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HEALTH AND WELLBEING SCRUTINY PANEL

Tuesday 16 July 2024
2.00 pm
Warspite Room, Council House

Members:
Councillor Murphy, Chair

Councillor Ms Watkin, Vice Chair

Councillors Lawson, McLay, Morton, Ney, S.Nicholson, Noble, Penrose, Reilly and Taylor.

Members are invited to attend the above meeting to consider the items of business overleaf. For further information on attending Council meetings and how to engage in the democratic process please follow this link - Get Involved

Tracey Lee
Chief Executive

Health and Wellbeing Scrutiny Panel

1. Apologies

To receive any apologies for non-attendance from Committee members.

2. Declarations of Interest

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

3. Appointment of the Chair and Vice-Chair

The Committee will be asked to note the appointment of Councillor Pauline Murphy as Chair, and Councillor Kathy Watkin as Vice Chair for the Municipal Year 2024/25.

4. Scrutiny Panel Responsibilities (Pages 1 - 2)

The Committee will be asked to note the Health and Wellbeing Scrutiny Panel's responsibilities.

5. Minutes (Pages 3 - 10)

The Committee will be asked to confirm if the minutes of 20 February 2024 are a correct version, for the record.

6. Chair's Urgent Business

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

7. H&ASC Quarterly Performance, Finance and Risk Monitoring Report: (Pages 11 - 34)

8. Peninsula Acute Sustainability Programme: Developing the Draft Case for Change: (Pages 35 - 54)

9. Disabled Facilities Grants: (Pages 55 - 68)

10. Right Care Right Person: (Pages 69 - 80)

11. Tracking Decisions (Pages 81 - 88)

For the Committee to review the progress of Tracking Decisions.

12. Work Programme (Pages 89 - 92)

For the Committee to discuss item on the work programme.

13. Exempt Business (as required)

To Consider passing a resolution under Section 100A(2/3/4) of the Local Government Act 1972 to exclude the press and public from the meeting for the following items of business, on the grounds that they involve the likely disclosure of exempt information as defined in paragraph 3 of Part 1 of Schedule 12A of the Act, as amended by the Freedom of Information Act 2000.

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Health and Wellbeing Scrutiny Panel

Linked to the Cabinet Member and Department with responsibility for:

- Public Health
- Public protection service
- Adult and Children's Health
- Mental Health Services
- Physical Disability Services
- Drug and Alcohol Services
- Learning Disability Services
- Ageing Well / Older Peoples Services
- Joint Health and Social Care Commissioning
- Leisure Services
- Health and Wellbeing

Statutory Role with regard to undertaking all the statutory functions in accordance with Section 244 of the National Health Act 2006, (as amended by Health and Social Care Act 2012) regulations and guidance under that section.

MEMBERSHIP – Proportionality applies, the Chair of the panel shall serve on the Scrutiny Management Board. All members of the panel will adhere to the general rules of Overview and Scrutiny.

There are 11 members of the panel including the Chair and Vice Chair.

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Health and Adult Social Care Overview and Scrutiny Committee

Tuesday 20 February 2024

PRESENT:

Councillor Murphy, in the Chair.
Councillor Harrison, Vice Chair.
Councillors Dr Mahony, McNamara, Nicholson, Noble, Penrose, Raynsford, Reilly and Ricketts.

Apologies for absence: Councillors Finn and Ms Watkin.

Also in attendance: Jane Bullard (NHS Devon ICB), Jonathon Cope (UHP), Tricia Davies (St Lukes), Ruth Harrell (Director of Public Health), Sharon King (Livewell), Shaen Milward (UHP), Chris Morley (NHS Devon ICB), Rachel O'Connor (Livewell SW), Sarah Pearce (Livewell SW), Gary Walbridge (Interim Strategic Director for People) and Elliot Wearne-Gould (Democratic Advisor).

The meeting started at 2.10 pm and finished at 5.20 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.

38. **Declarations of Interest**

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

Councillor	Interest	Description
Will Noble	Registered	Employee at University Hospitals Plymouth NHS Trust (UHP)
Natalie Harrison	Registered	Employed as a 'Community Builder'
Zoe Reilly	Registered	Non-executive director at Plymouth Community Homes

39. **Minutes**

The Committee agreed the minutes of 13 December 2023 as a correct record.

40. **Chair's Urgent Business**

There was one item of Chair's Urgent Business:

The Chair asked Councillor Mary Aspinall (Cabinet Member for Heath and Adult Social Care) to provide an update in relation to the outbreak of Measles in Plymouth. In response, it was reported that:

a) 465 cases of Measles had been reported across England this year, with a noticeable spike in January;

b) The majority of cases occurred in under ten year olds, with seven cases confirmed in the South West;

c) Vaccines were available, and people were encouraged to check with their GP that their vaccines were up to date;

d) While Measles was not currently a large issue in the South West, there was a requirement for caution and preventative action.

41. **End of Life Care**

Chris Morley (NHS Devon ICB), Jane Bullard (NHS Devon ICB), Shaen Milward (UHP), Jonathon Cope (UHP), Tricia Davies (St Luke's), Sharon King (Livewell SW), Sarah Pearce (Livewell SW), and Rachel O'Connor (Livewell SW) delivered a presentation on 'End of Life Care' to the Committee, and discussed:

a) The role of the Integrated Care System (ICS) in ensuring people with palliative and end-of-life care needs could access high quality, personalised care and support;

b) The recent amendment of statutory guidance to include palliative care services;

c) The establishment of a multi-disciplinary, end-of-life steering group in Devon which would oversee, monitor and make recommendations to NHS Devon;

d) NHS Devon's role in decision making and facilitating the delivery of end-of-life services to meet national, local and best practice guidance;

e) The Gold Standard Framework, and GP Workload;

f) Population statistics for Plymouth from 2021 census data detailed a population of 246,700, with an expected death rate of 2,647 per annum;

g) In Plymouth, 48% of deaths occurred in hospital, which was significantly higher than the Devon average of 37%;

h) Plymouth had higher levels of frailty amongst a younger population in comparison to other regional and national averages, largely due to deprivation;

i) University Hospital's Plymouth (UHP) had seen a decrease in the number of people dying in hospital in 2023;

j) Nationally, 1% of the GP-registered population were in their last year of life;

k) The Medical Examiner Service data for Plymouth showed fluctuating levels of people dying in the Emergency Department (ED);

l) Feedback from bereaved families was collated in Mortality Review Meetings;

m) Recommendations from the Devon End-of-life Commissioning review had included designing a Devon Service Specification to focus on equity of access and experience for all residents and their families;

n) There was a Devon-wide issue with the administration of 'Just-In-Case' (JIC) medications;

o) Key areas highlighted through the Devon End-of-life Commissioning review were:
i) The rollout of educational material and opportunities for staff training;
ii) Co-ordination of an equitable approach to training and education;
iii) The launch of NHS Devon's new 'end-of-life' webpage;
iv) Ensuring that funding and packages of care were made available in a timely fashion to ensure speedy and safe discharge, providing support to individuals and families to ensure their loved ones are cared for, and amending the package as need change;

p) Devon-wide end-of-life commissioning priorities were: supporting system wide projects, developing the end-of-life care service specification, and ensuring the appropriate equipment was available when required;

q) Treatment Escalation Plans (TEPs) required improvement however, the introduction of Electronic Treatment Escalation Plans (E-TEP) would be advantageous to this process;

r) A Care Co-ordination Function had been commissioned across Devon, allowing ambulance crews to access phone support from Advanced Care Practitioners and GPs, to discuss the terms of the TEP for each individual;

s) The six pillars within the National Framework for assessment were:
i) Each person was seen as an individual;
ii) Care was co-ordinated;
iii) Each person got fair access to care;
iv) All staff were prepared to care;
v) Comfort and wellbeing was maximised;
vi) Each community was prepared to help;

t) The core principles of establishing 'good practice' in Plymouth were: preferred place of death, maintaining the end-of-life register, visibility and use

of advanced care plans, and support at the final stages;

u) The three core measures put in place by the Southwest End-of-life Network were Recognition, Experience and Activity;

v) UHP had seen an increased number of complaints relating to individuals who had died in the Emergency Department;

w) Specialist advisory services were provided by St Luke's Hospice for UHP;

x) The UHP Palliative Care Team received between 120-140 referrals per month, with between 50-70 deaths in the same period;

y) In a brief survey carried out by UHP, 94% of people 'Agreed' or 'Strongly Agreed' that they were shown respect and dignity;

z) A dedicated bed space for end-of-life care had been created at Mount Gould Hospital;

aa) The holistic needs of the patient could not be met in an acute hospital setting. Death was a social event rather than a purely medical event;

bb) Services were expected to see greater demand due to demographic changes, particularly an increasingly elderly population;

cc) The 100 Day Challenge was a system-wide project, which focused on supporting Care Homes with high ED conveyances to maintain patients in their preferred place of care;

dd) The End-of-life Practitioner Role had been established in April 2023, helping to ensure patients received the care most appropriate to them;

ee) Funding had been obtained to double the capacity of the End-of-life Practitioner to support weekends and extended hours;

ff) The recent reduction of deaths within the Emergency Department was directly aligned with the inception of the End-of-Life Practitioner role;

gg) 60% of work undertaken by St Luke's Hospice was supporting people at home, with 300 active patients at the time of the meeting. This often differed from the public's perceptions of hospice care;

hh) From March 2023 there had been 4,396 face to face contacts between patients and St Luke's Hospice;

ii) A National Audit Tool had been used to acquire feedback from patients and their loved ones, and St Luke's Hospice had consistently held a five star rating;

jj) St Luke's Hospice three year strategy focussed on expanding Community Care Services;

kk) Social workers aided with the pastoral and emotional support for bereavement;

ll) The annual cost of delivering patient Clinical Services was in excess of £7.2 million;

mm) The St Luke's Hospice Community Team were led by a Consultant Nurse with advanced skills;

nn) The Core Grant Payment for St Luke's Hospice had a standardised formula to align with inflation;

oo) Livewell Southwest was a Social Enterprise that provided Integrated Health and Social Care Services for people across Plymouth, the South Hams and West Devon;

pp) Livewell Southwest colleagues were generalists and so would obtain specialist end-of-life or palliative care advise from St Luke's Hospice;

qq) Between January 2023 and December 2023, Livewell Southwest cared for 1,335 people who were entering the last months of their lives. Of these, 575 were supported to die in their own home, 596 died in care homes, 63 people died in local hospice and 71 people died in an acute hospital setting;

rr) Livewell Southwest Care Packages were holistic and therefore took into account the patients emotional, psychological and spiritual needs;

ss) Livewell Southwest Community Nurses could verify a person's death;

tt) A dedicated co-ordination system with one phone number would ease the hardship of end-of-life care;

uu) As part of the Compassionate City model, it was important to increase discussions around death and future planning however, there was a recognisable societal 'taboo';

vv) COVID-19 had prompted the creation of a co-ordinated Care Home Service;

ww) A Care Co-ordination Hub was being piloted.

The Committee agreed to adjourn the meeting at 17:20 and reconvene at a future date to finish the items of business.

The Committee reconvened at 10:00 on 06 March 2024.

Present:
Councillors: Murphy (Chair), Harrison (Vice-Chair), Krizanac, Mahony, McNamara, Nicholson, Noble, Penrose, Raynsford (Substitute for Cllr Tuohy), Reilly, and Watkin.

Also in attendance: Councillor Aspinall (Cabinet Member for Health and Adult Social Care), Gary Walbridge (Interim Strategic Director for People), Karen Burfitt (Marie Curie), Sharon King (Livewell SW), Shaen Milward (UHP), Chris Morley (NHS Devon), Jane Bullard (NHS Devon), Frances Hannon (St Luke's), Tricia Davies (St Luke's) and Elliot Wearne-Gould (Democratic Advisor).

Chris Morley (NHS Devon), Karen Burfitt (Marie Curie), Sharon King (Livewell SW), Shaen Milward (UHP), Jane Bullard (NHS Devon), Frances Hannon (St Luke's), and Tricia Davies (St Luke's) resumed the 'End of Life Care' presentation, and discussed:

xx) During the 100 Day Challenge, a particular effort was made to work with 10 care homes with the highest ED admission rates, examining what extra support was required. The ambition was to establish consistency in practise and standards across care homes, as well as the creation of a telephone line for professionals to call when needing advice;

yy) The creation of the Devon and Cornwall Shared Care Record would allow the collation and centralisation of patient data, to ensure coordination across the system. This now included patients Treatment Escalation Plans (TEP);

zz) Assessing a patients mental capacity in decision making was a complex process, and relied on clinical assessments;

aaa) It was important for the health system to recognise a patient's transition to end of life care at the earliest opportunity. Primary care staff were being trained to increase recognition of symptoms, as well as in the completion of advanced care plans;

bbb) Options were being explored to integrate patients Treatment Escalation Plans (TEPs) on the NHS app;

ccc) During statistical analysis of ED attendances, Estover had been identified as a City area with a higher proportion of older and less affluent patients, frequently attending ED. This was largely due to an increased prevalence of COPD and lung cancer;

ddd) In Estover, a six month project had been launched in a partnership with Marie Curie, to provide healthcare professionals and volunteers to help identify and support people who were nearing end of life care. The findings of the project would be valuable in identifying the most efficient and effective measures to improve residents and health, and social care system;

eee) If identified early, patients often benefited from home adaptations to enable them to live, be cared for, and die at home. The Cities' Housing Needs Assessment was currently being reviewed, to assess appropriateness of housing provision;

fff) It was important to capture and maintain the many elements of a 'Compassionate City' that had emerged during the Pandemic;

ggg) St lukes were currently funding Community Development workers, focussing on normalising conversations around death, dying and grief;

hhh) Dying matters week would be held on the 6-12 may.

The Committee agreed to recommend that:

1. NHS Devon and partners return to a future scrutiny session to bring an update on performance against the End of Life Care improvement Plan. This is to include delivery of the Palliative Care framework, findings of the Estover Pilot Project, and additional information on the below recommendations;

2. NHS Devon and Partners take into account, and record peoples preferences for place of death;

3. NHS Devon and partners return at a future time to report on falls prevention measures being undertaken and related performance;

4. NHS Devon and partners work to reduce the delay in testing and diagnosis to enable maximum choice for patients spend their remaining time in the way/location that they wish;

5. NHS Devon adopt processes to include patients' relatives in the planning and administration of care for their loved ones (where applicable, and consent given). This includes consultation in the development of a TEP;

6. The Council, in partnership with City organisations and individuals, seek to promote and recognise St. Luke's communication of "Care in the community" and "the hospice coming to you", rather than the misconception of patients having to be admitted to a hospice;

7. The Cabinet Member for Housing, Cooperative Development and Communities (Cllr Penberthy), ensures that the Housing Needs Assessment considers housing standards, and their appropriateness, for individuals with a variety of medical needs.

42. **Tracking Decisions**

Elliot Wearne-Gould (Democratic Advisor) delivered an updated on the Tracking Decision Log and discussed:

a) Five actions had now been completed, with seven remaining outstanding. The majority of these actions would be marked complete when presented to the Committee in the new municipal year;

b) The latest version of the action log would be circulated to the Committee before the start of the new municipal year.

The Committee agreed to note the progress of the Tracking Decisions Log.

43. **Work Programme**

Following a discussion of potential items to be considered in the New Municipal Year, the Committee agreed to note the work programme.

44. **Exempt Business**

There were no items of exempt business.

Health and Wellbeing Scrutiny Panel

Date of meeting:	16 July 2024
Title of Report:	**Health and Adult Social Care Performance Report**
Lead Member:	Councillor Mrs Mary Aspinall (Cabinet Member for Health and Adult Social Care)
Lead Strategic Director:	Gary Walbridge (Interim Strategic Director for Health, Adults and Communities)
Author:	Ross Jago (Head of Governance, Performance and Risk)
Contact Email:	Ross.jago@plymouth.gov.uk
Your Reference:	Click here to enter text.
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report
The purpose of this report is to inform members of the latest performance against a number of key indicators that provide a view of how health and adult social care is being delivered to the people of Plymouth.

Recommendations and Reasons
The Health and Wellbeing Scrutiny Panel notes the Health and Adult Social Care Performance Report and considers areas highlighted by the report for inclusion in the Committee's work programme.

Alternative options considered and rejected
N/A

Relevance to the Corporate Plan and/or the Plymouth Plan
This performance report links to the following Corporate Plan priorities; Working with the NHS to provide better access to health, care and dentistry, and Keeping children, adults and communities safe.

Implications for the Medium Term Financial Plan and Resource Implications:

There are no financial implications arising directly from this report.

Financial Risks

There are no financial risks arising directly from this report.

Carbon Footprint (Environmental) Implications:
There are no environmental implications arising directly from this report.

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

** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*

N/A

Appendices

**Add rows as required to box below*

Ref.	Title of Appendix	Exemption Paragraph Number (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	2	3	4	5	6	7
A	Health and Adult Social Care Performance							

Background papers:

**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are <u>unpublished</u> works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	Exemption Paragraph Number (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	2	3	4	5	6	7

Sign off:

Fin	N/A	Leg	N/A	Mon Off	Click here to enter text.	HR	Click here to enter text.	Assets	Click here to enter text.	Strat Proc	Click here to enter text.

Originating Senior Leadership Team member: Gary Walbridge

Please confirm the Strategic Director(s) has agreed the report? Yes

Date agreed: 08/07/2024

Cabinet Member approval: Cllr Mary Aspinall, Cabinet Member for Health and Adult Social Care

Date approved: 08/07/2024

ADULT SOCIAL CARE ACTIVITY AND PERFORMANCE REPORT

May 2024

CONTENTS

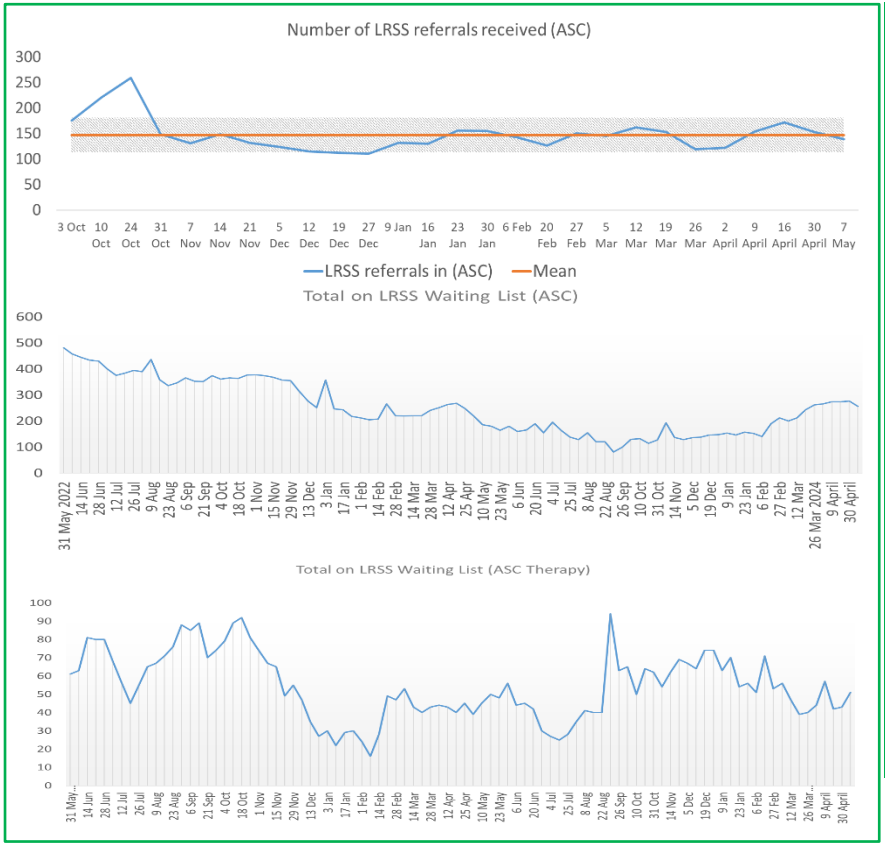
Purpose of report

This performance and activity report is designed to ensure regular dialogue on Adult Social Care performance between Plymouth City Council and Livewell Southwest, both organisations which will have an impact on the performance reported.

