



#caringplymouth



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## CARING PLYMOUTH

Thursday 10 December 2015  
2.00 pm  
Council House, Armada Way, Plymouth, PL1 2AA

**Members:**

Councillor Mrs Bowyer, Chair  
Councillor Mrs Aspinall, Vice Chair  
Councillors Mrs Bridgeman, Sam Davey, Mrs Foster, Fox, James, Mrs Nicholson, Parker-Delaz-Ajete, Dr. Salter and Stevens.

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

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**Tracey Lee**  
Chief Executive

# CARING PLYMOUTH

## PART I (PUBLIC COMMITTEE)

### 1. APOLOGIES

To receive apologies for non-attendance by panel members.

### 2. DECLARATIONS OF INTEREST

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

### 3. CHAIR'S URGENT BUSINESS

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

### 4. MINUTES (Pages 1 - 4)

To confirm the minutes of the last meeting held on 15 October 2015.

### 5. CORPORATE PERFORMANCE REPORT (Pages 5 - 32)

The Panel to receive Adult Social Care's Corporate Performance Report.

### 6. FAIRER CHARGING POLICY (Pages 33 - 50)

The Panel to be provided with the Fairer Charging Policy.

### 7. VOLUME / COST / REVIEW OF SOCIAL CARE PACKAGES (Pages 51 - 56)

The Panel to receive a presentation on Social Care Packages.

### 8. CQC REPORT AND ACTION PLAN / PERFORMANCE REVIEW (Pages 57 - 128)

The Panel to be provided with an overview of CQC Report and Action Plan.

### 9. DIAGNOSTIC WAITING TIMES

The Panel to receive a presentation on Diagnostic Waiting Times.

### 10. THRIVE PLYMOUTH (Pages 129 - 138)

The Panel to be provided with an update on Thrive Plymouth.

## **11. TRACKING RESOLUTIONS**

**(Pages 139 - 140)**

The Panel to review and monitor the progress of tracking resolutions and receive any relevant feedback from the Co-operative Scrutiny Board.

## **12. WORK PROGRAMME**

**(Pages 141 - 142)**

The Panel to discuss and agree future items for the Caring Plymouth Work Programme.

## **13. EXEMPT BUSINESS**

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

## **PART II (PRIVATE COMMITTEE)**

### **AGENDA**

#### **MEMBERS OF THE PUBLIC TO NOTE**

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

Nil.

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**Caring Plymouth****Thursday 15 October 2015****PRESENT:**

Councillor Mrs Bowyer, in the Chair.

Councillor Mrs Aspinall, Vice Chair.

Councillors Mrs Bridgeman, Sam Davey, Mrs Foster, Fox, James, Jarvis,  
Mrs Nicholson, Parker-Delaz-Ajete and Dr. Salter.

Apologies for absence: Councillor Stevens

Also in attendance: Kelechi Nnoaham – Director for Public Health, Jerry Clough – Chief Operating Officer of CCG and Managing Director, Western Locality, Ross Jago – Lead Officer and Amelia Boulter – Democratic Support Officer.

The meeting started at 2.00 pm and finished at 4.00 pm.

*Note: At a future meeting, the committee will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.*

**20. DECLARATIONS OF INTEREST**

There were no declarations of interest made.

**21. CHAIR'S URGENT BUSINESS**

Ross Jago, Lead Officer highlighted to the Chair and the Panel that a Public Health Consultation was taking place and input was required from the Caring Panel. This item would be discussed after Public Health's Corporate Performance Report.

**22. MINUTES**

Agreed that the minutes of the meeting of 2 September 2015 were confirmed.

**23. PUBLIC HEALTH'S CORPORATE PERFORMANCE REPORT**

Kelechi Nnoaham, Director of Public Health provided the Panel with an update on Public Health's Corporate Report and key outcomes K21, K46 and K47. It was reported that –

K21: Lead on the city's strategy for health and wellbeing

Thrive Plymouth was launched in November 2014 and is the city's strategy for health and wellbeing. Thrive Plymouth is based on the 4-4-54, i.e. that 4 key behaviours lead to the 4 diseases which cause 54% of the deaths in Plymouth. Thrive Plymouth has given a clear sense of direction of health within the city and since the launch of Thrive Plymouth, 41 workplaces have undertaken the wellbeing programme.

In response to questions raised it was reported that the next phase of Thrive Plymouth was being launched with the schools in November. A Health and Wellbeing Survey conducted with 4,000 children had also been undertaken and based on the data taken from the survey emotional resilience was raised as an issue. They were currently talking with schools on how to address emotional wellbeing for children and young people.

It was also reported that although breastfeeding numbers were still low figures had improved by 4% this was down to a very good peer support programme in place and making people aware. A discussion took place on the importance of breastfeeding and whether further scrutiny was required. It was felt that this was a good news story and further scrutiny on this subject was not warranted. It was proposed that a briefing report on breastfeeding would be circulated to Panel members outside of this meeting.

### K46: Develop a clear research and evidence base to understand health inequalities across the city

The Public Health Team lead the development of clear research and evidence based to understand health inequalities across Plymouth through the provision of analytical and intelligence-related expertise.

In response to questions raised it was reported that the Public Health Team have a working arrangement with the local authority which enables them to have a team working with each of the directorates. There was also strong partnership working with other agencies within the city. Public Health Team have recently submitted an Expression of Interest which has been forwarded to the NHS to participate in the Healthy New Town Programme which aims to make the connections between planning and health.

### K47: Deliver plans that reduce individual risk factors and strengthen the role and impact of early intervention and prevention

This key action describes much of the work of the Public Health Team in preventing or detecting and intervening early. Some of this is delivered through commissioning or delivering programmes of work and some by working with and influencing partners across the city.

### Agreed that –

1. A response to the Public Health consultation to be formulated and signed off by Chair and Vice Chair.
2. A briefing report on breastfeeding take-up is circulated to Caring Panel.

24. **NEW DEVON CCG FINANCE REPORT (SECTION ONE)**

Jerry Clough – Chief Operating Officer of CCG and Managing Director Western Locality provided the Panel with NEW Devon's CCG Finance Report. It was reported that –

- (a) the CCG currently have a deficit budget of £40m and receiving support from NHS England. The CCG were hoping for a significantly reduced deficit next year and to be out of monthly deficit by the middle of next year;
- (b) NEW Devon CCG was one of the 3 CCG's under the Success Regime which aims to strengthen and increase capacity;
- (c) the hospital have not been hitting A & E and diagnostic targets and have subsequently received repeated fines. To date this figure is £1.5m and this is something the CCG are required to do and will have discussions with the hospital on how to reinvest the money.

In response to questions raised it was reported that -

- (d) the hospital experienced a difficult winter last year and will go into this winter with a high demand of people arriving sicker. Additional capacity for this winter has been implemented with the opening of the Robin Community Assessment Hub which puts the hospital in a better position moving into this winter;
- (e) patients were entitled to choose where they wanted to be treated, i.e. an elderly patient can choose to have surgery near their family and transport would be provided depending on the treatment required.

25. **NHS MATERNITY REVIEW**

NHS England are undertaking a review of maternity services in England. The review will assess current maternity care provision and consider how services should be developed to meet the changing needs of women and babies.

Agreed that –

- 1. Councillors Mrs Bowyer, Mrs Aspinall and Mrs Bridgeman to form a small working group to take part in NHS England's Review of Maternity Services;
- 2. A desktop exercise is undertaken gathering local evidence on maternity services in Plymouth and review again in the New Year.

26. **TRACKING RESOLUTIONS**

The Panel noted the progress made with the tracking resolutions and agreed that the Chair formally invites Healthwatch to attend a Caring Plymouth meeting to share the Healthwatch Annual Report.

27. **WORK PROGRAMME**

The Panel noted the work programme and agreed that the following items are included -

- Healthwatch Annual Report
- Alcohol strategy
- Child Measurement Programme
- Wellbeing Survey Results
- Invite the Chair of the Health Wellbeing Board

28. **EXEMPT BUSINESS**

There were no items of exempt business.



**CARING PLYMOUTH**

Corporate Plan - Performance Report Q2 2015  
10th December 2015  
Chief Executive's Office

**Introduction**

The Corporate Plan was first established in July 2013 as a 4 year plan to drive the city's ambition to become a Brilliant Co-operative Council. The plan sets out the Council's values, objectives and outcomes that will deliver the required changes and is used as a key tool to help prioritise, manage and improve service delivery. The plan provides the framework for:

- **the most important things the council does**
- **what the council wants to achieve**
- **how and what services are delivered**
- **the way the council operates**

**Performance monitoring**

Key actions and milestones combined with performance indicators help to drive, support, monitor and track our progress. The plan has been refreshed on an annual basis to ensure that it remains relevant and reflective of priorities and achievements over time. The last review was completed in the summer of 2015.

**Allocated Key Actions**

Following direction from Cooperative Scrutiny chairs, more focused reports were requested for each of the scrutiny panels and the Cooperative board. The table below shows how all the key actions and their associated KPIs have been divided up between the Board and panels.

Scrutiny Panel	Key Actions
Co-operative Board	K6, K7, K39, K40, K41
Your	K1, K2, K22, K24, K25, K26, K29, K30, K43, K52
Working	K3, K4, K5, K12, K13, K16, K18, K32, K36, K37, K44
<b>Caring</b>	<b>K21, K23, K31, K46, K47, K48, K49, K50, K51</b>
Ambitious	K14, K15, K19, K45, K27a, K27b

**Focused report for Caring Plymouth Scrutiny Panel**

This report focuses specifically on the areas of greatest interest to Caring Scrutiny Panel themselves. For This report focuses on 3 outcomes, 9 Key Action and 9 Performance indicators. Attached to this report is:

- Page 2 – An extract from the 'report on a page' highlighting Q2 progress for Caring Scrutiny
- Page 3 -
  - A summary of each Key Actions "Milestones" for the first 6 months of this year and RAG rated.
  - Clarification (or not) that each Key Action has a deliverable action plan in place
  - Clarification (or not) that each Key Action is evidenced in departmental business plans
- Page 4 –
  - A summary of the RAG rating of relevant Key Actions since the plan started
  - A summary of the RAG rating of relevant Performance indicators since the plan started

# Caring Plymouth Scrutiny Panel

Customised report will focus on:

Key Actions: K21, K23, K31, K46, K47, K48, K49, K50 and K51

Performance Indicators: P14, P15, P16, P20, P21, P22, P28, P29 and P30

**We will be pioneering by designing and delivering better services that are more accountable, flexible and efficient in spite of reducing resources**

<b>Pioneering</b>	The Council provides and enables brilliant services that strive to exceed customer expectations.	Plymouth's cultural offer provides value to the city.	A Council that uses resources wisely.	Pioneering in reducing the city's carbon footprint and leading in environmental and social responsibility				
<b>Key Actions</b>	K1	K2	K3	K4	K5	K6	K7	K43
<b>Performance</b>	P1	P2	P26	P3	P5	P6	P7	P8
<b>Outcome Leads</b>	Faye Batchelor-Hambleton	David Draffan	Andrew Hardingham	A. Hardingham Paul Barnard				

**We will make our city a great place to live by creating opportunities for better learning and greater investment, with more jobs and homes.**

<b>Growing</b>	More decent homes to support the population.	A strong economy creating a range of job opportunities.	A top performing education system from early years to continuous learning opportunities.	Plymouth is an attractive place for investment.			
<b>Key Actions</b>	K44	K12	K13	K14	K15	K16	K18
<b>Performance</b>	P9	P10	P34	P11	P12	P27	P13
<b>Outcome Leads</b>	Paul Barnard	David Draffan	Judith Harwood	David Draffan			

**We will promote a fairer, more equal city by investing in communities, putting citizens at the heart of decision-making, promoting independence and reducing health and social inequality**

<b>Caring</b>	We will prioritise prevention.	We will help people take control of their lives and communities.	Children, young people and adults are safe and confident in their communities.	People are treated with dignity and respect.														
<b>Key Actions</b>	K19	K45	K21	K46	K47	K22	K23	K24	K25	K48	K26	K27 A	K27B	K29	K30	K31	K49	K50
<b>Performance</b>	P14	P15	P28	P16	P29	P30	P18	P19	P31	P32	P20	P21						
<b>Outcome Leads</b>	Kelechi Nnoaham Alison Botham Craig McArdle	Craig McArdle	Alison Botham	Craig McArdle														

**We will work towards creating a more confident city, being proud of what we can offer and building on growing our reputation nationally and internationally**

<b>Confident</b>	Citizens enjoy living and working in Plymouth.	Plymouth's brand is clear, well-known and understood globally.	Government and other agencies have confidence in the Council and partners: Plymouth's voice matters.	Our employees are ambassadors for the city and the Council and proud of the difference we make.				
<b>Key Actions</b>	K32	K51	K52	K36	K37	K39	K40	K41
<b>Performance</b>	P22	P23	P24	P33	P25			
<b>Outcome Leads</b>	David Draffan	Giles Perritt David Draffan	A. Hardingham Giles Perritt	Marion Fanthorpe				

- Not on target or at risk of not achieving outcome
- Outcome is at risk but mitigation in place
- On Target to achieve outcome
- Metric under construction

# Page 7 Caring Plymouth Scrutiny Panel - KEY ACTION summary

This summary below sets out individual Key Actions, if they have a recognised action plan and are linked directly to business plans. Progress is monitored by identifying the milestones due for completion each quarter and RAG rated accordingly. Incomplete milestones are automatically carried forward to the next quarter.

2015/16

Scrutiny Panel	KA	Key Action Description	Action Plan in place?	Link to B/Plan?	Milestones Q1 2015/16	Milestones Q2 2015/16	2015/16	
							Q1	Q2
							RAG direction	
Caring Plymouth	<a href="#">K21</a>	Lead on the city's health and wellbeing strategy through delivery of Thrive Plymouth Year 2. (Note: under the Plymouth Plan these "strategies" will become "plan for's)	Yes	Yes	<ol style="list-style-type: none"> <li>1. Evaluation of Thrive Plymouth launch</li> <li>2. ODPH behaviour workshops identifying key change enablers for reducing health inequalities</li> <li>3. Engage PHT in Thrive Plymouth approaches in their hospital setting</li> <li>4. Draft Annual DPH report for June 2015 CMT</li> </ol>	<ol style="list-style-type: none"> <li>1. Publicise Thrive Plymouth Year 2 launch to school leadership</li> <li>2. Present Annual DPH Report to Cabinet, at special Members meeting and publish</li> <li>3. Members briefing on Thrive Plymouth Year 2 proposals</li> <li>4. Develop plans with Plymouth University for the evaluation of Thrive Plymouth</li> </ol>		
Caring Plymouth	K46	Develop a clear research and evidence base to understand health inequalities across the city	Yes	Yes	<ol style="list-style-type: none"> <li>1 Complete a sexual health needs assessment to inform development of current services.</li> <li>2 Publish the final (post-consultation) version of the Pharmacy Needs Assessment.</li> <li>3 Produce the quarterly Public Health Outcomes Framework (PHOF) report to identify R/A/G performance against each of the indicators.</li> <li>4 Agree the Framework of Collaboration with Plymouth University to facilitate data sharing to support research into health inequalities</li> </ol>	<ol style="list-style-type: none"> <li>1. Review completed pilot of primary school health and lifestyle survey in 5 schools. Consider with schools whether can extend to city wide.</li> <li>2. Develop one-page health summaries as part of the JSNA</li> <li>3. Develop school profiles as part of the JSNA</li> </ol>		
Caring Plymouth	K47	Deliver plans for, that reduce individual risk factors and strengthen the role and impact of early intervention and prevention	Yes	Yes	<ol style="list-style-type: none"> <li>1 Convene a multi-agency Physical Activity Strategy Group to develop recommendations for increasing physical activity in Plymouth</li> </ol>	<ol style="list-style-type: none"> <li>1. Finalise Suicide Prevention Action Plan for Plymouth [with steering group] in preparation for presentation to Health and Wellbeing Board</li> <li>2. Undertake Veterans Health Needs Assessment</li> </ol>		
Caring Plymouth	K23	Deliver integrated commissioning as part of IHWB transformation programme.	Yes	Yes	<ol style="list-style-type: none"> <li>1 Begin developing the strategic performance framework for Integrated Commissioning</li> <li>2 Finalise the Wellbeing Strategy for Integrated Commissioning.</li> <li>3 Develop service user questionnaire to support Children's Social Care's understanding and analysis for the increase in numbers of contacts. Gain sign by PCSB.</li> </ol>	<ol style="list-style-type: none"> <li>1. Integrated Senior Leadership team established</li> <li>2. System design group held</li> </ol>		

Caring Plymouth	<a href="#">K31</a>	Improve the quality of the care and support market	Yes	Yes	1. Support providers to implement the new Care Certificate	1. Support providers to implement the new Care Certificate 2. To deliver a workforce development programme with care homes, including: - Leadership Programme - Dignity Forum Programme - Care Act Workshops 3. Support care homes to create Health Action Plans which give an historic picture of someone's health and any past interventions		
Caring Plymouth	<a href="#">K49</a>	Create a Dementia Friendly City working with partners	Yes	Yes	1. Libraries to work with Alzheimer's Society to deliver Dementia Awareness Week and other events 2. Dementia Friendly Pharmacies - Increase the number of Dementia Friends in Pharmacies across Plymouth	1. Complete the Strategic Clinical Network Project in care homes to increase diagnosis 2. Review the Dementia Pathway and develop Commissioning Intentions based on needs assessment and consultation 3. People with dementia who can demonstrate that they meet the eligibility criteria are encouraged to apply for the blue badge scheme using the discretionary powers of the Local Authority. 4. Put in place care co-ordination of over 75s with GP practices. 5. Ensure that Dementia is embedded into the End of Life strategy 6. Dementia Strategic Group to be involved in discussion about new System Design Group membership and consultation process		
Caring Plymouth	K50	Provide a seamless service for older people's care including smoother discharge from hospitals (working closely with the NHS)	Yes	Yes	1. Implement integrated hospital discharge team	1. Re-location of teams to relevant hospital site 2. Dedicated social care managers to lead teams in both acute and non-acute Plymouth hospitals working in partnership with NHS managers from each site 3. Introduction of daily Authorisation procedures for ASC packages 4. An Action plan to refocus priorities of the social care manager on delays attributable to ASC		

Caring Plymouth	K5I	Step up the delivery of the Child Poverty Plan.	Yes	Yes	<p><b>Page 9</b></p> <p>1. Conduct analysis of the draft Plymouth Plan to ensure that statutory requirements are met, and a forward plan to re-assess needs scoped and aligned with relevant Fairness Commission recommendations to the Council and city</p> <p>2. Initiate contact with schools from January 2015 regarding what they are doing to tackle child poverty in collaboration with members of the special advisory group to Cabinet for child poverty</p>	<p>1. Provide a cross party response from the Cabinet Advisory Group for Child Poverty to the Public Bills Committee on Welfare and Work Bill 2015,</p> <p>2. Agree framework with Child poverty champion to deliver a new Child Poverty action plan which will lead to full council endorsement on March 2016</p>		
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## Key Action and PI summary

### KEY ACTIONS

Key Action	2013/14					Review	2014/15					Review	2015/16			
	Q1	Q2	Q3	Q4	Q1		Q2	Q3	Q4	Q1	Q2		Q3	Q4		
K21	Yellow	Green	Green	Green	OK	Green	Green	Green	Green	OK	Green	Green				
K46	Grey	Grey	Grey	Grey	New	Grey	Green	Green	Green	OK	Green	Green				
K47	Grey	Grey	Grey	Grey	New	Grey	Green	Green	Green	OK	Green	Green				
K23	Yellow	Green	Green	Green	OK	Green	Green	Green	Green	OK	Green	Green				
K48	Grey	Grey	Grey	Grey	New	Grey	Green	Green	Green	OK	Green	Green				
K31	Green	Green	Green	Green	OK	Green	Green	Green	Green	OK	Green	Green				
K49	Grey	Grey	Grey	Grey	New	Grey	Yellow	Green	Green	OK	Green	Yellow				
K50	Grey	Grey	Grey	Grey	New	Grey	Green	Green	Green	OK	Green	Green				
K51	Grey	Grey	Grey	Grey	New	Grey	Green	Green	Red	OK	Red	Green				

### PERFORMANCE INDICATORS

PI's	Q1	Q2	Q3	Q4	Review	Q1	Q2	Q3	Q4	Review	Q1	Q2	Q3	Q4
PI4	Green	Green	Green	Green	OK	Green	Green	Green	Green	OK	Green	Green		
PI5	Green	Green	Green	Green	OK	Green	Green	Green	Green	OK	Green	Green		
P28	Grey	Grey	Grey	Grey		Grey	Grey	Grey	Grey	New	Grey	Grey		
PI6	Green	Yellow	Yellow	Yellow	OK	Green	Green	Yellow	Yellow	OK	Yellow	Yellow		
P29	Grey	Grey	Grey	Grey		Grey	Grey	Grey	Grey	New	Grey	Green		
P30	Grey	Grey	Grey	Grey		Grey	Grey	Grey	Grey	New	Grey	Yellow		
P20	Yellow	Yellow	Yellow	Yellow	OK	Yellow	Yellow	Yellow	Yellow	OK	Yellow	Yellow		
P21	Green	Green	Green	Green	OK	Yellow	Yellow	Yellow	Yellow	OK	Yellow	Yellow		
P22	Yellow	Yellow	Yellow	Yellow	OK	Yellow	Yellow	Yellow	Yellow	OK	Yellow	Yellow		

- Not on target or at risk of not achieving outcome
- Outcome is at risk but mitigation in place
- On Target to achieve outcome

Key	Key Action Description	Key	Key Action Description
<u>K1</u>	Speed up the delivery of Customer and Service Transformation Programme service reviews through developing a Council wide Customer and Service delivery blueprint and Customer Access Strategy.	K15	Develop and deliver a skills plan for the city, in line with the future growth agenda.
K2	Intensify performance improvement on top priorities identified by Plymouth residents.	<u>K16</u>	Create a Plymouth Plan (an overarching Strategy for the city)
<u>K3</u>	Step up support to the Culture Board in refreshing and implementing a city-wide cultural strategy - the Vital Spark.	<u>K18</u>	Enhance support to the Local Enterprise Partnership to maximise investment and economic growth in the Heart of the South West area through a Growth Deal and EU
<u>K4</u>	Strengthen support to Destination Plymouth to deliver the Visitor Plan and a programme of events to raise the profile of the city to investors as a major stepping stone towards Mayflower 2020	K19	Accelerate delivery of the service improvement plan, transformation project delivery for C&YP and actions within the Commissioning Strategy
<u>K5</u>	Transform the city's cultural assets to provide greater value to the city through the development of the Plymouth History Centre	<u>K21</u>	Lead on the city's health and wellbeing strategy through delivery of Thrive Plymouth Year 2. (Note: under the Plymouth Plan these "strategies" will become "plan for's)
<u>K6</u>	Align the five year Medium Term Financial Plan to the Corporate Plan and deliver the Council's Transformation Programme.	<u>K22</u>	Deliver the Housing Plan Objectives
<u>K7</u>	Maximise Plymouth's opportunities to secure external funding.	<u>K23</u>	Deliver integrated commissioning as part of IHWB transformation programme.
<u>K12</u>	Intensify work with the Plymouth Growth Board and partners to deliver the Local Economic Strategy through systems leadership and continue to invest in the GAME Programme providing additional capacity to ensure Plymouth benefits from growth opportunities.	<u>K24</u>	Strengthen and support co-ordination and capacity building in the voluntary sector and reinvigorate volunteering.
<u>K13</u>	Enhance support to the Local Enterprise Partnership to maximise investment and economic growth in the Heart of the South West area through a Growth Deal and EU	K25	Lead agreement on and implementation of a new framework for working with citizens and communities for the city
K14	Accelerate delivery of the Children and Young People's Plan	<u>K26</u>	Deliver the Community Safety Plan.

Key	Key Action Description	Key	Key Action Description
<u>K27a</u>	Ensure there is a relentless focus on safeguarding through the implementation of the Corporate Safeguarding Improvement Plan, Plymouth Safeguarding Children Board.	<u>K43</u>	Strengthen work with Plymouth residents, as well as the private and public sector within Plymouth, to create a low carbon city.
<u>K27b</u>	Ensure there is a relentless focus on safeguarding through the implementation of the Corporate Safeguarding Improvement Plan, Plymouth Safeguarding Children Board and Plymouth Safeguarding Adults Board plans.	<u>K44</u>	Encourage more homes to be available to rent or buy accelerating housing supply and deliver a range and mix of well-designed greener homes that will meet the housing needs of the city through the Plymouth Plan.
<u>K29</u>	Become a welcoming city that is diverse, inclusive and that combats hate crime.	<u>K45</u>	Create and deliver both the Early Years Strategy and SEN/D Strategy. (Note: under the Plymouth Plan these "strategies" will become "plan for's)
<u>K30</u>	Implement the findings of the Fairness Commission.	<u>K46</u>	Develop a clear research and evidence base to understand health inequalities across the city
<u>K31</u>	Improve the quality of the care and support market	<u>K47</u>	Deliver plans for, that reduce individual risk factors and strengthen the role and impact of early intervention and prevention
<u>K32</u>	Create and deliver a Skills Plan for the city working co-operatively with the Employment and Skills Board, Education, Learning and Families Service and the Local Enterprise Partnership	<u>K48</u>	Increase personalised packages of care to support people to live as independently as possible
<u>K36</u>	Reduce problems with potholes through increased investment in capital repair works.	<u>K49</u>	Create a Dementia Friendly City working with partners
<u>K37</u>	Strengthen the roll out of the Britain's Ocean City branding.	<u>K50</u>	Provide a seamless service for older people's care including smoother discharge from hospitals (working closely with the NHS)
<u>K39</u>	Implement City Deal for Plymouth	<u>K51</u>	Step up the delivery of the Child Poverty Plan.
<u>K40</u>	Develop a proactive approach to lobbying Government, working with the LEP and neighbouring authorities.	<u>K52</u>	Develop a programme to improve the quality of private rented housing and take action against rogue landlords.
<u>K41</u>	Implement People and Organisational Development Framework.		



Key	Performance Description	Key	Performance Description
P1	80% of customer contacts with the Council will be managed through the single point of contact, with 80% of enquiries dealt with at first point of contact.	P19	Children's Safeguarding timing of Core Assessments.
P2	Provide fully transactional services on the web – through a “Citizen Portal” with a target of the national average and 2% (from 3% to 25%) by volume.	P20	Percentage of residents who believe Plymouth is a place where people from different backgrounds get on well together.
P3	Increase in visitor numbers coming into the city.	P21	Overall satisfaction of people who use services with their care and support
P4	Increase the city’s national and international standing.	P22	Percentage of residents who are satisfied with Plymouth as a place to live.
P5	Percentage of residents satisfied that the Council provides value for money.	P23	**Attract more people to live, work and visit the city from both the UK and overseas.
P6	Increase the value of income levied to the Local Authority.	P24	An increase in the amount of external funding and support from Government and other agencies.
P7	Reduction in city wide carbon emission.	P25	Staff Survey – would you talk positively about the Council outside work.
P8	Carbon emissions reduction from Corporate estate & schools. (Tonnes Co2)	P26	(New) A "customer satisfaction" indicator will be included in Q3 monitoring report
P9	Increase the number of homes completed (net).	P27	(New) An indicator "% of residents with no qualifications" will be included into Q2 monitoring report
P10	Increase the number of jobs created.	P28	(New) An Indicator for "Early Help offer for children and young people" will be included in monitoring report for Q3.
P11	Maintain the number of schools and settings judged by Ofsted as good or better. (Top quartile nationally)	P29	(New) An indicator "The % of (adults) residents who volunteer at least once per month" will be included into Q2 monitoring report
P12	Raise the achievements of our most disadvantaged children.	P30	(New) An indicator "The % of adult social care clients receiving self-directed support" will be included into Q2 monitoring report
P13	** Increase in the quality and availability of employment land and premises.	P31	(New) An indicator "The proportion of people who use services who say that those services make them feel safe and secure" will be included Q2 monitoring
P14	Increase access to early help and support.	P32	(New) An indicator "Pupils who feel safe in the area where they live" will be included in Q2 monitoring report
P15	Increase the number of adults and families able to stay in their own home and communities.	P33	(New) An indicator "Success rate of the Plymouth Offer and Ask" will be included into Q3 monitoring report.
P16	Improve life expectancy particularly in those areas where i	P34	(New) An indicator "Increase the GVA (per head) will be included into Q2 monitoring report
P18	Reduce the gap between the worst 10 neighbourhoods and city average rate per 1000 population for overall crime.		

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# Corporate Plan Review



Caring Scrutiny Panel - 10<sup>th</sup> December 2015

Key Actions K23, K48, K31, K49, K50

Craig McArdle

# Key Action 23



Key Actions:

K23 - Deliver integrated commissioning as part of IHWB transformation programme

Supports outcome:

We will help people take control of their lives and communities

# K23 – Deliver integrated commissioning as part of IHWB transformation programme



## ONE SYSTEM... FOUR COMMISSIONING STRATEGIES

In order to deliver system wide change and improve outcomes, four commissioning strategies that cover the entire needs course (wellbeing, children and young people, community care through to enhanced and specialised care) and life course (pre-conception through early years, adulthood and to older age) have been developed:

### WELLBEING

People and communities will be well, stay well and recover well. This strategy supports healthy and happy communities by putting health and wellbeing at the heart of everything we do.

