Health and Wellbeing Scrutiny Panel

Tuesday 16 July 2024

PRESENT:

Councillor Murphy, in the Chair.
Councillor Ms Watkin, Vice Chair.
Councillors Lawson, McLay, Morton, S.Nicholson, Noble, Penrose, Reilly and Taylor.

Apologies for absence: Councillor Ney.

Also in attendance: Gary Walbridge (Strategic Director for Adults, Health and Communities), Stephen Beet (Head of ASC Retained Functions), Helen Slater (Lead Accountancy Manager), Emma Crowther (Service Director, Integrated Commissioning), Ross Jago (Head of Governance, Performance and Risk), Ruth Harrell (Director of Public Health), Liz Davenport (SRO, PASP), Jenny Turner (Programme Director, PASP), Paul McArdle (UHP), Dave Ryland (Head of Housing Standards), Councillor Chris Penberthy (Cabinet Member for Housing, Cooperative Development and Communities), Chief Inspector Fergus Paterson (D&C Police), and Elliot Wearne-Gould (Democratic Advisor).

The meeting started at 2.00 pm and finished at 5.11 pm.

Note: At a future meeting, the Panel 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.

46. **Declarations of Interest**

There were three declarations of interest in accordance with the Code of Conduct:

Councillor	Interest	Description
Lawson	Personal (Registered)	Employee at University Hospitals Plymouth NHS Trust
Morton	Personal (Registered)	Employee at University Hospitals Plymouth NHS Trust
Noble	Personal (Registered)	Employee at University Hospitals Plymouth NHS Trust

47. **Appointment of the Chair and Vice-Chair**

The Panel agreed to note the appointment of Councillor Murphy as Chair, and Councillor Watkin as Vice-Chair for the Municipal Year 2024/25.

48. **Scrutiny Panel Responsibilities**

The Panel noted the 'Health and Wellbeing Scrutiny Panel's' responsibilities, as set out in the Constitution.

49. **Minutes**

The Panel agreed the minutes of 20 February 2024 as a correct record.

50. **Chair's Urgent Business**

The Chair, Councillor Murphy, welcomed new members to the Panel for this Municipal Year.

51. **H&ASC Quarterly Performance, Finance and Risk Monitoring Report**

Stephen Beet (Head of ASC and Retained Functions) and Emma Crowther (Service Director for Integrated Commissioning) delivered the Quarterly Performance Report for H&ASC and discussed:

a) Livewell Southwest Referral Service (LRSS) 'front door' waiting lists had reduced;

b) Care Act Assessment waiting times and sizes had also reduced, and a new IT system had been adopted;

c) The number of 'Care Act Reviews' conducted per month had increased, with 61.4% of people receiving an annual review;

d) The process for reporting 'Adult Safeguarding' matters had been changed, resulting in higher quality referrals and a reduced investigation response time;

e) Numbers of people receiving 'Direct Payments' for care in Plymouth was above the national average at 25.5%, allowing people greater choice and control;

f) The quality and resilience of commissioned care providers remained stable, and strong oversight was in place. Waiting times for 'Domiciliary Care' remained low however, the number of people in 'Nursing Care' remained high. Exploratory work was being undertaken to understand the causes and possible solutions;

g) 'No Criteria to Reside' figures remained low for Plymouth however there were sustained pressures in Cornwall.

In response to questions, the Panel discussed:

h) Increased capacity amongst Domiciliary Care providers;

i) Safeguarding waiting lists, complexity, and investigation times;

j) Adult Mental Health service demand, waiting lists and delays;

k) Staff sickness, absences and the use of temporary cover.

The Panel agreed to:

1. Note the report;

2. Request further clarity regarding the number of Adult Mental Health referrals and assessment delays;

3. Request further details regarding staff sickness and absences.

Helen Slater (Lead Accountancy Manager) delivered the Quarterly Finance Update for H&ASC and discussed:

l) The Adult Social Care (ASC) budget was the largest revenue budget within the Council, at £103 million for 2024/25;

m) Month Two forecast reporting showed savings on the majority of packages: Domiciliary Care £139,000, Supported Living £105,000, Residential Long-stays £400,000 Direct Payments £40,000;

n) There was a pressure of circa £1million at Month Two, largely due to overspend within Nursing Care. Following analysis, it had been identified that this was due to the number of clients exceeding expected levels;

o) There were also pressures relating to 'client income', which was not performing as forecast. Budget containment activity was ongoing between partners to re-evaluate package rates and client numbers to mitigate risks;

p) Overall, a 'nil variance' was reported for the ASC budget at Month Two as it was expected that this £1 million pressure would be resolved in year.

In response to questions, the Panel discussed:

q) A 'Deep Dive' would be conducted to explore the budget variance;

r) The current financial position was an early year indication, and would be subject to changes.

The Panel agreed to note the report.