The performance reported is against quality improvement metrics that are not subject to any contractual monitoring, the report is for internal reporting within Plymouth City Council and Livewell Southwest performance frameworks.

Reporting period to: 7 May, 2024 **Theme:** Demand and Unmet Need

KPI	2 April	9 April	16 April	30 April	7 May	Direction	TARGET
LRSS Referrals in (ASC)	122	154	172	153	139	▼	
Referrals closed in LRSS (ASC)	131	154	216	175	163	▼	
% closed compared to LRSS referrals in (ASC)	107.4%	100.0%	125.6%	114.4%	117.3%	▲	tbc
Referrals generating onward referrals in LRSS (ASC)	172	23	51	43	72	▲	
% of referrals generating onward referrals (ASC)	141.0%	14.9%	29.7%	28.1%	51.8%	▲	
LRSS Referrals in (ASC Therapy)	8	13	16	13	10	6	
Total on LRSS Waiting List (ASC)	266	274	274	277	256	▼	tbc
Total on LRSS Waiting List (ASC) - RED	27	21	13	4	1	▼	tbc
Total on LRSS Waiting List (ASC Therapy)	44	57	42	43	51	▲	tbc
Total on LRSS Waiting List (ASC Therapy) - RED	2	4	1	5	7	▲	tbc



Analysis

The number of people on the Livewell Referral and Support Service waiting list is much improved on historic performance but has been increasing over the last few months. The Council will now also be able to monitor the number of people RAG rated as red on the waiting list. The number of people rated as a red risk was only one in the week of 7 May.

Narrative and Plan

LRSS has experienced long term sickness of two full time members of staff and another F/T member of staff on placement in another team as part of their social work studies. Therefore, team has lost 3 F/T members of staff from a team of 14 FTE.

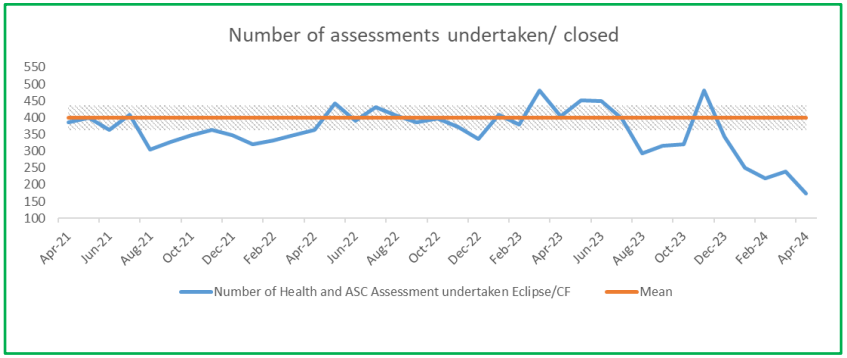
Two long term sick team members have now returned to work on phased returns. By reviewing data trends there is an annual increase of referrals in March and April, with data trends indicating that over May, June, and July that the waiting list reduces significantly. It is hoped that this trend will continue in 2024. PPN's continue to impact heavily here.

PLAN: Overtime has been offered to the team to reduce WL utilising hours within the establishment generated from a member of staff reducing their hours. There has been good uptake on this.

Co-ordinator continue to complete regular data cleanses to ensure that all waiters need to be waiting and have yet to be seen by the service

Reporting period to: April, 2024 **Theme:** Assessment Activity LWSW

KPI	December	January	February	March	April	Direction	TARGET
Number of LTC assessments undertaken - Eclipse	145	235	196	224	168	▼	183/m
Number of HSC Assessments closed – Eclipse/CF	344	251	219	240	173	▼	
% Care Act assessments completed within 28 days (community route)	78.4%	77.8%	88.1%	86.2%	81.5%	▼	



Analysis

The number of HSC Assessments closed includes those still being closed on CareFirst and are likely to include legacy pieces of work. Numbers undertaken/closed since December are lower than the monthly average of 2022/23 (399). Between July 2023 and April 2024 closed care act assessments (on Eclipse only) have taken on average 22 days, the longest of which is 277 days, these do however exclude those opened on CareFirst prior to July 2023.

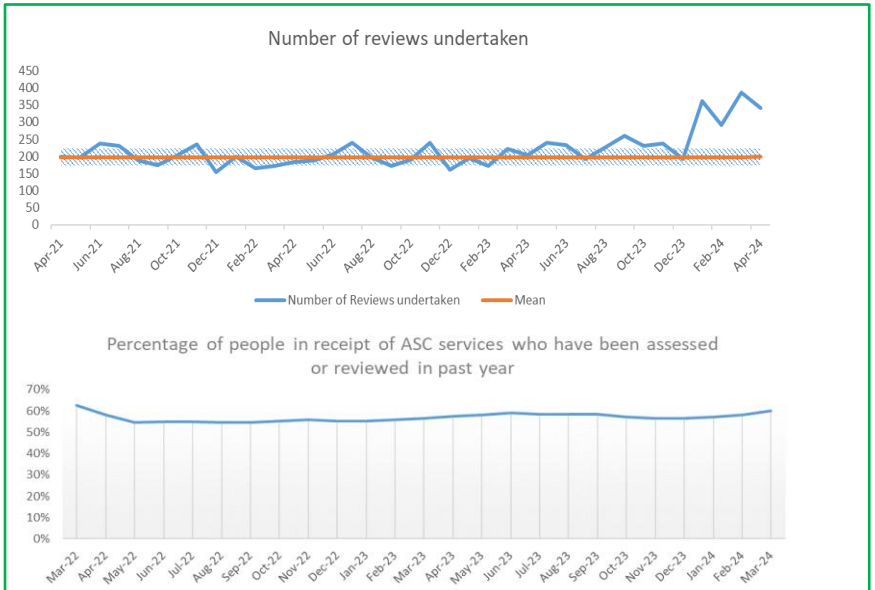
Narrative and plan

Our waiting list programme has been defined and is engaged in benchmarking where we are right now. Data Quality features heavily in this and some of the drop off in this month's performance (and next months) will be due to re engaging with people on the waiting lists. All lists are being re-triaged. It should still be noted that some of the ongoing work is seeing improvements in unallocated work and length of waits.

We will be using the escalation routes in the waiting list project to challenge system issues that are hindering this work – for example we are still identifying new CA assessments being created despite an open review activity – this accounts for 200 system CA assessments we aim to have the assessment review completed by the end of June.

Reporting period to April, 2024 **Theme:** Review Activity

KPI	December	January	February	March	April	Direction	TARGET
Number of reviews undertaken	193	361	292	387	**341**	▼	197/m
% of people in receipt of LT services assessed or reviewed in last 12m	56.4%	57.1%	58.0%	61.4%	**61.3%**	▼	75%
% of people in receipt of LT services assessed or reviewed in last 12m – using Client Level Dataset	43.0%	44.9%	46.1%	48.4%	**49.9%**	▲	



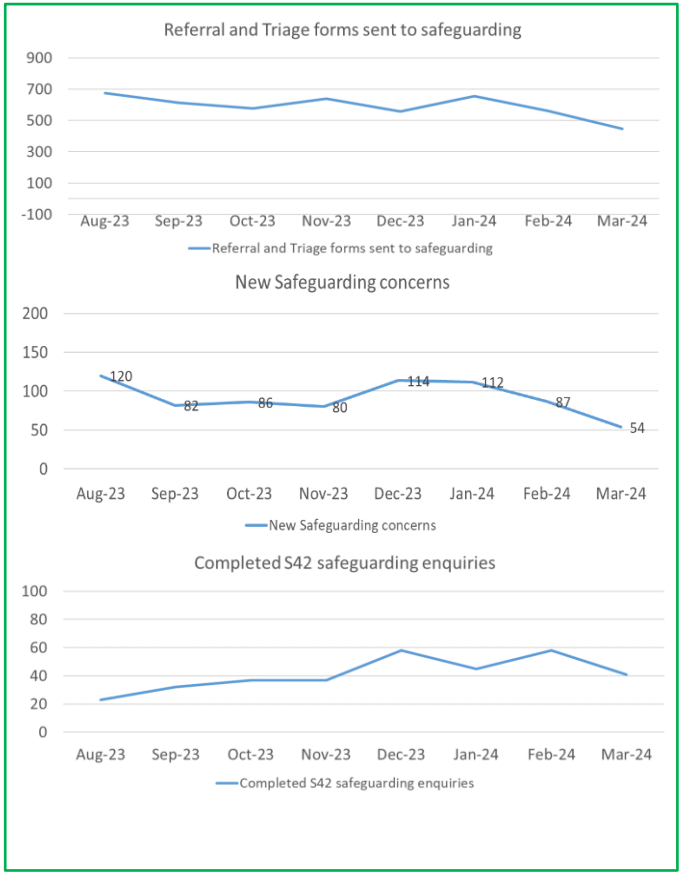
Analysis

The number of reviews undertaken is now on an increasing trend since April 2021, this trend improved by higher numbers of reviews completed in the early part of 2023/24. Since January 2024 reviews undertaken have increased significantly, averaging 345 between January and April, this figure still sits well above the monthly average between April and December 2023 (218).

Narrative and Plan – Performance continues to move in the right direction – we're still waiting on the telephone review form to go live. The impact of the focused review work starting to impact upon performance here. We can see clear gains in reduction of waits and overdue work. It should be noted that the increased activity in this area is entirely driven by the focussed ASC review team. As the waiting list work continues to develop, we may look to focus some of this resource in other priority areas.

Reporting period to: April 2024 **Theme:** Safeguarding Activity

KPI	December	January	February	March	April	Direction	TARGET
Referral and Triage forms sent to safeguarding	558	657	562	447	**434**	▼	500/m
Percentage of above that become a concern	20.3%	17.2%	16.0%	13.9%	**18%**	▲	20%
New Safeguarding concerns	114	112	87	54	**63**	▲	N/A
S42 Enquiries completed	58	45	58	41	**37**	▼	N/A



Analysis

The number of referral forms sent to safeguarding is now reducing, between July 23 and January 24 we were averaging 599 per month, this has reduced to 481 between February and April. On average, each month (between July 23 and April 24) 16% of those referrals became a safeguarding concern, the % becoming a concern increased in April to 18%, this may be the start of an increasing trend, which we would expect to see as referrals drop.

Narrative and Plan

PCC Update: The number of referral and triage sent to safeguarding has continued to reduce to its lowest number at 434 and by 35% from January. The main cause of this is the updating of the Safeguarding referral form aimed at clarifying the criteria and signposting to more appropriate referral routes. The other cause is the introduction of the live safeguarding advice line, which is designed to support referral decision making and has resulted in approximately 80% of calls being redirected. This has continued to enable the team to focus on core business, although there has been an impact on LRSS who are now being sent the redirected referrals and have seen an increase to their waiting list.

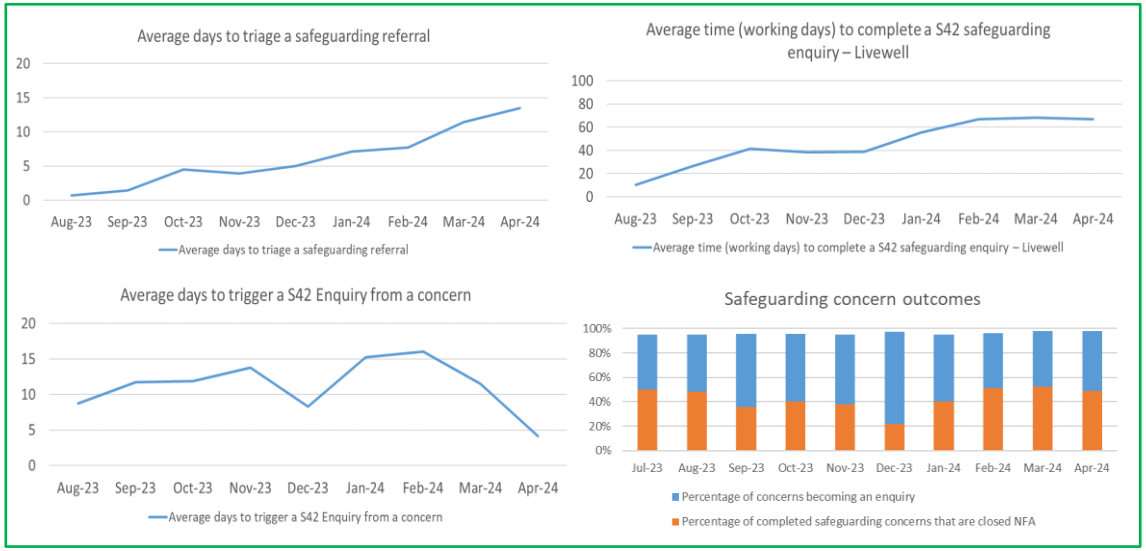
The % of above that become a concern has remained low despite the reduction in above forms and we expected the conversion rate to increase the %. However there has been a 4% increase in the last month and we will monitor this.

The number of completed safeguarding enquiries completed has further reduced and may be attributable to staffing levels increasing within the ASC LSW Pathway.

The Safeguarding Pathway project continues to progress and is now designing a "new way of working" proof of concept with the teams.

Reporting period to: April, 2024 **Theme:** Safeguarding Processes/Activity

KPI	December	January	February	March	April	Direction	TARGET
Average time in days to triage a safeguarding referral	5	7.1	7.7	11.4	13.5	▲	TBC
Average time in days to trigger a S42 Enquiry from a concern	8.3	15.2	16	11.5	4.1	▼	TBC
Percentage of completed safeguarding concerns that are closed for safeguarding	21.7%	40.3%	51.2%	52.3%	48.90%	▼	TBC
Percentage of concerns becoming an enquiry	75.50%	54.60%	45.10%	45.40%	48.90%	▲	TBC
Percentage of completed safeguarding concerns that lead to an ASC assessment	0%	1.70%	0%	1.20%	0%	▼	TBC



Analysis

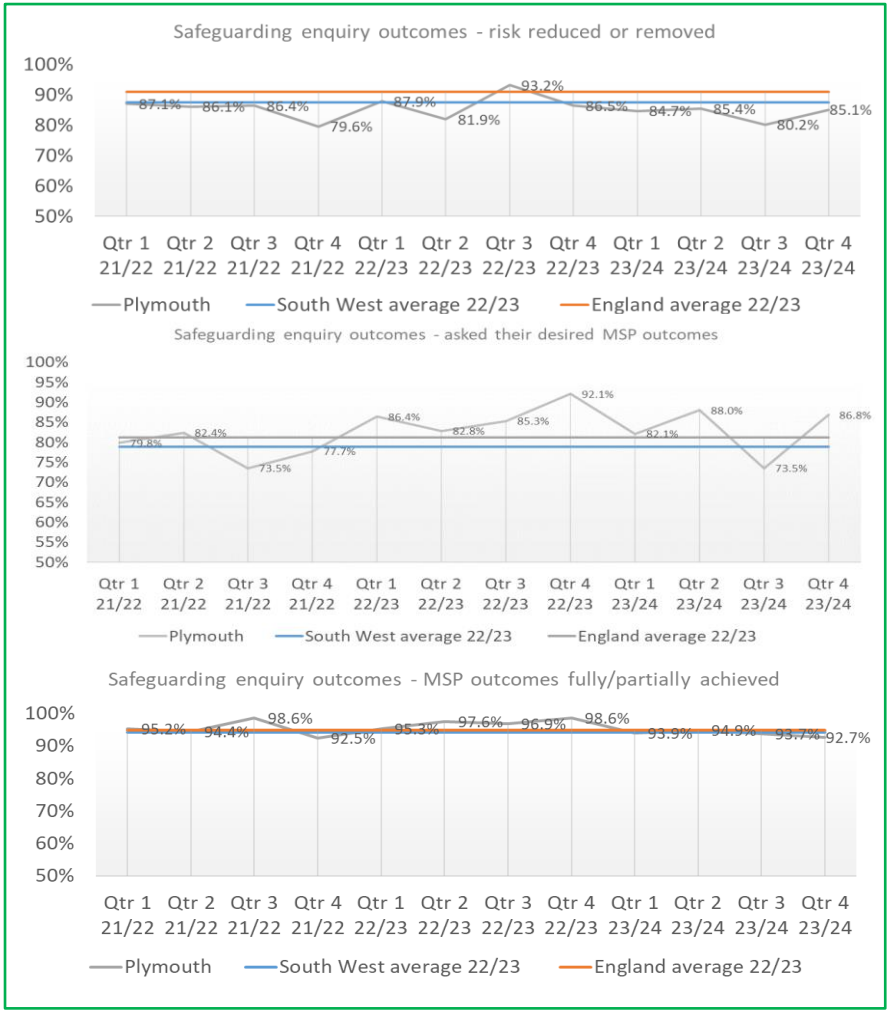
We do not yet know how these metrics will retrospectively change post reporting so any interpretation of performance should be discussed in this context. Since July 2023, the monthly average of the percentage of concerns that become an enquiry has been 53.5% and has a range between 45% and 60% (exception being December). On average 43% of concerns become NFA.

The average time taken to complete a safeguarding enquiry appears to be increasing, but a larger time series is needed to fully understand this.

Narrative and Plan – For PCC, we will be looking to respond to data for the current Retained Client Function tasks in the framework, by monitoring the expected reduction in demand and related changes. The plan is focused on the pathway development planning to align responses and have an integrated approach to future responses and reporting.