### CHILDREN AND YOUNG PEOPLE

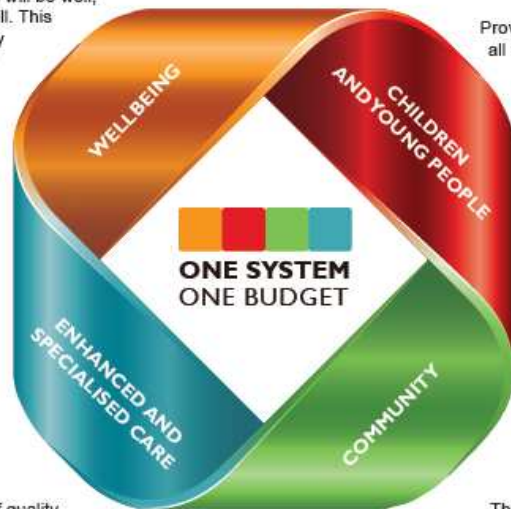
Provide the best start to life for all children from pregnancy to school age, and the right support at the right time for vulnerable children and young people.

### ENHANCED AND SPECIALISED CARE

A system that consists of quality specialist health and care services that promotes choice, independence, dignity and respect.

### COMMUNITY

This strategy targets services that support people to maintain their independence in their own home within their own community.



Services that:

- support people and communities to be and stay healthy through advice and guidance, primary prevention, and planned care services for people of all ages, across the whole life journey, and covering both physical and mental wellbeing

Services that:

- provide the best start in life for all children from conception to school age
- Have an integrated approach to early help and specialist support for children at risk of poor outcomes

Services that support:

- Support people with multiple care and support needs
- Support people requiring urgent care: responding to a crisis - providing a timely response, reablement and recovery
- Support people with long-term support needs, who need on-going personalised support

Services that:

- Provide the "top tier" of care covering Individual Patient Placements, care homes for both working age adults and those over 65, end of life care, acute hospital services and specialist and tertiary services

# K23 – Deliver integrated commissioning as part of IHWB transformation programme



## SYSTEM LEVEL OUTCOMES

Key system level outcomes that our approach is designed to impact on are set out below:

- Increased healthy life expectancy (quality of life as well as length of life)
- Reducing health inequality
- Increasing the amount spent on prevention through the lifecycle of this strategy
- Delaying and reducing the need for care and support – less need for residential care and hospital
- Preventing people from dying prematurely – reduce levels of preventable disease
- People are cared for and recover well – better quality care with people more able to return home more quickly
- People have a positive experience of care and support
- Children and adults are safeguarded
- Children well-prepared for adulthood – health, education and aspiration
- Reduction in children living in poverty
- Continuing to reduce the volume of victim-based crime (per 1,000 population)
- Number of recorded violence against the person offences (per 1,000 population)

- Supported by individual performance scorecards for each Commissioning Plan
- Quarterly performance updates to the Integrated System Performance and Intelligence Group (ISPIG)

## **K23 – Deliver integrated commissioning as part of IHWB transformation programme**



### **2015/16 Milestones achieved**

#### **Quarter one**

- Begin developing the strategic performance framework for Integrated Commissioning
- Finalise the Wellbeing Strategy for Integrated Commissioning.
- Develop service user questionnaire to support Children's Social Care's understanding and analysis for the increase in numbers of contacts. Gain sign by PCSB.

#### **Quarter two**

- Integrated Senior Leadership team established
- System design group held

# Key Action 48



Key Actions:

K48 - Increase personalised packages of care to support people to live as independently as possible

Supports outcome:

We will help people take control of their lives and communities



# K48 - Increase personalised packages of care to support people to live as independently as possible



## 2015/16 Milestones achieved

### Quarter one

- Be Care Act Compliant
- Draft Community Commissioning Plan completed
- Online self assessment tool launched

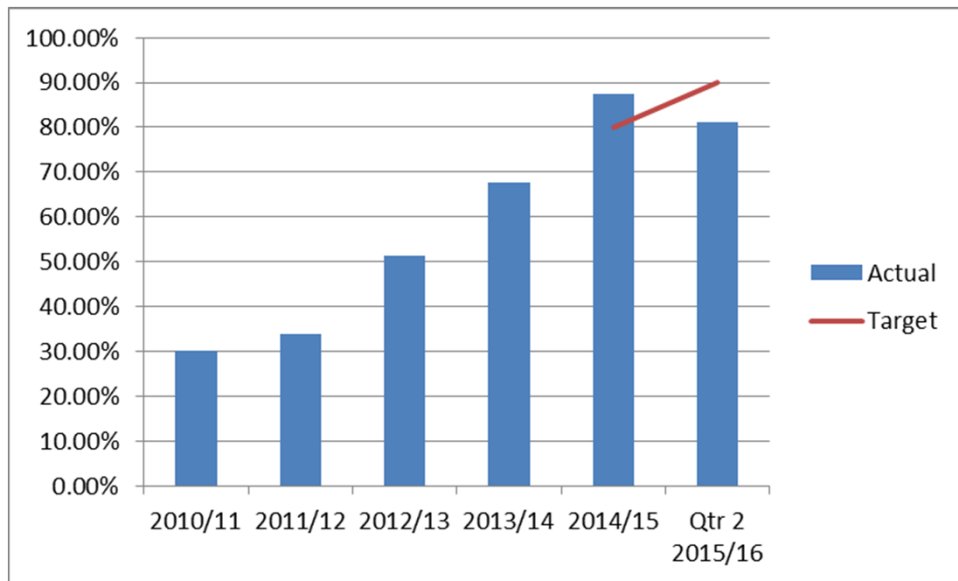
### Quarter two

- Carers Hub undertaking statutory Carers Assessments and administer Personal Budgets for Carers

# K48 - Increase personalised packages of care to support people to live as independently as possible



ASCOF National Measure 1C – Proportion of people using social care who receive self-directed support



- 87% of people using social care receive self-directed support at the end of 2014/15
- Higher than regional (79%) and national (84%) average performance
- Sub Measure – 31% of people using social care in receipt of a personal budget. Above regional (25%) and national (26%) average performance
- ASCOF 1B – 81% of people using social care say they have control over their daily lives. Above regional (80%) and national (77%) average performance

# Key Action 31



Key Actions:

K31 - Improve the quality of the care and support market

Supports outcome:

People are treated with dignity and respect.

# K31 – Improve the quality of the care and support market



## 2015/16 Milestones achieved

### Quarter one

- Support providers to implement the new Care Certificate

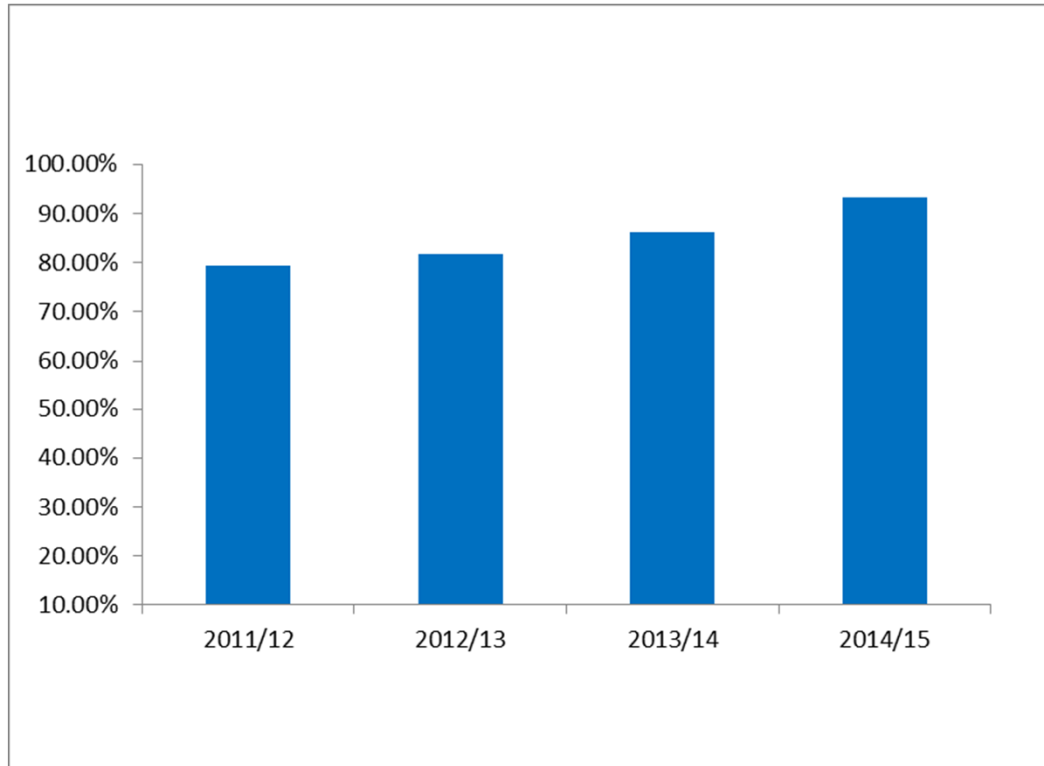
### Quarter two

- Continued support for providers to implement the new Care Certificate
- To deliver a workforce development programme with care homes, including:
  - Leadership Programme
  - Dignity Forum Programme
  - Care Act Workshops
- Support care homes to create Health Action Plans which give an historic picture of someone's health and any past interventions

# K31 – Improve the quality of the care and support market



ASCOF National Measure 4B – The proportion of people who use services who say that those services make them feel safe and secure



- 93% of people using social care say that services they receive make them feel safe and secure
- Higher than regional (87%) and national (85%) average performance
- CQC Care Home rating – Currently one outstanding and 10 good care homes
- 9 care homes known to require improvement

# Key Action 49



Key Actions:

K49 - Create a Dementia Friendly City working with partners

Supports outcome:

People are treated with dignity and respect.

## K49 - Create a Dementia Friendly City working with partners



- The number of people with dementia in Plymouth is set to increase from 3185 in 2015 to 3264 in 2020
- Currently we have achieved a diagnosis rate of 53% with a target to improve
- Lots of initiatives to raise awareness and identify people who may have dementia, of which the Dementia Friendly City is a key part.
- In 2015/16 the Action plan focuses on:
  - Dementia Friendly City Centre
  - Dementia Friendly Energy Company
  - Dementia Friendly Communities
  - Dementia Friendly Plymouth City Council
  - Dementia Friendly Primary Care
- Plymouth was presented with a national award by the Alzheimer's Society at a ceremony in London for being a finalist in the category of "Best Dementia Friendly Community Initiative".

# K49 - Create a Dementia Friendly City working with partners



## 2015/16 Milestones achieved

### Quarter one

- Libraries to work with Alzheimer's Society to deliver Dementia Awareness Week and other events
- Dementia Friendly Pharmacies - Increase the number of Dementia Friends in Pharmacies across Plymouth

### Quarter two

- Complete the Strategic Clinical Network Project in care homes to increase diagnosis
- Review the Dementia Pathway and develop Commissioning Intentions based on needs assessment and consultation
- People with dementia who can demonstrate that they meet the eligibility criteria are encouraged to apply for the blue badge scheme using the discretionary powers of the Local Authority.
- Put in place care co-ordination of over 75s with GP practices.
- Ensure that Dementia is embedded into the End of Life strategy
- Dementia Strategic Group to be involved in discussion about new System Design Group membership and consultation process



## Key Action 50



### Key Actions:

K50 - Provide a seamless service for older people's care including smoother discharge from hospitals (working closely with the NHS)

### Supports outcome:

People are treated with dignity and respect.

**K50 – Provide a seamless service for older people’s care including smoother discharge from hospitals (working closely with the NHS)**



**2015/16 Milestones achieved**

**Quarter one**

- Implement integrated hospital discharge team

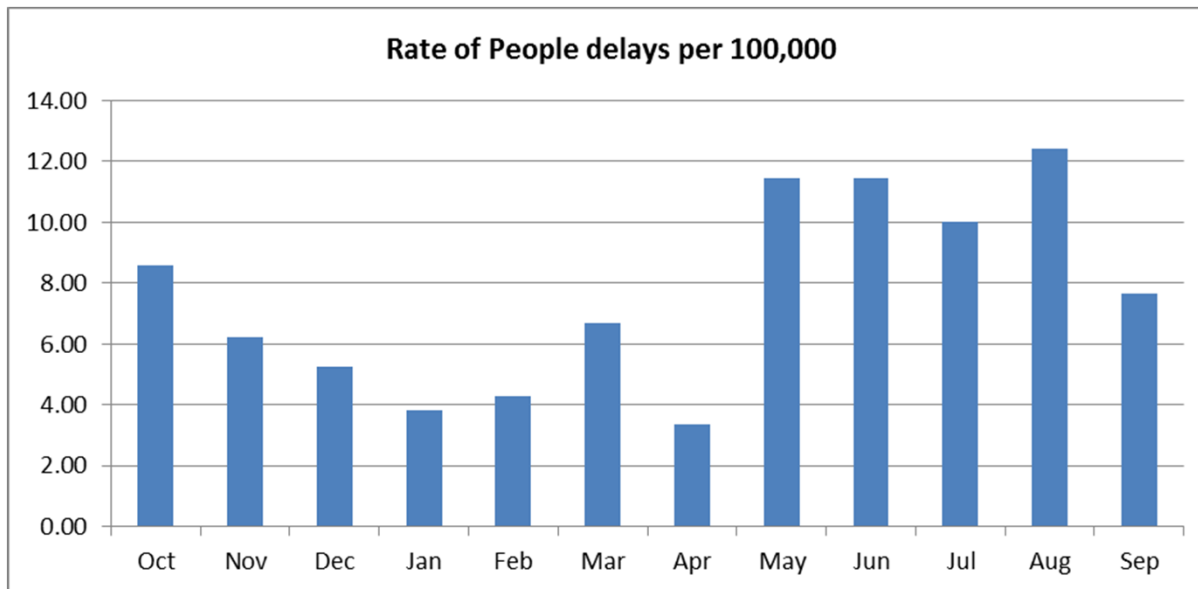
**Quarter two**

- Re-location of teams to relevant hospital site
- Dedicated social care managers to lead teams in both acute and non-acute Plymouth hospitals working in partnership with NHS managers from each site
- Introduction of daily Authorisation procedures for Adult Social Care packages
- An Action plan to refocus priorities of the social care manager on delays attributable to Adult Social Care

## K50 – Provide a seamless service for older people’s care including smoother discharge from hospitals (working closely with the NHS)



ASCOF National Measure 2C – Delayed transfers of care from hospital which are attributable to adult social care (per 100,000 population)



- Recognised performance issue
- Working with Plymouth Community Healthcare and PHNT to improve performance
- Improving trend in recent months
- South West Issue

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**Fairer Charging for Non-Residential  
Services  
Update for Caring Plymouth  
December 2015**

# Context and Background (I)



- Charging for non-residential services is discretionary. There is no statutorily defined procedure for assessing non-residential charges. Section 17 Health and Social Services and Social Security Adjudications Act 1983 (HASSASSAA) enables local authorities to recover such charge (if any) for a service as they consider reasonable.
- Charging under Section 17 HASSASSAA is subject to means testing.
- Prior to 2011 Plymouth City Council did take into account the income a person received from their Disability Living Allowance, excluding the mobility element, Attendance Allowance and Severe Disability Benefit. (The policy subsequently changed see below)

# Context and Background (2)



- Non-residential services include:
  - Day care
  - Personal care at home
  - Home care
  - Supported living
  - Direct payments
  - Respite for the carer – up to 28 days
  - As well as a range of individually commissioned services to meet an individual service user's needs

# Previous Policy



- Previous Policy disregarded Disability Related Benefits as Income for Community Based Adult Social Care Services
- System was not consistent between service users as did not take account of all income available to all service users and is therefore not equitable.
- In the previous system Disability allowances designed to pay for meeting care needs are not used to pay for care costs.
- The Council disregarded the governments disability allowances when calculating a service users contribution towards the costs of their care and support services (i.e. The government pay and then the local authority pays a second time)
- Policy was not in line with Fees, Charges, Concessions Policy (November 2013) where Disability Related Benefits were not one of the Categories for which concessions can be granted
- CIPFA Benchmarking (2012) evidenced Plymouth was in the extreme minority that totally disregarded disability benefits



# Principles of New Charging



- The Council's new Fees and Charges policy reflects the Corporate Plan objective that Plymouth is a Fairer City where everyone one does their bit.
- It has as a general principle that every service user should make a contribution towards the cost of their service provision.
- Charging should be based on the ability to pay
- Charging should promote fairness between different service users and promotes independence and social inclusion.
- Care related benefits should be used to pay for care costs to meet needs and maintain independence

# Fairer Charging Consultation Process



- Consultation documents on Council's consultation portal.
- Letters and survey questionnaires sent out at the beginning of January 2014 to all service users receiving community based services, financial representatives with an extended consultation deadline of 6 April 2014.
- Information sent out to umbrella voluntary organisations and interest parties
- Three two hour drop-in events were held across the City; Plymstock Library, The Highbury Trust and the Devonport Welcome Hall plus an all day drop-in event at the Plymouth Guildhall. Around 200 service users and their carers attended these events.
- Over 1100 surveys returned

# Consultation Changes



- Ensure Service Users are supported to maximise income from benefits
- Dispensation for night time care in line with government guidance
- Need to avoid risk of double charging from DRB. (If people are funding some of their own identified care needs from their disability allowances we will make an adjustment to their charges that takes account of this.)
- Ensure equity of service provision for those living at home supported by family members and those living independently supported by paid Carers.
- We will audit our own assessment process and the way in which we are applying the new Fairer Charging Policy after 6 months of operating, to ensure it remains fair and fit for purpose.

# New Policy



- To agree the proposed fairer charging policy as submitted which takes into account 70% of Disability Living Allowance, Attendance Allowance and Severe Disability Allowance as income, with the remaining 30% being disregarded to cover additional disability related expenditure. The proposal includes the ability for individuals to request an assessment and provide evidence of their disability related expenditure if they consider that their expenditure is greater than the equivalent of the 30% disregard.

# New Policy



- Proposed to take into account 70% of certain disability related benefits (DLA,AA&SDA) as income with the remaining 30% being disregarded to cover disability related expenditure.

Benefits Counted as Income	Benefits Disregarded as Income
<p>State benefits (e.g. Retirement Pension, Pension Credit, Incapacity Benefit, ESA, Severe Disability Allowance, Income Support and/or Universal Credit, Disability Benefits including Attendance Allowance, Disability Living Allowance Care Component and/or Personal Independence Payment.)</p> <p>Occupational and private pensions or other regular income from investments</p> <p>Tariff income on savings above £14,250 (this assumes £1 for every £250 of capital, or part thereof, between the lower and upper capital limits as stated in CRAG)</p> <p>Any other income from other sources, e.g. rental from property, etc.</p>	<p>Earnings from employment</p> <p>Mobility Component of; Disability Living Allowance, Attendance Allowance Personal Independence Payment, War Pensioner's Mobility Supplement</p> <p>Full disregard of any War Pensions</p> <p>War Widows Special Payments</p> <p>Savings credit element of Pension Credit</p> <p>Night rate of Disability Living Allowance (Care Component) or Attendance Allowance</p> <p>Guaranteed Income Payment paid under Armed Forces Compensation Scheme (payable to veterans only)</p> <p>Child Tax Credit</p> <p>An element of Armed Forces Independence Payment</p> <p>Working Tax Credits</p> <p>Child Benefit</p>

# Client Financial Services Process



- 1) Referral comes in via Carefirst or an Audit trail report
- 2) Admin staff contact the client or financial representative to book visit. At this point they advise what evidence would be needed
- 3) Visiting officer completed assessment form with client/fin rep, sites documents, explains process and carried out benefit checks
- 4) Completed form is brought back to office and assessment officer carries out assessment. The contribution is entered on the system & will be chargeable the Monday after date of assessment
- 5) Assessment breakdown letter sent to client/fin rep.
- 6) Invoice goes out to client/fin rep (unless DP client)

# Implementation Timetable



<b>6 January 2014</b>	Start of consultation, letters and surveys sent to service users, financial representatives and stakeholder. Closing date 06/04/14.
<b>February 2014</b>	Four drop in sessions held across the City for clients, financial representatives and stakeholders.
<b>1 May 2014</b>	Extension to closing date for consultation.
<b>15 July 2014</b>	Cabinet.
<b>1 October 2014</b>	Original implementation date – delayed.
<b>1 December 2014</b>	Implementation date.
<b>April 2015</b>	Three stakeholder workshops.

# Implementation Issues



- Large number of clients to assess
- Delays in sending out bills
- The CFS team were tasked with reassessing all cases over an 8 week period
- Large number of appeals and queries
- Issues raised from providers



# Lessons Learnt



- Amended the format of the letters to make information as clear as possible for the customer and reduce queries.
- Produced leaflets specifically for FCP and updated our website with useful information.
- Made adjustments to systems and given access to the CFS team to enable them to update other parts of the system that impact the service. For example the ability to update Financial Representative information.
- CFS work has been prioritised and a structured performance monitoring framework has been put in place.
- Improved accessibility to customers by having the contact centre take calls for CFS and filter queries through to the team.
- Dialogue across CFS and Social Services has increased to ensure a more joined up approach to the work.
- **Stakeholder meetings took place to explain FCP to agencies and service providers.**

# Fairer Charging Outstanding Work Position (23/11/15)



- Number of chargeable clients have rose from 150 to 1200
- Total Outstanding 148
  - 61 New Clients
  - 24 Reassessments
  - 63 Awaiting Contracts
- Weekly Referrals = 21
- Assessments Completed=58

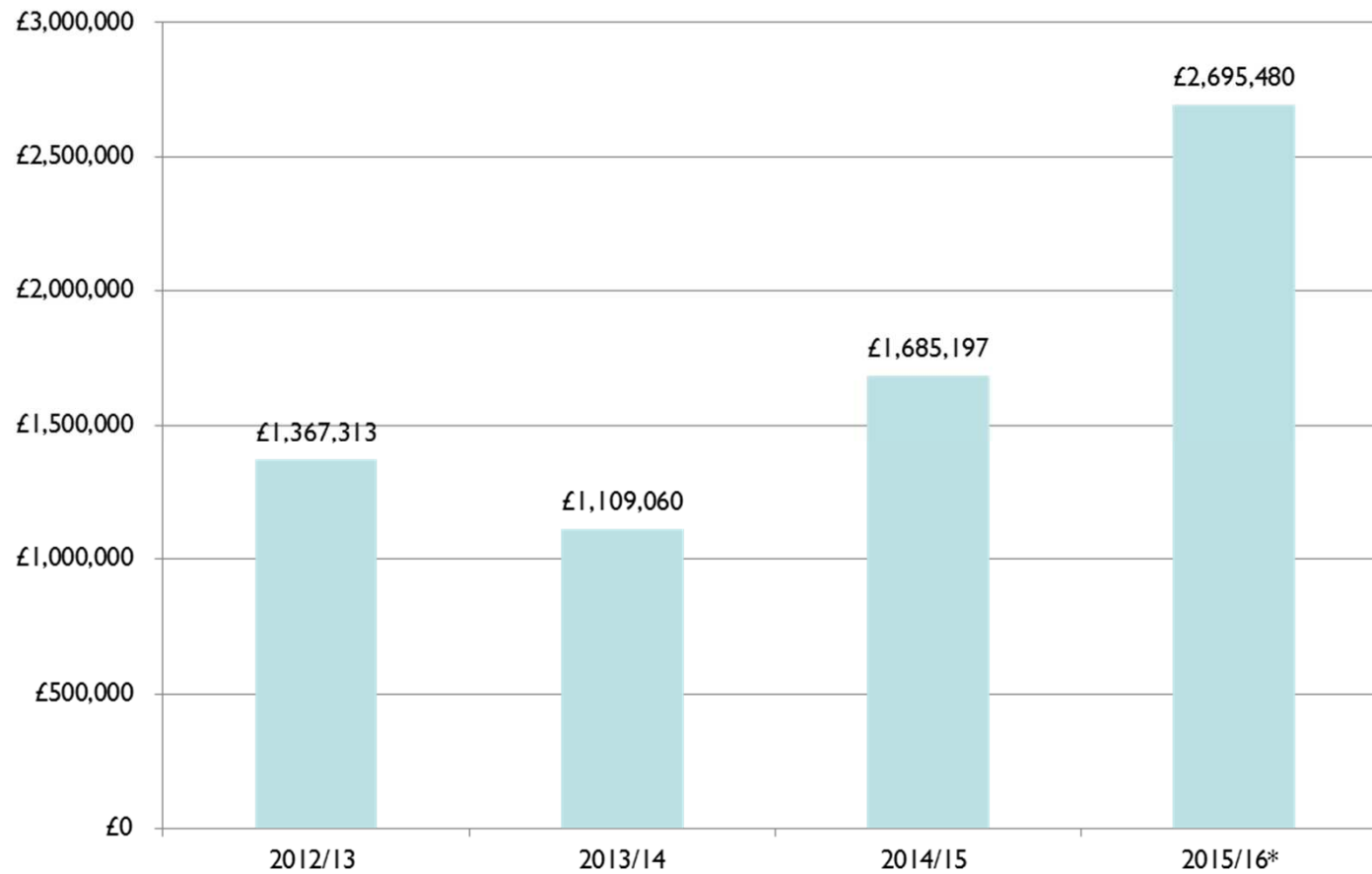
# Appeals



Month	Appeals Received
December	5
January	4
February	17
March	14
April	17
May	22
June	14
July	7
August	7
September	11
October	9
November	3
<b>TOTAL</b>	<b>130</b>

Appeal Outcomes	
16	One off reductions
8	Increase in charge
54	Reductions in Charge
37	No change
15	In Progress

# Financial Position



\*Forecast

# Continuous Improvement



- Training frontline staff so service users are fully aware of the assessment process at first point of contact.
- Review of staff resources is currently being undertaken.
- Clearer leaflets to be designed and rolled out to service users and partners. Website to be updated.
- When CFS review next year that they will make sure they have as much information as possible about household expenditure to ensure that assessments are accurate and in turn reduce the number of appeals.
- Review of Policy to be undertaken.

