#healthyplym

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Chief Executive's Department
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HEALTH AND WELLBEING BOARD

Thursday 26 January 2017
10 am
Warspite Room, Council House

Members:
Councillor Mrs Bowyer, Chair
Councillors Mrs Beer and Tuffin.

Statutory Co-opted Members: Strategic Director for People, NEW Devon Clinical Commissioning Group representatives, Director for Public Health, Healthwatch representative and NHS England.

Non-Statutory Co-opted Members: Representatives of Plymouth Community Homes, Plymouth Community Healthcare, Plymouth NHS Hospitals Trust, Devon Local Pharmaceutical Committee, University of Plymouth, Devon and Cornwall Police, Devon and Cornwall Police and Crime Commissioner and the Voluntary and Community Sector.

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

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Tracey Lee
Chief Executive

Health and Wellbeing Board

1. Apologies

To receive apologies for non-attendance by Health and Wellbeing Board Members.

2. Declarations of Interest

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

3. Chairs 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 meeting held on 19 October 2016.

5. Questions from the public

To receive questions from the public in accordance with the Constitution.

Questions, of no longer than 50 words, can be submitted to the Democratic Support Unit, Plymouth City Council, Ballard House, Plymouth, PL1 3BJ, or email to democraticsupport@plymouth.gov.uk. Any questions must be received at least five clear working days before the date of the meeting.

6. Future of Primary Care Services **(Pages 5 - 64)**

7. Plymouth and South West Devon Joint Local Plan

8. Plymouth Report (Health Chapter / JSNA) **(Pages 65 - 86)**

9. Health Protection Annual Report

10. Integrated Commissioning Scorecard **(Pages 87 - 98)**

11. Work Programme **(Pages 99 - 100)**

The Board are invited to add items to the work programme.

Health and Wellbeing Board

Wednesday 19 October 2016

PRESENT:

Councillor Mrs Bowyer, David Bearman – Devon Local Pharmaceutical Committee, Councillor Mrs Beer, Lee Budge - Plymouth Hospitals NHS Trust, Carole Burgoyne - Plymouth City Council, John Clark – Plymouth Community Homes, - Healthwatch, , Craig McArdle - Plymouth City Council, Prof. Steve Waite - Livewell Southwest, Councillor Tuffin, Andy Boulting – Devon and Cornwall Police, Judith Harwood – Plymouth City Council and Nick Pennel – Healthwatch.

Apologies for absence:
Alison Hernandez – Police and Crime Commissioner, Ann James – Plymouth Hospitals NHS Trust, Professor Patricia Livsey – Plymouth University, Jo Traynor and Tony Fuqua – Community and Voluntary Sector.

Also in attendance: Ross Jago – Lead Officer, Kristin Barnes – Democratic Support Officer.

The meeting started at 10.00 am and finished at 1.00 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.

44. **Declarations of Interest**

There were no declarations of interest made in accordance with the code of conduct.

45. **Chairs urgent business**

The Committee heard that Scrutiny and Health and Wellbeing Chairs are involved in a brief spotlight review around new models of care. When this was complete the resulting document would be circulated.

The Committee had been approached by the Local Government Association to take part in a workshop relating to the LGA Toolkit for Health and Wellbeing Boards. Members were requested to let the clerk know if they were available.

46. **Minutes**

Agreed that the minutes of 30 June 2016 were confirmed as an accurate record of the meeting.

47. **Appointment of a Vice Chair**

The Chair proposed the Steve Waite of Livewell Southwest stand as Vice Chair, this was seconded by Councillor Tuffin.

48. **Questions from the public**

There were no questions from the public.

49. **Joint Strategic Needs Assessment**

The Board received the Joint Strategic Needs Assessment (attached) presented by Rob Nelder.

The Committee heard that;

a) the JSNA informed the Healthy Plymouth section of the Plymouth report which was expected to be completed within the timescales;

b) the JSNA also informed the Prevention section of the Sustainable transformation plan;

c) a number of members of the committee wished to assist in compiling the JSNA

The Board noted the report and the offers of help from Judith Harwood, Plymouth City Council, and Lee Budge, NHS England.

50. **Director of Public Health Annual Report**

The Board received the Director of Public Health Annual Report (attached) presented by Ruth Harrell, Interim Director of Public Health, Plymouth City Council.

The Board heard that;

a) the report was distinct and separate from the JSNA. JSNA provided that evidence base and the Director of Public Health report had licence to use that information to be more engaging;

b) there were a number of recommendations within the report that had been parcelled up and sent to the relevant strategic Boards.

The Board noted the report (attached) and agreed to revisit progress on the recommendations contained within in 6 months' time.

51. **Alcohol Dashboard Update**

The Board received the Alcohol Dashboard (attached) presented by Ruth Harrell, Interim Director for Public Health, Plymouth City Council;

The Board heard that;

a) confidence around the figures was high;

b) the role of the Board was to seek assurance that the work around alcohol use and misuse use was progressing and the Interim director would welcome to opportunity to return to the Board in 6 months to report progress;

c) incidents involving domestic violence were not included in some data. This was because there had been a drive to increase the reporting of domestic violence and therefore it was appropriate to report that data separately as a rise was seen as a positive indicator.

The Board noted the report and recommended that scrutiny consider the Alcohol Dashboard.

52. **Children and Young People's Partnership Update**

The Board received a verbal update on the Children and Young People's Partnership from Judith Harwood, Assistant Director for Education, Participation and Skills, Learning and Communities.

The Board noted the update.

53. **Safer Plymouth Governance and the Health and Wellbeing Board**

The Board agreed that the Safer Plymouth Partnership Board be ratified as a sub-committee of the Health and Wellbeing Board as set out in the recommendations of the report.

54. **Work Programme**

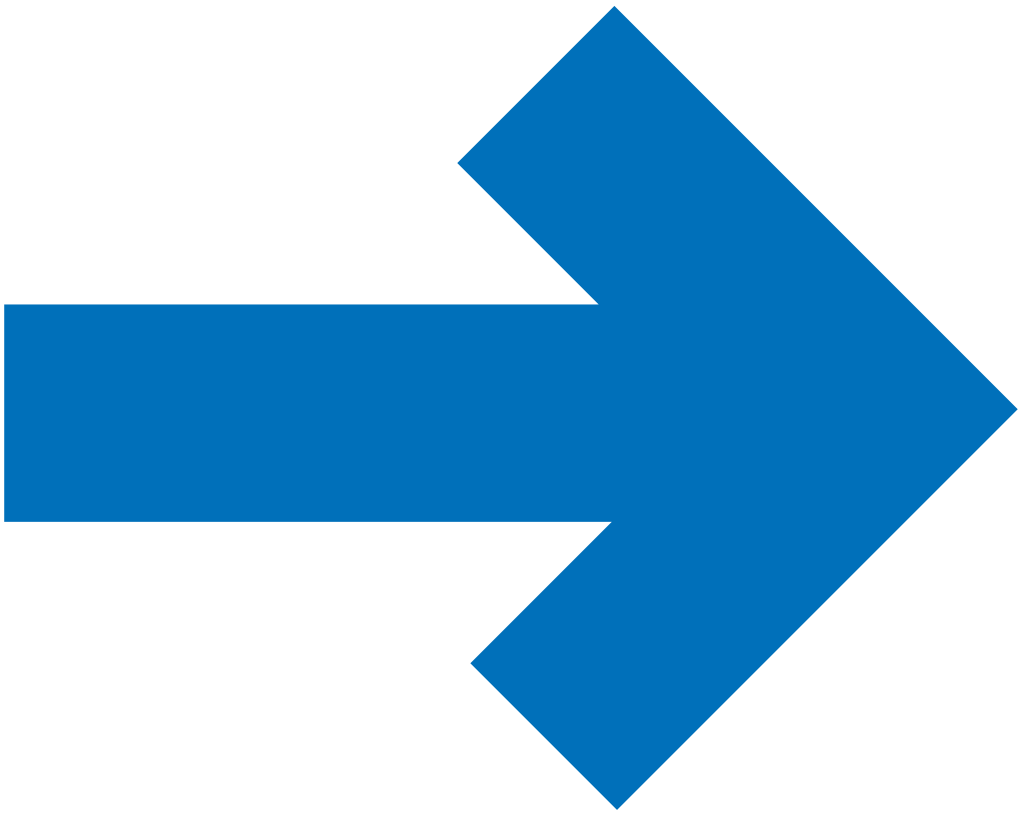
Board members were invited to forward items to populate the work programme. It was agreed to add the following items –

1. The GP Forward View to be added to the Agenda of the meeting on 26 January 2017.
2. OFSTED

NHS England

GENERAL PRACTICE FORWARD VIEW

APRIL 2016



Developed in partnership with:

RCGP Royal College of General Practitioners

NHS Health Education England

#GPforwardview

General Practice Forward View

Version number: 1

First published: April 2016:

Classification: Official

Gateway publication reference: 05116

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 22 33 or email: england.contactus@nhs.net

Contents

Introduction

There is arguably no more important job in modern Britain than that of the family doctor.

GPs are by far the largest branch of British medicine. A growing and ageing population, with complex multiple health conditions, means that personal and population-orientated primary care is central to any country's health system. As a recent British Medical Journal headline put it – "if general practice fails, the whole NHS fails".

So if anyone ten years ago had said: "Here's what the NHS should now do - cut the share of funding for primary care and grow the number of hospital specialists three times faster than GPs", they'd have been laughed out of court. But looking back over a decade, that's exactly what's happened. Which is why it's no great surprise that a recent international survey revealed British GPs are under far greater pressure than their counterparts, with rising workload matched by growing patient concerns about convenient access.

A recent report on GP workload pressures by the Primary Care Foundation and NHS Alliance said this:

"The strength of British general practice is its personal response to a dedicated patient list; its weakness is its failure to develop consistent systems that free up time and resources to devote to improving care for patients. The current shift towards groups of practices working together offers a major opportunity to tackle the frustrations that so many people feel in accessing care in general practice."

So rather than ignore these real pressures, the NHS has at last begun openly acknowledging them. We need to act. This document sets out exactly how. It contains specific, practical and funded steps – on investment, workforce, workload, infrastructure and care redesign.

On investment: by 2020/21 recurrent funding to increase by an estimated £2.4 billion a year, decisively growing the share of spend on general practice services, and coupled with a 'turnaround' package of a further £500 million. Investments in staff, technology and premises, and action on indemnity and redtape.

On workforce: pulling out all the stops to try to double the growth rate in GPs, through new incentives for training, recruitment, retention and return to practice. Having taken the past 10 years to achieve a net increase of around 5,000 full time equivalent GPs, aiming to add a further 5,000 net in just the next five years. Plus 3,000 new fully funded practice-based mental health therapists, an extra 1,500 co-funded practice clinical pharmacists, and nationally funded support for practice nurses, physician associates, practice managers and receptionists.

On workload: a new practice resilience programme to support struggling practices, changes to streamline the Care Quality Commission inspection regime, support for GPs suffering from burnout and stress, cuts in redtape, legal limits on administrative burdens at the hospital/GP interface, and action to cut demand on general practice.

On infrastructure: new rules to allow up to 100% reimbursement of premises developments, direct practice investment tech to support better online tools and appointment, consultation and workload management systems, better record sharing to support team work across practices.

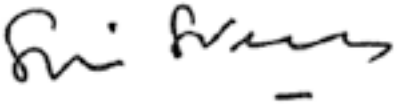
On care redesign: support for individual practices and for federations and superpartnerships; direct funding for improved in hours and out of hours access, including clinical hubs and reformed urgent care; and a new voluntary contract supporting integrated primary and community health services.

One of the great strengths of general practice in this country has been its diversity across geographies and its adaptability over time. So one size will not fit all when it comes to the future shape and work of primary care. But in the round, this support package is likely to herald a 'triple reinvention' - of the clinical model, the career model, and the business model at the heart of general practice. In his preface to this document Arvind Madan describes what this could mean from the practice and the patient perspective.

Thanks go to the many GPs, other NHS professionals and patient groups who've helped shape this urgent 'to do' list - including particularly our partners at the Royal College of General Practitioners, the British Medical Association's General Practitioners Committee, Department of Health, Health Education England, the National Association of Primary Care, NHS Alliance, the Family Doctors Association and in local CCGs and Local Medical Committees right across England.

Looking back over nearly seventy years, there have been key moments in NHS history when the health service has stepped up to support and strengthen general practice and wider primary care. Think: the New Deal for GPs in 1966. Think: new contractual models in the 1990s and 2000s. If properly implemented, the wide-ranging measures in this document may perhaps come to be seen as a similar inflexion point.

But be that as it may, the vital thing is to roll our sleeves up, get practical, and together begin to make a tangible difference, now, for practices and for our patients.



Simon Stevens
Chief Executive, NHS England

GP services for the future:
Dr Arvind Madan

The public relies on general practice services for the health and wellbeing of themselves and their family. It is one of the great strengths of the NHS, and is recognised time and again in international comparisons.

Over my 20 years as a GP demand for appointments, and particularly their complexity, has increased beyond recognition.

There has been a steady rise in patient expectations, a target driven culture and a growing requirement for GPs to accommodate work previously undertaken in hospitals, or in social care. This has resulted in unprecedented pressure on practices, which impacts on staff and patients. Small changes in general practice capacity have a big impact on demand for hospital care, so the need to support general practice in underpinning the whole NHS has never been greater.

However, a typical morning in general practice currently comprises a long arduous struggle through appointments, phone calls, repeat prescriptions, results, letters and home visits. Before you get time to look up, much less take a break, it is the afternoon and you have to start all over again.

Running the practice or having a meaningful conversation with staff is relegated to the edges of the day. Almost every practice is struggling to balance rising workload within tighter financial constraints. Add to this the strain of recruitment issues and it becomes easy to see why morale is so challenged. Clinicians increasingly feel unable to provide the care they want to give, and understandable resentment of working under this pressure is growing.

Yet patients rightly expect and deserve high quality care from a familiar team of healthcare professionals they know and trust. We know these relationships rest at the heart of how every general practice functions. They are fundamental to what we do, namely person-centred coordinated care of complex physical, mental and social issues, within the context of the individual, their families and the wider community.

I joined NHS England at the end of last year, in part driven by my frustration with how I felt high quality primary care for patients was being undervalued. Since starting I have made three observations. Firstly, there is a deep-seated recognition of how a strengthened version of general practice is essential

to the wider sustainability of the NHS. Secondly, there is acknowledgement of historic underfunding in general practice and the need for this to be reversed. Thirdly, practices themselves seem more open to new ways of working than at any time I can recall. As much because we want patient care to improve, as we recognise our survival depends on it.

Most observers now agree that the solution lies in a combination of investment and reform. It requires action from NHS England, clinical commissioning groups (CCGs), health and care organisations, and practices themselves. We know there is no single cause for the issues we face, and that no single part of the system acting in isolation can fix it either. We need a concerted approach of initiatives, involving all stakeholders, across a number of key areas.

The General Practice Forward View represents a step change in the level of investment and support for general practice. It includes help for struggling practices, plans to reduce workload, expansion of a wider workforce, investment in technology and estates and a national development programme to accelerate transformation of services. NHS England is committing to an increase in investment to support general practice over the next five years. Furthermore this will be supplemented by GP-led CCGs as they act to transform local care systems. This transformation will be built around patients, around the wider workforce, around the redesign of our workload and organisation of care, and creating a satisfying and rewarding career for everyone working in general practice.

Some patients want to be partners in their own care. They want the knowledge, skills and confidence to take more responsibility for their health and feel more in control of their outcomes. Channelling this growing patient appetite for services that help patients to help themselves unlocks both a better patient experience and a way to alleviate practice workload. No amount of reform of the existing system will work unless we also partner with our patients to manage demand more efficiently.

The GP is an expert medical generalist and must be properly valued as the provider of holistic, person-centred care for undifferentiated illness, across time within a continuous relationship. These are core strengths of general practice and must be preserved within any change. However, patient demand and GP shortages mean that we no longer have the time to use our expertise on patient issues that can be safely and competently managed by others. Wider members of the practice-based team will play an increasing role in providing day-to-day coordination and delivery of care. Greater use of skill mix will be key to releasing capacity, if we are to offer patients with complex or multiple long-term conditions longer GP consultations.

In the way we currently view practice nurses as an integral part of the practice team, the GP Access Fund schemes are already showing how a broad range of healthcare professionals can contribute to providing care, for example advanced nurse practitioners, clinical pharmacists, physician associates, physiotherapists and paramedics. Staff are navigating patients to a wider range of alternative services such as primary care access hubs, social prescribing

initiatives (including the voluntary sector) and pharmacy minor ailment schemes. Pharmacists remain one of the most underutilised professional resources in the system and we must bring their considerable skills in to play more fully.

We all accept that we have a long way to go to hit the ambitious recruitment targets set for primary care, but we must use every effort to try, as this will be necessary for much of the reform required. NHS England, alongside Health Education England and CCGs, will support a series of initiatives to grow and train the workforce in response to this challenge.

A common reason for poor morale is the daily struggle with growing workload. Much of this is generated by a fragmented system, over which practices feel they have little influence. Our first and most pressing priority must be to alleviate this wasteful burden, which takes away from direct patient care. We know we cannot work any harder, so we have to find ways to work differently. A key requirement for wider system change is the urgent need to identify and eliminate needless workload.

But this is a challenge when it is difficult to find time to look up from the day job. For GPs to believe in a better future we must first start to feel the impact of changes now. Some of the new measures within this document are specifically designed to provide immediate relief to existing pressures. We need to tackle issues such as irrelevant communications, duplicate reporting, unwieldy payment systems and streamline oversight and regulation.

Teams need support and space if they are to adopt new ways of working. This is why NHS England plans to invest in a national development programme at individual, practice and network or federation level. I have been struck by how positively received the recent NHS England and BMA roadshows on releasing capacity have been. However, this should be viewed as the start of a journey in supporting practices to build the capacity and capabilities required within our teams. We must and will go much further.

We will also develop different ways of managing clinical demand. In addition to increasing self-care, use of different triage methods and a broader workforce sharing the burden, we also need to grow capacity through a network of locality primary care access Hubs (as seen in the GP Access Fund areas) and increase clinical personnel behind services such as 111, for example, nurses, pharmacists and dentists.

It is becoming increasingly normal for general practices to work together at scale, and already over half the country have formed into networks or federations of practices. In the future there will be greater opportunities for practices to work collaboratively in larger groupings for the benefit of more sizeable populations, yet maintain their unique identity and relationship with their own patients. Larger organisational forms will enable greater opportunities for practices to increase their flexibility to shape, buy or build additional services, working from a more effective platform with other local health and care providers, including community health services, social care and voluntary organisations.

GPs must feel confident in the vision of where general practice could go and how it will feel to be a GP in the future. A significant proportion of demand must be managed through helping patients to stay well, self-care and navigate to other team members, or alternate services.

GPs' core role will be to provide first contact care to patients with undifferentiated problems, provide continuity of care where this is needed, and act as leaders within larger multi-disciplinary teams with greater links to hospital, community and social care specialists.

Primary care professionals will increasingly work at different organisational levels, for example, their own practice, a neighbourhood of practices and across the local health economy. This will open up opportunities in pathway design, service leadership, education, training and research, or developing areas of clinical interest. Specialists will develop more community facing roles, supporting primary care colleagues in developing case management expertise, both in person and remotely. There will be greater use of technology to connect primary care with others, for the sharing of best practice and sourcing of timely advice. These changes will develop a more unified team approach, in a variety of career structures, with satisfying and rewarding opportunities for both clinicians and non-clinicians, and a more coordinated experience of care for patients.

The General Practice Forward View will not solve all the issues we face immediately, but it does set a new direction and opportunity to demonstrate what a strengthened model of general practice can provide to patients, those who work in the service, and for the sustainability of the wider NHS. General practice has risen to challenges in the past and, with support from leaders across the system, it will again.