Reporting period to: Quarter four, 2023/24 **Theme:** Safeguarding Outcomes

KPI	Q4 23/24	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	Direction	TARGET
Enquiry outcome – risk reduced or removed	86.5%	86.1%	85.4%	80.2%	**85.1%**	▲	92.4%
Enquiry outcome – risk remains	13.5%	13.9%	14.6%	19.8%	**14.9%**	▼	7.6%
Enquiry outcome – asked MSP outcomes	92.1%	83.8%	87.8%	73.5%	**86.8%**	▲	87%
Enquiry outcome – MSP outcomes fully/partially achieved	98.6%	93.9%	95.0%	93.7%	**92.7%**	▼	95%



Analysis

Last Quarter: Between 1 January 2024 and 31 March 2024 (Q4), 144 individuals were the subject of a completed safeguarding S42 enquiry, 125 of which expressed a desired MSP outcome 92.7%at the start of the enquiry (86.8% compared to 73.5% in Q3). The percentage of people not asked about their preferred has fallen to 10.4%.

The percentage that has been either fully or partially achieved has dropped slightly, down from 93.7% (74 of 79) in Q3 to 92.7% (102 of 110) in Q4.

Narrative and Plan

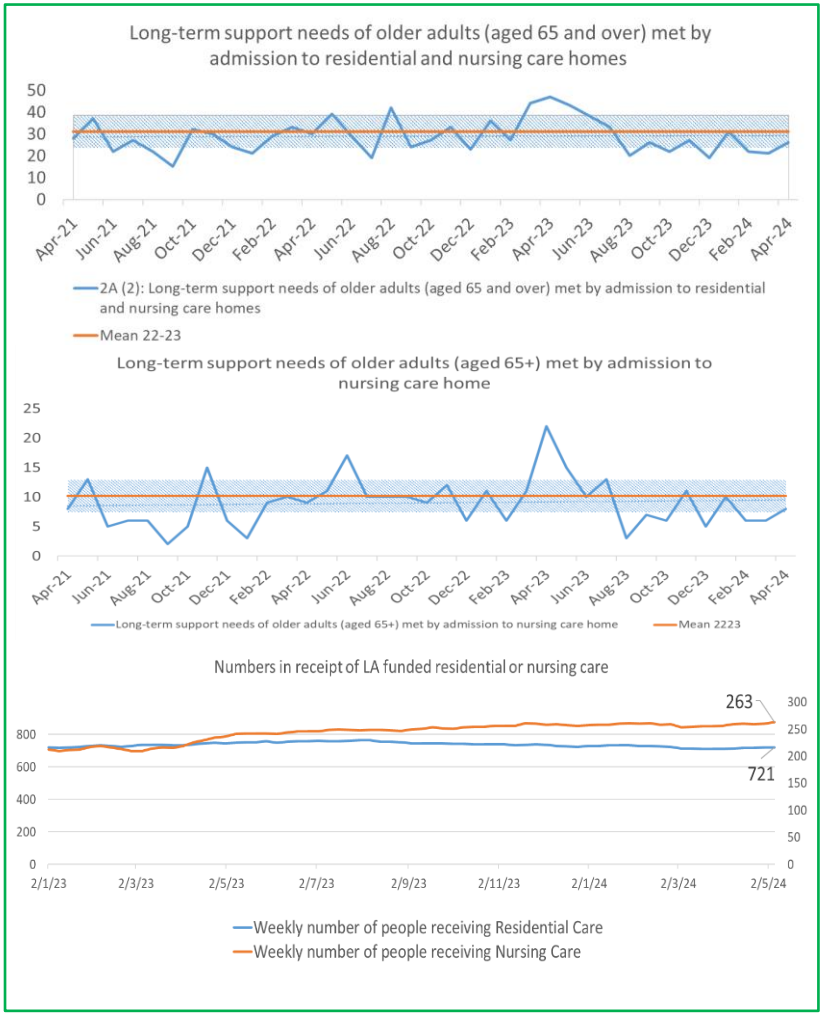
The % of people where a risk has been reduced or removed has increased which is positive and the % where risk remains has dropped because of this.

The % of people asked about their MSP outcomes has increased from last month, but we are still working on training and due to joint work with LWSW as part of the SG pathway project and oversight and actions to address. We will also look at separate data for PCC and LWSW to understand at which point in the process we need to improve.

The enquiry outcome being fully or partially met has not increased and is likely still due to setting unrealistic outcomes which we are addressing through above also.

Reporting period to: April 2024 **NATIONAL INDICATOR/ ICP INDICATOR** **Theme:** Care Homes

KPI	December	January	February	March	April	Direction	TARGET
LT admissions to residential/nursing care 65+	19	31	22	21	**26**	▲	31/m
LT admissions to res/nur care 65+/100k pop. (Cumulative.)	569.072	632.99	682.474	711.34	**53.6**	N/A	769.1
LT admissions to residential/nursing care 18-64	2	1	4	3	**2**	▼	3/m
LT admissions to nursing care 65+	5	10	6	6	8	▲	N/A
Numbers in receipt of Nursing Care	257	261	258	256	**263**	▲	224
Numbers in receipt of Residential Care	730	728	724	702	**720**	▲	735



Analysis

In 2023/24 we recorded 349 long term admissions of older people to a residential or nursing home, this is a reduction of 24 from 2022/23 (373). The number of admissions increased slightly in March 2024, but remains below the 2022/23 monthly average (31). Within this figure, the number into nursing care homes is following the same trend; in 2023/24 we recorded 114 long term admissions of older people to a nursing home, a reduction from 122 in 2022/23. The number of people in long term residential care remains on a declining trend but did increase at the end of April. The number of people in a nursing care setting is stubbornly high and presents a financial challenge.

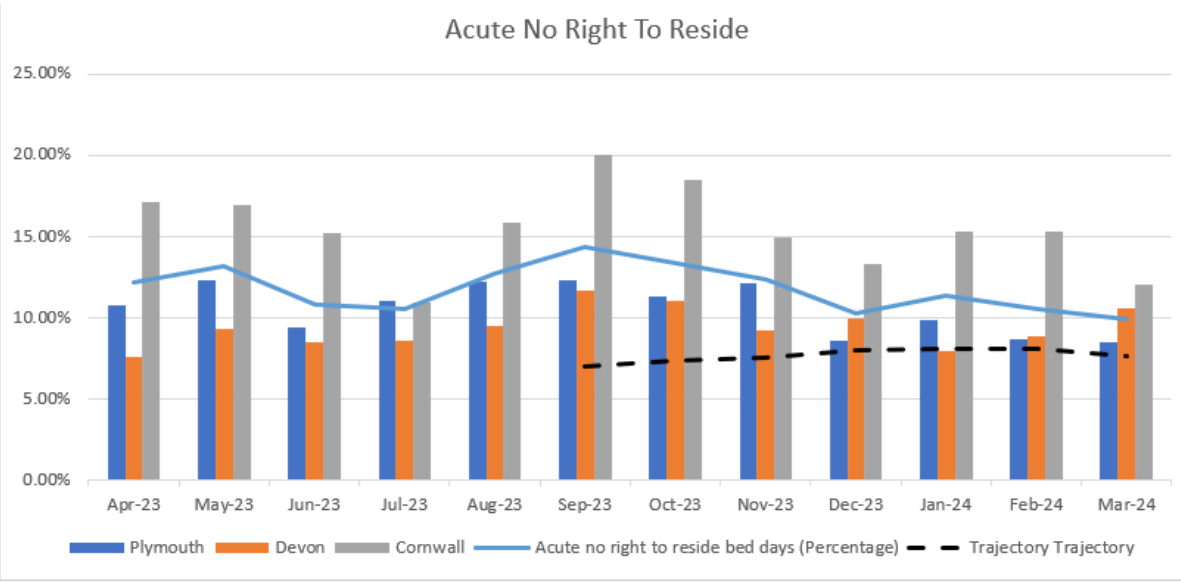
Narrative and Plan

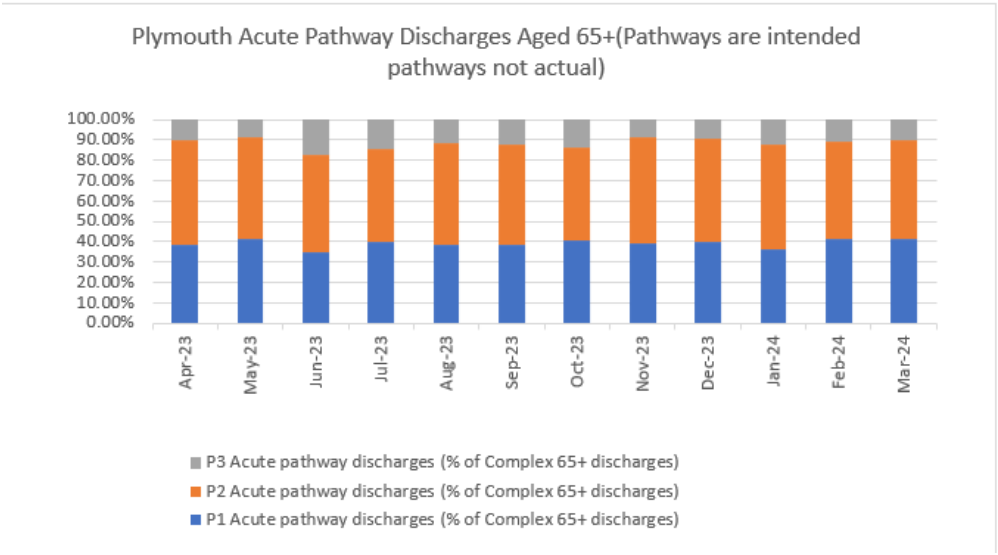
Admissions to care homes, particularly nursing care, is a key focus of our performance and budget containment activity over the next couple of months – we need to understand what is leading to a nursing home placement, whether this could be avoided and ensure we continue to pay a reasonable price for care. This will include an analysis of those clients and commissioned providers where we are funding at levels above standard rates.

Data Review

Average NCTR for March 24 is at 9.88%, a slightly improved position from February 24, 10.55%.

- Plymouth is maintaining its lower position of 8.45%, a slight decrease from February 24, 8.71%.
- Devon has seen an increase in March 24 to 10.54%, from the previously lower position of 8.85%.
- Cornwall has seen a positive decrease in NCTR to 12.06%, from 15.28% in February, but is still is still the lowest performing against the target.

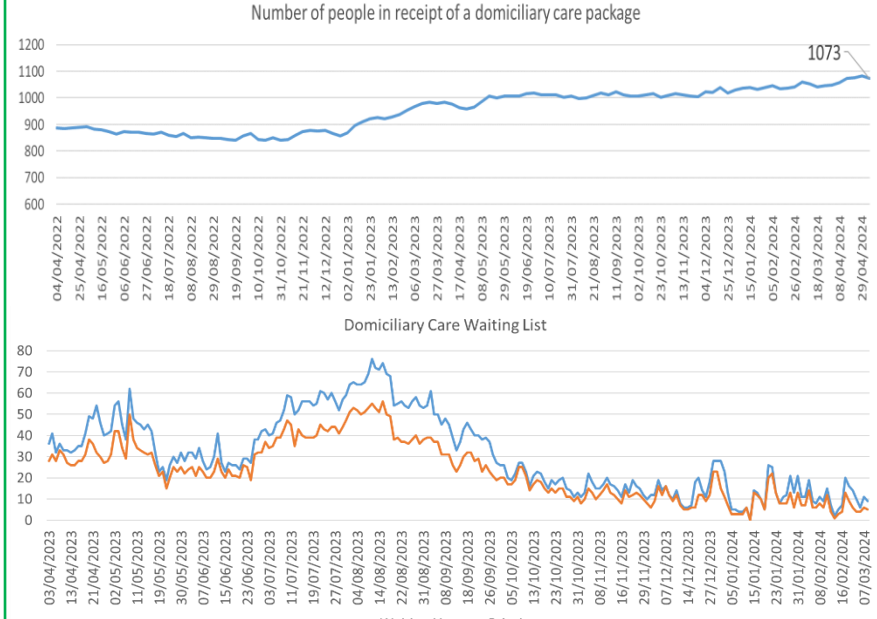




The John Bolton modelling for March 24 is consistent with February 24. 41.28% of complex discharges were recorded as intended P1, 48.25% as P2, and 10.47% as P3.

Reporting period to: April 2024 **Metric:** Domiciliary Care

KPI	December	January	February	March	April	Direction	TARGET
Number of people in receipt of domiciliary care (end of month snapshot)	1023	1042	1046	1051	**1083**	▲	977
Number of people awaiting care package (end of month snapshot)	28	9	16	8	**9**	▲	20
Number of people awaiting care package – RED priority (end of month snapshot)	23	6	9	5	**6**	▲	
Percentage of Dom Care packages opened within one week	87.8%	78%	85.9%	87.2%	**91.9%**	▲	
Number of Domiciliary Care packages started in period	228	283	235	264	**274**	▲	



Analysis

The number of people in receipt of Dom Care packages continues to increase, at the end of the month the snapshot had reached 1,083, a new high.

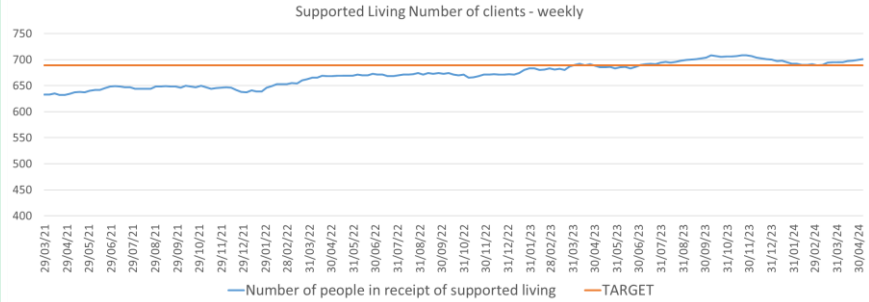
As the number of users have increased the numbers on the waiting list remains low, maintaining strong performance in this area. At the end of April, the waiting list is at 9. Low waiting lists and increased package numbers is supported by an increase in the numbers of Dom care packages started.

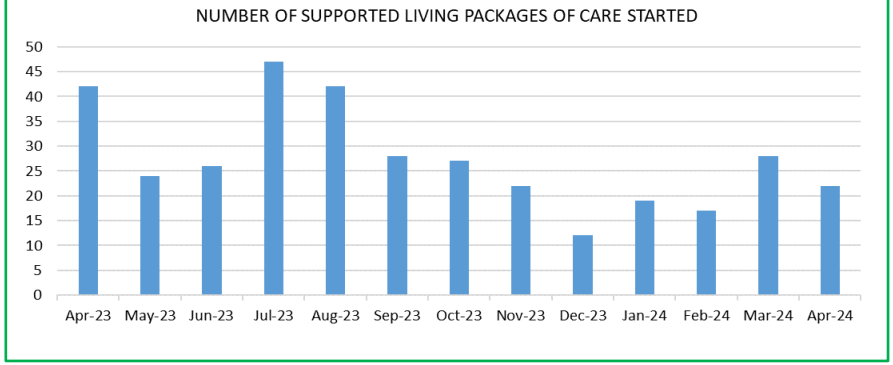
Narrative and Plan

The waiting list and wait times for home care continue to be low, with capacity in the market and providers reporting they can recruit staff to fill vacancies. This is also having the effect of reducing handbacks of packages of care – providers are aware they are not able to select clients from a large waiting list.

Reporting period to: April 2024 **Metric:** Supported Living

KPI	December	January	February	March	April	Direction	TARGET
Number of people in receipt of supported living (end of month snapshot)	703	694	693	697	**699**	▲	689
Number of people awaiting care package (end of month snapshot)				41	**32**	▼	TBC
Number of Supported Living packages started in period	12	19	17	28	**22**	▼	



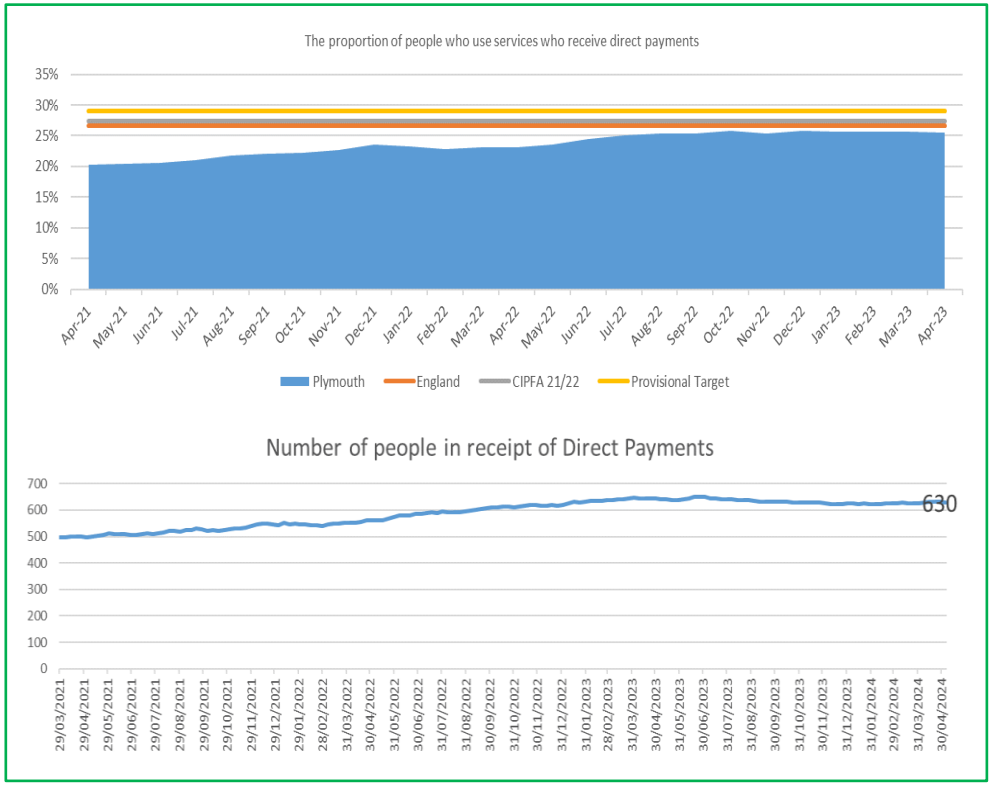


Analysis

These are new metrics. The number of people in receipt of supported living packages of care have been on an increasing trend over the long term, numbers being 10% higher than at the end of March 2021. Since the turn of the calendar year numbers have been reducing, down from a peak of 709 in November 2023. Numbers are currently 11 above budgeted target. The number of new packages started fluctuates month on month and the numbers currently awaiting a package remains low at 32.

Progress Flash Report for week to: April, 2024 **Metric:** Direct Payments

KPI	December	January	February	March	April	Direction	TARGET
Number of people in receipt of direct payments	626	625	624	620	630	▲	606
Percentage of people in receipt of direct payments	26.2%	26.1%	25.9%	25.5%	25.5%	▲ ▼	26.2%



Analysis

Like most types of care the number of direct payments had been increasing, in recent months however the numbers have stabilised. Following three months of decreases the numbers have shown an increase at the end of April, up to 630.

