clinical Commissioning Group

NHS England

Co-Commissioning Agenda

	NHS England	CCG	LA	Specialist Commissioning
CAMHS	✓	✓	✓	✓
Primary care (medical, dental, pharmacy, eye health)	✓	✓	✓	
Frailty	✓	✓	✓	
Practice Nurse and Community Nurse Development	✓	✓		
Strengthening the voice of the public in commissioning processes	✓	✓	✓	✓

Northern, Eastern and Western Devon Clinical Commissioning Group

NHS England

Co-Commissioning for Quality

	NHS England	CCG	LA	
Safeguarding Children & Adults	✓	✓	✓	
Sepsis	✓	✓	✓	
Tackling variation in Primary Care	✓	✓		
Learning from Significant Events in Primary Care	✓	✓		

Local Primary Care Co-Commissioning Initiatives

Northern, Eastern and Western Devon
Clinical Commissioning Group

- Establishment of the Peninsular Primary Care Commissioning Oversight Group (PCOG) Membership: AT, CCGs, LMCs, PHE
- Successful Peninsula bid for the Prime Minister's Challenge Fund. (£3.5m to pilot innovative access to GP Services)
- Appointment of chairs for the Pharmacy, dental, eye health Local Professional Networks (LPNs)
- Implementation of each LPN and agreement of annual work plan

Co-Commissioning Expression of Interest

NHS
Northern, Eastern and Western Devon
Clinical Commissioning Group

NHS England

- NHS England have recently announced that "Clinical Commissioning Groups will get new powers to improve local health services under a new commissioning initiative"
- That means giving local CCGs greater influence over the way NHS funding is being invested for their local populations
- Rather than specifying a one-size-fits all solution, NHS England are keen to hear from CCGs themselves about what next steps they would like to explore.
- CCGs must submit the Expression of Interest by the 20th June and take into account the views of stakeholders

Co-Commissioning Expression of Interest

Northern, Eastern and Western Devon Clinical Commissioning Group

NHS England

The Expressions of Interest should include information on the following areas:

- **At individual CCG or group of CCGs level?**
- **Intended benefits and realisation** e.g. fit with 5 year plan
- **Scope**, specific areas CCG want to take responsibility for
- **Nature of co-commissioning**, including proposed joint commissioning
- **Governance**, safeguards to manage conflicts of interest
- **Monitoring and evaluation**
- **Engaging Member Practices and Stakeholders**

Further information on the areas identified above is contained in the attachment CCG Co-commissioning letter.

HEALTHY PEOPLE
living healthy lives
in healthy communities

NHS

Northern, Eastern and Western Devon
Clinical Commissioning Group

Integrated, personal and sustainable

Foreword

We have a tremendous opportunity to help people improve their health and wellbeing, maintain their independence, and experience more appropriate care outside of large and busy hospitals and closer to - or in - their homes and communities. *Integrated, personal and sustainable: community services for the 21st century* sets out our proposed direction for community services and invites your views on this.

This strategic framework exists within the pillars of the Clinical Commissioning Group's overarching strategy. It is also in the context of our co-commissioning of primary care; the role of General Practice as the organising unit of care and our work with local authorities to advance integration of health and social care.

During the last year we have heard from hundreds of people about what they think is most important about community services - what is good now and what could be better. We have heard from patients, carers and communities – we have heard from bodies and organisations that represent them – and we have heard directly from senior and clinical leaders in health and social care. This has greatly influenced our thinking.

What is clear is that community health, and integrated health and care services, are highly valued. They are also ideally placed to make an impact on the whole pattern of care, shifting the emphasis of services - from acute to community settings, from hospital to home, and from care delivery to prevention of ill health. This is what people want to see, a change to the way services are delivered.

Advances in care mean there are more possibilities than before to improve, maintain and recover health. At the same time the age of the population is rising as is the complexity and scale of health need. Austerity is a reality - money is limited and costs are ever increasing - so we need to make every pound count. And, in doing so, we must keep improving quality and experiences of services.

Now we are translating many of the local views and insights we have heard so far accompanied by our understanding of health needs and information from national and local policy, into a proposed way forward - so that we can and do achieve integrated, personal and sustainable community services which are right up to date.

Getting this right requires a partnership approach. Community services benefit from the commitment of staff, carers, leagues of friends, a range of volunteers and many others. We see these existing vital partnerships - and new ones to be established with communities - as pivotal to the development and design of future services.

We would welcome your views and comments. We know future plans and services will be even better and stronger as a result. Thank you.

Dr Tim Burke
Chair, NHS NEW Devon Clinical Commissioning Group

Rebecca Harriott
Chief Officer, NHS NEW Devon Clinical Commissioning Group

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21st century community services for individuals, families and communities

Facts about us

- We are the largest CCG in the country
- We have an overall budget of £1.1 billion
- We serve a total population of 898,523
- We cover a total area of 2,330 square miles
- Our CCG chair is **Dr Tim Burke** and there are three locality chairs:

  North Devon – Dr John Womersley

  East Devon – Dr David Jenner

  West Devon – Dr Paul Hardy
- Our Chief Officer is **Rebecca Harriott**

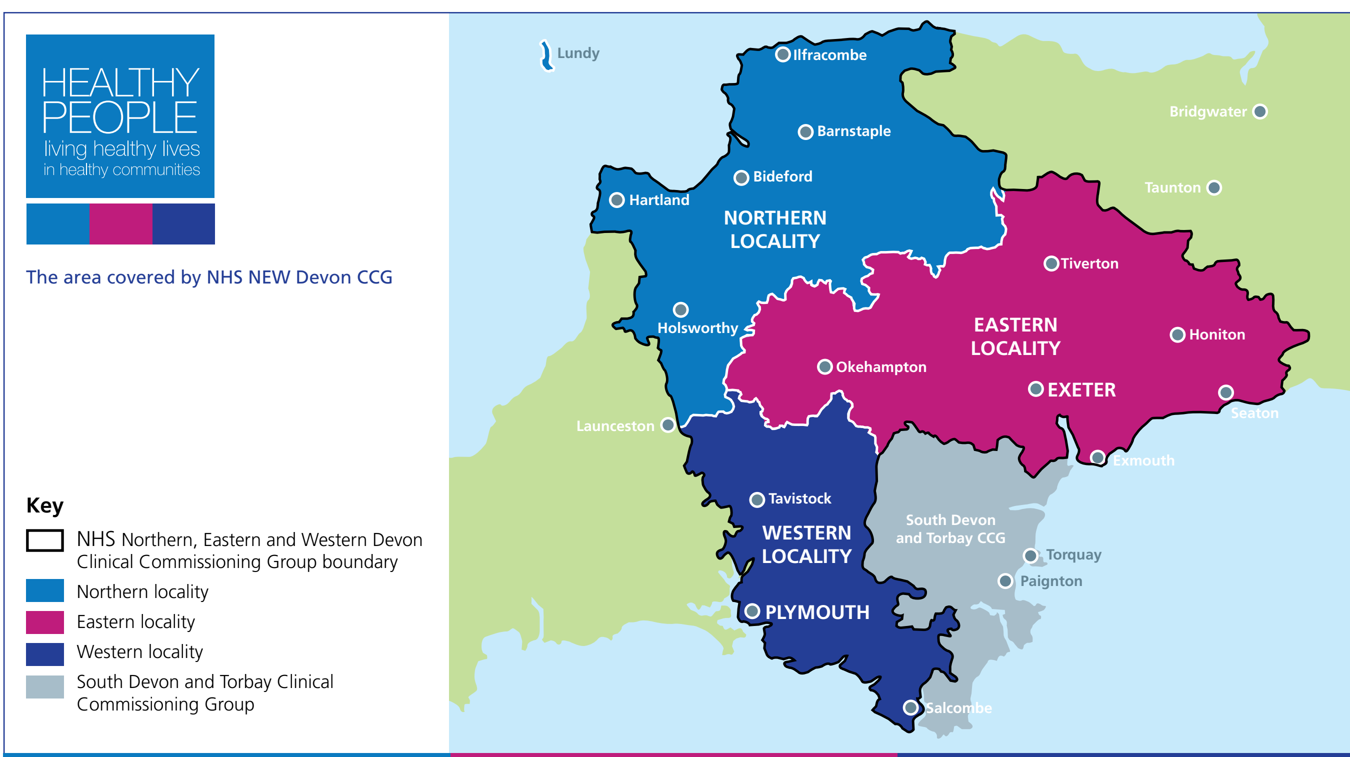
This strategic framework has been developed for the areas of Devon that are covered by NHS Northern, Eastern and Western Devon Clinical Commissioning Group, which leads the commissioning of the majority of local healthcare. Approximately 11per cent of the overall £1.1 billion resource is spent on community services - those health and integrated care services that take place in or close to people's homes and communities. Community services have a key role now and in the future.

As we look ahead we want to build on the many strengths of current services and to develop them further so that they can and do stand the test of time. This is why we have engaged so many local people in thinking about their future – and why we are checking our proposed way forward again through 'Integrated, personal and sustainable: community services for the 21st century'. We know that there are important decisions to make now to set the path for the coming years.

In addition to our local engagement there is national policy and guidance that is relevant to community services. This sets a direction of clear and simple pathways of care, focusing on outcomes and quality for patients whilst achieving the efficiency and effectiveness that will enable sustainable care and support.

Community services are of course part of a much wider system of health and social care and in looking at community services we have also been paying attention to this. The role of General Practice, the value of connections with acute and specialist healthcare, the possibilities for extending the integration of health and social care, the role of all agencies in adopting a greater health and wellbeing focus - have all been at the centre of our thinking.

In this framework we describe how community services could be, an approach to making this happen, and the inputs that will be needed to make a difference. We also set out the important experiences that people should be able to expect as a result of this work, and a number of guiding principles that have been identified as important.



The area covered by NHS NEW Devon CCG

Integrated, personal and sustainable - how this could be

People told us they wanted 'healthcare which does not stop at the boundaries', services that 'see me as a person, not a condition' and 'safe and secure services with future proofing in mind'. These and many other views and insights set a vision for 'integrated, personal and sustainable' community health and integrated health and care services. These views also framed the following six strategic priorities.

Help people to stay well

As well as a focus on caring we would expect the emphasis of community services to move increasingly towards prevention and maintenance of health. This includes recognising the importance of support for people with complex needs to help them to live well and to maintain independence.

Integrate care

The need for care and support to be wrapped around individuals and their families has been stressed time and again in local discussions. This means we would expect services to be joined up and integrated - removing and minimising the impact of organisational boundaries on great care.

Personalise support

Personalisation, choice and control over individual care was highlighted as important. Personalisation includes, and is much more than, personal health budgets and means advancing a flexible model of support which can increasingly be tailored to individuals.

Co-ordinate pathways

The value of pathway-based approaches to care with co-ordination through prevention to crisis and ongoing care has been identified time and again. This includes paying particular attention to pathways which reflect the natural flows of patients through different health and care services.

Think carer, think family

The key role of carers and the need to support carers' health and wellbeing - in addition to that of patients and the population is essential as more services are focused in people's homes and in the community. We want to commission mainstream services which are fully carer-aware.

Home as the first choice

There is growing understanding of the need to shift the model of services with less inpatient beds but a greater number of more responsive care packages at home. There is now a clear impetus for action to progress this at an early point to enable new models of community services to develop.

A shared direction

Over the last year in Northern, Eastern and Western Devon we have been:

- Listening to views of patients, carers, communities and their representatives
- Engaging with clinical and senior leaders involved in health and social care
- Reviewing needs, evidence and other details relevant to community services

This has been central to our community services programme which is designed to set the direction and delivery arrangements for the future - so that community services can and do realise their true potential for individuals, families and communities.

We are now ready to propose a way forward. *'Integrated, personal and sustainable: community services for the 21st century'* is a summary of extensive work on community services. A more detailed document and further information is available on https://www.newdevonccg.nhs.uk/involve/community-services/101039.

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Designing community services for the population - how this could be

Community services are those services which take place at home or nearby. They include nursing care and support, multi-disciplinary and integrated teams that help people with complex needs and a range of clinical and other services in community hospitals and local care settings. There are many good services but we know that more can be achieved if community services are to realise their true potential.

The latest health and wellbeing profile for NHS NEW Devon CCG shows that compared to England there are:

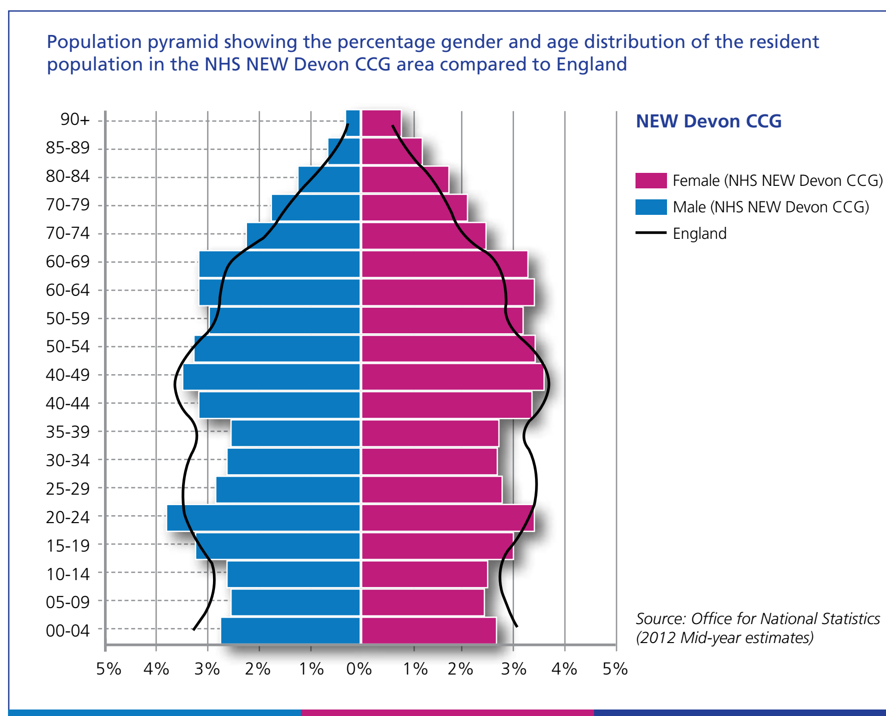
- Fewer children below age of 14
- More young adults aged 20-24
- Fewer working age adults 25 -50
- More older adults over age 60

The proportions of older adults are already higher than England and rising. By 2021, the population in the NHS NEW Devon CCG area is expected to grow by 6 per cent with a 9 per cent rise in 60-74 year olds and a further 26 per cent increase (over 22000 people) in those aged 75 and over. There are new houses and communities being developed too. We need to plan ahead.

Social isolation is an issue raised in many conversations and we know that in both urban and rural settings this can be a real issue, especially for older people. This can impact on health and wellbeing. Community services of the future have a role towards addressing this.

'As more people live into older age we need services which support people to remain as well as possible for as long as possible in their own homes and communities. The ambition is to increase the healthy years of life and reduce the social isolation.'

NHS England chief nursing officer



Locally relevant plans

In looking ahead, it is essential that we plan and prepare now for an increasing older population and their carers.

Age can bring an increased complexity of physical and mental health needs and frailty affecting the pattern of services required - especially in the oldest age groups.

We know that already people over 65 years in the NHS NEW Devon CCG area account for 72 per cent of all unscheduled days in a hospital bed (this is 10 per cent higher than the rest of England).

We also know that the impact of aging in the population is likely to bring an increase of up to 2 per cent a year extra activity in already busy acute hospitals locally.

Local Public Health audits have shown that around one third of people in community hospitals were fit and waiting for discharge.

Yet many older people would prefer to be at home. We need to plan and design services that will support this with home as the first choice for care.

Achieving the best from national and local policy - making it happen

There is a wealth of national and local policy which sets the foundations for excellent services - achievable even in the face of rising needs and the realities of financial austerity. The best care is not always the most expensive care. There is increasing evidence and examples of improving services for people while strengthening quality, efficiency and effectiveness too. This is how we can make it happen.

Integrated

We are already well on the path to integration of health and social care in Devon and Plymouth. The national Better Care Fund announced in 2013, is a pooled health and social care budget and is a helpful catalyst for taking this integration to the next level.

Starting this year and scaling up from 2015/16 onwards this is set to unlock the true potential of 'out of hospital' care and therefore community services - and to positively shift resources to where they can bring most benefit.

Locally we are looking to this pooled fund to enable integrated multi-disciplinary teams in each locality, to strengthen home care and to move more care out of hospital.

Personal

The King's Fund's recent review of community services in England described the important role of these services in transforming care. The report noted a range of changes are necessary including: simplifying community services; building multi-disciplinary teams supported by new models of specialist input; and reaching out to the wider community to improve prevention, supporting isolated people and to create healthy communities.

Our local engagement reflected the value of services that are tailored to enable personalised approaches to care and support.

A view from here

Views gathered through local engagement in community services compare well with national and local policy direction.

Hundreds of people took part in discussions over the last year including:

- Attending local health summits to directly give their views
- Joining focus discussions such as a long term conditions event
- Participating through bodies that represent a range of groups
- Joining senior leaders in events and workshops
- GP Member Practice and clinician to clinician discussions.

We heard that: prevention services are as important as crisis services; the person needs to be put first; we need to remember personalised care is not - one size fits every person. Further information is available on:

https://www.newdevonccg.nhs.uk/involve/community-services/101039.

Sustainable

Creating services that are strong and ready to stand the test of time is of utmost importance. It is recognised that change cannot wait and we need to prepare now for quality and affordable services in the future. Community services have a clear part to play in responding to the growing scale and complexity of needs, and in shifting from a focus on buildings to designing services around people - and engaging communities in sustainable services.

'...it is more important than ever that commissioners, providers and citizens are open and honest with one another about what can be achieved and work together to find solutions.' Think Local, Act Personal Partnership.

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Preventive and personalised support - making it happen

Making an impact

The management of complex long term conditions needs to happen every day at home and in the community to help people to live well. This needs a new approach by all services to 'make every contact count' and embed prevention into day to day activities.

Thinking differently

'We need pathways which start and end with wellness'

Outcomes

- Enhancing quality of life for people with long term conditions and care and support needs
- Helping people recover from episodes of illness
- Reducing emergency admissions to hospital and delayed discharges from hospital.

Community health and integrated health and care services are ideally placed at the heart of communities to tailor care and support services to the people who use them; and to harness the true power of communities in wellbeing, the maintenance of health, and mobilising community assets to support people to live well and at home.

Many more people are living with one or multiple long term conditions and complex health needs. In this section we are focusing on targeted support to prevent or delay deterioration of health and wellbeing, address heath inequalities and reduce the risk of admission to hospital or residential care. This will need the following key changes:

- Change the way facilities are used, with some community hospitals becoming hubs for health and wellbeing rather than maintaining their traditional inpatient focus. This new approach would bring more prevention, wellbeing and pro-active support into localities
- Develop personalised care planning for people with complex needs which include plans for prevention, self-management and support to maintain independence and, wherever possible, avoid a crisis
- Establish a framework for services that enables increasingly flexible and bespoke support so that individuals can be more in control, including through personal health budgets as these become established
- Build on existing targeted services that support people at high risk through information, self-management, 'making every contact count' towards prevention and establishing named clinical leadership throughout the whole pathway of care
- Use technology effectively to enable preventive and personalised support. Bring this into mainstream services where the benefits of technology are known and are relevant to the needs being addressed.

To fully make a difference to community wellbeing, particularly in the older age groups, there are real benefits in harnessing the power of communities. We want to explore innovative opportunities with communities as a key part of taking this programme forward.

Pathways for people with complex needs - making it happen

Making an impact

NHS England advocates a pathway approach especially for older people who are most likely to suffer problems with co-ordination of care and delays in transitions between services.

Thinking differently

'See me as a person - not as a condition'

Outcomes

- Enhancing quality of life for people with long term conditions and care and support needs
- Helping people recover from episodes of illness
- Reducing emergency admissions to hospital and delayed discharges from hospital
- Improved patient and service user experience.

