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HEALTH AND ADULT SOCIAL CARE SCRUTINY PANEL

Tuesday 15 July 2025
2.00 pm
Warspite Room, Council House

Members:
Councillor Murphy, Chair
Councillor Ney, Vice Chair
Councillors Lawson, Lugger, McLay, Moore, Morton, Noble, Penrose, Simpson and Tuohy.

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 Adult Social Care Scrutiny Panel

1. Apologies

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

2. Declarations of Interest

To receive any declarations of interest from Panel members in relation to items on this agenda.

3. Appointment of a Chair and Vice-Chair for 2025/26

For the Panel to note the appointment of Councillor Murphy as Chair, and Councillor Ney as Vice-Chair for the 2025-26 Municipal Year.

4. Minutes (Pages 1 - 10)

The Panel will be asked to confirm that the minutes of 11 February 2025 are a correct record.

5. Chair's Urgent Business

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

6. Quarterly Performance, Finance and Risk Reports for H&ASC: (Pages 11 - 24)

7. Palliative and End of Life Care: (Pages 25 - 40)

8. NHS Reforms and Re-structures: (Pages 41 - 44)

9. Work Programme (Pages 45 - 48)

For the Panel to discuss items on the work programme for 2025-26.

10. Action Log (Pages 49 - 50)

For the Panel to review the progress of the Action Log.

11. Exempt Business

To Consider passing a resolution under Section 100A(4) of the Local Government Act 1972 to exclude the press and public from the meeting for the following 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.

11.1. Private Meeting

Agenda

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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.

Health and Adult Social Care Scrutiny Panel

Date of meeting:	15 July 2025
Title of Report:	**Adult Social Care Activity and Performance Report**
Lead Member:	Councillor Mary Aspinall (Cabinet Member for Health and Adult Social Care)
Lead Strategic Director:	Gary Walbridge (Strategic Director for Adults, Health and Communities)
Author:	Stephen Beet, Head of Adult Social Care & Retained Functions Gill Nicholson Head of Innovation & Delivery
Contact Email:	Stephen.beet@plymouth.gov.uk Gill.nicholson@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 provide Scrutiny panel members with a performance update for Adult Social Care, including levels of demand for services and any priority actions.

Recommendations and Reasons
1. It is recommended that Scrutiny acknowledge the content of the report.

Alternative options considered and rejected
1. None

Relevance to the Corporate Plan and/or the Plymouth Plan
Plymouth Plan Priority: A Healthy City
Corporate Plan Priority: Keeping children, adults and communities safe

Implications for the Medium Term Financial Plan and Resource Implications:
The Adult Social Care budget is monitored closely, including the numbers of people needing a new service and the associated costs of services. The purpose of this report to Scrutiny is to provide an update on the key activity related to demand for services.

Financial Risks

None - as above

Legal Implications

(Provided by Alison Critchfield/Assistant Head of Legal Services)

None arising from this report

Carbon Footprint (Environmental) Implications:
Services for Adult Social Care are provided locally to the city as much as possible to enable people to remain close to their communities. This also aims to reduce the amount of travel required.

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.*
None

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	Adult Social Care Activity and 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 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
N/A							

Sign off:

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Originating Senior Leadership Team member: Stephen Beet, Head of Adult Social Care and Retained Functions

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

Date agreed: 07/07/2025

Cabinet Member approval: Councillor Mary Aspinall

Date approved: 07/07/2025

Adult Social Care Activity and Performance Report

The vision for Adult Social Care in Plymouth is to support people to lead "gloriously ordinary lives", living their best life doing the things that matter to them. Living in a place they call home and supported by their own thriving connected community, able to access high quality advice, information and timely local services and support, where appropriate, in a way that they choose.

To support the delivery of our statutory Adult Social Care duties, Livewell Southwest is commissioned by the Council to provide services including assessments and reviews. This is alongside some functions which are retained by the Council..

This report shows the position against some key activity and performance measures from across the health and social care system and will be provided to the Health and Adult Social Care Oversight and Scrutiny Committee on a quarterly basis. We continue to test the effectiveness of how we perform and we invited the Local Government Association to undertake a Peer Review of Adult Social Care in January 2025. This led to a revised improvement plan, and we have seen improvements in most areas including waiting times for assessments & reviews.

The Care Quality Commission completed their inspection of Adult Social Care in Plymouth in June 2025 and we are awaiting their report and findings.

Glossary	
ASC	Adult Social Care
CQC	Care Quality Commission
LCP	Local Care Partnership
LGO	Local Government Ombudsman
LWSW	Livewell Southwest
NCTR	No Criteria to Reside
SALT	Short and Long Term
P1	Returning Home – with Reablement support
P2	Short Term Care – Bed Package
P3	Long Term Care – Nursing/Residential

ADULT SOCIAL CARE KEY FACTS 2024/2025

PLYMOUTH CITY COUNCIL

Adult Social Care service have supported people, and many more through our wider health & care system activity.

14,563

Completing **5,127** assessments (including Care Act, Occupational Therapy, Carers, and Mental Capacity Assessments) & **4,023** Reviews of individual care support needs.

Average number of contacts per month via for care & support related to advice or activity.

838

Average number of contacts per month via our contact centre

WELLBEING HUBS

Supported the community through **182,000+** contacts

CARERS

All Adult Carers – 2021 Census showed **23,956** people provide unpaid care. Of those unpaid carers, 58.1% are aged 26-64 & 35.4% are aged 65-84

Young Carers (0-17) - **1,050**

Number of safeguarding concerns raised:

6,018

Number of safeguarding concerns that met threshold for S42 enquiry

419

(reducing or removing the identified risk in **352** cases)

£	24/25 Gross Budget	£103m
	25/26 Gross Budget	£114m
	People supported by Domiciliary Care Providers	2,218
	People supported in Care Homes	1,272
ECH	Extra Care Housing Places	240
	People supported by Out of Area Care Home Commissioned services	198
	People in supported living	796
DP	People Supported Through Direct Payments	724

OUR VISION FOR ADULT SOCIAL CARE

PLYMOUTH CITY COUNCIL

"Gloriously ordinary lives"

Social Care Futures

"People living their best life doing the things that matter to them. Living in a place they call home and supported by their own thriving connected community, able to access high quality advice, information and timely local services and support, where appropriate, in a way that they choose."