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# **Strategic Cooperative Commissioning - Budget Briefing**



**December 2015**

# 2015-2016 Budget & Forecast



	2015/16 Budget	2015/16 Forecast	Forecast Over / (Underspend)
	£'000	£'000	£'000
Income	(21,967)	(22,266)	(299)
Commissioned Contracts	17,598	17,465	(133)
Individual Care Packages	67,676	68,076	400
Management	5,559	5,452	(107)
<b>Totals</b>	<b>68,866</b>	<b>68,727</b>	<b>(139)</b>

Note: Approx. £5m of delivery plans to achieved in 15/16 – see next slide



# 2015/16 Delivery Plans



<b>Strategic Cooperative Commissioning Delivery Plans 2015/16</b>		
<b>Area of Savings</b>	<b>In Year Saving £000</b>	<b>Actions</b>
Residential Care	1,400	Achieved - reduced client numbers in Res and Nurs
Packages of Care	1,256	High cost reviews of care packages and clawback of Direct Payments plus one off savings
Supported Living	64	Achieved - covered by one off savings
Extra Care Housing	500	Achieved - covered by one off savings
Contract Savings	755	Achieved - reductions to contracts
Better Care Fund	1,100	Achieved - additional BCF monies
Staffing Efficiencies	20	Achieved
<b>Total</b>	<b>5,095</b>	

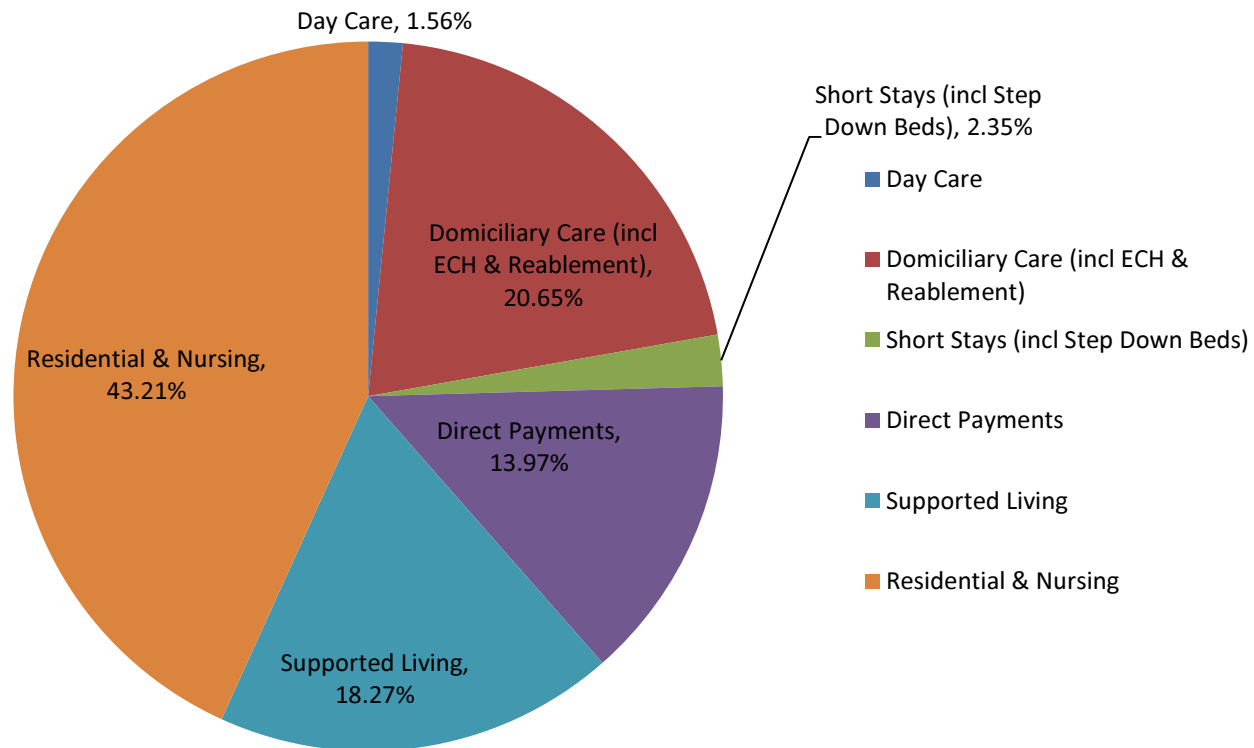
# Care Packages 2015/16



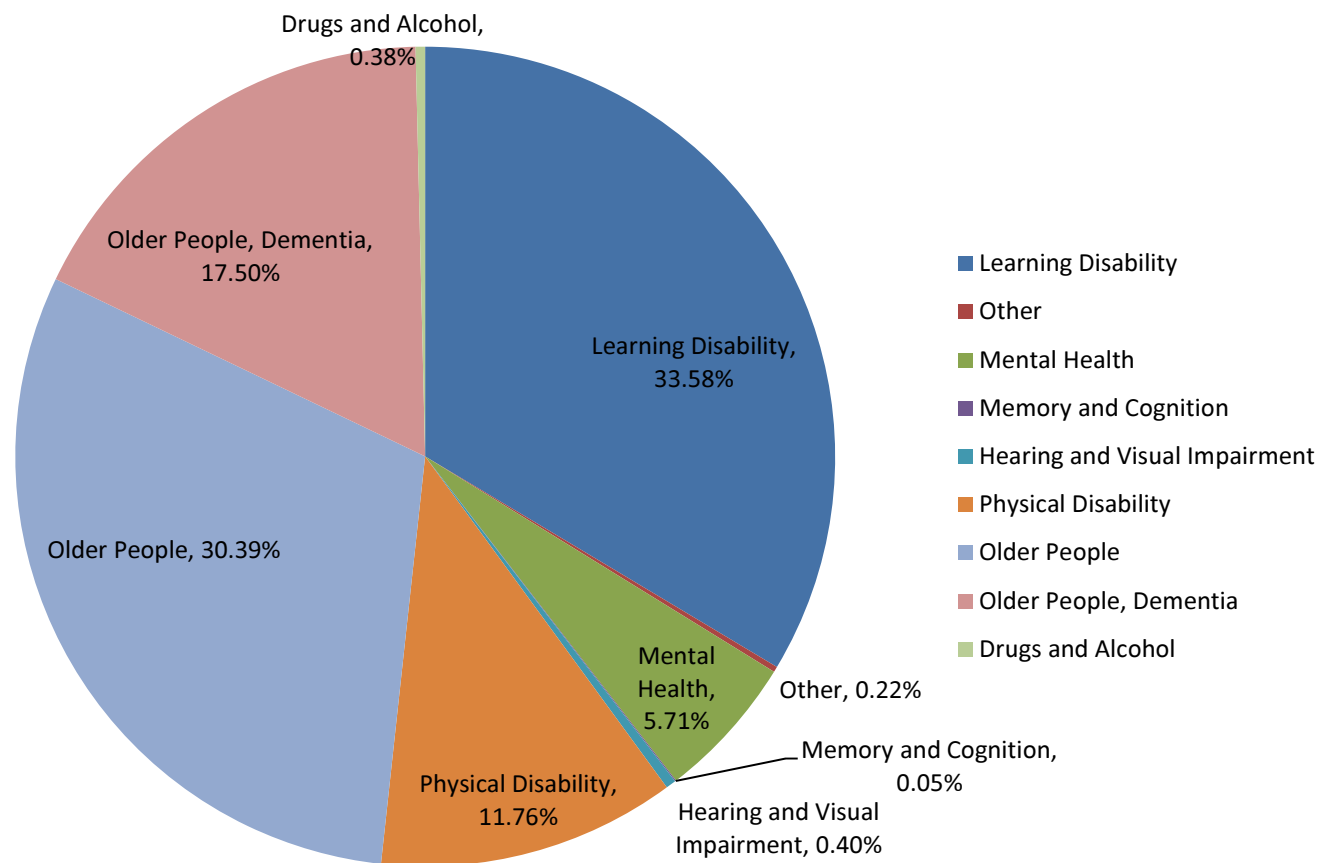
	2015/16 Budget	2015/16 Forecast	Forecast Over / (Underspend)
	£'000	£'000	£'000
Day Care	1,054	1,235	181
Domiciliary Care (incl ECH & Reable	13,976	13,918	(58)
Short Stays (incl Step Down Beds)	1,589	1,975	386
Direct Payments *	9,451	9,246	(205)
Supported Living	12,366	12,508	142
Residential & Nursing	29,240	29,194	(46)
<b>Totals</b>	<b>67,676</b>	<b>68,076</b>	<b>400</b>

\* Includes Clawback of £800k

# 2015/16 Care Packages by Type



# 2015/16 Care Package Budgets by Client Type



**SUMMARY REPORT**Plymouth Hospitals   
NHS Trust**Caring Plymouth**

10 December 2015

**Subject** Plymouth Hospitals NHS Trust: CQC Action Plan**Prepared by** Lee Budge, Director of Corporate Business**Approved by** Lee Budge, Director of Corporate Business**Presented by** Lee Budge, Director of Corporate Business**Purpose**

The purpose of this report is to update Caring Plymouth on the progress that we are making in delivering the action plan which has been developed to address the issues arising from the CQC's inspection of Plymouth Hospitals NHS Trust.

**Decision****Approval****Information** ●**Assurance** ●**Corporate Objectives**

Quality Care	Inspired People	Healthy Organisation	Innovate & Collaborate
●			

**Executive Summary**

The Care Quality Commission (CQC) rates healthcare providers against five domains of care. Following an inspection in April 2015, the CQC published a report in July 2015 on the care provided by Plymouth Hospitals NHS Trust (see attached) which incorporates the following ratings:

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement ●
Are services at this trust effective?	Good ●
Are services at this trust caring?	Outstanding ☆
Are services at this trust responsive?	Inadequate ●
Are services at this trust well-led?	Good ●

The Committee will be aware that the Trust has been openly reporting significant pressure as a result of a sustained increase in the number of attendances to our Emergency Department which has led to a higher than planned level of inpatient admissions, delayed discharges and an increase in the number of medical outliers. This continues to affect our ability to meet the Accident & Emergency (A&E) 4 hour standard and Referral to Treatment (RTT) within 18 weeks targets and, as such, is reflected in our rating for responsiveness. We remain resolutely committed to providing safe, caring, responsive, effective and well-led services so that all of our patients receive the quality of care that they expect and deserve.

The Trust has developed a comprehensive action plan and supporting governance arrangements to address the findings contained within the CQC's report. Regular progress monitoring reports are submitted to the Trust's Safety and Quality Committee and externally to the CQC and the NHS Trust Development Authority.

The latest monitoring report is attached for the Committee’s information, whilst the following table summarises overall progress with the actions.

Action status	No.	%
● Completed and closed on receipt of appropriate evidence	35	22%
● Completed – evidence to be submitted and reviewed	31	20%
● On Track	77	49%
● Revised timelines for completion: PHT	11	7%
● Revised timelines for completion: CCG	3	2%
	<b>157</b>	<b>100%</b>

**Key Recommendations**

The Committee is asked to note the Trust’s response to the CQC’s recommendations.

**Next Steps**

The Trust is in the process of implementing the action plan and will continue to report progress through the established governance framework.

## SUMMARY REPORT

Plymouth Hospitals   
NHS Trust

### Cornwall Overview & Scrutiny Committee

November 2015

**Subject** Plymouth Hospitals NHS Trust: CQC Action Plan

**Prepared by** Lee Budge, Director of Corporate Business

**Approved by** Lee Budge, Director of Corporate Business

**Presented by** Lee Budge, Director of Corporate Business

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**Decision**

**Approval**

**Information** ●

**Assurance** ●

#### Corporate Objectives

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●			

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# CQC Action Plan Monitoring

October 2015

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<b>Outpatients and Diagnostic Imaging</b>	<b>60</b>

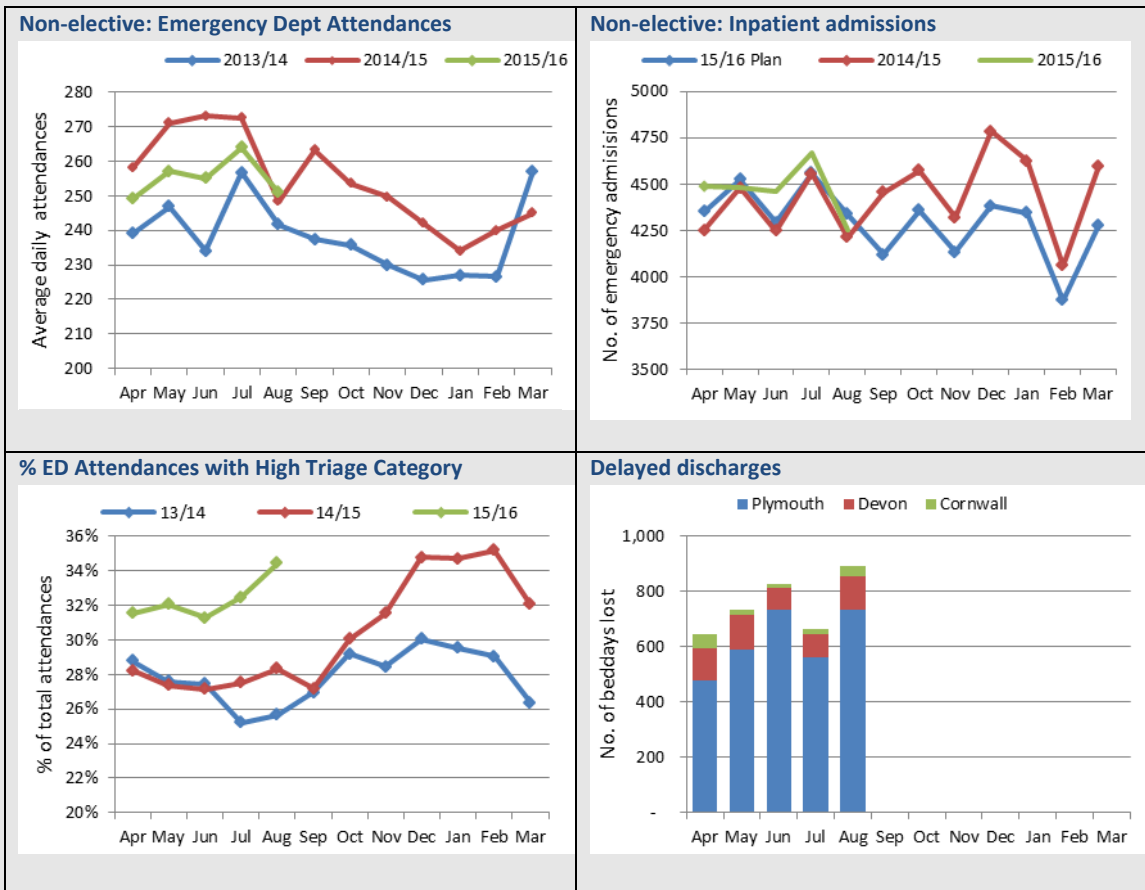
# Quality Summit Actions

**Urgent Care - reframing the goal around risk and how to achieve this.**

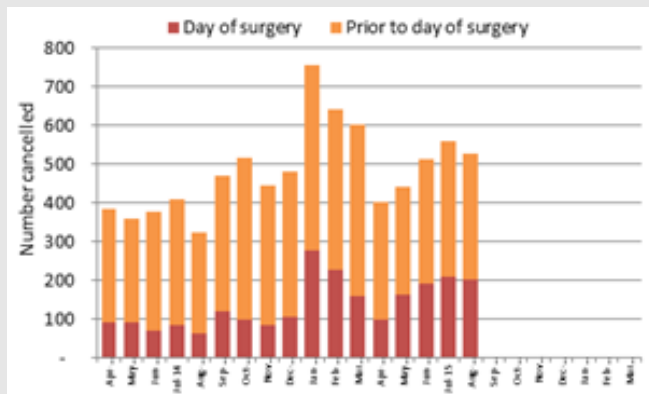
An urgent care system should be sustainable and able to plan, and collectively manage, the risk, of any unexpected or sustained increases in demand. How could we secure a different mechanism to manage the levelling up of clinical risk across our system and to ensure that the component parts of the network work as one?

## Current Performance

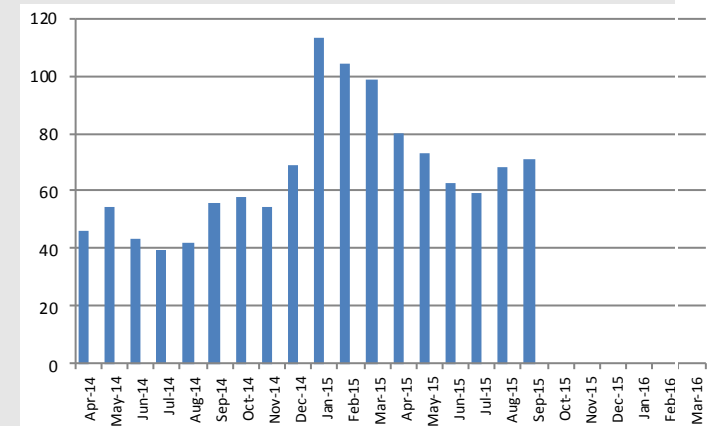
Understanding the operational context (source: Integrated Performance Report to Trust Board September 2015):



**Cancelled operations. Source: Integrated Performance Report to Trust Board September 2015.**



**Medical outliers. Source: Recovery Plan Update to Trust Board October 2015.**



### Comment on Current Performance

The average number of daily ED attendances reduced in August but remained higher than that in the two previous years whilst the complexity of those patients arriving is at its highest since Winter with over 34% of patients triaged in the highest two categories.

The volume of elective cancellations made both on the day and up to 7 days in advance remains a concern and the continued emergency medical demand and resulting medical outliers continues to compromise our ability to improve our elective throughput. This dynamic is also influenced by the delayed discharge position which has deteriorated.

### Planned action

Ref	Action	Lead	Deadline
1.2	The System Capacity map does not exist – pick up exact definition and requirements and commission work through SRG.	Jerry Clough CCG	31-Oct-15
1.3	Ensure SRG collective ownership of a comprehensive urgent care system plan including different models of care, 7 day working, 24 hour district nursing and shift of acuity into different care settings.	Jerry Clough CCG	Complete
1.4	Ensure urgent care plan focuses on key pathways to be discharged from PHT.	Sharon Matson/ Kevin Baber	31-Oct-15
1.5	Review practice in Plymouth to ensure discharge planning commences at the earliest possible opportunity, in line with best practice. To ensure this is not constrained by outdated policy or practice.	Sharon Matson	31-Oct-15
1.7	Senior leaders through SRG to oversee the development of comprehensive list of all patients moving towards discharge and the actions required to make more rapid progress.	Jerry Clough CCG	31-Oct-15
1.8	What is the role of the Urgent and Emergency Care Network? Be clear about key work areas that the SRG would want the UECN to focus on, including the following in the dashboard: <ul style="list-style-type: none"> <li>• Whiteboard delays</li> <li>• Trauma Network information – patients who are fit to be repatriated after 48 hours but have not been repatriated.</li> <li>• Neuro rehab</li> </ul>	Jerry Clough CCG	31-Oct-15
1.9	Investigate opportunities for reducing medical and surgical length of stay.	Kevin Baber	30-Nov-15

### Update on Actions

1.2 This will be completed through a thorough review of the DOS and the production of a whole system capacity plan by Alamac. This work was agreed and supported by the October SRG meeting.

1.3 Revised Governance and Action Plan structures were signed off by October's SRG meeting. These will be fully implemented for the November SRG / UCP meetings. This will include one action plan covering all developments for the Urgent Care System. The action plan includes a range of different service improvements and developments that will support 7 day working. Robin Community Assessment Hub is operational providing an alternative to hospital attendance and/or admission for patients with ambulatory care sensitive conditions and for frail older people. This service will operate 7 days a week from November.

1.4 The CCG is establishing a Tactical Control Centre which will be fully operational by 16 November 2015 (earlier if possible). This will augment the existing Integrated Health and Social Care Discharge Team. The Centre and the teams will have one, complete list of patients and the Centre will be focussed on unblocking pathways and processes to ensure rapid, effective and safe throughput of patients. PHNT have recently commissioned Recovery at Home from PCH. This will focus on patients who need to be discharged with some support but who are not labelled as "complex discharge". Medical responsibility will remain with PHNT. The Trust is implementing the SAFER bundle. PCH is implementing Enhanced Recovery for Medicine.

PHT update 29/10/15: the Discharge to Assess pilot on Monkswell worked well and the community have now agreed to establish 34 Discharge to Assess beds.

1.5 In addition to the activity detailed in 1.4, there have been three pilots undertaken - Discharge to Assess to care home, Discharge to Assess to patients' own home, Criteria Lead Discharge. These pilots are being extended for operationalisation for the surge and escalation period of 2015/16 and will be managed through the Tactical Control Centre. Completion now planned for 16/11/15.

1.7 - 1.4 and 1.5 relate.

1.8 In addition to the given specifics of:

- Whiteboard delays
- Trauma Network information
- Neuro rehab

the UECN will focus on those elements described in national policy/letters of direction such as workforce and accreditation of urgent care delivery centres.

1.9 This forms part of the work on bed reconfiguration. Presentation made to Board and key internal committees setting out the requirement to decrease medical and surgical LOS. Assessment is that medicine needs to decrease LOS by 0.5 of a day to release 24 beds. Surgery needs to address increased LOS for surgical emergencies and this gives an opportunity of 16 beds. Other improvement projects such as work on TTAs and implementation of the Safer Ward Bundle support the above. Safer Ward bundle includes Senior Review – all patients reviewed by 12 midday.

From 19/10/15 all Matrons and General Managers were re-focussed on Plan For Every Patient. General Managers are to ensure that they understand the patients on their wards with a green cross on SALUS i.e. those that are medically fit and awaiting an intervention to allow them to be discharged.

We will be working to deliver planned date of discharge in surgery in the first instance. The golden bed initiative is being implemented; this means a vacated bed before 10 am on 10 wards to enable flow from assessment areas. The patients who are vacating the golden bed will have been identified the night before, the patient informed of the plan to either discharge direct to home or sit in the dayroom or go to Tamar to sit in their seating area whilst waiting for drugs/transport etc. The site team are monitoring progress. The Service Line Manager and Matrons are reviewing the >14 day length of stay on a daily basis and the Service Line Managers then present those patients to the Head of Operations at 10.30 daily. On a weekly basis the Head of Operations, a senior physician, Site Matron and Operations Manager for Integrated discharge team are also undertaking a grand round of all those patients in medicine >14 days length of stay with no complex discharge icon on SALUS.

Urgent Care - reframing the goal around risk and how to achieve this.

111 and the out of hours commissioning process are both currently suspended and SWAST have served notice. How will this be managed given the critical nature of the services, particularly given that we will soon be returning to the additional pressure that winter will place on the urgent care system?

#### Planned action

Ref	Action	Lead	Deadline
1.10	With the ongoing reprocurement of NHS111 and the Out of Hours service (though the CCG's Urgent Care procurement), explore the options to use these changes to enhance the impact of both services on the numbers of attendances at A&E and emergency admissions.	Jerry Clough CCG	Complete
1.11	Understand and articulate the business case for time shifting arrival of patients at A&E / MAU with clarity on different cohorts of patients, options for time shifting (e.g. visiting times, transport) to determine the most cost and operationally effective options for improvement. Understand the full impact and anticipated benefit of any changes.	Sharon Matson (as part of SRG led, urgent care plan)	31-Oct-15
1.12	Hold an urgent care summit with GP Federations, CCG, PHT and PCH to investigate any further options for change. To explore issues including care homes, visiting, accessibility and vulnerable cohorts of patients	Kevin Baber	30-Nov-15
1.13	Investigate the potential of a system wide approach to Medicines Optimisation across primary, community, acute and specialist care.	Phil Hughes	31-Oct-15
1.14	Review urgent care comms plan and ensure SRG agree key approaches.	Sharon Matson / Kevin Baber (as part of SRG led, urgent care plan)	30-Oct-15

#### Update on Actions

1.10 The current provider will deliver a service until 30 September 2016. CCG is currently developing a procurement strategy development process following the release of the latest national procurement guidance.

1.11 A review of GP visiting times has been undertaken and found that moving forward the visiting times in the day would provide little benefit. The introduction of Robin Community Assessment Hub will ensure that all clinically appropriate patients who are classified for Healthcare Provider conveyance by SWASFT within 1, 2 or 4 hours to secondary care, will be conveyed to Robin. Work will be undertaken to understand if there are cohorts of patients that could be expedited through the system to improve flow.

1.13 Director of Pharmacy has had meetings with counterparts at PCH and the CCG to take this forward. This needs to be a joint action.

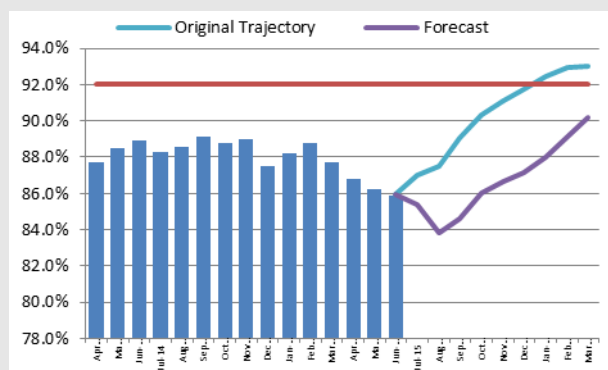
1.14 National approach - NHS England, Public Health England, the Department of Health, the NHS Trust Development Agency and Monitor are joining up their winter campaigns. CCG will utilise information produced by national team. Local solutions to be developed by SRG following review of DOS.

Planned Care and Follow Up - Improving access, follow up backlog and better management of demand.  
 How could other providers and professionals, embracing technology where possible, work with Plymouth Hospitals Trust to harness the capability of the whole system, all professionals, to ensure that routine, urgent and time critical pathways - like the 2 week wait – are delivered on time all the time?

**Current Performance**

**Referral To Treatment**

Source: Integrated Performance Report to Trust Board Sept 2015

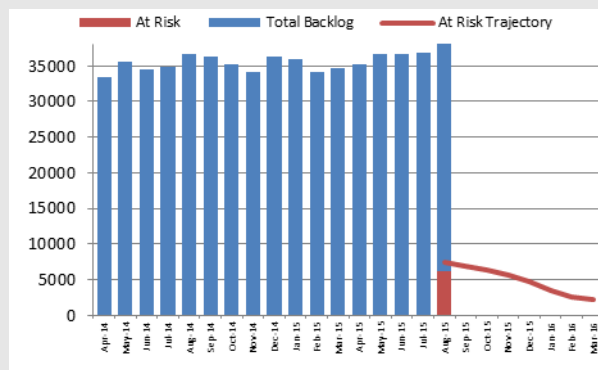


Our performance against the key RTT metrics for August 2015 is shown in the following table:

Description	Target	Actual
Incomplete pathways	92%	84.3%
Admitted backlog	1858	2500
Non-admitted backlog	82	162
52 week waiters	0	3

**Follow-up Backlogs**

Source: Integrated Performance Report to Trust Board Sept 2015



**Comment on Current Performance**

Monitoring of the RTT position showed a clear drift from the recovery trajectory during Month 4 which prompted a comprehensive piece of work to risk assess each service line’s action plans and recalculate the proposed benefits of all actions. This has been reflected in the forecast now shown on the chart.

The risk to our improvement over the coming months exists in both the CCG’s ability to control the above plan levels of demand for our services (current GP to consultant referrals 12% above plan) and our capability to deliver on the improvement plans submitted by each of our services.

At the end of August 2015, there were 37,199 patients past their ‘see-by-date’. Of these, 6153 patients are flagged as being at clinical risk; 1251 ahead of the reduction trajectory to reduce this cohort.

Service Lines have completed the risk identification and have now assessed every patient on the follow-up waiting list in line with the clinical risk criteria. This means that patients in high risk groups can now be systematically prioritised for appointments. Service groups have also produced trajectories to reduce the number of patients at risk of harm who have waited past their see-by-date. For 7 service lines, a process of service improvement will be undertaken as part of the agreed CQUIN scheme in order to review and improve how follow-up care is offered in high volume specialties.

**Planned action**

Ref	Action	Lead	Deadline
1.18	Investigate the use of technology to get access to care and to get information back into primary care for planned care.	Karen Kay	31-Oct-15
1.19	Assuming that electronic communication with primary care is agreed, PHT to scope printing and postage cost savings.	Kevin Baber	Complete and closed

1.20	Dedicated workshop on follow-ups to robustly challenge progress on reduction and explore all options for priority and non-priority patients.	Karen Kay/Kevin Baber	30/12/2015 – Deadline revised as per CQUIN schedule and the need for multiple workshops rather than a single one stop workshop solution.
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**Update on Actions**

1.18 Teledermatology implementation underway. Teleophthalmology opportunities being explored. E-transfer of information is work in progress within PHNT utilising email, Patient Knows Best and Docman.

1.19 Indicative costings have been completed for the Programme Board. These have not been fully audited but are anticipated savings.

1.20 Planned Care Partnership (workshop) agreed principles of "no face to face follow-up unless of proven clinical value" in 2014. Joint PHNT and CCG Programme Board in place monthly since July 2015 with clinical leadership and involvement. Service line workshops planned in accordance with CQUIN schedule (range of specialties over 2015/16). Workshops will have the purpose of developing follow-up protocols between primary and secondary care.

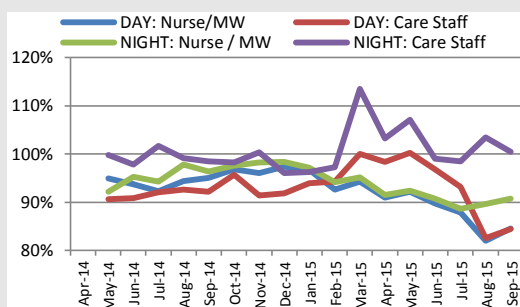
In developing new models of care, PHNT and primary care have identified three areas where clinical consensus has been established for a new model of care – one system, one budget – for introduction from April 2016. They are: dermatology, musculoskeletal, and pain services. Notionally ‘pooling’ budgets across the new network of providers will create opportunities to redefine objectives of the service and align incentives to stimulate the network to move as one – consistently - all the time. The expectation would be to reduce growth in demand, ensure capacity to meet demand and lower the cost of intervention through the use of new professionals and achieve reductions in prescribing spend.

## Staff numbers

Derriford Hospital: The Trust must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed to provide adequate levels of nursing and medical staff to ensure the safety of patients at all times. This applies to the emergency department, children's services, outpatients and diagnostics, maternity services and medical services. There were insufficient staff to address the backlog of reporting for diagnostic imaging scans.

### Current Performance

#### Source: Workforce Information



Fill rates for September 2015 are detailed in the following table:

Description	Fill-Rate
Day shift: Nurse / Midwifery	84.6%
Day shift: Care Staff	84.5%
Night shift: Nurse / Midwifery	90.0%
Night shift: Care Staff	100.5%

### Comment on Current Performance

The monthly safety staffing return for September was 88.31%. Staffing data is now extracted directly from health roster providing more reliability and assurance on data accuracy. There continues to remain significant operational activity resulting in increased bed capacity requiring additional staffing whilst sustaining an increasing vacancy factor.

Matrons and ward managers are working clinically to support their areas. The night duty care assistants 100.5% reflects specialising and HCAs covering RN vacancies. Work is on-going with using patient acuity and dependency to determine staffing need not just numbers.

### Planned action

Ref	Action	Lead	Deadline
2.2	Emergency Department (planned number of ED nurses not always met): Interview for current vacancies 14th August.	Sam Rafferty	Complete
2.3	Paediatrics (Shortfall in paediatric ward staffing levels): Nursing staff to be in post by September. x2 consultant posts to be in place by November.	Sue Stock	30-Nov-15
2.4	Radiology (not enough medical staff to deal with backlog): 1.Recruit to vacancies for consultant staff. 2.Commence Private partnership arrangements with external reporting body 1st October for resilience. 3.Complete Stress assessment with staff health and wellbeing. <b>Financial Impact: Revenue Above Budget £50,000</b>	Wendy Colley	Complete
2.5	Health Care of the Elderly Medical Staff (shortfall of medical staff): 1. Complete Recruitment campaigns. 2. Review different methods of delivering the service. 3. Review strategy following outcome of recruitment exercises. <b>Financial Impact: Revenue Above Budget £360,000</b>	Paul Hancock	31-Mar-16
2.6	Surgery (shortfall in staffing numbers): Philippine nurses to commence in post. <b>Financial Impact: Revenue Above Budget £320,000</b>	Sue Johnson	30-Nov-15



2.8	Consider working collaboratively across the region to source temporary staff - early discussions with the PPSA and 9 other Trusts. <b>Financial Impact: Too early to cost.</b>	Karen Launder	31/04/16
2.9	Medical Staffing Workforce Group to deliver key work streams. <b>Financial Impact: Too early to cost</b>	Director of Corporate Business	Variety of work streams with short-term deadlines - workforce group meets every two weeks
2.11	Finalise Recruitment and Retention Strategy to support the Trust's workforce requirements. <b>Financial Impact: Too early to cost</b>	Karen Launder	Complete

### Update on Actions

2.2 Nursing Establishment remains on Care Group risk Register ID 4994. Service Line Director requested an ED Risk Summit where nursing establishment was included in discussions. Head of Nursing has authorised a rolling advert and Matron has increased another 2 RN's above contracted RN's in adult nursing to help out with the Paeds area.