With more people living with multiple long term conditions and complex needs, it is essential to design the right model of care and treatment. It is increasingly recognised that all elements of care and organisations providing this are interdependent and that services and a pathway approach will achieve the best outcomes and reduce or avoid fragmentation and gaps in care that are sometimes experienced.

As well as personalised and preventive approaches to pro-active care already described, the pathway addresses help in a crisis and ongoing care with a focus on much of this care being community based and helping people to remain at home or nearby. We propose the following key changes:

- Create a model of service that offers a robust alternative to hospital stays both in preventing admission and reducing length of stay with effective community interventions including early specialist assessment when necessary
- Establish clinically led integrated multidisciplinary teams wrapped around a cluster of general practices that have a role in the whole pathway extending the skill base of teams to support more people out of hospital
- Design a small number of strategically located enhanced community hospitals, offering clinical assessment, inpatient care, outpatient care and diagnostics to enable more people requiring hospital appointments or admission to receive this in the community
- Arrange a consistent approach to supporting people living in care homes when they need healthcare to help them to remain in their care home where possible, rather than being moved or admitted to hospital
- Ensure strong co-ordination of the pathway with mental health expertise, particularly in the care of older people with dementia and other mental illness who require physical healthcare; and similarly with end of life expertise.

There are a number of local examples of strengthened community services including hospital at home, the development of local specialist clinics, and the use of technology to reach out to people at home. We want to build on the current work of complex care teams and see health and social care teams as part of a co-ordinated pathway within each locality geography.

Urgent care in the community - making it happen

Urgent care in community settings needs to be a consistent, high quality and resilient service which can be and is used as a first choice for routine urgent care. As part of a wider network of expertise it needs to be designed so that the majority of patients can be seen, treated and their care completed in a single attendance.

People with urgent needs can be supported in a range of ways. National review information indicates that patient priorities include: quick access and simplicity, being in control, and local services which are high quality and safe. Yet the reality is often an unclear system with variations in terms of service, name, location, opening hours which is thought to be increasing overall urgent care demand all over the country. In the NHS NEW Devon CCG area we propose a redesigned model with the following key changes:

- Facilitate prevention and a range of approaches to take services to patients including the use of technology, home visiting and other routes to accessing urgent support such as NHS 111 and near patient testing
- Establish a small number of hospital-based urgent care centres, replacing the current pattern of minor injuries provision, where possible within 30-40 minutes' drive time of communities accompanied by appropriate outreach support. Different approaches would need to apply in rural and urban centres
- Align the urgent care centres with primary care out-of-hours services including co-locating these on the same site where this is achievable, ideally linked with other facilities such as x-ray, to deliver a more comprehensive community service
- Arrange expert senior clinical leadership of the community service within the urgent and emergency care network arrangements in each locality plus shared information technology; protocols and governance for the most effective care.

This is a very different community model from that presently in place in that it enhances urgent care outside of large hospitals, and does this in a way which is connected to emergency and urgent care expertise to bring a convenient and reliable service that meets the needs of our population.

Making an impact

NHS England highlighted four improvements in urgent care: consistent, high quality and safe services; simplicity which enables good choices by patients and clinicians; right care in the right place with the right skills; efficient delivery of services.

Thinking differently

'I want healthcare which does not stop at the boundaries'

Outcomes

- Right care, first time with care completed in one visit
- Reducing emergency admissions to hospital
- Patient and service user experience.

Community specialty services – making it happen

Making an impact

We propose an in-depth piece of work designed to map the full scope of these services in Northern, Eastern and Western Devon.

It will also engage with professionals, commissioners, clinicians, patient and stakeholder representatives to consider current and future needs, the opportunities and challenges ahead and the relevant policy frameworks. This will provide a basis for proposing the strategic direction and future pathways for these services.

Outcomes

- Reducing emergency admissions to hospital and admissions to care
- Effectiveness of reablement
- Patient and service user experience.

There are a whole host of community specialty services. These are typified as those uni-professional services that take place in clinics or home. They particularly support people who may be vulnerable due to age, whose conditions require more specialist input. Working with patients in the community and linking with all parts of the health and care system, these services have an important role.

Specialty services include services such as: podiatry; tissue viability; musculo-skeletal physiotherapy; bladder, bowel and pelvic floor services; specialist nursing such as cardiac nursing and others. Generally, these services have many distinct individual features while also some core features in common including:

- Their role in supporting individuals who require specialist professional input due to specific needs from a patient group who are also often vulnerable due to age, long term conditions or following an episode of ill health
- Some services are small in volumes but complex in the nature of what is delivered, for example chronic fatigue services. Co-working in a networked approach with other specialty, acute, primary and community services is essential to assist the small resource to spread further
- The ethos of promoting and maintaining health and wellbeing is important in these services and most have established education strategies and support arrangements to reduce the impact of risk behaviours on the individuals themselves and others.

It is important these services are taken into account in this community service programme.

We will be undertaking further co-production work to look at these services in more depth. This will take place from the point of publishing this document and with a report on initial proposals available in July 2014.

INTEGRATED, PERSONAL AND SUSTAINABLE

A new model of care - making a difference

This programme builds on the strengths and proposes change to improve community services. It is centred on getting care in the right place at the right time and to the right standard for individuals, families and communities. It covers personalised and preventive support, pathways for adults with complex needs, community urgent care and specialty services in the community. The notes below describe some of the differences we would expect.

Community hospitals

Community hospitals/local care centres have an important role in the future although we expect this role to be different.

We see a number of hospitals becoming hubs for health and wellbeing - largely without beds but with a range of innovative services including clinics, prevention and wellbeing support, tailored particularly for people with complex needs.

We see a small number of others as clinical care facilities that offer enhanced outpatient services such as urgent care and diagnostics; with inpatient care consolidated into fewer settings than at present. Some may provide more specialist services.

In progressing change of this nature as it is agreed in principle, we would wish to discuss detailed implementation with primary care, providers, clinicians, partners and communities.

At home: integrated care and support every time

Home - and a person's own bed - becomes the focal point of care. Fully integrated multi-disciplinary teams - supported by specialists working in a co-ordinated way - enable more people to remain in their own homes and with the right mix of care and support in communities to achieve this. The role of district nursing, therapists, clinicians and others reflects latest national policy and skills are deployed to maintain more people at home. Learning from current successes - such as hospital at home and complex care teams - enables the spread of this learning and rapid implementation.

In each community

New partnerships in communities become established - beyond health and social care. These partnerships involve patients, primary care, community leaders, the voluntary sector, local charities and business. They also include other key departments and agencies at a local level for example education, police, fire and rescue services. They focus on harnessing the assets and power in communities to shape future care. In some areas community hospitals will also change their role to community health and wellbeing hubs while in others a more networked approach may be developed.

In each locality

The model of urgent care and pathways for adults with complex needs includes a range of Better Care Fund schemes and the development of a small number of strategically located enhanced clinical and integrated care facilities across the geography. This would bring more care out of busy acute hospitals and nearer to people's homes - and work to current day quality standards and outcomes. Strong networks and connections reflecting patient flows would support this.

Supporting future change - making a difference

To support change and transformation we need to take into account a range of important factors. These include: quality standards, the money, the workforce, technology and facilities for services, the actions and governance which will achieve transformation and the support during the period of transition to maintain quality safe services in the interim.

Quality and outcomes

There is something very powerful in describing community services as the 'golden thread' which holds seamless and high quality pathways together. Involving communities in defining this high quality can enable services and their delivery to reflect the experiences and outcomes that are important to people. Our engagement in co-production has helped us to progress this with six strategic priorities as described earlier. We have also been developing principles and experience outcomes to act as a guide to commissioning decisions.

The money

We spend 11 per cent of our commissioning resource on community services and the Clinical Commissioning Group has stated in its 2014/15 plan that the proportion of spend on community care and support will increase, showing a commitment to this model of care. However, as we all know, costs are rising and pressures on care are greater so we need to make every pound count. Add to that the fact that the local health economy is identified as one of 11 challenged communities nationally in relation to financial sustainability, anything new we do must, of course, be affordable.

Community services workforce

The workforce is central to the delivery of good care and we would wish to engage and work with the many community services clinicians, professionals and staff in the detailed design for the future. There is a need to consider new guidance and policy such as: the exciting developments in nursing roles; the benchmarks and staffing levels that will be required for the future; and the most effective ways of maintaining workforce skills. New models of care will bring new opportunities for skills development in the areas of wellbeing and prevention as well as clinically enhanced care.

The role of facilities and technology

During the stakeholder engagement phase, we were urged to make the best use of community hospitals and this framework aims to achieve this by thinking differently about the role of these important facilities. The clinical commissioning group does not own the buildings but would wish to see them used imaginatively and will work with providers, property services and communities in relation to this.

Technology is another feature yet to be fully embraced. Access to patient records by different teams, remote consultations, alarms and sensors to assist people at home, electronic appointment bookings, and many other developments all bring possibilities. We will be interested in innovative approaches to the use of technology in the delivery of effective home based and local care.

Towards a future pattern of provision

In addition to preparing community services for the future, we need to consider the arrangements for their provision. These arrangements will need to deliver the ambition of integrated, personal and sustainable care and support already described. Our proposed pattern of provision from 2015/16 until 2018/19 is described here for each of the making it happen sections of this framework.

We want to give current and prospective providers, local authorities, commissioners, key stakeholders and the public locally an opportunity to express their views before decisions are made on procurement (contract award) approach at the meeting of the Clinical Commissioning Group Governing Body on 16th July 2014. We have used the sound basis of NHS Procurement, Patient Choice and Competition (no 2) Regulations and associated guidance by Monitor to underpin our approach.

Current community services contracts in the Eastern Locality, South Hams, West Devon and Plymouth in the Western Locality, are all due to end in 2015/16. We therefore must plan ahead for provision of services in these areas from 2015/16 until no earlier than 2018/19.

- It is clear that we need to design community services with integration high on the agenda. We are therefore committed to ensuring that the future pattern of provision supports our drive towards integration with both Devon and Plymouth local authorities
- Breaking down barriers and simplifying and streamlining care for patients, particularly older people, across a patient's pathway is also crucial. We are therefore proposing to commission patterns of provision centred on locality geographies where appropriate for maximum care pathway co-ordination
- There are clear benefits of enabling enhancement of community services through clinical specialist input so that more care can and does take place outside of large hospitals. This requires taking positive steps working with the acute sector to maximise the shift of care to community settings
- We need to start now to fundamentally re-design towards a sustainable system that is centred on, and extends beyond, traditional health and social care. This includes adopting approaches which harness the power of communities and the voluntary sector and positively enable personalisation and flexible provider responses to flourish.

Towards a future pattern of provision

Personalised and preventive support

This is a developing set of services that will promote greater flexibility and innovation. We propose a competitive approach to facilitate a range of providers including the community and voluntary sectors to best serve needs.

Services for adults with complex needs

Integration and co-ordination of services with clear pathways of care centred on natural locality geographies. This underpins a no-competition proposal for these services, and re-procurement in each locality geography.

Community urgent care services

For community urgent care services we are proposing competition to achieve an alliance approach to harness the range of relevant expertise into a single arrangement for Northern, Eastern and Western Devon.

https://www.newdevonccg.nhs.uk/involve/community-services/101039.

Next steps and your views

Starting now we will:	In the first 12 months we will:
Communicate the contents of 'Integrated, personal and sustainable: community services for the 21st century' widely and invite and obtain feedback on the proposed direction for services by 8th July 2014.	As we know there is a clear impetus for action we will ensure an early focus on implementation on areas already in progress and also on more specific options and proposals as these are developed and agreed.
Engage local Health and Wellbeing Boards and local Healthwatch in Devon and Plymouth and consult with Devon Health and Wellbeing Scrutiny Committee and Plymouth Scrutiny Committee.	Some work is well advanced already and we are working with a number of communities to shape new models. This co-production will continue to develop, grow and guide local change in relation to this framework.
Further involve clinicians, commissioners, partner organisations, providers and their staff particularly through engagement of CCG localities, member practices, clinically focused care design groups and local authority colleagues.	Advance our work with local authorities on integrated health and wellbeing, commissioning and delivery to progress the model of integration Northern, Eastern and Western Devon.
Engage key groups who have an interest in this work including: carers, lay and professional stakeholder reference groups, council members, the voluntary sector, equality contacts, safeguarding leads and others.	Implement changes already underway with the support of communities, including the first of the new Health and Wellbeing hubs that are currently being designed.
Conduct in-depth work during the period between now and 8th July 2014 in relation to the contents of this framework including outcomes, impact assessments and the proposed approach to future provision.	Work towards early release and shifts of resources from current to new models of care with a clear and transparent programme, implementing this from the second half of 2014/15 and through 2015/16.
Review responses and decide the next steps towards 'Integrated, personal and sustainable: community services for the 21st century' at the Clinical Commissioning Group Governing Body meeting on 16th July 2014.	Progress the work to achieve sustainable delivery of services once decisions are made in July 2014 regarding the scope and nature of contract award processes.
In relation to future work as regards specific proposals we will begin a staged programme of publication - between June and September - for each of the care sections and localities - each with an eight-week period for comment.	Act on other changes that reflect national policy such as advancing our work on personalisation and personal health budgets, implementation of the Better Care Fund and greater integration.

Principles that will act as a guide

Early on in this programme, we established a large stakeholder reference group bringing together leaders and clinicians to add their experience and expertise. Taking into account the initial public engagement, this group set out ten principles for commissioning of community services. These have since been interpreted as 'I' experience statements and provide a framework for improvement through community services.

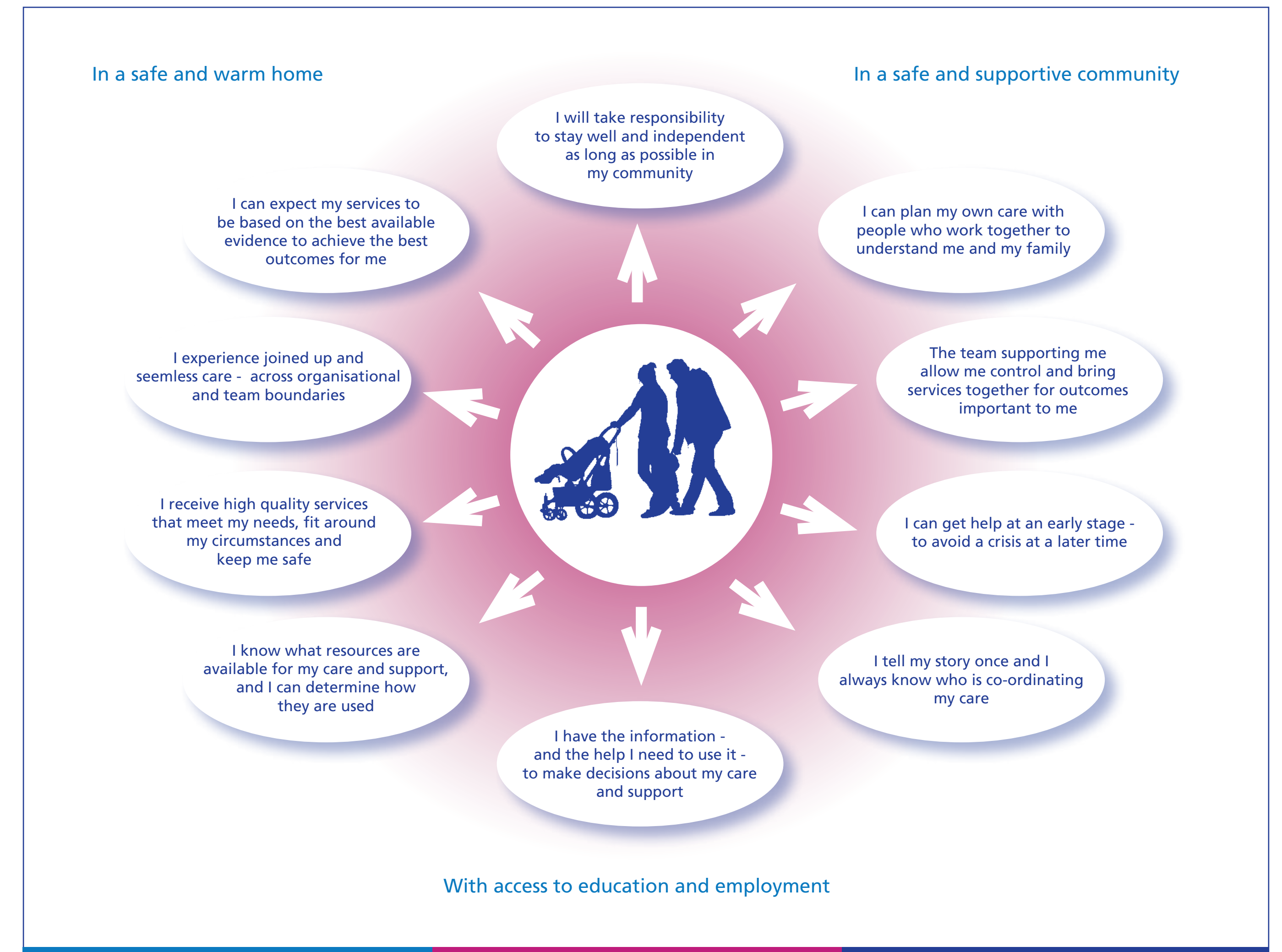
Community services commissioning principles

These principles will be an important marker to guide planning and decision making on the strategy and delivery arrangements for community services - and then at key milestone points in this journey of transformation so future services achieve the desired results:

- Integrated and seamless delivery
- Clear pathways and access
- Consistent outcomes
- Evidence-based foundations
- Individuals and carers at the centre
- Personalised and localised models
- Honest and open relationships
- Care which reflects health needs
- Sustainable, agile and flexible responses
- Shifts of resources and innovation.

Implications for experience

Built from these principles and the themes from engagement, these 'I' statements set out what individuals should be able to experience. They were developed with colleagues in Devon County Council and Plymouth City Council, and South Devon and Torbay Clinical Commissioning Group. Localities have also developed more detailed 'I' outcomes to reflect specific locality priorities identified through engagement. All of this will guide our work.



Please tell us your views

We would like your views to share with the Clinical Commissioning Group Governing Body and locality boards. At this stage we are asking you to comment on a strategic framework. Our approach to local implementation will be through co-production and should it be required for a specific change, further engagement and consultation. This means there will be opportunities to influence community services as more specific details become available.