The ambition remains to increase the numbers in receipt of direct payments in line with national average, and to improve our performance against the national indicator; the proportion of people who receive services who receive a direct payment. A change to the CIPFA group means that for 2022/23 we exceed the peer group average of 21%.

Narrative and Plan

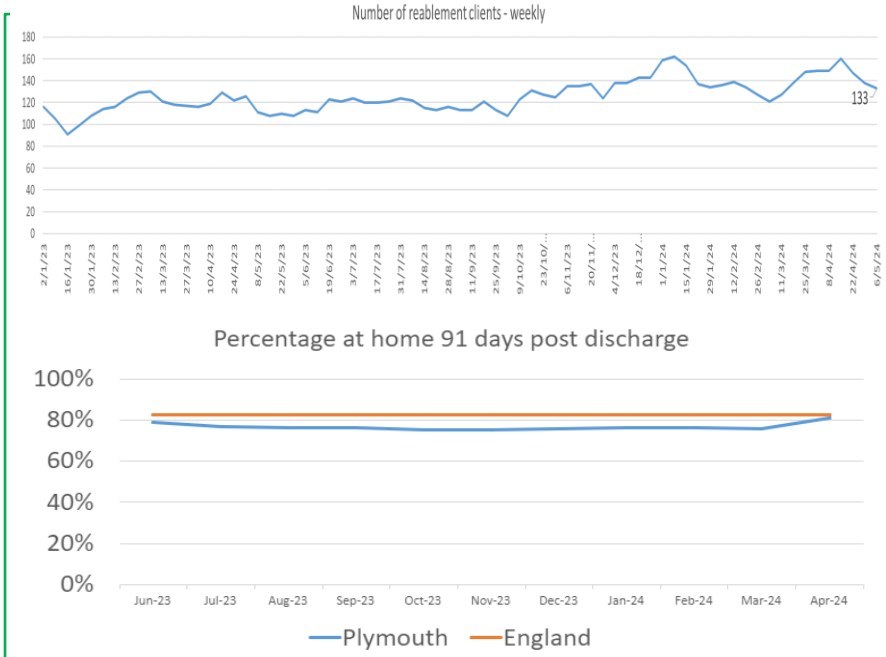
Direct Payment numbers have increased by ten since last month which is reassuring following a period very slight reduction in numbers. This ensures we remain at a good level and comparing well to national average. We believe that the increase is due to an increase in the number reviews being undertaken. Most of the new DPs users are employing PAs which is positive as it stimulates the PA market and reduces reliance on traditional domiciliary care. Our CQC Improvement plan should lead to further improvements in DP numbers and size, with the work being undertaken to reduce waiting times & review backlogs.

Our DP lead is now recruiting an additional officer within the team which will improve performance. A new training programme is being set up which will be mandatory and rolled out this year. We are also setting up a PA Bank to support DP users access PA. We have also now produced a draft Direct Payments Policy which will provide clear guidance to all practitioners and DP users and ensure successful management of DPs.

We are undertaking a deep dive into DP data to understand reasons for starting and ending of DPs and demographic make-up.

Progress Flash Report for week to: April, 2024 **Metric:** Reablement

KPI	December	January	February	March	April	Direction	TARGET
Number of people in receipt of reablement (end of month snapshot)	141	137	134	135	**138**	▲	
Percentage of people (65+) at home 91 days after discharge	75.6%	76.2%	76.2%	75.8%	**81.0%**	▲	80%
Number of Reablement packages started in period	112	108	96	122	**113**	▼	
Number of reablement hours delivered in period (predicted)	3,432	3,819	3,259	3,386	**3,429**	▲	



Analysis

Post October 2023 the numbers of people receiving reablement starting to increase following a prolonged period where the trend was relatively static. In the second week of January numbers reached a peak of 162 but since then numbers have reduced again and were 138 in the week of 6 May 2024.

The percentage of people who are still living at home 91 post discharge had consistently around the 75 to 76% mark, however in April performance has improved to above the 80% target. This remains below the national average of 82.3%, but above our BCF target of 80%. It will be important to monitor whether this improvement is maintained.

Narrative and Plan

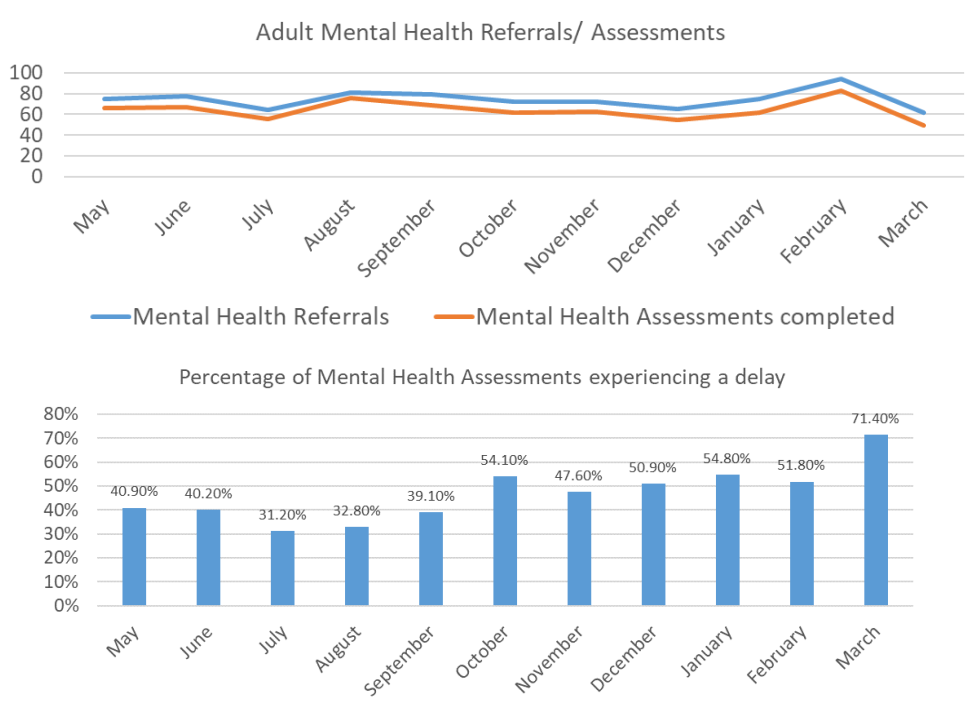
Reablement performance remains positive, and flow is good, and this is supporting Hospital flow, reducing NCTR and avoiding delayed discharges. The service continues to manage and oversee the delivery and governance of the peripatetic home care service which supports flow in and avoids delays out of reablement. The % of people at home 91 days after discharge is also in a positive position at 81%.

Reablement continues to be solely focused on supporting hospital discharge with little capacity to support needs in the community and this is an area identified on our CQC improvement plan for developing the reablement offer.

There has also been a Reablement review commissioned to look at reviewing working arrangements and scheduling to improve efficiencies within the service and the recommendations have been shared and are being implemented.

Progress Flash Report for week to: March, 2024 **Metric:** Adult Mental Health

KPI	November	December	January	February	March	Direction
Mental Health Referrals	72	65	75	94	62	▼
Mental Health Assessments completed	63	55	62	83	49	▼
Percentage of Mental Health Assessments experiencing a delay	47.6%	50.9%	54.8%	51.8%	71.4%	▲



Analysis

There was a decrease of 25.3% in the number of referrals received in March from February; of the 62 referrals received in March, 49 (79.03%) resulted in an assessment under the Mental Health Act (MHA). This is a decrease on February's 83 (88.2 %).

Requests for S.2 to S.3 MHA Assessments MHAA) decreased by 50.0% from February to March (constituting 10.2% of all MHAAs conducted in March).

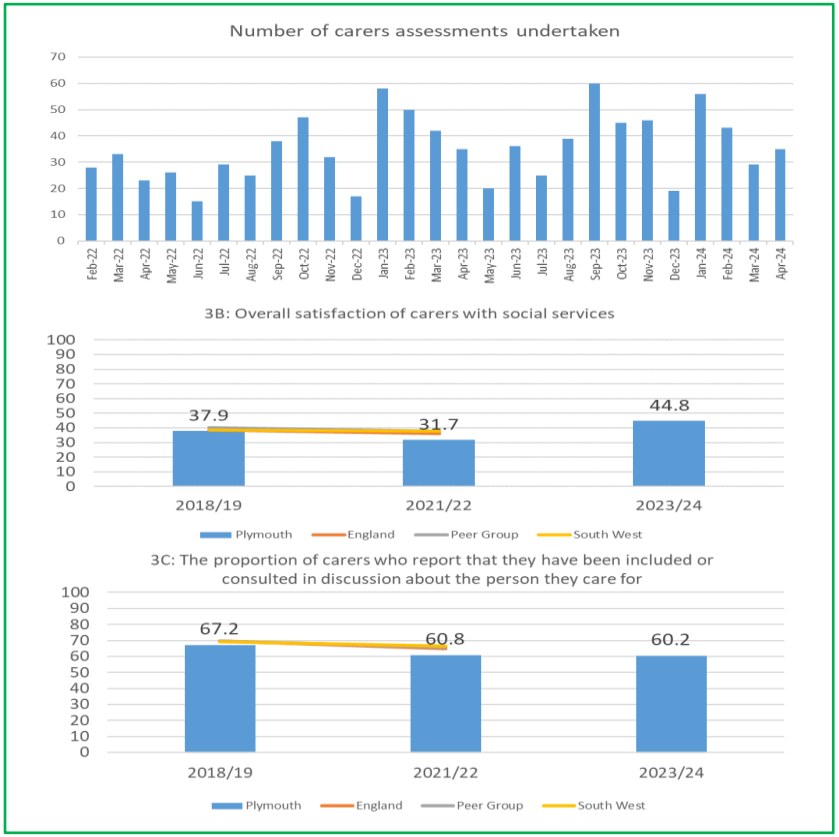
The percentage of S136 assessments in March decreased by 50.0% on February's figure.

Narrative and Plan

The number of referrals which have not progressed to a MHAA has remained consistent with an average of 10.6; these are largely due to Section 13 considerations deeming a MHAA inappropriate or the referring making further contact to advise the situation has changed and a MHAA is no longer required. However, 2 occasions represent a data error and a further 2 occasions represent MHA Assessments being carried out by other AMHP services on our behalf (due to the patient being admitted to hospitals elsewhere in the country). Delays in MHAAs being completed has increased, this is largely the result of increased delays with accessing suitable mental health hospital admissions, these account for many delays. Delays caused for this reason are followed by delays due to not being able to access the Place of Safety and then being unable to arrange for a suitable doctor to attend assessments.

Progress Flash Report for week to: April, 2024 **Metric:** Adult Carers

KPI	December	January	February	March	April	Direction
Number of carers assessments undertaken	19	56	43	29	35	▲
			2018/19	2021/22	2022/23	
3B: Overall satisfaction of carers with social services			37.9	31.7	44.8	▲
3C: The proportion of carers who report that they have been included or consulted in discussion about the person they care for			67.2	60.8	60.2	▼
1D: Carer-reported quality of life			7.0	7.1	7.0	▲



Analysis

The number of carers assessments has not been routinely monitored for some time. 402 assessments were undertaken in 2022/23, in 2023/24 this number has reduced to 356, but numbers will likely increase retrospectively. Work is ongoing to start tracking the outcomes of carer assessments.

Narrative and Plan

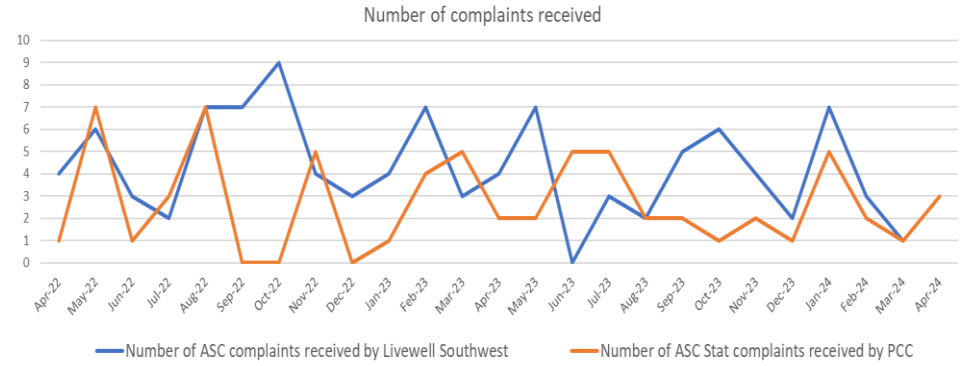
Livewell Southwest working with PCC to develop a carers strategy and the timeline is still to be confirmed – this work is overseen by the multi-agency Carers Strategic Partnership Board.

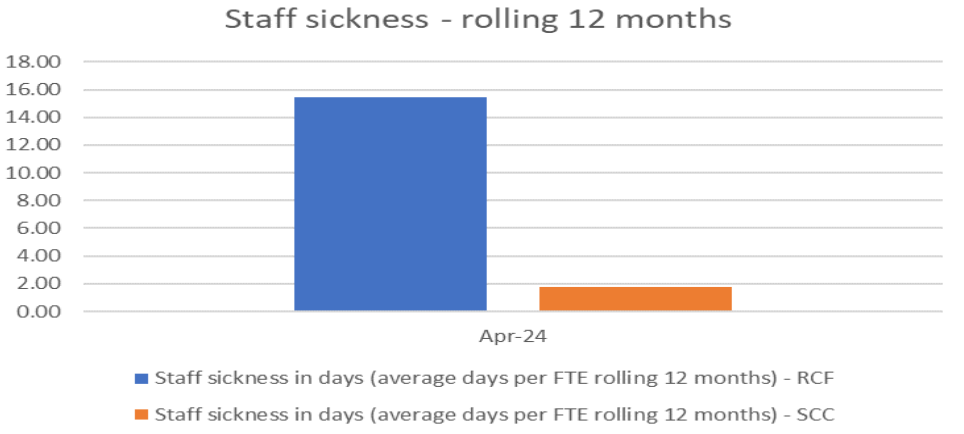
A project is underway with Children Services to jointly review the draft MOU for young carers "No wrong doors" for gaps and actions.

Performance Flash Report for week to: April, 2024

Theme: Corporate Performance – Strategic Co-operative Commissioning

KPI	January	February	March	April	Direction	TARGET
Number of ASC Stat complaints received by PCC	5	2	1	**3**	▲	**34**
Number of LGO complaints received	0	1	2	**2**	▲▼	**5**
Number of FOI's due in month	7	8	3	**7**	▲	N/A
% of FOIs completed within timescales	100%	87.5%	100%	**100%**	▲▼	**90%**
Staff sickness in days (average days per FTE rolling 12 months) – RCF				**15.47**		10.0
Staff sickness in days (average days per FTE rolling 12 months) – SCC				**1.8**		10.0





Analysis

Sickness reporting is now split between Commissioning and Retained Client Functions. This illustrates the challenges faced by our public-facing services in Retained Client, where staff need to be more aware of not passing on any illnesses to vulnerable clients and are not able to work from home if feeling slightly unwell.

The number of LGO complaints received towards the end of the year have increased with 2 reported in both March and April. Only one of these complaints has been upheld, and the organisation has already remedied at the time of reporting.

Narrative and Plan

Sickness continues to be closely monitored with plans in place where concerns have been identified. There remain no members of Commissioning staff on long term sick leave.

Practice/workforce meeting is used to review on a quarterly basis the themes and outcomes of complaints, and implications for practice.

Joint training on complaints was held recently for Commissioning, Retained and Safeguarding. In September specific LGO complaints training is booked for PCC and Livewell managers.

Strategic Risks – People Directorate

Risk Type	Title	Which Corporate Priority does this risk primarily relate to?	Risk Description	Existing Key Controls	Q3 23.24 Post-Mitigation Probability Update Score	Q3 23.24 Post-Mitigation Impact Update Score	Overall Risk Score @ Q3	Mitigation	Q4 23.24 Post-Mitigation Probability Update Score	Q4 23.24 Post-Mitigation Impact Update Score	Overall Residual Risk Score
Strategic	Increased and sustained pressure on Adult Social Care budget	Working with the NHS to provide better access to health, care and dentistry	The escalating and sustained strain on the Adult Social Care budget, driven by rising care costs, hospital flow challenges, and a growing population with complex needs, poses a risk of failing to meet statutory service obligations.	Real time management information Strong Reablement Offer Established Review Programme Commissioning Strategies / Intentions and Commissioning Activity to further develop models of care.	4	4	**16**	Strengthen Scheme of Delegation and management actions focused on practice with our key Partner Livewell South West Increase focus on Practice and outcomes Continued work with health partners to increase numbers discharged from Hospital to the "Home first" pathway Design of appropriate workforce development plans providing care workforce sufficient and skills 1-2 year mitigations Dom Care zoning approach included in procurement aimed to increase efficiency and reduce waste and intermediate care growth to include front door.	4	4	**16**
Strategic	Adult Social Care (ASC) Reforms	Spending money wisely	There are a number of reforms to ASC that have created significant financial uncertainty in terms of being able to accurately understand the cost, volume and funding that will be made available to deliver the requirements of these reforms.	National and regional groups including Local Government Association and ADASS ASC reform programmes established Fair cost of care exercise to better understand position Departmental and directorate management teams	2	1	**2**	Continued uncertainty over much needed reform increases risks of sustainability over time. We will continue to advocate for the need for reform along with the key issues and solutions we feel reform will need to address/can offer through regional ADASS and LGA bodies and the Offers and Asks of our directorate.	3	2	**6**
Strategic	Adult Social Care - funding for National Living Wage increase	Keeping children, adults and communities safe	Risk of adult placement providers withdrawing services or seeking to place with other local authorities if the cost of meeting the increase to the National Living Wage is not met.	Budget planning in hand to ensure that the cost of the increase is covered.	2	2	**4**	Regular provider forums, newsletter and communications. Contract managers are available for any providers experiencing financial issues to be able to have a more in depth discussion. Benchmarking with other local authorities as part of regional groups. Providers have generally accepted the proposed uplifts for 2024/25 and been understanding of our financial and funding position. We will continue to have individual conversations where this has not been accepted.	2	3	**6**
Strategic	Lack of adult social care workforce	Keeping children, adults and communities safe	Lack of adult social care workforce and growing fragility of Adult Social Care Market leading to inability of Authority to meet statutory duties and meet eligible need.	Real time management information Provider Contingency Plans and Mutual Aid Protocol Activity Dialogue with Care Market Enhanced risk management process around individual client list.	4	5	**20**	There has been some return to stability in the ASC Market workforce, although we would want to see another quater of good performance before we consider risk reductions.	2	2	**4**

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Health and Wellbeing Scrutiny Panel

Date of meeting:	16 July 2024
Title of Report:	**Adult Social Care Finance Report – Month 2 24/25**
Lead Member:	Councillor Mrs Mary Aspinall (Cabinet Member for Health and Adult Social Care)
Lead Strategic Director:	Gary Walbridge (Interim Strategic Director for Health, Adults and Communities)
Author:	Helen Slater (Lead Accountancy Manager)
Contact Email:	helen.slater@plymouth.gov.uk
Your Reference:	ASCFINM324
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report
The purpose of this report is to inform members around the forecast budget position for Adult Social Care at Month 2 2024/25

Recommendations and Reasons
The Health and Adult Social Care Overview and Scrutiny Committee notes the Adult Social Care Finance report.