Ross Jago (Head of Oversight and Governance) delivered the Quarterly Risk Report for H&ASC and discussed:

s) Risks regarding the Adult Social Care Workforce had reduced but would continue to be monitored to track long-term market sustainability;

t) Risks around Adult Social Care Reform had increased however, these would likely be subject to change following the upcoming King's Speech;

u) Budgetary pressures including the 'Living Wage' increase continued to present a financial risk.

The Panel agreed to note the report.

52. **Peninsula Acute Sustainability Programme: Developing the Draft Case for Change**

Liz Davenport (SRO: PASP, NHS Devon), Jenny Turner (Programme Director: PASP, NHS Devon) and Paul McArdle (University Hospitals Plymouth) delivered the Peninsula Acute Sustainability Programme (PASP): Developing the Draft Case for Change, and discussed:

a) The ambition of the PASP was to develop sustainable care for local people and deliver high quality equitable services;

b) It was important that care was delivered in the most appropriate setting for each individual and that care was accessible for all;

c) Engagement had been undertaken with patients and staff over several years, and feedback had centred around:

   i. Long waiting times for access to services;
   ii. Complex processes to gain access to services;
   iii. A need to ensure equity of access to services, particularly for deprived groups and rural areas;
   iv. A need to ensure services were 'joined-up' and integrated;
   v. The lack of an electronic patient record, and need for digital 'enablers' for delivering integrated care across the Devon system;
   vi. Patients were not always seen in the right place at the first point of entry;
   vii. A need to improve productivity and efficiency.

d) Healthcare was facing considerable challenges, particularly across Devon and Plymouth. Factors included a growing population and an elderly population with increasingly complex comorbidities;

e) There was a need to re-evaluate approaches to healthcare to ensure longer and healthier lives, as well as reducing the impact on health services;

f) Under new leadership UHP had adopted a 'One Method' approach, focussing on avoiding admissions, managing patient arrivals in a considerate, kind and effective manner, and ensuring successful discharges. This had resulted in an 18% improvement;

g) Working as isolated hospitals across the region was no longer sustainable and a collaborate approach was proposed to best optimise resources and demand across the region;

h) Future system challenges would include meeting the demand of an increasingly elderly population, as well as addressing inequalities;

i) The PASP was designed as a response to current financial and demand challenges, with the ambitions of developing sustainability for services, workforce and finances;

j) Each of the acute providers in Devon and the Integrated Care System (ICS) were in NOF4, the highest level of regulation, due to failings in performance and financial spend;

k) Across the peninsula there were enough staff to operate four hospitals however, there were five hospitals in operation. The hypothesis for building a sustainable acute service model was to improve diagnostic and assessment functions at the 'front door' of the hospitals to enable the redesign of 'non-core' elements and combat workforce challenges;

l) Having engaged with clinicians, Healthwatch, patients and staff to understand the challenges, a shared view had been identified;

m) The Case for Change was a technical document which set out the fundamental challenges faced, along with a vision for the future. The document would not include 'solutions' at this stage, but would help facilitate engagement and the development of modelling for solutions later on. The challenges identified were:

n) People & Health Needs:
    i. There were approximately 1.3 million people living across Devon, Cornwall and the Isles of Scilly, with over half of the population above 50 years old and nearly a quarter over 65. This was expected to significantly rise over the next 20 years;
    ii. The gap between 'life expectancy' and 'health life expectancy' was growing. In Plymouth, the gap was 18 years for men, and 23 years for women;

o) Performance:
    i. None of hospitals within the region were meeting the four hour wait target in A&E. As of January 2024, over 1,000 people were waiting over 18 months for an operation, and 6,000 people were waiting more than 15 months. Around 4,000 planned operations were cancelled last year;

p) Estates and Infrastructure:
    i. There was an estimated £4 million of estates improvements and repairs required;
    ii. It was also important to boost staff recruitment and retention;

q) Finances:
    i. There was an estimated overspend of £85 million in Devon for 2024/25. There was an expectation nationally that this would not continue;

r) The vision of the plan was: To work together to deliver safe, high quality, sustainable and affordable services as locally as possible;

s) The next stage would be to engage with the public to understand if all of the challenges had been accurately identified, what the impact of challenges was to the public, what 'good access' looked like, how the challenges could be best addressed, and what the best forms of engagement were.

