Health and Adult Social Care Scrutiny Panel

Tuesday 11 February 2025

PRESENT:

Councillor Murphy, in the Chair.
Councillor Ms Watkin, Vice Chair.
Councillors Freeman (substitute for Councillor Reilly), Lawson, McLay, Morton, S.Nicholson, Noble, Penrose, Raynsford (substitute for Councillor Taylor) and Simpson (substitute for Councillor Ney).

Apologies for absence: Councillors Ney, Taylor and Reilly.

Also in attendance: Councillor Mary Aspinall (Cabinet Member for Health and Adult Social Care), Stephen Beet (Head of ASC Retained Functions), Vanessa Crossey (Head of Nursing and Quality, NHS Devon), Ian Lightley (Chief Operating Officer, Livewell Southwest), Rachel O'Connor (Director of Integrated Care, Partnerships and Strategy, University Hospitals Plymouth), Sarah Pearce (Head of Adult, Frailty and Specialist Services, Livewell Southwest), Sarah Prideaux (Community Crisis Response Team Manager, Livewell Southwest), Helen Slater (Lead Accountancy Manager), Gary Walbridge (Strategic Director for Adults, Health and Communities) and Elliot Wearne-Gould (Democratic Advisor).

The meeting started at 2.00 pm and finished at 5.01 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.

80. **Declarations of Interest**

Name	Minute Number	Description	Interest
Councillor S.Nicholson	84	Family member employed by Livewell Southwest	Personal
Councillor Noble	86	Employee of University Hospitals Plymouth, NHS Trust	Personal
Councillor Lawson	86	Employee of University Hospitals Plymouth, NHS Trust	Personal
Councillor Morton	86	Employee of University Hospitals Plymouth, NHS Trust	Personal

81. **Minutes**

The minutes of the meeting held on 10 December 2024 were agreed as an accurate record.

82. **Chair's Urgent Business**

There were no items of Chair's urgent business.

83. **Quarterly Performance and Finance Reports for H&ASC**

Councillor Aspinall (Cabinet Member for Health and Adult Social Care) and Helen Slater (Lead Accountancy Manager) delivered the Quarterly Finance Report for Adult Social Care, and discussed:

a) Frequent variations in care budget performance across quarterly reports, which often fluctuated between underspend and pressures;

b) The ability for underspends in some budget areas to counteract pressures in others;

c) Month eight budget reporting demonstrated pressures of £759,000 for Package Budgets with pressures of £204,000 for Domiciliary Care, and £266,000 for Supported Living. Pressures on Nursing Long Stay budgets were offset by savings to Direct Payments, Extra Care Housing and Residential Long Stay budgets of £602,000. Pressures to reducing client income had been investigated, and mitigations had been identified;

d) It remained the ambition to achieve a balanced budget for 2024/25;

e) The budget forecast for 2025/26 included a growth of £12 million to mitigate for volume and inflationary pressures, including the national living wage increase to £12.21 per hour;

f) The final Local Government Settlement had been received, which did not contain compensation for the national living wage increase for social care.

In response to questions, the Panel discussed:

g) While there were three budget headings for Adult Social Care reporting underspend, the package budgets held a total pressure of £759,000 at Month eight. This would be funded by savings in other areas and any underspend in the remainder of the year;

h) Changes to National Insurance rates would take effect in the next financial year;

i) The cause of additional budget pressures was primarily attributed to volume and cost increases, with services receiving a higher complexity of need and increased demand;

j) Client Income pressures were primarily attributed to an overestimation of expected income in the previous financial year, and did not relate to failure to

recover monies. It was a complex challenge to correctly estimate demand and eligibility for client income.