Alternative options considered and rejected
1. N/A

Relevance to the Corporate Plan and/or the Plymouth Plan
This finance report links to the following Corporate Plan priorities; Working with the NHS to provide better access to health, care and dentistry, and Keeping children, adults and communities safe.

Implications for the Medium Term Financial Plan and Resource Implications:
Provides information about budgets set in line with the Medium Term Financial Plan

Financial Risks

N/A information only

Carbon Footprint (Environmental) Implications:
N/A

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:
** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*
N/A

Appendices

**Add rows as required to box below*

Ref.	Title of Appendix	Exemption Paragraph Number (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	2	3	4	5	6	7
A	ASC Finance Report – Month 2 2024/25							

Background papers:

**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are unpublished works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	Exemption Paragraph Number (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	2	3	4	5	6	7

Sign off:

Fin	CH.24.25.011	Leg	N/A	Mon Off	N/A	HR	N/A	Assets	N/A	Strat Proc	N/A

Originating Senior Leadership Team member: David Northey

Please confirm the Strategic Director(s) has agreed the report? Yes

Date agreed: 04/07/2024

Cabinet Member approval: *Cllr Lowry – approved by email*

Date approved: 02/07/2024

ADULT SOCIAL CARE

Budget Monitoring Month 2 2024/25

- The total budget for Adult Social Care for 2024/25 is **£103.127m**
- **£119.082m** relates to Care Package Expenditure, which is offset by income from clients and grant funding.

Care Packages Expenditure	£m
Residential & Nursing	53.423
Supported Living	29.403
Domiciliary Care	15.395
Direct Payments	12.478
Extra Care Housing	4.179
Short Stays & Respite	2.724
Day Care	1.480
Sub total	**119.082**

Main Sources of Income	£m
Income from Clients	(20.995)
Government Grants (incl. Better Care Fund)	(10.485)
Income from Health for Joint Funded Packages	(5.992)
Sub total	**(37.472)**

Other Budgets	£m	
Social Care Contract	7.531	
Contracts	6.961	e.g Domestic Abuse, Mental Health, Sheltered Housing, Support for Carers etc
Staffing*	3.454	includes Management, Commissioning, Safeguarding, Innovation and Operational Development staffing (excl Own Provision)
Own Provision*	3.293	includes Colwill Lodge, The Vines, Reablement, Independence at Home
Children's Commissioning	3.052	incl Family Hubs
Community Equipment*	0.940	
Sub total	**25.231**	*these budgets incl BCF funding also shown in the income table

Month 2 2024/25

Care Package Forecast Summary at Month 2*			
	Budget	**M2 Forecast**	**Variance**
	£m	**£m**	**£m**
Domiciliary Care	15.395	15.256	(0.139)
Supported Living	29.403	28.998	(0.405)
Direct Payments	12.478	12.438	(0.040)
Residential Long Stays	40.385	39.993	(0.392)
Nursing Long Stays	13.038	14.201	1.164
Short Stays and Respite	2.724	2.795	0.071
Total			**0.259**

**Extra Care Housing and Day Care will be monitored at Month 3*

- Our initial forecasting at Month 2 indicates savings in all Care Package types, except for Long Stay Nursing and Short Stays/Respite. At this point in the year, we are reporting an overall nil variance on these budgets. It is still very early in the year and forecasts could change substantially.

- Cost and Volume analysis of the variances reported indicates that the pressure within Nursing relates to growth in client numbers. At budget setting we estimated 245 clients, however currently we are forecasting 266 client full year, due to growth towards the end of Winter last year.

- Month 2 is also highlighting potential pressures within Client Income, with income assumptions not keeping track with fee rate increases.

- Budget Containment activity this year will focus on:
    - Client numbers, source of clients and profile of needs within Nursing placements
    - Package rates outside of bandings withing Nursing and Residential placements
    - Client income – historic trends versus current assumptions

  Targeted deep dive teams will feed back to the Budget Containment group to identify actions to contain and reduce budget pressures where possible.

Health and Wellbeing Scrutiny Panel

Date of meeting:	16 July 2024
Title of Report:	**Peninsula Acute Sustainability Programme: Developing the Case for Change**
Lead Member:	Councillor Mrs Mary Aspinall (Cabinet Member for Health and Adult Social Care)
Lead Strategic Director:	Gary Walbridge (Interim Strategic Director for Health, Adults and Communities)
Author:	Liz Davenport
Contact Email:	Jenny.turner3@nhs.net
Your Reference:	Peninsula Acute Sustainability Programme (PASP)
Key Decision:	No
Confidentiality:	Choose an item.

Purpose of Report

This paper covers the following:

- Context and Background of the PASP programme
- The outputs from Phase 1
- Our plans for Phase 2
- An outline of the challenges facing acute hospital services in the Peninsula
- How we would like to work with local populations during phase 2

We would also like to take the opportunity to ask for feedback from Members on two things, that are described in this paper:

- Your feedback on the challenges we are facing
  - Do you recognise the challenges?
  - Is there anything we have missed
  - What would your constituents say if they were here?

- To ask for your views on our proposed approach to involving people in developing our case for change
  - Is there anything else we should be asking local people about our case for change and challenges?
  - What is important to consider when making the information we use as accessible as possible for everyone to understand?
  - Are there other methods we could use to ensure as many people as possible are able to have their say?
  - Are there any groups who we might have inadvertently excluded using the approach outlined?

Recommendations and Reasons

1. That the Health and Wellbeing Scrutiny Panel provide feedback on the Peninsula Acute Sustainability Programme: Developing the Case for Change, and note its progress.

Alternative options considered and rejected

1. NA

Relevance to the Corporate Plan and/or the Plymouth Plan

NA

Implications for the Medium Term Financial Plan and Resource Implications:

NA

Financial Risks

NA

Carbon Footprint (Environmental) Implications:

NA

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

** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*

Click here to enter text.

Appendices

**Add rows as required to box below*

Ref.	Title of Appendix	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	**2**	**3**	**4**	**5**	**6**	**7**
A	Briefing report title							

Background papers:

**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are unpublished works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	**2**	**3**	**4**	**5**	**6**	**7**

Sign off:

Fin	N/A	Leg	N/A	Mon Off	N/A	HR	N/A	Assets	N/A	Strat Proc	N/A
Originating Senior Leadership Team member: Gary Walbridge											
Please confirm the Strategic Director(s) has agreed the report? Yes Date agreed: 08/07/2024											
Cabinet Member approval: Councillor Mary Aspinall, approved verbally Date approved: 08/07/2024											

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Devon, Cornwall and Isles of Scilly
Peninsula Acute Sustainability Programme

Peninsula acute sustainability programme: Developing the case for change

Plymouth Health Overview and Scrutiny
16 July 2024

July 2024

1. Introduction

This paper covers the following:

- Context and Background of the PASP programme
- The outputs from Phase 1
- Our plans for Phase 2
- An outline of the challenges facing acute hospital services in the Peninsula
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  - Are there any groups who we might have inadvertently excluded using the approach outlined?

Context

NHS organisations in Devon, Cornwall and Isles of Scilly are working together on an ambitious plan to improve acute services for local people and staff. The Peninsula Acute Sustainability Programme (PASP) involves the four NHS acute trusts and the two NHS commissioning organisations in Devon, Cornwall and Isles of Scilly:

- Royal Cornwall Hospitals NHS Trust
- Royal Devon University Healthcare NHS Foundation Trust
- Torbay and South Devon NHS Foundation Trust
- University Hospitals Plymouth NHS Trust
- NHS Cornwall and Isles of Scilly
- NHS Devon

Across Devon, Cornwall and the Isles of Scilly, we want everyone to be able to:

- live happy and healthy lives
- have equal chances (ie the same opportunities as everyone else regardless of where they live or who they are)
- live well for as long as possible

- have independence
- have choice
- live free from harm.

We are focused on caring where it matters using the latest technology, the best clinical evidence and the latest research to provide the best outcomes and experiences for our people.

What we believe should be true:

- the care that can be provided at home, is provided there
- the care that can be provided in local communities, is provided there
- the care that can only be provided in an acute hospital setting, is provided there
- the care that is best provided in a specialist hospital setting or centre of excellence, is provided there

What we already know, from what people have told us

Our fundamental challenges

The NHS in Devon, Cornwall and Isles of Scilly face significant challenges which have been exacerbated by the pandemic.

Acute services must be transformed to address:

- services that are struggling to meet the increasing demand and needs of patients
- a growing older population
- existing (and worsening) inequalities in access and experience of services
- challenges in recruiting and retaining staff

In addition we need to:

- support staff to deliver safe and high quality care
- ensure services conform to national and professional standards
- provide safe and high quality services across the whole geography
- meet demand now and in the future
- make the best use of our limited resources

In this YouTube video-link below the Devon, Cornwall and Isle of Scilly Chief Medical Officers/Medical Directors make the *case for change* for PASP:
https://www.youtube.com/watch?v=gW-AU0cXlgw

We've already made some progress

Across the Peninsula hospitals already work together supporting delivery of services. There are also organisations and teams working innovatively and collaboratively to successfully improving our performance as the examples below demonstrate:

One Devon Elective Pilot

Using the Nightingale Hospital as a specialist centre for orthopaedic, ophthalmology and spinal surgical services to achieve four aims:

- Maximise day case and High-Volume Low Complexity activity
- Standardise patient pathways
- Increase efficiencies in theatre utilisation
- Develop ability to support cross site working

Staff and Clinical Networks

Hospitals across the Peninsula are working together in a networked way to provide care

- Interventional Radiology rota
- Urology
- Cardiology
- Trauma networks
- Neonatal networks
- ICU network

Networks between RDUH North and East

- Oncology
- ENT
- Acute medicine
- Midwifery/obstetrics
- Upper GI

Use of technology

Shared Picture Archive System (PACS) that enables radiologists to share images across all peninsula Trusts

- Faster reporting, including overnight, without costly outsourcing.
- Faster diagnostics
- Faster time to treatment with results back to clinicians more quickly

Peninsula Acute Sustainability Programme (PASP) – purpose

The Peninsula Acute Sustainability Programme aims to ensure **clinical, workforce and financial** sustainability of services at the five acute hospitals in Devon, Cornwall and Isles of Scilly.

The **primary objectives** of the programme are to:

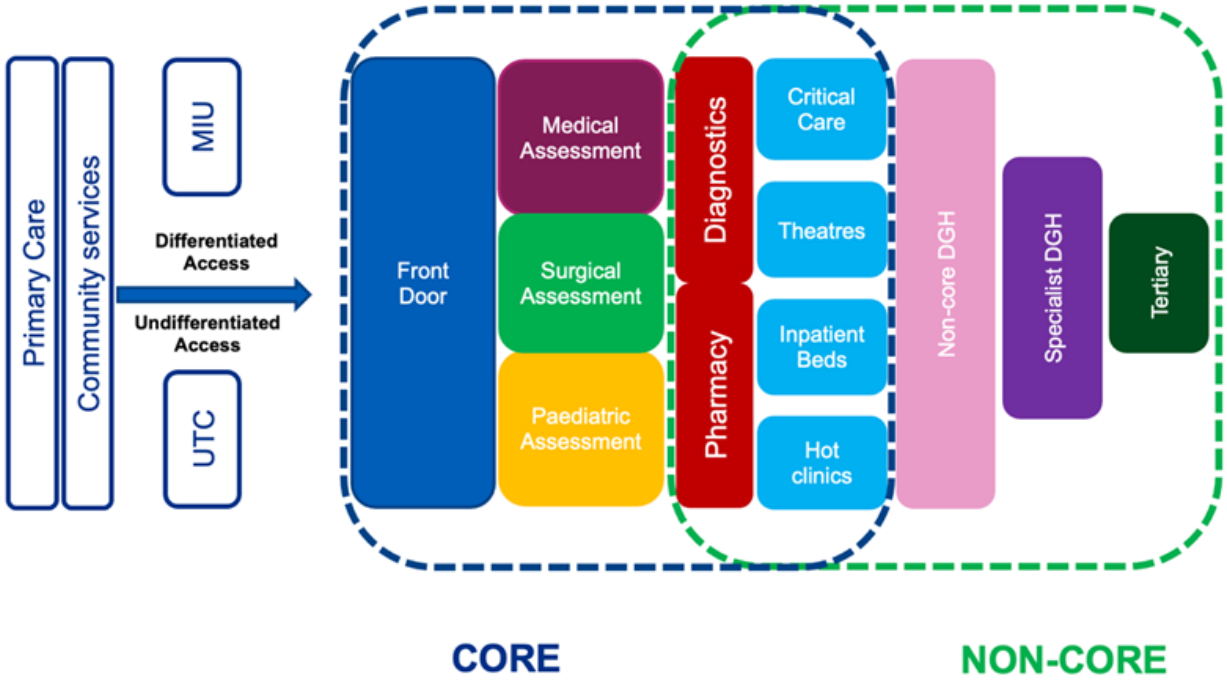
- Improve how we support our population's health needs and target health inequalities
- Ensure there are consistent and safe acute services across the Peninsula
- Address problems with fragile acute services
- Ensure that we have a sustainable workforce
- Make best use of our limited resources
- Learn from previous programmes of work and feedback from the public

The primary role of the PASP is to **support service sustainability in the long-term** creating a sustainable platform for strategic service improvement, and the **recovery of fragile services in the medium term** but it also needs to be **aligned with any short-term tactical improvements** to ensure support for recovery of elective, UEC, cancer and diagnostic services and Devon's exit from NOF4.

2. Outputs of Phase 1 - November 2022 – December 2023

Starting hypothesis

The simplistic outline hypothesis that this programme started with was that through strengthening the assessment and diagnostic functions aligned to the hospital front door, there could be **different approaches to delivering the non-core services** that would start to address some of the significant workforce challenges facing the Peninsula.



What we did in phase 1

We held a series of focused workshops within paediatric, medical and surgical specialties which involved a wide range of clinicians across the interdependent specialties, subspecialty and clinical support services from across Devon, Cornwall and Isles of Scilly.

We adopted a consistent approach for the paediatric, medical and surgical assessment workshops with 3 phases: Prepare the ground; Agree the position; Develop proposals.

A series of core questions, co-produced with Chief Medical Officers were used to stimulate workshop discussions. There was a clear requirement to think innovatively about what could be different.

Robust demand, activity and workforce data was essential input to considering the impact of changes in the demographic and health profile and needs of the population of Devon, Cornwall and Isles of Scilly and the complementary impact on staff.

We commissioned Healthwatch in Devon, Plymouth and Torbay, in collaboration with Healthwatch Cornwall, to support us in developing an understanding of patients

experiences of acute services in the Peninsula. This involvement happened in July 2023 and the report can be found here: https://healthwatchdevon.co.uk/pas-report/

Key outputs from Phase 1

- A shared understand of the challenges faced delivering health services in acute settings across the peninsula
- A set of key messages from the clinical workshops for paediatrics, medical and surgical assessment (appendix 1).
- Feedback from patients and their families on their experience of using medical, paediatric and surgical acute services (appendix 2).
- An outline a possible direction of travel to transform acute service to ensure sustainability in the future.

3. Phase 2 January 2024 – December 2025

To meet the needs of the population of the Peninsula we need to consider transforming some services. Phase 2 will include:

1. Developing a detailed formal case for change in partnership with staff and local people
2. Undertaking some detailed modelling in conjunction with staff and patients to further explore possible ways to tackle our challenges.

Ensuring we have robust arrangements to continue involve staff, patients and the public will be vital to meeting our objectives and our statutory responsibilities

Developing a detailed formal case for change in partnership with staff and local people

What is a case for change?

A case for change describes, in detail, the challenges facing services. It is a **technical document** that uses data to evidence the need to change. It is required as part of the regulated transformation process outlined by NHS England.

Our case for change is being developed using *Major service change: An interactive handbook JUNE 2023, NHSE*

The technical case for change is provided for:

- Regulators (NHSE)
- Peninsula Acute Provider Collaborative
- PASP Board
- Peninsula Acute Trust Boards
- Health Overview and Scrutiny Committee Members
- The public

A **summary will also be produced** to support our local populations and stakeholders to understand our challenges.

Summary of our challenges

The five acute hospitals across the Peninsula are facing unprecedented challenges in delivering high quality and timely care to patients. Many of our challenges existed before Covid, the global pandemic has exacerbated an already challenging position.

The NHS workforce are our biggest asset, but they are exhausted and burnt out from going above and beyond to deliver care for patients in processes that are not working for them.

An older age profile and more rapid population growth coupled with the impacts of the Covid-19 pandemic and ‘cost of living’ crisis, are contributing to increased demand for health and care services.

The greatest increased demand is for unplanned care and mental health services, with those living in disadvantaged communities and clinical vulnerability likely to be most severely impacted.

More detail of our challenges is provided in more information on the diagram overleaf. A detailed data pack will also be shared in due course.

Challenges: Multiple challenges face the Peninsula's hospital services and they are summarised as follows

Increasing demand and inequity	• Population growth expected to be highest in older people and those who use health services the most • Inequity in life expectancy, healthy life expectancy, outcomes and access to health services exist linked to deprivation, rurality and other inclusion health factors in the Peninsula.
Services not meeting demand or expectations – people are waiting too long for care	• Services unable to keep up with demand is causing unacceptable waiting times in A&E, diagnostic and elective surgery. • Patients are frustrated, becoming more unwell and losing more confidence in the NHS. • Lack of productivity is resulting in escalation of care needs to the highest point
Estates and infrastructure are not in place to deliver modernised care and effective system working	• There is a risk that our buildings could fail, impacting on the safety and quality of services that we are able to provide. Over £400m backlog of maintenance work needed to make our buildings fit for purpose • Lack of a system EPR (electronic patient record), combined with organisational boundaries makes joint working difficult and causes patients to repeat their story multiple times.
Unsustainable workforce model	• Vacancy and sickness rates are high, morale is low, and staff are exhausted. Services are reliant on Locally Employed Doctors, clinicians acting down and locums, which is not sustainable • Jobs are not attractive due to the rotas and providers are all competing for the same pool of staff when recruiting. Networking across acutes might make careers more attractive, with more opportunities.
Devon is a financially challenged system	• For 2024/25 the Devon system financial plan has a forecast deficit of £85.4m. For the 24/5 Plan.

Our vision for acute services

The Board of all five acute hospitals in the Peninsula have developed this shared vision for acute services in the Peninsula:

To work together to deliver high quality, safe, sustainable and affordable hospital services as locally as possible.