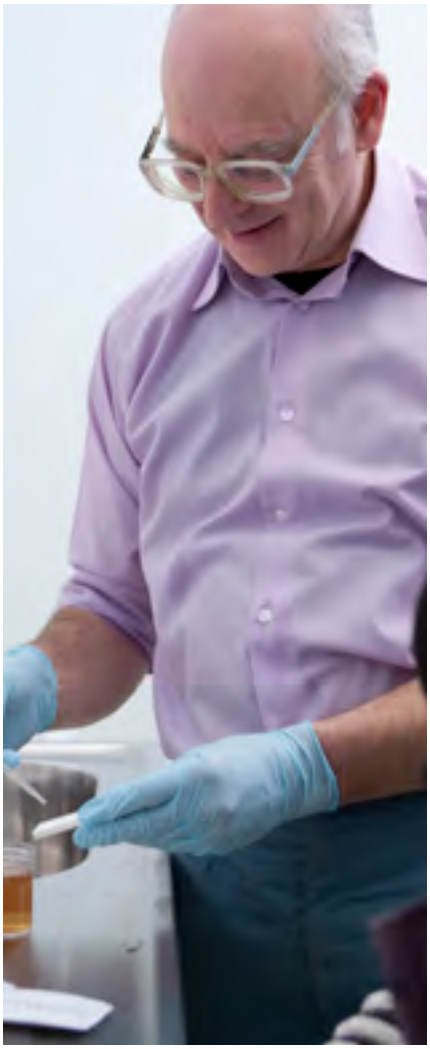
Dr Arvind Madan
GP, Director of Primary Care,
NHS England

Chapter 1: Investment

We will accelerate funding of primary care

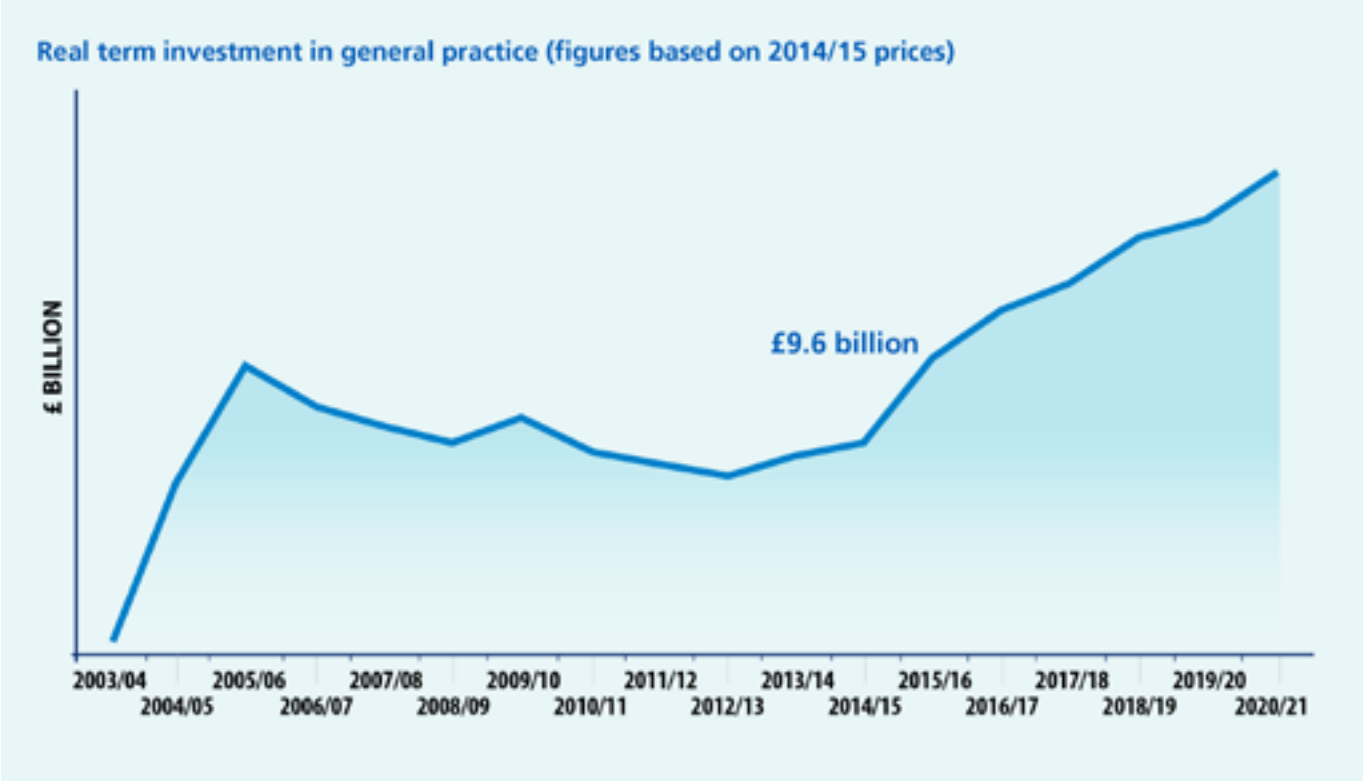
We will increase the levels of investment in primary care:

- By investing a further £2.4 billion a year by 2020/21 into general practice services. This means that investment will rise from £9.6 billion a year in 2015/16 to over £12 billion a year by 2020/21.
- Represents a 14 percent real terms increase, almost double the 8 percent real terms increase for the rest of the NHS.
- This is the expected increase nationally. Investment is likely to grow even further as CCGs build community services and new care models, in line with the Five Year Forward View.
- This includes capital investment amounting to £900 million over the next five years.
- Will be supplemented by a Sustainability and Transformation package, totalling over half a billion pounds over the next five years, to support struggling practices, further develop the workforce, tackle workload and stimulate care redesign.
- A new funding formula to better reflect practice workload, including deprivation and rurality.
- Consult the profession and others on proposals to tackle indemnity costs in general practice by July 2016.



The Five Year Forward View recognised that primary care has been underfunded compared to secondary care, and that this must change. The historic strength of general practice is being weakened by the relative under-investment in general practice that has occurred over the past decade.

Since the creation of NHS England in 2013, each year there have been real term increases in primary care funding. On the back of the Spending Review, which committed £10 billion a year more above inflation for the NHS by 2020 to back the Five Year Forward View, we know we need to sustain and accelerate growth in investment.



Package of investment in general practice[1]

We are committed to increasing the proportion of investment going into general practice services. This should reach over 10 percent by 2020/21, and will rise further as CCG investment in general practice rises also. Overall investment to support general practice services will rise by a minimum of £2.4 billion a year by 2020/21. This represents a 14 percent real terms increase, significantly more than that anticipated for CCG allocations.

The additional investment we are making in introducing new care models will benefit general practice too – and this will ensure investment rises at least in line with the plans set out above, and potentially even more.

For 2016/17, NHS England has allocated an additional £322 million in primary medical care allocations, providing for an immediate increase in funding of 4.4 percent.

Plus local investment

For the first time, the Planning Guidance for the NHS has made securing the sustainability of general practice, and in particular addressing workforce and workload issues, one of nine national 'must dos'. Every part of England has been asked to produce a Sustainability and Transformation Plan (STP), which will include plans to secure and support general practice, and enable it to play its part in more integrated primary and community services. These plans will be completed by July 2016. National actions on their own will not be enough – local leadership and investment will be vital.

Plus a five year general practice Sustainability and Transformation package

We have created a national £508 million five year Sustainability and Transformation package for general practice to help further support struggling practices in the interim, develop the workforce, stimulate care redesign and tackle workload.

This package will include:

- £56 million, to include a new practice resilience programme starting in 2016/17, and the offer of specialist services to GPs suffering from burn out and stress (see chapter 3)
- £206 million for workforce measures to grow the medical and non-medical workforce (see chapter 2)
- £246 million to support practices in redesigning services, including a requirement on CCGs to provide around £171 million of practice transformational support and a new national £30 million development programme for general practice (see chapter 5).

We will also continue to support capital investment in general practice through a programme of investment estimated to reach over £900 million over the next five years.

Fairer distribution of funding

The Carr-Hill formula applies a weighting (to General Medical Services (GMS) contracts only) to reflect the comparative workload associated with different patient groups.

[1] As part of agreed devolution arrangements, Greater Manchester has been allocated a transformation fund which includes an appropriate share of NHS England funding for primary medical care initiatives. It will be for Greater Manchester to determine how it is spent in the local area.

Many believe that the Carr-Hill formula is now out of date and needs to be revised to reflect changes in the population and the impact of this on comparative workload. NHS England is working with the BMA to review the Carr-Hill formula to specifically examine the impact of deprivation, age and other factors that influence practice workload. This work will be concluded in the summer of 2016, and form the basis of discussion with the BMA about changes that might be needed.

A minority of practices are yet to undergo their PMS contract reviews. We are committed to ensuring this process is completed in the interest of equity across all practices. However, in the interests of stability, these changes are being phased over a minimum of four years, ensuring there is a water tight reinvestment plan for all savings in local general practices, and engaging in individual conversations with practices that are particularly challenged.

CCG plans for reinvestment must be published before the full impact of Personal Medical Services (PMS) reviews are implemented for individual practices.

Tackling rising costs of indemnity

Indemnity costs have risen in the NHS in England significantly in recent years. This is the result of the rising number of claims, and the rising level of awards made by the courts, with the cost of care packages doubling every seven years. This is despite the fact that on objective measures, the quality and safety of care provided by GPs has never been higher. GPs tell us that these costs are distorting decisions about whether to remain in work (particularly for those choosing to work part-time), whether to work in GP out of hours and urgent care services for non NHS trust providers, and whether to deploy the wider clinical workforce (where costs for nurse indemnity can be the equivalent of medical indemnity).

NHS England has taken initial steps to alleviate these pressures through:

- the establishment in 2014/15 and 2015/16 of a £2.5 million 'winter indemnity' scheme to help with the costs of those working out of hours
- taking into account increases in indemnity costs, amongst other factors, in agreeing funding for the 2016/17 GP contract.
- working with the medical defence organisations and indemnity insurers to meet the needs of new ways of delivering care. For example, through products that treat the delivery of services across practices outside of core hours (with shared access to patient records) as similar to in-hours working, rather than charging the out of hours rate. This is in recognition of access to the patient record.

Some GPs have called for general practice to have Crown indemnity. This would mean it is not possible to sue for damages and that the small minority of patients who had suffered harm as a result of clinical negligence would not have recourse to any financial compensation. We do not believe that this is the intent of the profession, and this form of immunity does not apply to other health services.

Rather, we believe that the shared aim of all those working in the NHS is to bring down the overall costs associated with negligence claims in an appropriate fashion, and ensure that the way that those costs are borne does not dis-incentivise excellent clinical staff from working in the NHS or restrict access to justice.

The Department of Health will be consulting shortly on the options for introducing a Fixed Recoverable Cost scheme to cap the level of recoverable costs for claimant lawyers on clinical negligence claims. The aim is to make the cost of claimant lawyers more proportionate to damages and defence costs.

We and the Department of Health are also committed to reviewing the way in which costs are funded. Any changes would have a bearing on historical claims and handling of past liabilities. This is complex with the potential to create unintended financial consequences if mishandled. The Clinical Negligence Scheme for Trusts (CNST) is a risk-pooling arrangement for trusts, and requires every organisation to contribute funds. The rising costs of CNST has been an issue for providers in other sectors, and to date, we have not seen evidence that access to CNST would bring down the costs for practice partnerships. There would be significant implications for the treatment of historical claims, for the insurance market in general, and it might increase costs to practices. So this is not a simple solution.

The Department of Health and NHS England will instead bring forward proposals in July 2016 for discussion with the profession, medical defence organisations, the commercial insurance industry and the NHS Litigation Authority. This will consider potential solutions, including considering:

- how personal costs of indemnity and clinical insurance can be contained, provided certain clinical governance standards are met – with the objective of reducing the overall costs to the individual;
- reducing indemnity costs for individuals in particular circumstances, such as GPs who wish to remain in the workforce on a part-time basis past a certain age; and
- enable new models of care such as Multispeciality Community Providers (MCPs) to take on corporate indemnity, freeing up individuals working in those new models from the burden of personal indemnity costs.

In principle, GPs should be no more exposed to the rising costs of indemnity than our hospital doctors, and any solution will need to address this.

Taken together, this represents a significant programme of work to reform indemnity in general practice, addressing some short-term pressures whilst looking to bring down the overall costs to the system.

Better Care Fund

The Better Care Fund (BCF) requires CCGs and local authorities to pool budgets and to agree an integrated spending plan for how they will use their BCF allocation. In 2016/17, the minimum size of the BCF has been increased to £3.9 billion.

From April 2016, CCGs, local authorities and NHS England will be able to pool budgets to jointly commission expanded services, including:

- additional nurses in GP settings to provide a coordination role for patients with long term conditions;
- GPs providing services in care and nursing home settings;
- providing a mental health professional in a GP setting; and
- hosting a social worker in a GP surgery.

CASE STUDY

Wider integration of health and social care - Sunderland (MCP vanguard)

Through the Better Care Fund all of Sunderland's resources for out-of-hospital care from both the CCG and local authority are now contained within a single pooled budget of over £160 million. From April 2015, a Provider Management Board took on the leadership for redesigning existing services and investing new funds in additional GP and nursing sessions in integrated teams and a 24/7 Recovery at Home service.

Co-located multidisciplinary teams, working across several practices, provide an enhanced level of care to patients with complex needs. These are often frail older people and/or people with multiple co-morbidities both at home and in supported housing, including care homes, identified via a risk stratification approach.

Chapter 2: Workforce

We will expand and support GPs and wider primary care staffing

The General Practice Forward View cannot be delivered without sufficient recruitment and workforce expansion. Therefore NHS England and Health Education England (HEE) have set ambitious targets to expand the workforce, backed with an extra £206 million as part of the Sustainability and Transformation package. We will also support the development of capability within the current workforce and support the health and wellbeing of staff.

Expansion of workforce capacity

Plans to double the rate of growth of the medical workforce to create an extra 5,000 additional doctors working in general practice by 2020. This five year programme includes:

- Increase in GP training recruitment to 3,250 a year to support overall net growth of 5,000 extra doctors by 2020 (compared with 2014).
- Major recruitment campaign in England to attract doctors to become GPs, supported by 35 national ambassadors and advocates promoting the GP role.
- Major new international recruitment campaign to attract up to an extra 500 appropriately trained and qualified doctors from overseas.
- Targeted £20,000 bursaries in the areas that have found it hardest to recruit into GP training.
- 250 new post-certificate of completion of training (CCT) fellowships to provide further training opportunities in areas of poorest GP recruitment.
- Attract and retain at least an extra 500 GPs back into English general practice, through:
  - simplifying the return to work routes further, with new portfolio route, and other measures to reduce the length of time.
  - launch of targeted financial incentives to return to work in areas of greatest need.

A minimum of 5,000 other staff working in general practice by 2020/21. This five year programme will include:

- Investment in an extra 3,000 mental health therapists to work in primary care by 2020, which is an **average of a full time therapist for every 2-3 typical sized GP practices.**
- Current investment of £31 million to pilot 470 clinical pharmacists in over 700 practices to be supplemented by **new central investment of £112 million** to extend the programme by **a pharmacist per 30,000 population** for all practices not in the initial pilot – leading to a further 1,500 pharmacists in general practice by 2020.
- Introduction of a new Pharmacy Integration Fund.

- A general practice nurse development strategy, **with an extra minimum £15 million national investment** including improving training capacity in general practice, increases in the number of pre-registration nurse placements, measures to improve retention of the existing nursing workforce and support for return to work schemes for practice nurses.
- **National investment of £45 million** benefitting every practice to support the training of current reception and clerical staff to play a greater role in navigation of patients and handling clinical paperwork to free up GP time.
- Investment by HEE in the training of **1,000 physician associates to support general practice.**
- Introduction of pilots of new medical assistant roles that help support doctors, as recommended by the RCGP.
- **£6 million investment** in practice manager development, alongside access for practice managers to the new national development programme.
- £3.5 million investment in multi-disciplinary training hubs in every part of England to support the development of the wider workforce within general practice.

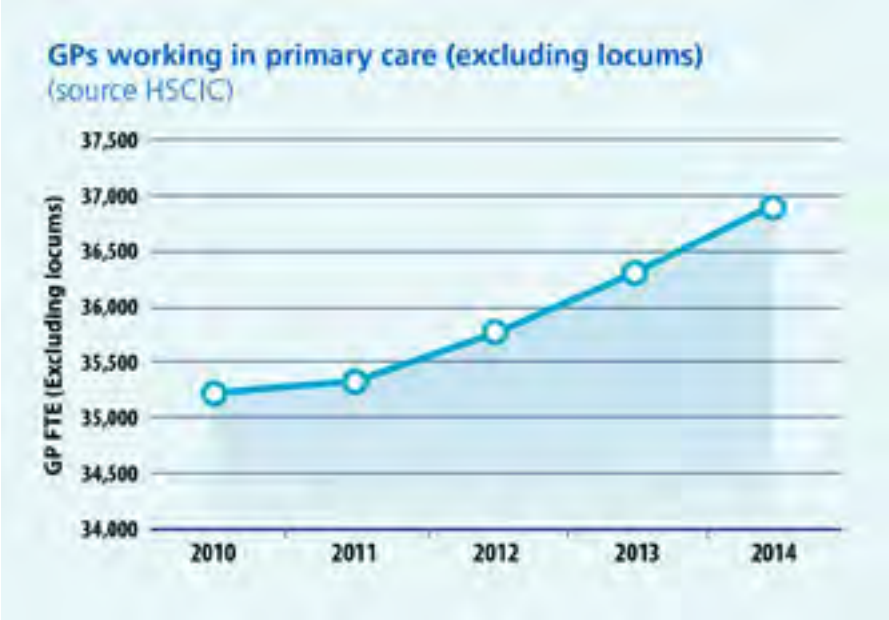
Health and wellbeing

£16 million extra investment in specialist mental health services to support GPs suffering with burn out and stress, and support retention of GPs, in addition to the £3.5 million already announced.

Over the past decade, the number of GPs (full time equivalents) working in general practice has risen by over 5,000.

But we know that many practices now face recruitment issues and are increasingly reliant on temporary staff. Moreover, a higher proportion of older GPs are signalling that they are considering leaving the workforce early.

We aim to double the rate of growth in the primary care medical workforce over the next five years, to create an extra 5,000 doctors working in general practice. This needs to be supported by growth in the non-medical workforce – a minimum of 5,000 extra staff – nurses, pharmacists, physician associates, mental health workers and others.



Work to date

The Primary Care Workforce Commission, set up by HEE and chaired by Professor Martin Roland, called for a broader range of staff to be involved in providing care. Their report, The future of primary care creating teams for tomorrow, set out how we can better deploy the talents of the wider workforce to reduce the workload burden on GPs, meet patients' needs and to free GPs up to do what they do best. The report also set out recommendations to increase the role of nursing, advanced clinical practitioners, medical assistants, practice pharmacists and physician associates along with stronger partnerships with the voluntary sector and better use of technology.

Last year, NHS England, HEE, Royal College of General Practitioners (RCGP) and the General Practitioners Committee (GPC) developed an initial 10 point action plan – Building the Workforce a new Deal for General Practice - to kick start initiatives to improve recruitment, retention and return to practice. Now that there is significant new investment for general practice, we will be working together – and with other professional bodies, such as the RCN, Queen's Nursing Institute, Royal Pharmaceutical Society, National Association of Primary Care and NHS Clinical Commissioners to step up actions to grow the workforce and stimulate a more diverse range of workforce models within primary care.

Through the 10 point action plan, together we have:

- delivered a marketing campaign to encourage foundation year 2 doctors who are applying for specialty training to choose general practice;
- launched a scheme to offer up to £20,000 bursaries for 109 GP trainees to attract doctors to parts of the country where there have been consistent shortages of trainees;
- established new post-CCT fellowships to provide further training opportunities in areas of poorest GP recruitment that encourage new CCT holders to work as GPs in those areas, whilst pursuing special interests and meeting local need such as urgent care and learning disability care;

- committed to invest £3.5 million in 13 new multi-disciplinary training hubs (Community Provider Education Networks) across the country to support the development of the wider workforce within general practice, including placements in general practices, development for current staff and workforce planning;
- created a national induction and refresher (returner) scheme, offering a new £2,300 per month bursary to doctors looking to return to general practice to help with costs and improving entry routes – leading to an increase in the number of applicants and improving coverage, given previous local variation;
- invested an extra £1.75 million nationally to support practice nurse development;
- invested in leadership development and coaching for individual GPs; and
- piloted new ways of working including the development of Primary Care Physician Associates.

For the wider workforce, we agreed a major £31 million scheme to pilot the deployment of over 470 clinical pharmacists in just over 700 practices over the next three years, helping practices with the costs of employment and training. We have published a practice and community nursing education and career framework, and

are developing a strategy for supporting the practice nursing workforce.

Building the workforce for 2020

To double the rate of growth of the medical workforce, and accelerate use of the wider workforce, we set out below the new programmes of work that will be needed. This will be backed by an extra £206 million over the next five years on top of previously announced initiatives.

Recruiting doctors into general practice

HEE has increased GP training capacity and increased recruitment to 3,250 doctors per annum recurrently. In the first round recruitment for 2016, 2,296 posts - 70 percent - have already been filled.