Our questions for you

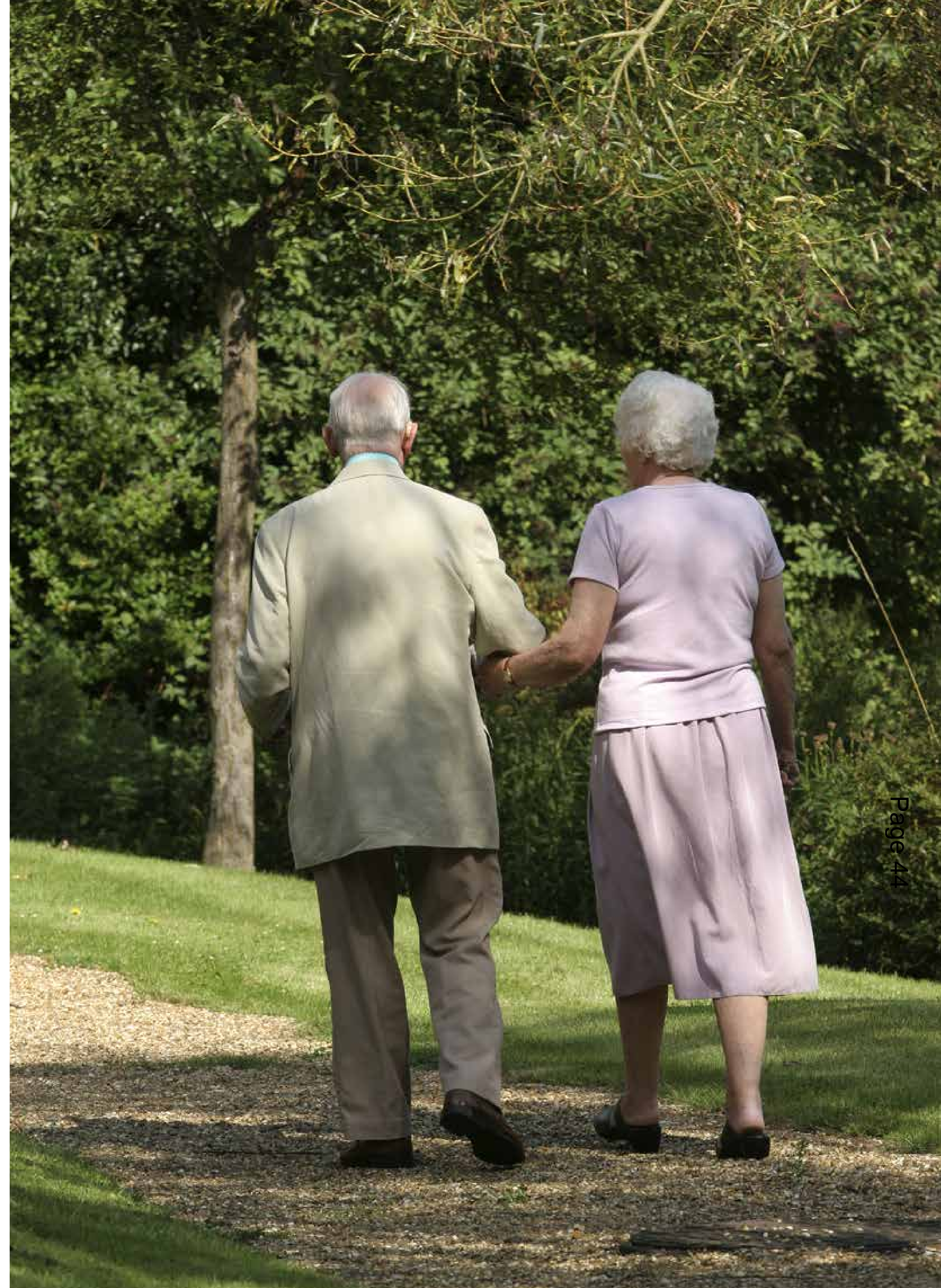
General questions:

- What are your views on the direction of travel?
- What are your views on the level of ambition in this framework?
- What do you like most about the proposed way forward?
- What is your main concern about the proposed way forward?

We would particularly welcome your responses to these questions for the framework overall as well as in relation to the following sections:

- Preventive and personalised support
- Pathways for adults with complex needs
- Urgent care in the community
- Community specialty services
- Towards a future pattern of delivery

When and how to comment	
When?	Anytime during the eight weeks from now until 8th July 2014 - although it would be helpful if we could have your comments as early as possible in this time period.
How?	There are a number of ways you can comment: Fill in the online form on https://www.newdevonccg.nhs.uk/involve/community-services/101039 or send an e-mail or written response to:
	Community Services, NHS NEW Devon Clinical Commissioning Group, County Hall, Topsham Road Exeter, D-CCG.Community@nhs.net
	Telephone one of our community relations managers to discuss your views by contacting Keri Ross on 01392 267680 or Sally Parker on 01752 398737
	Join in meetings or focus discussions that will be held over this time period as published on https://www.newdevonccg.nhs.uk/involve/community-services/101039
Need any help?	If you need this document in a different format or language then please let us know using the contact details above.



Integrated, personal and sustainable

May 2014

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Community Services

HEALTHY PEOPLE
living healthy lives
in healthy communities

NHS
Northern, Eastern and Western Devon
Clinical Commissioning Group

Integrated, personal and sustainable

Building on strengths

- ✓ Clinical, professional and care staff commitment
- ✓ Extensive community support
- ✓ Work of leagues of friends and volunteers
- ✓ Progression to integration of health and social care
- ✓ New and innovative projects already in place

A view to the future

Six priorities built from engagement

Help people to stay well
Integrate care
Personalise support
Co-ordinate pathways
Think carer, think family
Home as the first choice

I want healthcare that does not stop at the boundaries

See me as a person not a condition

Carers are vital

Context for change

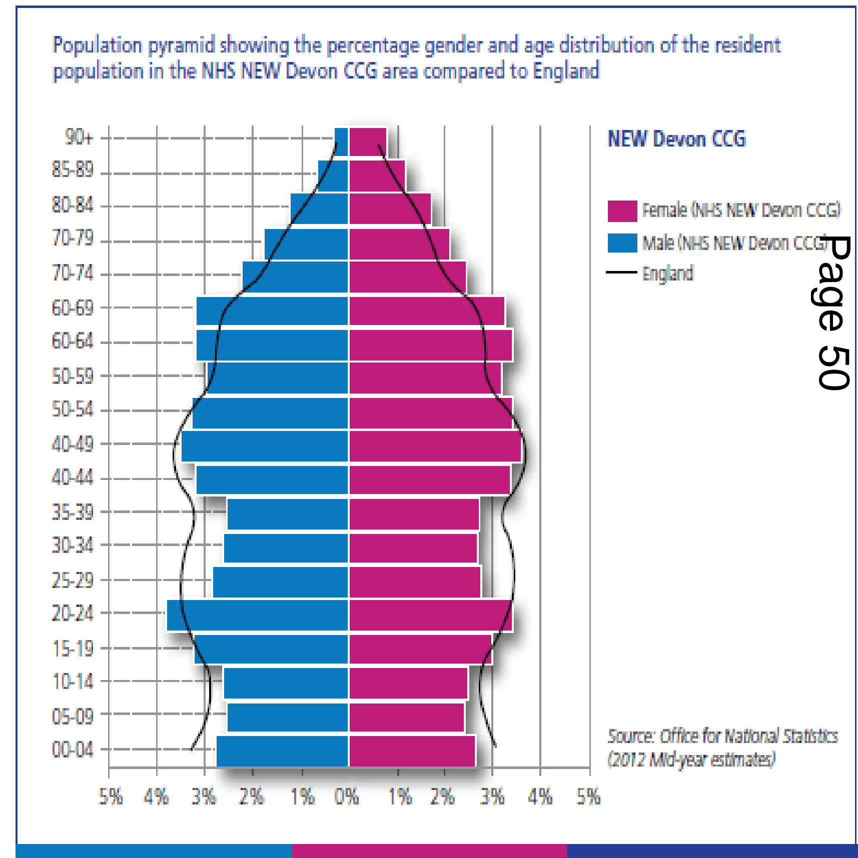
Population is getting older

Greater complexity of needs

Out of hospital care is achievable

Sustainable services important

People and policy signal change



Preventive and personalised support

Hubs for health and wellbeing

Personalised care planning

Personal health budgets

Pro-active care for high level needs/risk

Technology and communities

'We need pathways that start and finish with wellness'

Pathways for complex needs

Out of hospital model of care

Clinically –led multi-disciplinary pathway teams

Enhance small number of community hospitals

Co-ordination, consistency and links to wider expertise

'See me as a person – not a condition'

Urgent care in the community

Clear, simple, easy to use urgent care

Uses early support when possible e.g. 111

Urgent care centres replacing current MIU model

Links to primary care services and wider networks

'I want healthcare that does not stop at the boundaries'

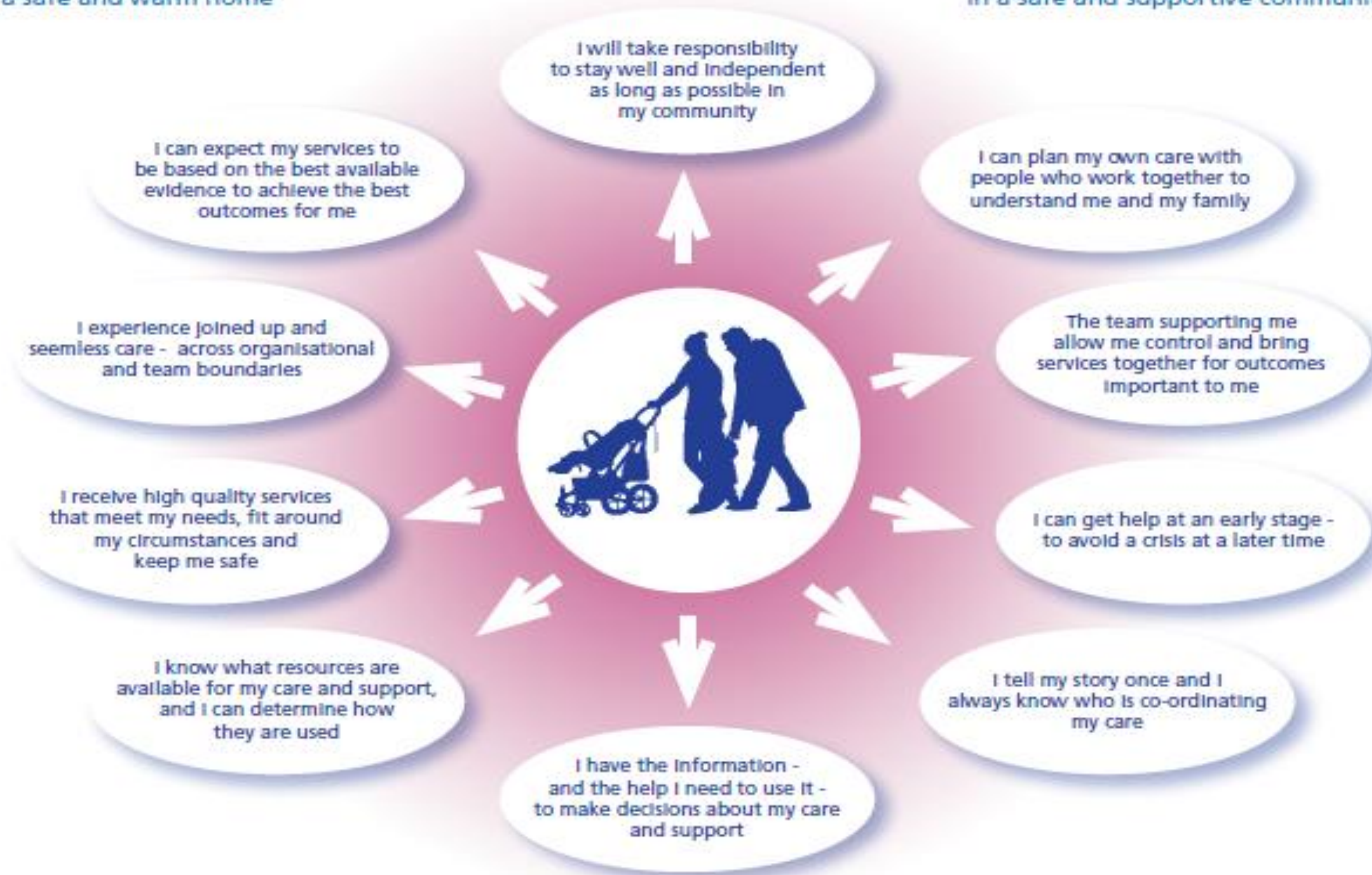
Community specialty services

Co –production to get future design right

Model for low volume and specialty community provision

Emphasis on health and wellbeing

Underpinned by Integration Principles



Next steps

- Views gathered until 8th July 2014
- Governing Body discuss on 16th July 2014
- Further more detailed engagement in period until Sept 2014

PLEDGE 90 – MENTAL HEALTH REVIEW REPORT

Final Report - March 2014

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1. ACKNOWLEDGEMENTS

This report has been developed in partnership with a large number of individual stakeholders and organisations.

Without the support of everyone involved it would not have been possible to create such a comprehensive and wide ranging document.

We would therefore like to extend our thanks to all who have contributed information, evidence, thoughts, and opinions to the Pledge 90 Review.

2. GLOSSARY

AOS – Assertive Outreach Service

ASC – Adult Social Care

ASD – Autistic Spectrum Disorder

BME – Black and Minority Ethnic

CAMHS – Child and Adolescent Mental Health Service

CMHT – Community Mental Health Team

CPN – Community Psychiatric Nurse

Glenbourne – Psychiatric inpatient hospital

Healthwatch - Independent consumer champion created to gather and represent the views of the public

HTT – Home Treatment Team

IAPT – Improving Access to Psychological Therapies

MHFA – Mental Health First Aid Course

NEW Devon CCG – North, East, West Devon Clinical Commissioning Group

PCH – Plymouth Community Healthcare CIC

PIPS – Plymouth Involvement & Participation Service

Plymouth Options – Plymouth's IAPT service

PMHPN – Plymouth Mental Health Provider Network

POD – Plymouth Online Directory

POS – Place of Safety Suite (Section 136)

PTSD – Post Traumatic Stress Disorder

SQIP – Mental Health Strategic Quality Improvement Partnership

3. BACKGROUND AND INTRODUCTION

In May 2012 Plymouth City Council announced 100 pledges around the 10 priority areas identified in the Corporate Plan. Pledge 90 was to 'Conduct a wide ranging review of the adequacy of mental health services and support in the city alongside local mental health providers and charities'.

The review was overseen by the Portfolio Holder for Public Health and Adult Social Care and the delivery of this pledge was a central theme of 'Caring Plymouth'.

A Key Stakeholder Working Group was established to lead the day to day implementation of the Review. This included key representatives from PCC Joint Commissioning Team, PCC Office of the Director of Public Health and the NEW Devon Clinical Commissioning Group.

As the review commenced it became clear that there was already a lot of information available and that the stakeholders and partners in the delivering or mental health services were wide-ranging with a lot to say. We therefore committed to ensure that we use as much information currently available to avoid duplication and ensure a comprehensive picture is pulled together in one place and we also committed to reaching out widely to as many people with an interest in mental health as possible.

This Pledge 90 Mental Health Review Report summarises a number of different documents that have been created as part of the review. The main elements include:

- Strategic Context
- Mental Health Needs Assessment Refresh 2013
- Performance
- Service User & Carer Views
- Community & Stakeholder Views

4. STRATEGIC CONTEXT

4.1 Introduction

This report provides a summary of the current national and local strategy and policy impacting on Plymouth Mental Health Services. It also discusses the current governance structures for commissioning decisions and how these are informed through the local mental health strategic partnership.

4.2 National Strategy

Over the last 15 years the national policy context around mental health has evolved and developed significantly. The wider social impacts, recovery ethos, preventative and personalized approach to delivering holistic services have become increasing important. This journey is described through these summaries of key policy documentation:

4.2.1 1999 - National Service Framework for Mental Health

The 'National Service Framework for Mental Health' set quality standards for mental health services. It stated what they should aim to achieve and how they should be measured. The NSF aimed to combat discrimination against individuals and groups with mental health problems, make it easier for anyone who may have a mental health problem to access services and create a range of mental health services to prevent or anticipate crises where possible

The NSF created defined mental health teams and services consistently across the country. Significant progress was made around the treatment of mental health problems with defined health commissioned mental health teams still forming the foundation of mental health teams and services today.

4.2.2 2009 New Horizons: a shared vision for mental health

This policy document recognised the progress made under the NSF but started to place more emphasis on individual recovery, wider determinants and preventative approaches. It set out the vision using key themes such as; prevention of mental ill health and promoting mental health, early intervention, tackling stigma, strengthening transitions, personalised care and innovation. Although quickly superseded in 2011 New Horizons set a new direction in mental health policy.

4.2.3 2011 No Health Without Mental Health – a cross government mental health outcomes strategy for people of all ages

Mental health is everyone's business. This strategy states, 'good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential.' At any one time, roughly one in six of us are experiencing a mental health problem. While that is a staggering figure in itself, we are also faced with the fact that mental health problems are estimated to cost the economy an eye-watering £105 billion per year. It states that the title of the strategy, No Health Without Mental Health, perfectly captures the ambitious aim to mainstream mental health in England. The commitment to achieving parity of esteem between mental and physical health services was clear throughout the document. This strategy remains the current mental health strategy. It has six key objectives:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support

- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

4.2.4 July 2012 – No Health Without Mental Health Implementation Framework

This document aims to translate the vision of 'No Health Without Mental Health' into reality by setting out 10 priorities for action:

1. Mental health has 'parity of esteem' with physical health within the health and care
2. People with mental health problems, their families and careers are involved in all aspects of service design and delivery
3. Public services improve equality and tackle inequality
4. More people have access to evidence-based treatments
5. The new public health system includes mental health from day one
6. Public services intervene early
7. Public services work together around people's needs and aspirations
8. Health services tackle smoking, obesity and co-morbidity for people with mental health problems
9. People with mental health problems have a better experience of employment
10. We tackle the stigma and discrimination faced by people with mental health problems

4.2.5 Health & Social Care Act 2012

The Health & Social Care Act 2012 fundamentally changed the health landscape, both in terms of commissioning and provision. Key impacts on mental health include:

- The transfer of the responsibility for Public Health to local authorities
- The creation of local health and wellbeing boards. The boards are statutory and lead on the development of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy. These boards are required to bring together key partners to ensure co-ordinated commissioning to secure better health and wellbeing outcomes, better quality care for patients and care users and better value for the taxpayer.
- Creation of Clinical Commissioning Groups – this new commissioning structure replaced the Primary Care Trusts in April 2013 and means that clinicians have lead responsibility commissioning of services.

4.2.6 National Outcomes Frameworks

There are three separate national outcomes frameworks for health, adult social care and public health. Together they provide a coherent and comprehensive approach to tracking national progress against an agreed range of critical health and social care outcomes. Although separate there is overlap across them reiterating the interdependencies of the three policy areas. The outcomes frameworks are not, as a whole disease-specific. They apply equally to mental and physical health (NHWMH, 2011). It is possible therefore to see how mental health policy and development is critical to the delivery of all of the three outcomes frameworks.

The outcome frameworks include generic measures that impact on mental health, e.g. all the wider determinants referenced in the PHOF impact on people with mental health issues and well as impacting on people's mental health. In the ASCOF "we know not only that some mental health problems are long term but also that the rates of mental health problems in people with long term physical illness are high. To improve quality of life for this group of people means that their mental health needs should be identified and met" (NHWMH, 2011).

There are also mental health specific indicators in each outcome framework which are reported in the Performance section of this report.

4.2.7 Preventing Suicide in England (DH, September 2012)

This strategy gives an expectation that key services, including mental health services will have a co-ordinated approach to recognising suicide risk and proactive processes for intervening and preventing suicide.

4.2.8 Care Bill 2013

The Care Bill was published on the 10th May 2013 and based on the White Paper Caring for our Future. It takes account of the Dilnot Commission Report into the funding of care and support and the Law Commission report to codify Community Care law into a single piece of legislation. The Care Bill is designed to create a new principle where the overall wellbeing of the individual is at the forefront of their care and support. It also places a new duty on Local Authorities to promote integrated care, mirroring the duties in the Health and Social Care Act 2012. The Bill makes it clear that this refers to; housing, health and social care delivery/commissioning and not just health and social care.

4.2.9 Welfare Reform

The Coalition Government has enacted a series of reforms to the welfare system, which are intended to make the system fairer, and support more people into work. The reforms include a simplification of the benefit structure, with the creation of the Universal Credit to replace a range of benefits and tax credits. The reforms also introduce a new Personal Independence Payment to replace Disability Living Allowance.

4.2.10 Closing the Gap: Priorities for essential change in mental health (DH, January 2014)

This document aims to bridge the gap between the Government's long-term ambition and shorter-term action. It seeks to show how changes in local service planning and delivery will make a difference, in the next two or three years, to the lives of people with mental health problems.

It therefore sets out 25 areas where people can expect to see, and experience, the fastest changes. These are the Government's priorities for action: issues that current programmes are beginning to address and where our strategy is coming to life.

Many are about mental health care and treatment, but others reflect the work done across the entire health and care sector, and indeed across government as a whole, to reduce the damaging impact of mental illness and improve mental wellbeing. In addressing these priorities, we will also continue to rely on the involvement of many partners across the voluntary sector – from national charities to local community groups.