2.3 Paediatric nursing staff now in post. Consultant posts still on track for November.

2.4 There are currently two vacancies in Radiology at Consultant level; interviews for one post taking place on the 2nd November and the other post is out to advert. The department has a short term Locum coming in to cover the additional workload in the run up to Christmas. Private partnership arrangements started 1 October. Stress assessment completed August.

2.5 Recruitment and retention premium now in place to fill vacancies and national campaigns underway. Working with PCH on different ways of working.

2.6 International recruitment of staff successfully completed with Italian nurses now in place. Up to 50 nurses from the Philippines appointed with current start dates Feb 2016 - Visa application has resulted in the delay as the nurses are required to sit English exams.

2.8 PHNT are now part of an established regional Agency Stakeholder Group led by the PPSA. Regional agency Framework rates have been agreed, plans are underway to implement an exit strategy from Thornbury Nursing Services, our most expensive agency and discussions are taking place regarding regional recruitment. Monthly meetings have been arranged to ensure traction is maintained. It is expected that there will be a permanent solution to this problem by 1st April 2016.

2.9 Detailed delivery plan in place, regularly updated and reported to TME and MEC. Doctors Assistants are being piloted on 2 wards and 13 have been approved for recruitment with plan to review possibilities for expansion at the end of the year. Also looking at adoption of Physicians Associates.

2.11 The strategy has now been agreed by the HR&OD committee. The HR team have been tasked with prioritising production of more specific plans for the recruitment and retention of certain staffing grades including nursing and consultants. These more detailed plans will set out specifically the actions being taken to address issues.

## Mental Capacity Act

Derriford and Mount Gould Hospitals: The Trust must ensure that all staff have sufficient knowledge of and implement the Mental Capacity Act so that patients' mental capacity is confirmed and to identify patients who lack capacity to make decisions, so that patients' best interests were being served. There were variations in staff knowledge and application of the Mental Capacity Act and some had not completed training. The processes and systems in place to identify persons at risk of harm in accordance with the Mental Capacity Act 2005 were not understood in the Chestnut Unit and Ophthalmology or Mount Gould Hospital.

### Current Performance

#### Training Delivered to date:

Service Line	Attendees	Date
Health Care of the Elderly Doctors	12	3 <sup>rd</sup> July 2015
F2 Training Session	29	28 <sup>th</sup> September 2015
Health Care of the Elderly Doctors	11	9 <sup>th</sup> October 2015

### Comment on Current Performance

2 sessions delivered to HCE service line. F2 teaching programme changed from vulnerable adults to MCA (2005) and DoLS (2007). This training is to be included in F1 training programme next year. Palliative care, MAU and Renal have training dates booked. Respiratory, Neurology and Gastroenterology have requested training – dates being arranged.

DoLS pathway, risk assessment and capacity/best interest checklist all ready for HRSG and steering groups – following approval will be launched Trust wide.

MCA and DoLS principles now included in Level 2 mandatory training.

### Planned action

Ref	Action	Lead	Deadline
2.12	Undertake review of policies and procedures for MCA and DoLS.	Sean Lynch/Jo Brancher	31-Dec-15
2.13	1.Culture change - Deliver Mental Capacity Awareness Campaign. 2.Identify Service Line medical and nursing leads. 3.Increase awareness of wide spectrum of issues ranging from impact on Shared Decision Making to DOLS. <b>Financial Impact: Revenue Above Budget £12,000</b>	Sean Lynch/Jo Brancher	31-Apr-16
2.14	Provide training programmes for each Service Line, including security- mandatory training, workshops, seminars. Training bespoke and relevant to needs and issues facing that Service Line. Follow up discussion to be a part of the programme. <b>Financial Impact: Revenue Above Budget £3,000</b>	Sean Lynch/Jo Brancher	31-Jul-16
2.15	Develop External (external assessor and QA Organisation) / Internal quality review (service user/carers/clinical staff/administrative staff for MHA and MCA). <b>Financial Impact: Revenue Above Budget £2,000</b>	Sean Lynch/Jo Brancher	31-Apr-16
14.16	Mount Gould Hospital: See actions 2.12-2.15 which also apply to all other locations	As above	As above

### Update on Actions

2.12 Review of scope / format of current policies and procedures undertaken. Sean Lynch to review MCA policies in other hospitals. DoLS Pathway, DoLS Risk Assessment Tool, Recording of Mental Capacity and Best Interest Decision Tool drafted and consultation period closed. Documents to be sent to HRSG and then through steering group. Sean Lynch to

write MCA policy, to include DoLS.

2.13 Reminder in Daily Email 14/08/15 and Vital Signs 21/08/15 and 23/10/15. Teaching opportunity bulletin sent to Consultants/Junior doctors direct regarding MCA and DoLS training. Also placed in daily briefing.

2.14 MCA and DoLS covered in level 2 safeguarding adults and children's mandatory training. Bespoke training - 3 sessions now completed, HCE and F2 teaching. Sessions being advertised with 3 sessions booked and 4 other areas having dates arranged. Contact made with F1 teaching programme, booked for 2016-2017.

2.15 SL and JB to review sample of notes from DoLS database. Review capacity assessments and documentation around the MCA and DoLS process. Audit template drafted.

## Records management

Derriford Hospital: The Trust must ensure that patients' records are stored securely at all times to prevent unauthorised access to them. Examples include Fal, Postbridge and ENT clinic.

### Current Performance

Satisfactory response to the Environment Audit question 'Are all notes trolleys locked if not in use or attended by an identifiable staff member if in use?' 26/10/15. Source: Meridian.



Satisfactory response to the Environment Audit question 'Are there any unattended notes on the ward/department that may be accessed by patients, or other non-authorized persons?' 26/10/15. Source: Meridian.



### Comment on Current Performance

Performance will continue to be monitored.

### Planned action

Ref	Action	Lead	Deadline
3.1	1. Fit Digilock to the cupboard on Postbridge. 2. Identify solution for the Trolley by the nurse's station for Postbridge. 3. Identify solution for Fal 4. Identify solution for ENT. <b>Financial Impact: Capital £2,000</b>	Julie Richards	Complete

### Update on Actions

1. Postbridge digilock fitted.
2. Postbridge notes trolley needs to be converted to a lockable one. A suitable product has been identified and is with the department to order.
3. FAL reception has been assessed and has all the right tools to comply with the safe management of patient records. The department has therefore been asked to re-affirm the procedure of securing notes with the shutter when they leave.
4. ENT reception needs a lockable cupboard. A suitable product has been identified and is with the department to order.

Derriford Hospital: The Trust should ensure that patients' personal and confidential information on computers and electronic systems is kept securely. We observed a computer which had been left unattended. The screen displayed patients' confidential details which were visible to other patients and visitors to the ward.

**Current Performance**

Assurance mechanism to be identified – see action point 4.

**Comment on Current Performance**

N/A at this time.

**Planned action**

Ref	Action	Lead	Deadline
3.2	<ol style="list-style-type: none"> <li>1. Reiterate the importance of locking screens in IG communications and with Matrons via the Heads of Nursing.</li> <li>2. Visit the specific area, discuss screen positioning and remind staff to lock screens.</li> <li>3. Complete implementation of the Agile Desktop Framework system for use by 2000 Clinical staff. This will allow fast user switching and will log users out after 5 mins of inactivity. This will be fully implemented by March 2016.</li> <li>4. Investigate whether this can be added to the Environment audit on Meridian to provide ongoing assurance.</li> </ol>	Penny Taylor	31-Mar-16

**Update on Actions**

Screen Savers currently appear after 7 minutes of inactivity.

1. Reminder to staff in Daily Email 13/08/15 and 28/08/15. PT also emailed Heads of Nursing 22/9/15; cascaded on.
2. Specific area not defined by CQC however Clinical Systems walk through the wards on 22/10/15 will include checking for unattended screens and raise awareness.
4. PT has requested that a question is added to a suitable Meridian audit as the Environment audit is being revamped.

## Medicines management

**Derriford Hospital: The Trust must ensure that the checking systems for ensuring medication is fit for use, is consistently followed by staff. Intravenous fluids should be stored securely so that they are not accessible by patients and visitors to wards and departments.**

### Current Performance

Assurance of compliance and development of metrics will be developed further to the following:

- 1) Inclusion in ward storage audits from December 15
- 2) ATO competency assessment results will be published in the pharmacy dashboard from November.
- 3) Next audit due January 2016.
- 4) Inclusion in the ward storage audits from December'15

### Comment on Current Performance

Not applicable at this time.

### Planned action

Ref	Action	Lead	Deadline
4.1	1.Review the current process for labelling and managing liquid medicines supplied to clinical areas (NC) 2.Reinforce the need for expiry date checking by pharmacy ATOs during ward top ups.(NC) 3. Include Expiry date checking of controlled drugs in the daily procedure for reconciling ward stocks.(DW) 4.Review the current storage of IV fluids across all Derriford and peripheral sites.(DB) 5.Remedial work to be conducted where possible. Where it is not possible to make the areas more secure a robust risk assessment will be undertaken and systems for monitoring / auditing will be developed. (DB)	Simon Mynes	31-Oct-15

### Update on Actions

- 1.Process for labelling liquid medicines has been reviewed. Labels now available in all clinical areas. Guidance to ward staff to be published w/c 26th October. Will be included in storage audit from December.
2. Complete. Frequency of ATO ward based competency assessment increased from September. Reviewed through internal pharmacy QMS and results to be reported into pharmacy dashboard.
- 3.Guidance drafted –to be published w/c 26th October. Audits to commence at next quarterly audit planned for January 2016.
- 4.and 5. Initial audit of IV storage completed on 07/10/2015. Report to be completed and presented to November meeting of MUAC. The audit results will identify next steps in terms of remedial works and risk assessment.

Derriford Hospital: The Trust must ensure that medications are managed appropriately in the outpatients departments and trust processes and policies are followed. This includes the safe keeping of the keys to medication stores/cupboards, investigation of stock discrepancies and staff not following the correct procedure for the checking of fridge temperatures.

**Current Performance**

Audit results will be available for the November meeting of MUAC.

**Comment on Current Performance**

Not applicable at this time.

**Planned action**

Ref	Action	Lead	Deadline
14.1	1. Communicate the requirements as defined in the medicines policy to all out patient departments.(DW) 2. Pharmacy staff to undertake 3/12 audits of all areas (Derriford and peripherals) and results fed back to the service lines / care groups.(NC) 3. Define and communicate a standardised process for the monitoring of fridge temperatures.(IB) 4. Develop a business case for the introduction and roll out of a wireless temperature monitoring system. (SJM)	Simon Mynes	31-Oct-15

**Update on Actions**

1. Security of medicines is being reinforced as part of the FP10 audit and changeover. All the onsite clinics have been visited and will be followed up with an audit, all the offsite locations holding FP10s bar 3 have been audited.
2. Audits commenced in October 2015.
3. Temperature monitoring guidance being developed and will be published in October.
4. Business case for wireless temp monitoring in development. To be included in capital bids for 16-17.

Derriford Hospital: The Trust should review the standard operating procedures for Patient Group Directions used in Outpatients to ensure these comply with the legislation and best practice. In ophthalmology we found that patient group directions were not being followed appropriately.

**Current Performance**

Audit to be undertaken starting in December 15. Results will be available for March 16 MUAC.

**Comment on Current Performance**

Not applicable at this time.

**Planned action**

Ref	Action	Lead	Deadline
14.11	1. Review and modify the current process for the approval of PGDs.(DW/PG) 2. Develop and communicate a standardised SOP for the implementation of PGDs(DW/PG) 3. Develop a training tool to support nursing staff in the application of PGDs.(PG) 4. Implement audit of compliance (including record keeping in medical notes, use of most current PGD versions, and checking the authorised staff have signed departmental PGD signature lists) as part of the annual medicines management audit programme overseen by MUAC.	Simon Mynes	Complete

**Update on Actions**

Approval process of PGDs reviewed and modified.  
 Training package developed and ratified at MUAC 29/09/15.  
 Audit planned for Dec'15 - results will enable ongoing monitoring of compliance.



Mount Gould Hospital: The Trust must ensure at Mount Gould Hospital the consistent application of medicines optimisation across the services, in particular: safe storage and management of stocks of FP10 and outpatient prescription forms, safe disposal of surplus or wasted medicines, and safe custody of medicines keys, so that prescription forms and medicines are only accessible to staff with suitable authority.(Also requirement to record room temperature and ensure that staff have undertaken assessment of competence or continued learning in medicines optimisation).

**Current Performance**

Audit results will be available from the November meeting of MUAC.

**Comment on Current Performance**

Not applicable at this time.

**Planned action**

Ref	Action	Lead	Deadline
14.13	The following actions apply to all off site locations: 1. Develop revised guidance on the management of FP10 prescriptions.(DW) 2. Introduce and audit pre-populated tracking sheets.(DW) 3. Audit the storage of medicines and FP10s - to be undertaken by pharmacy staff every 3/12 (NC) 4. Implement daily room temperature monitoring with quarterly auditing as part of new outpatient facilities assurance process which reports into Medicines Utilisation and Assurance Committee (MUAC). 5. Check completion of annual update training. 6. Develop annual competency assessment.	Simon Mynes	30-Nov-15

**Update on Actions**

Revised SOP for the management of FP10s developed in conjunction with the Heads of Nursing.  
 Pre-populated tracking sheets developed and being rolled out from 20th July.  
 Communication to staff via Daily Email 02/09/15 and 04/09/15 and Vital Signs 04/09/15.  
 Audit visits commenced in Sept. 2015.  
 Audit of pre-populated sheets ready to commence once they are returned.  
 Temperature recording to be implemented in November.  
 Competency assessments developed for the handling of FP10 prescriptions, medicines keys and medicines.  
 Enhanced security arrangements implemented at Mount Gould – locks changed on cupboards.  
 Clear defined process for the disposal of waste medicines developed and disseminated to all staff.

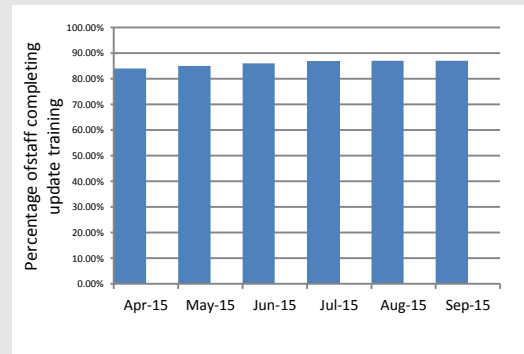
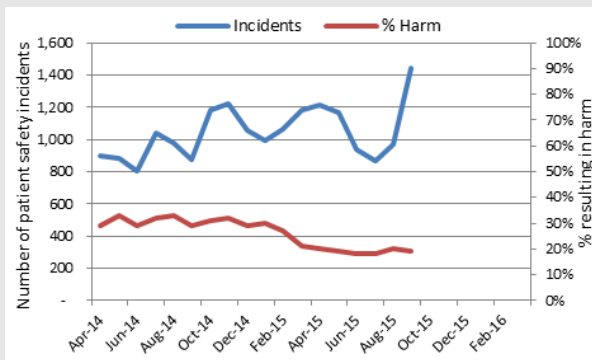
## Quality governance

### Derriford Hospital:

- The Trust must ensure that all staff are aware of their role in incident reporting and there are systems and process in place to monitor not only individual incidents but trends and themes.(Particular link to Urgent and Emergency - see 7.1)
- Ensure that the dissemination of information from investigations following incident reporting should be communicated more thoroughly to support learning across the trust.

### Current Performance

#### Source: Performance Databook



### Comment on Current Performance

The Trust's incident reporting rate of 14.55 incidents per 100 admissions places Plymouth Hospitals firmly within the national upper quartile and demonstrates a positive reporting culture.

The increase in reporting during September is due to tidying up of incidents which have been sat in the holding areas on Datix. There was a backlog of 408 incidents from 01/04/2015 – 31/08/2015; without these the number of incidents reported would be 1037 and reporting rate 10.44 %

Incident reporting is part of Trust induction and mandatory update training. For September 87% of all staff have completed their update training.

### Planned action

Ref	Action	Lead	Deadline
5.2	Recirculate communication in Daily Email and Vital Signs as part of a regular programme of communications.	Comms Team	31-Dec-15
5.5	Develop and deliver Governance module of Service Line Director & Service Line Manager training package. This will clearly set out the requirements of the service lines and include a section on incident reporting.	Steve Mumford	30-Dec-16
5.6	Develop Quality Governance Staffnet page that will share learning, trends and themes.	Steve Mumford	30-Dec-15
5.7	Complete roll out of new Service Line governance reports which will be reviewed at quarterly meeting with the Service Line (minimum) to review all Governance outputs including incidents, led by the Clinical Governance Lead.	Clinical Governance Leads.	Complete
5.8	Create a 'REACT' learning bulletin for each Serious Incident which will be signed off by EDs and circulated to all Matrons and Clinical Governance Leads for wider distribution to relevant staff groups. The sharing of this learning with staff will be tested via the Risk and Incident Team Serious Incident Assurance Visit programme.	Rachel Newport	Complete

5.9	Develop Quality Governance web page that will share learning, trends and themes.	Steve Mumford	30-Dec-15
5.10	Complete roll out of new Service Line governance reports which will be reviewed at quarterly meeting with the Service Line (minimum) to review all Governance outputs including incidents, led by the Clinical Governance Lead.	Clinical Governance Leads.	Complete
5.11	Publish anonymised RCAs on Staffnet page.	Risk & Incident Team in liaison with Comms Team	Ongoing for every SIRI

## Update on Actions

5.2 Article in Vital Signs 09.10.15

5.5 The Governance module of the Service Line Director & Service Line Manager training package is in draft form. First session to be delivered November 15.

5.11 Team have been briefed that when RCAs are submitted to the CCG a learning bulletin must be created and an anonymised RCA must be added to Staffnet.

Mount Gould Hospital: The Trust should review the process for incident reporting to ensure that all staff act in accordance with the risk and incident reporting policy. An electronic incident reporting system (DATIX) was in place which staff confirmed they were trained to use. However, we saw examples where personal responsibility for reporting safety incidents was not taken by staff. A revised incident reporting policy was recently introduced across the trust. Staff we spoke with told us they were not aware of the new policy and could not recall any communication about its introduction. This meant that consistency in reporting and the full extent of safety incidents was not fully assured, placing people at risk of similar incidents occurring in the future.

#### Current Performance

Incidents reported for Chronic Pain. Source: First Service Line Governance Report.

	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
No. SIRI* raised	0	0	0	0	0	0	0					
No. SIRI overdue	0	0	0	0	0	0	0					
Duty of Candour <sup>1</sup>	0	0	0	0	0	0	0					
No. Moderate	0	0	0	1	0	1	0					
No. Mod overdue	0	0	0	0	0	0	0					
Duty of Candour <sup>1</sup>	0	0	0	NA	0	1	0					
No. Near Miss	0	0	0	1	0	0	0					

#### Comment on Current Performance

The Chronic Pain Service Line Governance report has now been produced and discussed with Service Line management leads

#### Planned action

Ref	Action	Lead	Deadline
14.18	Develop and deliver Governance module of Service Line Director & Service Line Manager training package. This will clearly set out the requirements of the service lines and include a section on incident reporting.	Steve Mumford	30-Dec-16
14.19	Deliver presentation to MGH staff, content to include overview of Incident Management and Duty of Candour.	Risk & Incident Team with Di Sheppard.	30-Sep-15
14.20	Undertake assessment of all of the offsite services and locations to best determine the most appropriate methods of communicating with teams and provision of training which will include communication on the policy, attendance on some sites and ensuring service lines and care groups understand their responsibility towards staff so that they are aware of their individual responsibility for incident reporting and receiving feedback and learning.	Rachel Newport and Steve Mumford	Assess by 31/10/15 Delivery of plan to be defined based on assessment

#### Update on Actions

14.18 The Governance module of the Service Line Director & Service Line Manager training package is in draft form. First session to be delivered November 15.

14.19 Chronic Pain Services is booked in for DoC/Incident Management training for 15th December 2015; this is their next CME meeting.

14.20 Community Paeds at Child Development Centre had Duty of Candour training on 17th September 2015. Assessment of services provided underway to identify where services are solely provided off site

Mount Gould Hospital: The Trust should Improve the dissemination of learning from safety incidents and complaints. There was no record of further action or the lessons learned in three out of five of the incidents. This meant that there was a risk that similar incidents would not be prevented from happening in the future.

**Planned action**

Ref	Action	Lead	Deadline
14.22	REACT' learning bulletin for each incident circulated to all Matrons and Clinical Governance Leads for further dissemination.	Rachel Newport	Complete
14.23	Publish anonymised RCAs on Staffnet.	Risk & Incident Team in liaison with Comms Team	Ongoing for every SIRI
14.24	Develop Quality Governance web page that will show learning, trends and themes.	Steve Mumford	30-Dec-15

**Update on Actions**

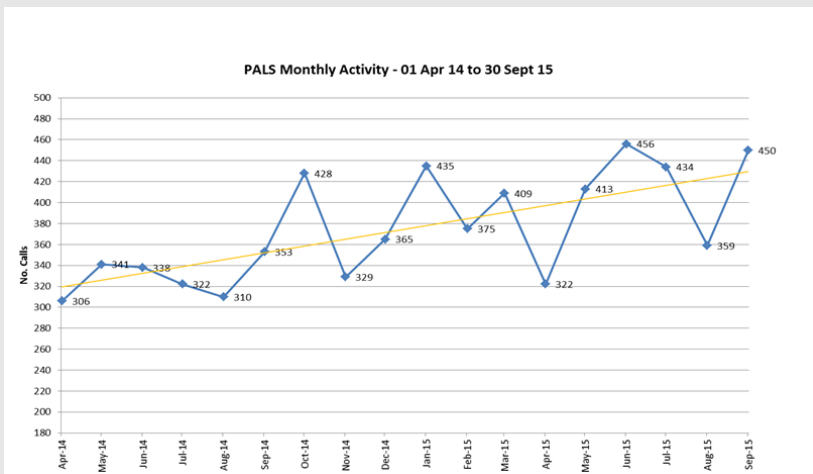
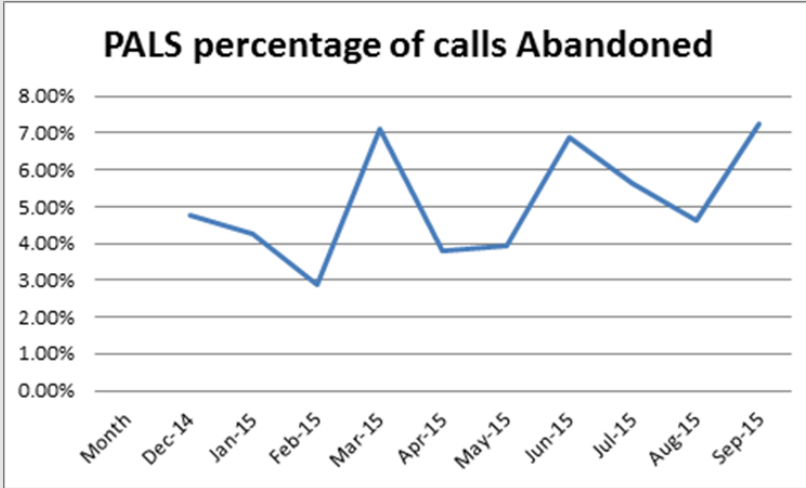
14.23 Team have been briefed that when RCAs are submitted to the CCG a learning bulletin must be created and an anonymised RCA must be added to Staffnet.

The first Service Line Governance report for Pain was produced in August 2015 and discussed 23/09/15.

Derriford Hospital: The Trust should ensure that the PALS department is able to respond promptly and efficiently to patients and visitors to the hospital. There was a lack of posters or directions regarding how to access the PALS team.

**Current Performance**

Source: Telecom system database



**Comment on Current Performance**

The PALS Team were transferred to the Netcall system in December 2014, which had reduced the overall number of calls missed or left unanswered. Netcall enables us to closely monitor the levels of calls abandoned and received. The above chart shows an increase in September which is partly attributed to staffing issues in the department and the number of calls received overall. For September there was an increase in the number of calls and face to face interactions for PALS; the charts above demonstrate that activity and calls abandoned generally correlate. An additional PALS person was appointed 27 October which will improve the situation. Information has been circulated with staff throughout the Trust to ensure that they are aware of PALS and know how to direct patients and members of the public to their services. The office on level 6 has greatly increased awareness of PALS and is reflected in the number of walk in and face to face enquiries.

**Planned action**

Ref	Action	Lead	Deadline
5.12	Update PALS and Complaints information in the Patient Bedside Booklets which are available at every bedside.	Jayne Glynn/Kylie Glynn	30-Sep-15
5.13	Introduce posters relevant to each ward or department detailing how to raise a concern – initially through the clinical team or alternatively signpost to PALS or Complaints.	Jayne Glynn/Kylie Glynn	30-Sep-15
5.14	Increase PALS presence on Level 6 and improve signage throughout hospital at lifts and key points.	Jayne Glynn	31-Mar-16
5.15	1. Explore cost and implementation of 'info point' stations at each exit providing free taxi call facility and up to 4 additional numbers, one of which would be to PALS. 2. Finalise decision about implementation. <b>Financial Impact: Revenue Above Budget £3,000</b>	Jayne Glynn	1. Complete 2. 31/03/2016
5.17	Undertake a review of the quality of the PALS service.	Jayne Glynn	31-Dec-15

### Update on Actions

5.12 Quotes received from RNS Publication, can only deliver the completed booklets by 31 Dec 15. Draft being reviewed and updated in preparation for publication. Sponsors sought by external company. Second meeting held with RNS publications to agree possible improvements to booklet content on 15 October 2015. Alternative examples received 19 October 2015.

5.13 Noticeboard review for wards will consider what information should be included on existing posters. Currently there are various options across wards and departments.

5.14 Plans submitted for executive approval as part of the retail provision review, will increase PALS footprint on level 6.

5.15 1. Complete: Second meeting held to progress infopoint. Implementation costs established and possible infopoint locations identified. Taxi company are not willing to pick up additional costs at present.

2. Further enquiries being made about taxi contract. Decision to be made about progressing and absorbing the cost for 2 infopoint locations funded by the Trust.

Derriford Hospital: The Trust should review the provision of translation services in the emergency department to ensure they can be provided in a timely manner. (This particular concern related to access to British Sign language trained interpreters of which there are very few in the region.)

Mount Gould Hospital: The Trust should ensure patients have access to information on translation services should these be required.

**Current Performance**

Poor service provision will be identified via complaints; themes will be identified and any arising action monitored through Patient Experience Committee.

**Comment on Current Performance**

No complaints identified for the period January 2014 to October 2015 (28/10/15).

**Planned action**

Ref	Action	Lead	Deadline
7.12	ED 1. Investigate with Language Empire the possibility of using Skype 2. Review whether flash cards are being used and if they are effective. 3. Consider developing cards for sign language for ED. <b>Financial Impact: Revenue Above Budget £5,000</b>	Jayne Glynn	31-Mar-16
14.32	Mount Gould Hospital 1. Information on translation services to be provided to all clinics and locations. 2. Language Empire posters to be displayed in departments and areas to ensure patients understand they can request an interpreter – circulation through Patient Services Team. 3. Circulate updated information to all staff ensuring they are aware of the fact that translation service requirements should be identified as part of the booking process. 4. Update Public website to include details of interpreting services in multiple languages.	Jayne Glynn	31-Dec-15

**Update on Actions**

7.12 ED: Meeting held with Language Empire on 18 Aug 15. Advised of new BSL video translation service. Requested costings and logistics of implementation.

14.32 MGH: The booking process will identify when a patient needs an interpreter. This information is usually contained within the referral letter and then when the patient is booked on the waiting list, comments that they require an interpreter are added on. Reminder of the process to be circulated in Vital Signs 23 October 2015 and through Daily Email, ward clerks and medical secretary emails.

1. and 2. Additional posters have been received from Language Empire regarding the translation services.



Mount Gould Hospital: The Trust should ensure feedback from patients using Mount Gould Hospital is gathered, reviewed and acted on.

**Current Performance**

Friends and Family recommender percentage. Source: Service Line Governance report August 2015

	June	July	Aug	Sept	Oct	Nov	Dec
Pain Clinic	95	96					

**Comment on Current Performance**

**Planned action**

Ref	Action	Lead	Deadline
14.35	Review all off site services to ensure that feedback is gathered wherever possible.	Jayne Glynn	31-Dec-15

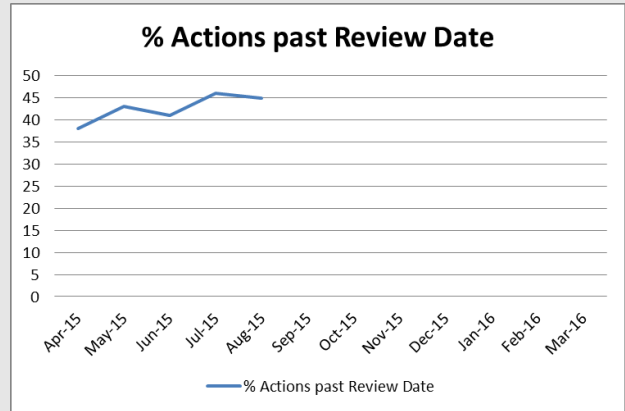
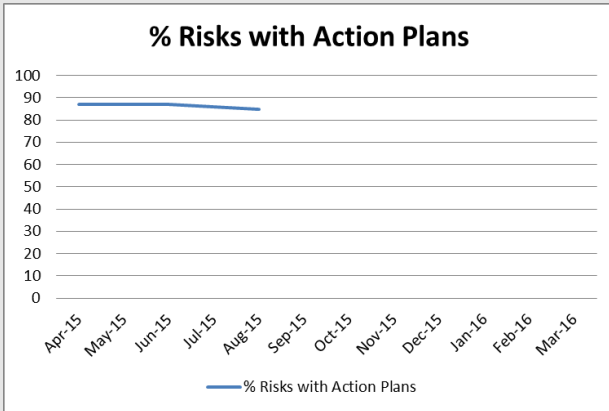
**Update on Actions**

FFT feedback mechanism in place for Mount Gould. Further work underway to identify all community sites and services – this will be an ongoing piece of work. Existing option for all patients to leave feedback through Trust Website.