Remaining Independent

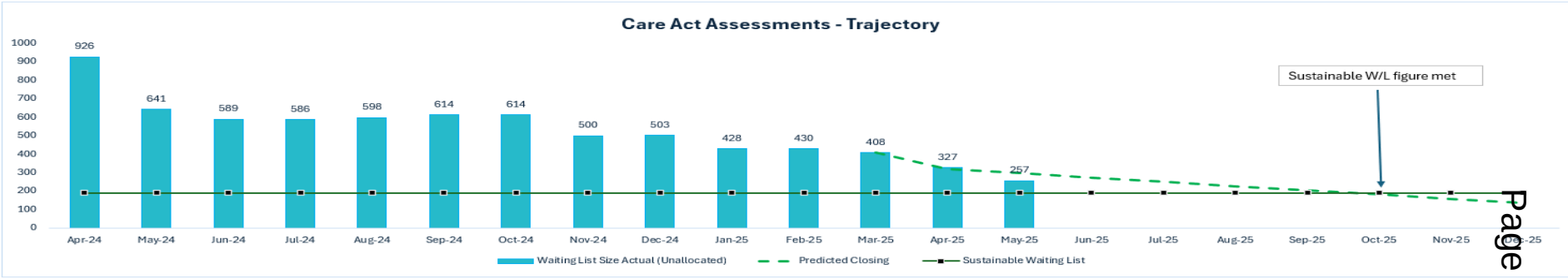
Effective & timely assessment

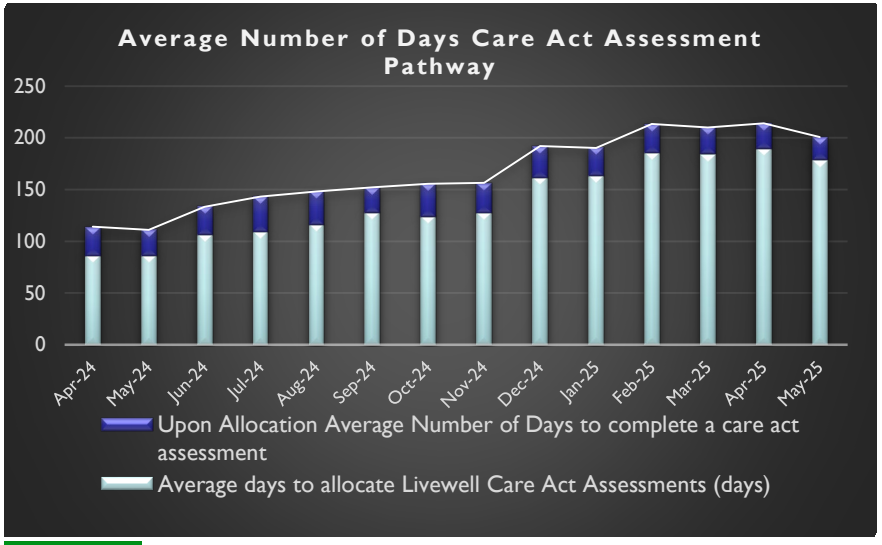
Ensuring choice & control

Good quality care & support from a skilled workforce

Theme 1:Waiting Lists – New Care Act Assessments

Key Performance Indicator	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Target	
Number of People Waiting	641	589	586	598	614	614	500	503	428	430	408	327	257	183	▼
Average number of days for an assessments to be completed (upon allocation)	27.6	24.6	26.7	33.6	32.1	24.1	31.5	28.9	30.2	27	27.6	25.6	24.3	20	▼
Number of Care Act Assessments Completed	255	228	186	170	151	200	180	154	223	197	186	198	243	183	▲





Narrative

Upon allocation to a social worker, we know that the average Care Act assessment takes 24.3 days to complete. Focused work continues to bring down the waiting times. We have implemented a "Waiting Well" policy which ensures that people are waiting safely and we consistently prioritise allocation of work in an effective, safe and proportionate way.

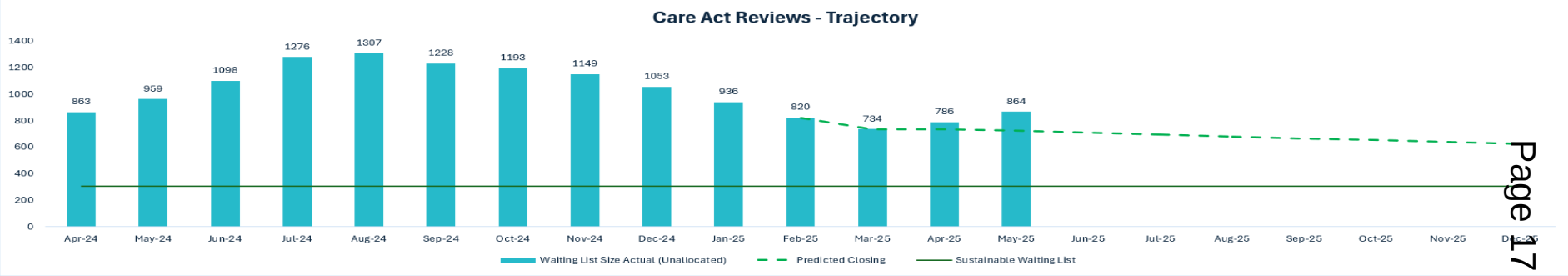
As of 2nd June we have 15 people waiting over 300 days for an assessment, these will be allocated to a social worker within the next four weeks. We anticipate that we will reach a sustainable waiting list position in October 2025. The overall length of the assessment pathway is currently taking on average 200 days from point of triage due to focused work being undertaken to review those who have been waiting longest.

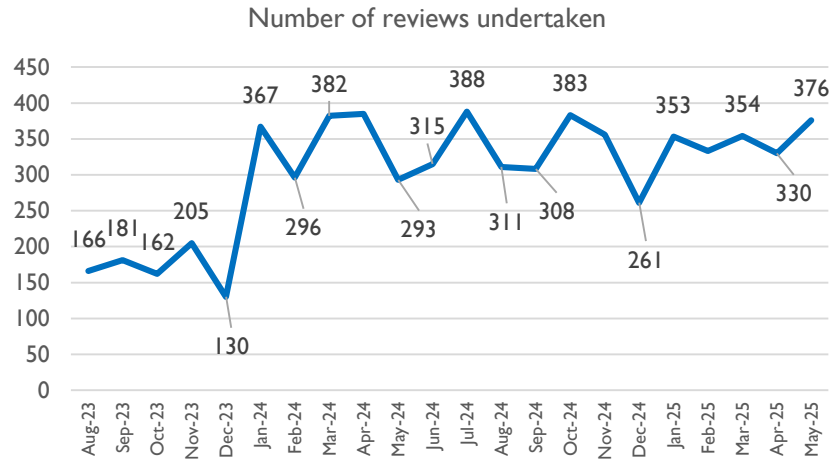
Our next priority is to undertake a review of our "front door" contact centre pathways to ensure people are receiving the right information and support when they contact us. This also includes practitioners working in our community wellbeing hubs.

PLYMOUTH CITY COUNCIL

Theme 1: Waiting Lists – Care Act Reviews/Change of Circumstances

Key Performance Indicator	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Target	
Number of People Waiting	959	1098	1276	1307	1228	1193	1149	1053	930	793	709	739	864	277	▲
% of reviews with increased cost	12%	16%	17%	12%	19%	17%	18%	10%	16%	21%	15%	19%	TBC		
% of long-term service users with an assessment or review in the last year	50.50%	50.30%	50.60%	50.80%	51.60%	53.40%	55.50%	57.10%	59.40%	60.70%	60.40%	59.70%	57.90%	60.7%	▼





Narrative

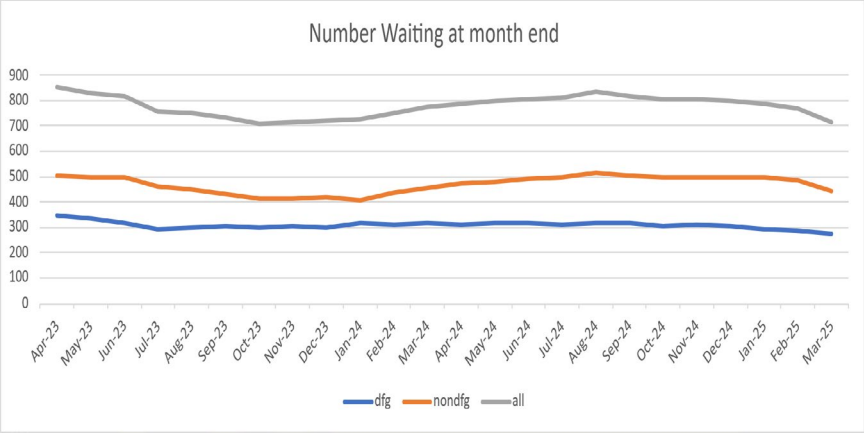
The sustained enhancement in the review of individuals receiving long-term care and support is a significant achievement, with performance increasing from 36.1% in April 2023 to 57.9%. This progress brings us closer to the regional benchmark of 60.7%.