This represents a welcome increase of around 7 percent on last year's first round of recruitment.

HEE will in partnership with the RCGP, and the profession continue refining and developing GP specialty training to provide greater career flexibility while maintaining standards in order to maximise recruitment.

We know we need to improve the number of medical school graduates choosing to join general practice. There is a strong correlation between training placements in general practice and eventually working in general practice. HEE is currently working with the Medical Schools Council, higher education institutions, the RCGP and the GPC to increase the profile of general practice in medical schools and in their curricula.

A working group, chaired by Professor Valerie Wass OBE, will publish recommendations in summer 2016 about recruitment and selection, finance and curriculum and the promotion of general practice as a speciality.

The recommendations will improve the medical school experience of general practice through greater exposure to the diverse and stimulating reality of general practice professionally and personally. More graduates will be encouraged to make a positive choice of general practice as a career.

HEE and the RCGP will continue to develop the current **recruitment campaign** to raise the profile of general practice as a career. The campaign showcases the variety of different opportunities and the flexibility of the specialty, as well as the central role that GPs play in the community and their patients' care. HEE has recruited and trained 35 campaign ambassadors and advocates to support and promote national and regional activities including attendance at recruitment events and through social media.

We will supplement this with a **major international recruitment drive**, to attract up to 500 appropriately trained and qualified doctors – and possibly more - from overseas over the next five years.

Working with HEE we will evaluate its £20,000 bursary scheme to attract trainees into hard to fill areas and identify if more needs to be done.

HEE will roll out a total of **250 post CCT fellowships** by summer 2017 to offer wider and more varied training opportunities in areas of poorest GP recruitment.

Retaining the current medical workforce

One of the strengths of general practice as a career is its flexibility, with the chance to work part-time or combine general practice with work in other settings. We want to make it easier and more attractive for GPs to return to work in English general practice.

Already, the new induction and refresher (returner) scheme has seen:

- the end to multiple different policies, with one single national policy, supported by single website, a consistent set of written guidance to applicants, and a new single point of contact;
- a significant increase in NHS England bursaries for the period of time that the doctor is in a supervised placement - £2,300 per month – up from a range of £0 to £500 per month previously depending on which part of the country you are in;
- the end to requiring doctors working overseas to return to England to start the application process, with the ability to hold interviews now via Skype and sit initial assessments in countries all round the world; and
- a review of the appropriate and relevant content of all assessments, leading to a doubling of pass rates in the last nine months.

As a direct result, we have seen a significant rise in the number of doctors applying to return to work in general practice, with an increase of 40 percent in the number of doctors booking to sit the multiple-choice questions (MCQ), one of the routes for returning to practice, in 2015/16 compared to 2014/15.

We need to accelerate this further so that we can attract at least **an extra 500 doctors** over the next five years back into general practice. The RCGP has sought feedback on some of the main barriers experienced by returning doctors, and this has formed the basis of our action plan for improvement. Our aim is to start measuring the time it takes for a doctor to return to work, and halve the average time.

We will build on the improvements to establish a straightforward route for doctors to return to work in England.

In addition, we will:

- from April 2016, introduce a **new Portfolio Route (2016) for GPs with previous UK experience**, continuing to work in equivalent primary care roles outside the UK, removing the need for them to sit the current exams to return to practice;
- create a central contact point for any doctor wishing to return to work in English general practice, so that doctors are supported in navigating any regulatory issues and to support and guide them through the process;
- address delays in securing Disclosure and Barring Service checks – taking several weeks and sometimes months – and sort out information governance issues to enable checks to be valid across different parts of the system;
- **increase the financial compensation available through the current GP retainer scheme from 1 May 2016**; and introduce a new GP retainer scheme more fit for purpose from 1 April 2017; and
- **offer targeted financial incentives to GPs from May 2016 for returning to work in areas of greatest need.**

We also need to find ways to attract GPs to remain in practice towards the end of their career. The published evidence on retention suggests that the single biggest enabler would be to address concerns over workload, and create a greater sense of 'status' for general practice within society. The totality of the General Practice Forward View is aimed at addressing these fundamental issues.

In addition, we will invest further in leadership development, coaching and mentoring skills for experienced doctors – enabling them to build on their skills and offer the value of their experience to younger doctors. We will take stock of the findings of evidence on retention, and address any further issues identified.

Building the wider workforce

The success of general practice in the future will also rely on the expansion of the wider non-medical workforce – including investment in nurses, pharmacists, practice managers, administrative staff and the introduction of new roles such as physician associates and medical assistants.

Our ambition is to use some of the extra investment going into general practice to support the **employment of a minimum of 5,000 extra staff**.

To achieve this, at a national level, NHS England and HEE, over the next five years, will:

- invest an extra **£15 million nationally in general practice nurse development,** including support for return to work schemes, improving training capacity in general practice for nurses, increases in the number of pre-registration nurse placements and other measures to improve retention;
- extend the clinical pharmacists programme with a **new £112 million offer to enable every practice to access a clinical pharmacist** across a minimum population on average of 30,000 - leading to an extra 1,500 pharmacists in general practice. Appetite for the original pilot scheme was high. We will need to learn more from the evaluation but early indications suggest clinical pharmacists may have a role in streamlining practice prescription processes, medicines optimisation, minor ailments and long term conditions management. We will roll this out further across the country over the next five years, so that every practice can benefit. We will also open up the clinical pharmacist training programme to practices that have directly funded a clinical pharmacist;
- introduce a Pharmacy Integration Fund, worth £20 million in 2016/17 and rising by a further £20 million each year, to help further transform how pharmacists, their teams and **community pharmacy** work as part of wider NHS services in their area. Subject to a separate consultation, our proposals include better support for GP practices, for care homes and for urgent care for the use of the fund;
- invest in an **extra 3000 mental health therapists** to be working in primary care by 2020 to support localities to expand the Improving Access to Psychological Therapies (IAPT) programme;
- provide **£45 million extra funding** nationally over five years so that every practice in the country can help their **reception and clerical staff** play a greater role in **care navigation**, signposting patients and handling clinical paperwork to free up GP time. This builds on successful pilots tested through the Prime Minister's GP Access Fund schemes and vanguard sites where the majority of clinical correspondence can be managed through trained staff;
- pilot new medical assistant roles that help support doctors;
- pilot the role of primary care physiotherapy services;

- invest an extra **£6 million in practice manager development;**
- roll out the recently published HEE Community (District) and General Practice Nursing Service Education and Career Framework and the accompanying HEE Education and Career Framework;
- implement the Queen's Nursing Institute Voluntary Education and Practice Standards for District and General Practice Nursing; and
- work with general practice to ensure general practice nurses have access to mentorship training.

This also needs to be supplemented at a **local level**, and for the first time - through the Planning Guidance – the NHS locally has been asked to produce plans to address workforce issues in general practice. We will review these plans in the summer, and identify any further actions that need to be taken or ideas that can be spread nationally to accelerate the growth, retention and development of the general practice workforce.

The vanguard sites that are testing new integrated models of care and the GP Access Fund schemes are already developing many different ways of using the wider workforce, and proving that this can be better for patients and free up GP time.

A balanced GP workforce

The model of independent contractor status and partnership has proved a valuable foundation for general practice. Partners provide leadership and continuity, and in recent years this has been invaluable as general practice has come under pressure.

We also recognise that a more flexible workforce better enables practices to secure short-term support to cover sick leave, parental leave or transition periods between leavers and joiners. However many practices now report that a shift to reliance on locums is undermining service continuity and stable team working.

It is therefore in the interests of GPs and practices to improve the relative attractiveness of partner and salaried positions versus a shift to a more unstable and short term workforce.

First, **we will work with the profession to introduce new measures entitling GPs who want flexible working but who can commit to working in a practice or an area for a period of time, additional benefits relative to undertaking a rolling series of short term locum roles**. In other words, while continuing to incentivise partnerships and salaried commitments to practices on the one hand, we also want to **create an alternative to day-by-day or week-by-week locuming for those at a point in their career or family life who need more flexibility**.

Second, NHS England will set indicative rates for locums and will ask practices to indicate in the annual e-declaration information where they are having to pay above those rates. This is to understand the scale of the issues practices are facing and help plan how we can target workforce support to areas facing the greatest pressures.

Third, we envisage 'at scale' working in larger practice groupings will create opportunities to embed a more locally focused team based approach which incorporates locums.

Promoting health and wellbeing to combat burnout

A new national service is being established to improve GPs' access to mental health support. Support for GPs suffering mental health problems is part of NHS England's plans to retain a healthy workforce. **NHS England has already committed to spend up to £3.5 million in this new service, and will now increase that investment by a further £16 million**. The procurement will start in June 2016 and the service is expected to be available across England from December 2016. This means all GPs will be able to access free, confidential local support and treatment for mental health issues, supporting GPs who are at risk of suffering stress or burnout.

Implementation

We will establish a new Workforce 2020 oversight advisory group, with representation from national bodies, to steer the delivery of this ambitious programme, and review where further actions need to be taken in light of progress nationally and locally over the next five years.

CASE STUDY

Multidisciplinary workforce - West Wakefield Multispecialty Community Provider (MCP)

West Wakefield Health and Wellbeing Ltd is a GP Federation in West Yorkshire serving a population of 65,000 and is a wave one GP Access Fund site. It is now leading one of the new care models MCP vanguard sites with two other GP networks covering a total population of 152,000 people.

Among a series of initiatives designed to relieve pressure on GPs, they are training care navigators to break down the automatic assumption that a GP appointment is the best first place to go for any problem.

As well as reduce the number of patients needing to access their GP, care navigators are able to 'queue bust' at reception by offering patients who arrive at the practice advice to signpost them to the most appropriate solution for their needs.

Over 70 staff have received training on available resources, services and innovations within the practice and MCP programme, and in the wider voluntary and third sector.


#GPforwardview

Chapter 3: Workload

We will reduce practice burdens and help release time

Support for general practice with the management of demand, diversion of unnecessary work, an overall reduction in bureaucracy and more integration with the wider health and care system including:

- Major £30 million 'Releasing Time for Patients' development programme to help release capacity within general practice (see also Chapter 5).
- New standard contract measures for hospitals to stop work shifting at the hospital/general practice interface.
- New four year £40 million practice resilience programme, starting in 2016.
- Move to maximum interval of five yearly CQC inspections for good and outstanding practices.
- Introduction of a simplified system across NHS England, CQC and GMC.
- Streamlining of payment processes for practices, and automation of common tasks.

Workload was identified by the 2015 BMA survey as the single biggest issue of concern to GPs and their staff. Latest research, published in the Lancet, suggests that there has been an average increase in workload in general practice of around 2.5 percent a year since 2007/8, taking account of both volume and acuity. Whilst some of this rise can be addressed by increasing the workforce, we also want to support practices in moderating demand and reforming how we support and organise services.

The Primary Care Foundation and NHS Alliance have identified the changes that will have the biggest impact in reducing bureaucracy and reshaping demand. Their report, Making Time in General Practice, identified a number of practical, high-impact ways to remove unnecessary pressures on general practice and free up time for patient care.

The report found that the top three sources of bureaucracy experienced in general practice are: the processes used to make and claim payments; keeping up to date with information from commissioners and national bodies, and reporting for contract monitoring or regulation.

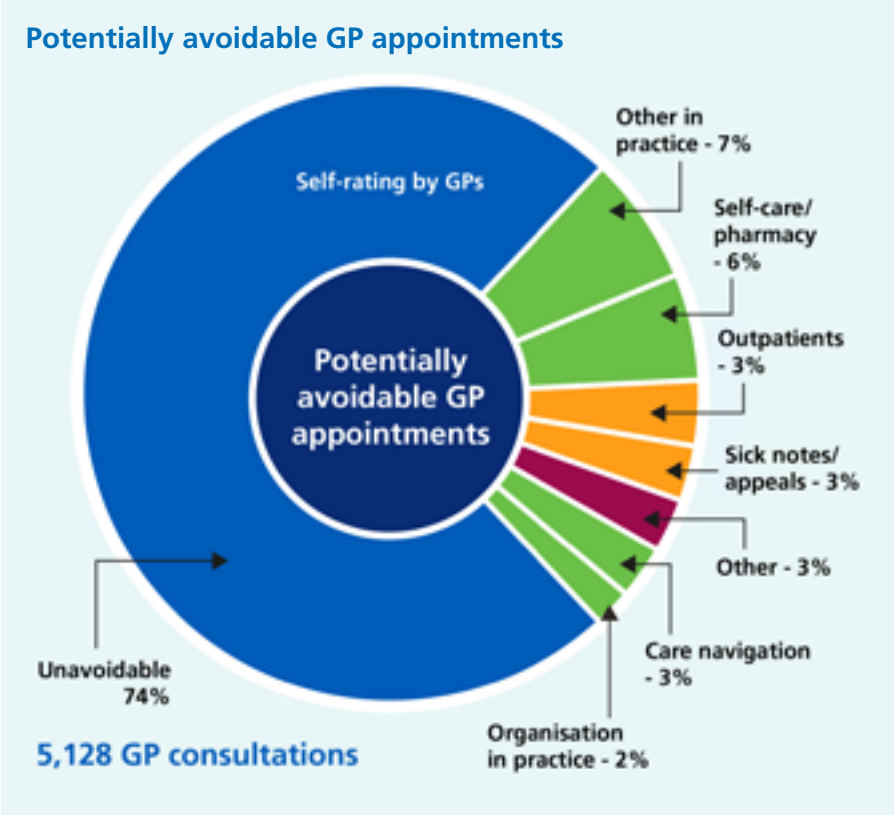
The report also estimated that **around 27 percent of appointments could potentially be avoided** if there was more coordinated working between GPs and hospitals, wider use of primary care staff, better use of technology to streamline administrative burdens, and wider system changes.

NHS England is therefore taking immediate action in the following areas:

Managing demand more effectively

NHS England is investing in a major new £30 million 'Releasing Time for Patients' development programme to support practices release time (see Chapter 5).

Practices have identified that one way of doing this is to assist patients in managing a greater proportion of their minor self-limiting illnesses for themselves. We will therefore use some of the funding for workforce and technology, outlined elsewhere in this document, to support practices in doing so.



In addition, by September 2016, we will have launched a **national programme to help practices support people living with long term conditions to self-care**. Practices will be offered tailored support to offer high quality care planning to patients who have low levels of knowledge, skills and confidence to manage their own health and wellbeing. The aim is to equip the workforce with the tools and skills to do this. This should help improve patient outcomes, and over time, reduce the demand in general practice. We will design this in conjunction with the wider national development programme for general practice.

GPs can also influence the commissioning of local pathways for community pharmacy to help patients with self-care and minor ailments. The developments in digital interoperability and access to a shared primary care record provide practices with an opportunity to harness this potential for reducing demand for urgent appointments.

Alongside a reformed 111 service, we will also work with CCGs to ensure they institute plans to address patient flows in their area using tried and tested ideas such as access hubs, social prescribing and evidence based minor ailment schemes.

Building practice resilience

In 2015, NHS England committed to invest £10 million to support vulnerable practices. Eligible criteria for accessing this additional support was developed with NHS Clinical Commissioners and other national stakeholders, with around 800 practices identified as meeting the criteria.

This support is designed to build resilience in primary care and to support delivery of new models of care. RCGP support for inadequate rated practices will continue as part of this programme. A multi-supplier (call off) framework will be available to commissioners from September 2016 to support the programme. This is likely to include a range of local and national providers and may be expanded over time. In order to maximise the impact of this support, from April 2016, NHS England will offer support to eligible practices that are willing to match fund this additional support, or offer the equivalent resources commitment 'in kind'.

In addition, a further **£40 million** will now be committed to develop a **practice resilience programme**, starting with a **£16 million** boost in 2016/17. We will work with the RCGP and the BMA to develop this programme as quickly as possible, and consider introducing practice resilience teams.

New standards for outpatient appointments and interactions with other providers

We have introduced a number of **new legal requirements in the NHS Standard Contract for hospitals** in relation to the hospital/general practice interface from April 2016. These should relieve some of the administrative burden on practices.

The changes include:

- **Local access policies:** hospitals will not be able to adopt blanket policies under which patients who do not attend an outpatient clinic appointment are automatically discharged back to their GP for re-referral. Also a new requirement on hospitals to publish local access policies and evidence of having taken account of GP feedback when considering service development and redesign.
- **Onward referral:** unless a CCG requests otherwise, for a non-urgent condition related to the original referral, onward referral to another professional within the same hospital is permitted, and there is no requirement to refer back to the GP. Re-referral for GP approval is only required for onward referral of non-urgent, unrelated conditions.
- **Discharge summaries:** hospitals will be required to send discharge summaries by direct electronic or email transmission for inpatient, day case or A&E care within 24 hours, with local standards being set for discharge summaries from other settings. Furthermore, the hospital should provide summaries in the standardised format agreed by the Academy of Medical Royal Colleges, so GPs can find key information in the summary more easily.
- **Outpatient clinic letters:** hospitals to communicate clearly and promptly with GPs following outpatient clinic attendance, where there is information that the GP needs quickly in order to manage a patient's care (certainly no later than 14 days after the appointment). For 2017/18, the intention is to strengthen this by requiring electronic transmission of clinic letters within 24 hours.

- **Results and treatments:** new overarching requirement on hospitals to organise the different steps in a care pathway promptly and to communicate clearly with patients and GPs. This specifically includes a requirement for hospitals to notify patients of the results of clinical investigations and treatments in an appropriate and cost-effective manner, for example, telephoning the patient.
- **Medication on discharge:** a new requirement on providers to supply patients with medication following discharge from inpatient or day case care. Medication must be supplied for the period established in local practice or protocols, but must be for a minimum of seven days (unless a shorter period is clinically necessary).

These changes apply to all acute and community providers. GPs should notify their CCG in the event that the contract is not being followed. The CCG is responsible for holding providers to account for the contract changes.

A new NHS England, NHS Improvement, RCGP and GPC Working Group will drive action to improve the current interface between primary and secondary care. The Group's work will include practical steps to enable better communication between GPs and consultants, and how to improve GP access to consultant advice on potential referrals, and managing complex cases in the community.

As part of this, NHS England has established a **Rapid Testing Programme in three sites across the country to review ways of better managing outpatient demand**. This will include assessment of the practical application of consultant hotline and advice services, enabling GPs to get rapid advice rather than referring the patient. In light of the outcome of this programme, the most effective measures will be rolled out for use by CCGs from late summer 2016 onwards. Alongside this, work is underway to make the current functionality of the Choose and Advice system more functional for use by GPs.

New software to automate common tasks

Clinicians are frequently required to undertake a series of tasks on the computer when putting a care plan in place or responding to incoming correspondence. We will work with innovative practices, federations and software suppliers to develop, test and implement the technical requirements for a new task automation solution to reduce workload. It is expected that practices will have access to the new automation function in 2017/18.

Streamlining Care Quality Commission (CQC) practice oversight

In October 2014, the Care Quality Commission (CQC) began to inspect general practice services. CQC ratings have, for the first time, provided a comprehensive assessment of the quality of care provided by practices. By April 2016, they had inspected over a third of practices (35 percent) and found that the vast majority (87 percent) are providing care that is good or outstanding.

The CQC will complete its first round of comprehensive inspections of all practices in 2016/17. CQC is consulting on changes to its regulatory model for its work thereafter.

These proposals will reduce the workload related to inspection for those practices that deliver good or outstanding care, while encouraging improvement and ensuring a proportionate approach that protects patients from the risks of poor care.

Another issue related to CQC has been that of the fees increase for registration. In recognition of this, NHS England agreed with the GPC to reflect these costs in the 2016/17 GP contract settlement to address this cost pressure for practices.

What can practices expect nationally?

- **A reduction in inspections from CQC.** This will apply once all GP practices have been inspected later this year. CQC will tailor its inspection activity, taking a more risk-based approach where it monitors and acts on intelligence and information. It will reduce the frequency of some inspections, so that it targets its resources on those practices where there is a risk of poor care. CQC will agree with NHS England and local CCGs a shared framework to understand and report on quality. **Practices rated good and outstanding - currently the vast majority - will move to a maximum interval between inspections of five years**, subject to the provision of transparent data, available to CQC, NHS England and CCGs; and also to CQC remaining assured that the quality of care has not changed significantly since the previous inspection. Where CQC has concerns, it may revisit sooner.
- **New streamlined approach to inspection for new care models and federated or super-partnerships practices.** CQC will continue to develop the way it inspects to take account of changes to the way the sector is organised and delivered, for example, through new models of care or federated practices – with a focus on the leadership, governance and learning culture of the provider, not necessarily on inspecting every single site.
- **Funding for CQC.** NHS England will discuss with the GPC how best to recognise any further fee increases and will ensure practices are appropriately compensated.
- **Improving and simplifying transparency of information about general practice.** A report from the Health Foundation to the Department of Health made a number of recommendations on valid quality indicators for general practice. A set of key 'sentinel' indicators will therefore be published on My NHS in July 2016.