4.3 Local Strategy

4.3.1 The Plymouth Mental Health and Well-Being Promotion Strategy 2011-2014

This strategy provides the framework for delivering improved mental health and well-being for the people of Plymouth. It emphasises the need for a whole systems approach involving all sections in the community.

4.3.2 Plymouth Mental Health Network Strategy – Whole Life Whole Systems

The strategy is called "Whole Life – Whole Systems". It focuses on the wide range of factors improving this city's mental health (work, housing, social contact) as well as the services available to provide specialist support. The strategy was developed by and with the local mental health community.

4.3.3 Improving the State of Our Minds – Emotional Wellbeing and Mental Health of Children and Young People in Plymouth (2009-14)

This five year joint commissioning strategy, which was developed in partnership across all agencies with supporting information/input from users and carers, aims to;

Improve all children and young people's mental health;

Develop a shared understanding and collective responsibility for children and young people's emotional wellbeing and mental health;

Ensure that agencies work in partnership to promote mental health, provide early intervention, and meet the needs of children and young people with established or complex problems;

Provide mental health care and support based upon the best available evidence, exceeds minimum core standards, is needs based and delivered by staff with the right range of skills and competencies.

4.3.4 Plymouth Health and Wellbeing Strategy (in development)

The Health & Social Care Act 2012 placed a duty on local authorities to lead a Health & Wellbeing Board (HWBB). One of the statutory duties of this board to develop a Health and Wellbeing Strategy.

In Plymouth the Portfolio Holder for Public Health and Social Care chairs the HWBB and the strategy is in development. The Strategy will use the JSNA to set priorities for the city that will clearly impact on the mental health sector and decision making. Initial developments indicate that mental health has been identified as a priority for the HWBS.

The Health and Wellbeing Board's vision is "Happy, Healthy, Aspiring Communities". The purpose of the Board is "To promote the health and wellbeing of all citizens in the City of Plymouth".

4.3.5 NEW Devon CCG Mental Health Commissioning Plan (in development)

This plan is currently in development. The strategy intends to be high level setting out national policy and direction of travel, and how locally this will be taken forward. The Pledge 90 Review will be key in informing local action against this strategy.

4.3.6 Commissioning Governance

Established in January 2012, the Joint Commissioning Partnership (JCP) is the central body for commissioning health and social care services in Plymouth. It is responsible for ensuring a coordinated and consistent approach to commissioning services on behalf of partner agencies. 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. Representation at the JCP includes Plymouth City Council (including Adult Social Care, Children Social Care, Community Safety, Social Inclusion, Director of Public Health), Police and Crime Commissioner, Clinical Commissioning Group and Probation Services.

The JCP has strong links with local partnerships and strategic groups ensuring the commissioning decisions are grounded and responding to the real time issues in Plymouth.

This Partnership provides a strong foundation for developments around more integrated and cooperative commissioning being driven by local and national policy.

4.3.7. Mental Health Strategic Quality Improvement Partnership (SQIP)

The Mental Health Strategic Quality Improvement Partnership (SQIP) is a crucial part of the 'strategic context' in Plymouth. The Partnership meets bi-monthly and is well attended bringing together a wide range of stakeholders. This includes:

- Providers - nominated through the local Plymouth Mental Health Provider Network to ensure comprehensive representation and communication of key issues.
- Service users and careers – again representing a wider group through PIPS,
- Commissioners across health and social care.

At a recent meeting it was agreed that more performance information would be provided at these meetings to help the MH SQIP identify key areas for further investigation with a detailed exploration of specific themes at each meeting.

4.4 Summary

Over the last 15 years the national policy context around mental health has evolved and developed significantly. The wider social impacts, recovery ethos, preventative and personalised approach to delivering holistic services has become increasingly important.

Within national strategy there is a clear intention to focus on transforming the way mental health services are commissioned, delivered and experienced with a particular emphasis on personalised approaches, earlier intervention and a shift towards greater use of community treatment.

In order to achieve the best outcomes from prevention and early intervention work it will be necessary to facilitate and develop integrated commissioning, provision and prevention.

There are 3 main local strategies currently driving activity in Plymouth across different elements of the mental health 'system' in Plymouth.

In addition the Health and Wellbeing Strategy (HWBS) and the NEW Devon Western Locality Clinical Commissioning Group Mental Health Commissioning Plan are in development and will hold significant influence going forward.

The Review has identified a well engaged and motivated mental health sector in Plymouth across providers, commissioners and service user / carer engagement. The mechanism for collectively identifying and responding to emerging issues is predominantly through the MH SQIP.

5. NEEDS ASSESSMENT

A comprehensive Mental Health Needs Assessment was completed in 2012. This has been reviewed in line with Pledge 90 and is included as Appendix 1 of this Report. Below is a summary of some of the key findings of the Needs Assessment.

5.1 Prevalence (2012)

Children and Young People (5-15)	
3,500	Mental health disorder
700	1+ Mental health disorder
Adults (18-64)	
26,000	Common mental health disorder
700	Borderline personality disorder
575	Anti-social personality disorder
650	Psychotic disorder
11,800	2 or more psychiatric disorders
Older People (65+)	
3,700	Depression
3,000	Dementia

5.2 Risk Factor Data

There are a number of risk factors that increase the prevalence of mental health conditions. The following table provides local data on how risk factors affect mental health in Plymouth.

Children and Young People (<19)	
1,500	Vulnerable families with 4+ risk factors identified in Health Visitor Survey
22.6%	Children living in poverty
> average	Number of children in care
> average	Numbers not in education, employment or training
> average	Numbers entering criminal justice system

Adults (18-64)	
10,000	Alcohol dependent
5,600	Dependent on drugs
Older People (65+)	
21,000	Living with a limiting long term condition

5.3 Demand Information 2012/13

6,700 residents receiving mental health services from PCH.

5,700 referrals to Plymouth Options (56% engagement).

100,000 individual contacts with services (37% adult community mental health team,15% older people community mental health team, 12% assertive outreach team, 6% memory service).

378 emergency mental health admissions.

1250 A & E attendances for self-harm (21% under 19).

Above average levels of prescribing for antidepressants, anxiolytics and hypnotics (could be due to greater need, prescribing practice or poor access to alternatives such as psychological therapies).

Rate of suicide above national average (10.3 deaths/100,000 compared to 7.9 deaths/100,000). However the numbers are small (average 25 per year).

5.4 Veterans Mental Health

The estimated local population of veterans in Plymouth is 18,900 – 20,300.

Mental health problems linked with alcohol dependence, depression and Post Traumatic Stress Disorder (PTSD).

Risk factors include:

- Low numeracy and literacy standards of recruits (often from areas of social deprivation).
- Exposure to combat.
- Transition to civilian life especially if no home and family to return to.
- Short Service Time - personnel leaving the service within four years are associated with a higher incidence of mental health problems.
- Hazardous alcohol consumption.
- Estimated that 10% of all Plymouth Options (Plymouth's 'Improving Access to Psychological Therapies' service) clients are veterans, reservists or serving armed forces personnel.

A comprehensive Veterans Health Needs Assessment incorporating mental health is currently in development.

6. PERFORMANCE

6.1 Introduction

The review has completed a critical analysis of performance information in relation to commissioned mental health services. This review has provided the opportunity to combine information for the first time and create a comprehensive picture of the information available and the interdependencies across services.

This summary performance section pulls together a range of performance information from different commissioners about specific mental health services.

6.2 Summary Supply Map and Approximate Spend

The Mental Health Needs Assessment 2012 contains comprehensive details of the wide range and extent of mental health services in the city.

6.3 Approximate Annual Spend

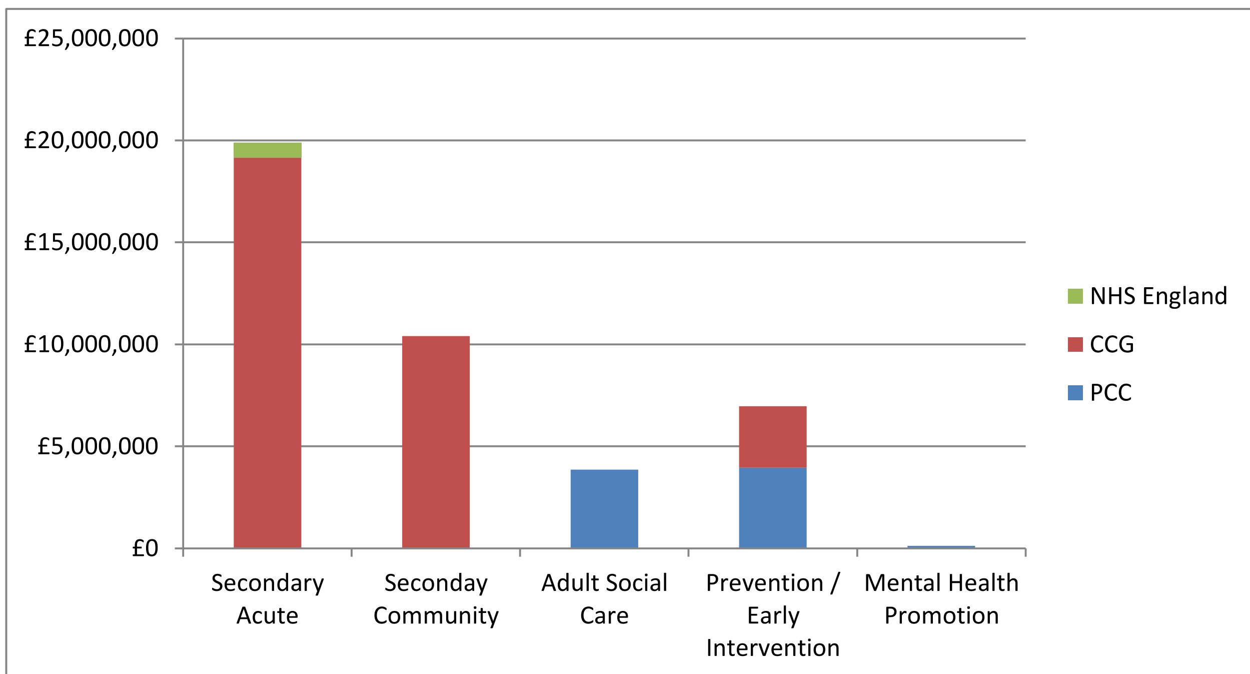
The below table attempts to summarise the approximate annual spend against the main mental health services commissioned across Plymouth City Council (PCC) the NEW Devon Clinical Commissioning Group (CCG), and NHS England.

Table 1

Service Category	Examples of services (some of these fall across the defined 'service category')	Commissioner	Approximate Annual Spend
Mental Health Promotion	Training, Plymouth Mental Health Network, Mental Health Promotion Strategy, Libraries	PCC	£125,000
Preventative / Early Intervention	Employment support, community development, Icebreak, Insight, IAPT	CCG	£3,013,129
	Floating support, supported accommodation, drop ins, recovery college, CAMHS	PCC	£3,953,817*
Secondary Mental Health Services – Acute / Inpatient	Glenbourne, Recovery Units, Home Treatment Team, Out of Area Placements, Individual Patient Placements, Continuing Healthcare	CCG	£19,145,259
	Lee Mill only – not just Plymouth (Specialist Commissioning Spend currently unknown)	NHS England	£731,786
Secondary Mental Health Services – Community Based	Assertive Outreach Service, Community Mental Health Teams, CAMHS	CCG	£10,407,136
Adult Social Care	Direct Payments, residential & nursing care, community services	PCC	£3,853,000

*This includes approximate apportioned spend on non specialist preventative services that work with clients who have mental health support needs.

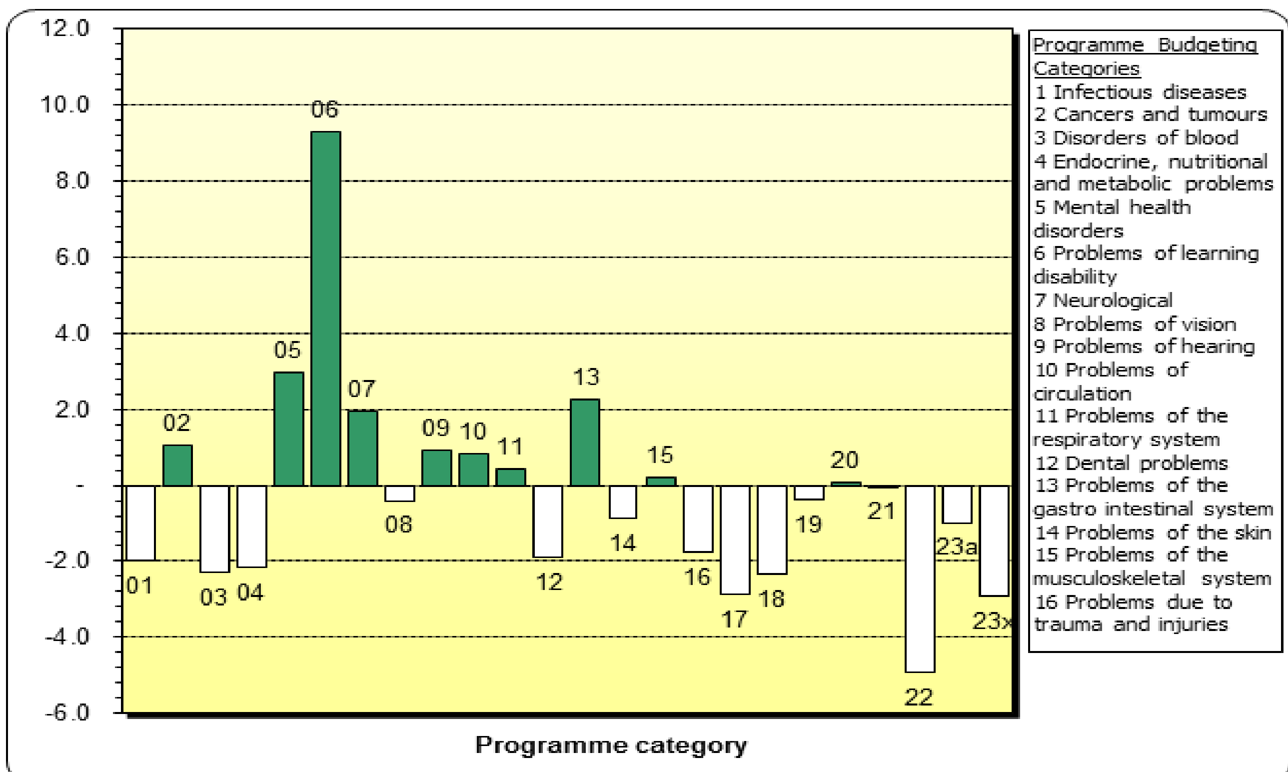
Figure 1 – Approximate Annual Spend Graph



6.4 How We Compare to Others

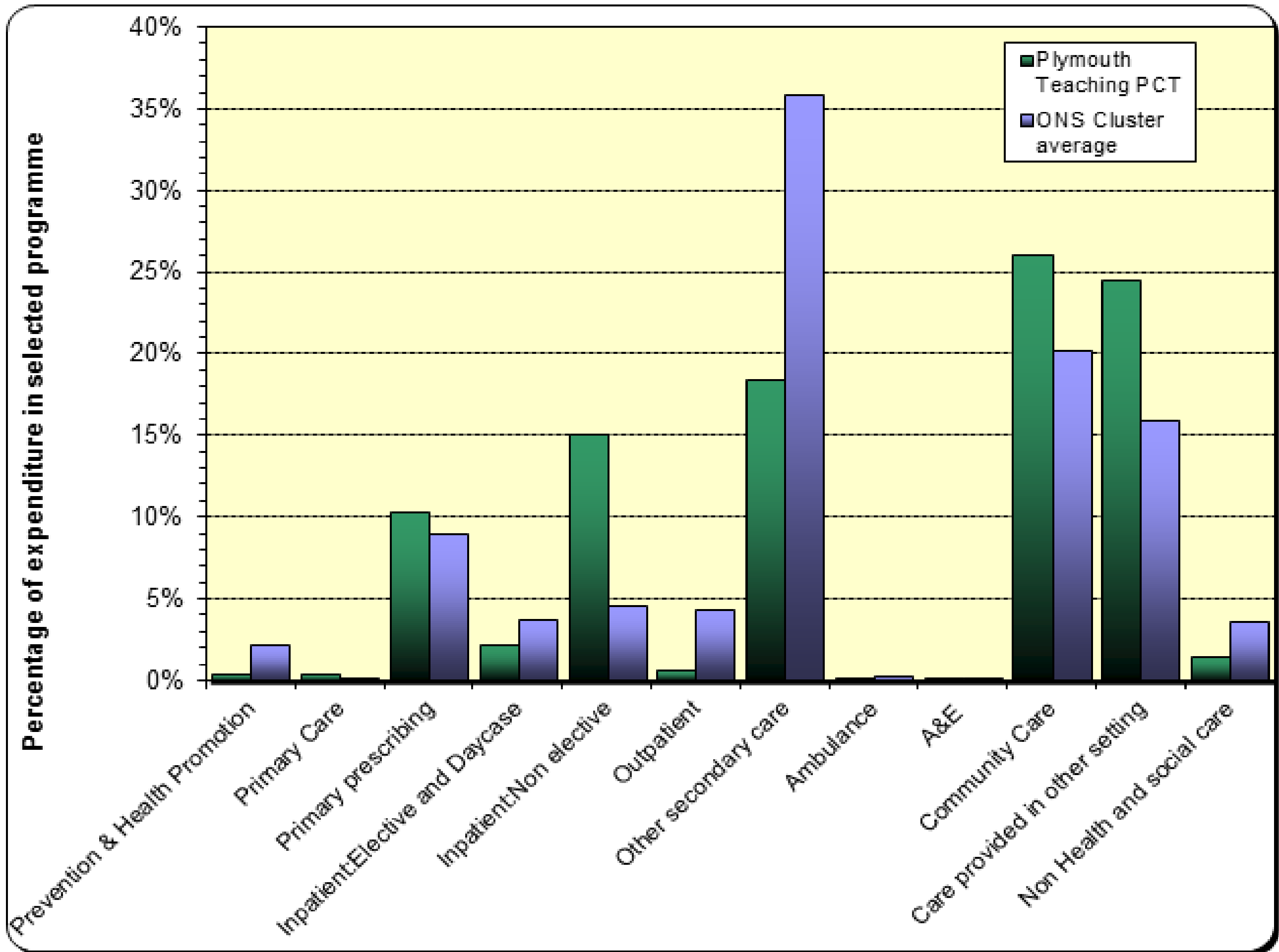
The NHS Health Investment Network has produced an interactive benchmarking tool that contains detailed information on PCT expenditure by health care condition. Although the boundaries are now different with the NEW Devon CCG covering a much wider area than the former Plymouth PCT this tool is helpful in enabling this review to compare historic spend. The benchmarking tool shows that in 2011/12 Plymouth PCT invested above average levels of funding into services for mental health disorders.

Figure 2



The benchmarking tool also indicates that in 2011/12 Plymouth PCT invested more than our ONS cluster on 'Community Care' and 'Care Provided in Other Setting', and less on 'Other Secondary Care'.