Derriford Hospital: The Trust should ensure that staff understand their role in relation to the responsibility, management and oversight of the risk registers throughout all levels of the organisation related to outpatients and diagnostic imaging.(Outpatients)

**Current Performance**

Source: Datix report



**Comment on Current Performance**

Continue monitoring performance via Quality Managers review of all risks as part of the Service Line governance reports.

**Planned action**

Ref	Action	Lead	Deadline
5.18	1. Review the Trust's risk management arrangements. 2. Develop a plan for implementation of actions arising from the review.	Steve Mumford	30-Dec-15

**Update on Actions**

New risk management policy (draft) has been produced and is being reviewed by the Risk Management project group. This will form the basis of retraining across the organisation.

## Equipment

Derriford Hospital: The Trust should ensure that there is evidence that up-to-date servicing and maintenance of equipment has taken place. Not all equipment had a sticker identifying the last servicing date or when servicing / maintenance was next due. For example, urinalysis testing machines, blood pressure recording machines, or sluice masters (used for the safe disposal of soiled bedpans).

### Planned action

Ref	Action	Lead	Deadline
6.1	Design new date label to replace current 2 x label system to cover all maintenance / servicing / testing / inspecting for medical devices under MEMS remit. Deployment of new design label achievable through normal annual servicing round.	Jonathan Applebee	31-Jul-16
6.3	Review contract performance management processes for non-clinical equipment.	Julie Richards	30-Mar-16

### Update on Actions

6.1: New labels produced and being deployed as at 13-Aug-15. Reminder Daily email 28/08/15. 11/09/15: On schedule. We previously labelled sluice masters and stopped because the labels proved hard to keep clean and it was decided that to label them was unhygienic. All critical equipment is on the Estates Management System and the records are up to date.

## Urgent and emergency care

**Derriford Hospital: The Trust must ensure that all staff are aware of their role in incident reporting and there are systems and process in place to monitor not only individual incidents but trends and themes.**

**The Trust should review the governance systems to improve the function, monitoring and learning from incidents, complaints and risks.**

### Planned action

Ref	Action	Lead	Deadline
7.1	<p>1. Complete Safety Culture questionnaire - When we have enough responders the results will be feedback to the Lead and to the service line, will be discussed in safety and research forums and action taken accordingly. The survey will then be repeated at a later date (A Rickard).</p> <p>2. Consider how to improve feedback to staff and discuss this with the ED Safety Team 23/09/15 and at the Safety days scheduled for September and October 2015.</p>	Andy Kelly	31-Dec-15
7.14	Review of effectiveness of governance system to be undertaken by ED Safety Team (meeting 23/09/15) to see how we can improve things further, including how to improve sharing learning with other departments.	Andy Kelly	31-Dec-15

### Update on Actions

7.1: Systems already in place e.g. safety days, handover, screensavers, adhoc comms and Comm Cell.

1. Verbal feedback on Safety Culture Questionnaire received. In order to use this information and evolve the department's safety culture, multiple opportunities for staff to receive feedback and to further highlight areas of concern regarding our underlying safety culture are being planned. This will allow improved engagement regarding safety culture and positive work on the valuable feedback that 60% of our staff gave when we conducted the Safety Culture questionnaire. We also need to clarify various responses which were received in the free text sessions and plan to do this by speaking with small groups to understand certain areas of response in the survey, such as those reflecting our strong burnout climate and some perceived problems with leadership and teamwork. This will not only allow solutions to come from within our own multiprofessional cohort but, in the process of listening and engaging in meaningful discussion around our safety culture, we hope to provide effective feedback.

Senior doctors and nurses will be addressed at the monthly governance and education meeting (GEMS) on Wednesday 21st October and the plan is to start focussed feedback sessions in small groups on the same day. After these initial feedback sessions have happened, we will need to work on some further ongoing methods to ensure the culture of effective feedback and engagement is embedded within the department and also between the department and senior leaders in the Trust.

2. Have discussed with staff on first safety day. Have now separated safety and "social" newsletters. Also looking at communications to the team on news from the rest of the Trust. Discussed at meetings and on the four half safety days in September/October to seek the thoughts and feedback of staff. The team have started a new safety newsletter with the first one issued week commencing 12/10/15. Ongoing work to share feedback via safety alerts and daily handover.

7.14: We have introduced an extensive clinical governance overhaul which we are still embedding and developing. Mechanisms for learning and sharing currently include email, newsletters, screensavers, clinical governance meetings, handover, adhoc communication, safety notices, clinical guidelines, and safety days. The culture of the department was discussed at the safety days. Staff feel that the department has a transparent culture but don't feel that they get feedback about incidents.

**Derriford Hospital: The Trust must ensure that staff are administering medicines in line with the NMC standards for medicines management. (Issue identified with Propofol infusion)**

#### Planned action

Ref	Action	Lead	Deadline
7.2	1. Issue a reminder to all staff and include in the department newsletter. 2. Undertake monthly observations of propofol infusions Sept-Dec 2015.	Tim Parham Fiona Veale, Resus Lead	Completed and closed

#### Update on Actions

All staff are required to undertake online mandatory training on IV drug administration.

1. Complete - Email issued to all ED nurses 30/07/15 and staff 04/09/15. Guidance on the labelling of syringes issued by PG in Pharmacy. Switch to pre-made propofol syringes implemented from 9 Oct 15.
2. Action no longer required given switch to pre-made propofol syringes.

**Derriford Hospital: The Trust must ensure that patients receive appropriate and ongoing risk assessments such as mental health risk assessments and complexity scoring, to determine the appropriate place for them to be cared for and monitored.**

#### Current Performance

Ongoing assurance will be provided via repeat audits.

#### Comment on Current Performance

N/A at this time.

#### Planned action

Ref	Action	Lead	Deadline
7.3	1. Complete implementation phase for ED Mental Health proforma. 2. Gather user feedback and feed into the final version of the document. 3. Undertake a formal evaluation of this document (Research Fellow in ED). This will look at how the proforma is used, will amend the proforma as required and will result in the approved final version.	Anne Hicks	31-Oct-15

#### Update on Actions

Implementation phase complete.

Derriford Hospital: The Trust must ensure that patients in the emergency department that are awaiting x-rays in the corridor and the reception area away from staff vision are suitably monitored.

**Current Performance**

Successful implementation will be monitored via the call bell audit.

**Comment on Current Performance**

N/A at this time.

**Planned action**

Ref	Action	Lead	Deadline
7.4	1. Issue a reminder to staff that patients must be suitably monitored. 2. Investigate the possibility of installing wall mounted call bells in this area or purchasing wireless fobs which would feedback to the main call bell panel in ED. Financial Impact: Capital £20,000	Tim Parham	31-Oct-15

**Update on Actions**

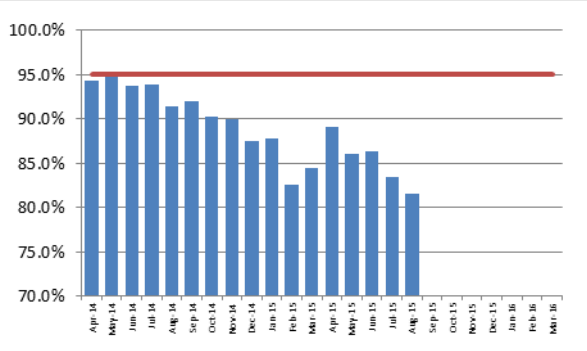
Patients in the corridor can be monitored via CCTV by the radiographers and also by staff in the staff room. Any patient that required close monitoring would always be accompanied.

1. Emailed reminder to ED nurses 30/07/15 and CDU staff 04/09/15.
2. Installation is complete and will be commissioned 04/11/15.

Derriford Hospital: The Trust must ensure that patients are protected from risk through improvement of systems and performance in relation to the time patients spend in the emergency department.

**Current Performance**

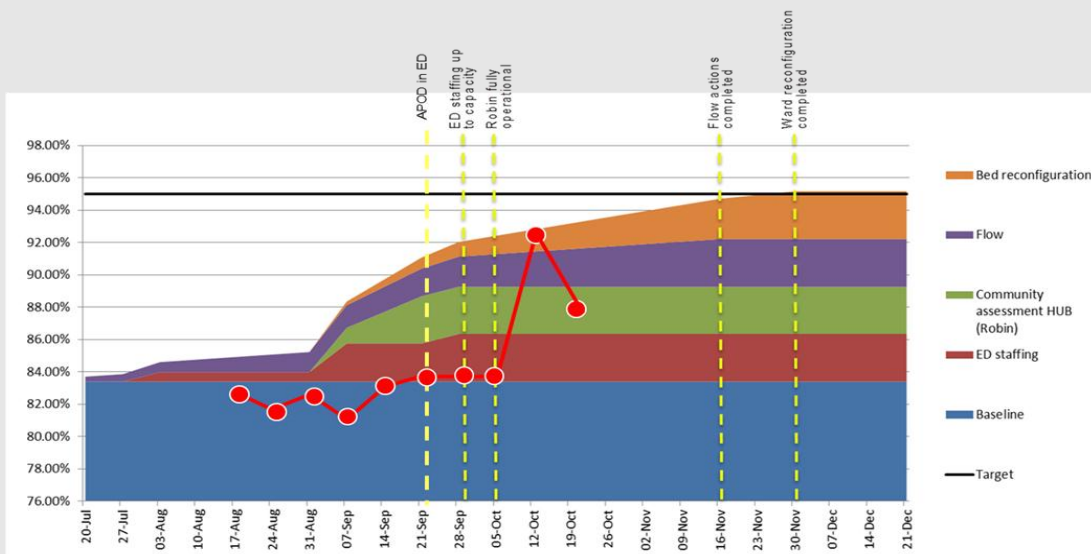
The Trust failed the A&E 4hr wait standard in August 2015 at 81.5% (source: Integrated Performance Report Trust Board September 2015):



Performance Against Improvement Trajectories. Source: Recovery Plan Update to Trust Board October 2015.

Introduction	<b>Operational plan</b>	Financial plan	Conclusion and next steps
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## Performance against improvement trajectories Emergency Department



**Comment on Current Performance**

Following an increase in ED attendances from Feb-15 through to May-15, the daily average volume of people attending ED has plateaued at 251 per day in August.

The numbers of patients triaged in the highest two categories is 6% higher than the same time last year and as a result performance against the 4 hour standard remains challenging.

An internal and cross-community ECIST plan to recover ED performance by the end of Q3 is being implemented.

The Performance Against Improvement Trajectories graphic demonstrates that each intervention will incrementally impact on our ability to deliver the 4 hour target.

**Planned action**

Ref	Action	Lead	Deadline
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7.6.1	Implement Service Improvement Project focussed on ED Flow designed to improve compliance with the 4 hour standard. Test several solutions - further actions to follow the results of the tests. <b>Financial Impact: Too early to cost</b>	Richard Best	Ongoing improvement programme
7.6.2	1. Increase staffing overnight when highest breaches occur. 2. Implement Acute Physician of the Day (APOD) in ED and electronic handover. 3. Implement ECIST recommendations for 'safer ward bundle' & flow.	David Brown	Ongoing improvement programme
7.7	Implement Service Improvement Project for MAU Flow focussed on optimising handover to wards, rapid consultant review and the appropriate use of the Ambulatory Care Unit. Test several solutions - further actions to follow the results of the tests. <b>Financial Impact: Too early to cost</b>	Richard Best	Ongoing improvement programme

### Update on Actions

7.6.1 Initial tests reveal opportunity for 40min reduction with changes to assessment and Xray flows. Further tests ongoing, This approach is to be standardised from November along with reception resource. Repeat tests have re-enforced benefit.

7.6.2 (1) - 3rd SHO in place overnight, 4th SHO starting 26th October. 5th doctor (F1) to start 1<sup>st</sup> December.

7.6.2 (2) - APOD in ED and electronic handover both active.

7.6.2 (3) - SAFER bundle work is ongoing. This is an iterative improvement cycle.

7.7 Three areas being pursued: MAU consultant and Team working in ED on afternoons 21/9 - significant impact.; increase flow to ambulatory care – impact has been minimal, tests to reduce time moving to ward from MAU – this has been stuck and is being re-launched in the next week to work on improvement.



Derriford Hospital: The Trust must ensure that the reception and waiting area in the emergency department complies with the Disability Discrimination Act.

#### Planned action

Ref	Action	Lead	Deadline
7.8	Estates team to work with ED to come up with a compliant and workable solution for the minors reception desk. <b>Financial Impact: Capital £10,000</b>	Julie Richards	30-Oct-15

#### Update on Actions

Finance is agreed. We are finalising the works to be done and should be able to complete the works subject to access being agreed over the next few weeks, by end November.

Derriford Hospital: The Trust should review privacy arrangements for patients arriving in the emergency department, either through reception or via ambulance, awaiting investigations such as x rays and while in the 'corridor' area.

#### Current Performance

Monitoring arrangements to be determined based on the outcome of the review.

#### Comment on Current Performance

N/A at this time.

#### Planned action

Ref	Action	Lead	Deadline
7.11	Undertake a review of privacy arrangements. Consider the use of privacy screens.	Tim Parham	Review complete

#### Update on Actions

The department trialled a new system for assessing patients by keeping three cubicles free but this was not successful. Currently assessing possibilities for use of alternate space which would free up a Minors solution.

Derriford Hospital: The Trust should review bereavement and viewing facilities within the department.

#### Planned action

Ref	Action	Lead	Deadline
7.13	Undertake a review of bereavement and viewing facilities.	Tim Parham	Complete

#### Update on Actions

Physical layout and space is an issue. Currently use cubicles 11, 14 and 15. Have adopted the use of a butterfly symbol to put on the door to increase staff awareness. The butterflies will be laminated and put into majors cupboard opposite room 11. If a patient is at the end of their life or has indeed passed away place the butterfly on the door.

Derriford Hospital: The Trust should review nursing leadership within the CDU.

#### Planned action

Ref	Action	Lead	Deadline
7.15	Band 7 manager of Short Stay ward to run CDU and Short Stay. Annual leave etc would be covered by a Band 7 in ED.	Tim Parham	Complete and closed

#### Update on Actions

Band 7 has started in post 12/10/15.

Derriford Hospital: The Trust should review the provision of a play specialist for the paediatric emergency department area. While there were some toys available and a television was on, these were designed for younger aged children. Though the department had free Wi-Fi available, this was not advertised to young people attending.

#### Current Performance

Monitoring to be determined once a solution is identified.

#### Comment on Current Performance

N/A at this time.

#### Planned action

Ref	Action	Lead	Deadline
7.16	<ol style="list-style-type: none"> <li>1. Work with the Childrens and Young People Service Line to seek input into the ED paed area in terms of advice re environment and resources and training for ED staff so that they can use the basic techniques 24/7.</li> <li>2. Explore opportunities for joint funding a post, or buying time from the CYP SL.</li> <li>3. Advertise WIFI to patients e.g. via a poster.</li> </ol> <p><b>Financial Impact: To be determined</b></p>	Ian Higginson	31-Mar-16

#### Update on Actions

1. In talks with Matron Dykes.

3. Wifi posters put up 13/08/15

## Medical care

**Derriford Hospital: The Trust must ensure that care and treatment is provided in a safe way for patients by ensuring premises are safe to use for their intended purpose, that is cleaning materials and sharps materials are stored securely in areas that are not accessible to patients or visitors. The sluices contained cleaning materials that were accessible and needles were left on unsecured phlebotomy trolleys in ward corridors.**

### Current Performance

Assurance of compliance to be obtained via Matrons' Checklist – see action 2.

### Comment on Current Performance

N/A at this time.

### Planned action

Ref	Action	Lead	Deadline
8.1	1. Review the existing COSHH policy. 2. Review compliance by adding this to the Matrons' checklist. Patient Safety Team to add to Meridian for the Matrons' checklist. 3. Review in 3 months. 4. Matrons to review the location of phlebotomy trollies when not in use and ensure these are not stored in an area that is unobserved or unsecure.	Sam Rafferty	30-Nov-15

### Update on Actions

Quality Manager attended Matrons' meeting on 8th October 2015. Matrons were asked to ensure that the Health and Safety risk assessment checklists are completed for their areas and any unresolvable issues are raised on their respective risk registers. Monitoring should then be via Service Line Quality Governance Reporting meetings where the risk register is reviewed. These meeting are minuted.

**Derriford Hospital: The Trust should ensure the safe storage of medical gases at all times.**

**Medical Care: A number of medical gas cylinders were stored in an area without any medical gas signage. This may pose a risk to patients, visitors and staff.**

### Current Performance

Audits are to commence in December. First report will be presented at January meeting of MUAC as part of the storage audit report.

### Comment on Current Performance

N/A at this time.

### Planned action

Ref	Action	Lead	Deadline
8.2	1. Implement the required signage. 2. Include medical gas storage in quarterly ward medicines storage audit. <b>Financial Impact: Capital £3,500</b>	1. Bryan Kidger 2. Simon Mynes	1. 30/09/2015 2. 31/12/2015

### Update on Actions

The required signage was delivered on site 22/09/15 and is currently being fitted by Estates. Training for pharmacist staff was delivered on 19th October. Training for ATOs to be delivered. Audits to commence in December as planned

**Derriford Hospital: The Trust should ensure that service specific mortality and morbidity meeting minutes are recorded in sufficient detail to enable any trends or issues to be identified, in order to take action or learning from the minutes.**

#### Planned action

Ref	Action	Lead	Deadline
8.3	Request that Service Lines feedback to the Care Group management team regarding how they document their M&M meetings currently. If a good example exists, an existing proforma will be shared as best practice. If not, a new proforma will be designed.	Phil Hughes	31/03/16

#### Update on Actions

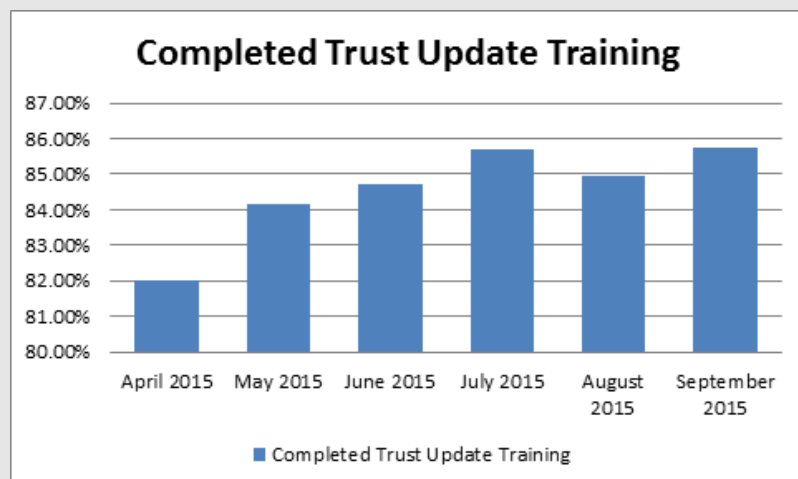
Rather than just focussing on the Medicine Care Group, the Trust as a whole via the Mortality Review Panel is looking at Mortality Reviews and the process within service lines for minuting their meetings. Phil Hughes, Medical Director will now lead this action as Chair of the Mortality Review Panel. An audit of what we are currently doing will be undertaken and then areas of standardisation will be agreed. The Quality Manager for Medicine has, as of 7th October 2015, provided evidence for 6 of 11 Service Lines. Further update to be provided in November.

Service Lines will be asked to present evidence of their M&M meetings to the Mortality Review Panel at least yearly. Phil Hughes is writing to service lines to detail what the expectations are related to the format and function of M&M meetings.

**Derriford Hospital: The Trust should ensure staff consistently complete infection control training and that patients with communicable infections requiring isolation are cared for in isolation.**

#### Current Performance

Source: Workforce Information data for clinical staff.



#### Comment on Current Performance

Infection Control is inherent in Trust Update training. Within the Medical care group this is scrutinised at quarterly Service Line Governance Meetings, with a report showing the breakdown by staff groups.

#### Planned action

Ref	Action	Lead	Deadline
8.4	Review the Mandatory training plan for the nurses.	Sam Rafferty	Complete and will be ongoing.

#### Update on Actions

This was raised at the Matrons meeting on 8th October. Difficulties with releasing staff to undertake training should be escalated to Head of Nursing. Infection Control is inherent in compliance with Trust Update training. Within the Medical Care Group this is scrutinised at quarterly Service Line Governance Meetings, with a report showing the breakdown by staff groups. For Nursing Staff this is also covered in the matrons' 2 to 1 with Heads of Nursing and performance reviews with Ward/department managers.

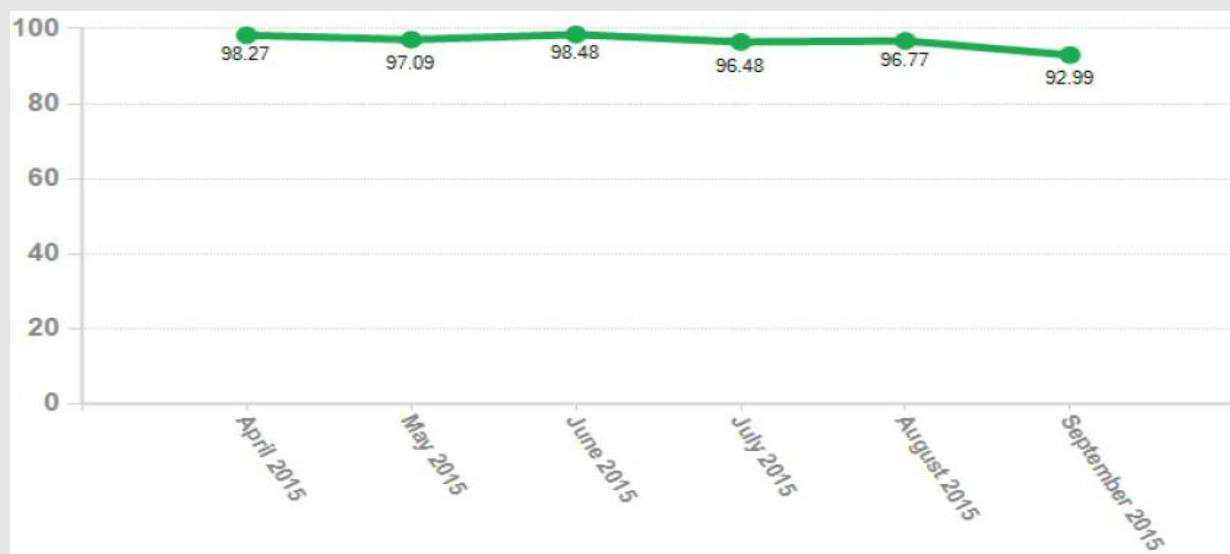
Derriford Hospital: The Trust should ensure risk assessments and care documentation for individual patients are consistently and appropriately completed by staff. For example VTE risk assessments were not consistently completed in full or actioned promptly.

**Current Performance**

Risk assessments are inherent in the Fundamentals of Care audits.

**Source: Meridian report (27/10/15) April to September 2015 for the Medicine Care Group for the following questions:**

- 11. Has the Waterlow score been completed on admission?
- 12. Within the last 24 hours, has the ongoing Waterlow score been recorded?
- 13. Has the pressure ulcer score (EPUAP) been recorded on admission?
- 14. Within the last 24 hours, has the ongoing skin assessment (EPUAP) score been recorded?
- 15. Has the Manual Handling Risk Assessment been completed on admission and is it up to date?
- 19. Has MUST assessment been completed?



**Comment on Current Performance**

See update on actions.

**Planned action**

Ref	Action	Lead	Deadline
8.5	Finalise consolidation of a number of assurance processes to form a Nursing Assessment and Assurance Framework (NAAF) that will make intelligence gathering and action from audits more effective.	Sam Rafferty	Complete and ongoing monitoring through Fundamentals of Care

**Update on Actions**

This continues to be embedded in Matron’s 2 to 1 meetings with the Heads of Nursing. Replacement for Pressure Ulcer risk assessment is currently being subjected to a pilot. Targeted work with key wards going forward via Matrons and Practice Educators with oversight at Matrons’ 2 to 1 meetings. Regular quarterly agenda item at Matrons meetings to review themes and trends related to fundamentals of care.

With regards to VTE risk assessments there needs to be further dialogue between the Care Group Director and the VTE lead to determine what the improvement plan should look like for the Care Group. The Quality Manager has asked the Care Group Director and Care Group General Manager to discuss at the Service Line Directors’ Meeting.

Derriford Hospital: The Trust should ensure that all staff are knowledgeable about the sepsis identification and management system in operation within the trust.

**Current Performance**

Audit results not yet available.

**Comment on Current Performance**

Not Applicable at this time.

**Planned action**

Ref	Action	Lead	Deadline
8.6	Action reframed: 1. Implement requirements of national sepsis alert re access to screening form to be available in all areas. 2. Implement programme of education. 3. Deliver ongoing 8 Step programme of work.	Paul McArdle/Tim Nutbeam	1. 31-Oct-15 – Complete 2. Complete 3. Ongoing improvement programme

**Update on Actions**

A sepsis programme has been introduced in ED and MAU. A formulated sepsis assessment tool has been implemented in areas where patients are admitted i.e. MAU, SAU, ED and Paediatrics. Regular safety briefings are held on MAU. Sepsis is included in Induction / Statutory update training. A nurse has been appointed with the responsibility of leading sepsis education and a programme of education is in place. Sepsis simulation is in place on MAU, a Researcher has been appointed to undertake simulation work and a student has been attached to MAU to undertake regular audit. Interim audit results for the Sepsis CQUIN are now available. It is recognised that the sensitivity of the audit could be improved to identify patients who might benefit most from this. This is currently being discussed with the CCG. A forward plan is being developed to address issues identified by the national CQUIN. A SEPSIS group reviews progress. An antibiotic app has been developed by Rob Tilley. In addition, software is being developed to pilot in ED which will help spot sepsis early. The next hurdle for this is interface management with IT.

Derriford Hospital: The Trust should ensure that the system for advising staff of the medical cover for medical outliers is disseminated efficiently and to all staff. A number of staff were not all aware of the email detailing cover arrangements. The medical outlier consultants had individual bleep numbers and on the staff handover sheets we saw these numbers were included but did not specify which consultant was caring for which patient. The electronic bed management system identified the consultant cover for the medical outliers. However, not all staff we spoke with were aware of this or how to access this information.

#### Current Performance

We will seek assurance of the effectiveness of this process by asking staff to test their awareness.

#### Comment on Current Performance

N/A at this time.

#### Planned action

Ref	Action	Lead	Deadline
8.7	Medical staffing plan for the next week is confirmed at the weekend staffing meeting each Friday. Share this information with all senior nurses via group email and include as part of the ward handover information the following week.	David Brown	Complete
	Ward reconfiguration project intended to limit the amount of Medical outliers required.		31/12/15

#### Update on Actions

Medical cover arrangements for the outlying wards have been stabilised with the same consultant team having responsibility for the wards for the week duration. Dedicated junior doctors are also allocated rather than doubling up with medical wards teams. Three outlier teams have been established who look after patients for one week at a time. Survey of ward teams to confirm their understanding of medical cover to be completed by end November. First two phases of bed reconfiguration are complete. Third phase expected to be complete by Dec 15.

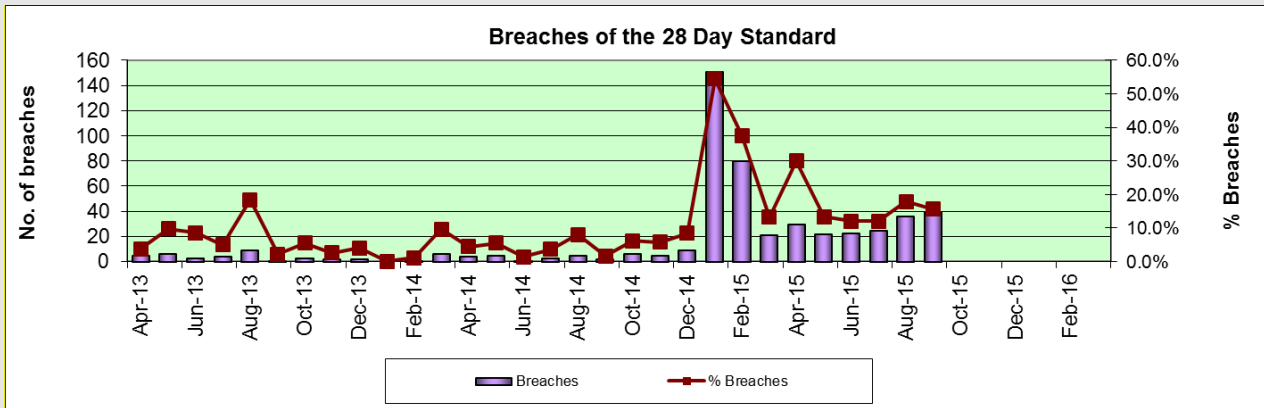


# Surgery

Derriford Hospital: The Trust must ensure there are systems in place so that the impact of system escalation does not delay patients who are cancelled at short notice and that they are re booked for their surgery within the 28 day requirement.