A successor to the Quality and Outcomes Framework (QOF)

QOF has created a more focussed approach to chronic disease management and provides a structured way of engaging in secondary prevention. However, some argue that it has served its purpose and requires review or even replacement and that it is a barrier to holistic management of health conditions. **NHS England has agreed to undertake a review of QOF with the GPC in the coming year** to address these issues, whilst recognising that it is one of the best public health databases in the world and, done right, can support population-based healthcare.

There are already areas of the country exploring local alternatives to QOF. For practices opting in to the proposed new voluntary MCP contract (see Chapter 5) QOF will be replaced with more holistic team-based funding.

NHS England and GPC have agreed that we will discuss during the next round of negotiations the GPC's wish for the avoiding unplanned admissions enhanced service to be discontinued from April 2017.

Reporting requirements and information, and streamlining the payment system

We will introduce a simplified system for how GP data and information is requested and shared across NHS England, CQC and GMC. This will be backed by a programme of work to cut the bureaucratic burden of oversight.

We are also taking action to simplify the general practice payment system. It is unacceptable for hard-pressed practices to have to waste time chasing or reconciling payments. Where technical issues arise that may delay payments to practices, NHS England has introduced failsafe procedures that allow practices to submit activity data manually into CQRS, therefore ensuring practices cash flow is maintained.

In addition, based on a recent review of the payment processes and systems for general practice, we will now work with the payment providers to focus on:

- improvements in the consistency and accuracy of payments;
- increasing the transparency and availability of information to support them; and
- the feasibility of a single payment vehicle as a single view with an itemised bank statement like reconciliation of claims and payments.

Accelerating paper free at the point of care within general practice

General practice already has the most computerised records in the NHS, and many practices are already considered to be paperless. However, owing to a lack of interoperable systems across the NHS, its dealings with other providers are often on paper, creating risks and inefficiencies that we are committed to reducing.

Examples include tackling the significant workload involved in every practice receiving, checking and processing many prescriptions every day. Rolling out electronic prescriptions is speeding up processes for practices and helping to reduce clinical risk for patients. Work is almost complete which removes the need for practices to print paper copies of records when a patient moves practice. This is already in place for practices using the most up-to-date software, and final testing of updates for the remaining systems is expected to be completed in May 2016.

A major programme is also underway to ensure that by 2020 all incoming clinical correspondence from other NHS providers is electronic and coded. This will reduce practice workload and the risks of errors in data entry, as well as improve the usefulness of incoming information and facilitate more seamless patient care.

Promoting best practice and monitoring improvements

We hosted a series of BMA and NHS England workshops to share evidence and examples with practices of the opportunities to release staff capacity. 95-98 percent of practices that attended reported that these gave them new practical ideas to release staff time.

We will continue to support the spread of good ideas. We will monitor the impact of work to reduce pressure on practices, and we want to empower practices to also do this. We are therefore commissioning a new audit tool to be available for all practices that will allow practices to identify ways they could reduce appointment demand. This will use the same methodology as in the 'Making Time in General Practice' report and allow practices to compare themselves with the national data.

Practices in the GP Access Fund are about to begin testing of an automated appointment-measuring interface to give them detailed information about their activity and how it varies over time. This will help practices match their supply of appointments more closely to demand. We will make it available for every practice from 2017/18.

Mandatory training

Practices have told us that there seems to have been a growth in mandatory training requirements for clinicians and other practice staff. Examples include basic life support, safeguarding, information governance, health and safety, complaints handling, fire safety, fridge procedures etc. Whilst it is easy to see the justification behind each one, the sum of them all creates a significant burden on staff, and crowds out the more targeted training needs of individuals.

NHS England will work with relevant bodies to review and reduce these requirements to ensure a far more proportionate approach is taken. We will also keep in mind the impact of appraisal and revalidation requirements in the analysis.

Support for more integration across the wider health and care system

Social support

Voluntary sector organisations can also play an important role in supporting the work of general practice. For example, local models of social prescribing can enable GPs to access practical, community-based support for their patients, including access to advice on employment, housing and debt. Some areas have developed call-off services for specific groups such as carers.

Local leadership

We want all local Health and Wellbeing Boards (HWBs) to recognise the centrality of primary care in integrating their local health and care systems and the need to ensure access to all relevant support services. The Department of Health will issue guidance to Health and Wellbeing Boards asking them to ensure that joint health and wellbeing strategies (JHWSs) include action across health, social care, public health and wider services to build strong and effective relationships with general practice services. This will ensure that they understand our vision for general practice and how they can and should support it.

Work and health

There is clear evidence that good quality work is good for health and, conversely, being out of work has significant negative impacts on health. The Five Year Forward View set out a vision for the NHS to play a stronger role in prevention, including a focus on helping people at risk of falling out of work. Easier access to health services for people in employment should help individuals to seek help at an early stage, and general practice staff have a role to play in recognising when early referral or treatment may be indicated for someone at risk of falling out of work.

This means that GPs will have greater access to treatment pathways, especially for conditions that have an impact on the ability to work for large numbers of people, such as mental health conditions (IAPT) and musculoskeletal problems.

Over the last year, the Government has set up Fit for Work and will continue to develop this approach. Fit for Work offers a free advice, assessment and case management service for people who are employed and off sick. It is intended to help GPs by improving outcomes and reducing demands on them for fit notes and detailed work-related advice.

In addition, the Government will now consider whether 'early dialogue on work and health' and the resulting sickness certification (fit note) - currently restricted to registered medical practitioners - could be undertaken by other healthcare professionals.

To promote the development of social prescribing, a key measure by which patients can benefit from wider support, NHS England are appointing a new National Champion for Social Prescribing.

CASE STUDIES

General practice and community collaboration managing patient demand and making a difference to people's wellbeing - Robin Lane Medical Centre MCP

Robin Lane Medical Centre in Leeds has nine doctors, employs 50 people, has 13,000 patients and is growing. It also has a wellbeing centre, a cafe and 19 groups run by over 50 volunteer champions every week. By taking a new approach they have seen no increase in demand for primary or secondary care consultations despite patient lists increasing by 4,500 people. The practice has now established a charity to support the wellbeing centre which is run by a board of volunteer champions.

Redirecting administrative tasks away from GPs to release capacity - Brighton and Hove

In Brighton and Hove some practices have developed a robust protocol to allow clerical staff to read, code and where appropriate take action on incoming clinical correspondence, rather than the GP having to deal with every letter. Forty eight practices have now been trained and implemented workflow redirection with substantial changes demonstrated. On average, only 20 percent of letters previously directed to a GP required their direct input. This is saving an average of 40 minutes of each GP's time per day, with no significant events in the first 15,000 letters to be processed. Feedback clearly demonstrates reduced workload pressures and with the time savings generated, increased opportunity for activities related to direct patient care.

Training includes clear mechanisms to provide internal governance and auditing of activity. GPs report being satisfied with the safety of the approach, the improved quality of coding and the release of their time. Clerical staff report that they are confident to run the new process and describe renewed job satisfaction.

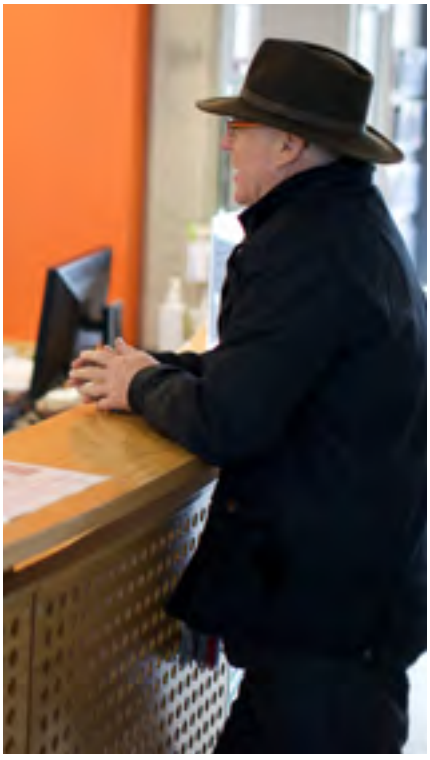

#GPforwardview

Chapter 4: Practice infrastructure

We will develop the primary care estate and invest in better technology

We will go further faster in supporting the development of the primary care estate:

- Investment for general practice estates and infrastructure – supported by continued public sector capital investment, estimated to reach over £900 million over the course of the next five years. This will be backed with measures to speed up delivery of capital projects.
- New rules on premises costs to enable NHS England to fund up to 100 percent of the costs for premises developments, up from a previous cap on NHS England funding of 66 percent (with a proposed date of introduction of September 2016).
- New offer for practices who are tenants of NHS Property Services for NHS England to fund Stamp Duty Land Tax for practices signing leases from May 2016 until the end of October 2017, and compensate VAT where the ultimate landlord has chosen to charge VAT.
- New funding routes for transitional funding support for practices seeing significant rises in facilities management costs in the next 18 months, in leases held with NHS Property Services and Community Health Partnerships.



Greater use of technology to enhance patient care and experience, as well as streamlined practice processes:

- **Over 18 percent increase** in allocations to CCGs for provision of IT services and technology for general practice.
- **£45 million national programme** to stimulate uptake of online consultations systems for every practice.
- Online access for patients to accredited clinical triage systems to help patients when they feel unwell.
- Development of an approved Apps library to support clinicians and patients.
- Actions to support the workload in practices reduce, and achieve a paper-free NHS by 2020.
- Actions to support practices offer patients more online self-care and self-management services.
- Actions to make it easier for practices to work collaboratively, including achievement of full interoperability across IT systems.
- Wi-Fi services in GP practices for staff and patients. Funding will be made available to cover the hardware, implementation and service costs from April 2017.
- A nationally accredited catalogue and buying framework for IT products and services, supported by a network of local procurement hubs offering advice and guidance.
- Work with the supplier market to create a wider and more innovative choice of digital services for general practice.
- Completion of the roll out of access to the summary care record to community pharmacy, by March 2017.

Development of the primary care estate

In 2015/16, NHS England began a multi million investment programme to support primary care and general practice make improvements in premises and in technology, as part of the overall estates strategy for the local NHS. This was backed by both capital and revenue funding, and will continue as the Estates and Technology Transformation Programme. Additional capital investment will also be flowing into general practice beyond this programme, bringing the estimated overall total of capital investment in general practice over the next five years to over £900 million.

NHS England is inviting CCGs to put forward recommendations for investment in primary care infrastructure in future years **by the end of June 2016**. CCGs are developing commissioning plans designed to provide health care services for the future and producing Local Estates Strategies, in conjunction with Community Health Partnerships and NHS Property Services.

Investment in the GP estate is needed not just to improve or extend existing facilities. We also need to increase the flexibility of facilities to accommodate multi-disciplinary teams and their training, innovations in care for patients and the increasing use of technology. And new premises may be needed to cater for significant population growth, and to facilitate primary care at scale or enable patient access to a wider range of services.

Investment in infrastructure can require planning permissions, building regulation approvals, procurements and construction. Given concerns about delays, and the handling of revenue consequences, we have made some changes in response:

- Firstly, the programme of **capital investment will now accommodate schemes that need support over more than one year**.
- Secondly, we will **invest in 'at scale' project support** for schemes to enable them to move quickly through the financial, legal and design processes.
- Thirdly, we have discussed with the GPC changes to the rules governing the funding of premises so that over the next three years NHS England will be able to increase the levels of funding for a wider range of improvements to practices and new facilities. NHS England will work with the Department of Health with the aim of introducing **new rules from September 2016 which will enable NHS England to fund up to 100 percent of the costs of premises developments, rather than the previous cap of 66 percent funding**.

NHS England will agree arrangements to come into place from 1 May 2016 until 31 October 2017 to provide **additional support to practices** in three areas:

- Stamp Duty Land Tax for practices
- VAT on premises, where the ultimate landlord has elected to charge VAT
- Transitional support where practices have seen a significant increase in the costs of facilities management on leases held with NHS Property Services and Community Health Partnerships. We will work quickly to clarify the route by which this new funding support can be provided.

NHS Property Services and Community Health Partnerships are working with CCGs in local areas to agree local estates strategies. CCGs will agree the improvements that will be made so that buildings are used productively and provide the capacity and flexibility that is required. While there are some GP practices that urgently require improvement, there are buildings which are unused or underutilised. Working with their CCGs and estates advisors, general practices will need to help to ensure that buildings are all used productively and effectively.

We will also work more closely with NHS Property Services using existing premises rules to unlock opportunities to transform primary care services, for example, considering wider commissioning gains against underwriting lease arrangements or buying out GP or third party owned premises.

In addition, the Department of Health is working with Community Health Partnerships to mobilise the potential of public and private sector partnerships in the development of the primary care estate, building on the LIFT programme which covers almost half the country.

Investment in better technology

New technology is already playing an important role in improving patient care. Practices round the country are using technology to move from paper to digital records, offering online transactions including online registration, appointment booking, ordering of repeat prescriptions and viewing of medical records. Some practices have gone far beyond these more transactional interactions, and we now need to support much more widespread adoption of their innovations.

A growing number of practices are introducing new apps and web portals that help patients assess and manage their own health risks. These provide information, symptom checkers and sign posting to alternate services, such as community services, expert patient groups and community pharmacies that also have a large role to play in health promotion. They also can include online and telephone consultations.

What does this mean for practices?

Our ambition is to support the adoption and design of technology which:

- enables self-care and self-management for patients;
- helps to reduce workload in practices;
- helps practices who want to work together to operate at scale; and
- supports greater efficiency across the whole system.

We will do this in three ways:

- through **extra investment** – with an increase of over 18 percent going into allocations for CCGs for the provision of IT and technology services for general practice, and a specific **£45 million** multi-year programme to support the uptake on online consultation systems;
- through **setting new core requirements** – making it clear what general practice should be able to expect from IT services, and creating a new framework to assess progress – the Digital Primary Care Maturity Index; and
- through **national enabling work** – to both stimulate the development of the supplier market, and provide certain functions at a national level where that makes sense.

Core GP information technology (IT) services

NHS England is introducing a greater range of core **requirements for technology services to be provided by vendors to general practice** through the CCG-controlled GPIT budget. During 2016/17, services should include:

- the ability to access digital patient records both inside and outside the practice premises, for example, on home visits;
- specialist support including services for information governance, IT and cyber security, data quality, clinical system training and optimisation, clinical (systems) safety and annual practice IT review;
- outbound electronic messaging (for example, SMS) from the practice for direct individual patient clinical communication;
- the ability for patients to transact with the practice through online appointment management, repeat prescription requests and access to their detailed record and test results, with the aim that at least 10 percent of patients will be using one or more online services by the end of this year;

- the ability for electronic discharge letters/summaries from secondary care to be transmitted directly into GP clinical systems – from June 2016; and
- specialist guidance and advice for practices on information sharing agreements and consent based record sharing – from December 2016.

This will be extended further in 2017/18 with:

- funding for Wi-Fi for staff and patients within practice settings;
- the ability to access data and tools that aid GPs (and local commissioners) in understanding and analysing demand, activity and gaps in service provision allowing effective planning, resourcing and delivery of practice services - from June 2017;
- a national framework for the cost-effective purchase of telephone and e-consultation tools - from December 2017;.
- funding to support education and support for patients and practitioners to utilise digital services to best effect and impact - from December 2017; and
- enhancements to the Advice and Guidance platform on the e-referral system to allow two way conversations between GPs and specialists, alerts to let GPs or other practice support staff know when a response (or no response) is received, interoperability with the clinical software system, easier conversion from advice to referral where clinically necessary, and decision support tools to help direct referrals correctly.

Each locality is different with its own mix of demographics, service pressures, commissioning priorities, and local relationships. So, in addition to funding for core GPIT services, CCGs will also have access to funding for subsidiary technology services to support their GP practices. Over time, some of these local investments may become core service offerings once adoption becomes widespread and benefits evaluated. These will include technologies and digital tools:

- to help practices operate collaboratively, such as shared care planning, or telephone and appointment management systems;
- to help practices in becoming more efficient (for example,reduced printing and filing of paper records, online ordering of diagnostic tests); and
- to join up pathways between different healthcare sectors and professional groups, for example, pharmacists.

At a national level, NHS England will continue with its programme of work that supports this direction of travel. This includes:

- the development of online access for patients to clinical triage systems to help patients when they feel unwell;
- the development of an approved Apps library to help GPs to recommend apps that might best suit patients' needs and where there is evidence of clinical efficacy; and
- a range of technology initiatives to drive towards improved practice efficiency and a paper-free NHS by 2020:
  - increase uptake of the electronic prescription system (EPS) and training for batch prescribing;
  - increase electronic transfer of records between practices
  - improve remote data extraction to reduce manual processes;

- access to summary care records in community pharmacies;
- accelerate access to patient records across different services;
- interoperability of different clinical software systems;
- automation of tasks and appointment software to help match appointment supply to demand.

To stimulate the uptake of new technologies, NHS England will be clear that practices can bid for additional technology resource as part of the Estates and Technology Transformation Programme.

In addition, from 2017/18 NHS England will launch a new programme to offer every practice in the country over the coming years support to adopt **online consultation systems.** Depending on uptake, there will be up to **£45 million extra investment** to support this.

Building on the successes of existing procurement approaches, future primary care digital services will be available through a national accredited catalogue with national and regionally negotiated buying frameworks, supported by a network of local procurement hubs offering advice and guidance.

We expect practices and CCGs to work closely together to realise the benefits of this approach and to exploit the opportunities of collaboration through GP federations, locality footprints and local procurement hubs. A new system for measuring the maturity of digital primary care will help CCGs improve commissioning.

NHS England has also published an overarching Interoperability Strategy that enables information sharing, based on Open Application Interfaces (APIs) using open industry standards (HL7 FHIR) and underpinned by key digital standards (the GP Connect project). The standards prioritised will:

- support federated practices by enabling appointments in one practice to be booked from another or an administrative hub using different clinical systems; and
- let healthcare professionals from different settings inform and update a practice through the sending and management of tasks.

NHS England will work with professionals to ensure that these standards on interoperability and control of patient data will become embedded in the minimum standards required for accreditation of future digital primary care systems. NHS England and HSCIC will work with the supplier market to create a wider and more innovative choice of digital services for practices, helping them to improve the way they work and the care they deliver.

The forthcoming publication of the National Data Guardian's review of data security and consent/opt-outs will support GPs by clarifying data security standards, resolving issues around data flows, and proposing a new model for data sharing.

Practices have identified that one way of doing this is to assist patients in managing a greater proportion of their minor self-limiting illnesses for themselves by using online resources. We will therefore use some of the funding for workforce and technology, outlined elsewhere in this document, to support practices in doing so.

CASE STUDY

Redesign of space to enhance capacity for clinical consultation - St Helen's, Merseyside

NHS England has provided a £63,790 contribution to support the development of St Helens Rota, Albion Street. The development, which included an extension to the existing building, will allow the practice to create an additional consulting room plus additional office / meeting room space.

The project will also create an additional Skype triage room within the current patient waiting room. This will allow clinicians to undertake more urgent care such as children's clinics and general clinics especially during the day-time, for example, in hours, particularly during times of increased winter demand, when urgent care services such as A&E are under most pressure.

CASE STUDY

Major expansion to practice buildings offering a wider range of treatment areas and access to care - New Hayesbank Surgery, Kennington

NHS England funding is being used to fund a major extension of the practice building, adding seven clinical rooms, a theatre for minor operations, along with recovery rooms and a larger reception area. The additional treatment areas will enable the practice to offer more appointments and provide more vital local treatment. Building work started in November 2015 and the new premises are to be open to patients later in 2016.

CASE STUDY

Digital services - Modality

Modality MCP, recognising that Birmingham has the highest proportion of smartphone users in the UK and that more than 80 percent of people make transactions on broadband, developed an app through which people can book appointments, send messages to clinicians and provide real-time feedback.

Individuals with long term conditions who previously might have attended A&E at the weekend and been admitted to hospital are often now able to avoid a crisis by 'sending a quick message to their doctor'.

Modality's call centre handles up to 1,300 calls per day, with most patients now given advice or treatment without visiting a surgery. Around 90 percent of both Skype consultations and call-backs by GP partners are closed without a surgery visit. Salaried GPs and advanced nurse practitioners close nearly half of their telephone consultations in the same way.