Stephen Beet (Head of ASC Retained Functions) delivered the Quarterly Performance Report for Adult Social Care, and discussed:

k) A Local Government Peer Review had recently been conducted of Plymouth's Adult Social Care services, proving advice, support and recommendations;

l) Overall, feedback was positive. Areas for improvement action included reducing waiting times and increasing co-production of care with clients. A detailed report was expected to be received next month and an action plan had been put in place to address these recommendations;

m) Plymouth City Council had received formal notification from the Care Quality Commission (CQC) of the intention to visit to conduct a review of services within the next six months;

n) It was normal for service demand to increase over the winter period, and these numbers had begun to fall again. Ongoing work was being undertaken to prevent unnecessary placements;

o) Domiciliary care demand increases were seen as positive, with an intention to increase the number of people receiving care in the community. This was in line with budget allocations and performance targets;

p) The number of people receiving re-ablement care had increased, but the hours of care delivered had temporarily declined due to capacity challenges in December 2024. The service remained on target for enabling people to remain at home;

q) There had been a reduction in the number of people receiving direct payments for their care. This was largely attributed to an increased number of care act reviews conducted in 2024/25, ensuring people received the appropriate care. It remained the ambition to increase Direct Payments, with the target raised to 635.

(The Panel agreed to move to item five, 'Livewell Southwest Performance Report', before considering questions and recommendations jointly with this item)

84. Livewell Southwest Performance Report & Alternatives To Admission

Ian Lightley (Chief Operating Officer, Livewell Southwest) delivered the Livewell Southwest performance report, and discussed:

a) Changes to the management and prioritisation of outstanding cases and demand;

b) A reduction in the 'longest days waited' by an individual, since the last meeting;

c) Reviews of outstanding cases to ensure they were still relevant and correctly prioritised;

d) Letters had been circulated to all clients on the waiting list to provide information and signposting. This included average waiting times, reasoning for the waiting list and advice on where to go for interim support. Clients were advised to contact Livewell for re-prioritisation if their situation changed;

e) Improved performance oversight had been achieved, with monthly management updates on actions to reduce waiting times;

f) Recognition of further work required to reduce waiting lists;

g) A reduction in the total number of people waiting for services from 931 in April 2024 to 428 in February 2025;

h) An ambition to shorten the waiting time for those with lower needs, who typically waited longer. Urgent and high priority cases were generally assessed in good time;

i) Ongoing efforts to improve the collection and utilisation of data to support triaging and enhance efficiency;

j) Collaborative work between Livewell Southwest and Plymouth City Council to reduce waiting lists, maintain patient communication, and improve productivity and oversight;

k) A reduction in the number of 'outstanding reviews' from earlier in the year;

l) The continued prioritisation of supporting people outside of hospital. There was a target for 75% of people with complex needs to be discharged directly home.

In response to questions, the Panel discussed:

m) Dissatisfaction and concern for the waiting list figures, which showed 438 people waiting 21 weeks. It was explained that a large proportion of these figures were people assessed as low need, and that cases were monitored to track risk, and escalated as appropriate;

n) The criteria for eligibility for a care act assessment was relatively low, creating a significant number of applications for assessments, which identified a low clinical need. These cases often only required advice and signposting however, addressing them was often delayed by priority cases;

o) It was recognised that advice and signposting to those of low clinical need could be given earlier, and that this would likely be beneficial to all parties;

p) It was recognised that the report presented to Panel did not demonstrate the level of risk pertaining to each of the cases of the waiting list, and it was therefore difficult to assess the significance of these numbers. Future data would include a representation of risk, and Livewell were working to enhance their prioritisation and triage systems to reflect this;

q) Livewell were developing the 'waiting well protocol', proactively contacting people on waiting list to provide advice and signposting;

r) While it was impractical to expect the complete abolishment of waiting lists, it was nationally accepted that a 30 day waiting period was reasonable;

s) There had been a continued growth in demand, and there was an expectation this would continue;

t) Livewell's staff recruitment and retention was strong, and there were few staff vacancies;

u) There were no delays for carers assessments.