## Current Performance

Source: Performance Information Data Book 26/10/15



## Comment on Current Performance

There were 36 breaches of the 28-day rebooking standard in August 2015. The operational pressure is making it extremely difficult to rebook these cancelled patients within the 28-day window.

## Planned action

Ref	Action	Lead	Deadline
9.1	1.Undertake weekly list reviews (as per scheduling policy). 2. Consider bed bureau for elective bookings. 3. Improve scheduling of Level 1 patients, (implementation of outlook booking system to ensure greater visibility). 4. Maintain weekly monitoring of theatre utilisation, including relets and weekly RTT meetings chaired by Chief Operating Officer. 5. Review performance data and highlight concerns for individual patients to Service Line Managers.	Ian Wren	Complete

## Update on Actions

1. An Assurance Framework is being developed with the support of the Service Improvement Team to develop metrics which can be used to check compliance with weekly list reviews. The metric should be available within the next two weeks.
2. Lynher and Neurosurgery are starting bed bureau as proof of concept.
3. Scheduling policy approved by Surgical Care Group Governance meeting.
4. Weekly RTT meetings are in place. More metrics are being identified to monitor performance.

Derriford Hospital: The Trust must ensure that systems for booking theatre slots are robust and coordinated across the trust so that theatre time is utilised to provide a timely and consistent service. The system used for booking operations failed to identify when mistakes were made resulting in patients being cancelled. This placed patients at risk of harm due to delays in their treatment.

#### Current Performance

Arrangements for assurance and monitoring to be defined – see action point 4.

#### Comment on Current Performance

N/A at this time.

#### Planned action

Ref	Action	Lead	Deadline
9.2	1. Implement TIMS. 2. Undertake List reviews. 3. Redesign and application of scheduling policy. 4. Surgery Care Group Manager to identify mechanism and resources required to support implementation and monitoring of compliance and ensure that this links with ongoing Board oversight. <b>Financial Impact: Revenue above budget £40,000</b>	Ian Wren	TIMS 2016 Other actions complete.

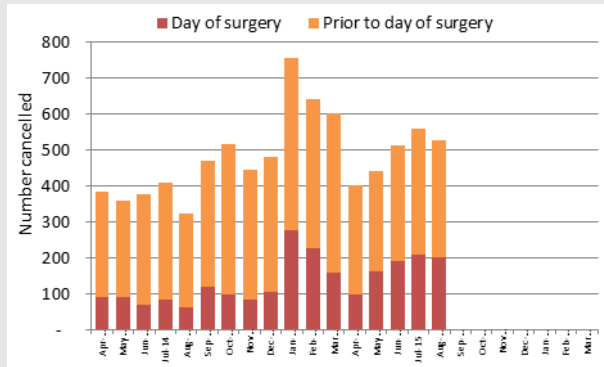
#### Update on Actions

- The Trust is disappointed with the progress with design and implementation of TIM's. If the concerns are not addressed within the next 4-5 weeks then the contract will be terminated. This action is therefore not on track to deliver.
- Metrics will be available within the next couple of weeks to ensure that list reviews are being completed.
- Scheduling policy approved by Surgical Care Group Governance meeting.
- A full set of metrics is being developed with the Service Improvement Team. Once the full set of metrics is available, these will be presented to Safety and Quality Committee.

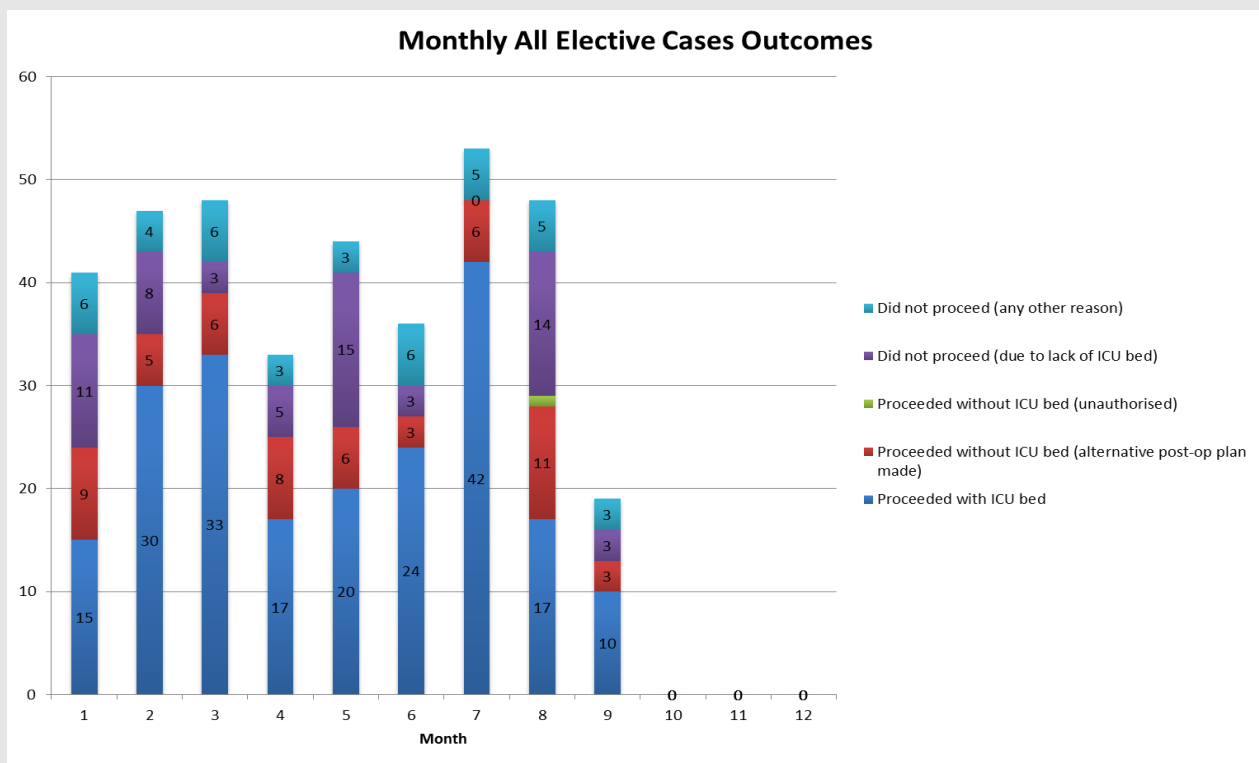
Derriford Hospital: The Trust must ensure that it improves the experience of patients by addressing the high numbers of elective operations that have been cancelled.

Current Performance

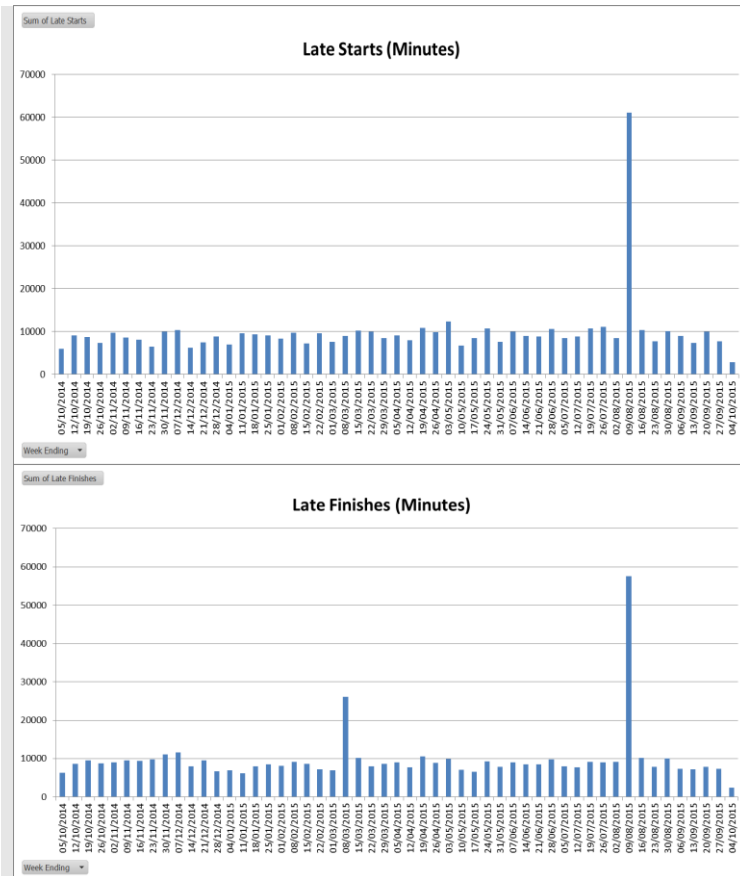
Cancelled Operations. Source: Integrated Performance Report to Trust Board September 2015.



Reduction in ICU cancellations and therefore cancelled operations. ICU cancellations are monitored continuously in a cancellation log. Source: Critical Care, data for calendar year.



Theatre Utilisation Elective sessions Jan-Aug 2015. Source: Performance Information



Period Utilisation  
 Total Utilisation For Period Selected **67.62%**

Aiming for 85%.

**Comment on Current Performance**

201 operations were cancelled on the day of admission in August 2015 representing 4.3% of elective admissions. A further 325 operations were cancelled in advance of the day of operation during the month. Bed availability continues to be the most prevalent reason for cancellation.

**Planned action**

Ref	Action	Lead	Deadline
9.4	Review bed configuration to ensure Surgical Care Group have c.300 beds available for emergency and RTT activity. <b>Financial Impact: Revenue above budget £1,152,000</b>	Ian Wren	31-Dec-15
9.5	Review theatre timetable and redistribute sessions to hard pressed specialties (those with higher cancellation rates)	Ian Wren	Complete
9.6	Improve overall scheduling of theatre cases and develop a care group process to review - level scheduling	Karl Trimble	Complete
9.7	Scope Service Improvement Project focussed on theatre start times, cancellations, scheduling and ringfencing surgical beds. <b>Financial Impact: Too early to cost</b>	Kevin Baber	Complete

**Update on Actions**

9.4 Phase 1 ward moves commenced 19/09/15 with SAU and Hound switch. Phase 2 Norfolk to Meavy was completed by 14/10/15. PIU Norfolk commenced its first full week on level 7 week commencing 19/10/15 and Merrivale is now partially open on level 10 and will be used to care for medical patients and the frail elderly. Phase 3 options appraisal complete with one final review by senior managers planned before proceeding.

9.5 Review complete.

9.6 Scheduling policy has been reviewed. Bed bureau proof of concept and development of metrics with Service Improvement Team.

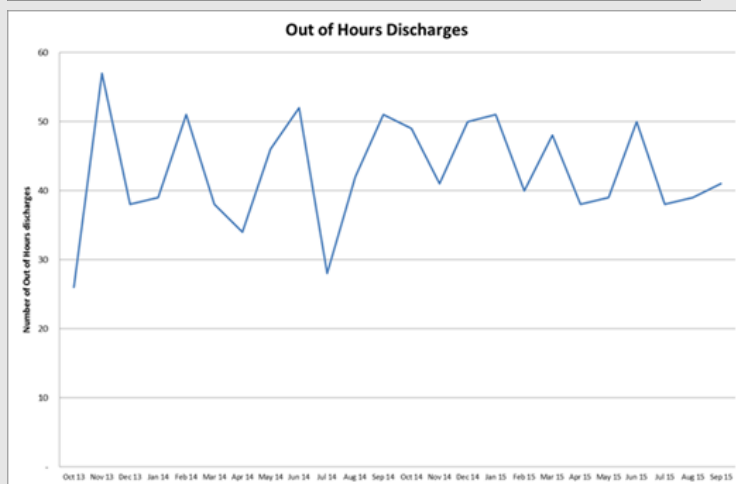
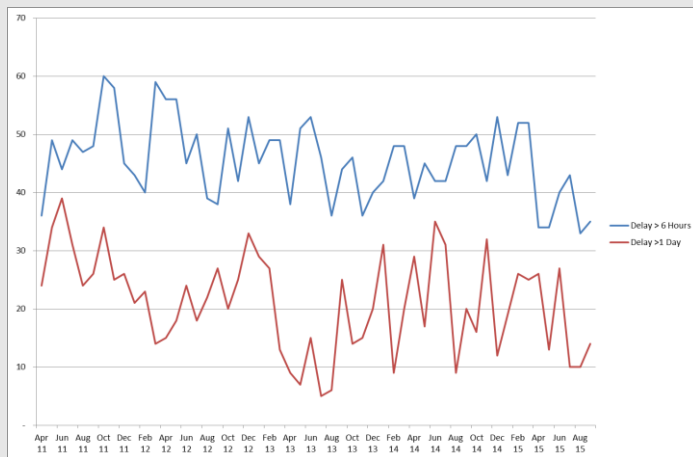
9.7 Emphasis changed to theatre stop time; a Stop Policy has been developed. Currently looking to implement the NCEPOD classifications for surgery which determines what constitutes urgent surgery.

## Critical care

Derriford Hospital: The Trust must ensure that the critical care service improves the experience of patients by addressing the significantly high levels of discharge from the unit that are either delayed for more than four hours or happen at night.

### Current Performance

Source: ICNARC



### Comment on Current Performance

As of 22 July 2015 this is working very effectively and continuing to improve. Ongoing review of process. Measurement of delayed discharges, times recorded. CQUINN target for <10% >24h delays. New hospital target for <6h discharge. Step change noted in July; performance monitoring continues.

### Planned action

Ref	Action	Lead	Deadline
10.1	Revise Discharge process. Established principle of moving all dischargeable ICU patients within 6 hours and between 0700-2200.	Sam Waddy, Ed Cox, Kevin Baber, HONS	Complete and closed

### Update on Actions

N/A

Derriford Hospital: The Trust should prioritise pressure area care within critical care to reduce the incidence of pressure ulcers. The target levels for patient harm from falls or pressure ulcers being considered as 'acceptable' at levels above zero should also be reviewed and reflected on. Data on venous thromboembolism (VTE) or urinary tract infection (UTIs) should also be captured in dashboard reports and incident data.

**Current Performance**

QUALITY IMPROVEMENT														
	Current Month Target	Tolerance	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
<b>SAFE CARE</b>														
Grade 2,3,4 Hospital Acquired Pressure Ulcers	8		5	3	1	2	2	6						

**Comment on Current Performance**

The original action plan was based around practice in Penrose ward as this has historically been an area of high incidence of unit-acquired pressure ulcers. The most recent data extracted from Datix does not show a sustained reduction in the rate of unit-acquired pressure damage, nor does it show a significant increase. However, Matron has reviewed the September incidents and many are related to medical devices (NG tubes, ET tubes, foot pumps) and span both Penrose and Pencarrow Wards. To help reduce these incidents further the Matron for Critical Care invited the Lead Nurse for Tissue Viability (ME) to attend the ICU Band 7 meeting on 20 October 2015. Out of this meeting, new actions have been generated:

- Trial of new pressure relieving material to reduce pressure damage from ET tapes.
- Reinforcement of the correct way to 'hammock' an NG tube to reduce risk of pressure damage from the tube.
- We will be holding a 'Pressure Ulcer Awareness' week in November to coincide with STOP the Pressure Ulcer day.
- Development of a new Mnemonic 'ULCER' to heighten awareness of device related pressure damage and how to reduce this.
- Continued use of the mini-RCA tool for all unit-acquired pressure damage to establish whether the damage was avoidable or unavoidable.
- Review the use of Hibiscrub as a routine decolonising agent due to risk of skin drying and subsequent moisture damage.
- Refresh of Penrose action plan as many actions now complete

**Planned action**

Ref	Action	Lead	Deadline
10.3	1. Develop new nursing metrics dashboard (corporate). 2. Discuss all pressure ulcer incidents at weekly incident meeting. 3. Implement new Rapid Review tool reviewing all ICU-acquired pressure ulcers to assess whether they were avoidable. 4. SW to check last 2 year's VTE events with VTE CNS. 5. Add VTE prophylaxis assessment to Innovian.	Ed Cox	Complete

**Update on Actions**

1. Nursing Assessment and Assurance Framework in place and reported to NMOC quarterly.
- 2 and 3. Established action plan for pressure injury on ICU. All pressure ulcer incident reports are discussed at the weekly incident meeting. The Band 7s are using a rapid review tool to review all grade 2 pressure ulcers and an RCA is completed for any grade 3 or 4s.
4. Last 12 months VTE data shows 8 events. No avoidable events.  
All VTE events involving ICU patients will now be included on the ICU dashboard.
5. Innovian has a VTE prophylaxis assessment daily.  
99% of ICU patients are catheterised therefore urinalysis is always positive due to colonisation. Deciding if a UTI is present is a complex clinical analysis similar to VAP, there is not a definitive test.

## Derriford Hospital:

- The Trust should review the level of physiotherapy provided to general and neurosurgical critical care patients, as it did not meet recommended levels of the Faculty of Intensive Care Medicine for therapeutic treatments.
- The Trust should review the level of pharmacy support provided to general and neurosurgical critical care patients, as it did not meet recommended levels of the Faculty of Intensive Care Medicine.
- The Trust should review the provision of mental health support given to patients and their families who are or have been patients in the critical care unit.

## Planned action

Ref	Action	Lead	Deadline
10.5	1.Meet with contract team to establish deficiencies in commissioning. (completed) 2.Establish list of requirements in preparation for 2016 commissioning. 3.Meet with Support services lead and establish model for expansion of physio provision in ICU. <b>Financial Impact: Revenue above budget £87,400</b>	Sam Waddy	31/04/2016
10.6	1.Meet with contract team to establish deficiencies in commissioning. (completed) 2.Establish list of requirements in preparation for 2016 commissioning. 3.Meet with Support services lead and establish model for expansion of pharmacy provision in ICU <b>Financial Impact: Revenue above budget £43,800</b>	Sam Waddy	31/04/2016
10.10	1. Progress the business case with clinical psychology team to improve psychology provision for ICU. 2. Submit the business case to the contracts team to be discussed in this year's round of contract issues both in relation to intensive care and psychology. <b>Financial Impact: Revenue above budget £31,400</b>	Sam Waddy/ Rupert Noad	31/04/2016

## Update on Actions

Met with commissioning team. Contracting Issues document submitted to PHT Finance department for inclusion in the 2016/17 contract negotiation.



**Derriford Hospital:** The Trust should review the professional development of the nursing team within critical care and ensure over 50% have a post-registration award in critical care nursing, as recommended for safe care by the Faculty of Intensive Care Medicine. Appraisal rates should be improved to trust levels and continuous professional development should be funded and included in this review, to ensure staff skills and rates of retention are continually improving.

#### Planned action

Ref	Action	Lead	Deadline
10.7	Develop robust Training Needs Analysis to ensure that over 50% of the nursing team achieve post registration award in critical care nursing. <b>Financial Impact: Revenue above budget £57,100</b>	Intensive Care education team lead Peter Branfield	August 2017

#### Update on Actions

ICU Course is now re-established in the locality and run by the education team at Derriford and nurses are now attending this course to achieve a post graduate qualification. All new starters will have planned progression towards qualification. Currently 35% with the course ongoing. This will take significant time to reach 50% target due to the length of the course.

**Derriford Hospital:** Decisions around consent, mental capacity assessments and the use of any deprivation of liberty or restraint should be improved in the critical care medical notes.

#### Current Performance

Audit data when it is available.

#### Comment on Current Performance

Not applicable at this time.

#### Planned action

Ref	Action	Lead	Deadline
10.9	1. Update Daily checklist to ensure capacity assessments are documented more clearly. 2. Add to the audit diet to provide a check on compliance.	Sam Waddy	Complete and closed

#### Update on Actions

Tool is in place in ICU notes and the team is working on utilisation. Too early to audit yet, but have added to audit diet.

## Maternity & gynaecology

Derriford Hospital: The Trust must ensure that the environment and equipment on the delivery suite is fit for purpose and is able to be effectively cleaned and decontaminated to prevent the risk of cross infection. Sinks were badly stained and none of the sinks had elbow operated taps. Infection control risks were not on the maternity risk register.

### Planned action

Ref	Action	Lead	Deadline
11.2	Matron to work with Estates to cost and plan the recommended refurbishment. <b>Financial Impact: Capital £112,000</b>	Nicola Phillips	30-Nov-15

### Update on Actions

Refurbishment has been costed and planned and placed on the Risk Register as there is no funding to proceed.

Replacement sinks have been approved in principle, however Matron has not yet been able to obtain a definite date for their installation.

Derriford Hospital: The Trust must ensure that there are sufficient resources to ensure the cleaning of blood and body fluid spillages does not pose a risk that clinical staff are unable to meet the clinical needs of patients in preference to cleaning.

### Planned action

Ref	Action	Lead	Deadline
11.3	1. Review rostered time for cleaning and impact on provision of patient care. 2. If the review concludes that dedicated cleaning provision is required, undertake options appraisal for the possible solutions.	Nicola Phillips	30-Nov-15

### Update on Actions

We currently have an HCA funded establishment to ensure that there is sufficient staff on duty to ensure the environment is maintained to the required standards of cleanliness.

The Matron for Delivery suite has had a discussion with the Hotel Services Lead and a contract meeting was held on 21st September to review the requirements needed. HCA staff are continuing to provide cleaning support to the delivery suite and surrounding areas whilst the new contract is discussed. A work checklist is on the delivery suite to ensure that all staff are aware which items have been cleaned. Costings were received from SERCO in order to plan for additional services – this quote came back but was based on the ad hoc rates and exceeded £70 000 pa; a new quote has been requested. It is likely that this is not going to be achieved during this contract and we will need to continue to use clinical staff to provide the level of cleaning required.

**Derriford Hospital: The Trust must ensure that the ratio of supervisor of midwives to midwives is at the recommended level of 1:15 . The high ratio was not on the maternity risk register at the time of our inspection.**

**Planned action**

Ref	Action	Lead	Deadline
11.4	1. SoM's to complete training. 2. New Risk Manager to commence in post (due to start August 2015 and is a SoM).	Janette Thomas	31-Oct-15

**Update on Actions**

Three SoM's currently in training. Two due to finish in October 2015. Two further places commissioned for 2015- 2016 cohort. Full Time SoM commenced in post (July 2015) and taking an increased caseload.

The ratio of supervisor of midwives to midwives is included on the Risk Register. The successful qualification of two existing members of staff, and the appointment of two new staff (already qualified Supervisors of Midwives) will mean that the date of Dec 1<sup>st</sup> 2015 to achieve the 1:15 ratio is achievable. This will however be dependent on the LSAMO appointing the two new members of staff as SoM's by that date. Two additional Midwives will commence the course this month (Oct 2015) for ongoing succession planning.

**Derriford Hospital: The Trust must ensure that staff working in gynaecology are supported to have annual appraisals.**

**Current Performance**

Source: Performance dashboard 26/10/15.

CORE STANDARDS														
	Current Month Target	Tolerance	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
<b>APPRAISALS</b>														
Appraisals completed by due date	95%	85%	44.4%	45.9%	45.7%	54.5%	54.6%	57.1%						

**Comment on Current Performance**

See update on actions below.

**Planned action**

Ref	Action	Lead	Deadline
11.5	Devise Appraisal forward planning programme.	Cath Williams	31-Mar-16

**Update on Actions**

From Gynae point of view there are 50 nurses on the appraisal list:

- 34 in date
- 4 have been completed but not recorded correctly
- 7 have dates for appraisal over the next 4 weeks
- 1 on maternity leave, 1 on long term sick leave, 2 have left the Trust, 1 AWOL – going through HR process.

The plan for the ward is for the 2 x band 6s to undertake their appraisal training (1 has already completed this) and a rolling programme is being put together between them and the band 7 to ensure that appraisals are completed 1-2 months prior to an individual's incremental date.

Both outpatients and Ocean are such small teams that the band 7s are able to ensure that everyone has an appraisal each year in line with their incremental date; they have not been a problem.

The problem appears to be with admin and this has been escalated.

Derriford Hospital: The Trust should ensure all patient records on the delivery suite are stored securely and have accessible monthly midwife to birth ratio figures in order to be able to confidently audit and monitor safe staffing levels.

**Current Performance**

Satisfactory response to the Environment Audit question for CDS 'Are all notes trolleys locked if not in use or attended by an identifiable staff member if in use?' 07/10/15. Source: Meridian.



Satisfactory response to the Environment Audit question for CDS 'Are there any unattended notes on the ward/department (CDS) that may be accessed by patients, or other non-authorized persons?' 07/10/15. Source: Meridian.



**Comment on Current Performance**

None.

**Planned action**

Ref	Action	Lead	Deadline
11.6	1. Undertake a sweep of the ward to check that there are no other records held insecurely. 2. Commission a review of records storage to review the storage of notes awaiting coding. Financial Impact: Capital £1,000	Nicola Phillips	31/10/2015

**Update on Actions**

Records that are used for current episodes of care are stored in a locked central store on labour ward or are in the delivery rooms. The records identified during the inspection were old records used for teaching. The Notes trolley is now stored in a cupboard with a padlock. Notes waiting for coding are all in blue boxes in the main CDS office; only staff with swipe access can enter the delivery suite. However these notes are now going to be moved to the Risk Office which is locked when unattended. Monthly review included on Matrons check list which can be seen on Meridian. Monthly Midwife to Birth ratio is integral to the dashboard and has been calculated for this purpose.

Derriford Hospital: The Trust should ensure the process for learning from incidents is embedded in practice at ward level.

#### Planned action

Ref	Action	Lead	Deadline
11.7	Develop a further governance board for all clinical areas with such learning integral to the agenda.	Trudie Roberts	30-Nov-15

#### Update on Actions

All learning is circulated via Maternity newsletters and email. Included within the action plan and audit trail arising from each incident report is a check to make sure that staff are aware of the incident and actions.

Consideration is being given to putting on a study day: learning from incidents. This may be included within the Mandatory Training block as many current sessions are devised reflective of this agenda.

Derriford Hospital: The Trust should provide a staffed perinatal mental health service. The trust had developed a pathway but there were no personnel in place such as specialist mental health midwives or psychologists or plans to develop these services. As a result, clinicians were only able to signpost women to external mental health services. These issues were not on the maternity risk register at the time of our inspection.

#### Planned action

Ref	Action	Lead	Deadline
11.8	1. Care Group Manager to maintain ongoing consultation with CCG to highlight service disparity. The context of CQC concern will be articulated in these discussions. 2. Issue to be added to the risk register. <b>Financial Impact: Too early to cost</b>	Ian Wren	31/04/2016

#### Update on Actions

It is understood that there will be a national fund to support the provision of this service but guidance on how bids may be placed to secure some of the funding is unlikely to be released until the end of the financial year. Discussed with commissioners week commencing 19/10/15.

Derriford Hospital: The Trust should have a baby abduction policy, and review the policy and procedure for discharge of patients from the maternity unit.

#### Current Performance

Assurance mechanism to be determined once policy has been developed.

#### Comment on Current Performance

N/A at this time.

#### Planned action

Ref	Action	Lead	Deadline
11.13	Develop Policy.	Pauline Claridge	31-Oct-15

#### Update on Actions

Policy currently out with guideline group for review. Ratification scheduled for November 16th.

## Children and young people

Derriford Hospital: The Trust must ensure the safety of adolescents with mental health issues when using any of the paediatric services at all times. Some of the staff on Wildgoose Ward told the CQC that they did not feel confident in looking after the number of children and young people admitted with mental health problems. During a recent safeguarding incident the internal security team although present were not able to assist in restraining a young person who was trying to leave the unit.

### Current Performance

This will be monitored via the Datix process and regular meeting with CAMHS staff. The number of incidents reported on Datix where children are at significant risk to themselves or others is small. They are however extremely difficult to manage and challenging for staff.

### Comment on Current Performance

1 serious incident in June 2015. No CAMHS incidents since June 2015

### Planned action

Ref	Action	Lead	Deadline
12.2	1. Provide additional training for security services. 2. Meet with Director of Facilities and undertake a risk assessment for Wildgoose Ward. 3. Create a de-escalation area. 4. Deliver additional training re Mental Health Act to nursing staff in September/October 15. <b>Financial Impact: Capital £1,000</b>	Anita Dykes	31/10/15 (training) 31/01/16 (de-escalation area).

### Update on Actions

Meeting has taken place with Director of Facilities, a risk assessment has been completed for Wildgoose Ward and the need for a de-escalation area has been identified.

L1, 2 and 3 de-escalation and conflict resolution training is being provided for ward staff (3 year programme). Additional training re Mental Health Act has been provided for medical staff.

The programme has now been reduced to 2 years (Sept 15). Working with CAMHS to develop joint strategies for management of teenagers with challenging behaviours.

De-escalation area has been identified. Working with a charity organisation called "Give a Child a chance" to re-furbish the room.

**Derriford Hospital: The Trust must ensure that all children using the acute or community paediatric services have a care plan in place that is updated at regular intervals or when changes occur to the child or young person.**

#### Current Performance

Audit data will be available from November for community (a 3 monthly audit will occur as part of supervision with annual full notes audit.)

Audit data will be available from March 2016 for the Acute service who will complete an audit 3 months after implementation and will audit annually thereafter.

#### Comment on Current Performance

Not applicable at this time.

#### Planned action

Ref	Action	Lead	Deadline
12.3	1. Revise and implement Community care plan. 2. Undertake document review for Acute service. 3. Implement Audit programme.	Sue Syers and Anita Dykes	Community – Complete 31 December 15 (Acute)

#### Update on Actions

Acute service have undertaken a document review and will adopt the Bristol Care Plan format. Care plans for the acute service have gone for typesetting and drafts will be available in November for pilot.

Community Care plan has been revised and implemented. Audit of community paediatric care plans will take place in November 15.