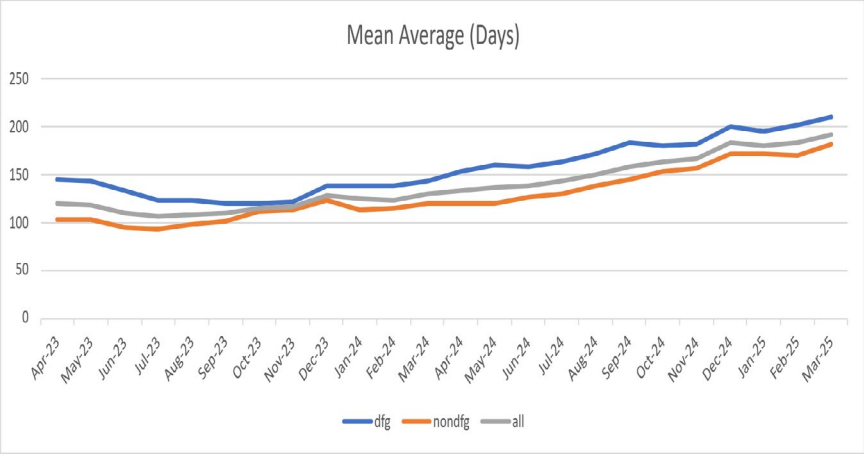
Over the past month, there has been a small increase in the backlog of those awaiting a review. This is attributable to the redeployment of additional resources aimed at reducing the number of individuals drawing upon care and support services who area awaiting a Care Act Assessment. However, people added to the overdue list are only overdue by a matter of weeks or months and we have no one with an overdue review of over two years We will continue to use resources flexibly to reduce waiting times for both assessments and reviews depending on assessment of risk.

PLYMOUTH CITY COUNCIL

Theme 1:Waiting Lists – Occupational Therapy Assessments

Key Performance Indicator	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Target	
Number Waiting	784	796	806	811	833	818	803	806	800	786	771	715	700	TBC	▼
Maximum Wait (in days)	446	477	507	386	417	439	428	458	489	520	548	535	585	36	▲
Mean Wait (in days)	118	123	129	134	136	146	149	156	172	175	176	185	220		▲





Narrative

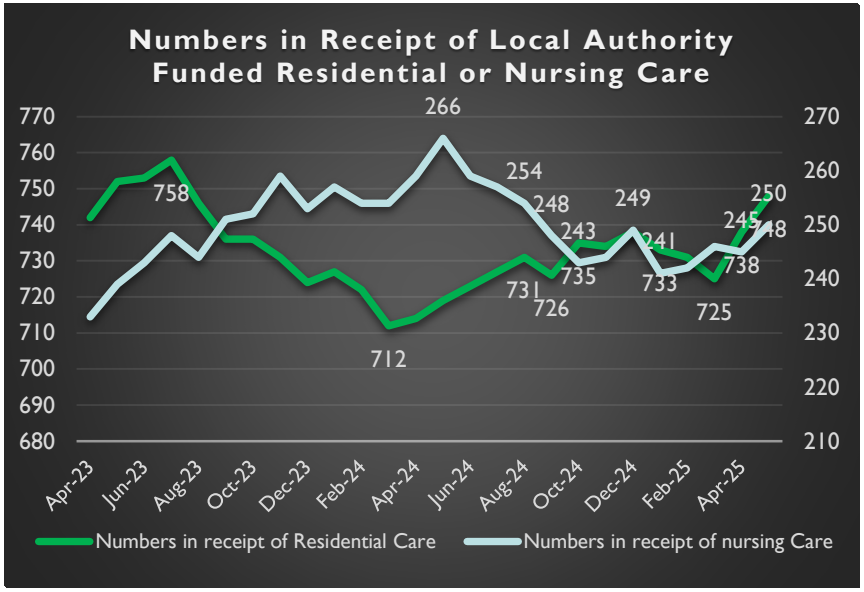
Occupational Therapy has been identified as a service area under significant pressure, with current demand consistently exceeding available capacity. To address this, a time and motion study was conducted using the NHS Education for Scotland (NES) workforce planning model. This analysis aimed to determine the staffing requirements necessary to reduce the waiting list to a sustainable level.

The team has implemented measures to enhance transparency of the waiting list and has proactively contacted all individuals awaiting a service, in accordance with the "Waiting Well" protocol. Additionally, a comprehensive review of documentation processes has been undertaken. This includes streamlining assessments and improving information-sharing to minimise duplication. Collaborative efforts are also underway with Plymouth Community Homes (PCH) to align with their Trusted Assessor model.

PLYMOUTH CITY COUNCIL

Theme 2: Residential and Nursing Care

Key Performance Indicator	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Target	
2C Adults aged 65+ whose needs are met by admission to residential/nursing care homes (per 100,000 population)	125.7	177.2	234.9	267.9	296.7	368	426.5	498.7	562.5	614.1	710.9	41.2	90.7	594	▲
Adults aged 18-64 whose needs are met by admission to residential/nursing care homes (per 100,000 population).	3.7	5.6	5.6	5.6	5.6	6.2	8.1	10	11.2	12.4	15.6	3.1	5.6	N/A	▲
Numbers in receipt of nursing Care	266	259	257	254	248	243	244	249	241	242	246	245	250	224	
Numbers in receipt of Residential Care	719	723	727	731	726	735	734	738	733	731	725	738	748	735	▲ ▲



Narrative

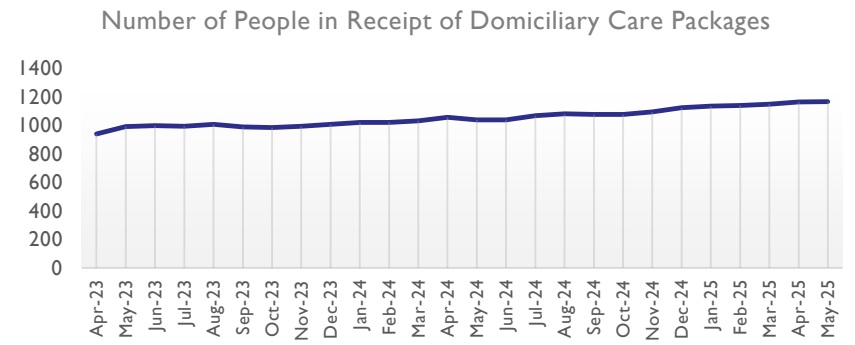
Progression from Intermediate Care following hospital discharge remains the most common pathway into both Residential and Nursing Care placements, accounting for on average 76% of Residential referrals and 86% of Nursing referrals.

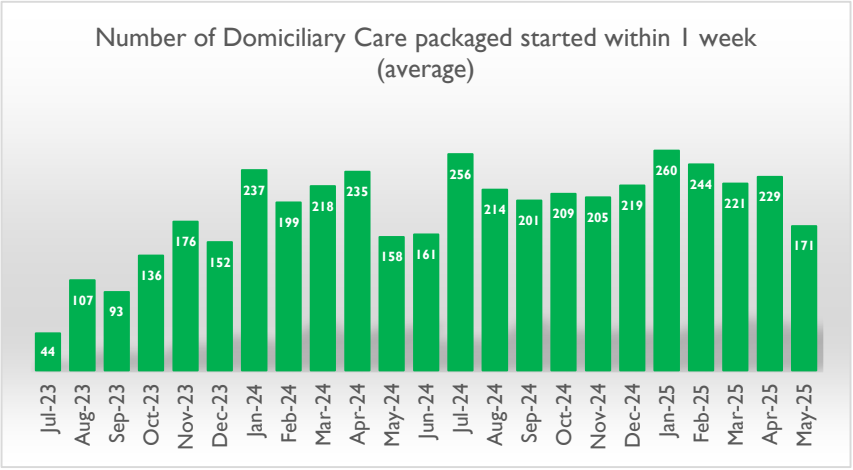
We continue to work closely with our NHS partners to make sure that people leaving the hospital have a full range of options for their care and support, and those who wish to return home and live independently are given the opportunity to do so. Our multi-agency discharge work between January 2024 and January 25 has seen an improvement in the percentage of Pathway 1 intermediate care discharges from hospital to home from 23% to 55%, with the aim of reaching 75% by August 2025.