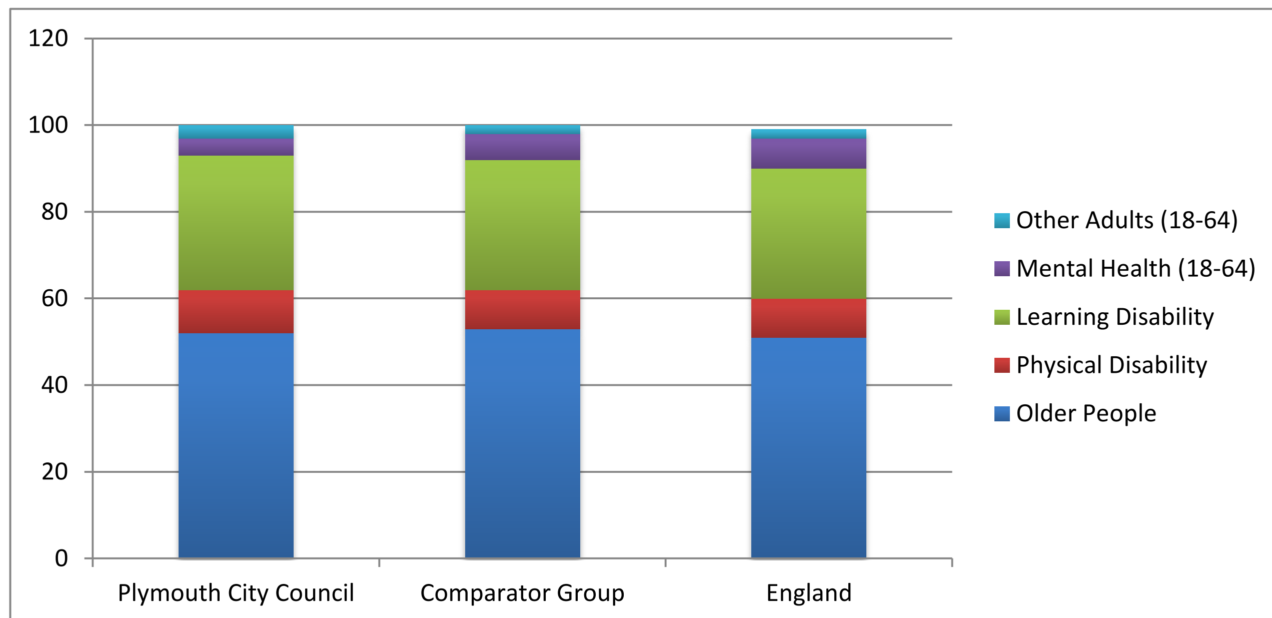
Figure 3



Adult Social Care is also able to benchmark the costs of care for adults with mental illness.

Figure 4 shows the % distribution of total gross current expenditure on Adult Social Services broken down by client group. Compared to our comparator group Plymouth invests a slightly lower proportion of total adult social care expenditure on Mental Health (18-64) (4.44% compared to approximately 6%).

Figure 4



Source: Use of Resources Report 2012/13 Plymouth, National Adult Social Care Intelligence Service

In Plymouth this expenditure is broken down as follows

Table 2

Client Group	Expenditure	Percentage
Older People	£45,414,000	52.38%
Physical Disability	£8,737,000	10.08%
Learning Disability	£26,746,000	30.85%
Mental Health (18-64)	£3,853,000	4.44%
Other adults	£1,943,000	2.24%
Total	£86,693,000	100%

6.5 National Outcomes Data

4.5.1 Adult Social Care Outcomes Framework

The Adult Social Care Survey is used to measure performance against a number of indicators in the Adult Social Care Outcomes Framework (ASCOF).

For the 2012/13 Adult Social Care client survey in Plymouth, 170 clients whose primary client group is Mental Health received a survey, of these 50 returned the survey (a response rate of 29%). This response rate compared to an overall response rate to the survey of 39.8%.

ASCOF 1B – The proportion of people who use services who have control over their daily life. Based on responses to the question 'Q3a - Which of the following statements best describes how much control you have over your daily life?' The proportion of people with mental health issues who use services who have control over their daily life is 84%.

The proportion of mental health clients who have control over their daily life is the same when all clients are considered, for all clients the percentage who have control over their life is also 84%.

ASCOF 3B
Based on responses to the question 'Q1 - Overall, how satisfied or dissatisfied are you with the care and support services you receive?' The proportion of people with mental health issues who are satisfied with the services they receive is 74%.

The proportion of mental health clients satisfied with the care and support they receive is higher than the proportion when all clients are considered, the satisfaction rate for all clients' stands at 68.5%.

Table 3 - Summary

Indicator	**Plymouth - All clients**	**England – All clients**	**Plymouth Mental Health Clients**
ASCOF 1B – The proportion of people who use services who have control over their daily life	84	75.9	84
ASCOF 3B – Satisfaction with care and support services	68.5	63.5	74

ASCOF 1F

Table 4 Proportion of adults in contact with secondary mental health services in paid employment

Area	2010/11	2011/12	2012/13
Plymouth	N/A	7.3	5.1
South West	N/A	9.3	8.7
Unitary	N/A	9.0	7.1
CIPFA Comparators	N/A	8.1	5.6

Source: Towards Excellence in ASC Performance Report (2013).

ASCOF 1H

Table 5 Proportion of adults in contact with secondary mental health services who live in their own home

Area	2010/11	2011/12	2012/13
Plymouth	N/A	53.6	53.3
South West	N/A	44.8	50.9
Unitary	N/A	52.8	53.4
CIPFA Comparators	N/A	56.4	50.1

Source: Towards Excellence in ASC Performance Report (2013).

4.5.2 Public Health Outcomes Framework

PHOF 1.18

Social isolation: the % of adult social care users who have as much social contact as they would like

Area	2010/11	2011/12
Plymouth	46.30	51.20
Southampton	41.00	43.30
Portsmouth	50.90	46.30
Sheffield	39.50	41.30
England	41.90	42.30

We have improved performance against this indicator going up from 46.30 to 51.20 and Plymouth performs significantly better than England overall.

PHOF 2.08

Emotional wellbeing of looked after children

Area	2010/11	2011/12
Plymouth	16.00	17.30
Southampton	15.40	No data
Portsmouth	14.50	13.70
Sheffield	15.40	No data
England	13.90	13.80

Data is collected from the ‘strengths and difficulties questionnaire’ (SDQ). We have a higher average SDQ score compared to our comparators and England for children in care for the last 12 months. A higher score on the SDQ indicates more emotional difficulties, with a score of 0 to 13 being considered normal, a score of 14 to 16 considered a borderline cause for concern, and one of 17 or more a cause for concern

PHOF 2.23

Self-reported well-being – percentage of people with a low satisfaction score

Area	2011/12
Plymouth	21.86
Southampton	24.42
Portsmouth	24.46
Sheffield	26.09
England	24.27

Plymouth has a lower percentage of people with a low satisfaction score, but this isn't significantly different to England's value.

Self-reported well-being – percentage of people with a low worthwhile score

Area	2011/12
Plymouth	18.96
Southampton	22.57
Portsmouth	24.24
Sheffield	21.13
England	20.08

Plymouth has a lower percentage of people with a low worthwhile score, but this isn't significantly different to England's value.

Self-reported well-being – percentage of people with a low happiness score

Area	2011/12
Plymouth	29.05
Southampton	29.49
Portsmouth	31.28
Sheffield	31.33
England	29.02

Plymouth has a lower percentage of people with a low happiness score compared to the comparators, but this isn't significantly different to England's value.

Self-reported well-being – percentage of people with a high anxiety score

Area	2011/12
Plymouth	42.81
Southampton	38.03
Portsmouth	37.00
Sheffield	42.27
England	40.11

Plymouth has a higher percentage of people with a high anxiety score, but this isn't significantly different to England's value.

The estimate of subjective well-being comes from the first annual experimental Annual Population Survey (APS) Subjective Well-being dataset (April 2011 to March 2012).

PHOF 4.10
Suicide rate

Area	2009 - 11
Plymouth	10.33
Southampton	9.72
Portsmouth	8.55
Sheffield	6.45
England	7.87

Plymouth has a higher rate of suicide and injury of undetermined intent; this is significantly higher than England's value.

PHOF Summary Table

Indicator	Latest Plymouth	England	Significant test
PHOF 1.18 Social isolation: the % of adult social care users who have as much social contact as they would like	51.20	42.3	Significantly better than England's average
PHOF 2.08 Emotional wellbeing of looked after children	17.30	13.8	N/A
PHOF 2.23i Self-reported well-being - people with a low satisfaction score	21.86	24.27	Not significantly different
PHOF 2.23ii Self-reported well-being - people with a low worthwhile score	18.96	20.08	Not significantly different

PHOF 2.23iii Self-reported well-being - people with a low happiness score	29.05	29.02	Not significantly different
PHOF 2.23iv Self-reported well-being - people with a high anxiety score	42.81	40.11	Not significantly different
PHOF 4.10 Suicide rate	10.33	7.87	Significantly worse than England's average

Source: Public Health Outcomes Framework (www.phoutcomes.info)

6.6 Early Intervention and Preventative Support

PCC and the CCG commission a large range of support services in the community that aim to intervene early and prevent the need for more specialist or acute service provision.

6.6.1 Supported Accommodation and Floating Support Services

Examples of these services include hostels and supported accommodation to support that 'floats' into an individual's own accommodation. The services aim to enable independent living by building the skills and mechanisms required based on individual need and circumstances.

Table 4 – this table shows the number of people with a primary or secondary client group of 'mental health' that accessed these services in Plymouth.

Year	Primary Client Group	Secondary Client Group	Total
2013/14 (Apr-Jun 13)	55	100	155
2012/13	143	322	465
2011/12	170	221	391
2010/11	245	219	464

This indicates that there has been a slight decrease in the number of people with a primary client group of mental and an increase in the number of people with mental health as a secondary client group. This is in line with a national trend around increasing common mental health issues.

However, clients who define themselves having a different 'primary' need may also require support with mental health issues. This is particularly relevant to people where they have a 'primary client group' of substance misuse, homelessness / rough sleeping, offenders, domestic abuse and young people. The following table indicates how many people completed a programme of support from these services where they had a need around mental health, and also whether that need was met by the services. The information indicates that an increasing proportion of people using services have a need around mental health – rising from 36% in 2010/11 to nearly 50% currently. The table also indicates that the services are consistently meeting the needs of these clients.

Table 5

	2010/11	2011/12	2012/13	2013/14
The total number of people completing a programme of support	2163	2026	2217	576
The number of people with a needs around mental health who completed a programme support	786 (36.34%)	812 (40.08%)	971 (43.80%)	282 (48.96%)
The number of people who had their mental health support need met	683	722	854	254
% of people who had their support need met	86.90%	88.92%	87.95%	90.70%

6.6.2 Other Commissioned Early Intervention and Prevention Services

PCC commission a range of other bespoke services accessible to people with mental health issues. These include drop-ins, advice and information services, advocacy services and volunteering support.

The varied nature of the above service models and different commissioning arrangements, means that performance monitoring is carried out on an individual contract basis. Often the information collected is not directly comparable or easy to aggregate. The following section provides some headline information against these services.

Crossroads – this service supports approximately 70-100 people a year. So far this year 20 people have moved on from the service in a planned way with improved recovery outcomes.

MIND Recovery College – this service had already supported 147 people through focussed courses between April-June this year.

Avenues – this service supports people with mental health issues to access volunteering opportunities. They work with over 60 people a year.

Advice Plymouth – this new service started on 01 October 2012. It provides an outreach service in Glenbourne and has been working closely with the mental health community to ensure its advice and information offer to people with mental health issues is of high quality and easily accessible. Performance figures indicate that approximately 800 people who self-define as having a mental health problem are supported with an enquiry in a 12 month period, however the numbers are likely to be much higher when including people with a mental health issue who don't 'self report'.

Plymouth Guild Mental Health Advocacy – this service works with approximately 120 people a year. Outcomes reporting show that a high proportion of people using the service have improved quality of life as a result of the service.

PAGES Advocacy – this service provides Independent Mental Health Advocacy to people subject to the Mental Health Act. The service is based at Glenbourne and supports approximately 112 people a year.

Active for Life – this service provides support for people with mental health issues to access opportunities for physical activity. As well as running specific sessions they also provide a buddy service to support people to access mainstream services. So far this year the service has worked with 351 individuals, provided 16 buddies, provided 9 taster sessions, 57 walks and 130 community activities.

Libraries – this pilot project creates health and social care information "hubs" in all libraries which carry out; 'Information Prescriptions', information and support from library staff including mental health, support to carers, specialist information sessions, 'Books on Wheels' service. Specific 'Feel Better with a Book' groups are also delivered. 35,061 interventions were carried out during the year comprising of health books borrowed, hits of health webpage, hits of health booklist webpage, staff-assisted enquiries. A questionnaire received 254 responses and indicated that 86% of people now knew more about their health condition.

Training – 4 people have been trained to deliver the Mental Health First Aid (MHFA) course in Plymouth, with 125 places available on both MHFA and MHFA Lite. 4 people have also been trained to deliver ASIST suicide prevention training, with course provision for approximately 60 people. In addition the development and running of a trainers network to support trainers delivering these courses and allow for peer support and sharing of best practice has been set up.

The CCG also commissions services that work with people in the community outside of secondary mental health provision. The below provides some further information on the type of services this includes. The schedule for monitoring these specialist providers varies dependent on the size and risk levels of the service delivered for most services this is quarterly but some maybe bi-annual.

Eating Disorder Service – a small charity providing community services to people with eating disorders. Monitoring is quarterly reviewing numbers of referrals / waiting times /people engaging with the service. There has been a rise in the numbers referred and the waiting times (most recent figures indicate 5 weeks from referral to assessment, and 9 weeks from assessment to treatment) which are anticipated to reduce with the recruitment of new staff. The service also provides a comprehensive annual report which includes patient feedback. This report shows that in 2012/13 the service saw approximately 40-50 clients per week, received 200 referrals, and 197 people completed a programme of support.

The Zone: Youth Enquiry Service

Monthly data sets are reported to the commissioners and meetings held quarterly.

Insight – early intervention for emerging psychosis (14-35 year olds) with up to 30 new clients taken onto caseload per annum depending on ability of the service to discharge, and clients worked with for up to three years. Numbers referred have increased slightly and the service has experienced some temporary staffing shortages recently which have resulted in increased waiting times we expect to be addressed with staffing levels returning to normal and staff engaging in processes for service redesign. The service supports a caseload of approximately 70-85 people at any one time and approximately 3 people complete a programme of support every month.

Icebreak – early intervention service for young people with an emerging personality disorder (16-25 year olds) with up to 30 new clients taken onto caseload per annum depending on ability of the service to discharge, and clients worked with for up to two years. This service is not designed to meet crisis need but should provide early intervention. Currently the Zone report that individuals are being referred in their early 20's rather than the lower end of the age range, similarly they are exploring if certain groups by demographic are underrepresented within the service. The service has seen a doubling of referrals since 2008 and whilst the numbers of individuals being worked with has also risen significantly there have also been staffing shortages in this service which has seen a rise in waiting times. Temporary funding has been made available to facilitate a reduction in the waiting times and work to reduce the age at which people are referred to facilitate early intervention. This will rely on the system overall seeking solutions for working across the PD pathway, as opposed to Icebreak working in isolation.

Race Equality Council – Community development worker BME communities. BME communities were under represented in mental health services the aim of the service is to work with BME communities and service providers to break down the barriers for people from the BME

community accessing M/H services. They report number of sessions undertake/ numbers of people supported / work with other organisations and emerging issues with the changing ethnic groups in the city.

CHIK – Community Health in Keyham

This project aims to address health inequalities including Mental Health in Keyham. They report on activities undertaken, numbers of people using the services and the outcomes for people using the service.

Huntington's Care Advisory Service

Provides support to individual's disease they report numbers of people supported and outcomes for individuals and families supported in an annual report.

Plymouth Involvement Participation Service (PIPs)

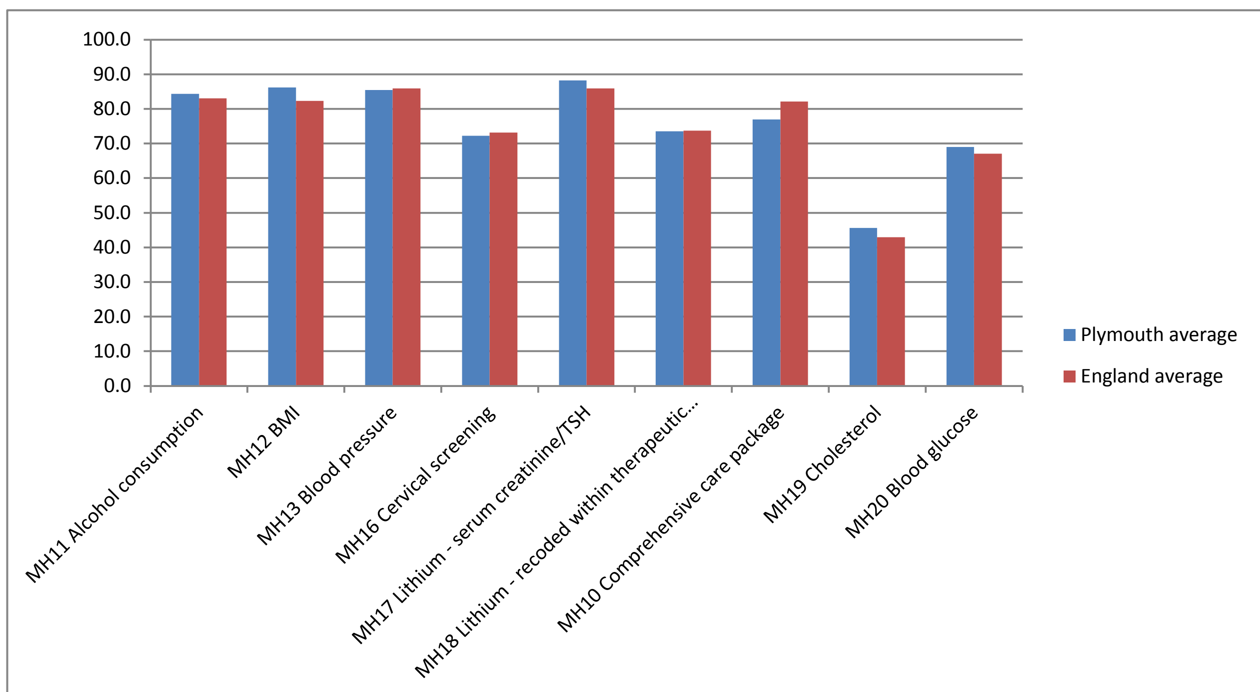
PIP's provide regular updates and reports re work undertaken at the Strategic Quality improvement partnership meetings including feedback and challenge about the quality of services being provided.

6.7 Primary Care

GP Practices are required to report Quality Outcomes Framework (QOF) information. There are 9 specific mental health QOF indicators (2012/13). This predominantly relates to whether GP's have carried out physical health interventions with patients who have a mental health condition.

Figure 6 shows the % of patients in Plymouth that receive the required interventions. This indicates Plymouth GP Practices are in line with the England average.

Figure 6 Average % of eligible mental health clients receiving QOF interventions (2012/13)



6.8 Adult Social Care

6.8.1 Number of clients

Table 6 – the total number of Adult Social Care clients with a RAP code of 'mental health' broken down by age and Dementia and compared to England (provisional 12/13 figures):

	Plymouth	England Average	Plymouth Rate per 10,000 population	England Rate per 10,000 population
Mental Health Clients aged 18-64	156	872	5	40
- Of which Dementia	15	14	0	0
- Of Which Non Dementia	141	858		
Mental Health Clients aged 65+	964	887	210	160
- Of which Dementia	829	521	180	89
- Of Which Non Dementia	135	366		
Total number of Mental Health clients	1,120	1,759		
- Of which Dementia	844 (75%)	535 (30%)		
- Of Which Non Dementia	276 (25%)	1,224 (70%)		

Source: Health and Social Care Information Centre.

In total 2012/13 there were 276 mental health clients (excluding dementia) who received a service commissioned by Adult Social Care. This figure of 276 compares to an average of 1,224 across all local authorities. Plymouth also has low numbers when compared against its CIPFA comparator group with 276 clients against an average of 935.

Initial investigation has identified potential reasons for this including; recording issues (e.g. some Local Authorities have partnership arrangements with Health providers meaning all clients are recorded), and increased reablement and preventative services which promote independent living and reduce the need for formal care and support. The figures also indicate that there is a significant variance across the country around the extent to which local authorities distinguish between mental health and dementia clients within this RAP code. Plymouth is strong at identifying Dementia clients with 75% of total mental health clients identified as having Dementia. Some local authorities are as low as 3%. This indicates that further investigation would be required to identify true performance comparisons.