The Panel agreed:

1. To request that Livewell Southwest performance data returned to a future meeting to enable continued tracking, and that data included an assessment of risk;

2. To recommend that an introductory briefing and training session was scheduled for Panel members in the new municipal year, and opened to all councillors;

3. To note the reports.

Sarah Pearce (Livewell Southwest) and Sarah Prideaux (Livewell Southwest) delivered the 'Alternatives to Admission' report, and discussed:

v) The Integrated Admission Avoidance Service delivered a 24 hour offer, split into three services:

   i. Urgent Community Response service;

   ii. Integrated Alternative to Admission service;

   iii. Out of Hours Nursing service;

w) The Urgent Community Response service provided two categories of responses: an under 2 hour response, and a 24 hour response;

x) The service provided support and additional capacity for UHP (University Hospitals Plymouth) colleagues, delivering Virtual Wards and IV therapies;

y) The service utilised a range of integrated professionals across UHP and the South West Ambulance Service (SWAST).

(A video was played at this point on the Community Urgent Response Service)

z) An overview of caseloads, demand and activity figures demonstrated an increasing number of people successfully helped to remain in the community;

aa) Despite increasing demand, figures for 'extended length of stay' remained low;

bb) The service in Plymouth already outperformed national targets, with over 80% of patients receiving care within a two hour period;

(A video was played at this point of a patient's experience with the service)

In response to questions, the Panel discussed:

cc) Staffing and resource requirements – some areas had received new investment and resource, such as virtual wards, as part of the national shift to provide care in the community. Other measures were expected be self-funding through efficiencies created by implementing the changes;

dd) The One Plan – acute and community services were working together to improve efficiency and appropriately direct funding. The Community Frailty Virtual Ward had been established by releasing funding from acute hospital into community;

ee) The Community Crisis Response Team were fully equipped to provide care within the community, and had access to transport, lifting equipment, and other specialised assets;

ff) The Community Crisis Response Team was available within the SWAST directory of services, enabling paramedics, GPs and other medical professionals to refer patients into the programme, and call for timely advice / assistance;

gg) Staff were being increasingly trained in multi-disciplinary skills, enabling them to diagnose or refer to the most appropriate service. This included training for social workers to spot sepsis, and training for all staff in the Care Act.

The Panel <u>agreed</u> to:

1. Thank and praise staff for the success of the Admission Avoidance initiatives;

2. Note the report.

85. **Armed Forces Friendly GPs and Dental Surgery**

Vanessa Crossey (Head of Nursing and Quality, NHS Devon ICB) delivered the Armed Forces Friendly GPs and Dental Surgery presentation, and discussed:

a) Every resident was entitled to a General Practice (GP) registration. The Armed Forces Covenant stipulated that no one in the Armed Forces family should be disadvantaged due to where they lived, or their requirements for travel;

b) Armed Forces family members should retain their place on NHS waiting lists and should not be removed when their forces posting / deployment changed;

c) All General Practices in Plymouth were accredited to the Veterans Accreditation Scheme, which provided training on referrals into appropriate veterans programmes such as Op. Restore and Op. Courage;

d) All large acute providers and Livewell Southwest were members of the Veterans Accreditation Scheme. This encouraged providers to work collaboratively to prioritise veteran's care, as stipulated in the Covenant.

e) Veterans and serving members held responsibility for informing their GP of their service links. There was currently no automated system link between military and civilian medical records however, work was ongoing to develop this;

f) There was a military culture of avoiding reporting medical issues wherever possible, due to fear of compromising career progression and opportunities;

g) Cornwall had recently undertaken a campaign to encourage veterans to register their service links with their GPs;

h) There were national and regional challenges for dental provision. Significant work was ongoing within the ICB to improve the commissioning of dental services;

i) In general, veterans left the military with good dental health. There were considerable variations between veterans expectations of civilian dental care, and the reality of availability;

j) There was a need to improve support to forces families in attaining an NHS Dentist, as well as ensuring they were not disadvantaged by deployments.