PLYMOUTH CITY COUNCIL

Theme 3: Domiciliary Care

Key Performance Indicator	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Direction
Number of people in receipt of domiciliary care	1039	1040	1068	1081	1076	1077	1095	1124	1135	1140	1149	1165	1168	▲
Of which in Intermediate Placements							72	54	58	68	67	67		▼
% of Domiciliary Care package opened within one week	94.40%	89.80%	90.20%	88.60%	90.10%	87.80%	94.00%	85.20%	93.50%	94.60%	85.30%	85.10%	70.40%	▼
Number of Domiciliary Care packages started	158	161	256	214	201	209	205	219	260	244	221	229	171	▼





Narrative

The number of individuals receiving domiciliary care continues to increase each month, putting pressure on both the budget and forecasts, but offering more people the ability to remain living in their own homes. The percentage of new domiciliary care clients coming from Intermediate Care is the highest it has been in recent months, which correlates with more people leaving hospital with domiciliary care support (Pathway 1).

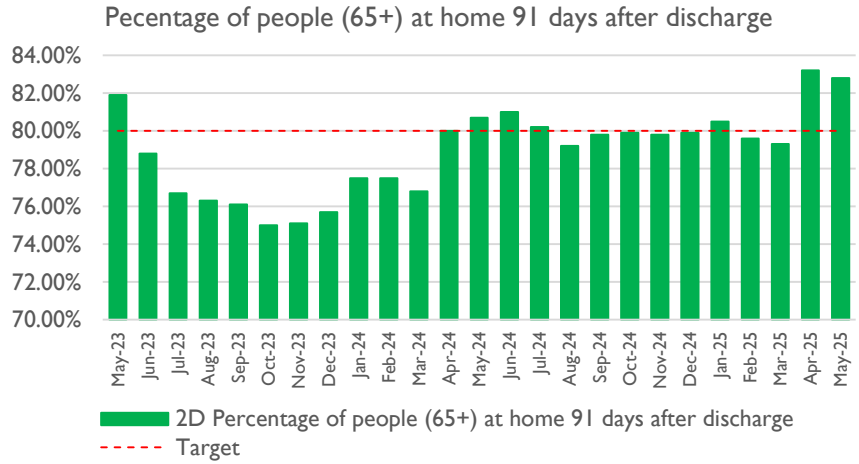
Provider fee uplifts for 2025/26 have been communicated and at the current time are not leading to a sense of vulnerability within the market. Provider Forums were held on 5th March, and 16th April 2025 to enable feedback.

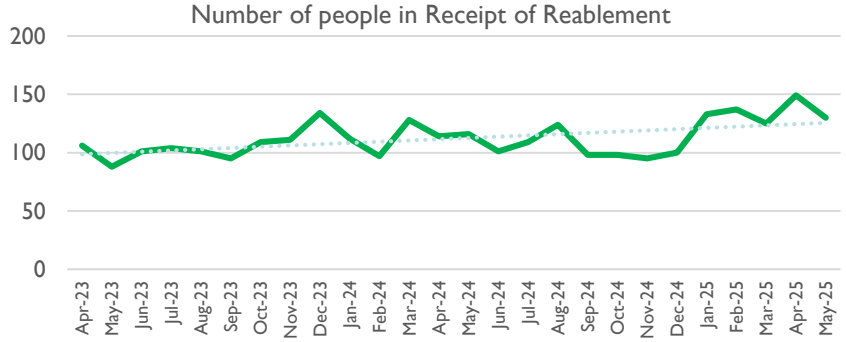
Regular meetings are held with the CQC to share concerns about regulated care providers we are collectively worried about, including where providers are not able to demonstrate their ability to improve.

PLYMOUTH CITY COUNCIL

Theme 4: Reablement

	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Target	Direction
Number of people in receipt of Reablement	116	101	109	124	98	98	95	100	133	137	125	149	130	N/A	▼
Percentage of people (65+) at home 91 days after discharge	80.70%	81.00%	80.20%	79.20%	79.80%	79.90%	79.80%	79.90%	80.50%	79.60%	79.30%	83.20%	82.80%	80%	▲
Number of reablement packages started in period	121	85	110	105	84	93	104	112	118	104	118	110	108		▲
Actual reablement hours in period	3144	3626	4651	3902	3966	3781	3151	3842	4356	4416	4547	4097	3144		▲
Average Length of Time in receipt of Reablement (In weeks)						5.7	4.86	3.46	4.03	4.61	4.99	4.8	5.5	6.0	▲





Narrative

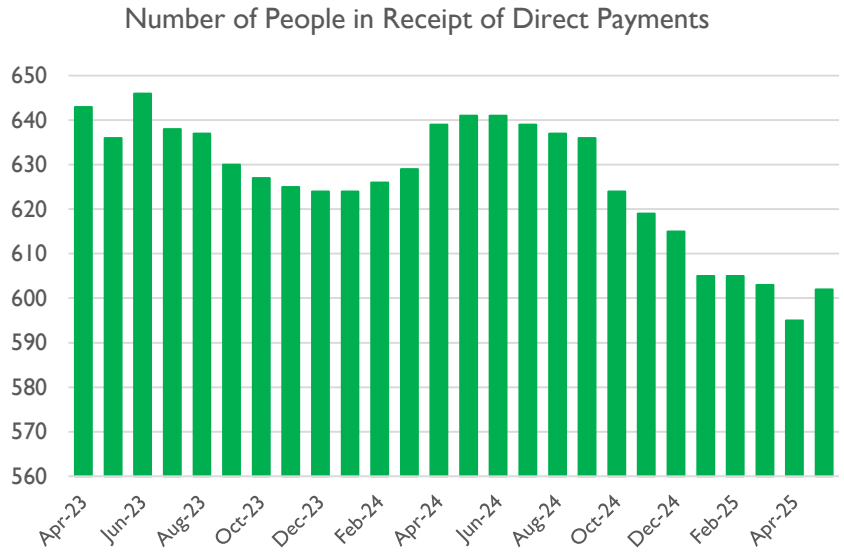
As a system the average length of time individuals receive reablement care is below the national target, at 4.9 weeks and has remained within target across the financial year.

The percentage of people remaining at home 91 days after discharge is exceeding our target of 80%.

The number of people receiving reablement has remained at an effective level.

Theme 5: Direct Payments

Key Performance Indicator	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Target	
Number of people in receipt of direct payments	641	641	639	637	636	624	619	615	605	605	603	595	602	635	▲
Number of new Direct Payments in Month										19	8	10	6	TBC	▲



Narrative

After a period of decline in the number of people receiving Direct Payments, we are now seeing this increase. The previous reduction in Direct Payments is attributed to the death of previous recipients or payments being stopped following reviews (and people no longer requiring a service). There continues to be new Direct Payments recipients each month.