Modality's work to improve access has seen:

- a 72 percent fall in 'did not attends' (because fewer patients book well in advance as they are confident of speaking to a clinician when they need to)
- the ability to meet increases in demand within existing resources
- average remote consultation times falling to under five minutes
- 70 percent of patients say the new system has improved access
- 100 percent of clinicians agree they would not go back to the old system.

CASE STUDY

'My Healthcare' - Birmingham South and Central

My Healthcare is extending GP opening hours and reshaping how over 120,000 patients, from 23 practices, access health services. The scheme joins up primary care, community based services and urgent care providers, including local walk in centres, via a single point of contact. Services can be accessed and delivered physically and virtually through a hub system, across three sites, seven days a week, from 8am – 8pm by a multi-disciplinary team, including an advanced nurse prescriber, GPs, community nurses, pharmacists, a roving doctor and an out-of-hours doctor.

Using digital technologies (once patient consent is obtained), clinicians working within any hub, have access to patient records from all of the member GP practices. Interoperability, across the system, enables staff to access clinical records and send an electronic summary of the consultation to the patient's registered practice, enabling continuity of a fully informed healthcare record. With a variety of choices for patients, including booking appointments and ordering prescriptions online and telephone or video consultations, the services suit different lifestyles, health needs and personal circumstances.

A roving doctor service, designed to see patients within two hours of contacting their GP, has helped reduce the number of patients needing emergency care. The service, triaged by an on-call GP, is for patients who need a home visit but are not at the point of needing hospital care. This model of service delivery, when in full operation, is expected to create over 90,000 additional appointments per year, with no patient in the area being more than three miles from a hub.

Other future improvements will include a click and collect prescribing service for prescriptions and a lifestyle app to help GPs gain a holistic view of patient health. Patients using the app will benefit from video consultations via the app, instant messaging, a symptom checker, and feedback to/from patients.

Patients and clinicians who have used the service have provided positive feedback. NHS Birmingham South and Central CCG has already commissioned two extra hubs, in response to the success of My Healthcare so far. The CCG is now working to expand the scheme to include all of its 55 member practices.


#GPforwardview

Chapter 5: Care redesign

We will provide a major programme of improvement support to practices

Support to strengthen and redesign general practice:

- Commissioning and funding of services to provide extra primary care capacity across every part of England, backed by over £500 million of recurrent funding by 2020/21. This forms part of the proposed increase in recurrent funding of £2.4 billion by 2020/21.
- Integration of extended access with out of hours and urgent care services, including reformed 111 and local Clinical Hubs.
- £171 million one-off investment by CCGs starting in 2017/18, for practice transformational support.
- Introduction of a new voluntary Multispeciality Community Provider contract from April 2017 to integrate general practice services with community services and wider healthcare services.

A new national three year 'Releasing Time for Patients' programme to reach every practice in the country to free up to 10 percent of GPs' time.

- Building on recent NHS England and BMA roadshows, spread the best innovations across the country, helping all practices use 10 High Impact Actions to release capacity.
- Learn from the GP Access Fund and vanguard sites to support mainstreaming of proven service improvements across all practices.
- Fund local collaboratives to support practices to implement new ways of working.
- Provide free training and coaching for clinicians and managers to support practice redesign.

Support to strengthen and redesign general practice, including delivering extended access in primary care

Public satisfaction with general practice remains high, but increasingly, we are seeing patients reporting more difficulty in accessing services. We know that many practices report that they would like to offer better access, but that they are experiencing increasing pressure and are having difficulties in offering their patients timely appointments. This is frustrating for practice staff, and for patients alike.

NHS England will provide additional funding, on top of current primary medical care allocations – **over £500 million by 2020/21 - to enable CCGs to commission and fund extra capacity across England to ensure that by 2020, everyone has access to GP services, including sufficient routine appointments at evenings and weekends to meet locally determined demand, alongside effective access to out of hours and urgent care services.**

So how is this achievable at a time of such challenge to general practice?

Of course, good access is not just about getting an appointment when you need it. It is also about access to the right person, providing the right care, in the right place at the right time. Experience from the £175 million investment over the last two years in the GP Access Fund sites covering 18 million patients has demonstrated that enhanced access relies on working across providers and redesigning the way services are delivered, working with patients and making best use of four key elements:

- enabling **self-care and direct access to other services**, for example, online self-management and signposting to other services;
- better use of the talents in the **wider workforce**, such as advanced nurse practitioners, clinical pharmacists, care navigators, physiotherapists and medical assistants;
- greater use of **digital technology**, for example, apps connecting patients to their practice, phone and email consultations, webcams links with care homes.

- **working at scale across practices to provide extended access collectively**, in a similar way to how many GPs currently collaborate within GP co-operatives to provide out of hours care. These services are often called **Primary Care Access Hubs** and offer additional clinical capacity across a group of practices. Patients are referred there by the local practices, often after some degree of triage process to ensure they are suited. They are then seen and managed at the hub, often by a local GP or nurse, with the benefit of access to the patient's medical record.

We will now build on the lessons learned from the GP Access Fund schemes to support CCGs in commissioning additional capacity more consistently across the country, and in developing closer links with urgent care and out-of-hours services. Done well, this can lay the foundations for transforming the way in which other general practice and community services can be delivered collectively too.

We have set out below some of the key questions raised.

Who will be responsible for commissioning and providing these services?
CCGs, working in conjunction with their urgent and emergency care networks, will be responsible for commissioning these services to expand capacity. CCGs will be required to ensure that this extra investment in general practice dovetails with plans to develop a single point of contact to integrated urgent care and GP out of hours services, accessed through a reformed 111 service. In addition, we will be seeking more joined-up services, for instance, hubs hosting GP out of hours bases, community nursing teams and greater access to diagnostic services. CCGs will be required to meet minimum requirements before accessing the additional funding.

Does this mean every practice will have to open at evenings and weekends?
Delivering improved evening and weekend access is **not** about every GP or every practice nurse having to work seven days a week. Nor does it mean that every practice in the country needs to be open seven days a week. It will mean that groups of local practices and other providers will be offered the funding and opportunity to collaborate to staff improved in and out of hours services.

The provider could be a Federation if local GPs decide to express interest. It could also be a mix, for example, a Federation supplying additional capacity on weekdays and Saturdays, with an existing urgent care organisation providing pre-bookable GP appointments on a Sunday.

Who decides what the service looks like?
The balance of pre-bookable and same-day appointments, and the level of capacity required on different days of the week, will be up to individual commissioners and schemes to determine in light of patient demand in their area and to ensure best value for money.

There will be some minimum requirements and these will be published later in the year. They will be tested with the current GP Access Fund sites during 2016/17, ahead of further roll out to more parts of the country in 2017/18 and years beyond.
How will it be rolled out?
Waves of increasing recurrent funding will be made available each year, linked to CCG plans, to support the overall improvements in general practice. This phased increase in investment is designed to match the planned growth in the workforce.

What support will there be?
This document sets out a range of national action to provide support to practices over the coming years, whilst the core funding for general practice increases. In addition, NHS England will ask CCGs to **provide £171 million of practice transformational support**.

This is designed to be used to:

- stimulate development of at scale providers for extended access delivery;
- stimulate implementation of the 10 high impact changes in order to free up GP time to care;
- secure sustainability of general practice to improve in-hours access.

CCGs have a responsibility to ensure a balanced financial position, and will want to target investment in practice support where it can have most impact.

What does this do to my existing workload?
Offering a greater range of evening and weekend appointments, for example, through a local access hub, should improve overall patient flow and help reduce avoidable demand across the system. GP Access Fund areas are already reporting improvements and the intention is that all practices will benefit from this reduction in workload as they are rolled out.

It is vital that alongside extending hours we also strengthen in-hours services. In addition to improving local appointment capacity, there will be investment in online resources that will help patients self-manage, for example, more self-help content on NHS Choices, online consultations and 111 Online, which is currently in development. As part of the review into urgent and emergency care there will also be a step change in the 111 phone service.

A new Multispeciality Community Provider (MCP) contract

Through the actions in this document we aim to sustain, renew and strengthen general practice. The MCP model is a fundamental element of this plan, currently being developed by 14 MCP vanguards across the country.

Today the range of services funded within general practice owes much to history rather than optimal working arrangements for GPs or patients.

The MCP model is about creating a new clinical model and a new business model for the integrated provision of primary and community services, based on the GP registered list, but fully integrating a wider range of services and including relevant specialists wherever that is the best thing to do, irrespective of current institutional arrangements.

At the heart of the MCP model, the provider ultimately holds a single whole population budget for the full breadth of services it provides including primary medical and community services.

Armed with that larger budget and the flexibility to deploy it, the job of the MCP is to focus on better population health management, to suit different groups of the population, and get away from the treadmill of the 'one size fits all' 10 minute consultation followed by outpatient referral or prescription. This means:

- a stronger focus on population health, prevention, and supporting and mobilising patients and communities;
- more integrated urgent care as part of a reformed urgent and emergency care system;
- integrated community based teams of GPs and physicians, nurses, pharmacists, therapists, with access to step up and down beds, in reach into hospitals, for example, redesigning outpatients, geriatric care, and diagnostics as part of extended community based teams.

NHS England will shortly publish the MCP Care Model Framework and contract elements describing the emerging model options in more detail. Six local healthcare systems are working intensively with us to complete the design of the contract, with the aim of going live, on a voluntary basis, in April 2017.

We are working through the legal, contractual and payment options, but anticipate that key features are likely to include:

- the MCP defined as an **integrated provider** not a form of practice based commissioning or total purchasing. Its scope is the services it will itself be providing, not all acute and specialised services;
- **a choice of different organisational forms**, for example, a community interest company, LLP or joint venture with a local trust. Some GP federations, working with partners, may well want to become MCPs and explore this as part of the work CCGs are leading within the STP process;
- a new payment model based on combining all the existing relevant budgets within the MCP service scope;
- a new blended pay for quality and performance scheme that **replaces CQUIN and QOF at MCP level, with the ability for the MCP to flex its own internal arrangements according to local circumstances and the arrangements it makes with its constituent clinicians**;
- depending on the degree of integration of existing practices, there will be an ability for some activities/requirements currently at practice level to be performed at MCP level, including potentially elements of CQC inspections;
- NHS England will develop a model procurement process and criteria for commissioners to let MCP contracts, with a funding model dependent on the number of patients on the registered list of the practices within the MCP; and
- **new employment and independent contractor options** for MCPs to offer clinicians, whether GPs or others, including equity partnership or salaried roles. These could be instead of existing GMS or PMS, with the right for existing GMS or PMS practices either to hold a 'dormant' contract that can be reactivated, or a right to return. **Moving 'off' GMS or PMS contracts to new arrangements within an MCP will be entirely voluntary**.

Working at scale

The majority of GP practices are now working in practice groups or federations. We are seeing that these can have benefits for patients, practices and the wider system:

- **Economies of scale:** practices can create common policies and procedures once, sharing the work between all members. They can also combine their purchasing power to achieve best value.
- **Quality improvement:** some federations are becoming a focus for sharing professional development, clinical governance and service improvement, and are building in-house expertise to benefit all practices.
- **Workforce development:** many are also providing new opportunities to train and support staff, improving resilience and enabling new ways of working.
- **Enhanced care and new services:** the GP Access Fund and vanguard programmes are demonstrating how collaboration at scale makes it possible to improve access, introduce new members of the workforce and provide innovative care in ways that are simply not possible at the level of a single practice.

- **Resilience:** a growing number of federations are helping practices improve their resilience through sharing back office functions, developing business intelligence systems and creating shared pools of staff.
- **System partnerships:** establishing a shared identity across practices makes it easier for primary care to have a larger voice in the local health and care system, and facilitates partnership working with other providers. This is key to creating new models of care for the future.

These are welcome developments we wish to see grow in coming years. We will share these examples more widely to ensure that all emerging groups are able to benefit from opportunities to expand services, stabilise practice income and realise the benefits that working at scale offers.

We will continue to ensure that national investment programmes, such as on access and new care models, support the development of at-scale infrastructure.

National three year 'Releasing Time for Patients' development programme

For many years, the improvement support offered to other parts of the NHS such as the acute sector has not been matched by equivalent support for primary care.

In 2014/15, NHS England established an initial development programme for general practice, offering support to practices that were part of the GP Access Fund schemes – to enable them to work together, and to introduce new ways of delivering care, such as telephone consultations or different use of other professionals in the general practice workforce. The feedback on this programme from GPs has been positive, with 96 percent reporting that it had a large impact on their ability to lead rapid service redesign.

We want to scale up the offer of support to practices to accelerate change. So in 2016/17 we will establish a new national development programme, available to all practices, with an investment of £30 million over three years.

The main components proposed for the programme are:

- **Innovation spread:** a national programme to gather and disseminate successful examples and measure impact. This will include support on implementation of the Ten High Impact Actions, and a specific focus on addressing inequalities in the experience of accessing services, where there are national trends.
- **Service redesign:** locally hosted action learning programmes with expert input, supporting practices and federations to implement high impact innovations which release capacity and improve patient care.
- **Capability building:** investment and practical support to build change leadership capabilities in practices and federations, enabling providers to improve quality, introduce care innovations and establish new arrangements for the future.

Ten High Impact Actions to release capacity

Measuring workload and improvement

Currently it is difficult for practices or commissioners to assess their workload, identify specific priorities for action or track improvements. Creating new tools to measure demand and activity is therefore important to empower practices and monitor progress.

A rapid clinical audit was developed for the 'Making Time in General Practice' report which allowed practices to measure appointment demand. We will commission a simple online version of this for all practices, to allow them to identify ways they could reduce pressure for GP appointments and compare themselves with others.

Practices in the GP Access Fund are about to begin testing of an automated appointment-measuring interface to give them detailed information about their activity and how it varies over time. This will help practices match their supply of appointments more closely to demand. We will make it available for every practice from 2017/18.

Stimulating local support

CCGs have a legal responsibility to improve the quality of care in general practice. A growing number are also focusing on the need for significant provider developments in order to meet the changing needs of their population and address current pressures.

CCGs will need to strengthen arrangements for protected learning time and backfill to enable GPs time and space for development. Many are already providing significant support for practices and federations to redesign care and build more sustainable organisations for the future, but the current provision of support is too patchy. We wish all practices in England to benefit from locally funded development.

CCGs who have already been involved in provider development are finding that three things are most effective: creating space for practices to meet and plan together, through funding backfill; providing expert facilitation to make rapid progress on reviewing options and creating improvement plans; and focusing development on improving care and ways of working before addressing questions of organisational form. CCGs are encouraged to ensure their Sustainability and Transformation Plans contain details of their approach and plans for provider development. NHS England will review these in summer 2016.

Support, consultancy and capability-building for general practices are available from a range of regional and local bodies. We will work with them to ensure that practices and federations have ready access to credible, relevant and high quality support for the full range of their development needs. We will develop frameworks to enable practices to choose the support that is right for them.

This national development programme will be designed in collaboration with practices, professional leaders and improvement experts. Further details, including how federations and practices can join, will be published in the summer.

CASE STUDIES

Same day access - Southern Hampshire

In the Better Local Care (Southern Hampshire) vanguard, four practices have created a Same Day Access Service (SDAS) which pools the same day primary care workload and workforce for the four practices into a single service, operated from a central location at Gosport War Memorial Hospital. The SDAS operates from 8am-7pm, Monday – Friday. Patients call their own surgery and those who require same day advice or care are managed in the SDAS.

Of 5,500 patients referred to the service in its first six weeks of operation, 3,350 (61 percent) were able to have their needs met on the telephone. The remaining 2,150 patients attended a face-to-face SDAS consultation. The face-to-face consultation service is staffed by GPs, emergency nurse practitioners, paediatric nurses and practice nurses.

The initiative has contributed to greater GP availability in the practices; better working conditions for practice staff; longer appointments available for patients with complex needs; and reduced waiting time for routine appointments.

Providing 8am-8pm access to GP services - Morecambe

This involved five pilot practices where patients at all sites have access to a GP triage service between the times of 6.30pm-8pm during the week (above usual offering of until 6.30pm) and 8am-8pm on the weekend.

Both the weekday telephone triage and pre-bookable weekend services are provided at a central site at Morecambe Health Centre, chosen because of its co-location with the same day service (SDS) and the out of hours (OOH) service.

The service is staffed by existing GPs from the participating practices and is supplemented by an Advanced Nurse Practitioner (ANP) at weekends. Since the 8am-8pm service has been operational, an additional 31 hours of non-core GP time has been made available per week to provide both access to GP triage calls or face to face appointments at weekends. Over this period, an additional 16,400 appointments have been made available of which 79 percent were by telephone. Over the Easter bank holiday weekend, over 400 calls were received by the service. Of these, 300 were triaged and resolved and only 5 percent were required to be booked in elsewhere in the system (SDS or their own GP practice for example).


#GPforwardview

Conclusion

General practice is under pressure. This affects patients, and it impacts on the wider NHS. Yet, given the nature of future health needs, never have we as a country needed great general practice services more.

Implementation

This is a substantial package of investment and reform. What matters now is getting on and delivering it so that practices can start to feel the difference. An advisory oversight group with patients and partners (including the GPC and the RCGP) will steer the implementation of the measures outlined in this General Practice Forward View. This is a five year programme of work, and it will be important that we continue to learn and respond to changing circumstances.

Overview of measures

Our priorities will be:

- **investing a further £2.4 billion a year by 2020/21 into supporting and growing general practice services. This represents a 14 percent real terms increase**, reversing the decline in general practice funding, and raising the proportion of investment in general practice to over 10 percent of the NHS England healthcare budget. It is likely to grow even further as CCGs shift care and resources into the community;
- **supplementing this with a one off Sustainability and Transformation package of non-recurrent investments, totalling over half a billion pounds** over the next five years.

The package will include:

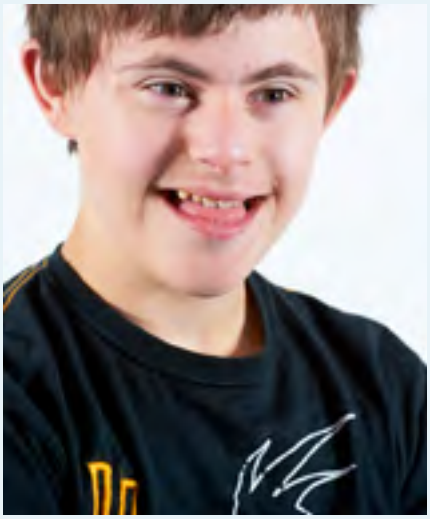
- **£40 million for a new practice resilience programme** starting in 2016/17, and **an extra £16 million to provide services for doctors suffering from burn out;**
- **£206 million for workforce measures** to grow the medical and non-medical workforce, including:
  - Major national and international recruitment campaigns to **double the growth rate of doctors** working in general practice;
  - A new offer to every practice in the country to access a **clinical pharmacist** – leading to an extra 1,500 pharmacists in general practice;
  - Support for every practice to help their reception and clerical staff play a greater role in signposting patients and handling paperwork to free up GP time;
  - Investment in **practice nurse** development and return to work schemes;
  - Investment in practice manager development
  - Piloting medical assistant roles; and
  - Training and investment for **1,000 new physician associates, and 3,000 new mental health workers** to support practices;

All supported by a network of multi-disciplinary training hubs;

- **£246 million to support practices in redesigning services**, including a requirement on CCGs to provide around £171 million of Practice Transformational Support and a new national £30 million **Releasing Time for Patients** development programme for general practice, to help practice **release capacity and work together at scale**, enable self-care, introduce new technologies, and make best use of the wider workforce, so freeing up GP time and improving access to services;

- **Supporting the increased use of technology** backed by both increases in recurrent funding for GP IT, and investment to support the take up of online consultation systems in every practice;
- Adopting an intelligent approach to introducing extended access through flexibilities in delivery of the Government's access commitment, enabling **integration** with out of hours provision, the ability for extended access to boost overall capacity and reduce demand in normal working hours, and an understanding that no GP will be forced to open seven days or work seven days;
- **Supporting new models of care** in vanguard sites, to spread innovative solutions, and the development of a voluntary MCP contract for larger GP groups and community health services;
- **Improving the interface between hospitals and general practice**, beginning with changes to the NHS Standard Contract from April 2016;
- Continuing to make **capital investments**, with the estimated likely capital investment over the next five years to reach over £900 million;
- Bringing forward proposals to tackle **indemnity costs;** and
- Reducing the frequency of CQC inspection for good and outstanding general practices, whilst continuing to protect patients and drive up quality.

Taken together, these measures represent the most far-reaching support offered to general practice in a decade.