In response to questions, the Panel discussed:

k) Challenges for forces families in securing NHS dental treatment when posted or moved;

l) Dental services were provided for forces families by the military when posted abroad. RMAS Sandhurst and Aldershot also provided UK access to forces families;

m) Concerns that not all dentists in Plymouth were fulfilling the NHS dental contracts they had signed. There was a recognised struggle to recruit and retain NHS dentists in the South West;

n) There were approximately 23,000 people in Plymouth on the dental waiting list;

o) NHS Devon ICB were investing heavily in early prevention, commissioning children's dental health and tooth cleaning schemes;

p) There was currently no dental accreditation scheme for veterans;

q) Investment of £900,000 had been received to deliver oral health schemes such as the 'Open Wide, Step Inside' programme of prevention;

r) Op. Courage and Op. Restore were programmes funded by military charities. There were no contributions made by the Ministry of Defence (MOD) to general practice and dentistry;

s) There were considerable challenges for veterans when leaving the military, including adjusting to the concepts of no free prescriptions, waiting lists for appointments, and access challenges for dental and primary care.

The Panel agreed to:

1. Request that 'Armed Forces Friendly GP and Dental Provision' returned to the Panel at a future date;

2. Requested that further clarity was provided regarding armed forces prioritisation for medical procedures, as well as referral rates for Op. Courage and Op. Restore;

3. To note the report.

86. **Urgent and Emergency Care 'One Plan' & Winter Preparedness**

Chris Morley (NHS Devon ICB), Rachel O'Connor (UHP) and Ian Lightley (Livewell Southwest) delivered the Urgent and Emergency Care 'One Plan' & Winter Preparedness report and discussed:

a) The report presented an update on the progress of the Urgent and Emergency Care 'One Plan', which had previously been presented to the Panel;

b) The plan was a collaborate strategy between multi-agency partners, drawing together detailed analysis of anticipated demand and capacity modelling from previous year's performance;

c) The plan was comprised of:

   i. A clear communication strategy;
   ii. The seasonal vaccination strategy;
   iii. A targeted approach to 'home first' delivery for hospital discharge;
   iv. A collaborative approach to local demand/capacity escalation;

d) The most acute pressures were often experienced in the Emergency Department (ED). It was essential to ensure flow was maintained;

e) This year had presented a challenging winter period for demand and capacity. All hospitals in Devon had experienced significant periods of pressure however, due to sufficient planning and protocol, Devon was able to quickly reduce pressures and return to normal;

f) Significant progress had been made at UHP this year, particularly in reducing ambulance handover times and meeting the four hour A&E target;

g) Vaccine uptake had been lower this year than in previous years, and was likely due to an increase in vaccination fatigue. Investigations were ongoing between Public Health and partners to understand more;

h) There had been a positive uptrend in patients being discharged directly home, increasing to 55% this year in comparison to 23% last year. The target for next year would be 75%;

i) Innovation was being utilised to increase capacity and support care in the community, including the commissioning of the mobile X-ray car;

j) Due to recruitment challenges, not all 64 Community Frailty Virtual Ward beds had been opened. The beds were currently operating at 97% occupancy, and would be expanded to 67 beds by 24 February 2025, and 84 beds by 31 March 2025;

k) The Expanded End of Life Care Team were fully staffed, and supported an average of 31 patients per month move from ED to Mount Gould Hospital, or their home setting. Mount Gould now had 8;

l) The 'timely discharge' focus was performing well, with an additional 60 patients per month being discharged directly home on the 'home first' pathway;

m) UHP demonstrated improvement on all key performance metrics in comparison to last year;

n) It was recognised that there was further improvement required to the six and eight hour ambulance handover waiting times however, UHP was the fourth most improved provider nationally.

In response to questions, the Panel discussed:

o) Recognition of the significant improvement in performance since last year;

p) The implications of low vaccine uptake, as well as its prevalence across staff, patients and care-givers;

q) Improvements to ambulance handover delays and ongoing work still required;

r) Targeting of the X-ray car towards vulnerable and/or disabled demographics who would have otherwise presented at ED with suspected fractures.

The Panel agreed to:

1. Thank presenters for their ongoing work, and for their regular attendance at scrutiny over the past year;

2. Note the report.

87. **Tracking Decisions**

The Panel agreed to note the tracking decision log.

88. **Work Programme**

The Chair thanked scrutiny members and officers for their hard work and commitment over the past municipal year.

The Panel agreed to note the Work Programme.