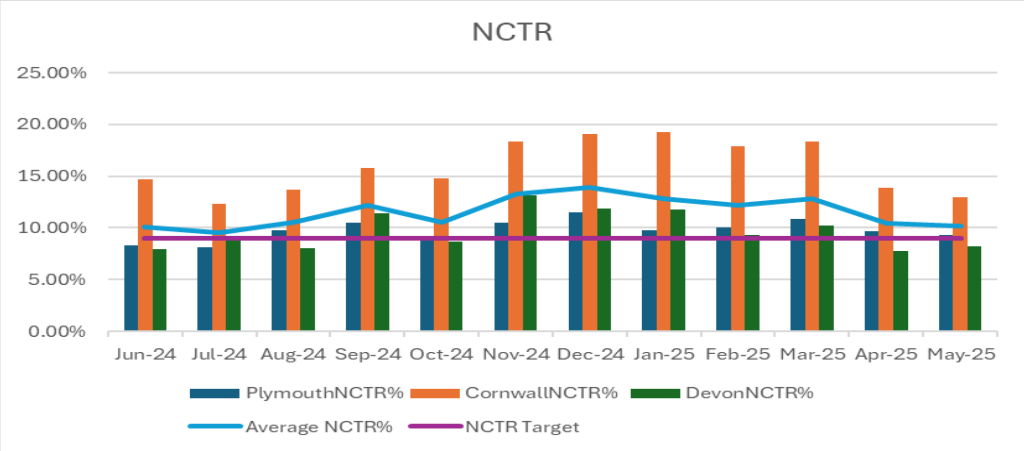
Direct Payment training for staff is being developed and will be rolled out to staff in quarter three of this year.

Recent feedback from the LGA highlighted that individuals receiving care and support would benefit from more structured guidance during the setup and ongoing management of Direct Payments. The team have developed some new guides to support people, and these will be shared on the Plymouth Online Directory.

We have identified that those providing care and support, such as personal assistants, need better training and fairer pay to reflect their essential role. We will be investing in improved training for personal assistants to strengthen the overall care and support ecosystem, fostering a reciprocal relationship between those who provide support and those who receive it.

PLYMOUTH CITY COUNCIL

P1 Performance Update



This metric represents the proportion of patients with *No Criteria to Reside* and is calculated from when the patient is medically fit for discharge and when they leave the hospital.

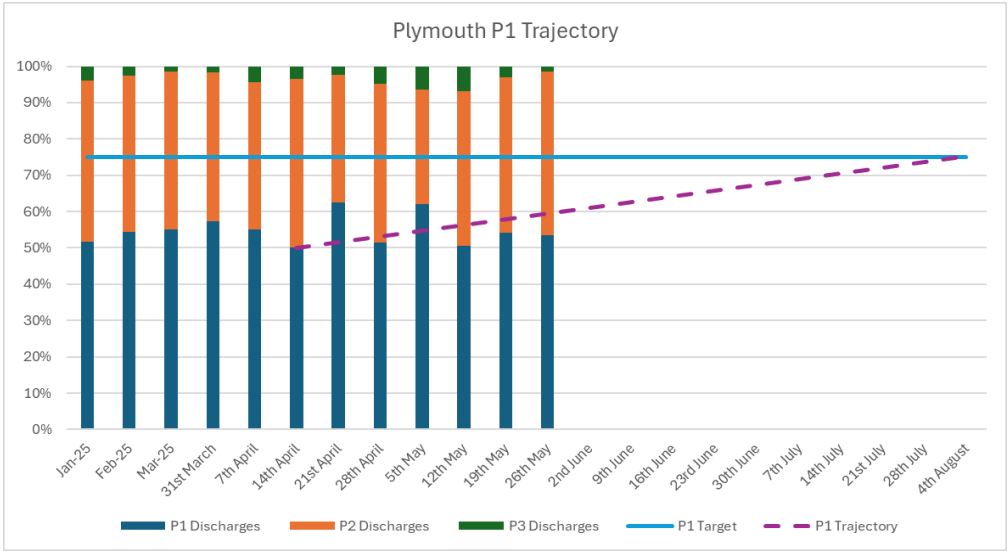
Our target for NCTR is 9%.

- Average NCTR has improved for May at 10.14%. – Devon 8.26%, achieving the 9% target, Plymouth 9.32% and Cornwall 12.93%.

This metric is calculated by determining the proportion of pathway 1 discharges that make up the total number of complex discharges (P1, P2 and P3).

Our target is for 75% of complex discharges to be P1 by the end of August

- To achieve this, we need to increase the proportion of Plymouth P1 discharges by 1.57% each week.
- W/c 26th May, Plymouth P1 53.42%, against weekly target of 59.42%
- Our Plymouth position for May was 55.21% against the 75% target.



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Health and Adult Social Care Scrutiny Panel

Date of meeting:	15 July 2025
Title of Report:	**End of Life Care**
Author:	Chris Morley, Locality Director, NHS Devon ICB
Contact Email:	christopher.morley@nhs.net
Your Reference:	Click here to enter text.
Key Decision:	No
Confidentiality:	Choose an item.

Purpose of Report
To provide an update on delivery of the End of Life improvement plan and OSC recommendations

Recommendations and Reasons
1. To note the report.
   Members to support the continued programme of activity to improve end of life care within Plymouth

Alternative options considered and rejected
1. Alternative options considered and rejected

Relevance to the Corporate Plan and/or the Plymouth Plan
N/A – This is an NHS report and does not relate to the Plymouth City Council Corporate Plan.

Implications for the Medium Term Financial Plan and Resource Implications:
N/A

Financial Risks

N/A

Legal Implications

(Provided by Insert Name / Initials)

N/A

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	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: N/A – NHS report											
Please confirm the Strategic Director(s) has agreed the report? Choose Date agreed: Date.											
Cabinet Member approval: *[electronic signature (or typed name and statement of 'approved by email/verbally')]* Date approved: Date.											

Plymouth EoL Overview & Scrutiny Committee update

July 2025

Chris Morley, NHS Devon ICB
Laura Daniel, University Hospitals Plymouth
Sharon King, Livewell Southwest
Tricia Davis, St Lukes Hospice

Contents

- Introduction
- Update on progress of End of Life locality plan
- Performance update – Deaths in Hospital
- UHP End of Life update
- St Lukes Coordination Hub update