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THE PLYMOUTH REPORT

Health & Wellbeing Board, 26 January 2017

PLYMOUTH CITY COUNCIL

1. INTRODUCTION

1.1 The Plymouth Report is a high level report that aims to provide readers with a single strategic analysis of the key issues for the city - one version of the truth to enable sound, intelligent decision making and inform strategic priority setting. It has been developed in close collaboration with the Plymouth Plan process.

1.2 Developed as part of the Council's Intelligent Organisation programme, the Plymouth Report will enable, for the first time, all relevant data sets to be analysed in conjunction with each other and will be fed by a range of monitoring reports, strategic needs assessments, evidence base updates that include relevant forecasts. Specifically, the Plymouth Report will meet the locally defined requirements of the Joint Strategic Needs Assessment (JSNA) as well as act as the Annual Monitoring Report (AMR) for the Planning Authority.

1.3 On a more practical note, the report will give Officers across the city easy access to a consistent narrative about needs, along with headline data for the Council and city – this is particularly useful when working on single issue needs assessments, commissioning plans, awards submissions, bids, briefing papers, press statements, etc.

1.4 The Plymouth Report is intended as an interactive, web based document, with links to the more detailed needs assessment or source data if required. It will use infographics to present headline data, and case studies to illustrate notable examples of where strategic interventions are addressing need.

1.5 The Plymouth Report will be updated annually - horizon scanning will also enable an annual programme of 'deep dives' to give a more detailed analysis of some of the bigger challenges facing the city or where significant intelligence gaps have been identified.

2. OVERVIEW OF THE PLYMOUTH REPORT

2.1 Where possible, the Plymouth Report follows the themed approach used in the Plymouth Plan (see below). There are however some exceptions to this based on the inherent differences between needs focused and strategic planning documents. The final report will allow progress on the delivery of the objectives and outcomes of the Plymouth Plan to be examined alongside the identification of new issues and new ways of dealing with existing challenges.

2.2 A brief overview of each section can be seen overleaf (Table 1). Please note that the location of some content may change to ensure readability and flow of analysis across sections.

Table 1 – Overview of contents

Section 1: Introduction / Executive Summary	Plymouth overview, strategic context, overview of each section.
Section 2: Living Plymouth	Population, neighbourhoods, resident insight, deprivation, poverty, environment, transport, housing, crime & community safety, education & schools.
Section 3: Healthy Plymouth	Life expectancy, mental health, dementia, life conditions, geography of health, chronic conditions, mortality, vulnerable groups.
Section 4: Growing Plymouth	City region, economy, economic sectors, employment and skills, worklessness, infrastructure and investment, land use.
Section 5: International Plymouth	Community cohesion, welcoming city, visitor economy, culture and heritage.
Section 6: Conclusions: Challenges & Ambitions	Key issues, questions and challenges, gaps in knowledge/data, alignment between city needs and Plymouth Plan outcomes (positive, neutral, gaps).

3. TIMELINE

3.1 Overseen by the Director of Public Health and prepared by a cross council team of Analysts, the Plymouth Report is still under development. A working draft of the full document is expected at the end of February 2017.

3.2 While the Healthy Plymouth section is being presented to the Health and Wellbeing Board meeting at its meeting on the 26th January (included in the next section), it is proposed that the full Plymouth Report document be brought back to the Board when it next meets. This will enable a broader discussion of the key issues, questions and challenges that arise from the full analysis.

3.3 Where possible, inter dependencies with other sections are highlighted and addressed within this iteration of the Healthy section.

4. HEALTHY PLYMOUTH

4.1 Overview

Overall the health and wellbeing of the Plymouth population is mixed compared with the England average. Of the 31 indicators presented in the 2016 Public Health England Health Profile[1], Plymouth has 13 that were significantly worse ('red') compared to England. These include adult smoking prevalence, life expectancy, under 75 deaths from cancer and cardiovascular disease, and under 18 conceptions.

The health and wellbeing of children in Plymouth is also mixed compared to the England average according to the 2016 Public Health England 'Child Health Profile'.[2] Whilst there are some clear successes such as mothers smoking at time of delivery, vaccine uptake, and A&E attendances in 0-4 year olds, Plymouth compares negatively to England for 12 of the 32 indicators including breastfeeding, and hospital admissions due to alcohol-specific conditions, injuries, and self-harm.

The following section highlights some of the key health and wellbeing issues in the city and outlines some of the innovative work going on to address them.

4.2 Life expectancy

From 2001-03 to 2012-14 life expectancy in Plymouth has improved by 2.8 years for males (to 78.5 years) and 2.1 years for females (to 82.5 years). Over this time male life expectancy has been consistently below the England average and the gap in male life expectancy between Plymouth and England has widened. Female life expectancy has, on occasions, been slightly higher than the England average. However, the life expectancy of females in Plymouth is currently lower than the England average. The gap in female life expectancy between Plymouth and England has also widened since 2001-03.[3]

Life expectancy varies across the city; from 86.5 years in the Plympton Chaddlewood ward to 76.4 years in Drake. Figure 1 highlights that wards just a few miles apart can have life expectancy value varying by years. Travelling the seven miles west from Plympton Chaddlewood, or south from Southway, each mile closer to St Peter and the Waterfront represents over one year of life expectancy lost.

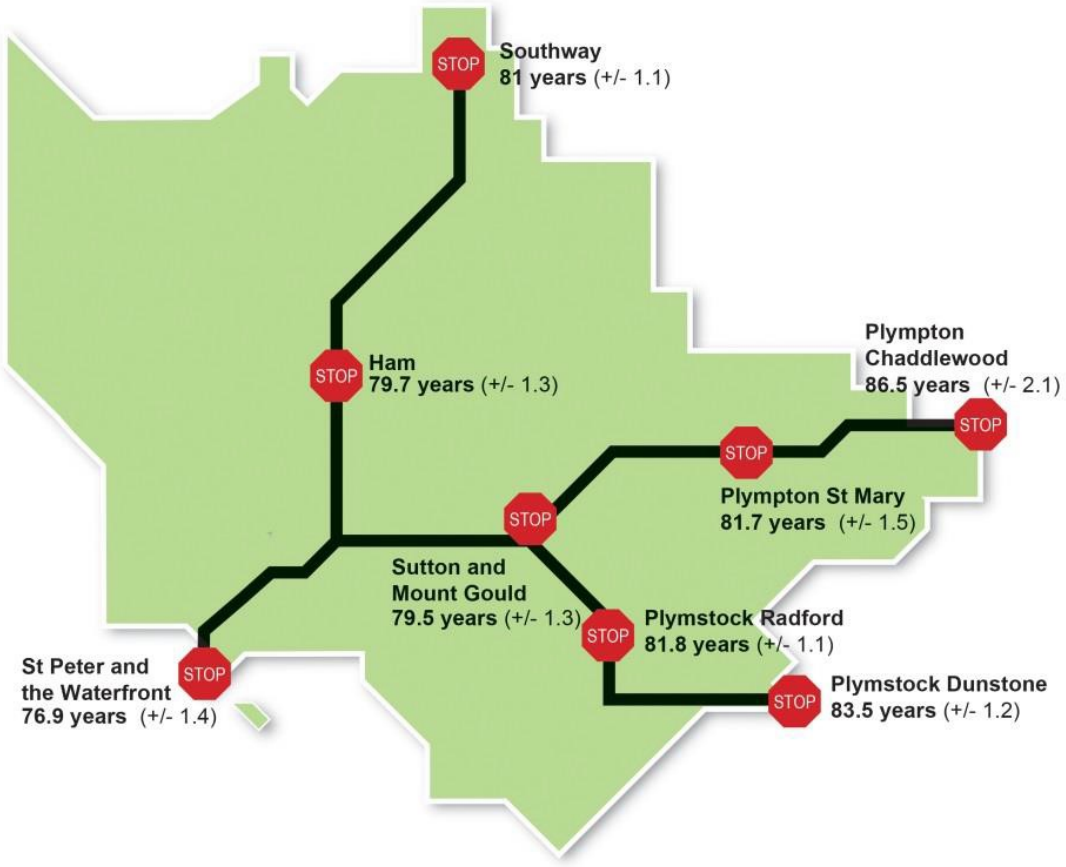
In terms of inequalities, the life expectancy gap between those living in the most deprived areas and those in the least deprived areas remains significant; life expectancy in the most deprived areas of Plymouth (at 78.4 years) is 4.4 years lower than in some of the least deprived areas.[3]

[1] Health Profile 2016: Plymouth, Public Health England, 06 Sep 2016
[2] Child Health Profile: Plymouth, Public Health England, 15 Mar 2016
[3] Life expectancy in Plymouth 2001-03 to 2012-14, Public Health, Plymouth City Council, Mar 2016

Using the Public Health England 'Segment Tool'[4] it is possible to understand the broad causes of death which contribute most to the gap in life expectancy between Plymouth and England. For men these are cancer (34.5%), circulatory disease (17.9%), and external causes including deaths from injury, poisoning, and suicide (17.4%); and for women these are circulatory disease (33.5%), mental and behavioural factors including dementia and Alzheimer's disease (15.3%), and cancer (14.1%).

Healthy life expectancy in Plymouth (the average number of years a person can expect to live in good health) was significantly lower than the England average for both males and females in 2012-14.[5] Males in Plymouth had a healthy life expectancy of 59.0 years whilst females had a healthy life expectancy of 59.5 years. Unlike life expectancy, healthy life expectancy in Plymouth shows little difference between genders.

Figure 1: Plymouth's life expectancy bus route by electoral ward, 2012-14



However, due to the differences in overall life expectancy men in Plymouth can expect to live on average the last 19.5 years of their lives in poor health whilst for women it's their last 23.0 years.

[4] https://fingertips.phe.org.uk/profile/segment

[5] Healthy life expectancy and life expectancy at birth by upper tier local authority: England, Office for National Statistics, 10 Mar 2016

Continued efforts will need to be made to improve life expectancy and healthy life expectancy in Plymouth, and close the gap between the most and least deprived areas of the city.

4.3 Mental health

Poor mental health is the largest cause of disability in the UK.[6] It's also closely connected with other issues, including poor physical health and problems in other areas like relationships, education, and work prospects. Almost three in every five people with mental health conditions are currently unable to work, despite evidence showing employment can be a crucial part of treatment. It has been estimated that mental health problems in England cost over £100 billion a year.[7] Over recent years, mental health services in England have received additional investment and undergone significant reform, but demand for mental health services has been rising, and there is still significant unmet need.

The Plymouth mental health needs assessment[8] highlights a number of factors which may promote good mental health and wellbeing and protect against developing mental health problems. These include employment, education, physical activity, green space access, and community cohesion. It also highlights a number of risk factors which increase the likelihood of experiencing poor mental health and wellbeing. These include poor quality housing, deprivation and inequality, unemployment, crime, poor physical health, and drugs and alcohol misuse. The breadth of these factors highlights how interconnected mental health is with physical health, environment, and behavioural choices.

In 2015 there were over 26,200 people in Plymouth estimated to be suffering from common mental health problems including depression, anxiety, and obsessive compulsive disorder.[9] It is also quite common for people to meet the diagnostic criteria for two or more mental health problems and suffer from psychiatric co-morbidity. This is an important issue as it is associated with greater disease severity, longer illness duration, more functional disability, and an increased use of health services. Over 11,700 Plymouth residents aged 18-64 years in 2015 were estimated to have more than one mental health problem; a figure that is projected to decrease to around 11,500 by 2030.[9]

The number of referrals to the Child and Adolescent Mental Health Services (CAMHS) in Plymouth in 2015/16 was 1,207. This is a 10% increase from the 1,099 referrals reported in 2014/15.[10] Mental health service providers report that they have noticed not only an increase in the number of referrals but also an increase in the complexity of children and young people's needs and issues requiring attention.[11]

Over the last three years hospital admissions of young people (aged 10-24 years) for self-harm has increased in both Plymouth (425.5 per 100,000 population to 473.6 per 100,000)

[6] Department of Health. 2010 to 2015 government policy: mental health service reform, 08 May 2015
[7] Economic and social costs of mental health problems, Centre for Mental Health, Oct 2010
[8] Adult Mental Health Needs Assessment for Plymouth, Public Health, Plymouth City Council, Mar 2012
[9] Mental health problems predictions, Projecting Adult Needs and Service Information, 2014
[10] Livewell Southwest, November 2016
[11] Children and young people, a single view of need/ demand, 2016

and England (346.3 per 100,000 to 398.8 per 100,000). The latest 2014/15 data is significantly higher in Plymouth than England.[12]

In response to the 'Emotional Wellbeing and Mental Health Strategy 2009-14' and the 'Early Intervention and Prevention Strategy', there have been a number of developments to better target the services in this system. This includes a range of brief interventions in schools. For example, a co-commissioned system of support for vulnerable children and young people began in September 2016 in 26 of Plymouth's secondary and special schools. A redesign of CAMHS has enabled specialist staff to be based in these schools for half a day a week. In addition, to ensure a more holistic population-based system, The 'Healthy Child Quality Mark' (a development tool which gives schools a framework to plan, deliver, and measure healthier behaviour change) has also been developed to improve schools' offer in respect to emotional wellbeing and mental health education, sex and relationship education, and promotion of healthy lifestyles.[11]

4.4 Dementia

In 2014, 3,134 people over the age of 65 were estimated to be living with dementia. By 2030 it is expected that this number will have risen to 4,855.[13] Understanding the local situation is very important to providing early diagnosis and appropriate support to people and their carers. Plymouth City Council, working alongside the Plymouth Dementia Action Alliance, is continuing to deliver its commitment to being a Dementia Friendly City. In November 2016 this was recognised when Plymouth won the Dementia Friendly Community category at the Alzheimer's Society's national awards in London.

4.5 Life conditions

There are higher levels of long-term health problems or disability, and lower levels of reported 'good' or 'very good' health in Plymouth compared to England. According to the 2011 Census, 10.0% of Plymouth residents reported having a long-term health problem or disability that limits their day-to-day activities a lot and has lasted, or is expected to last, at least 12 months. The England value was 8.3%. The 2011 Census also reported fewer Plymouth residents thought their health was 'good' or 'very good', compared to England.[14]

Over the past five years the percentage of people reporting that they have a low 'self-reported life satisfaction' has been falling nationally, from 6.5% in 2011/12 to 4.6% in 2015/16. Within Plymouth the results have been inconsistent, ranging from a high of 5.8% in 2014/15 to a low of 4.2% in 2015/16.[15] Although the current figure (4.2%) is a move in the right direction it is difficult to predict whether this better performance will be maintained given the previous trend.

[12] Child Health Profiles, Public Health, 2016

[13] People aged 65 and over predicted to have dementia, by age and gender, projected to 2030, Projecting Older People Population Information System, 2014

[14] 2011 Census table QS303EW (long-term health problem or disability), Office for National Statistics, 30 Jan 2013

[15] Headline estimates of personal well-being, Office for National Statistics, 27 September 2016

4.5.1 OBESITY

Results from the 'National Child Measurement Programme' (NCMP) 2015/16 show that by the time they start primary school around one in four children living in Plymouth are either overweight or obese, and by the time they leave this has increased to over three in ten.[16]

Compared to Plymouth, fewer children in England are overweight or obese when starting primary school, but more fall into this category by the time they leave. This suggests that the environment in Plymouth may be more 'obesogenic' for pre-school children, but less obesogenic for those of primary school age when compared to England.

As a result of more sedentary lifestyles and increased availability and affordability of high calorie food the prevalence of obesity among adults has grown considerably over the past few decades. Survey data for Plymouth 2013-15 shows that 62.4% of adults aged 16 are classified as overweight or obese, a value similar to the 64.8% seen for England.[17]

4.5.2 CHILDREN'S DENTAL HEALTH

Whilst the overall level of dental disease in Plymouth is similar to the national average this figure masks oral health inequalities across the city and a small number of people bear the greatest burden of disease in the city. These groups include children living in material and social deprivation and at risk groups such as older people, people living with a disability, or those in long term institutional care.

Dental decay remains a significant problem for many children in Plymouth. There are large differences in the extent of decay experienced by children depending on where they live; those from more deprived areas often suffering from a higher burden of disease. In Plymouth, 848 children (aged one to 16 years) had teeth removed under general anaesthetic (GA) in 2015/16. On an electoral ward basis the rate of dental extractions ranged from 56.2 per 10,000 children aged 0-16 years in the Plympton Chaddlewood ward to 292.0 per 10,000 in the Honicknowle ward (this represents over a five-fold difference) whilst the rate was over three times higher in children from the most deprived areas of the city (261.5 per 10,000) compared to the least deprived (85.1 per 10,000).[18]

One of the four priorities in Plymouth's 'Child Poverty Action Plan 2016-19'[19] commits to improve the dental health of children aged under-16 and reducing the number of children having teeth removed. Delivery of the plan's outcomes will be achieved by priority activities including an accessible targeted fluoride varnish scheme and oral health promotion initiatives. These key activities will complement citywide efforts to tackle child

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[16] National Child Measurement Programme England 2015/16, NHS digital, 03 Nov 2016

[17] Active People Survey: percentage adults classified as overweight or obese 2013-15, Public Health Outcomes Framework indicator 2.12, Nov 2016

[18] Dental extractions under general anaesthetic in Plymouth Children 2015/16, Public Health, Plymouth City Council, 26 Jul 2016

[19] Plan for Child Poverty, 2016-19, Plymouth City Council, 2016
http://modgov/documents/s74516/Child%20Poverty%20Action%20Plan%20FINAL%2020092016.pdf

poverty, as outlined in the 'Plymouth Plan' and will be achieved by coordinated partnership working, with an emphasis on shared and joined up service provision that relies on targeting and sharing skills and capacity when and where required.

4.6 Geography of health: lifestyle behaviours

Four lifestyle behaviours (poor diet, inactivity, lack of exercise, tobacco use, and excess alcohol consumption) are risk factors for four diseases (coronary heart disease, stroke, cancers, and respiratory problems) which together account for 54% of deaths in Plymouth.[20] These behaviours remain highest in the areas where people are most deprived. It is these behaviours and chronic diseases that form the basis of the Thrive Plymouth (for more detail see section 3.10).

4.6.1 DIET

In a health-related behaviour survey of secondary school pupils in Plymouth, 16% reported eating five or more portions of fruit and vegetables on the day prior to the survey in both 2013/14, and when the survey was repeated in 2015/16.[21]

Plymouth has a similar proportion of adults eating the recommended '5-a-day' (51.4%) compared to England (52.3%).[22]

In order to support healthy eating and improve access to good food the 'Plymouth Plan' states a responsibility to promote access to food growing opportunities, ensure healthy catering choices at facilities and events across the city, and protect the food environment within 400m of providers of secondary education. A key achievement of this policy has been the refusal of planning applications for hot food takeaways within close proximity to secondary schools. A future opportunity will be to encourage other types of local shops to improve the healthiness of their food offer.

4.6.2 PHYSICAL ACTIVITY/INACTIVITY

In 2015 56.2% of adults in Plymouth were classed as physically active, a figure similar to the England average of 57.0%.[23] Results from a health related behaviour survey carried out by the Schools Health and Education Unit in secondary schools across the city reported that 67.3% of the pupils surveyed 'exercised enough to breathe harder and faster on at least three days in the week' in 2015/16 (an increase from 66.0% in 2014/15).[21]

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[20] Positive choices for better health in a growing city: director of public health annual report 2014/15, Public Health, Plymouth City Council, Jul 2015

[21] Health Related Behaviour Survey: Plymouth secondary schools 2014 and 2016, Public Health, Plymouth City Council, Nov 2016

[22] Active People Survey: proportion of the adult population meeting the recommended '5-a-day' on a usual day, Public Health Outcomes Framework indicator 2.11i, 2015

[23] Active People Survey: percentage of inactive adults 2015, Public Health Outcomes Framework indicator 2.13ii, Nov 2016.

In a response to the issues around physical activity, the 'Plymouth Plan' outlines the commitment to improve sporting facilities in the city. A 'Plan for Sport' is being created that will bring together activities across a wide range of council departments including; Sports Development, Commissioning, Economic Development, Events, and the Green Infrastructure teams. Key achievements to date include the adoption of the 'Plan for Playing Pitches' and the drafting of the 'Sports and Leisure Facilities Plan'.[24]

4.6.3 SMOKING

The rate of smoking in Plymouth has fallen in recent years however it remains higher than the England average. Currently 20.6% of the adult population of Plymouth smokes compared to the England average of 16.9%.