What will out vision mean for everyone

For patients and families

- More timely access to the right specialist teams
- Reduced waiting lists, with fewer procedures and operations cancelled, including at short notice
- Faster ambulance response times because they will spend less time waiting outside hospitals
- People spending less time in hospital, because of closer working with community teams
- Improved equity of access, so that where people live or who they are is never a barrier to them accessing the services they need
- Services that are more joined up, so people don't have to tell their story multiple time.
- Closer working between acute and community teams so people spend less time in hospital and receive care as close to home as possible

For staff

- Improved systems and processes to help teams to provide consistently high-quality care
- A range of different staffing models across our hospital sites, tailored to the service and its needs
- Investment in digital technology to support the delivery of modern healthcare
- Colleagues will be supported to have a healthy work life balance

For acute hospital services

- 24/7 urgent and/or emergency care will remain at the five acute hospitals
- Services able to adapt to meet changing population needs
- Organisations working together more effectively to provide a joined-up health and care service,
- New and innovative ways of organising care in line with best practice standards
- Better use technology to provide better experiences and more convenient and efficient care
- Development of rapid assessment, diagnosis and treatment for patients (who would otherwise require a hospital stay) so they can go home the same day if clinically safe to do so – this is better for patients and also helps to free up inpatient beds for those who are more acutely unwell

4. Our early thinking on further involving people in developing our case for change

We plan to launch a period of involvement with the people across Devon, Cornwall and the Isles of Scilly, in the autumn, so that we can further develop our case for change.

Through the involvement, we hope to learn:

- Whether there are any other challenges people experience that we have not covered?
- How challenges impact local people
- What 'good access to care' feels like for patients
- Whether people have any ideas or thoughts on how we could tackle some of our challenges?

We plan to use a variety of involvement methods to ensure we hear from everyone, and so that everyone who wants to, has the opportunity to tell us what they think. The list below are some of our approaches, but is not exhaustive

- Survey (under pinning the involvement)
- Focus groups
- Attendance at meetings
- Market stall type events
- Targeted outreach with people who experience health inequalities

5. Our from Members

As elected representatives of local people, the views and the committee and its Members are invaluable to helping us shape the second phase of this programme. We would therefore welcome your feedback on the below elements of this paper:

The Challenges

- Do you recognise the challenges?
- Is there anything we have missed?
- What would your constituents be saying their challenges are?

The Approach

- Is there anything else we should be asking local people about our case for change and challenges?
- What is important to consider when making the information we use as accessible as possible for everyone to understand?
- Are there other methods we could use to ensure as many people as possible are able to have their say?
- Are there any groups who we might have inadvertently excluded using the approach outlined?

Appendices

Appendix 1: Key messages from paediatric, medical and surgical assessment workshops

Paediatric assessment

- Many services are fragile, patient experience is worsening, and staff are at risk of burnout
- We need to be brave, realistic, and honest and about the need for changes, recognising that these conversations won't always be easy
- Solutions must be clinically-driven, data-driven, affordable, and deliverable
- We need to break down organisational silos and create an environment that makes it easier to work together.
- We agreed that the level of demand for acute paediatric services is increasing. We need to explore how we can manage the demand differently, recognising the impact the increased demand is having on clinicians in terms of extra workload.
- We discussed how we can support parents and families to be confident to self care and be able to make the right choices when accessing care with the support of effective navigation.
- We recognised that parents want rapid access to expertise.
- We felt that we needed to support clinicians working with children and young people in the community to increase their confidence, skills and knowledge.
- We acknowledged that there was a role for digital in providing support to both clinicians and families whilst remembering that some people do not have access to technology
- We agreed that any emerging models of care needed to make the distinction between meeting urgent need and providing routine care.
- We noted that lots of families do not have access to their own transportation and public transport is poor, so we need to consider this in the planning for services. Otherwise, there will be an adverse impact on deprived communities.
- We recognised that they were opportunities for individuals to develop and increase their scope of practice and to improve the working lives of staff, recruitment and retention
- Do have opportunity to consolidate resource and rotas - consolidation gives more resilience.
- We outlined the risks of any potential scenarios particularly in relation to travel (staff and patients), managing demand, lack of alternative provision and capacity.

Medical Assessment

- Many services are fragile and face challenges with recruitment and retention
- We need to be brave, realistic, and honest and about the need for radical changes, recognising that these conversations won't always be easy and that maintaining trust and confidence is key

- We should focus on sharing resources, streamlining processes and working virtual wherever possible, we need to establish the right infrastructure around medical assessment with the same core offer.
- Improve patient care and access by treating people in the right place for their needs, which might not necessarily be their nearest hospital and could be provided by other services in the community
- We have a substantial cohort of frail patients with multiple needs who need a rounded assessment and plan in order to avoid the ED “revolving door”. We have an opportunity to develop a Peninsula approach.
- Create a service that people want to work in by rethinking roles, skills, and careers to entice new people and retain existing staff
- We need to develop a consistent and compassionate approach to addressing end-of-life care and give our workforce the skills & tools to manage this.
- Technology (including electronic patient records) has the potential to improve care, avoid duplication, and support people closer to home
- We agreed that we need to have a collective approach to managing risk with patients and their families.
- Break down organisational silos to make it easier to work together e.g. with standardised approaches, models and core competences, working as a system gives the opportunity to standardise pathways and break down silos
- Virtual Wards can result in a reduction in readmission. They need to be consistent across the Peninsula and supported by a single EPR.
- We need a more integrated approach towards psychological support for people with functional illness.
- We need to design a multidisciplinary workforce with the right skills and competencies with a focus on recruitment, retention and training to attractive roles with clear career paths
- The time spent managing the ‘back door’/discharge and supporting patients who are fit to go home is impacting on our ability to manage patients coming into ED and assessment units.
- Travel is significant for patients, families and staff, we will need to make sure that we mitigate the risk of increasing health inequalities if people have to travel further for care
- Diagnostics and Triage are fundamental for all sites

Surgical Assessment

- A number of services are fragile, and several are in need of mutual aid – we need to address this
- Waiting lists are increasing for elective surgery and we have not addressed the backlog from pandemic
- Also need to consider the amount of activity we are purchasing from the independent sector
- Patient and staff experience is in decline.
- Too much surgical resource is allocated to out of hospital hours care where there are low volumes requiring surgery, compared to in-hours need with high volumes
- Referral to treatment times (RTT) are variable across different Trusts with some Trusts having pressures in areas where other do not. We need to look at the surgical capacity of the Peninsula as a whole to match demand against supply of surgical capacity
- Full implementation of GIRFT will not be enough to meet increasing demand: it’s more than population growth but about meeting the needs of a larger aging population with multiple co-morbities

- Recruitment and retention are a challenge in some areas but on the whole acute general surgery workforce is not an issue
- Barriers need to be broken down to work more collaboratively as a system. Each organisation uses its skill mix differently – we need to understand what drives variation in our staffing models
- We should consider having a consistent approach to training across the region and more flexible training for some roles
- We need to improve flow: from diagnostics, through to discharge and social care
- We need to review how services can be organised – centralisation, networking, hub and spoke and the implications for other services of each model
- Reducing waste and inefficiencies is where some real gains could be made – for example improving our ability to see and treat (reducing revolving door patients), managing the worried well in the right place, having diagnostics at the front door (in ED)
- We need a single electronic system to support joined-up working
- Access to beds is the primary issue for general surgery – because we cannot discharge people and because medical patients are in surgical beds.
- We also need to ensure equitable access for all patients across the Peninsula
- There are good models for ambulatory general surgery

Appendix 2: Feedback from patient and carer involvement about paediatric, medical and surgical services

Paediatric services

Feedback was received from 37 patients and their families in paediatric settings. The focus was placed on their experiences of accessing urgent care for their child.

- 65% of experiences were reported as positive with the most common reasons being because of the staff treating their child, the quality and consistency of care and attention provided and timeliness in terms of moving through the hospital system.
- Experiences could have been improved by better communication to support continuity of care, more personalised care, reduced waiting times for assessment and medication, and better staffing levels.
- The responses revealed that the most important factor for families is good communication - (1) between the staff and the family, (2) between staff delivering the care and (3) between two or more services, (where care is being managed by more than one).
- Communication factors that parents felt were most important were:
    - Being involved in the treatment and care
    - Being kept informed
    - Being listened to
- Communication, quality of care and timely access to services were most important to parents when accessing children's hospital services with parents wanting to feel informed, heard and involved.

Medical assessment

10 members of the public took part in three focus groups which allowed for direct discussions focused on what went well, what could have been better and what mattered most to them when accessing services.

- Experiences were overall positive, participants had high praise for NHS staff in the main and there was much recognition that some go above and beyond in their delivery of care.
- There was recognition across the groups for the caring staff working in the NHS. However, there was also a sense from what people had observed that some staff did not feel confident or that tasks were not within their remit, and that staff need to feel empowered to make choices to ensure patients are well cared for.
- It was also evident from the discussions that there is a level of variability in staff and the quality of care provided across the NHS, but there were several comments from participants pertaining to the whole service being underfunded and staff being overworked and the impact this had on waiting times
- People felt that their experiences could have been improved by better access for people with physical disabilities, better communication and easier navigation of a complex system (including 111 and 999 call handling)
- Being treated with dignity and respect was most important to people – to be listened to and heard.
- Personalised care, recognising and meeting the individual needs of patients, was also important along with the need for this information to be communicated between staff.
- People wanted services to be more joined up and services to share information to improve continuity for the patient.
- People also said that waiting times and being seen quickly and having easy access to services were important.

Surgical services

- People on waiting lists were invited to focus groups to find out how elective care waiting lists have impacted patients and how people would like these waiting lists to be addressed.
- Eight virtual focus groups were held between March 2022 and April 2022 with a total of 39 patients attending.
- Focus groups were facilitated and the report produced by Healthwatch Devon, Plymouth and Torbay
- Key Findings – a snapshot:
    - Waiting for elective treatment has a significant impact on participants' physical and mental health. Worsening pain and discomfort has a knock-on effect on sleep, ability to work or provide care, and quality of life. The uncertainty caused by cancelled appointments causes stress and anxiety. Participants felt that better communication about waiting times was needed and would reduce anxiety and uncertainty.
    - Participants were overwhelmingly in favour of addressing waiting times as quickly as possible wherever possible, rather than waiting for a Devon-wide solution.
    - Participants saw the benefits of moving elective care to a dedicated facility shared between Trusts, however, there were concerns about patients being required to travel longer distances, and the length of time it may take this solution to be enacted. Participants agreed that a combined approach would be beneficial to suit the needs of different areas, e.g. urban vs rural, and the needs of patients who may require more complex treatment.
    - When deciding where to have treatment, the three most important considerations for participants were the speed at which they could be seen, who would be providing their treatment, and distance from home.

Survey and Social Media feedback

Feedback from 240 NHS survey responses and 39 comments on social media

- The survey consisted of three questions. The questions asked were open-ended and the findings are summarised themes and trends identified from the responses.
- More than half of the responses to the survey mention waiting times – largely in a negative way. There were lots of comments about being in ambulance queues outside hospitals or in the ED waiting room for hours with many of these mentioning a lack of effective communication.
- There were however many positive comments about staff attitude and capability, particularly ambulance staff.
- There were comments from people who felt the environment was cramped and unhygienic in ED waiting rooms and a few comments about food
- The consensus from respondents seems to be that once people were seen the care was good – but the waiting times are not good at all, with a few respondents suggesting they thought this led to them getting more unwell.
- Many respondents see the primary challenge for the NHS as a systems failure, mentioning issues such as bed blocking, underfunding by Government, and problematic social care structures resulting in discharge delays. People also highlight the lack of GP appointments and the impact of people misusing the system.
- The majority of respondents, when asked about the impact of the challenges faced by the NHS, highlighted the emotional impact of using urgent NHS hospital services and a lack of faith/trust in the system after their visit. Lots of respondents cited issues with waiting times both before and during their visit.
- The general feeling of social media comments was much more positive than negative with many people reporting good urgent care experiences – particularly with staff and treatment – however, some did cite having issues with waiting times.

Health and Wellbeing Scrutiny Panel

Date of meeting:	16 July 2024
Title of Report:	**Disabled Facilities Grants**
Lead Member:	Councillor Chris Penberthy (Cabinet Member for Housing, Cooperative Development and Communities)
Lead Strategic Director:	Gary Walbridge (Interim Strategic Director for Health, Adults and Communities)
Author:	David Ryland Head of Housing Standards
Contact Email:	dave.ryland@plymouth.gov.uk
Your Reference:	DFG/S1
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report
To provide detail regarding Disabled Facilities Grants, how they are delivered in Plymouth, waiting times, budgets and demand.

Recommendations and Reasons
1. Note the contents of the report

Alternative options considered and rejected
1. None

Relevance to the Corporate Plan and/or the Plymouth Plan
The provision of DFG's contributes to the corporate plan by promoting independence, fairness, and reducing health and social inequality, helping people to take control of their lives and to be treated with dignity and respect. DFG funded major adaptations enable people to remain in their own homes, thereby helping to contain the potential for increases in costs to health and care services and minimising risks to disabled people, their family and carers. Wellbeing is a guiding principle throughout the Care Act 2014 which sets out the framework for the future provision of adult social care. Suitability of living accommodation is one of the matters local authorities must take into account as part of its duty to promote wellbeing. The provision of major adaptations is a preventative measure which can promote someone's wellbeing allowing them to live as independently as possible and for as long as possible.

Working with the NHS to provide better access to health, care and dentistry.

Keeping children, adults and communities safe.

Focusing on prevention and early intervention.

Spending money wisely.

Implications for the Medium Term Financial Plan and Resource Implications:
Nationally an additional £102m funding has been announced between 2023/25. Whilst there is no commitment beyond this currently from the Better care Fund, the risk is believed to be minimal that funding will be ceased.

Financial Risks

Demand exceeding the reach of budget allocation resulting in delays for clients or overspend.

Carbon Footprint (Environmental) Implications:
N/A

Appendices
**Add rows as required to box below*

Ref.	Title of Appendix	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	**2**	**3**	**4**	**5**	**6**	**7**
A	July 2024 DFG Briefing							

Background papers:

**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are <u>unpublished</u> works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	**2**	**3**	**4**	**5**	**6**	**7**

Sign off:

Fin	CH.24.25.010	Leg	LS/0000360/1/LB/03/07/24	Mon Off	N/A	HR	N/A	Assets	N/A	Strat Proc	N/A
Originating Senior Leadership Team member: Gary Walbridge											
Please confirm the Strategic Director(s) has agreed the report? Yes Date agreed: 02/07/2024											
Cabinet Member approval: Councillor Chris Penberthy – approved verbally Date approved: 02/07/2024											

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JULY 2024 DFG BRIEFING
HEALTH AND WELLBEING SCRUTINY

1. INTRODUCTION

The purpose of this briefing is to provide detail regarding Disabled Facilities Grants, how they are delivered in Plymouth, waiting times, budgets and demand.

2. OVERVIEW

A Disabled Facilities Grant (DFG) is a means tested grant designed to help meet the costs of adaptations to a property for a disabled occupant. In summary, in order to qualify for a DFG:

- The required adaptations need to be necessary and appropriate (as determined by Livewell Southwest or Children's Services) to meet the needs of the disabled person; and
- It must be reasonable and practicable (determined by the housing department – Community Connections, Major Adaptations Team) for the relevant works to be carried out.

Reasonable and Practicable

As mentioned above, in order to get a DFG for alterations in the home, those alterations must be reasonable and practicable. When deciding whether proposed alterations are reasonable and practicable, a Local Housing Authority has to have specific regard to the age and condition of the building. The Local Authority will also consider things such as the effect on other residents, the practicalities of carrying out work on properties with limited access, conservation considerations, and the structural characteristics of the property.

A Local Authority may consider it more reasonable to move a person to another property rather than fund the alterations which have been requested. Whether this is lawfully allowed will depend on the facts of the individual case. The guidance available states that, if the alterations needed are not cost-effective, the option of moving to alternative accommodation should be considered.

Necessary and Appropriate

In addition to the requirement that any alterations be reasonable and practicable, a Housing Authority should also consult the relevant Social Services department (Livewell Southwest or Children's Services) to ensure that any alterations are necessary and appropriate. This means that it would be necessary to get a Occupational Therapist assessment from your Social Services department before any application for a DFG would be granted.

The maximum mandatory award for a DFG is £30,000. As this grant is means tested, some people may have to pay a contribution towards the required work themselves.

Disabled Facilities Grants were introduced by the Housing Grants, Construction and Regeneration Act (HGCRA) 1996. There are also annual regulations called the Housing Renewal Grants Regulations which govern how Local Authorities administer Disabled Facilities Grants.

There is also good practice guidance which Local Authorities are encouraged to follow when administering DFG's, called Delivering Housing Adaptations for Disabled People: A Good Practice Guide.

Eligibility

A DFG is only available to people who are disabled within the meaning of the National Assistance Act 1948. This means that a DFG will not be granted to a person who is merely elderly or retired.

In addition, a DFG is only available to pay for alterations to a disabled person's main residence. It is possible for a disabled person to apply for a DFG if they are a tenant. The disabled person must have lived, or be intending to live, in the property in question for at least five years, or for such a shorter period as their health and other relevant circumstances permit.

Eligible Works

Mandatory grants can be awarded for the following works:

1. Facilitating a disabled person's access to:
    a. The dwelling.
    b. A room usable as the principal family room, or for sleeping in.
    c. A toilet, bath, shower, etc (or the provision of a room for these facilities).
2. Facilitating the preparation of food by the disabled person.
3. Improving/providing a heating system to meet the disabled person's needs.
4. Facilitating the disabled person's use of a source of power.
5. Facilitating access and movement around the home to enable the disabled person to care for someone dependent upon him or her.
6. Making the dwelling safe for the disabled person and others residing with him or her.
7. Facilitating access to and from a garden, or making a garden safe.

Adaptations to facilitate access around the home can include adaptations allowing a disabled person to do things such as prepare and cook food, although full adaptations to a kitchen are unlikely to be funded if the majority of cooking is done by another family member.

Adaptations for access will also include work for access to the principal family room, a room used for sleeping and rooms containing a toilet and/or washing facilities. In particular, the importance of being able to wash and bathe has been emphasised by the Local Government Ombudsman.

Discretionary Grants – 'Top Up' Grant

The Local Housing Authority (responsible for the administration of the DFG) also has the discretion to give grants for a wide variety of other adaptations. These include works to make a home suitable for a disabled occupant's accommodation, welfare or employment.

In some circumstances the Housing Authority may also give a discretionary 'Top Up' grant for works which meet the purposes for a mandatory grant, but which cost more than the maximum mandatory amount of £30,000. If, for example, the agreed adaptations would cost £40,000, then the first £30,000 would be mandatory but the council could then give a discretionary 'Top Up' grant for the extra £10,000.

Applicants should be aware that it is often difficult to get a discretionary grant as the Local Authority does not have to award them and they usually have other competing demands on their budget. However, the Local Authority does have to consider the application.