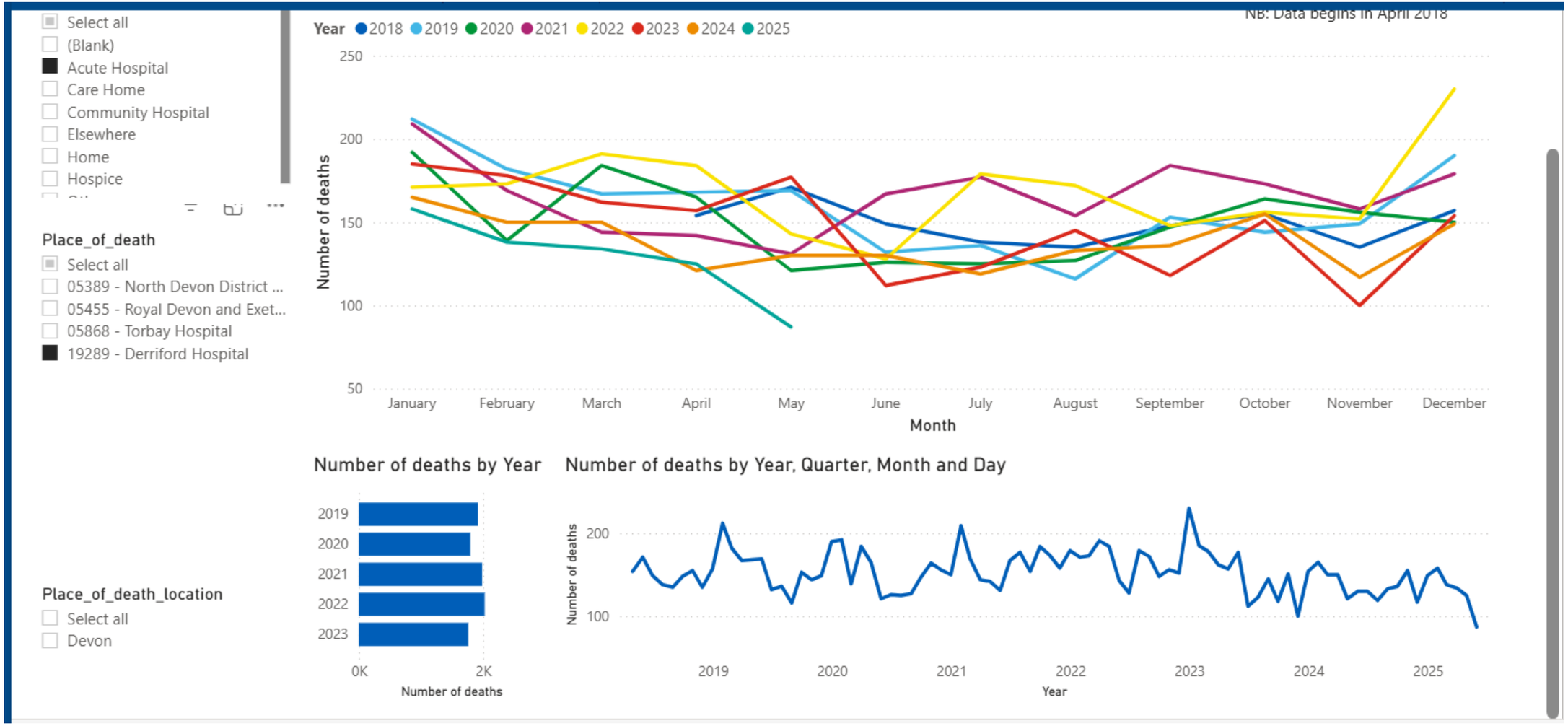
Introduction

- The ICB has continued to coordinate the delivery of the Plymouth End of Life Locality plan in line with the recommendations from the Plymouth Overview & Scrutiny Committee.
- The work programme continues to be driven through the Plymouth End of Life steering group and directly reports into the Devon End of Life Steering Group who are overseeing the delivery of the Devon End of Life strategy.
- This slide pack provides an update on the delivery actions, along with offering an overview on improvement activity related to end of life care within University Hospitals Plymouth and the St Lukes End of Life coordination centre.

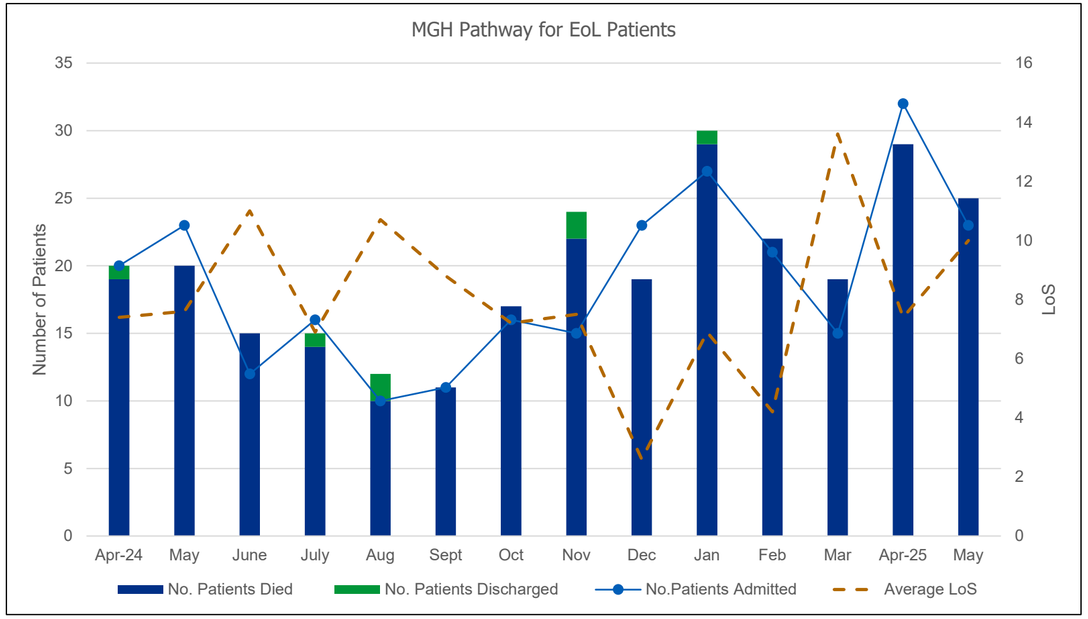
End of Life Locality Plan

Milestone Description	Owner	Milestone Update – July 25	Status	Due date*
Consistent use of a tool to **identify of End of Life phase** and embedding DCCR End of Life register	NHS Devon	This programme has broadened now to incorporate the development of an Integrated Care Plan System	In Progress / On track	31/12/25
Ensure the End of Life care service offer is universally understood with a **central information point for individuals** and system partners	St Lukes	EOL Care Co-ordination hub for St Lukes patients is now in place	In Progress / On track	31 /03/ 25
Undertake **demand and capacity analysis** for End of Life care, including assessment of needs and gap analysis	All partners / NHS Devon co-ordination	Complete and incorporated into Devon Commissioning Plan	Complete	Complete
Complete an options appraisal and develop commissioning intentions to meet any identified needs	NHS Devon	Part of NHS Devon EOL review - task and finish group leading work	Complete	Complete
Use the National Audit of Care at the End of Life (https://www.nacel.nhs.uk/) to ensure priorities for individuals are being met and use this audit to evaluate any service improvements	UHP and St Lukes	Audit underway in Autumn 2024	In Progress / On track	31 /12/ 24
Ensure **specialist end of life support** is embedded in the local coordination hub for urgent and emergency care (7 days 8am-8pm)	NHS Devon	EOL Care Co-ordination hub for St Lukes patients is now in place .	Complete	Complete
Development and implementation of an **End of Life care communication and training resources** on Hive which includes implementation of a data capture process to monitor End of Life care training uptake	Training partners	Webinars were completed. Hive not progressing – funding redirected to training hub to support management leadership as identified by PCC commissioning leads	Complete	Complete
Developing a strategy for working with communities to expand ‘death literacy’, building on community assets and the Compassionate City programme	all partners	Work continues with Plymouth recognised as an exemplar	In Progress / On track	30 /09/ 24

Number of Deaths in Derriford Hospital



UHP End of Life Update



Our goal is to compassionately support patients and their families, ensuring they experience a dignified and peaceful death outside of an acute care setting, respecting their wishes and preserving their comfort and dignity throughout the process

End of Life teams and PICT team have been embedded in the medicine care group for approximately 6 months transitioning across from corporate services following Tupe

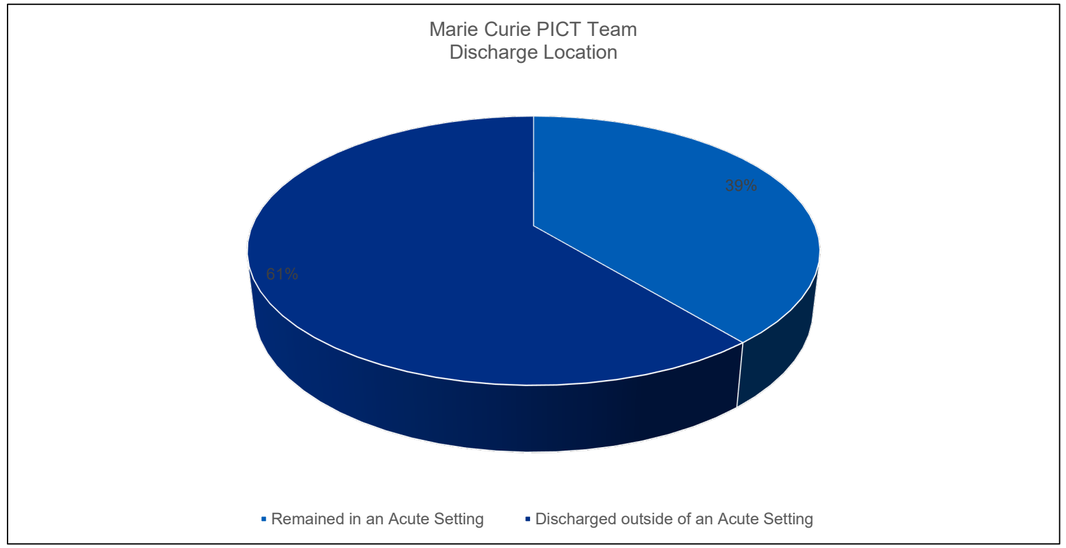
Significant staffing changes that impacted upon structure and delivery – being worked through in line with organisational review