Rates are higher among specific groups of people such as those who live in more deprived areas. The rates of smoking in wards in Plymouth range from 4.1% to 37.1%. Generally the more deprived wards have a higher rate of smoking and a higher rate of children who report that they have tried smoking. This is important because smoking is a fundamental cause of ill health and the principle reason for the difference in life expectancy within the city.[25]

Fundamental drivers behind the prevalence of smoking relate to supply and demand. These include: access, price, age of uptake, peer influence, and support to stop smoking. In order to further address prevalence and reduce inequalities in smoking rates amongst Plymouth's population there is a need for local focus and action to tackle the fundamental determining factors and prioritise specific groups of people. This will help contribute to the 'Plymouth Plan' priority to encourage a smoke-free Plymouth.[25]

4.6.4 ALCOHOL AND DRUG MISUSE

Alcohol and drug (illegal and prescribed) dependence are significant issues for Plymouth. They are commonly associated with mental health problems, homelessness, and offending, and have negative impacts on families and children. In 2015 over 5,500 people in the city aged 18-64 were estimated to be dependent on drugs; and nearly 10,000 were predicted to be alcohol dependent.[26] This has significant consequences and costs for the city in terms of individual health and wellbeing, family breakdown, and social cohesion.

The number of alcohol related hospital admissions provides a measure of the burden of health harms and the impact of alcohol related disease and injury. The number of admissions in Plymouth has risen significantly over recent years. In 2014/15 there were

[24] Sports Development Team, Plymouth City Council, 2016

[25] Tobacco Control Needs Assessment for Plymouth 2017, Public Health team, Plymouth City Council, in development

[26] Drug/alcohol predictions, Projecting Adult Needs and Services Information, 2014

over 5,600 admissions which is significantly higher than the England average.[27] Rates of alcohol related hospital admissions are higher in more deprived areas.

Under 18 admissions for an alcohol specific condition has been on a downward trajectory both locally and nationally since 2007. Although the number of admissions has reduced, Plymouth continues to have a significantly higher rate (53.9 per 100,000 population) than England (36.6 per 100,000).[27]

As alcohol use impacts across a wide range of policy and service priorities a robust partnership approach is essential to reducing harm. 'Promote Responsibility, Minimise Harm, A Strategic Alcohol Plan for Plymouth 2013-18'[28] defines a partnership approach to addressing alcohol in the city. It focuses on changing attitudes to alcohol, managing supply, identifying need earlier, and ensuring evidence based interventions are available where necessary.

Commissioners across Plymouth are working to develop a whole system approach for re-commissioning mental health, homelessness, drug and alcohol treatment services and some offender services. This is focused on providing integrated responses across the system and ensuring that people's needs can be met wherever they access services. This will make a step change in how services for people with drug and alcohol dependency and complex needs are provided in Plymouth and will achieve cost efficiencies for key organisations in the city.

4.7 Chronic diseases

The following data is not available at local authority level. Instead they are available at Clinical Commissioning Group (CCG) level. Plymouth sits within the Western locality of the NHS Northern, Eastern, and Western (NEW) Devon CCG.

4.7.1 CORONARY HEART DISEASE

Since 2012/13 the prevalence of coronary heart disease in England has remained between 3.2-3.3%. The prevalence in NEW Devon CCG has been consistently higher than England. The current prevalence of 3.9% is significantly higher than England.[29]

4.7.2 STROKE

Since 2012/13 the prevalence of stroke in England has remained static at 1.7%. The prevalence in NEW Devon CCG has been consistently higher than England and has increased by 0.1% annually. The current prevalence of 2.2% is significantly higher than England.

[27] Local Alcohol Profiles for England 2016: Plymouth, Public Health England, 06 Sep 2016
[28] Strategic Alcohol Plan for Plymouth 2013-18, Public Health, Plymouth City Council, Jul 2013

[29] PHE Cardiovascular Disease Profiles https://fingertips.phe.org.uk/profile/cardiovascular

4.7.3 CANCERS

Since 2012/13 the prevalence of cancer England has increased in England. The prevalence in NEW Devon CCG has also increased and consistently been higher than England. The current prevalence of 2.9% is significantly higher than England (2.4%)

4.7.4 RESPIRATORY DISEASE

Since 2005/06 the prevalence of Chronic Obstructive Pulmonary Disease has increased in England.[30] The prevalence in NEW Devon CCG has been consistently higher than England since 2010/11 and has increased at a greater rate. The current prevalence of 2.0% is significantly higher than England (1.8%).

4.8 Mortality

Since 1995 rates of all-age all-cause mortality have fallen for males, females, and hence persons in both Plymouth and England as a whole. Despite this fall, rates of male all-age all-cause mortality in Plymouth have consistently been higher than the England average, whilst rates for female all-age all-cause mortality have generally been similar to England.[31] The rate in Plymouth in 2012-14 was 102.8 per 1,000. This compares with 94.9 per 1,000 for England.[32] Rates across Plymouth vary from a low of 58.8 per 1,000 in the Plympton Chaddlewood ward to a high of 129.5 per 1,000 in the Drake ward.[33]

In 2012-14 the all-age, all-cause mortality rate in those aged under the age of 75 years (i.e. considered to be premature mortality) in Plymouth was 37.6 per 1,000 under-75 population.[34] This varied across the city, with more deprived areas having rates nearly twice as high as the least deprived areas.

Plymouth has higher mortality rates than England for three of the four Thrive Plymouth chronic diseases (cancers, coronary heart disease, and respiratory disease) that account for the majority of deaths in Plymouth[35] (see section 3.10). Rates of death for all four diseases are higher in the more deprived areas of the city.[36]

Combining the four causes of death locally results in a 2012-14 mortality rate of 55.1 per 10,000 all-age population. Rates by ward vary from a low of 31.1 per 10,000 in the Plympton Chaddlewood ward to a high of 76.4 per 10,000 in the St Peter and the Waterfront ward.

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[30] PHE Inhale Profiles https://fingertips.phe.org.uk/profile/inhale

[31] Mortality from all causes: directly standardised rate, all ages, annual trend, MFP, NHS Digital, Dec 2015

[32] Mortality from all causes: directly standardised rate, all ages, 3-year average, MFP, NHS Digital, Dec 2015

[33] Public Health, Plymouth City Council, Oct 2015

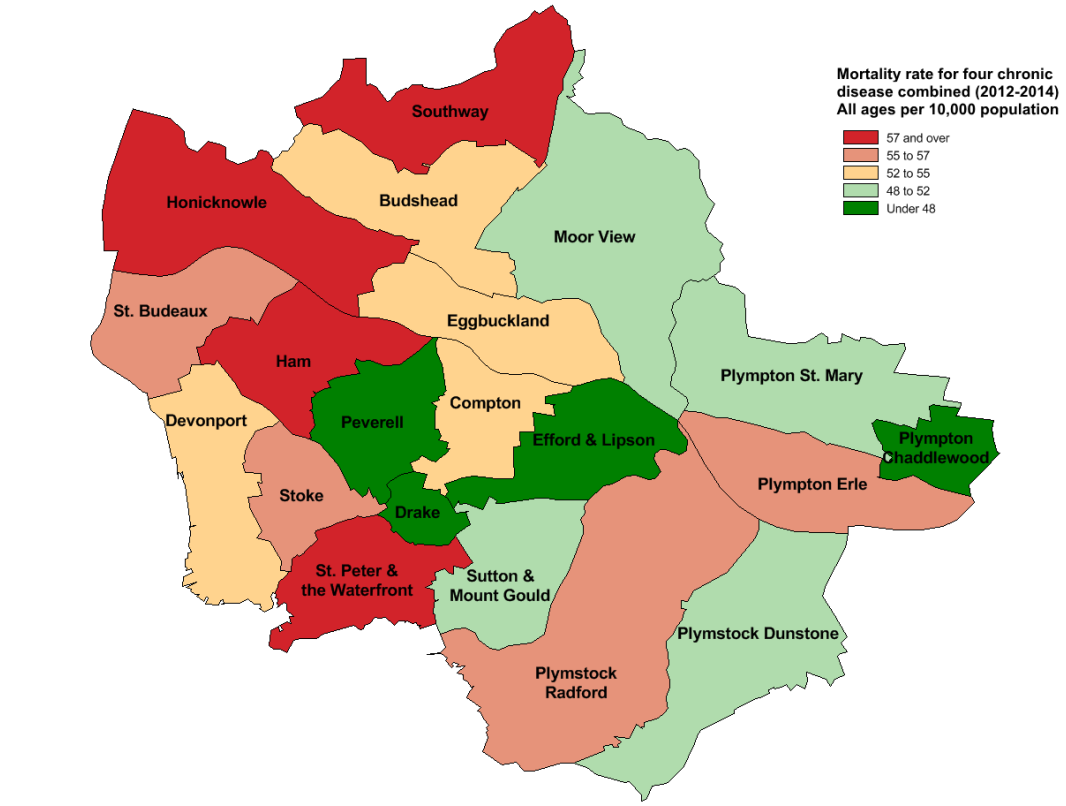
[34] Mortality from all causes: directly standardised rate, <75 years, 3-year average, MFP, NHS Digital, Dec 2015

[35] Mortality from coronary heart disease/stroke/cancer/: directly standardised rates, all ages, 3-year average, MFP, NHS Digital, Dec 2015

[36] Public Health, Plymouth City Council, Aug 2016

Again this varied with deprivation, with the more deprived areas of the city having higher rates than the lesser deprived areas.

Figure 2: All-age mortality rate for cancer, heart disease, respiratory disease, and stroke combined, 2012-14



3.9 Vulnerable groups

3.9.1 CHILDREN IN CARE

Nationally it is known that achieving positive outcomes for children in care is a challenge. Department for Education, Centre for Social Justice data tells us:

- 12% of looked-after children gained five or more A* to C GCSE's including English and maths in 2014 compared to 53.4% of all children.
- Nearly 6% of looked-after children aged between 10 and 17 were convicted of an offence or subject to a final warning or reprimand in 2014.
- 20% of young homeless people were previously looked-after children.
- 24% of the adult prison population have been in care.
- 70% of sex workers have been in care.

Narrowing the gap in educational achievement between looked-after children and the rest of the school population locally and nationally is a priority and there has been some progress on this in recent years. 2016 attainment results for Key Stage 2 show

that Plymouth's pupils' attainment in achieving the expected standards in Reading, Writing and Maths is either on par with, or better than, pupils nationally, regionally and those within our statistical neighbour group. Additionally, the gap between the attainment of disadvantaged children and all other pupils in Plymouth is smaller than the gap nationally, regionally, and amongst our statistical neighbours. Attainment results for Key Stage 4 are released in January. All results will be analysed and key findings reported when available.

For the last three years the number of children and young people in care has ranged between 380 and 400, remaining relatively stable compared to the national trend.

In 2015/16, 205 children and young people (115 males, 90 females) came into the care of the local authority. Of these, 80 were aged 0-4 years, 35 were aged 5-9 years, and 80 were aged of 10-17 years.

Young people who enter into care later in life often struggle to settle into a placement and form new attachments to carers or staff. It is critical that a range of placements are available to meet need, with carers and staff able to provide a robust and resilient response to children and young people. Carers and staff need to be skilled in understanding the manifestations of trauma – both from a history of abuse and the process of removal from family members.[37]

Placement stability and permanence processes are vitally important in securing stable homes for looked-after children; a team approach with clear planning is required for each child. All permanence options need to be considered as part of the process to secure the most appropriate long term option for the child or young person.[37]

4.9.2 FAMILIES WITH MULTIPLE AND COMPLEX NEEDS / SAFEGUARDING CHILDREN

In Plymouth the main problems facing families with children subject to a child protection plan are domestic abuse, unsafe parenting, at sexual risk from an adult, parental mental health problems, parental alcohol misuse, or parental drug misuse.

Ofsted's report 'In the child's time: professional responses to neglect' (2014), highlighted an inconsistency in the quality of professional responses to neglect. Where children were not making positive progress, a common feature was lack of parental engagement. The Targeted Family Support Service in Plymouth has a well-developed approach to parental non-compliance aimed at diverting families from the statutory intervention. However there is still a need to review how to address parental engagement across the system of early help services to prevent the need for child protection referrals.[37]

The Corporate Safeguarding Improvement Plan identifies a number of areas where the Plymouth Safeguarding Children's Board (PSCB) want to focus its activity. These include:

- reducing the number of repeat referrals and child protection plans
- reducing the number of children subject to child protection plans

[37] Children and young people, a single view of need/ demand, 2016

The Board is taking a number of steps to improve the quality of supervision, care planning and assessments, and developing and embedding an enhanced, systems-based approach to quality assurance. It is also taking the lead on the multi-agency work being undertaken to try to better understand and tackle Child Sexual Exploitation.[37]

4.9.3 ENHANCED AND SPECIALIST CARE

The focus of commissioning is on the provision of Individual Patient Placements (IPPs), care home support, and end of life support. Enhanced and specialist services are needed by people when other interventions have not achieved their outcomes and their health care needs cannot be met or provided elsewhere. Often referrals originate from another health care organisation. In 2015/16 the identified spend on services within scope of the 'Enhanced and Specialised Care Strategy' was £29.30 million*.

An ageing population will mean increased prevalence of dementia, other long-term conditions, and multiple comorbidities. The complexity of need of people living in care homes is increasing. This will mean care home provision will need to be better at supporting people with complex needs, particularly dementia and mental ill-health.

(* N.B. Highly specialised healthcare services in hospital are commissioned by NHS England on behalf of the local population – an additional budget in excess of £130m)

4.9.4 CARERS

In England and Wales there are around 5.4 million people providing unpaid care for an ill, frail, or disabled family member or friend. Using data from the 2011 Census, there were 27,247 of these carers in Plymouth. This was a 13% increase on number identified in the 2001 Census. The majority (57.3%) provided 1-19 hours of care per week but nearly 30% (7,566 individuals) were committing over 50 hours. Challenges around Plymouth's ageing population and an increased complexity of need will put increasing pressure on unpaid carers. Currently, only 24% (approximately) of carers in Plymouth are registered with the local carers support service.[38]

Under the 'Care Act' (2015) all adult carers became entitled to a full carer's assessment. Within Plymouth there has been a substantial increase in the numbers of carer's assessments undertaken. Between April 2016 and the end of September 2016 564 carer's assessments have been undertaken by either Livewell Southwest or the Plymouth Guild Carer's hub, this is compared to just 150 during the same period in 2015/16. The number of completed carer's assessments is on track to more than double in 2016/17. This increase is seen as a real positive for carers in the city and an attempt to improve the performance against national outcome indicators in relation to carer quality of life and the level to which they feel consulted on care provision.

[38] Children and young people, a single view of need/ demand, 2016

4.9.5 YOUNG CARERS

Young carers are the children and young people who take on the responsibility of caring for a family member, most often a parent or sibling, who has a condition such as a disability, illness, mental health condition or a drug and/or alcohol problem. The approximate total number of children and young people aged 18 years and younger in Plymouth is 56,155. Using the national estimate, that 1.5 per cent of young people are carers, it suggests there are at least 840 children and young people with caring responsibilities in the city. There are approximately only 200 young carers under the age of 18 known to Plymouth City Council, therefore there could be around 640 young carers unknown to the local authority.[38]

4.9.6 COMMUNITY-BASED CARE

Plymouth's rising population (described in section one of this report) is likely to put increasing pressure on community-based provision within the definition outlined in the 'Community-based care commissioning strategy'. One of the most significant factors that will impact on further demand for community services is the growing number of older people in Plymouth.[39] It is estimated that Plymouth's population will increase by over 16,000 by 2030. The largest increase will be seen in 75+ year olds (54.6%).[40]

Community-based care delivers targeted services for people who need support in the community to maintain independence or those who may be at risk in the future of losing their independence. The services support people with multiple care and support needs, people requiring urgent care, and people with long-term needs who require ongoing personalised support. The 'Community-based Care Needs Assessment' undertaken in 2016 provides an extensive overview of community based care needs and demand.

4.9.6.1 People with multiple care and support needs

Local information, combined with national modelling, indicates that adults experience complex needs (relating to homelessness, substance misuse, offending, and mental health) at different levels. Within Plymouth the 'Community-based Care Needs Assessment' identifies that there are;

- in excess of 25,000 people with a hazardous drinking need, and in excess of 6,000 people with a harmful drinking need[41]
- more than 1,000 households prevented from becoming homeless in 2015/16[42]
- around 5,600 people with a drugs need[43]

[39] Community-based Care Commissioning Strategy, 2016
[40] Office of National Statistics Population Projections
[41] Alcohol needs assessment, 2011
[42] Community Connections Department
[43] Substance misuse atlas

- in excess of 26,000 people with a common mental health disorder need[44] and 4,500 people with depression and severe depression need[45]

Analysis of the above has identified that;

- There is a core group of approximately 270 individuals requiring intense support for a number of issues at the same time.
- There are approximately 3,000 people that are not in immediate crisis but could shift into core without intervention.
- There are approximately 5,000 people who have complex needs but are stable and engaging with support.

4.9.6.2 People requiring urgent care

These people may need services such as rapid response home care, mental health support services, reablement and/or community equipment.

The 'Community-based Care Needs Assessment' reports that the number of emergency admissions to hospital is expected to rise by around 1.1% per year. However, due to the ageing population it is expected that the total number of emergency bed days will increase by around 1.6% per year. It is also known that the prevalence of long-term conditions is rising, which will place an additional demand pressure on the urgent care system.[46]

There has already been an increase in the number of domiciliary hours commissioned by Plymouth City Council and Northern, Eastern and Western Devon Clinical Commissioning Group. A 12.5% increase in hours was reported in 2014/15[47]

4.9.6.3 People with long-term needs who require ongoing personalised support

In 2014, a total of 12,041 people over the age of 65 were predicted to have a long-term limiting illness where their day-to-day activities were limited a lot (self-definition as per the 2011 Census). Between 2014 and 2030, it is expected that the number of people aged over 65 with a limiting long- term illness will rise from 12,042 to 16,538.[48] Reasons for requiring long-term support include; sensory impairment, dementia, frailty, mental health issues, and learning disabilities.

[44] Projecting Adult Needs and Service Information System
[45] Projecting Older People Population System
[46] Community-based Care Needs Assessment, 2016
[47] Community-based Care Commissioning Strategy, 2016
[48] Projecting Older People Population Information

4.9.7 Residential and nursing care

There were in excess of 1,000 clients in long-term residential care in 2015/16. Although numbers are stable (1,092 in 2014/15) the average annual cost of a long term residential care package has risen, from £31,530 at 2015/16 year end to £34,419 as at the end of November 2016.

The numbers in long-term nursing care are increasing. In 2015/16 192 clients accessed long term nursing care. Between April and November 2016 that number was 209 so numbers for 2016/17 will be higher. The average annual cost of a long-term nursing care package has also increased, from £27,764 at 2015/16 year end to £31,659 as at the end of November 2016.

The increase in the cost of residential and nursing care placements (including short-term placements) is a concern. An action plan is currently in place with Livewell Southwest (the provider) to try and mitigate the financial pressures.

The quality of residential and nursing care provision in Plymouth remains high. The percentage of homes that are rated by the Care Quality Commission as 'good' or 'outstanding' is higher than the England average. The most recent adult social care client survey also showed that 70% of people in receipt of long-term social care were either 'satisfied' or 'very satisfied' with the care they receive. This is also above the national average.

4.9.8 Safeguarding adults

The Adult Safeguarding Health needs assessment provides an in-depth analysis in relation to the people in Plymouth who are in need of safeguarding (i.e. in need of care and support who also, due to these needs, may be unable to protect themselves, and therefore must be protected from the risk of or actual abuse).

In 2015/16 there were 1,731 safeguarding concerns reported. This number is likely to increase again in 2016/17 due to the continued efforts to raise awareness and tackle potential under-reporting. Based on the reported incidents, those most at risk of needing safeguarding are older people in receipt of physical support and who are resident in a care home setting or who live in their own home. However, ongoing analysis has also identified a cohort of people who are the subject of a disproportionately low number of safeguarding alerts. These are people who are in receipt of their social care support via a direct payment meaning less is known about their circumstances and they are subject to much less social care supervision.

The Adult Safeguarding Board remains on target to deliver against its strategic plan. Safeguarding information and the facility for online referral for professionals and members of the public are also now more prominent on the new Plymouth City Council website. Across the safeguarding network, partnership work on the modern slavery agenda continues and representatives from a variety of agencies and sectors recently undertook training to raise awareness of signs and processes. Whilst the recent modern slavery referral mechanism review pilot is due to end for evaluation at the end of March 2017, the Home Office thanked Plymouth for its participation.