6.8.2 Type of provision

Table 7 shows a breakdown of the type of services Mental Health clients (excluding Dementia) receive

Year	Number of Mental Health clients (excluding Dementia)	Number receiving Community Based Services	Number receiving Residential Care	Number receiving Nursing
2012-13	276	235	47	10
2011-12	292	248	50	11

Table 8 – the breakdown of community based service provided for clients with a RAP code of mental health (excluding Dementia)

Year	Total	Home care	Day care	Meals	Short Term Res	DP's	Prof Support	Equipment
2012-13	235	100	15	1	16	46	136	68
2011-12	248	65	22	13	20	42	166	93

6.8.3 Personalisation

Table 9 – the proportion of adults aged 18-64 with a RAP code of mental health using social care who receive self-directed support

Area	2010/11	2011/12	2012/13
Plymouth	37.1	28.8	37.8
South West	2.9	7.9	4.5
Unitary	8.8	14.0	16.8
CIPFA Comparators		17.6	33.8

Source: Towards Excellence in ASC Performance Report (2013).

This table shows strong performance against the comparator authorities.

6.9 Safeguarding and Serious Case Reviews

6.9.1 Safeguarding

Table 15 – the number of safeguarding alerts where the alleged victim has a RAP code of mental health (excluding dementia)

Table 10

Year	Total number of safeguarding alerts - Mental Health	Total number of safeguarding alerts – all client groups
2012-13	49	822
2011-12	103	1157

6.9.2 Serious Case Review

There is currently one on-going serious case review relating to mental health. Some preliminary issues have been identified that the review is looking into, they include:

1. Transition from adolescent to adult mental health services
2. Communication between professionals
3. 'Safety net' if patient is missing appointments
4. Meeting the needs of BME clients
5. Information sharing with family carers
6. Mental Health Act assessment - processes

6.10 Secondary Mental Health Services

The CCG commissions Plymouth Community Healthcare CIC (PCH) to provide secondary mental health services in Plymouth. These services include; inpatient services, Home Treatment Team, Assertive Outreach Service, Community Mental Health Teams, Plymouth Options - Improving Access to Psychological Therapies (IAPT), Community Forensic Team, Asylum Seeker and Refugee Service, Psychotherapy and Child and Adolescent Mental Health Services (CAMHS).

The performance data collected is mainly proxy data which serves to indicate changes in the system and prompt deeper investigations into services. Many of these data sets are nationally prescribed.

The data for Plymouth Community Healthcare (PCH) is monitored at monthly integrated provider assurance meetings (IPAM).

Appendix 2 provides an extract of some of the data collected through the IPAM Report. However the following narrative pulls out the main points and provides some context around current performance.

6.10.1 Access – Referral to Treatment

PCH consistently meets the nationally set 18 week 'referral to treatment' targets for most mental health services. Referral to treatment times (RTT's) are described as averages and therefore can be affected significantly by outliers.

Community Mental Health Teams (CMHT's) – there are 5 locality based teams all have seen a slight rise in waiting times but are well within the referral to treatment time (RTT) targets set by the NHS.

The numbers waiting and the mean length of wait show monthly fluctuations in all teams.

There are a number of small specialist team's such as the Community Forensic Team and Asylum Seekers Service. These services also show a fluctuation in waiting times and numbers waiting but remain within RTT targets.

Psychotherapy services have not been meeting RTT targets and services are the subject of a more detailed pathway review – these services encompass a range of therapy services the numbers waiting and waiting times vary within the service and for different therapies.

6.10.2 Improving Access to Psychological Therapies (IAPT)

This service is provided by Plymouth Options part of PCH. This service has been failing to meet the nationally set targets relating to access / waiting times and recovery rates. As a result PCH have put in place an action plan to meet the targets and this is monitored regularly at IPAM. Improvements have been made and it is anticipated that these will continue with targets being met in December 2013.

6.10.3 CAMHS

Performance monitoring highlights concern around access and waiting times against set targets, and improved outcomes for individuals using the service.

This service has had an extensive service improvement plan from PCH. This has been being closely monitored on a monthly basis with Commissioners. The original improvement plan is now coming to an end following evidence that practice has improved and Plymouth Community Healthcare has and is continuing to taken clear action to address concerns. A range of on-going monitoring has been agreed to ensure that service standards are reviewed through a regular "deep dive" contract monitoring processes that will ensure change continues to be implemented. Nationally CAMHS have experienced similar difficulties and the DH have been rolling out an extensive training package to ensure evidence based treatment options are available in CAMHS through its Children and Young People's Increasing Access to Psychological Therapies (IAPT).

6.10.4 Inpatient Admissions Gatekept

The data shows that the number of admissions to inpatient provision is staying relatively constant.

The percentage of admissions 'gatekept' by crisis resolution to ensure appropriate admissions are taken forward fluctuates. 2013/14 Year to date performance shows that 84% of admissions were gatekept against a target of 95%. Further investigation has identified differences in the way mental health Providers record this with PCH CIC including Section 136 patients which could distort the figures.

Additionally the changes are monitored by a Glenbourne redesign group which has service user/carer reps on it who provides feedback to the Strategic Quality Improvement Partnership group.

6.10.5 Individual Patient Placements / Out of Area

Changes to commissioning mean that NHS England is now responsible for commissioning and monitoring secure and specialist services, currently these are all located outside Plymouth although PCH do provide one of the services at Lee Mill (Ivybridge).

The CCG do commission in-patient acute services at the Glenbourne Unit and 4 Psychiatric Intensive Care Beds with Cornwall Foundation Trust (CfT) in Bodmin. PCH have a target to reduce use of Psychiatric Intensive Care Beds to only these four and work is on-going between PCH and CfT to improve the pathway between services both in and out.

In addition the CCG commissions 'Individual Patient Placements' (IPP). A snapshot from January 2014 indicates there were 28 IPP's for people with a primary mental health diagnosis within Plymouth and 22 outside of the Plymouth City boundaries. These will continue to be monitored with a view to increased repatriation.

6.10.6 Discharge

PCH has been re-designing its acute and recovery pathways in line with national policy. The progress and effect of this work is monitored at IPAM to ensure that the small reduction in acute beds does not result in greater use of out of area placements. The work intends to deliver a reduction in delayed discharges and a smoother pathway to recovery for patients whilst ensuring that beds are available when needed.

Performance figures indicate that the numbers of people being discharged from CPA are increasing.

Performance figures also indicate that 100% people discharged receive the required follow up within 7 days.

Where people are discharged from inpatient facilities approximately 93% receive follow up within 48 hours (against a target of 95%).

There are two CQUIN targets that have additional reporting (Commissioning for quality and innovation); one of them is to deliver improved links from CMHT's to GP surgeries.

6.10.7 Reviews & Outcomes

2013/14 year to date Performance information indicates that 78% of people have had a CPA reviews in the last 12months against a target of 95%.

2013/14 year to date performance information indicates that 79% of people have had a HONOS* assessment in the last 12 months against a target of 90%. National performance indicates a percentage of 84% in 2012/13.

There are two CQUIN targets which have additional reporting (Commissioning for quality and innovation), one is to trial the use of alternative patient outcome measures for services and use the reported outcomes to identify good practice and areas for improvement.

*In 1993 the UK Department of Health commissioned the Royal College of Psychiatrists' Research Unit (CRU) to develop scales to measure the health and social functioning of people with severe mental illness. The initial aim was to provide a means of recording progress towards the Health of the Nation target 'to improve significantly the health and social functioning of mentally ill people'.

6.11 Quality

6.11.2 Plymouth Community Healthcare CIC

The Care Quality Commission (CQC) inspected all PCH services in 2013. All standards are met across the organisation.

The latest CQC report for the Glenbourne Unit was published on 10 September 2013. All standards were met and some of the comments from the summary include:

Patients we spoke with who were staying at the Glenbourne Unit said that their care and welfare needs were being well met. We saw plenty of positive interactions taking place and patients looked relaxed and comfortable asking staff for advice or information.

The latest CQC report focussing on CAMHS and adult mental health services was published in 20 March 2013. All standards were met and some of the comments from the summary include:

People who used the services understood the care and treatment choices available to them. People we spoke with confirmed that they felt safe and supported by staff and had no concerns about the ability of staff to respond to safeguarding concerns. As a result of changes to the Child

and Adolescent Mental Health Services (CAMHS) risks had been identified about a decline in staff morale, increased sickness absence and stress.

At the start of 2013 PCH sent 850 people receiving community mental health services at The Community Survey 2013. 219 people returned the survey. The overall results were positive with all areas showing better or similar than average performance.

6.11.2 Residential Care

In March 2013 CQC completed a routine inspection of Balmain Care Home, Plymouth's largest residential care home for people with mental health issues. All standards were met with positive comments around staff and service user experience noted.

6.12 Mental Health Act Assessments & Section 136 / Place of Safety

2013/14 Year to Date figures indicate a total of 533 Mental Health Assessments have been carried out in Plymouth. Plymouth City Council is now monitoring the types, referral sources, and outcomes of Mental Health Act assessments. Although this is a new system it will be used in the future to identify trends and performance improvement across all agencies.

Section 136 is the section of the Mental Health Act that gives the police power to detain individuals who they suspect have mental health issues and pose immediate risk to themselves or others in a public place. Devon & Cornwall Police is an outlier nationally and their use of Section 136 is high. The majority of Section 136 patients (locally and nationally) are then not detained under part 2 of the Act following assessment.

A person detained under Section 136 should be taken to a 'place of safety' (POS). This can be for up to for 72 hours while waiting to be examined by a doctor and interviewed by an Approved Mental Health Professional (AMHP). The Code of Practice states that a police station should be used as a place of safety on an exceptional basis. For some of 2012 the POS suite at Glenbourne was closed, however, a new POS suite has recently opened at Glenbourne and is now operational, On-going monitoring of the new POS will identify how this impacts on the proportion of Section 136 detentions being taken to police cells.

The table below indicates that the total number of Section 136 detentions at Charles Cross and Glenbourne since 2010

Year	Number detained Charles Cross	Number detained Glenbourne	Total Number of Section 136
2010	183	156	339
2011	193	146	339
2012	269	8	277
2013	250	134	384

The Clinical Commissioning Group is working with Devon and Cornwall Police and the Home Office to pilot new schemes and options for responding to crisis situations, including a 'Street Triage Service', to reduce the use of Section 136 and ensure appropriate support and training is available to Devon and Cornwall Police.

6.13 Summary

The review has identified the following points.

6.13.1 Spend

That there is significantly more investment in acute and secondary provision than preventative services

In 2011/12 Plymouth PCT invested more on mental health services than comparator groups – both in total and in some preventative provision

Plymouth City Council spent a slightly lower % of total gross current expenditure on mental health (18-64) in 2012/13 than comparator groups.

6.13.2 Early Intervention and Prevention

That although there are increasing numbers of people with a need around mental health accessing low level preventative services those needs continue to be met.

6.13.3 Adult Social Care and Public Health Outcomes Frameworks

Plymouth is performing well in indicators relating to the proportion of mental health clients feeling in control, satisfaction with care and support, and people having as much social contact as they would like

Plymouth's performance relating to indicators around employment and mental health, emotional wellbeing of looked after children, and suicide rates is less positive.

6.13.4 Adult Social Care

Information from the Health & Social Care Information Centre indicates Plymouth City Council supports a lower number of mental health clients than comparator groups or England average. Initial investigation has identified potential reasons for this including; recording issues, and increased reablement and preventative services which promote independent living and reduce the need for formal care and support, a significant variance across the country around the extent to which local authorities distinguish between mental health and dementia clients within this RAP code. This indicates that further investigation would be required to identify true performance comparisons.

A higher proportion of mental health clients receive Self Directed Support than comparator groups and England average.

6.13.5 Plymouth Community Healthcare CIC

Performance information indicates strong performance against targets and quality requirements in the following areas:

- All patients discharged received the required follow ups
- All services meet the required CQC standards
- Positive feedback from the national community mental health survey

Performance information indicates improvement against some targets is required. Where this is identified the CCG is working closely with PCH to ensure resolution. The key areas this review has identified are:

- IAPT – access and recovery rates
- CAMHS – access / waiting time and individual outcomes
- Gatekept admissions

- CPA & HoNoS Reviews

6.13.6 General

The review has identified there are different levels and types of contract monitoring across different commissioners and services. This can create difficulty in trying to build a full picture of services and outcomes.

More outcome information across the services will be collected this year which will help demonstrate the difference services are making to individual lives and recovery.

7. SERVICE USER FEEDBACK

Plymouth has a well-established and proactive mental health service user and carer group called Plymouth Involvement and Participation Service (PIPS). PIPS is closely aligned to Healthwatch, ensuring that the wider community is also represented in the work they do.

This review commissioned PIPS to lead a process of gathering service user and carer feedback on mental health services. This arrangement, which was be led by services users, created a genuine ethos of meaningful feedback and consultation owned by the community themselves.

The approach adopted by PIPS was wide ranging both in terms of approach and scope. It involved meeting with key community groups across the City as well as gathering individual's views and feedback on mental health services from members of the public. PIPS reached a wide cross section of the population in terms of age, marital status and parental responsibility. The majority of respondents to the questionnaire were White British and there is a recognition that further work to identify feedback from the Black and Minority Ethnic community is required.

In addition specific client groups were targeted such as homeless, LGBT, children and young people with mental health issues, veterans and single parent carers.

Feedback was sought on a wide range of issues including awareness of services, accessibility of services and the quality of provision. There was also a series of questions around lifestyle with a particular focus on what would keep people well and what would assist with recovery.

7.1 PIPS Feedback – Consultation Event 19 August 2013

The full report of this event is included as Appendix 3, however the main points are summarised below.

7.1.1 What would you like to see provided for carers in the city?

The majority of feedback given was around respite, support groups and training. Other feedback received was that not everyone is an internet user, there needs to be better advertising of what support is available. Also the carers assessment needs to be improved and the process needs to be quicker and more readily available.

7.1.2 How do you make person centred care a reality?

Feedback was around attitude, relationships and flexibility. Other feedback received was to make it easier for service users to tell commissioners about bad service and Governance seems to be based on the needs of the organisation instead of the individual at the moment.

7.1.3 What suggestions do you have for improving mental health services?

The majority of feedback given was around communication, continuity of care, easier access and non-statutory support. Other feedback received was more training and up to date information for professionals, online directory of what services are available that is publicised and kept up to date and more acute beds to stop people from being sent out of county.

7.1.4 What level of support would be useful in maintaining good mental health?

Common feedback was around issues of social isolation, to have more drop-ins, using skype/email to support people and have a personalised service. Other feedback was to support low level need rather than waiting until people are in crisis and to have a single point of access.

7.1.5 How do we identify those that need intervention?

The majority of feedback given was around stigma, training and access. Other feedback received was to provide good quality services that people will want to engage in, to have mental health needs assessment in schools and colleges. Schools to have the knowledge to be able to signpost individuals to the appropriate service.

7.1.6 What would make the transition from children to adult services smoother?

The feedback offered was around working collaboratively, having a more planned transition and joining up child and adult services. Other feedback received was to have a flexible but consistent service, to intervene earlier so they don't need a transition to adult services and service involvement shouldn't be governed by diagnosis, more integrated service.

7.1.7 How would engagement and involvement in the commissioning and delivery in mental health services be improved?

Feedback given was around accessibility, widening the service user involvement and accountability. Other feedback received was agendas and minutes to arrive in plenty of time to prepare, better representation of transgender issues and to make better use of existing networks such as (MHSQIP) Mental Health Strategic Quality Improvement Partnership, PIPS, (PMHN) Plymouth Mental Health Network instead of continually reinventing the wheel.

7.2 PIPS Feedback – Questionnaire and Community Consultation

The full report of this event is included as Appendix 3, however the main points are summarised below.

7.2.1 Accessibility of Mental Health Services

There is a wide range of opinion about whether mental health services are accessible.

The majority of people would go to their GP for help with a mental health issue. Just under half respondents said they found their GP helpful with regards to mental health issues.

Users and carers had experienced delays in accessing CAMHS

7.2.2 Keeping Well and Promoting Recovery

The report demonstrates the importance of physical exercise, social contact including groups and activities in the community, and family / friends. PIPS members also felt that good information about services and prevention / early intervention are important.

7.2.3 Gaps / Further Development

Reponses indicate that a high proportion of new mothers were not informed about services for post natal depression, and that there was not enough help or information available.

A high proportion of parents were not aware whether their children have education about mental health and wellbeing at school.

7.2.4 Satisfaction with Mental Health Services

There is a wide range of opinion about how well mental health services in Plymouth are rated.

The transition process from children's to adult services received a large amount of feedback and suggestions for improvement.

Services were not always joined up or wrap around the person.

Carers felt that when a family member was suffering from mental health problems engagement with the carer needed to be improved.

7.3 Service User Feedback Summary

Both reports (appendix 3 and 4) provide a wealth of detailed information and feedback that form a crucial part of the Pledge 90 Review.

In terms of the future of mental health services there was a strong recommendation that there should be a far greater focus on prevention and early intervention. This is reflected in some of the specific recommendations

- Need to reduce the stigma of mental illness and raising awareness of mental health in the wider community
- Better mental health awareness training for frontline services, including GP's and Police
- A focus on tackling isolation especially amongst elderly and young people
- Improvements needed to the CAMHS and transition pathways
- Greater focus on person centred care
- More support required for carers, including easier access to respite services and recommended adoption of the 'Advance Statement of Wishes' and 'Triangle of Care' model

8. STAKEHOLDER FEEDBACK

8.1 Introduction

A stakeholder questionnaire was designed in partnership across the key stakeholder group overseeing the Pledge 90 Review.

The questionnaire was sent to all stakeholders with an interest in mental health, including; providers, community groups, businesses, strategic partnerships, networks, statutory partners and decision makers.

51 responses were received (including 9 service user / parents or carers)

8.2 Respondents

Table 11 shows the total number of completed questionnaires received was as follows:

Stakeholder Type	Number of responses received	% of total responses received
Community Group / Forum	2	4%
Partner Agency – someone who works for an organisation with an interest in mental health services/support (includes statutory, private or voluntary & community sector agencies and schools)	22	43%
Provider – someone who works for an organisation that provides mental health services or support **or** **Provider representative body**	18	35%
Service User / Carer / Parent	9	18%
Total	51	100%

8.3 How people 'rated' mental health services

People were asking to tell us the extent to which they agreed with the following statements:

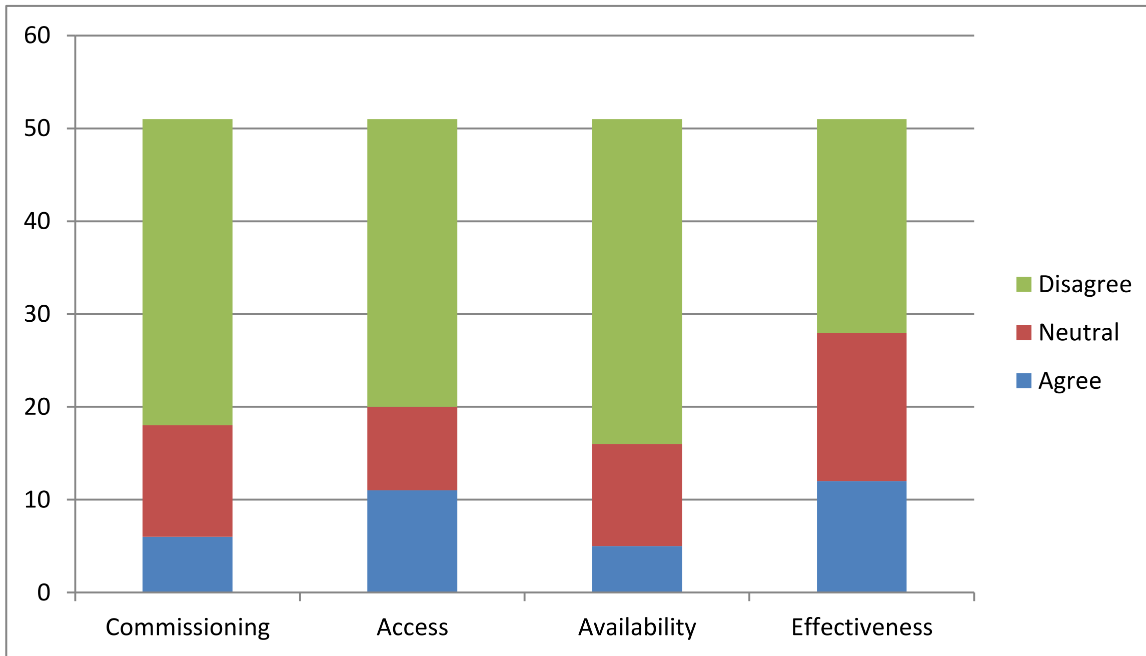
"Mental Health services and support are currently **commissioned** in ways which are efficient; provide good value for public money and which meet the needs of local people"

"Mental Health services and support are currently provided in ways, at times and in locations which make it easy for people to **access** the help they need"

"Mental Health services and support have **sufficient availability** so that people with a mental health issue can receive help when they need it, for as long as they need it"

"Mental Health services and support are **effective** in meeting people's mental health needs"

Figure 7 provides a summary of the extent to which respondents agreed or disagreed with the above statements.