Means Testing

The mandatory part of Disabled Facilities Grants are means tested, which means that some people may have to pay a contribution towards their grant. Only the financial circumstances of the disabled person, his or her spouse or civil partner or co-habiting partner are assessed and not other members of the household.

Applications on behalf of a disabled person under the age of 19 are not means tested.

Customers in receipt of certain benefits are also exempted, and considered 'passporting', details of which will be given upon application.

Following the means test, if the income is below a certain threshold the applicant will be entitled to the full mandatory maximum of £30,000. If income exceeds the threshold, the grant may be reduced by a certain amount depending on the clients income.

Timescales

The timescales will depend upon the urgency and complexity of the adaptations required. More urgent cases will be prioritised for action, but larger and more complex schemes will take longer to complete.

Upon an application becoming valid, works should be approved within 6 months of that date. Works are then required to be paid off within 12 months of this date.

The following highlights the 5 key stages of any application and a table showing best practice targets.

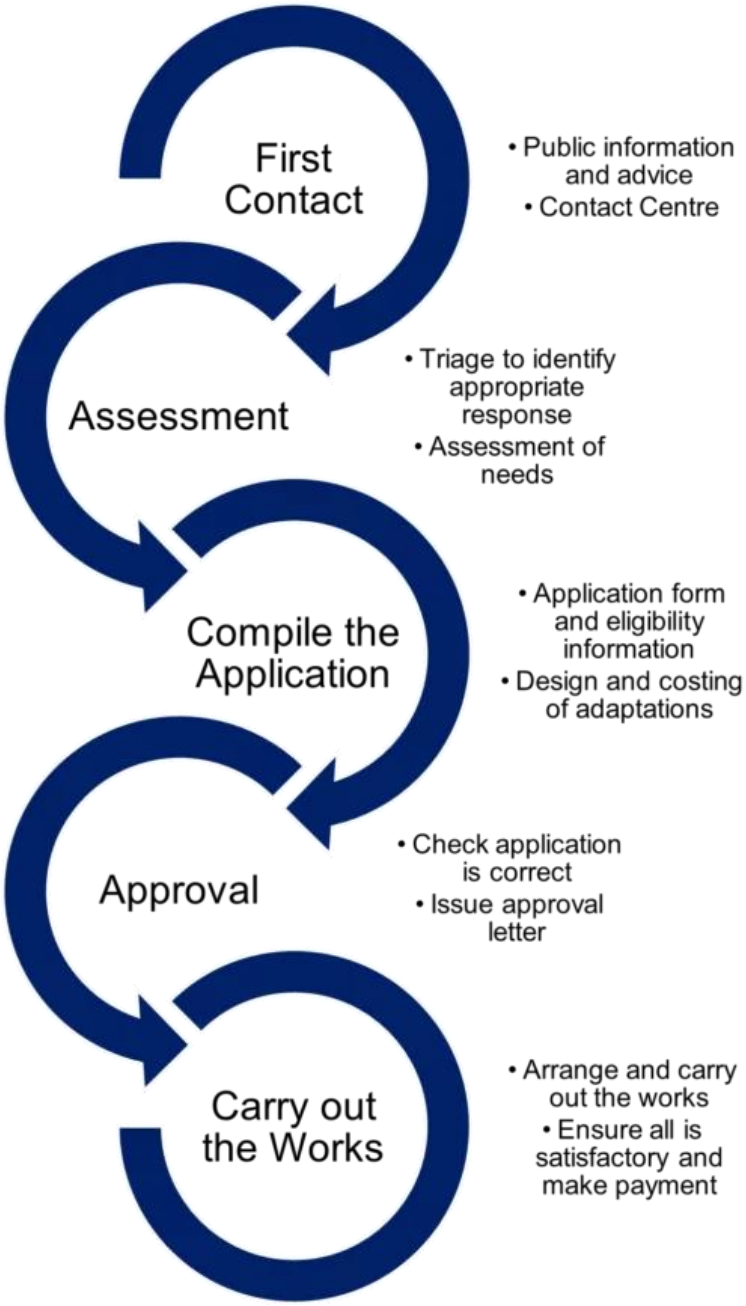
Stage 0: first contact with services

Stage 1: first contact to assessment and identification of the relevant works

Stage 2: identification of the relevant works to submission of the formal grant application

Stage 3: grant application to grant approval

Stage 4: approval of grant to completion of works.



Target timescales (working days)					
Type	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Total**
Urgent & Simple	5	25	5	20	**55**
Non-urgent & Simple	20	50	20	40	**130**
Urgent & Complex	20	45	5	60	**130**
Non-urgent & Complex	35	55	20	80	**180**

Prioritisation
It is recommended that authorities use a triage system to make an initial assessment of the complexity and urgency of a case. A good triage system will help everyone gain a shared understanding of the likely timescales for delivery. It will also enable the right team with the right skills to properly assess the case.

Authorities are recommended to treat cases as urgent in the following circumstances:
Coming out of hospital and at risk

- Living alone and at risk
- Severe cognitive dysfunction and at risk
- Living with a carer who is elderly or disabled
- Living without heating or hot water and at risk
- Limited life expectancy

Categorising complexity and urgency at this early stage will set the target timescales for the rest of the process. However, this should be kept under review as circumstances change or if further information is uncovered during the assessment.

3. PLYMOUTH DELIVERY MODEL

In Plymouth the Major Adaptations Team consists of:

1 x Major Adaptations Team Manager

1 x Technical Lead

2 x Senior Community Connections Officers

2 x Community Connections Officers

2 x Part time Occupational Therapists

In line with the above-mentioned timescale section the following displays the process of an application, who is responsible and what the actions are.

Stage 0 - first contact

In Plymouth the first contact will either be with Livewell Southwest or Children's Services.

Stage 1 - first contact to assessment and identification of the relevant works

As part of the clients holistic assessment there will be considerations regarding the home environment and what adaptations may be necessary and appropriate. In Plymouth this will be completed by Livewell Southwest or Children's Services Occupational Therapists.

Stage 2 - identification of the relevant works to submission of the formal grant application.

Where adaptations have been identified and classified as necessary and appropriate by Livewell Southwest or Children's Services Occupational Therapists, a referral will be completed and sent to Community Connections, Major Adaptations Team.

Stage 3 - grant application to grant approval – Pre Validated

Upon receipt of the application business support will input information onto systems used to manage major adaptations. Business support will consider property ownership, seeking landlord approval, requesting relevant supporting information from the clients and conducting means testing where required.

Stage 4 - approval of grant to completion of works. Valid Application

Upon an application becoming valid it's progression will be prioritised in line with other valid cases using the following rule:

Fast Track – 1 month

Red – 3 months

Amber – 5 months

Green – 6 months

Once the case is ready for progress in line with prioritisation it is uploaded onto the Dynamic Purchasing System (DPS). The DPS is a system which permits eligible contractors to tender for works, creating a competitive process which considers performance and costings. Upon a contractor being selected they will then attend the property, complete site surveys, discuss adaptions with the client, complete drawings and submit them to the Major Adaptations Team to review. Once satisfied with the drawings funding will be approved and the contractor will have a set period in which they are expected to complete works, this is usually 6 weeks however this will be reviewed depending on urgency.

** It should be noted that many DFG cases require multiple pieces of work to be undertaken in a home. Last year whilst 255 cases were completed, 374 pieces of work were delivered. Where multiple pieces of work are required, it is likely that both pieces will require tendering due to different contractors being required.*

4. PLYMOUTH DEMAND

The table below shows the number of clients referred into the Major Adaptations Team. Further the table provides detail in respect of the number of adaptations required to be delivered, the estimated costs determined by average costs of the adaptations requested (works in progress will be post site visit and as such will be the most accurate), and priority rating.

Stage	Number of Cases	Number of Adaptations	Cost	Priority			
				Fast Track	Red	Amber	Green
Pending Validation	313	422	£2,621,000	13	104	117	79
Valid	106	163	£1,089,000	6	31	46	23
Valid - Works in Progress	83	206	£840,165	16	49	46	23

Due to the nature of the client group having complex needs, there are occasions where cases are not able to be progressed in line with the desired timescales. Examples of where cases may get delayed; hospital admissions, condition deterioration, sickness, requirement of alternative housing to be provided during the period of works, supply chain shortages.

Further delays are caused by clients failing to provide additional information to permit the completion of means testing. Cases remain in pre validated stages until such time as information has been received and checks completed. Focused work is periodically conducted to follow up with clients in respect of this.

Beyond the current cases that the Major Adaptations Team are progressing, there are currently in the region of 240 cases with Livewell's Occupational Therapist Teams which are likely to result in an application for a DFG.

5. PLYMOUTH WAITING TIMES

Every year the Department for Levelling Up, Housing and Communities asks Housing Authorities to submit data on their DFG programme which is referred to as the DELTA return.

The following displays the waiting times in working days for Plymouth through financial years 21/22 and 22/23.

	22/23	21/22
Enquiry to Valid Application	55	105
Valid Application to Approval	112	77
Approval to completion	66	85

6. PLYMOUTH BUDGET

The £625 million allocated for DFG in 2024-25 represents a 184% increase in funding for home adaptations since 2015, and Government remains committed to helping older and disabled people to live as independently as possible in their own homes.
Of the central funding, Plymouth receives a percentage allocation displayed below. Further the table shows the number of cases completed in the period.

	Number of completed cases	Better Care Fund Allocation
24/25 To Date	63	£3,069,132
23/24	255	£3,059,312
22/23	316	£2,813,781
21/22	272	£2,813,781
20/21	160	£2,813,781
19/20	170	£2,479,859

Means Testing

In 2022/23 means testing of all clients over 19, who didn't have passporting benefits, brought in a total of £5,598.67. This figure is likely to be less than or equal to the costs of conducting the tests. Whilst other areas have removed means testing in order to speed up processes, they are now finding that they are seeing increased demand which is believed to be linked. In order to contain demand and ensure money is spent on those in greatest need, Plymouth will not be considering the removal of means testing currently.

Current Position

Of the year's £3,069,132 allocation, £482,759 has been spent on the delivery of works and £839,295 is committed with contractors for specified works. Following deductions for Minor Adaptations, maintenance programs and resourcing there is £1,335,440 left to spend. Works totaling £178,853 will be tendered every month for the rest of the financial year.

The available budget of £1,355,400 permits the major adaptations team to deliver all cases considered valid currently. However, the residual available budget of £246,440 will not cover all works currently listed as pending validation, and this does not consider clinical fast track cases, red cases or other cases which are currently unknown to service.

Risks and Mitigation

The Plymouth report displays that there will be a major shift in the population structure of Plymouth over the next 20 years as the proportion of the population aged 75 and over increases. The ONS projects a rise in the percentage of the Plymouth 75+ population of 60.3%, from 22,800 to 36,550 by 2043.

Building on this the report further highlights that more people are living with a disability now than in the past because the population, as a whole, is living longer and improved medical treatments are enabling more people to manage long-term health problems.

The delivery figures of 22/23 show there were 18 adaptations delivered for those aged 17 or under, 134 for those aged 18-65 and 134 delivered to those aged 66+.

Combining these factors together with a budget that, which whilst it has grown, is not sufficient, highlights that action is required to ensure that those in greatest need, have the adaptations they require.

The following actions are being undertaken mitigate risks posed by increasing demand, delivery costs and budget shortfalls.

1. Approach the Better Care Fund for additional funding.

2. Introduce a multi-disciplinary Discretionary Funding Panel – all cases now set to exceed the £30,000 grant maximum will be reviewed by Livewell, Children's Social Care and Community Connections, to consider alternative options in order to drive down costs.

3. Contractor reviews – all works proposed are reviewed in order to ensure that additional costs are not incurred delivering works outside of what is necessary and appropriate and in line with grant rules.

4. Increase buying power – The below figures show the average cost increases over the past 5 years. With this only likely to grow, we are now working with the DPS provider and other authorities nationally to approach suppliers direct in order to reduce costs by combined buying power.

2019/20 £7,040

2020/21 £6,355

2021/22 £7,207

2022/23 £9,444

2023/24 £11,311.72

5. Work with Occupational Therapists to ensure that adaptation requests are to meet client need and not client want. Ensuring that we manage expectations at the front door and not over promising.

6. Independent Living Policy 2019 (ILP 2019)Review – the Adult Social Care White Paper had intended implementing change for DFG's, and as such the ILP 2019 review was delayed. However, the ASC White Paper has now been shelved, as such later in 2024 the Policy will be reviewed to ensure that we are using money in the best way and in lie with legislation.

7. Explore alternative funding opportunities on a case-by-case basis to seek relief on the DFG budget and share costs where appropriate. Whilst the number of children's cases is considerably lower, due to the requirement to cater for changes in client need, cases are usually more expensive to deliver. Working with Children's Social Care has opened additional funding opportunities on some cases and the Major Adaptations Team will continue to explore this moving forwards. Further examples of this may be Community Health Care funding, charity funding or employer funding.

8. Work with the Better Care Fund to ensure that topography is considered in grant calculations. Early reviews of areas which receive similar funding allocations are shown to have less gradient changes. Considerations should be given to the substantial costs associated with ramp and platform lift installations when determining the grant allocation.

9. Work across the private rented sector to increase awareness of adaptations – with 186 adaptations delivered to private rented properties in 22/23 it is key that landlords are aware of adaptations, understand their importance and how they can maintain installations to permit continual use post tenants moving on.

10. Consider schemes such as Lendology for all cases set to exceed the grant maximum. This will place the financial responsibility onto the client and away from the local authority.

11. Introduce new systems to manage adaptations – currently the Major Adaptations Team use multiple platforms to deliver their work. Bringing these into one system, with customer, contractor and partner facing platforms, this will increase resource efficiencies permitting better client journey, time saving, information sharing and permit a level of innovation.

12. Offers and Asks – DFG budgets need to increase inline with inflation and increasing demand. Nationally Local Authorities do not have available budgets to mitigate budget shortfalls and greater pools of funding are required in order to prevent, delay and reduce social care demand, enabling people to live in their homes for longer.

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Right Care Right Person (RCRP)

Public Health & Wellbeing Scrutiny Panel

T/Chief Inspector Fergus Paterson

What is Right Care Right Person

- A cross-government approach so people in need get the most appropriate care and support.
- A National Partnership Agreement (NPA) signed by police and health government departments and national professional bodies. CYP signed by chief execs.
- **Police must focus on policing duties.**

- Police duties
  - Prevent and investigate crime
  - Keep the King's Peace
  - Save life (Section 2 Human Rights Act) and prevent serious harm and suffering (Section 3) when crime is involved. Help other agencies when needed.

- Police duties
  - Police must follow guidance for ethical and professional behaviour.
  - Respect article:
    - Article 5 – right to liberty and security of person.
    - Article 8 – right to private and family life.

Right Care Right Person

From police doing this non-crime work.....

CRISIS

To partners with the right skills, training, expertise and experience doing this.....

NHS

Department of Health & Social Care

Risk based
Behaviour A2/A3

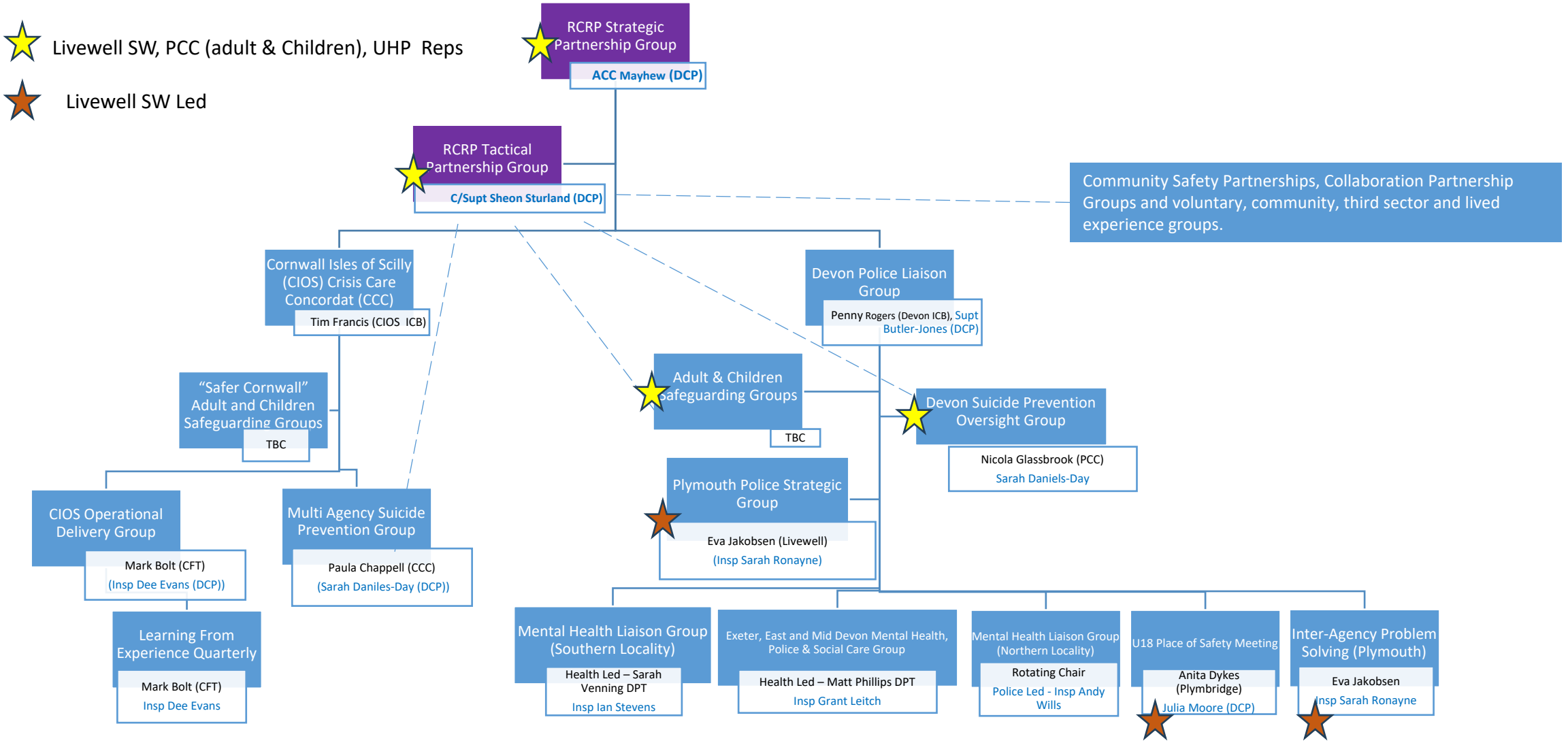
Suicidal Ideation
Self Harm
Emotional Distress
Medical

Welfare checks

ASSOCIATION OF MENTAL HEALTH PROVIDERS

CRISIS

Devon and Cornwall Isles of Scilly Right Care Right Person
Partnership Governance and Escalation Structure



Partnership engagement started March 2023. Strategic Partnership Group June established 2023.