**Derriford Hospital: The Trust should ensure the milk kitchen is kept locked so it is not indiscriminately accessible to patients or visitors on Woodcock Ward (used by the High Dependency Unit (HDU) and Child Assessment Unit (CAU)).**

#### Planned action

Ref	Action	Lead	Deadline
12.5	1. Undertake review of milk kitchen. 2. Lock the kitchen in the interim. 3. Plan and undertake refurbishment. <b>Financial Impact: Capital £5,000</b>	Anita Dykes	Review complete September 2015  Lock fridges and freezer complete September 2015  Awaiting quote for refurbishment, unlikely to take place due to the capital freeze.

#### Update on Actions

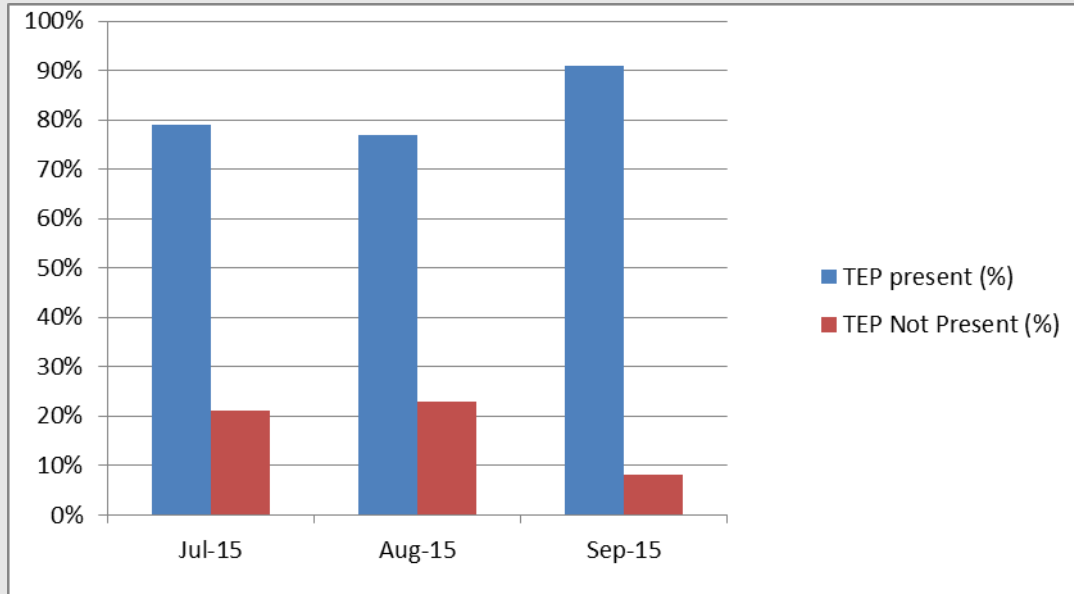
Fridge and freezer now have clasp locks as the room needs to be available to parents for bottle cleaning and making up of feeds. Sink has been replaced. The quote for re-furbishment has gone to estates for costing, however all capital projects have been withdrawn and we are unlikely to get funding from elsewhere.

## End of life care

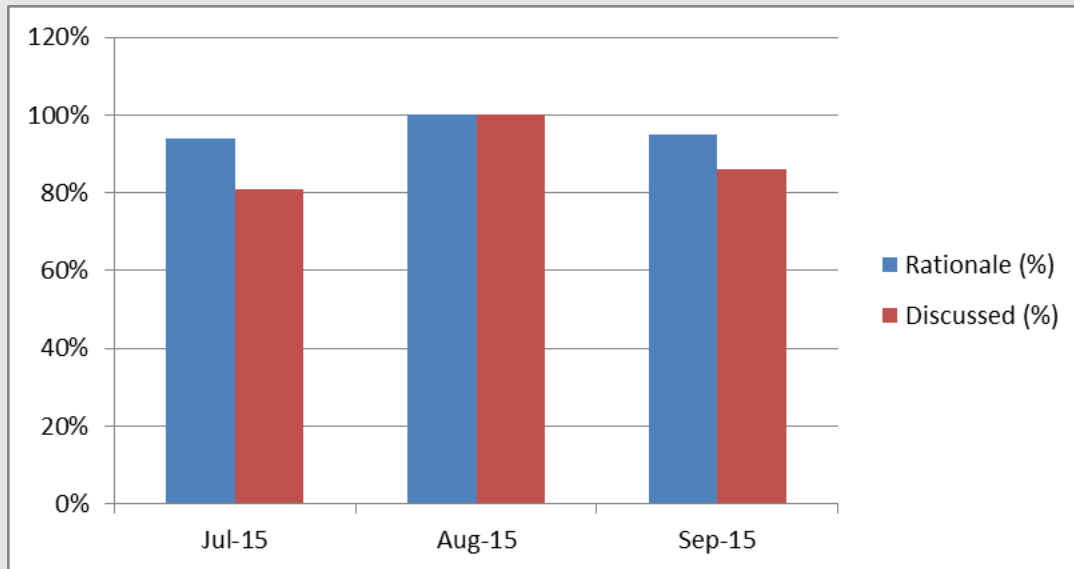
Derriford Hospital: The Trust must ensure that Treatment Escalation Plans (TEPS) are fully completed to ensure patients' choices and preferences and ceilings of care are identified.

### Current Performance

Resus Team Emergency Calls Retrospective TEP Audit July-September 2015



Patients who were not for resuscitation (NFR) but had rationale and discussion documented on their TEP:



### Comment on Current Performance

The TEP Emergency Calls Retrospective Audit (July-September 2015) highlights that the Treatment Escalation Plan (TEP) and Resuscitation Decision Form is present and completed in the medical notes of 77-91% of those patients who have had a call for the emergency team to attend. 94-100% of patients had the rationale documented for the decision 'not to resuscitate' and had ceilings of care determined for their future management. 81-100% of patients/relatives had been involved in the resuscitation decision process.

From August 2015 the audit now assesses for patients who lack capacity whether the mental capacity assessment component of the TEP has been completed. From August 2015, 5 patients who lacked capacity did not have the mental capacity component of the TEP form completed. Where appropriate the Nurse Lead will discuss incomplete TEP forms



directly with medical staff. Action taken to address trust wide is set out below (13.1).

**Planned action**

Ref	Action	Lead	Deadline
13.1	1. Integrate into resus training programmes and junior doctors induction. 2. Implement TEP Audit onto Meridian for individual service lines to be responsible for their TEP completion compliance to identify areas and monitor improvement. Arrange meeting between Phil Hughes, Jamie Fulton and Jackie Williams to agree implementation and process and discuss including within service line performance dashboard.	Jackie Williams	31-Jan-16

**Update on Actions**

1. Updated Resus Officers with areas for TEP improvement and integrated into Resus Training immediately. Changed current Emergency Call Audit Form to capture areas identified by CQC. Added key points of learning to new doctors induction training (Aug)
2. Meeting with Medical Director who has approved the roll out of the Meridian TEP audit; 10 x sets of random notes audited from each clinical area (by a junior doctor) with outcome of audit fed into Service Lines / Care Groups. Presentation to be given to HMSC (date to be agreed). Meridian Audit Tool has been reviewed by stakeholders.

Derriford Hospital: The Trust should ensure that patients' dignity and respect are considered in the arrangements for discreet use of lifts when transporting the deceased.

#### Current Performance

We will undertake a review to check that the actions have addressed the concerns raised. Spot check with porters to be undertaken by end December 2015.

#### Comment on Current Performance

N/A at this time.

#### Planned action

Ref	Action	Lead	Deadline
13.3	Investigate the installation of split lifts to improve privacy and dignity with a view to requirement for additional lifts within the long term overall strategic plan. <b>Financial Impact: Several million</b>	Julie Richards	31-Dec-16
13.4	1.Service existing trolley to reduce 'rattling' sound. 2.Review existing mortuary trolley to explore possible improvements.	Jayne Glynn	1. Complete 2. 31/03/16
13.5	Ensure porters are aware of and have access to the override swipe card (to prevent the doors opening to the public on each floor when they need to use public lifts) accessible in the porter's office as some porters were not aware of this or the code needed.	Louise Pelley	31-Oct-15

#### Update on Actions

13.3: Current major refurbishment of all lifts.

13.4: Service of mortuary trolley completed 20/07/15. Review of existing mortuary trolley underway.

13.5: During the time of the CQC inspection the lifts were undergoing refurbishment. After the refurbishment of the lifts the porters have now been given access back to the Theatre lift via a swipe card enabling the porters to move patients with dignity and respect. The porters will also be given access to the code on the main lifts.

## Outpatients and diagnostic imaging

Derriford Hospital: The Trust must ensure that it improves the premises for patients who are using Interventional Radiology, to make sure there is a suitable environment for patients to recover post procedure.

### Current Performance

To be monitored through PLACE.

### Comment on Current Performance

N/A at this time.

### Planned action

Ref	Action	Lead	Deadline
14.3	<p>1. In the short to medium term patients must not be delayed in returning to their end destination for non-clinical reasons and the senior in charge of the area will escalate any delays to the deputy service line manager.</p> <p>2. Progress the OBC for the Lightwell development which will deliver the long term solution with regards to suitable infrastructure.</p> <p><b>Financial Impact: Revenue above budget £60,000. Capital £8,500,000</b></p>	Wendy Colley / Mark Walker	<p>short term immediately, medium term option to be identified, long term OBC to Board summer 2016 for approval to proceed to TDA</p>

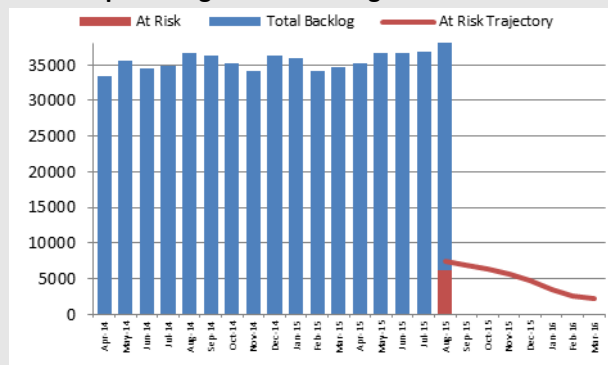
### Update on Actions

The Full Business Case for the new facility will not be ready until at least next summer. The build will be long and complicated so Imaging will not have a new facility for at least 18 months. Post procedure rooms are part of Phase 2 of the development so are several years away. A more immediate solution must therefore be identified. MW to meet with Estates team to identify options.

Derriford Hospital: Systems and process are in place to manage the backlog of follow-up appointments and the backlog of imaging reporting, to mitigate the risks to patients of delayed diagnosis and treatment. Action plans to manage the backlog need to be focused and realistic in achieving what is required.

**Current Performance**

**Follow-up Backlogs. Source: Integrated Performance Report to Trust Board Sept 2015**



**Comment on Current Performance**

At the end of August 2015, there were 37,199 patients past their ‘see-by-date’. Of these, 6153 patients are flagged as being at clinical risk ; 1251 ahead of the reduction trajectory to reduce this cohort.

**Planned action**

Ref	Action	Lead	Deadline
14.5	1. Identify solutions and trajectory to eliminate the at risk backlog in Ophthalmology. 2. Deliver trajectories to clear the at risk backlog in all specialties. 3. Address the lower risk back logs through rapid service improvement projects over the next 6 months in high volume services.  Imaging - duplicate of next action (14.6)	Phill Mantay	31/03/16

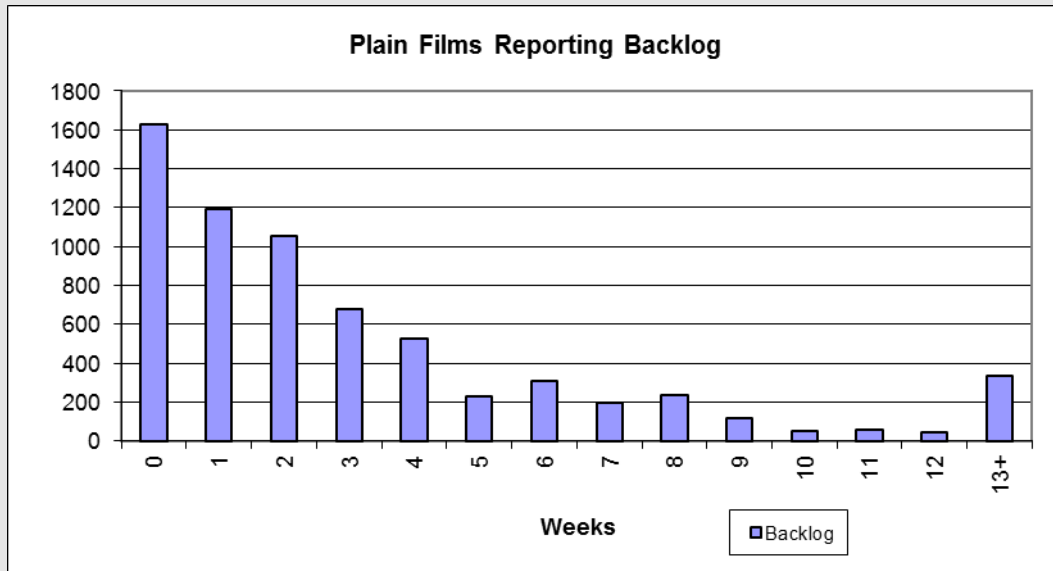
**Update on Actions**

Service Lines have completed the risk identification and have now assessed every patient on the follow-up waiting list in line with the clinical risk criteria. This means that patients in high risk groups can now be systematically prioritised for appointments. Service groups have also produced trajectories to reduce the number of patients at risk of harm who have waited past their see-by-date. For seven service lines, a process of service improvement will be undertaken as part of the agreed CQUIN scheme in order to review and improve how follow-up care is offered in high volume specialties.

Derriford Hospital: Systems and process are in place to manage the backlog of follow-up appointments and the backlog of imaging reporting, to mitigate the risks to patients of delayed diagnosis and treatment. Action plans to manage the backlog need to be focused and realistic in achieving what is required.

**Current Performance**

Plain films reporting backlog. Source: Imaging Dashboard at 26/10/ 15



**Comment on Current Performance**

Imaging sending 700 per week to Medica for plain film reporting with a 72hr turnaround has now been initialised. This capacity is to be used for GP film reporting to ensure fixed and sustainable capacity and enable the Consultant Radiologists at PHNT to focus on the Planned and Urgent category in all modalities.

**Planned action**

Ref	Action	Lead	Deadline
14.6	1. Outsource GP plain films to an external reporting house until backlog is eliminated at 700 per week as of 06/07/15. 2. Work in partnership with procurement to seek external reporting houses that are capable of providing reporting capacity for all modalities if required - in progress with Steve Carter. Fee for service in situ for PHNT consultant reporters particularly for CT and plain film. 3.Continue to seek to fill consultant vacancies and manage long term sickness absence	Wendy Colley / Mark Walker	Backlog to be delivered by 31/08/15 Work with Procurement 01/10/15

**Update on Actions**

- 1.Outsourcing is continuing and backlog has reduced. Current trajectory indicates that the backlog will be eliminated at the end of the year. A previous trajectory of improvement assumed an earlier agreement from Medica and therefore the backlog is slightly behind plan but improvement for the next two months until full recovery of the backlog is anticipated. Imaging is currently exploring options of outsourcing with another provider to reduce the backlog even sooner and using Medica in tandem for a short period of time to achieve this.
- 2.A meeting has been held with potential providers for an external partnership on 10/09/15 and is ongoing with a potential implementation date by late November. Formal external reporting contract is close to sign off.
- 3 New Cardiac/General Consultant to start in November 2015, Breast Consultant in October 15 and an advert for a neuro Consultant is out with an interview date arranged for November 2015.

Derriford and Mount Gould Hospitals: The Trust must ensure that they review the managerial and governance arrangements in outpatients, so that risks systems and processes to minimise likelihood of risk in relation to access to services and a standard booking process for appointments across all departments are fully implemented.

#### Current Performance

To be defined.

#### Comment on Current Performance

Not applicable at this time.

#### Planned action

Ref	Action	Lead	Deadline
14.7 & 14.15	1. Review the current management arrangements around the outpatient administration function.	Kevin Baber	Complete
MG	2. Ensure the continued roll-out of the OMC structure to ensure best practice booking.	Samantha Sheridan	30/10/15
	3. Work with Service Lines to ensure there is an adequate framework to enable best practice booking - pilots and test of changes.	Samantha Sheridan	Complete

#### Update on Actions

Roll out of the OMC has commenced and will continue until all relevant Service Lines are engaged.

The work with the Service Lines will form part of the 8-step game changers for the Trust.

1. Review of management structure complete. Recommendations will now be implemented.
2. The roll out of the OMC model has been delayed to allow for a period of "bedding-in" for those areas that have gone live. Currently determining pace and priorities for continued roll out which is planned to be concluded by Dec. 2015.
3. A series of standards and expectations have been agreed by the Clinical Administration Programme Board which establishes a framework of roles and responsibilities to enable best practice booking. A set of expectations for Service Lines has been developed and signed off by the Exec Team. This includes for example making sure that rotas are completed.

**Derriford Hospital: The Trust should ensure that staff (inc reception staff) in outpatients have an adequate understanding of safeguarding to ensure that incidents are identified appropriately.**

#### Current Performance

Staff understanding will be tested via questionnaire/survey.

#### Comment on Current Performance

N/A at this time.

#### Planned action

Ref	Action	Lead	Deadline
14.8	1. Make bespoke workshops available to all staff. 2. Implement focussed workshops for Reception staff in outpatients.	Jo Brancher	29-Feb-16

#### Update on Actions

All staff have L1 safeguarding training as part of mandatory training. Bespoke training has been offered but there has been little uptake to date. This will now be promoted through Matrons.

**Derriford Hospital: The Trust should ensure that there is adequate and suitable seating available for patients waiting for an outpatient appointment and that these seating areas are not obstructed.**

#### Current Performance

To be monitored through PLACE.

#### Comment on Current Performance

Not applicable at this time.

#### Planned action

Ref	Action	Lead	Deadline
14.9	Review Ophthalmology, Fracture clinic and Oncology outpatient areas to identify the issues and appropriate solutions. Solutions may include additional seating but may also focus on booking practice to manage peaks in arrivals into the department. Further timelines will be identified when solutions are agreed. <b>Financial Impact: Capital £50,000</b>	Bev Cox	31/08/2015 - In line with the action stated, timeline now revised to 31/03/16 to reflect arising actions.

#### Update on Actions

Ophthalmology: Bariatric chair has been sourced; with clinic changes this has created more space in the Department.  
Fracture Clinic: Receptionist to email Service Line Manager updates during the day wc 21/09/15 to report when it gets to standing room only. We will probably need to do this for a few weeks to get a clear picture of the problem.  
Oncology: We have outgrown the current footprint and these issues are on the Risk Register. In recognition of this, a Strategic Outline Case was submitted to relocate Chemo DCU to Burrator L8 and expand Onc OP into the current Chemo footprint on L2 in Aug 2014. This was put on hold due to the Trust's need to first address the medical bed base. We have subsequently agreed to establish a project board and steering group to progress this from November 2015. Meanwhile, we have maximised use of the space currently available and continue to provide overflow seating in the Mustard Tree during peak times.

Derriford Hospital: The Trust should review the processes for the referral to diagnostic imaging scans, particularly in computed tomography to reduce the risks of patients receiving multiple scans.

**Current Performance**

Monitor via Incidents on Datix from December 2015.

**Comment on Current Performance**

N/A at this time.

**Planned action**

Ref	Action	Lead	Deadline
14.10	Commence the electronic vetting service and roll out electronic requesting to all services. This will eliminate paper requesting and with a mandatory pause and check built into the electronic system, this risk will no longer be evident	Abdul Gafoor -SLCD	31-Nov-15

**Update on Actions**

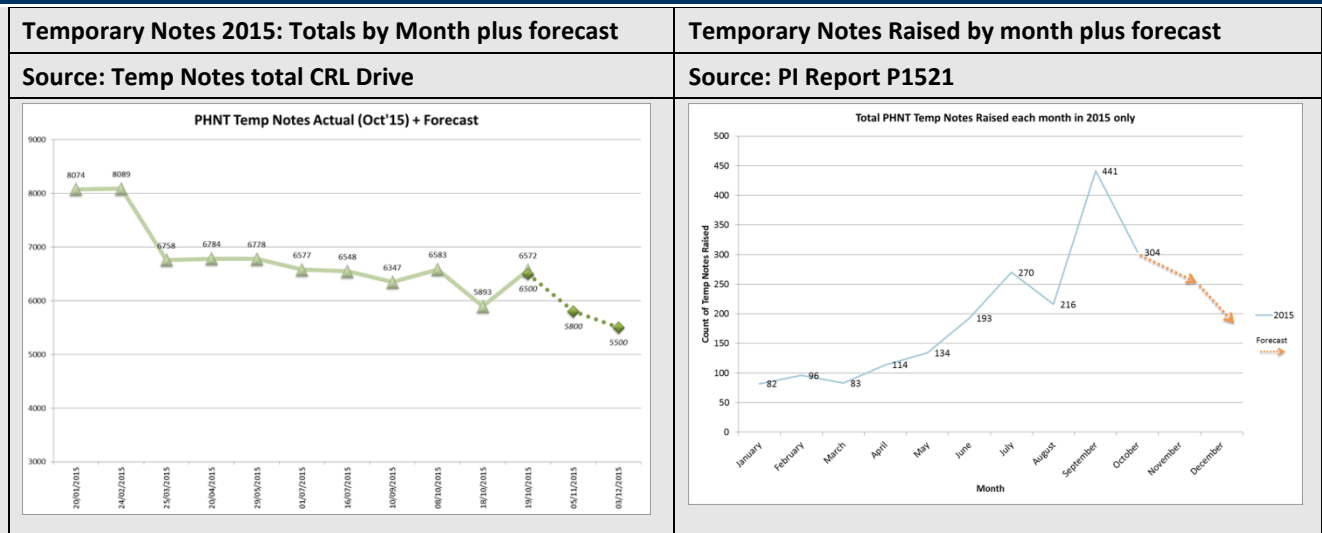
Electronic vetting is now 92% complete and movement towards Electronic Ordering is now underway.

Update 07/10/15: Hope to go live Oct/Nov but there is a possibility of delay until January to finalise the project plan. To ensure that the right clinical governance decisions are being made.



Mount Gould Hospital: The Trust should assess the impact of using temporary notes for clinics, to ensure systems do not compromise patient safety. We were told that on occasions the full set of people’s medical records were not available, and that temporary notes would be made up for patients. There was inconsistency in the approach doctors took in their decision to see patients with temporary notes. There was incomplete audit data to enable us to assess the impact of this.

**Current Performance**



**Comment on Current Performance**

See update on actions below.

**Planned action**

Ref	Action	Lead	Deadline
14.27	<ol style="list-style-type: none"> <li>Continue to monitor the creation of Temporary Case Notes report on a monthly basis.</li> <li>Target departments that create a high number of Temporary Case Notes to identify reasons for this and ensure that training is completed if a valid reason is not provided.</li> <li>Undertake a Temporary Notes amnesty across the Trust to be complete by 31/07/16.</li> <li>Review Main Notes to check if the Temps have already been amalgamated and not deleted from iPM.</li> <li>Monitor the Tracing Report.</li> <li>Review temporary notes incidents raised on Datix.</li> <li>Continue with all of the above until the implementation of eNotes.</li> </ol>	Anne Bussell	Ongoing awaiting the implementation of eNotes

**Update on Actions**

New reporting provided by the Performance Team has helped the eNotes Business Change Team (BCT) to identify areas/individuals raising high numbers of temporary folders. This has revealed an increase in the number of Temporary notes raised in September. This was due to the number of late addition clinics and the inability of the Clinic Prepping teams to source the main case note in time for the clinic. There were also staffing issues within the team. The BCT are now working with the Central Prepping Team to improve processes and the graph above shows a reduction in raised temporary notes in October. They are also working on identifying the backlog of temporary folders which may or may not have already been merged with the main notes. This work will significantly reduce the overall number of temporary folders.

Mount Gould Hospital: The Trust should ensure GP letters are typed and sent within the required time scale, so that information is available to relevant practitioners when required. Staff told us there had been problems with delays of typing and sending doctors' letters to GPs. On average this had been four days later than the agreed target. One patient we spoke with had experienced a delay in their initial consultation as the letter had arrived after the date of the first appointment.

**Current Performance**

**Typing Delays. Source: Databook 26/10/15**

Trust Total	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Max					247	30						
Mean	4	3	4	5.0	4.51	4.21						
> 2 Days					2,324	2,043						
Total					4,599	3,843						
% Breaches					51	53						

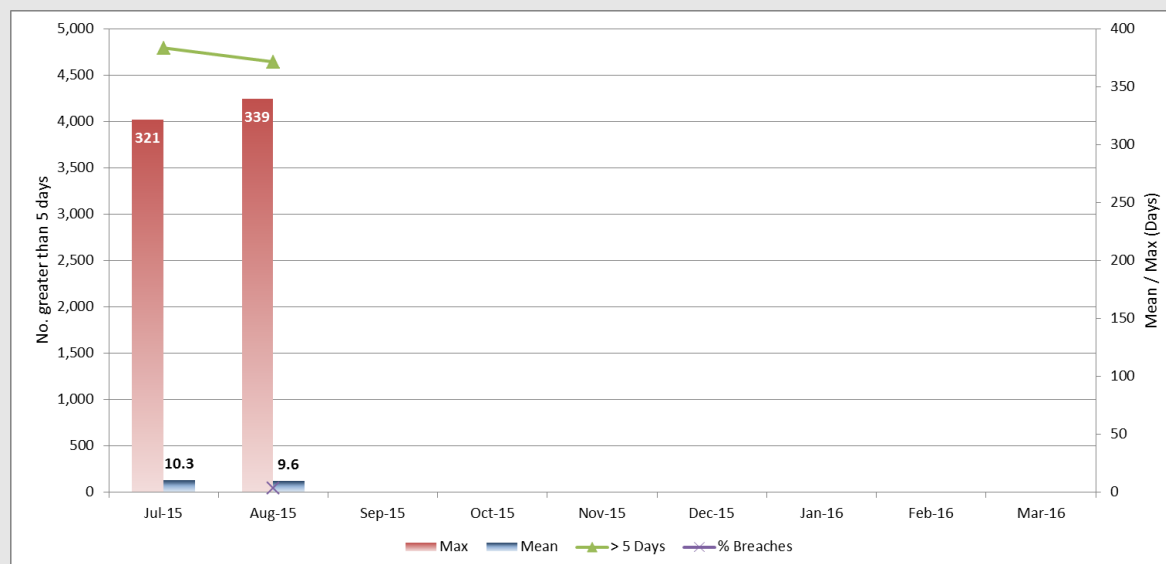
**Signing Delays. Source: Databook 26/10/15**

Trust Total	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Max					334	308						
Mean	10	5	14	12.0	10	7.77						
> 2 Days					2,242	2,826						
Total					3,757	4,542						
% Breaches					60	62						

**Overall Delays. Source: Databook 26/10/15**

Trust Total	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Max	321	339	326						
Mean	10.3	9.6	8.89						
> 5 Days	4,792	4,642	4,497						
Total		10,111	9,838						
% Breaches		46	46						

**Overall Delays. Source: Databook 26/10/15**



**Comment on Current Performance**

A lot of work has been put into making the reporting mechanisms more sophisticated and as a result of this we are now more able to report directly from the digital dictation system. There is a current workstream around ensuring that the data quality controls are sufficiently rigorous to ensure accuracy of reporting. Once these data quality errors have been worked out of the system then the organisation should see a significant improvement in the performance of its service lines. Despite there being some data quality errors, it is clear that the majority of service lines are improving their position with a majority achieving either the standard or are very close to it.

**Planned action**

Ref	Action	Lead	Deadline
14.30	Continue weekly review of typing and signing as part of the overall RTT weekly review process.	Sam Sheridan	Ongoing weekly review

**Update on Actions**

Despite the improvements made to date work continues with more challenged specialties and the following actions are currently being scoped out with the relevant areas:

- Redistribution of backlogs where there is not a pooled typing arrangement.
- Review of buddying systems for clinical and secretarial staff.
- Ensuring an appropriate level of admin time prior to annual leave for clinicians.
- Attempting to establish a system of pooled approvals rather than it being dependent on individual availability.

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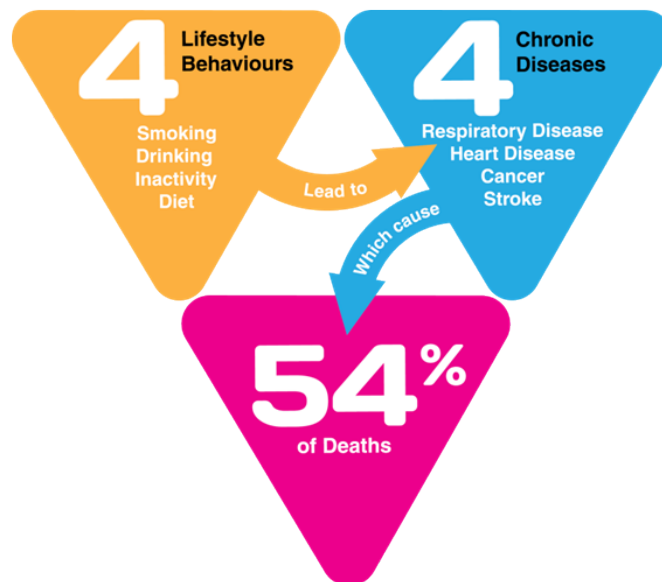
# CARING PLYMOUTH

10 December 2015



**PLYMOUTH**  
CITY COUNCIL

## Thrive Plymouth update



Author: Robert Nelder  
Job Title: Consultant in Public Health  
Department: Public Health, Office of the Director of Public Health

Date: 30<sup>th</sup> November 2015

## I. Background

In January 2014, at a Budget Scrutiny meeting, the following recommendation was agreed:

*'An action plan addressing the revised approach to health inequalities across the city is brought to the Caring Scrutiny Panel within six months by the incoming Director of Public Health.'*

Thrive Plymouth was developed in response to this recommendation and is a 10-year programme to improve health and wellbeing and reduce health inequalities in Plymouth. It is being led by the Office of the Director of Public Health, Plymouth City Council. Thrive Plymouth is based on the local 4-4-54 construct, i.e. that poor diet, lack of exercise, tobacco use and excess alcohol consumption are risk factors for coronary heart disease, stroke, cancers and respiratory problems which together contribute to 54% of deaths in Plymouth (i.e. 4-4-54). Changing these four behaviours would help prevent four diseases and reduce the number of deaths due to these chronic diseases.