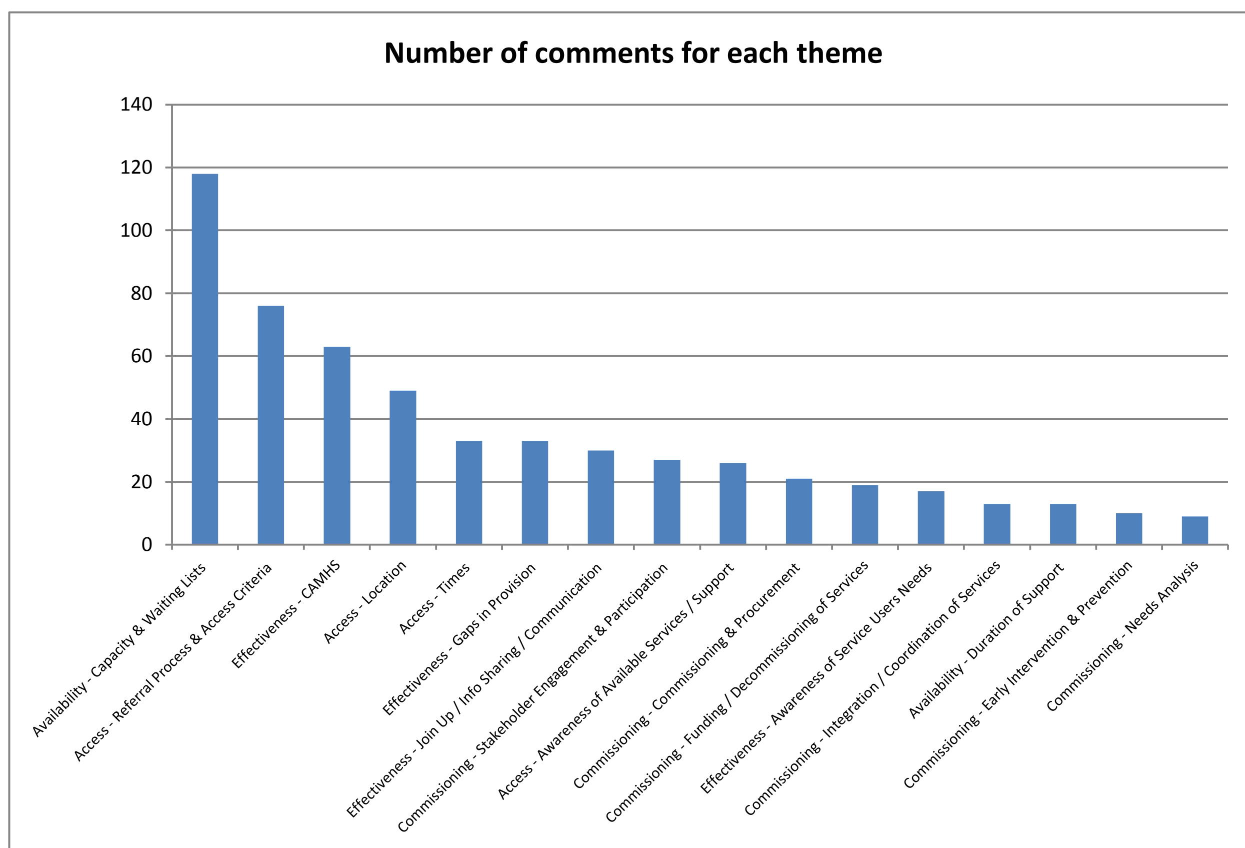
8.4 What people told us

Stakeholders were also asked to give reasons for their responses, and to outline any suggestions they had for improving the way in which mental health services and support are commissioned.

For the purposes of this report general themes have identified from the large number of comments about mental health services received.

Figure 8 provides a summary of the number of comments that were made against each theme. The comments made against each theme are described in more detail in the following section.

Figure 8



8.4.1 Commissioning

Theme a) Commissioning & Procurement Processes (21 comments)

- Some respondents questioned the need to tender services if they are performing well, and also highlighted that it can be unsettling for service users when providers change regularly. Longer contracts were seen as a positive.

- The financial and time-consuming cost of tender processes to both commissioners and providers was raised as a query.

- Respondents were keen to see Commissioners focus more on outcomes rather than inputs/outputs when developing specifications. There was a suggestion the Commissioners shadow frontline workers before developing service specifications to ensure targets are appropriate.

- People (including service users) want to be more involved in the monitoring of contracts performance. There was a clear message that Commissioners have responsibility to manage underperformance with suggestions around how to do this made, such as unannounced visits.

- Some comments suggest a perception that services are commissioned on the basis of least expenditure.

Theme b) Early Intervention & Prevention (10 comments)

- There was overwhelming support for prioritising early intervention and preventative services on the basis that it will save money, reduce crisis, and improve mental health in the long term.

The distinction was made between 'mental health services' and 'support' with the suggestion that more emphasis on 'support' would prevent the need for services.

- There was particular emphasis early identification and range of person centered interventions for young people.

- Theme c) Funding & De-commissioning (19 comments).

- Impact of decommissioning / reducing services was described in terms of increased stress levels for service users, maintaining adequate staffing levels, meeting increasing need.

- Comments called for greater investment in mental health services, specifically CAMHS, voluntary and community sector services, and working with the Police.

Theme d) Integration & Co-ordination of Services (13 comments)

- The comments indicate a sense that there is duplication and lack of co-ordination across the system.

- There is a suggestion that agencies across different sectors could work better together to maximise resources and improve outcomes for individuals.

Theme e) Needs Analysis (9 comments)

- The majority of comments in this section related to CAMHS with some suggestions about different ways Commissioners could identify need in the future e.g. rising birth rate, the new "SAE tool" from the Excellence Cluster, factor in number of occasions when schools have sought/received support elsewhere, not just the number of attempted referrals to CAMHS, forthcoming audit of emotional and social needs by the Plymouth Learning Trust Inclusion and Wellbeing Practitioners Group.

Theme f) Stakeholder Engagement & Participation (27 comments)

- Comments suggest confusion/lack of awareness regarding local commissioning processes and a need for greater transparency and 'real' consultation (not just tick box) to ensure everyone has a voice.

- Specific suggestions for more involvement with various stakeholders, throughout the commissioning process e.g.

- Community pharmacists (e.g. re support for service users to manage their medication).

- Service users (e.g. seek their views in designing services, and regularly seek their feedback on the effectiveness of existing services).

- Young people and parents regarding CAMHS (a Mental Health Board including lay people was suggested).

- Partner agencies (e.g. consultation regarding thresholds for referral to specialist services, to ensure services are accessible, responsive and people do not 'fall between the gaps'; consultation regarding where services should be located and targeted).

- Schools (e.g. CCG Commissioning Officer to meet annually with each school's designated person for child protection, re CAMHS).

- Providers (e.g. suggestion of a more "partnership approach", rather than specification, tender & contract approach to commissioning).

8.4.2 Access

Theme a) Location (49 comments)

- Having a variety of access points available was seen as positive (e.g. CAMHS can be accessed at Mt Gould, School, alternative places offered, general flexibility).

- There was a mixed response about whether city centre locations or neighbourhood / community based provision is preferred. Some comments indicate centres which are outside city centre require 2 bus journeys and can be difficult to access, whereas other comments ask for a focus on locality/neighbourhood/community based services rather than central location, very often encouraging co-location staff.

- Comments suggest a perceived lack of provision around drop-in centres/sessions – both for children and adults. The benefits of these session are described as increase engagement, decrease family stress, decrease stigma, support to manage a reoccurrence of a MH issue, implement coping strategies in order to help themselves, to increase engagement by those whose lives are stressed and/or are lacking in confidence and organisational skills.

- Comments also suggest a lack of provision around home visits which may be required for people who are unable to leave their homes due to their mental/physical health; some elderly people do not want to visit agencies, asking vulnerable families to go into clinical environments as a barrier to engagement, home visits provide a valuable opportunity to see the whole family in their environment.

Theme b) Times (33 comments)

- Wide variety of services, some can be accessed quickly and the use a variety of providers, including those in the VCS, offers flexibility in times.

- There was a lot of feedback provided about the need for both adult and children support services to be available outside of normal office hours (evenings and weekends).

Theme c) Awareness of Available Services / Support (26 comments)

- Several comments suggested a need for promotion and awareness raising of available services & support to a range of audiences (public, professionals/front line staff across all relevant agencies) by a range of methods: on-going in public arenas, leaflets, posters, promotion of POD/Council's webpage re MH/new MH Provider Network website and extend Local Directory of Services. One comment suggested considering whether more targeted advertising of services to specific groups would be beneficial. This is particularly true for children services where they want to make referrals for adults (9 comments).

- Awareness raising/training for GPs and Pharmacies to increase their understanding of available services & support and assist them to signpost/refer appropriately was suggested.

- Making best use of existing resources e.g. people taking medicines for should be encouraged to speak to their pharmacist for advice and support on most effective way to take medication, pharmacists are available for longer hours & usually at weekends for medicine related queries, to enhance their on-going support.

Theme d) Referral Process & Access Criteria (76 comments)

- A number of comments suggest need to do more to share clear criteria on eligibility and referral processes for services to avoid confusion, disappointment and raised expectations. This comment was made across both children and adult services.

- A number of suggestions were made to respond to the barriers people with mental health issues have in accessing services to improve engagement e.g. if a patient doesn't attend appointments or opt in s/he may be discharged despite still needing help. Suggestion for the support network around families to be made aware of appointments to ensure a better rate of attendance – both initially and for subsequent support sessions; CAMHS 'did not attend' cases followed-up and monitored so families'/children's needs didn't fall through the net, allow more time for staff to support other teams working closely with a child or young person who will not directly access mental health support.

- There were a number of comments about the thresholds different service operate which means that some people can't access services until their condition deteriorates.

- Specific feedback about CAMHS included:

General communication issues:

- Hard to refer / get an appointment for young people (e.g. complex, bureaucratic, unclear and inconsistent process), suggest joint screening / referral process, audit of current referral system suggested, CAF - where CAMHS attend these, referrals appear to be picked up more quickly and appointments subsequently honored.

- Suggestion for a duty CAMHS worker to be available or advice line which may reduce referrals.

- GPs are increasingly passing cases for (CAMHS) referrals to schools which is not our specialism (2 comments).

- Difficulty accessing support for 'looked after' young people who are in transition.

- Initial assessments could be offered earlier if done by staff trained in triaging referrals, or Primary Mental Health Worker rather than by CAMHS team;

8.4.3 Availability

Theme a) Capacity & Waiting Lists (118 comments)

- CAMHS - there were 45 comments received about the availability of this service e.g. long waiting lists – referral to assessment; long waiting lists – assessment to treatment; professionals are superb but they are stretched to the limit; lack of cover for staff sickness; lack of capacity to become involved in care of inpatients with MH issues, resources too low for level of need, leading to unmet need and escalation of need, sometimes to crisis levels;

- Counselling - there were 12 comments specifically relating to the lack of availability and long waiting lists for counselling services.

- Other services that were mentioned specifically by 1-2 people as having a lack of capacity, and/or long waiting lists were; Assertive Outreach Service, Cognitive Behavioural Therapy (CBT), Clinical Psychologists, Community Psychiatric Nurses (CPNs), Family Therapy, Glenbourne, GPs, Home Treatment Team, Psychotherapy, Schools/Education settings.

Theme b) Duration of Support (13 comments)

- The comments focused on the short term nature of available support and how support is sometimes needed for longer or means people relapse after discharge.

8.4.4 Effectiveness

Theme a) Awareness of Service Users Needs (17 comments)

- The way mental health services are commissioned and provided to respond to the individual needs of clients who have autistic spectrum disorders, dementia, BME clients, and people affected by welfare reform were commented upon. There was a suggestion of ensuring health and social care professionals receive specific training.

Theme b) Gaps in Provision (33 comments)

Individual respondents provided comments on services that they felt could be developed or were missing in Plymouth these ranged from:

IAPT Therapies specifically for people with autism (3 comments)

Assistive technology

Buddy System

Mental Health Carers Support Group

Support with Chronic illness / Medicines compliance

Crisis Line & Mobile Crisis Team – to work with Police

Crisis management

Counselling

Employment support

Homelessness

Huddersfield model (24/7 service and outreach available)

Parenting (2 comments).

Self-esteem/confidence

Self-harm

Support for families of young people with MH issues - residential beds

Soteria Houses (often see as a gentler alternative to Inpatient provision)

Triangle of Care model to be adopted in Plymouth (2 comments)

A variety/range of therapeutic interventions as alternative to antidepressants (4 comments).

Theme c) Join Up / Information Sharing / Communication (30 comments)

- This theme was raised again under this statement and reiterates the need for increased cohesion between health and social care organisations including statutory, voluntary and private sector to maximise resources and improve experience and outcomes for service users.

- The need to improve links between young peoples and adult services were also commented on. There were a number of comments relating to the need to ensure that services are delivered to whole families rather than individuals.

- Comments regarding information sharing and communication were consistently made. The benefits in terms of risk management, patient experience and outcomes were made.

Theme d) CAMHS (63 comments)

- There were 10 positive comments reflecting that once support commences with CAMHS it is an effective service. Other positive comments were received about TAMHS (CAMHS Targeted Mental Health in Schools Service), Plymbridge House and Terraces (Inpatient).

- There were a large number of comments and suggestions regarding the need for improved communication and joined-up working between CAMHS and other agencies including; colocation of staff, sharing information on what support is being delivered or what referrals are being made, single point of contact, mobile clinicians, responsibility for CAF's, joint visits, school clinics and, joint support planning.

- There were 3 comments on CAMHS administrative arrangements were appointments had been missed or double booked.

- There were a large number of comments regarding perceived inconsistency / gaps in CAMHS service provision. There were also a number of suggestions for improvement. These related to both support provided within a school setting as well as relating to links with inpatient care.

8.5 Summary

The analysis indicates that a majority of stakeholder responses disagreed with or felt neutral about the positive statements they were asked to rate around commissioning, access, availability, and effectiveness of mental health services.

The largest number of comments received related to:

- Capacity and waiting times
- Referrals process and eligibility criteria
- CAMHS
- Location and opening times of services

9. CARING PLYMOUTH – OVERVIEW & SCRUTINY

The Pledge 90 Review formed part of Caring Plymouth's annual work plan for 2013/14.

The purpose of this was to provide assurance that the requirements of Pledge 90 had been met and the Report was comprehensive and wide ranging.

Caring Plymouth received an initial presentation of the Pledge 90 Review in November 2013 and agreed to hold a Task & Finish Group to further consider the full draft Pledge 90 Review Report.

The Task & Finish Group was held on 4 December 2013. The Panel included five Plymouth City Council Councillors and a co-opted panel member from Healthwatch.

The Panel invited witnesses to cover each element of the review; Stakeholder Feedback, Service User and Carer Feedback, Needs Assessment, and Performance.

The Task & Finish Group discussions re-iterated and expanded on the information already included in the Pledge 90 review.

As a result of the Task & Finish Group Caring Plymouth was assured that the Pledge 90 review and subsequent report satisfies the requirement to 'conduct a wide ranging review of the adequacy of mental health service and support in the city alongside mental health providers and charities'.

Some of the specific recommendations that Caring Plymouth made as a result of the Task & Finish Group and in response to the information provided through Pledge 90 include:

1. early intervention and prevention of mental health problems should be delivered by a range of professionals. Identification and brief advice (IBA) training for all front line professionals would aid the identification of problems at an early stage, provide basic support and signposting / referral to most appropriate services;

2. promotion and communication of mental health services available to young people and adults should be undertaken through schools and GP surgeries;

3. awareness of mental health issues, particularly within hard to reach communities, is raised and adequate provision is in place;

4. the partnership approach to mental health issues should be strengthened to ensure that service provision is integrated, as all public services could have an impact on an individual's mental health;

5. a single mental health strategy is produced for the city and that it is resourced for delivery;

11. a mental health champion is identified from the Health and Wellbeing Board to provide support to the carers support network;

6. wider promotion by Public Health on health and wellbeing should include a focus on mental health awareness.

Task & Finish Group concluded that the requirements of Pledge 90 had been met and the full Caring Plymouth Report is included as Appendix 5.

10. SUMMARY & CONCLUSION

10.1 Strategic Context

The review sets out the policy journey from the National Service Framework (1999) to a mental health strategic context around wider social impacts, recovery ethos, preventative and personalised approach to delivering holistic services where mental health is everyone's business and there is parity with physical health.

There are 3 main local strategies currently driving activity in Plymouth, with 2 more in development. The majority of these either cover adults or children.

Locally the Review has identified a well engaged and motivated mental health sector in Plymouth across providers, commissioners and service user / carer engagement.

Opportunity:

To consolidate the strategic documentation and take a more holistic strategic approach to the life course

10.2 Needs Assessment

The comprehensive Mental Health Needs Assessment that was completed in 2012 has been refreshed and updated to ensure it remains relevant and accurate. This will ensure a clear picture of the population and prevalence of mental health issues within Plymouth's communities, as well as identifying protective and risk factors.

10.3 Performance

The review has mapped service provision across all aspects of mental health and wellbeing across the City including approximate spend and comparisons with other areas.

The review considers all available performance information across a range of preventative and specialist services, commissioners and providers identifying key areas of good performance as well as areas for improvement.

The review identified there are different levels and types of contract monitoring across different commissioners and services, often focussing on outputs rather than outcomes. This can create difficulty in trying to build a full picture of performance.

Opportunity:

To develop a performance dashboard of key information to be collected consistently and monitored through the SQIP to identify trends and problem solve performance issues.

10.4 Service & Carer Feedback

Plymouth has a well-established and proactive mental health service user and carer group called Plymouth Involvement and Participation Service (PIPS). PIPS is closely aligned to Healthwatch, ensuring that the wider community is also represented in any feedback and work they do.

PIPS lead the process of gathering service user and carer feedback on mental health services creating a genuine ethos of meaningful feedback and consultation owned by the community themselves.

A full Report has been developed and forms part of the Review.

Opportunity:

Use the Report to identify key areas of service improvement, solutions and decision making. In particular to:

- Reduce the stigma of mental illness and raising awareness of mental health in the wider community (e.g. by providing better mental health awareness training for frontline services, including GP's and Police)
- Focus on tackling isolation especially amongst elderly and young people
- Improve the service to children and young people through CAMHS and transition pathways
- Have a greater focus on person centred care
- Improve support for carers (e.g. including easier access to respite services and recommended adoption of the Triangle of Care model)

10.5 Stakeholder Feedback

Community and stakeholder views were gathered predominantly through a widely circulated questionnaire which asked respondents to rate how well they thought mental health services in Plymouth are; commissioned, accessible, available, and effective.