NHS South Western Ambulance Service NHS Foundation Trust

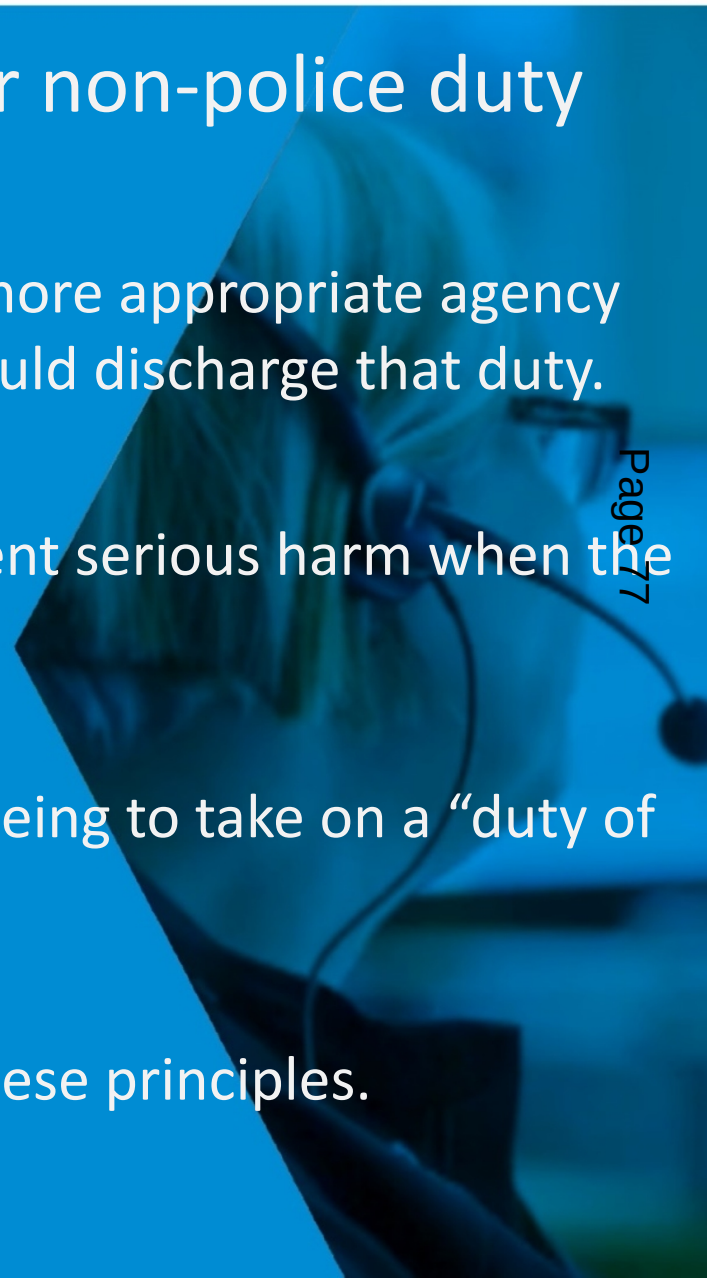
NHS

CPS

Devon & Cornwall POLICE

Right Care Right Person

- The structured control room decision process for non-police duty incidents based on legal principles:
  - ***Police may chose to accept an Article 2 and 3 duty*** when a more appropriate agency (better knowledge, skills, training, equipment, legal basis) could discharge that duty.
  - ***Police will "share" Article 2 and 3 duty*** to save life and prevent serious harm when the more appropriate state agency is unable to.
  - Police **must** consider the circumstances carefully before agreeing to take on a "duty of care" for non-police duties.
  - A "toolkit" app has been created for call handlers to apply these principles.



Right Care Right Person

When and how is this being introduced?

Phase 1

- **Concern for Welfare.** Went live mid Jan 2024. 35% fewer CFW responded to. Quicker call handling. VAWG & criminality prioritised.

Phase 2

- **"Absconders" / MHA AWOL**. Went live 3rd June. Results awaited.

Phase 3

- **Section 136 and voluntary attendees.** Planned go live end of year.

Phase 4

- **Transport of patients.** Plymouth command supports a Joint Response Police. Force vision is SWAS and MHP response. Police to support if crime or threat. Planned 2025.

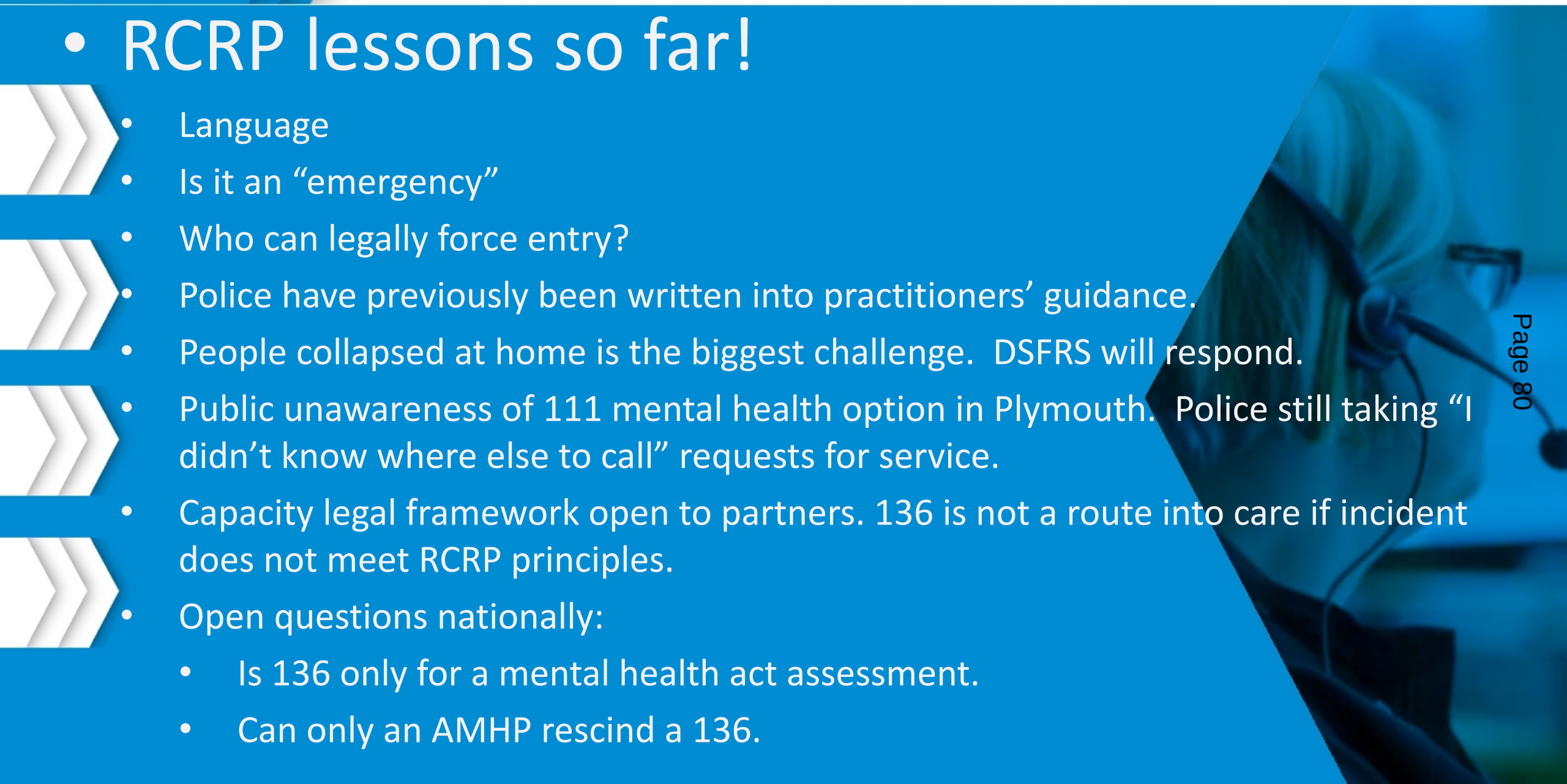
Right Care Right Person

Distribute through partnership structures:

- Escalation Process
- Scrutiny Panel

Right Care Right Person

- RCRP lessons so far!
  - Language
  - Is it an “emergency”
  - Who can legally force entry?
  - Police have previously been written into practitioners’ guidance.
  - People collapsed at home is the biggest challenge. DSFRS will respond.
  - Public unawareness of 111 mental health option in Plymouth. Police still taking “I didn’t know where else to call” requests for service.
  - Capacity legal framework open to partners. 136 is not a route into care if incident does not meet RCRP principles.
  - Open questions nationally:
    - Is 136 only for a mental health act assessment.
    - Can only an AMHP rescind a 136.



HEALTH AND ADULT SOCIAL CARE OVERVIEW SCRUTINY COMMITTEE

Tracking Decisions Log 2024-25

Please note that the Tracking Decisions Log is a 'live' document and subject to change at short notice.

For general enquiries relating to the Council's Scrutiny function, including this committee's work programme and tracking decisions, please contact Elliot Wearne-Gould, Democratic Support, on 01752 398261

Tracking Decision Overview	
Complete	**2**
In Progress	**5**
On Hold	**0**
Awaiting Action	**0**
Total	**7**

No.	Meeting Date	Resolution	Responsible	Status
1	20/02/2024	End of Life Care: 1. NHS Devon and partners return to a future scrutiny session to bring an update on performance against the End of Life Care improvement Plan. This is to include delivery of the Palliative Care framework, findings of the Estover Pilot Project, and additional information on the below recommendations. 2. NHS Devon and Partners take into account, and record peoples preferences for place of death. Collect figures in the hospital and report back into future scrutiny (as per rec 1). 3. NHS Devon and partners return at a future time to report on falls prevention measures being undertaken and related performance. 4. NHS Devon and partners work to reduce the delay in testing and diagnosis to enable maximum choice for patients spend their remaining time in the way/location that they wish; 5. NHS Devon adopt processes to include patients' relatives in the planning and administration of care for their loved ones (where applicable, and consent given). This includes consultation in the development of a TEP. – Proactively suggest to patients- "what about your family?" and "would you like to consult with a family member?" etc.	NHS Devon and partners + Gary Walbridge.	In-Progress

		6. The Council, in partnership with City organisations and individuals, seek to promote and recognise St. Luke's communication of "Care in the community" and "the hospice coming to you", rather than the misconception of patients having to be admitted to a hospice. 7. The Cabinet Member for Housing, Cooperative Development and Communities (Cllr Penberthy), ensures that the Housing Needs Assessment considers housing standards, and their appropriateness, for individuals with a variety of medical needs (Accessibility and quality). – Have some houses specially built/ adapted for those with additional medical needs.		
Response: NHS Devon and partners will return to Scrutiny in September 2024 to bring an update on the End of Life Care Improvement Plan. The Cabinet considered these recommendation at the 08 July 2024 meeting, and the Cabinet member for Housing, Cooperative Development and Communities (Cllr Penberthy) delivered a response.				

2	13/12/2023	1. To request figures detailing the number of people awaiting an assessment for a care package, and figures for short-term vs long-term need. 2. To note that the Quarterly Performance report would be reviewed and updated to include other appropriate benchmarks, targets and metrics.	Rob Sowden (Senior Performance Advisor)	In-Progress
Response: These figures have been compiled and will be included in the next updated format of the Quarterly Performance report for this Committee. This will be brought to the first meeting of the new municipal year.				

3	13/12/2023	1. To request further information regarding the level of funding that had been secured for the 100 Day Challenge	Chris Morley (NHS Devon ICB)	Complete
A report from the ICB regarding the 100-Day Challenge has been circulated to members.				

4	13/12/2023	1. To request further information regarding the total number of people impacted by the planned and enacted pharmacy closures; 2. To request further information regarding the cause of pharmacy closures; 3. To request that results from the Independent Prescribing Pathfinder Programme are brought to a future meeting;	Melissa Redmayne (NHS Devon ICB)	Complete

Response: Additional information provided below. The Pathfinder Programme has been added to the Work Programme for future consideration.

Pharmacy Name	Address	Exit Date	Average items / months (Exit)	Distance (miles) to nearest	Pharmacies within a mile	Nearest Pharmacy Name	Address
Boots Pharmacy	Plympton Health Centre, Mudge Way, Plympton, PL7 1AD	18/11/2023	9497	0.2	3	Boots Pharmacy	3 St Stephens Place, Ridgeway, PL7 2ZN

Boots Pharmacy	Chard Road Health Centre, St Budeaux, Plymouth, PL5 2UE	06/01/2024	7850	0.4	2	Well Pharmacy	St Budeaux Health Centre, Stirling Road, PL5 1PE
Boots Pharmacy	6-8 Eggbuckland Road, Mannamead, Plymouth, PL3 5HE	06/01/2024	7468	0.5	3	Well Pharmacy	146 Eggbuckland Road, Higher Compton, PL3 5JU
Boots Pharmacy	7 Claremont Street, Plymouth, PL1 5AQ	06/01/2024	9055	0.4	5	King Street Pharmacy	140 King Street, Stonehouse, PL1 5JE
Boots Pharmacy	4B Cattedown Road, Cattedown, Plymouth, PL4 0AY	22/03/2024	5276	0.6	4	Ebrington Pharmacy	61A Ebrington Street, PL4 9AA
Boots Pharmacy	58 Salisbury Road, St Judes, Plymouth, PL4 8SY	23/03/2024	6481	0.6	5	Ebrington Pharmacy	61A Ebrington Street, PL4 9AA

Positively Boots have indicated that they are going to increase their Supplementary hours at a number of their remaining branches.

There are a range of factors that will be driving closures however, key factors cited by the sector are workforce and financial viability. The hub have requested site specific reasons from Boots but unfortunately no further information has been provided other than for business reasons which was reported at the meeting.

5	26/10/2023	1. The Committee recommended that the Cabinet Member for H&ASC install defibrillators at the 5 locations identified within the report, and that the methodology was re-examined to include additional locations such as the Council House, and appropriate city libraries.	Ann Thorpe (Service Manager, FM)	In-Progress

		The Committee welcomed the Cabinet member's amendment of recommendation 7: 'That PCC work with partners to provide defibrillators at St Budeaux library and Southway library' to include "and other appropriate locations".		
Response: Following my earlier response, I have been contacted by the DHSC and following some discussions with the PICs at our sites have been able to confirm that all 5 sites (St Budeaux library, Southway library, Raglan Court, The Reatch Centre and Colwell Lodge) could match the criteria for the funding and they have now offered us partial funding for 5 defibrillators. The Guildhall. There is a unit at The Guildhall with standard availability being 8.00 to 16.30, with additional availability when there is an event onsite. We will be making this available 24/7 by locating it externally subject to Historic England advice. Chelson Meadow. There are 2 units at Chelson Meadow, one at The Ride available 24/7 and one in the recycling centre available 08:30-17:30. An additional defibrillator has been located at Southway Youth Centre with support from the local community group. The defibrillators in situ as shown above are also registered on The Circuit and with Facilities Management for ongoing maintenance. Further updates to follow shortly.			

6	26/10/2023	The Committee requested: 1. To be provided with further information regarding the financial implications of compensation awards, following LGO complaint recommendations. 2. To recommend that the Cabinet Member for H&ASC review the template and process for complaint responses, to ensure they are clear, readable and personal. 3. To recommend that the Cabinet Member for H&ASC has oversight of all LGO reports and recommendations relating to their portfolio.	Emma Crowther	In-Progress

A report detailing the financial implications of LGO complaints has been compiled and will be included in the next Quarterly performance report for H&ASC. The Cabinet member has agreed to review the process for complaint responses, and an update will be brought to the Committee when complete. The Cabinet member has oversight of LGO complaint responses during PFH meetings.

7	Mental Health Select Committee 07/03/2023	Based on evidence submitted by the Plymouth Youth Parliament, the Committee recommends to the Plymouth Education Board, that a 'place-based' teaching approach of the physical health and mental wellbeing section of the statutory relationships, sex and health education curriculum be developed in the city, which must address social media, exams, drugs, alcohol and vaping.	Service Director Education, Participation and Skills	In-Progress
Response: This item has been covered at the Plymouth Education Board in May 2023 – particularly the focus on mental and emotional health. Further communications to schools about vaping have been jointly produced by Public Health and EPS. A further discussion took place at the PEB in February 2024. Further updates and outcomes will be reported to the Committee shortly.				

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Health and Wellbeing Scrutiny Committee: Work Programme 2024/25

Please note that the work programme is a 'live' document and subject to change at short notice. The information in this work programme is intended to be of strategic relevance.

For enquiries relating to the Council's Scrutiny function, including this Committee's work programme, please contact Elliot Wearne-Gould (Democratic Advisor) on 01752 398261.

Date of Meeting	Agenda Item	Prioritisation Score	Reason for Consideration	Responsible Cabinet Member/Lead Officer
16 July 2024	Quarterly Performance & Financial Report for H&ASC, + Risk Monitoring Report	4 (Medium)	Regular monitoring of performance and finance for H&ASC.	Rob Sowden, Helen Slater and Ross Jago
	PASP Draft Case for Change	4 (Medium)	Requested by NHS due to potential service change implications	Katie Harding (NHS D)
	DFG performance	4 (Medium)	To scrutinise concerns regarding DFG waiting lists, financing and performance.	Dave Ryland
	Right Care Right Person	4 (Medium)	To scrutinise introduction of new Police initiative, and its implications.	D&C Police
22 October 2024				
	End of Life Care Update	4 (Medium)	To receive an update against the NHS D performance plan for End of Life Care	Chris Morley (NHS D)

10 December 2024				
11 February 2025				
Standing Items				
Quarterly Performance & Financial Report for H&ASC, + Risk Monitoring Report		4 (Medium)	Regular monitoring of performance and finance for H&ASC.	Rob Sowden, Helen Slater and Ross Jago
Items to be scheduled for 2024/25				
Local Care Partnership Plan				
Maternity Care (Following Derriford's CQC Report)				
Update On The Progress And Outcomes Of The Drug And Alcohol Oversight Board				
ICB Capital Funding Report				
Health And Wellbeing Hubs: Update And Future Sites				
Overview Of Adult Social Care Provider Market (Workforce, Quality, Capacity)				
Better Care Fund Update on Progress				
Systems Plan for Winter Progress Monitoring Update				
Independent Prescribing Pathfinder Programme (NHS Devon)				
Residential Care Homes Commissioning Plan				
Mental Health				
Items Identified for Select Committee Reviews				

Scrutiny Prioritisation Tool

		Yes (=1)	Evidence
Public Interest	Is it an issue of concern to partners, stakeholders and/or the community?		
Ability	Could Scrutiny have an influence?		
Performance	Is this an area of underperformance?		
Extent	Does the topic affect people living, working, or studying in more than one electoral ward of Plymouth?		
Replication	Will this be the only opportunity for public scrutiny?		
	Is the topic due planned to be the subject of an Executive Decision?		
Total:			High/Medium/Low

Priority	Score
High	**5-6**
Medium	**3-4**
Low	**1-2**

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