The 4-4-54 construct is based on the original work of the Oxford Health Alliance (OxHA). The OxHA came up with the concept of 3four50. In other words, that there are three risk factors to health that together contribute to four chronic diseases which in turn contribute to more than 50% of preventable deaths worldwide. This focus on chronic diseases is appropriate as they are now the major cause of death and disability worldwide, having surpassed infectious diseases and injuries. The work of the OxHA has been considered by Plymouth's Public Health Team and its implementation in San Diego, U.S.A. has been reviewed. A Plymouth-specific version of this approach to chronic disease reduction was therefore developed to address health inequalities in the city.

In addition to an on-going focus on the four behaviours, Thrive Plymouth also has a specific annual focus. In year one the focus was workplace health and wellbeing. This is based on the fact that employee health is critical to company culture and output. The focus of Thrive Plymouth in year two (from November 2015) is schools.

Thrive Plymouth is based on the following three approaches:

(i) **Population prevention approach**

A large number of people at a small risk (of developing a disease) may give rise to more cases of disease than the small number who are at high risk. This approach is based on shifting the population distribution of a condition in order to prevent a higher number of cases. The changes are happening to the whole population and the societal effects of a distributional shift may be large.

(ii) **Common risk factor approach**

Unhealthy behaviours are often shared by groups or populations. The clustering of risk factors occurs in individuals and groups, particularly those at the lower levels of the social gradient. By directing action on these common risks and their underlying social determinants, improvements in a range of chronic conditions will be achieved more efficiently and with greater effectiveness.

(iii) **Changing context of choice**

Most people know how to improve their health and many want to do it. Change is hard to achieve and intention to change isn't enough. There is a disconnect between knowing what needs to be done and actually doing it.

## 2. Why do we need Thrive Plymouth?

Figure 1: Trends in male and female life expectancy

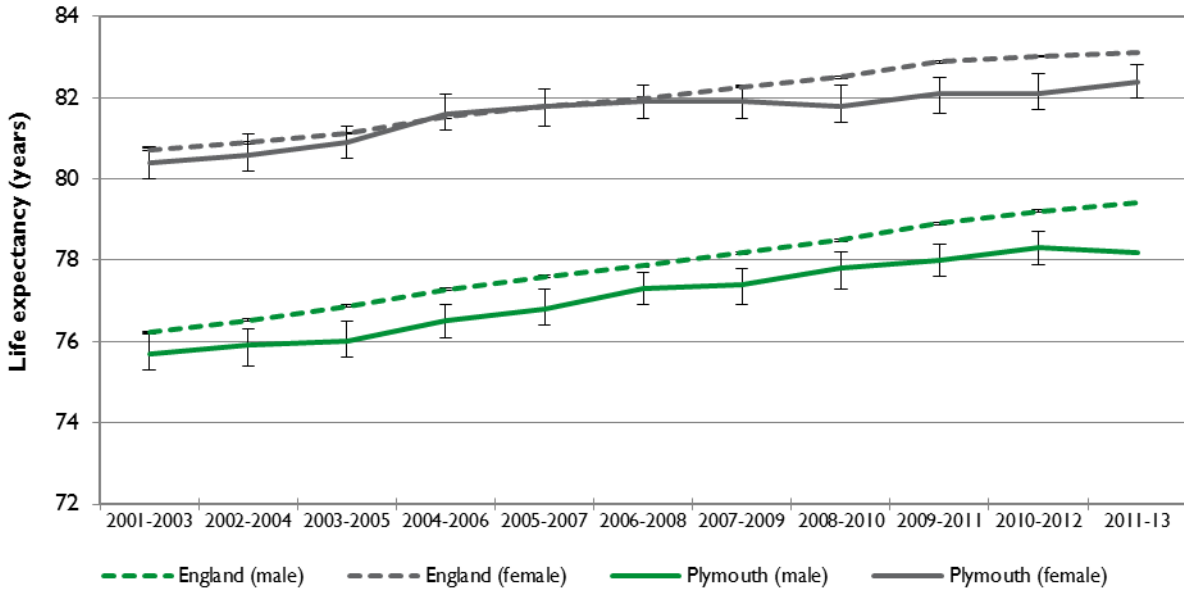


Figure 2: Trends in the life expectancy 'gap' in Plymouth (for males and females combined)

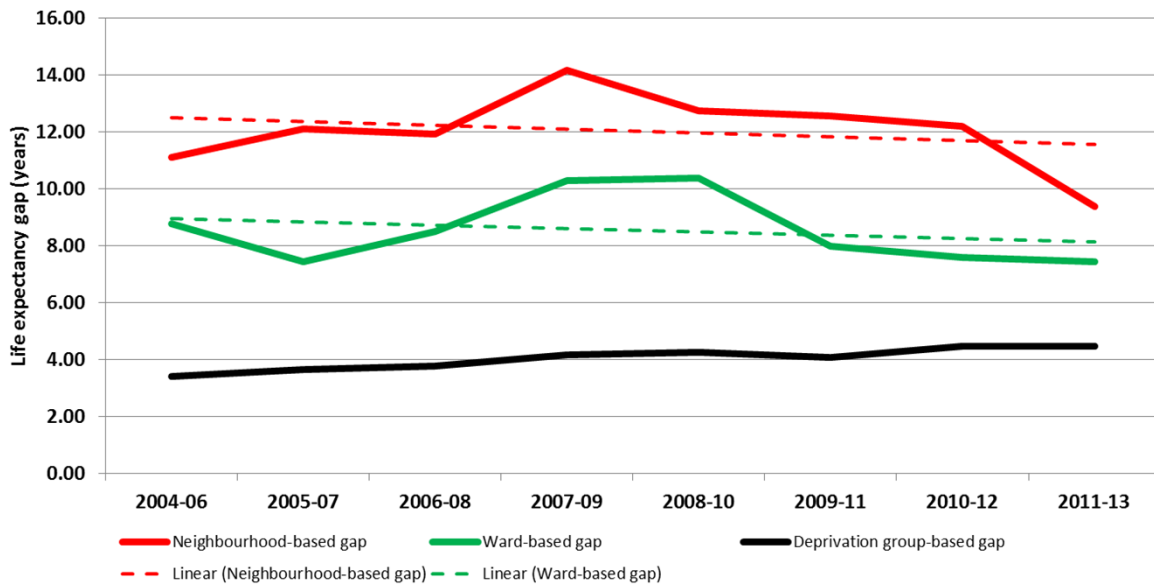


Figure 3: Plymouth's life expectancy bus route (2011-13) by electoral ward

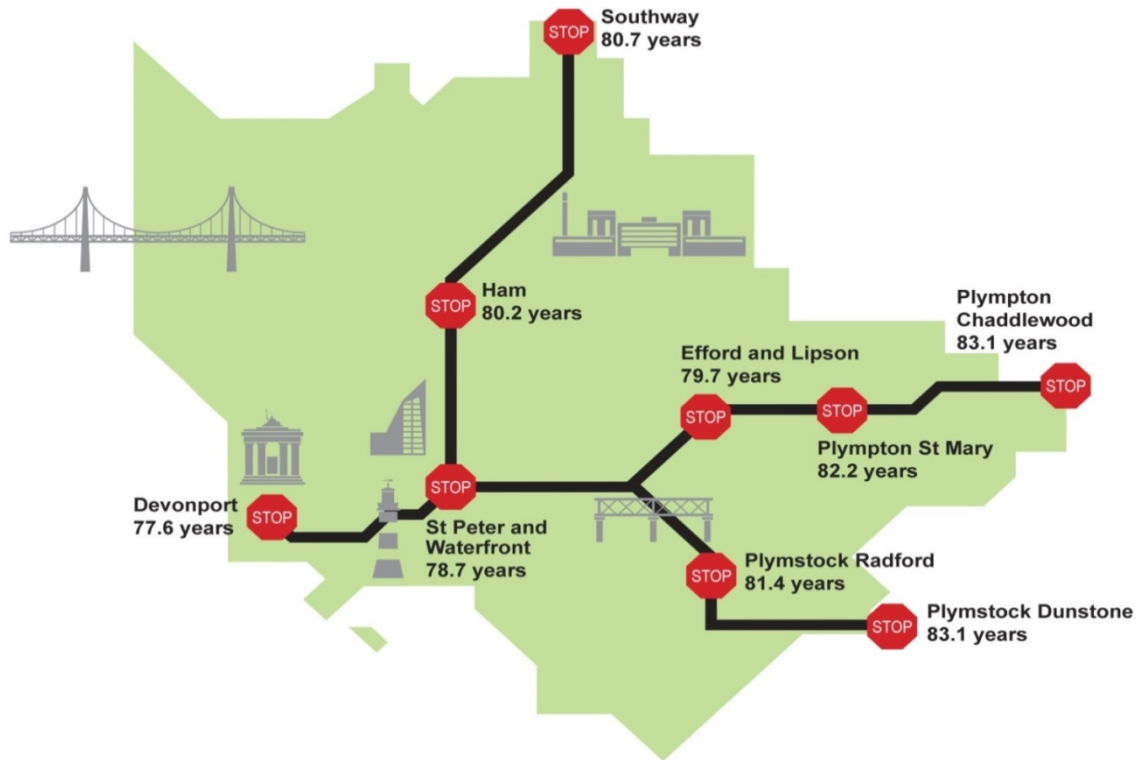
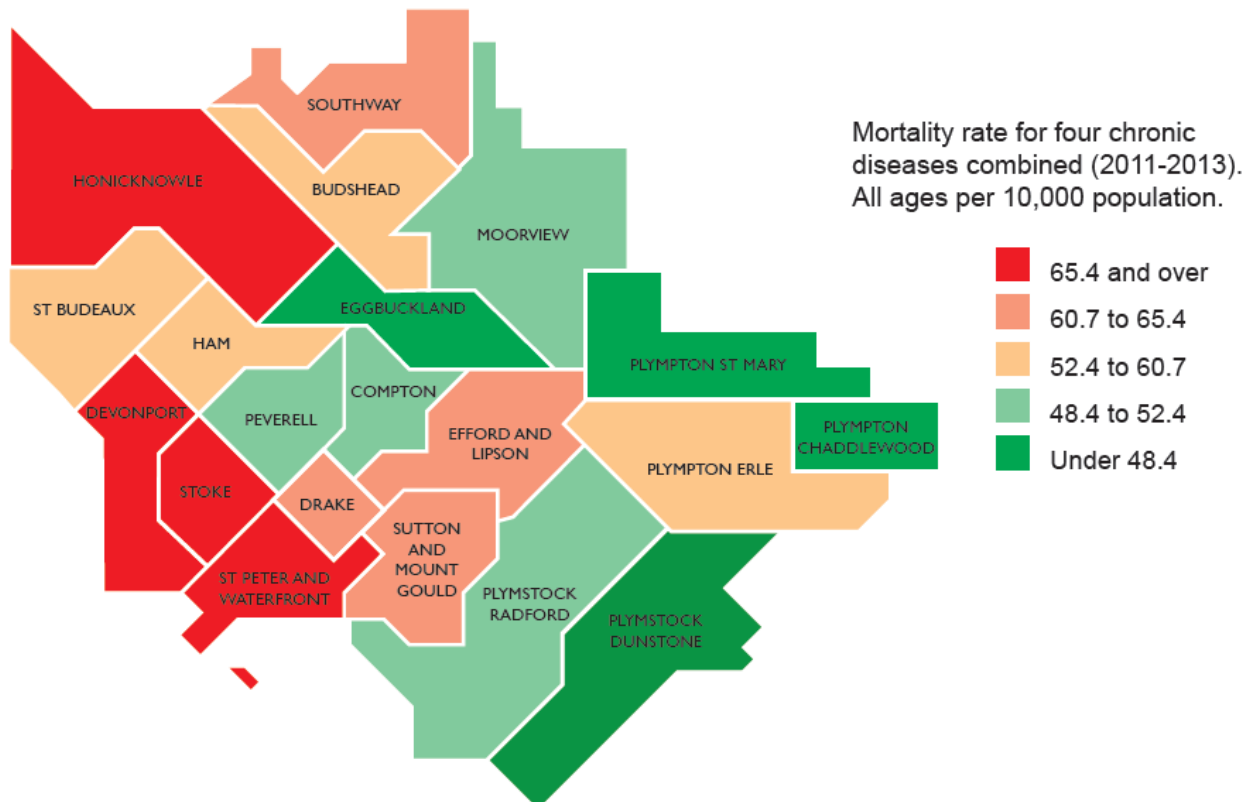


Figure 4: Death rates for the four chronic diseases combined (2011-13)





### 3. Launch event and year one focus

Thrive Plymouth was launched on 10 November 2014 at an event held in the Council House. The launch was attended by 100 city leaders, businesses and institutions as well as the leader of the Council and Portfolio Holders. Through their employers, 22,000 employees were represented at the event. All 35 organisations attending the event pledged to take action to improve their workforce's health and wellbeing. This event launched Thrive Plymouth as a framework to city leaders and introduced the targeted campaign to city employers. Launching Thrive Plymouth to city leaders was the first step to developing action plans to address health inequalities using common approaches around the identified priorities. Introducing the framework to targeted audiences will enable sections of society to receive tailored messaging and a relevant offer of support and call to action.

Workplaces were chosen to be the focus for year one as the positive impact that employment can have on health and wellbeing is well documented. There is strong evidence that having a healthy workforce can reduce sickness absence, lower staff turnover and boost productivity. In short, employee health is critical to company culture and output. Over and above this however, it was recognised that positive messages delivered in the workplace are likely to be shared with families and friends. At the launch event delegates received a pack of Thrive Plymouth materials. This included details of a free offer of support from (i) Livewell@work (part of Plymouth Community Healthcare's Livewell Team), (ii) Plymotion, and (iii) the Sports Development Unit. The free support available was (and remains) as follows:

- (i) **The Workplace Wellbeing Charter (supported via Livewell@work)**  
This is an opportunity for employers to demonstrate their commitment to the health and wellbeing of their workforce. It provides employers with a guide on how to make workplaces a supportive and productive environment in which employees can flourish. Organisations of all sizes can use the Charter standards. The entry level has been developed as a baseline for all businesses to achieve and acts as a checklist for smaller organisations to ensure that legal obligations are met.
- (ii) **Plymotion**  
Plymotion is a scheme that aims to make it easier to get around Plymouth by bus, by bike and on foot. The Team encourage and make it easier for people to travel more sustainably, whether on their way to work, going shopping or just getting out and about to enjoy the city and surrounding countryside.
- (iii) **Sports Development Unit**  
The Team is responsible for maintaining and improving the provision of sport and physical opportunities in the city through a mixture of direct provision and by working in partnership with organisations. They aim to increase participation in sport and physical activity by reaching those who need it, working with key partners, promoting opportunities in the natural environment, supporting community sport and attracting external funding.

As already stated, all 35 organisations attending the event pledged to take action to improve their workforce's health and wellbeing. Importantly, this support is on-going and doesn't stop at the end of year one.

As well as the launch event described above, and related to the year one focus on workplaces, the Public Health Team has presented and described Thrive Plymouth to a number of key audiences across the city. These include to members of:

- Plymouth and Devon Chamber of Commerce at a 'crunchy breakfast' event
- Plymouth's Social Enterprise Network
- Plymouth Manufacturers' Group

As well as these formal presentations to business groups, the three (free) offer providers represented Thrive Plymouth at this year's Plymouth Business Show.

In addition to the business focussed presentation highlighted above, the Public Health Team has presented, discussed and written about Thrive Plymouth whenever the opportunity has arisen. As a direct result of this, Thrive Plymouth (and the 4-4-54 construct) is now recognised across the city as the single, agreed approach to addressing health inequalities.

At the end of Thrive Plymouth year one, each of the three offer providers was sent a questionnaire thanking them for being part of the free year one offer and requesting an update on their activities (related to year one of the campaign). As well as a request for ongoing support, provision of case studies, and examples of best practice, the following questions were included:

- Can you advise on the contact and describe what type of engagement they have had with your services?
- There have been other opportunities where Thrive Plymouth has highlighted your 'offer' such as the Plymouth Business Show, Plymouth Social Enterprise Network AGM, Chamber of Commerce Crunchy Breakfast, etc. Please describe further contacts and engagement generated for your service?
- Please describe any other spin off projects that have been generated or are planned?

The responses from the offer providers are currently being gathered and a report based on their responses will be available in the New Year.

#### **4. Director of Public Health Annual Report**

Thrive Plymouth was the focus of this year's Director of Public Health Annual Report. Entitled 'Positive choices for better health in a growing city', it was published in July 2015. The focus of this annual report is on positive choices (eating a healthy diet, leading an active lifestyle, drinking sensibly and not smoking tobacco) and the contexts in which these choices are made and influenced. There are four parts to the report. Section one introduces Thrive Plymouth and gives an overview of the programme and the 4-4-54 construct. Section two discusses lifestyle choices and health inequalities in Plymouth. It focuses on each of the four behaviours, describes the positive choice and the differences in the pattern of the behaviours across the city. It also considers the wider 'context of choice' in the city and links these to the ambitions of the Council outlined in the Plymouth Plan. Section three reflects back on the launch of Thrive Plymouth in 2014 and outlines the annual campaigns. Section four presents the Thrive Plymouth Dashboard. This shows details for all the data included in the report and the key measures that will be used to monitor changes in health and wellbeing in the city over the next 10 years. It also describes the two local surveys undertaken to provide baseline information for Thrive Plymouth. This report has been presented and discussed widely, including at an all-Member briefing held in July and at subsequent meetings of Caring Plymouth and the Health and Wellbeing Board.

## 5. Plan for evaluation

The Public Health Team is currently working with Plymouth University (School of Government) to develop an evaluation framework for Thrive Plymouth. The Council's Public Health Team holds and has access to comprehensive datasets that allow trends in inequalities and health and wellbeing status to be monitored over time. The datasets are available at sub-city level and will allow the impact of Thrive Plymouth to be monitored (via selected key performance indicators (KPIs)) over the 10-year period of the campaign. In addition to this, existing data on health behaviours in the Plymouth population is available from a 2014 Wellbeing Survey (conducted across the 20 electoral wards in the City) and a schools health-related behaviour survey undertaken in the same year (in 15 of the 18 providers of secondary education in the city).

Therefore the Team wishes to evaluate the effectiveness of Thrive Plymouth utilising intelligence and critical analysis that goes beyond the existing quantitative KPIs. Thrive Plymouth as a programme sits alongside other initiatives and programmes within the city and the programme evaluation will explore its performance and effectiveness in this context. It is envisaged that the formulation of the evaluation framework will be undertaken in conjunction with key stakeholders and public health policy makers in the city. The focus will be on establishing an evaluation framework that (a) captures intelligence on the strategic influence of Thrive Plymouth on city-based initiatives, (b) evaluates the effectiveness of the settings chosen as the annual focus, and (c) enables feed-forward of evaluation outcomes into decision-making processes for each subsequent year of the Thrive Plymouth programme. The challenge for the evaluation framework is that the annual focus will be identified year-on-year thus requiring a degree of flexibility and adaptation in the methodological framework. In other words, although the foci in the first two years (workplaces and schools) are settings-based, it might change to be client-group-based in subsequent years.

Key to the evaluation will be the establishment of a Steering Group consisting of the evaluation leads (Plymouth University strategic partners), Plymouth City Council, key stakeholders and other interested parties, to be discussed and agreed. The exact membership will be sensitive to changing contexts. The terms of reference and reporting structures for the steering group will need to be agreed and confirmed.

## 6. Plan for marketing

Plymouth's Public Health Team has engaged a local company (the Knowledge Collective) to work in partnership with the Team to devise a marketing strategy for Thrive Plymouth. It was important to secure the appropriate expertise to develop a strategy that is sustainable and flexible to cover the 10 year Thrive Plymouth campaign. This marketing strategy is currently being developed and will consider the following:

- The marketing tools required to better engage key audiences and get messages out into the communities more effectively.
- How a marketing strategy could make the most of the national campaigns (e.g. the Public Health England 'One You' campaign, to be launched in 2016) and compliment/align with the work carried out by Plymouth Community Healthcare's Livewell Team.
- Developing some advice on using the Thrive Plymouth brand (or parts of it) for partner organisations.

The Public Health team is looking for a strategy that safeguards the Thrive Plymouth identity, ensures alignment with the Council identity, advises on how the tools can be used internally and externally (by partners and the wider public), and clarifies how the identity can be used (e.g. in terms of sizing, colour palette, etc).

This is not a about creating behaviour change through a marketing strategy, this is about how a social movement is created and communities are mobilised across the city, using Thrive Plymouth as the driver. Linked to the evaluation (being led by Plymouth University and described in section four) the strategy needs to have an evaluation plan built in. The Public Health Team would like to ensure the marketing approach is both sustainable and flexible so that learning is captured to ensure plans are progressive and continually connected.

### **7. Year Two launch and focus**

As already stated, the focus for year two of Thrive Plymouth is schools and educational settings (hereafter referred to as 'schools'). Year two was officially launched at event held at the Future Inns on Wednesday 18 November 2015.

Year Two will provide the framework for all key stakeholders to help create the conditions for children and young people (CYP) to make positive health choices and contribute toward reducing health inequality. The focus on CYP also supports the assertion made by the Department of Health that, 'the best possible health underpins a child's or young person's ability to flourish, stay safe and achieve as they grow up.' The evidence base supports developing a strong and effective partnership with schools to improve health outcomes, for example:

- Pupils with better health and wellbeing are likely to achieve better academically.
- Effective social and emotional competencies are associated with greater health and wellbeing, and better achievement.
- The culture, ethos and environment of a school influences the health and wellbeing of pupils and their readiness to learn.
- A positive association exists between academic attainment and physical activity levels of pupils.

Additionally evidence shows that health outcomes for CYP are supported through engaging pupils through encouraging pupil voice, authentic involvement in learning, decision-making, and peer-led approaches.

In focusing on schools the need to address two key stakeholder groups (the senior leadership and the CYP themselves) has been recognised. Senior leadership has a significant role to play in creating the conditions within the school settings to support positive choices. Empowering CYP to actively engage in conversations and decision making around their own and their peers' health will maximise the chances that CYP have to take-up the opportunity for healthy choices. Whilst the focus is clearly on the whole population within the school, in recognition of these two key stakeholder groups, it is proposed that the approach is delivered in two phases shaped by initial engagement with schools' senior leadership (phase one) followed by engagement with CYP themselves (phase two).

The recent launch in November focused on the senior leadership within the schools. This event was similar to the original Thrive Plymouth launch but utilised best practice examples from schools linked to the Thrive Plymouth behaviours. The best practice examples were identified from those schools that had achieved silver or gold award through the Healthy Child Quality Mark programme. The links to Thrive Plymouth Year One and its workplace focus were reflected and a new 'offer and ask' specific to schools was presented.

Phase two will commence in Spring 2016. This phase is about enabling children and young people to have conversations not only based around the Thrive Plymouth behaviours but also focussing on emotional wellbeing and mental health. In particular:

- What the behaviours mean to them including emotional wellbeing and mental health.
- What may stop them from making positive health choices in regard to the behaviours and emotional wellbeing and mental health?
- What would help them make positive health choices in regard to the behaviours and emotional wellbeing and mental health?
- Health inequality across the city.

The intention is to empower and facilitate CYP to take part in conversations in their schools across the city. The route to having these conversations in each school will be through each School Council. The intended outcome is that each school's leadership team receive the findings from their school's 'conversation' and wherever possible utilise the findings to create improved conditions for positive choices and improved wellbeing. An additional outcome would be to record those aspects of the conversations that describe city-wide solutions to improving health outcomes linked to the Thrive Plymouth behaviours and to emotional wellbeing and mental health.

Plymouth University has agreed to sponsor an event in November 2016 to showcase the findings from phase two. The University will provide all the resources and logistics to deliver the showcase event.

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# CARING PLYMOUTH

Tracking Resolutions and Recommendations  
2015 - 2016



Date, agenda item and Minute number	Resolution	Target date, Officer responsible and Progress	
11 December 2014 Minute 36 – Peninsula Treatment Centre	<u>Agreed</u> that the Panel to monitor the supply and demand following the closure of the Peninsula Treatment Centre; looking at capacity and ensuring Plymouth residents receive the best service.	Date	2015
		Officer	Karen Kay, NEW Devon CCG
		Progress	Email sent to the NEW Devon CCG. Awaiting a briefing paper to be circulated to the Panel.
2 July 2015 Minute 5 - PHNT Performance Report (for the period APRIL 2015)	<u>Agreed</u> that -  1. to continue to monitor mortality rates, diagnostic services and referral to treatment times to provide assurance to the panel that progress is being made against these key indicators and that recovery plans are improving performance;  2. that a report on the new immigration rules for lower-earning non-EU workers to be provided to the panel as soon as impact on the trust is assessed;  3. that a joint performance review involving commissioners and lead providers from Health and Social Care should take place at the next meeting. Decisions on format and key performance indicators delegated to the lead officer in consultation with Chair and Vice Chair.	Date	02/09/15
		Officer	Ross Jago
		Progress	Added to work programme. (1) – a report will be provided at the December meeting.  (2) – a report will be provided at the January meeting.

Date, agenda item and Minute number	Resolution	Target date, Officer responsible and Progress	
		Date	Officer responsible and Progress
15 October 2015 Minute 23 - Public Health's Corporate Performance Report	<p><u>Agreed</u> that –</p> <p>1. A response to the Public Health consultation to be formulated and signed off by Chair and Vice Chair.</p> <p>2. A briefing report on breastfeeding take-up is circulated to Caring Panel.</p>	Date	October 2015
		Officer	Kelechi Nnoaham
		Progress	(2) - A requested has been sent to Public Health and a report will be provided and circulated to Panel members on breastfeeding.
15 October 2015 Minute 25 NHS Maternity Review	<p><u>Agreed</u> that –</p> <p>1. Councillors Mrs Bowyer, Mrs Aspinall and Mrs Bridgeman to form a small working group to take part in NHS England's Review of Maternity Services;</p> <p>2. A desktop exercise is undertaken gathering local evidence on maternity services in Plymouth and review again in the New Year.</p>	Date	October 2015/New Year
		Officer	Amelia Boulter
		Progress	Councillors Mrs Bowyer, Mrs Aspinall and Mrs Bridgeman met and took part in NHS England's Review of Maternity Services. Results expected in the New Year.

### Recommendations sent to the Cooperative Scrutiny Board.

Date, agenda item and minute number	Caring Plymouth Recommendation	Corporate Scrutiny Board Response	Date responded

#### Recommendation/Resolution status

**Grey** = Completed item.

**Red** = Urgent – item not considered at last meeting or requires an urgent response.



# CARING PLYMOUTH

Work Programme 2015 - 2016



**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 and is subject to approval at the Cooperative Scrutiny Board.**

For general enquiries relating to the Council's Scrutiny function, including this committee's work programme, please contact Amelia Boulter, Democratic Support Officer, on 01752 304570.

Date of meeting	Agenda item	Purpose of the agenda item	Reason for consideration	Responsible Officer
2 July 2015	Plymouth NHS Hospital Trust Performance Report			Kevin Baber/Lee Budge
	Success Regime			Jerry Clough/Kelechi Nnoaham
3 Sept 2015	Tour of PCH			
	CAMHS	Update		Steve Waite
	Delayed Transfer of Care			Steve Waite
	Integrated Commissioning Strategies	To feed into the consultation and review performance measures.		Craig McArdle/NEW Devon CCG
	Integration – transfer of staff and the pooled budget	Performance review of last 6 months		Steve Waite/Craig McArdle
15 Oct 2015	Corporate Performance Report - K21, K46, K47 - K23, K48, K31, K49, K50	Co-operative Scrutiny Board Recommendation		Kelechi Nnoaham
	NEW Devon CCG Finance Report (Section One)	Co-operative Scrutiny Board Recommendation		Ben Chilcott
	Maternity Services Review	To feed into NHS England's consultation reviewing Maternity Services.		Ross Jago
10 Dec 2015	Thrive Plymouth			Kelechi Nnoaham
	Corporate Performance Report - K23, K48, K31, K49, K50			Craig McArdle
	Fairer Charging			Craig McArdle

Date of meeting	Agenda item	Purpose of the agenda item	Reason for consideration	Responsible Officer
	Volume / Cost / Review of Social Care Packages			Craig McArdle
	CQC Report and Action Plan / Performance Review			PHNT
	Diagnostic Waiting Times			PHNT
21 Jan 2016	New Immigration rules impact on Health Services			PHNT
	Safeguarding Adults Board			Andy Bickley
	A 'Fair Price for Care' for Older Persons' Residential and Nursing Homes			Craig McArdle
	A 'Fair Price for Care' for Residential and Nursing Homes for Adults under 65 years of age			Craig McArdle
	Dental Provision			NHS England Primary Care Commissioning
	Success Regime			NHS England
17 March 2016	Health and Social Care Integration			Graham Wilkin

Scrutiny Review Proposals	Description
Maternity Services	