The responses have been analysed and form a key part of the review.

Opportunity:

Use the Report to identify key areas of service improvement, solutions and decision making. In particular to address:

- Capacity and waiting times
- Referrals process and eligibility criteria
- CAMHS
- Location and opening times of services

10.6 Caring Plymouth

The Caring Plymouth Task & Finish Group review process provides assurance that the requirements of Pledge 90 were met, and this Pledge 90 Report is comprehensive and wide ranging.

Opportunity:

Use the Caring Plymouth Report and recommendations to identify key areas of service improvement, solutions and decision making.

10.7 Conclusion

Plymouth City Council has worked in partnership with a large number of providers, stakeholders, service users, and communities to complete Pledge 90 and 'conduct a wide ranging review of the adequacy of mental health services and support in the city alongside local mental health providers and charities'. This review will be available for commissioner, decision makers, providers, service users, carers and all citizens of Plymouth to use for the purposes of improving mental health and wellbeing services for everyone.

10.8 Recommendations

To develop a single strategic response to the Pledge 90 Review across all partners in Plymouth that includes:

1. Development and monitoring of a single mental health performance dashboard

2. Raising awareness and reducing stigma of Mental Health

3. Increasing promotion, prevention and early intervention services

4. Remodelling the children and young people pathway for mental health services and support

5. Developing services to ensure carers are well supported

6. Developing understanding of mental health issues in the BME community

7. Working co-operatively with the local mental health community to drive commissioning decisions

8. Develop a more integrated approach to commissioning and service provision

9. Develop an understanding of the mental health and wellbeing needs of veterans, particularly in relation to the transition back to civilian life, and work in partnership to deliver the armed forces community covenant

10. Ensuring that Pledge 90 feeds into and supports the work of the Fairness Commission

10.9 Implementation

The Plymouth Health and Wellbeing Board has identified the Mental Health of the population as a priority in the Health and Wellbeing Strategic Framework and will be responsible for the taking forward recommendations of the Pledge 90 Review.

The Health and Wellbeing Board commission an Implementation Plan to ensure a consistent and comprehensive response to the findings of Pledge 90, bringing together all strategic plans and activity impacting on mental health and wellbeing. The Health & Wellbeing Board will monitor the implementation plan annually and by exception.

11. APPENDICES

Appendix 1 – Mental Health Needs Assessment Refresh

Appendix 2 – Secondary Mental Health Services Performance Scorecard

Appendix 3 – PIPS Consultation Event Report

Appendix 4 – PIPS Pledge 90 Service User and Carer Report

Appendix 5 – Caring Plymouth Pledge 90 Task & Finish Group Report

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PLEDGE 90 REVIEW

PLYMOUTH
CITY COUNCIL

A report of the Caring Plymouth Co-operative Review Scrutiny Group following a review of the Pledge 90 - Mental Health Review Report

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FOREWORD

The emotional health and well-being of our citizens across Plymouth is a very important issue. In today's fast-paced, ever-changing society, people are faced with increasingly complex lives and a diverse set of challenges.

Pledge 90 was part of the 100 pledges announced by Plymouth City Council in July 2012. The purpose of pledge 90 was to 'Conduct a wide ranging review of the adequacy of mental health services and support in the city alongside local mental health providers and charities'.

Mental health of the population has been and will continue to be a core theme for the Caring Plymouth Scrutiny Panel; as such we have undertaken a scrutiny review to ensure the requirements of Pledge 90 are satisfied and identify where there are any gaps in the information.

Through this review, City Councillors now have a greater understanding of the mental health pathway which will assist further scrutiny in the new municipal year.

Finally, I would like to thank all those people who have contributed to and supported this review. Without their assistance it would not have been possible.

Councillor Mary Aspinall

Chair, Caring Plymouth Scrutiny Panel

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1. SUMMARY

1.1 The Caring Plymouth Scrutiny Panel agreed to hold a scrutiny review into the Pledge 90 – Mental Health, which was endorsed by the Cooperative Scrutiny Board on 27 November 2013.

1.2 A review of mental health services was undertaken and officers attended the Caring Plymouth panel to report findings in July and November. Following the November meeting the panel requested a further review to ensure that the review met the requirements of Pledge 90 and to identify whether there were any gaps in the information.

1.3 The panel, in analysing all of the information submitted by officers, witnesses and users of the mental health services, agreed that the Review had met the requirements of Pledge 90 and made a number of recommendations; these will be submitted to Cabinet via the Cooperative Scrutiny Board and are presented in section 8 of the report.

2. INTRODUCTION

2.1 This report presents the findings from the Caring Plymouth Scrutiny Panel's Cooperative Review on the topic of the Pledge 90 – Mental Health Review.

2.2 The Cooperative Review took place on 16 December 2013.

2.3 Members appointed to the Cooperative Review were as follows:

- Councillor Mrs Aspinall (Chair)
- Councillor Bowie
- Councillor James
- Councillor Mrs Nicholson
- Councillor Parker
- Karen Morse - Healthwatch

2.4 Officers supporting the Cooperative Review were as follows:

- Katy Shorten – Strategic Commissioning Manager
- Craig McArdle – Head of Joint Strategic Commissioning
- Candice Sainsbury - Lead Officer
- Amelia Boulter - Democratic Support Officer

3. BACKGROUND INFORMATION

3.1 Introduction

In May 2012 Plymouth City Council announced 100 pledges around the 10 priority areas in the Corporate Plan. Pledge 90 was to 'Conduct a wide ranging review on the adequacy of mental health services in the city alongside local mental health providers'.

4. COOPERATIVE REVIEW PROCESS

4.1 Aims and Objectives

The aims and objectives of the Pledge 90 – Mental Health Review were to consider all the findings to date and ensure all groups have been properly consulted. The panel reviewed –

- the needs assessment and supply of mental health services
- performance on mental health outcomes
- service user and carer views
- community and stakeholder views

4.2 Cooperative Review Methodology

4.2.1 The review took place over one day to review background information and to hear from a number of witnesses.

4.2.2 Meeting dates –

- 16 December 2013

4.2.3 The witnesses who presented evidence to the Panel were –

- Carol Hannaford – Principal, Stoke Damerel Community College
- Anita Frier – Vice-Principle, Stoke Damerel Community College
- Sarah Miller – Stoke Damerel Community College
- Sharon Claridge – Plymouth Mental Health Network Chair
- Mel McMahon – Excellence Cluster
- Lisa Hartley – Excellence Cluster
- Alan Fuller – Educational Psychologist, Plymouth City Council
- Georgia Rose – Plymouth Involvement and Participation Service (PIPS)
- Chris Everratt – Plymouth Involvement and Participation Service (PIPS)
- Dot Throssell – Plymouth Involvement and Participation Service (PIPS)
- Sarah Lees – Public Health Consultation, Plymouth City Council
- Michelle Thomas – Director of Operations, Plymouth Community Healthcare
- David McAuley – Plymouth Community Healthcare
- Emily Street – Commissioning Manager, NEW Devon CCG
- Lin Walton – Mental Health Commissioner, NEW Devon CCG
- Rob Sowden – Policy Officer, Plymouth City Council
- Ian Bowden - Rethink

5. PROCEEDINGS FROM THE COOPERATIVE REVIEW

5.1 The panel met on 16 December 2013 where they received an introduction from Katy Shorten (Strategic Commissioning Manager) and Councillor Sue McDonald, Cabinet Member of Public Health and Adult Social Care prior to interviewing a range of witnesses.

5.2 Stakeholder Feedback

- Early intervention and prevention was key in terms of mental health, children not identified early could develop serious and continuing mental health problems.

- It was essential that services are integrated and to look at the whole person, with clearer pathways to treatment. It was felt that the current system was not working.

- Low attendance of CAMHS at CAF or similar meetings was identified as a problem, leading to a child or young person losing days at school.

- More parents wanted support and the knowledge to access services, this need was increasing as more young people with mental health issues were being identified.

- Anecdotal evidence suggest that GP's awareness on mental health issues was low and where unaware of how to signpost those with mental health needs to the right services.

- There was a great deal of investment into secondary mental health services whilst there is minimal investment in looking at building mental health resilience in the community and raising awareness of mental ill health.

- Partnership working and revising mental health pathways could reduce the need for secondary services.

- People wanted to understand how they can look after themselves and their wellbeing.

- There was still a stigma around mental health issues.

- There were a significant number of children with hidden mental ill health problems in the city. This was having an adverse effect on their schooling and impact it had on their on families.

- The SHINE project aims to help teenage girl's recognise, with confidence, that they have worth, strength, choice and purpose and provides support to young girl's with eating disorders.

- One strategy was required for the city and all services should work towards that strategy.

5.3 Service and Carer Feedback

- Schools and GPs need more information on mental health illness and have a clearer pathway to access mental health support and services.

- The general public did not know how to access services and were unaware of how to get a referral to access other therapies such as Improving Access to Psychological Therapies (IAPT), counselling and social prescribing.

- An advanced statement of a person's wishes, which covers of the requirements a person may need during a time of crisis would be useful and should be highlighted as part of the review.

- Carers receive very little in the way of support and it was highlighted that there was no specific mental health carer group in the city.

- Plymouth Community Healthcare would firmly embed the triangle of care into the acute unit and roll out into the community.

- Anecdotal evidence suggested that many GPs did not have a great deal of knowledge on what mental ill health support was available. People who presented with physical and mental illnesses were not receiving the appropriate support as a result.

- Mothers were being sent home too early after giving birth and were not being properly discharged into the community where robust community care was required. Early transfers of mothers following delivery from hospital into the community required continued support to prevent post-natal depression.

- Black Minority and Ethnic (BME) groups were consulted with as part of this review, unfortunately this was minimal and further research was being undertaken.

- Carers were concerned that the transition from children to adult services seems to focus on age rather than need. It was felt that when a young person reached 18 years, they were overlooked or they were unsure on their continued support for their mental wellbeing.

- Those suffering with mental ill health were unaware of what services were available to them and clarity was needed on what services are available needs to be more clearly defined. There was still a stigma of being referred into mental health service.

- It was important to normalise mental health conversations and to get the message to the general public on the public health's 5 a-day promotion for wellbeing and looking after your own mental wellbeing should hold equal importance as physical health.

5.4 Needs Assessment Feedback

- Plymouth Community Healthcare and MIND provide a programme of mental health training for frontline workers or volunteers within community or service provider organisations in Plymouth.

- The demographics of Plymouth with high levels of deprivation, unemployment and an ageing population meant a higher level of people suffering with mental ill health. However, Plymouth has a good environment to enable people to look after themselves and their mental wellbeing.

- Suicide prevention rates for Plymouth were above the national average.

- The Mental Health and Wellbeing Strategy, promotes mental health in three key areas – stigma, life transitions and transition through bereavement.

- Transition from children to adult services was sometimes unclear and some services difficult to access, there was a need for a clear pathway for young people to follow for continued support for their mental wellbeing.

- Veterans are a hidden population unless they identify themselves to the GP. There is an improved offer through 'Plymouth Options' looking peninsula wide at veteran's health. A stakeholder event taking place early 2014 would help identify the gaps and feed into the clinical commissioning group. Work was undertaken at the Armed Forces event 2013 and PIPs were involved in the work.

5.5 Performance Feedback

- Plymouth Community Healthcare had been through a long process to resolve the issues with the CAMH service. Changes were put in place such as additional clinics and in January 2015 patients would not have to wait longer than 6 weeks, to achieve this they will look at referral routes and have a clear plan in place. They were also considering early intervention and preventative support.

- Commissioning teams met with the CAMH service on a monthly basis to monitor performance and further action would be undertaken by the provider if they were not meeting targets.

- Medium secure placements were not located in Plymouth and a programme of repatriation was in place with a prioritised list of people returning to the city. One person did slip through the system, this was addressed and subsequently new processes were put in place to ensure this does not happen again.

- Glenbourne had undergone significant change and had shifted from beds focus to community focus. They were confident the model developed was followed NICE guidelines, it was also reported that the Home Treatment Team would be available for 24 hours day from April 2014.

- Since 2001, 'Rethink Plymouth' had provided community based support for low level mental health symptoms and were working over and above capacity to meet targets. Their biggest challenge was helping resolve people's needs quickly and to providing support so that they did not end up in secondary care services.

- There was good partnership working with the police liaison service with the courts, street triage and section 136 and young people's place of safety would be based in Exeter and there were concerns raised that young people would be transferred to Exeter.

The Chair thanked Officers for their responses to questions and attendance at the meeting.

6. CONCLUSION

6.1 In reviewing all of the witness evidence and analysing all of the data provided the panel identified that the report met the requirements of Pledge 90 and was correct but would benefit from the following additions –

- to include scrutiny as a chapter;
- further work to identify the needs of the BME community and hard to reach groups and awareness on mental health,
- data on out of area placements;
- additional information on eating disorders.

The panel felt reassured that the report reflected the views from the feedback received from the witnesses, although it was apparent the views from service users, stakeholders, commissioners and providers views of the CAMH service were different. The panel highlighted that CAMHS as an issue despite previous interventions by scrutiny and the need to highlighting other services available to children and young people as an alternative to the CAMHS service.

6.2 Healthwatch's response

- The review detailed various consultations and surveys that were used to collate the status of services and the views of their users. However, upon further questioning of those attending the panel, these respondents were white british in all but two cases. Healthwatch would recommend that targeted consultation of non-white british service users and their families is undertaken to ensure a comprehensive review, and would urge the use of PIPS to facilitate this as a separate piece of work.

- Mental Health Community Champions – Healthwatch recommends that the option of trained and supported individuals within communities is explored, to enhance front line services in a less formal way. Existing services such as PIPS and MIND could be commissioned to roll out this project.

- Healthwatch would like to see CAMHS involving service users and their families in a more meaningful way.

- Healthwatch recommends that in depth consultation is carried out regarding enhancing the transition from child/young people's services to adult services. Users of services should detail their experiences, how they feel they could have been enhanced and become involved in future work around improvements.

- CAMHS – Following the information presented to the panel, and that contained within the various reports, further work with CAMHS made a priority.

7. RECOMMENDATIONS

It is recommended to cabinet that -

- in reviewing all of the witness evidence and analysing all of the data provided, the panel was assured that the Pledge 90 review and subsequent report satisfies the requirement on the Executive to 'conduct a wide ranging review of the adequacy of mental health service and support in the city alongside mental health providers and charities', but would benefit from the following additions –

- to include scrutiny as a chapter;
- further work to identify the needs hard to reach groups and increase awareness on mental health,
- data on out of area placements;
- further information on eating disorders.

The panel highlighted CAMHs as an issue despite previous interventions by scrutiny and the need to highlighting other services available to children and young people as an alternative to the CAMHs service.

It is recommended to the Caring Plymouth Panel that the future work programme considers –

- the remodelling of the children and young people pathway for mental health services and support referred to in the Pledge 90 report recommendations;

- action plans to improve the current CAMH service in Plymouth, in particular plans to reduce waiting times to six weeks by January 2015;

- the provision on 'places of safety' for vulnerable people in Plymouth.

It is recommended to the Health and Wellbeing Board that –

- early intervention and prevention of mental health problems should be delivered by a range of professionals. Identification and brief advice (IBA) training for all front line professionals would aid the identification of problems at an early stage, provide basic support and signposting / referral to most appropriate services;

- promotion and communication of mental health services available to young people and adults should be undertaken through schools and GP surgeries;

- awareness of mental health issues, particularly within hard to reach communities, is raised and adequate provision is in place;

- the partnership approach to mental health issues should be strengthened to ensure that service provision is integrated, as all public services could have an impact on an individual's mental health;

- a single mental health strategy is produced for the city and that it is resourced for delivery;

- a mental health champion is identified from the Health and Wellbeing Board to provide support to the carers support network;
- wider promotion by Public Health on health and wellbeing should include a focus on mental health awareness.

CO-OPERATIVE REVIEW PROJECT PLAN

PLEDGE 90 – MENTAL HEALTH REVIEW

Background	
Chair:	Councillor Mrs Aspinall
Lead Officer:	Katy Shorten – Strategic Commissioning Manager
Democratic Support Officer:	Amelia Boulter
Membership:	Councillor Bowie Councillor James Councillor Parker
Relevant Cabinet Member:	Councillor McDonald
Date review approved by the Co-operative Scrutiny Board:	27 November 2013
Summary of subject to be reviewed:	In May 2012, Plymouth City Council announced 100 pledges around the 10 priority areas identified in the Corporate Plan. Pledge 90 was to 'conduct a wide ranging review of the adequacy of mental health service and support in the city alongside mental health providers and charities'.
Reason(s) and rationale for the review:	Improved Mental Health Services.
Objectives of the review:	To ensure the review has met the requirements of Pledge 90. To identify whether there are any gaps in the information.
What will the review look at?	To consider all the findings to date and ensure all groups have been properly consulted. To review – - the needs assessment and supply of mental health services - performance on mental health outcomes - service user and carer views - community and stakeholder views
Which areas will be excluded from the review?	Dementia Care
What City and Council Priorities does the review relate to:	Caring Plymouth and Pioneering Plymouth
Identify links to other Council policies, projects or strategies:	Health and Wellbeing Strategy, Carers Strategy, Joint Strategic Needs Assessment, Commissioning of Services.
Who will benefit from the review:	Service users, carers, family, friends, health providers and charities.

Methodology	
The method and approach of the review:	• Document analysis; • Interviewing experts; • Interviewing witnesses and service users;
Witnesses and experts:	• Senior Managers/Chief Officers; • Service users; • External partners; • Voluntary and Community Groups; • Professional experts.
Co-opted representatives:	Healthwatch
Documents and/or reports for analysis e.g. internal/external reports or legislation):	The panel to review existing work/consultations already taken place.
Site visits:	Not applicable.
Consultations/Research:	Work/consultation already undertaken.
Publicity:	To be discussed/agreed.
Evaluation method	Evidence based The recommendations of the review will be provided to the Cooperative Scrutiny Board for review in January 2014; the Caring Plymouth panel will review the progress and the Caring Plymouth Panel will undertake a progress review later in the year.
Resource Requirements:	Cost of Lunch and officer time.
Barriers and Risks:	No barriers and risks identified.

Timetable		
Activity	**Timescale / Date(s)**	**Intended Outcome(s)**
Meeting 1:	Monday 16 December 2013	To interview stakeholders and service users
Draft report:	Friday 20 December 2013	To submit draft recommendations.
Submit report to the Co-	Due to tight	To agree the recommendations.

operative Scrutiny Board Meeting:	timescales Chair and Vice-Chair to agree outside of Cooperative Board Meeting.	
Submit to Cabinet Meeting:	N/A	Keep Cabinet Member for Public Health and Adult Social Care informed of progress.
Submit to other bodies/organisations:	Thursday 16 January 2014	Health and Wellbeing Board – the review and any recommendations to form part of the Health and Wellbeing Strategy.
Scrutiny Panel to evaluate and track the outcomes of the Co-operative Review:		

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GLOSSARY OF TERMS

PLEDGE 90 – MENTAL HEALTH REVIEW

MIND	Provide advice and support to empower anyone experiencing a mental health problem and campaign to improve services, raise awareness and promote understanding.
IAPT	Improving Access to Psychological Therapies
PCH	Plymouth Community Healthcare
GPs	General Practitioner (Doctor)
NEW Devon CCG	Northern, Eastern and Western Devon Clinical Commissioning Group
CCG	Clinical Commissioning Group
PIPS	Plymouth Involvement and Participation Service
Rethink	Rethink helps millions of people affected by mental illness by challenging attitudes and changing lives.
Glenbourne Unit	Glenbourne is an acute hospital for people suffering from mental health problems aged between 18 - 65 who cannot be supported at home.
CAMHS	Child and Adolescent Mental Health Service
CAF	Common Assessment Framework
Section 136 'Place of Safety'	Section 136 of the Act gives police officers the power to remove a person with mental health issues from a public place who could be a danger to him/herself or to other people, to a "place of safety" where they may be assessed by a doctor.

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