In response to questions, the Panel discussed:

t) The role of the Nightingale Hospitals in alleviating pressures on local services and reducing waiting times;

u) Concerns around accessibility of services and the requirement to travel for care, which could inequitably affect disabled, elderly and deprived communities. It was stated that requirements for travel would be kept to an absolute minimum, and only used to enhance accessibility of services;

v) The importance of equity of access and outcomes;

w) Services would be designed around patient safety, effectiveness and wrap around patient care;

x) A commitment to engage, listen and incorporate patient feedback during development of the PASP;

y) The importance of developing a prevention and intervention strategy to mitigate long-term demand, beginning with children and young people;

z) Concerns that transferring patients from acute setting to the community would transfer financial pressures to Local Authorities;

aa) The target for completion of the Case for Change was November 2024, which would then be followed by a formal consultation period;

bb) An electronic patient record system was being developed, which was critical for transformation and efficiency;

cc) Funding through the New Hospitals Programme, and the importance of ensuring appropriate investment was made, considering long term future needs;

dd) The public engagement campaign would include an 'easy read version' and a translated version (upon request). The campaign would use surveys and

meetings to engage with the public, utilising existing networks and targeting vulnerable groups and service users.

The Panel agreed to-

1. Provide feedback on the Peninsula Acute Sustainability Programme to NHS Devon, summarising this meetings discussions;

2. Note the report.

53. **Right Care Right Person**

Fergus Paterson (Chief Superintendent, D&C Police) delivered the 'Right Care Right Person' report and discussed:

a) 'Right Care Right Person' was a cross-government approach to ensure people in need received the most appropriate care, from individuals and agencies with the right skills, experience and training;

b) The Police had been serving as a 'helper to all', detracting from their core police responsibilities: 'prevent and investigate crime'; 'keep the King's peace'; 'save Life and prevent serious harm and suffering when crime is involved'; 'help other agencies when needed';

c) The majority of Police lacked advanced medical training and were of an equivalent level to a workplace first-aider. It was therefore not appropriate for them to attend patients who required specific medical care or specialist services;

d) It was important that agencies with the right skills and expertise attended events such as welfare checks, suicidal ideation, self harm, emotional distress and medical emergencies, while the police attended risk based behaviour under A2/A3 of the Human Rights Act: Save life (Section 2 Human Rights Act) and prevent serious harm and suffering (Section 3) when crime is involved;

e) The Police had strong links with mental health providers in Plymouth including Livewell Southwest. A Joint Response Unit had been established, comprising of a Police officer and a mental health professional to conduct joint attendances;

f) In response to recognition of failings due to high demand and resource diversion, Devon and Cornwall Police had committed to 'prevent and investigate crime (including in health and social care settings and supporting victims in associated professions)';

g) A toolkit had been developed for call handlers, based on legal principles:

i. Police may choose to accept an Article 2 and 3 duty when a more appropriate agency (better knowledge, skills, training, equipment, legal basis) could discharge that duty;
ii. Police will "share" Article 2 and 3 duty to save life and prevent serious harm when the more appropriate state agency is unable to;
iii. Police must consider the circumstances carefully before agreeing to take on a "duty of care" for non-police duties.

h) The Police could not force entry to a property for a welfare check alone. It was required that there was reasonable belief that the person was inside, and that entry was required to save 'life and limb';

i) The changes were being introduced in a phased approach, and were overseen by a scrutiny panel:

i. 'Concern for Welfare' had gone live in January 2024, resulting in 35% fewer attendances than the previous year;
ii. 'Absconders and Mental Health Act Absence Without Leave' had gone live in June 2024 in collaboration with mental health partners and acute trusts, introducing necessary steps before Police action was required;
iii. 'Section 136 and voluntary attendees' would go live by the end of 2024, providing acute trusts and the ambulance service an understanding of police capabilities, as well as defining the appropriate time/stage they should be called;
iv. 'Transport of patients' was the final phase, which would ensure transport for those with mental illnesses was conducted solely in specialist medical vehicles.

j) An escalation process and scrutiny panel had been established to ensure a coordinated, safe and appropriate transition through the Right Care Right Person initiative;

In response to questions, the Panel discussed:

k) The important role of Community Support Officers and their training in phases one and two, as well as partnership working with health providers;

l) The potential positive impacts of the scheme, allowing the Police to focus on crime and disorder (prevention & reaction), as well as providing the appropriate trained professionals for patient attendances;

m) Concerns around the capacity of health agencies to fill the 'gap' created through the re-focussing of police responses. It was reported that there were scrutiny panels and safeguards in place to identify and address these gaps, although no gaps had yet been identified through evidence;

n) The requirement for ongoing assurance and partnership work to mitigate potential risks at the introduction of each new phase of the programme;

o) The challenges of identifying the level of threat and risk to an individual for call handlers.

The Panel agreed to-

1. Request an update on the progress and performance of the Right Care Right Person initiative at a later date to provide assurance and scrutiny of any risks and issues that emerge through the phased introduction;

2. To note the report.

54. **Tracking Decisions**

The Panel agreed to note the progress of the Tracking Decision Log.

55. **Work Programme**

The Panel agreed to add the following items to the work programme:

a) Adult Mental Health;

b) End of Life Care Update;

c) Policy Brief for Health and Adult Social Care.

56. **Exempt Business**

There were no items of exempt business.