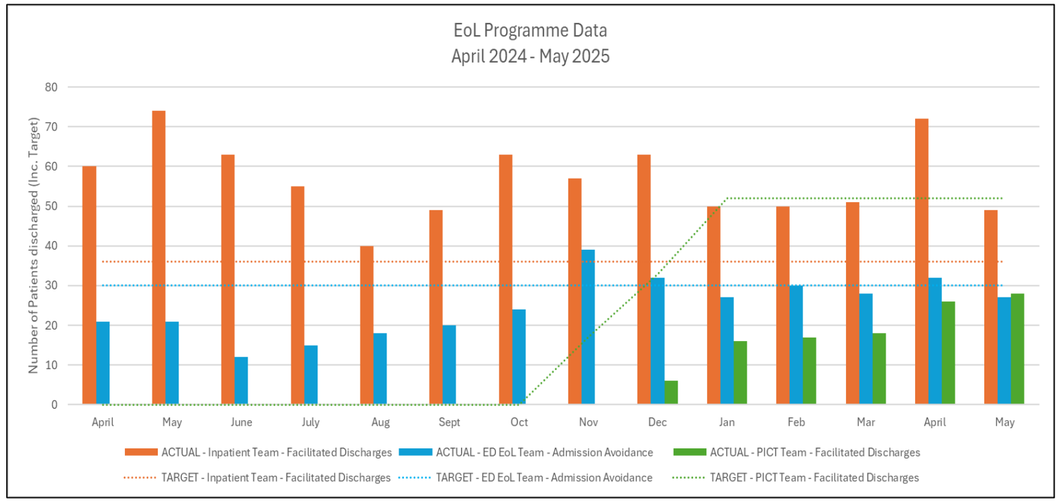
Full bed capacity reached at MGH – 12 beds on-line with over 400 people supported through the pathway

Feedback has been positive in terms of patient care, dignity, environment, support available for patients and their families and the experiences of the staff

Integration of Marie Curie staff into this space has been positive

UHP End of Life Update





New EoL Inpatient Team consistently supporting patients to be discharged to their place of residence or MGH

Marie Curie PICT Team working well with UHP inpatient wards to identify and support EoL patients to be discharged sooner

ED EoL Team support patients conveyed to ED, to avoid admission to an acute setting

Continue to work with Supportive & Palliative Care Teams with PDSA improvement cycle to ensure continuous improvement

Successfully embedded electronic Treatment Escalation Plans (eTEPs) to ensure clear documentation and consistent respect of patients' wishes and best interests

St Luke's
Hospice Plymouth

St Luke's Co-ordination Hub April 2025

Role of the St Luke's Coordination Hub for patients who have been identified by a professional to be in their last 12 months of life

Proof of concept project and aims of the service are to:

- Provide a timely co-ordinated approach to care for patients who have been identified to be in their last 12 months of life, who are registered with GPs in the Western locality of Devon ICB in their own homes (Nursing/Home, Residential Home, Hostel etc.)
- Provide a single point of access to these patients and the professionals involved in their care, for advice and support during the last 12 months of life.
- Support the wider teams looking after these patients and complement existing services rather than a handover service, working in partnership to ensure the patient receives a timely approach to Advance Care Planning, deteriorating changes referrals for Carers support and recognising the signs of dying.
- Provide remote monitoring of patients within the Coordination Hub to support decisions around hospital admission or hospital avoidance, utilising other services to prevent an acute hospital admission e.g. community virtual ward, Devon Urgent Community Response (UCR) Service.

St Luke's Hospice Plymouth

This service can provide support and advice relating to.

Rapid navigation of end-of-life services/support

Shared decision making and specialist advice

Clarifying TEP decisions

General advice and guidance, where a patient appears to be in the last phase of life

The Hub Staff can give advice and support to SWAST or /community partners eg whether a patient should be conveyed to ED, where there is doubt as to whether the conveyance is wanted/needed/clinically indicated.

End of Life Care Scrutiny – Feb 24. Recommendations

The Committee Recommends 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. 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.

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.

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Written statement from Councillor Terri Beer:

Palliative care through to end of Life care

There has been a misrepresentation regarding my motion which is Palliative care through to end of life.

Palliative care doesn't mean end of life and that should be acknowledged. People with palliative care can have years enjoying a reasonable quality of life as in my own experience with a family member.

Palliative care in my experience is a real postcode lottery in Plymouth and it seems those who speak up for loved ones get the care they seek. It's not consistent. Some will contradict my statement, but this is a real fact having spent many months talking to residents in the city and my own ward as well as sharing my own personal experience.

My family member has been in Palliative care for over two years and during treatment he gets the best care because I would speak up for him if he didn't. As a carer I get no support what's so ever just hurdles and obstacles to go through. It shouldn't be like that. Employers in some cases don't recognise the issues around Palliative care and the impact it has on the person supporting the person in Palliative care. The Council don't in my view understand the issues a member faces when dealing with someone living in Palliative care and going through treatment or even recognise bereavement and its impacts.

There needs to be better support and understanding. I tell people and speak up about Palliative care that I am facing with my family member.

Palliative care does mean that in the middle stage of any illness that for example Cancer dictates your life and plans. The very reason I can't be with you today to share my voice.

End of life care is still failing and although partners will sit before you and tell you it's alright it's far from that.

Examples:

A man with terminal cancer who chose to die at home. Nurses came and because he was asleep, he was not washed or changed. He missed medication and pain relief on more than one occasion. Family members then faced the challenge of changing this man who had been in soiled pads most of the day causing soreness and made to feel extremely bad of the situation he had no control over. End of life meds were not available and even I supported this family with a trip to the hospital to get medication and pain relief. This was a personal friend of mine. He died in pain crying out and family could do nothing as nursing staff were not available. His body lay in the house all night and until 11am the next day. The trauma to the family was imminence.

A lady who during Covid had been in hospital for over 11 months and during this time the family found out she had cancer that had gone to her brain, leaving the

patient with brain damage. Fed through a tube, non-verbal because of the brain damage. (Paraneoplastic Cerebellar Degeneration) Living in a nursing home in Palliative care. Due to low staff levels often the family would find their loved one unclean and sat in faeces. Medication was hit and miss and at times family had to demand care and attention. Feds were often late and administered quickly. There then came a transfer to another nursing home and within three weeks this patient died. She died not in pain and in the arms of her sister, that was me. No nursing staff present. Its was a good job it was me there as I spoken up, complained until I got the care for this relative. The failing here was the sudden move, lack of staff and again as the close family member no support.

Palliative care through to end of life:

For two years I cared for my family member at my home. No help, no aids until I fought for them. No night-time support. I covered it all. That was my commitment. Then a stay in hospital and within no time the family member got Covid and I was told not to visit. I did visit and used PPE provided which was very poor. My family member accepted that he was approaching end of life and wanted to die at St Luke's. Enquiring about the I was told they have 12 beds at St Luke's and there is a long waiting list. Prompted by experience and knowing who to talk to I was able to carry my family members wishes out and get him transferred to St Luke's in a Ward. He was there for three weeks stabilising his pain relief. He was clean, washed and comfortable but that was because I had spoken up and spoken out to get this for him. Not everyone at this point has a Terri.
My brother died in a private room with my daughter holding his hand one side and me on the other. A nurse was present and was advising us of the final moments. The point is this would not have happened if I didn't know who to talk too. Not everyone has the energy at this time.

The above examples are my experience and because I am the person who speaks up, fights for what is right I did things my way.

These examples show very different points not consistent and like I have stated if I wasn't strong enough to speak up then the above would have been very different.

Palliative care has shown me different stages of an illness and its not the end game by no means but a journey that you shouldn't have to demand care it should be consistent and it's not.

This needs to be reviewed regularly to ensure equal care for all.

Councillor Mrs Terri Beer

One Devon

Plymouth Health and Adult Social Care Overview and Scrutiny Committee

15 July 2025

ICB reorganisation and transition

We are writing to share an important update about how NHS organisations in our region will be working together more closely to improve care and outcomes for the communities we serve.

This week, we received confirmation from NHS England and government ministers that our new 'cluster' – covering Devon, Cornwall and the Isles of Scilly – has been formally approved.

This is part of a national move to bring together Integrated Care Boards (ICBs) into 26 clusters across England, down from the current 42.

'Clustering' means that, although both ICBs will continue to exist, we will work as one – with a single Board, leadership team and staffing structure.

This is ahead of a formal merger, which is expected from either April 2026 or April 2027, subject to local government reorganisation and further guidance.

In the south west, the seven current ICB will transition into three clusters as follows:

1. Devon and Cornwall and Isles of Scilly *(two ICBs)*
2. Bristol, North Somerset and South Gloucestershire (BNSSG), and Gloucestershire *(two ICBs)*
3. Somerset, Dorset, and Bath and North East Somerset, Swindon and Wiltshire (BSW) *(three ICBs)*

While there are still important details to be worked through – such as arrangements for continuing healthcare, safeguarding, and services for people with special educational needs and disabilities (SEND) – we are moving forward with purpose to ensure a smooth transition that prioritises the needs of local people.

Leadership and transition

To support this change, we will shortly begin the process to appoint a new Cluster Chair and Chief Executive.

These roles will help lead the development of our future operating model and ensure continuity and stability through this period of change.

We expect appointments to be confirmed by the end of July.

Alongside this, work is also underway to develop our structure and implementation plan in line with a national Model ICB Blueprint that was published in May.

The Blueprint outlines the core roles and functions that ICBs will be responsible for with a significantly reduced running costs budget – a 33% reduction for NHS Devon and 38% for NHS Cornwall and Isles of Scilly.

National work is also underway to clarify how the new NHS operating model will function, and we expect more information to be shared over the summer.

What this means for partners, patients and the public

While this is a change in structure, our focus remains firmly on the health and wellbeing of our population. Our commitment to high-quality, compassionate care for people in Cornwall, the Isles of Scilly and Devon is unchanged.

Our absolute priority this year is to continue providing high-quality patient care and reduce waits whether that is waits for surgery, waits for an ambulance, waits to be seen in the emergency department or waits to be discharged with hospital.

We will continue to work in partnership with local authorities, voluntary organisations, community leaders and others to ensure that services are designed and delivered around the needs of our communities – especially those who are most vulnerable or face health inequalities.

Financial position

On 30 April 2025 the Devon ICS submitted a breakeven plan to NHS England which included £53.8m of Deficit Support Funding (DSF) and a further £10.0m of regional support. Within the overall plan of breakeven, Torbay and South Devon NHS FT have a plan of £8.0m deficit and Devon ICB have a plan for £8.0m surplus.

The plan included £255.8m efficiencies which is 7.8% of Devon ICB allocation. £13.9m (5%) efficiencies were unidentified at the time of submission. At month 2 this has reduced to £6.4m (2%), with a commitment to have identified the entire programme by the end of June 25.

Gross risks of £164.0m (of which £92.2m related to efficiencies) and £56.5m mitigations were identified at the planning stage resulting in a net risk of £107.5m. At month 2, at the time of writing, the system is in the process of collating the updated gross and net risks.

The system allocation is £163.3m in excess of it's fair share of the NHS resources, and this will be reduced over time by allocation reductions, known as convergence, towards target. The system is developing its Medium Term Financial Plan which will include scenarios regarding the pace at which this resource is removed and the actions to maintain financial sustainability within its allocation. This will be linked to the Devon Health & Care Strategy which is also under concurrent development, due for completion over the summer.

A full update on the current financial position was provided to the NHS Devon Board on 29 May 2025. The Board papers are available on the One Devon website (pages 359-382).

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Health and Adult Social Care Scrutiny Panel
Work Programme 2025/26

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 general enquiries relating to the Council's Scrutiny function, including this Committee's work programme, please contact Elliot Wearne-Gould (Democratic Advisor) on 01752 305155.

Date of Meeting	Agenda Item	Prioritisation Score	Reason for Consideration	Responsible Cabinet Member/Lead Officer
15 July 2025	Performance, Finance and Risk Reports for H&ASC (Inc Livewell SW performance)	3	Standing Item	Helen Slater, Stephen Beet, Ian Lightley (NHS Devon)
	End of Life Care MoN I Motion on Notice - End of Life Care.pdf	4	Referred by City Council	NHS Devon ICB. Chris Morley
	NHS Changes and re-structure (inc NHS Devon/ England)	4	To scrutinise upcoming changes to the structure and operation of NHS management	NHS England + NHS Devon
14 September 2025				
02 December 2025				

03 February 2026				
Items to be scheduled for 2025/26				
2025/26	UHP New Hospital's Programme Update	3	To provide an update on progress of UHP construction facilities and services	Rachel O'Connor (UHP)
2025/26	PCC CQC Outcome	4	To review pertinent outcomes of the CQC inspection	Gary Walbridge / Stephen Beet
2025/26	Transitions to ASC (from Children's)	3	To review performance of transitions to ensure adequate support throughout	Gary Walbridge
2025/26	Local Care Partnership Plan	3	To ensure greater engagement and collaboration with the LCP	LCP / NHS Devon
2025/26	Better Care Fund Update on Progress	3	Update on funding and opportunities	Gary Walbridge
2025/26	Independent Prescribing Pathfinder Programme (NHS Devon)	3	Review of performance of the programme following prior scrutiny	NHS Devon
2025/26	Urgent and Emergency Care One Plan - performance against targets	4	To continue scrutiny of UHP capacity and performance	NHS Devon
2025/26	Armed Forces GP / Surgery / Dental Update	3	To request further detail regarding Armed Forces' access to dental and surgery care	NHS Devon
Items to be scheduled for 2026/27				
2026/27				
2026/27				
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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HEALTH AND ADULT SOCIAL CARE SCRUTINY PANEL

Tracking Decisions Log 2025-26

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	1
In Progress / Part Complete	1
On Hold	1
Awaiting Action	0
Total	3

No.	Meeting Date	Resolution	Responsible	Status
1	11/02/2025	Requested that Livewell Southwest performance data returned to a future meeting to enable continued monitoring, and that the data included an assessment of risk.	Ian Lightley (Livewell SW)	In Progress
Response: A Livewell SW performance report will be scheduled for the next Panel meeting in July 2025, which will contain this data.				
2	11/02/2025	Recommended that an introductory briefing and training session for Health and Adult Social Care was scheduled for Panel members in the new municipal year.	Gary Walbridge (Strategic Director for Adults, Health and Communities)	Complete
Response: A Health and Adult Social Care introduction briefing session has been provisionally scheduled for 3 July 2025.				
3	11/02/2025	Requested that 'Armed Forces Friendly GP and Dental Provision' returned to the Panel at a future date; Requested that further clarity was provided regarding armed forces prioritisation for medical procedures, as well as referral rates for Op. Courage and Op. Restore.	Gary Walbridge (Strategic Director for Adults, Health and Communities)	On Hold
Response: Armed Forces Friendly GP and Dental Provision has been added to the Panel's work programme for scheduling at the appropriate time.				