4.10 Example 1: 'Thrive Plymouth'

In January 2014, at a Plymouth City Council 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 four behaviours (poor diet, lack of exercise, tobacco use and excess alcohol consumption) are risk factors for four diseases (coronary heart disease, stroke, cancers and respiratory problems) which together account for 54% of deaths in Plymouth (i.e. 4-4-54). Changing these four behaviours would help prevent these diseases and reduce the number of deaths due to these chronic diseases.

Thrive Plymouth is based on the following three approaches:

(1) Population prevention

Population prevention is about the whole population making positive changes, big or small, to their lifestyle choices. This is because lots of people with a small risk of getting a disease can cause as much ill health as a small number of people with a large risk. So everyone making even a small change will help Plymouth Thrive.

(2) Common risk factors

Common risk factors are based on the fact that one unhealthy behaviour can be the basis of many diseases, and several of these unhealthy behaviours tend to cluster in individuals in less affluent groups. Focusing on these common risks and how they cluster is more efficient and effective.

(3) Changing the context of choice

Context of choice acknowledges that despite an understanding of what is unhealthy, and good intentions to be healthier, change is hard to achieve. This is because we all make choices in settings we often don't control, where the healthy choice can be harder than the unhealthy choice is the easy choice

An electoral ward performance dashboard has been developed to monitor change in 20 relevant indicators and is updated as new data becomes available.

In addition to an on-going focus on the four behaviours, Thrive Plymouth also has a specific focus every year. In year one the focus was workplace health and wellbeing. In year two the focus was on schools. The focus for year three (from November 2016) is on localising Public Health England's 'One You' campaign.

4.11 Example 2: Integrated health and wellbeing: 'One System, One Budget'

Public sector organisations across the country are facing unprecedented challenges and pressures due to changes in demography, increasing complexity of need and the requirement to deliver better services with less public resource. Plymouth, and Devon as a whole, face a particular financial challenge because of the local demography, the historic pattern of provision, and pockets of deprivation and entrenched health inequalities.

On the 1st April 2015 Plymouth City Council (PCC) and the Northern, Eastern and Western Devon Clinical Commissioning Group (CCG) pooled their wellbeing, health and social care budgets and formed an integrated commissioning function. The primary driver of this was to streamline service delivery and provision with the aim of improving outcomes for individuals and providing value for money.

Four integrated commissioning strategies were developed to drive activity across the wellbeing, health and social care systems. The strategies describe the current picture and the integrated commissioning response across the health and wellbeing 'system' in Plymouth, specifically covering:

- Wellbeing
- Children and young people
- Community
- Enhanced and specialist

APPENDIX A: PUBLIC HEALTH ENGLAND DATA AND ANALYSIS TOOLS

A single point of access to all nationally produced Public Health England data profiles and tools, and other high quality resources can be accessed via the link: https://www.gov.uk/guidance/phe-data-and-analysis-tools.

The resources cover a range of public health topics including:

- specific health conditions – such as cancer, mental health, cardiovascular disease, and diabetes
- lifestyle risk factors – such as smoking, alcohol, and obesity
- wider determinants of health – such as environment, housing, and deprivation
- health protection

The interactive tools require one or more steps to select the desired geography. Often the option to download a PDF is then available.

APPENDIX B: OTHER USEFUL RESOURCES

- Director of Public Health annual report 2014/15
  http://web.plymouth.gov.uk/public_health_annual_report.pdf
- Director of Public Health annual report 2015/16
  http://web.plymouth.gov.uk/public_health_annual_report1516.pdf
- Integrated commissioning strategy needs assessments: 'Wellbeing', 'Children & Young People', Enhanced & Specialised Care', and 'Community-based Care'
  http://web.plymouth.gov.uk/homepage/socialcareandhealth/hscintegrationstrategies.htm
- Thrive Plymouth
  http://web.plymouth.gov.uk/homepage/socialcareandhealth/publichealth/thrive.htm

APPENDIX C: LINKS TO LOCALLY PRODUCED PLYMOUTH JOINT STRATEGIC NEEDS ASSESSMENT PROFILES AND REPORTS

- 2011 Census profiles

  http://web.plymouth.gov.uk/homepage/socialcareandhealth/publichealth/healthandwellbeingboard/jsna/census2011profiles.htm

- Area profiles, 2014
  http://web.plymouth.gov.uk/homepage/socialcareandhealth/publichealth/healthandwellbeingboard/jsna/areaprofiles.htm

- Alcohol harm mapping: Plymouth neighbourhood profiles 2016
  http://web.plymouth.gov.uk/alcohol_harm_mapping_neighbourhood_profiles.pdf

- Health related behaviour survey analysis: secondary education providers in Plymouth 2014
  http://web.plymouth.gov.uk/healthrelatedbehavioursurvey_plymouthgeographies_finalv1.0_-_secure.pdf

- Index of Multiple Deprivation (IMD) 2015: Plymouth summary analysis
  http://web.plymouth.gov.uk/index_of_multiple_depravation.pdf

- Life expectancy in Plymouth, 2001-03 to 2012-14
  http://web.plymouth.gov.uk/jsnalifeexpectancyreport.pdf

- Mental health review 2014 (Pledge 90)
  http://web.plymouth.gov.uk/pledge_90_mental_health_review.pdf

- National Child Measurement Programme Report 2014/15

  http://web.plymouth.gov.uk/plymouths_national_child_measurement_programme.pdf

- Physical activity needs assessment for Plymouth 2015 to 2018
  http://web.plymouth.gov.uk/physical_activity_needs_assessment_2015_to_2018.pdf

- Prevalence of smoking, obesity, and high blood pressure in Plymouth, 2010/11 to 2012/13

  http://web.plymouth.gov.uk/smoking_obesity_high_blood_pressure_in_plymouth.pdf

- Survey of health visitor caseloads, 2002 to 2016

  http://web.plymouth.gov.uk/healthvisitorsurveyreport_2016_final_v1.0_-_secure.pdf

The full list can be found here:
http://web.plymouth.gov.uk/homepage/socialcareandhealth/publichealth/healthandwellbeingboard/jsna.htm

INTEGRATED HEALTH & WELLBEING

SYSTEM PERFORMANCE SCORECARD

NOVEMBER 2016

NHS

Northern, Eastern and Western Devon Clinical Commissioning Group

PLYMOUTH CITY COUNCIL

1. INTRODUCTION

Public Sector organisations across the country are facing unprecedented challenges and pressures due to changes in demography, increasing complexity of need and the requirement to deliver better services with less public resource. Plymouth and Devon also face a particular financial challenge because of the local demography, the historic pattern of provision and pockets of deprivation and entrenched health inequalities.

On the 1st April 2015 Plymouth City Council (PCC) and the Northern, Eastern and Western Devon Clinical Commissioning Group (CCG) pooled their wellbeing, health and social care budgets and formed an integrated commissioning function. Four Integrated Commissioning Strategies were developed to drive activity across the wellbeing health and social care system.

The primary driver of this is to streamline service delivery and provision with the aim of improving outcomes both for individuals and value for money. Integrated commissioning must deliver integrated wellbeing.

The four strategies describe the current picture and the integrated commissioning response across the health and wellbeing 'system' in Plymouth, specifically covering

- Wellbeing
- Children and young people
- Community
- Enhanced and specialist

To monitor progress of the Integrated Commissioning activity an Integrated System Performance Scorecard has been developed. The scorecard will be updated on a quarterly basis and will capture and understand the impact of integration across the system, and inform future commissioning decisions.

2. COLOUR SCHEME – BENCHMARK COLUMN

For indicators taken from either the Public Health Outcomes Framework or the Children and Young People's Health Benchmarking Tool:

- Indicators highlighted green show where Plymouth is significantly better than the England average.
- Indicators highlighted amber show where Plymouth is not significantly different to the England average.
- Indicators highlighted red show where Plymouth is significantly worse than the England average.
- Indicators highlighted white show where no significance test was performed, or where no local data or no national data were available.

For the rest of the indicators:

- Indicators highlighted green show where Plymouth 15% better than England's average.
- Indicators highlighted amber show where Plymouth within 15% of England's average.
- Indicators highlighted red show where Plymouth 15% worse than England's average.
- Indicators highlighted white or N/A show where no local data or no national data were available.

3. TREND GRAPHS

Each indicator is accompanied by a trend graph showing where possible the latest six values. Caution is required when interpreting the graphs as there is no Y axis displayed and as such the significance or flow of the change is difficult to interpret.

4. COLOUR SCHEME - TREND COLUMN (RAG)

- Indicators highlighted dark green show where there the latest 3 values are improving.
- Indicators highlighted green show where there the latest 1 or 2 values are improving.
- Indicators highlighted amber show where the latest value is between plus and minus 2.5% of the previous value.
- Indicators highlighted red show where there the latest 1 or 2 values are deteriorating.
- Indicators highlighted dark red show where there the latest 3 values are deteriorating.
- Indicators not highlighted have no trend data

5. PERFORMANCE BY EXCEPTION

WELLBEING

Estimated diagnosis rates for dementia – Increasing trend

Following a dip in quarter one there has in quarter two been an increase in the dementia diagnosis rate to 59.7%. This is mainly driven by a reduction in the number of people waiting to have their diagnosis confirmed in Livewell SW. There are a number of improvement plans in place to continue the improvement but reaching the national target of 66.7% is likely to prove challenging.

Number of carers receiving a statutory Carers Assessment – Increasing trend

We continue to deliver more adult carer's assessments, by the end of quarter two this year 564 assessments have been completed by either Livewell SW or the Plymouth Guild Carer's hub. We are in the fieldwork period of the 2016 adult carer's survey and have achieved the desired response rate. As at the 10th November the response rate is in excess of 40%.

CHILDREN AND YOUNG PEOPLE

First time entrants to the youth justice system – Reducing trend

Plymouths rate of first time entrants to the youth justice system has decreased over the last 5 years from a rate of 1171 per 100,000 10-17 year olds in 2010 to 431 in 2015; this has led to a decrease of the gap between Plymouth and England.

Breastfeeding prevalence at 6-8 weeks after birth – Increasing trend

Breastfeeding prevalence has seen an increase in the last couple of years (in 2010/11 it was 35% and in 2014/15 it is 38.2%), it has decreased for 2015/16 but due to a change in data collection method it is hard to identify if this is a decrease in prevalence or just down to the change in data collection.

Public Health are currently working with commissioned services to enhance our community offer with a focus on developing voluntary and peer (mother to mother) support to families residing in our most deprived neighbourhoods.

Children Social Care Re-referrals – Reducing trend

Repeat referrals are relatively stable at 33.5% within quarter two, and remain on a reducing trend since the end of last year. It is anticipated that the early intervention and step down processes being embedded will contribute to an improvement in the number of re-referrals in the early part of 2017.

Number of children subject to a Child Protection plan – Increasing trend

The overall number of child protection plans Increased in October by 8 to 379. This is comparable with the same period in the previous year. The percentage of children on multiple plans has improved slightly and stands at 29.1% at the end of October. Multiagency partnership work for the Plymouth Safeguarding Children's Board has been completed and service managers will use the key messages within this document to inform next steps.

Number of looked after children – Decreasing trend

Children in care decreased to 406 at the end of quarter two, which is in line with the statistical family group (based on 2014/15 but above the England benchmark). Over the longer term regional and national evidence is showing that children in care numbers are increasing.

COMMUNITY

Successful completion of drug treatment – Increasing trend

The percentage of non-opiate drug users that left treatment successfully and do not re-present to treatment 6 months later for Plymouth is 38.5% which is not significantly different than the England average.

Delayed Transfers of Care – Reducing trend

Nationally, since August 2010, the number of delayed transfers of care has been increasing. Locally the trend is an improving one for delays attributable to Adult Social Care, improvement that continued through quarter two – the rate of delays reducing from 8.8 per 100,000 population at the end of quarter one to 6.6 per 100,000 population at the end of quarter two. A comprehensive action plan is in place and is overseen by the Urgent Care Partnership. Key initiatives includes establishment of an Integrated Hospital Discharge Team and scaling up of Discharged to Assess.

Preventing Homelessness – Increasing trend

Levels of homelessness (as well as demand for specialist casework interventions to prevent homelessness) have continued to rise steadily – the first two quarters of this year again saw statutory homeless approaches rise 18% compared to last year's quarterly average.

In quarter two 299 households were prevented from becoming homeless, an improvement from 213 in quarter one. Increased homelessness prevention over the last few years had seen Plymouth move above the regional and national averages, but sustaining this high performance has proved challenging. A number of actions have been taken to combat this, including changes to culture and practice within the PCC Housing casework team.

Reporting Domestic Abuse – Reducing trend

The level of all Domestic Abuse incidents being reported has decreased over the last couple of years, a reduction linked to changes in recording processes within Devon and Cornwall Police. The number of reports resulting in a recorded crime has increased and partnership work continues to raise awareness of service for victims.

ENHANCED AND SPECIALISED

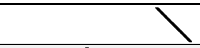
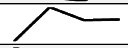
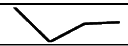
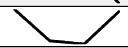
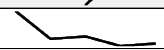
Referral to treatment waiting times – Reducing trend

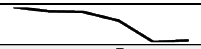
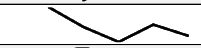
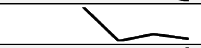
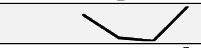
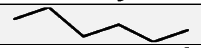
Performance against the 18-week referral to treatment waiting has decreased in the first part of 2016/17. However, local data is showing that performance in October has started to improve. This trend is expected to continue as a result of a comprehensive action plan that is in place overseen by the Western Delivery Group. Key measures centre on reducing demand and increasing system wide capacity. The number of referrals into Plymouth Hospital NHS Trust has decreased compared to last year and the overall level of capacity across the whole Western Locality has started to increase in key areas. Capacity will continue to increase until Q4 2016/17 when it will be back to the required level.

CQC providers with a CQC rating of good or outstanding – Increasing trend

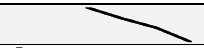
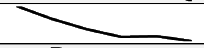
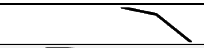
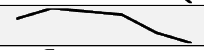
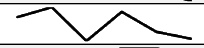
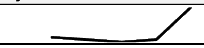
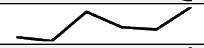
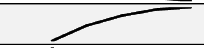
At the end of quarter two 84% of active providers of Adult Social Care have been rated as good or outstanding by the Care Quality Commission, this maintains the previous quarter's performance and is better than the England average. At the end of quarter two there were no providers rated as inadequate.

6. WELLBEING

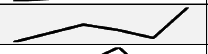
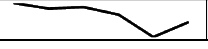
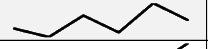
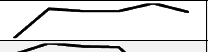
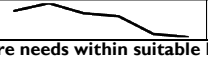
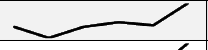
Source	Indicator	Measure	Most Recent Period	Benchmark England	First Value of Graph	Graph	Last Value of Graph	Trend
Sustain the improvement in healthy life expectancy and health inequality and reduce both all-age all-cause deaths and deaths due to cancer, stroke, heart disease and respiratory disease								
PHOF	2.12 - Excess Weight in Adults	Percentage	2013 - 15		62.4		62.4	
PHOF	2.13i - Percentage of physically active and inactive adults - active adults	Percentage	2015		59.2		56.2	
PHOF	2.13ii - Percentage of physically active and inactive adults - inactive adults	Percentage	2015		27.6		30.2	
PHOF	2.14 - Smoking Prevalence in adults - current smokers (APS)	Percentage	2015		24.1		20.6	
Commission only from providers who have a clear and proactive approach to health improvement, prevention of ill health, whole person wellbeing and working with the wider community in which they operate.								
ONS	Self-reported well-being: % of people with a low satisfaction score	Percentage	2014/15		6.2		5.4	
ONS	Self-reported well-being: % of people with a low worthwhile score	Percentage	2014/15		5.5		4.2	
ONS	Self-reported well-being: % of people with a low happiness score	Percentage	2014/15		12.8		12.6	
ONS	Self-reported well-being: % of people with a high anxiety score	Percentage	2014/15		22.7		19.5	
ASCOF	Social Isolation: percentage of adult social care users who have as much social contact as they would like	Percentage	2015/16		43.8		47.0	
ASCOF	Social Isolation: percentage of adult carers who have as much social contact as they would like	Percentage	2013/14		33.2		33.2	N/A
Care Act Metric (Local)	Total number of people for whom an advocate is arranged	Count						
Local - Carefirst	Number of carers receiving a statutory Carers Assessment	Count	2016/17 - Q2	N/A	71.0		293.0	
Local - Safer Plymouth	Percentage of people who feel safe after dark	Percentage	2014	N/A	59.5		62.3	
Local - Safer Plymouth	Percentage of people who feel safe during the day	Percentage	2014	N/A	89.3		88.3	
Local – Housing Options	Total Category 1 hazards removed CAT1	Number	2016/17 - Q2	N/A	89.0		43.0	
ASCOF	The proportion of people who use services and carers who find it easy to find information about support - Client element	Percentage	2015/16		80.8		75.0	
ASCOF	The proportion of people who use services and carers who find it easy to find information about support - Carer element	Percentage	2014/15		58.3		43.2	

Source	Indicator	Measure	Most Recent Period	Benchmark England	First Value of Graph	Graph	Last Value of Graph	Trend
Place health improvement and the prevention of ill health at the core of our planned care system; demonstrably reducing the demand for urgent and complex interventions and yielding improvements in health and the behavioural determinants of health in Plymouth								
PHOF	2.04 - Under 18 conceptions	Rate per 1,000	2014		46.0		29.6	
PHOF	3.02 - Chlamydia detection rate (15-24 year olds)	Rate per 100,000 population	2015		2,490.7		2,529.0	
PHOF	3.04 - HIV late diagnosis	Percentage	2013 - 15		43.4		33.3	
CCGOF	CCGOF Referral to Treatment waiting times (patients waiting over 18 weeks on incomplete pathway (%) (PHNT)	Percentage	Aug-16	N/A	85.0		83.5	
CCGOF	CCGOF Total health gain as assessed by patients for elective procedures - Hip replacement Primary	EQ-5D™ index	2015/16		0.42		0.41	
CCGOF	CCGOF Total health gain as assessed by patients for elective procedures - Knee replacements - primary	EQ-5D™ index	2015/16		0.32		0.33	
CCGOF	CCGOF Total health gain as assessed by patients for elective procedures - Varicose veins	EQ-5D™ index	2015/16		0.04		0.07	
CCGOF	CCGOF Incidence of healthcare associated infection (HCAI) - MRSA	Count	2015/16	N/A	4		2	
CCGOF	CCGOF Incidence of healthcare associated infection (HCAI) - C-Difficile	Count	2015/16	N/A	32		42	
CCGOF	CCGOF Incidence of healthcare associated infection (HCAI) - Cat 2,3 & 4 new pressure ulcers	Count	2015/16	N/A	174		51	
www.primarycare.nhs.uk	NHSOF Estimated diagnosis rates for Dementia (Percentage)	Percentage	Sep-16	N/A	59.0		59.7	
CCGOF	In hospital Falls with harm	Percentage	Sep-16	N/A	0.0		0.1	

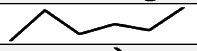
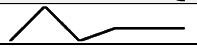
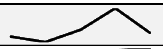
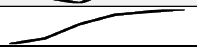
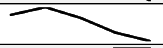
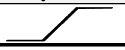
7. CHILDREN AND YOUNG PEOPLE

Source	Indicator	Measure	Most Recent Period	Benchmark England	First Value of Graph	Graph	Last Value of Graph	Trend
Raise aspirations: ensure that all children and young people are provided with opportunities that inspire them to learn and develop skills for future employment								
Local - PCC	Overall School attendance(absence sessions against the total available attendance sessions, includes authorised and unauthorised absence)	Percentage	2014/15	N/A	6.0		4.5	
PHOF	1.04 - First time entrants to the youth justice system	Rate per 100,000	2015		1,171.3		431.0	
PHOF	1.05 - 16-18 year olds not in education employment or training	Percentage	2015		8.4		5.6	
Deliver Prevention and Early Help: intervene early to meet the needs of children, young people and their families who are 'vulnerable' to poor life outcomes								
PHE C&YP	Child mortality rate (1-17 years)	Rate per 100,000	2012 - 14		11.6		6.2	
PHOF	1.01i - Children in low income families (all dependent children under 20)	Percentage	2013		21.3		19.4	
PHOF	4.01 - Infant mortality	Rate per 1,000	2013 - 15		5.0		4.5	
PHOF	2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth*	Percentage	2015/16		35.0		36.7	
PHOF	1.02i - School Readiness: The percentage of children achieving a good level of development at the end of reception	Percentage	2014/15		57.3		62.6	
PHOF	2.06i - Child excess weight in 4-5 and 10-11 year olds - 4-5 year olds	Percentage	2014/15		22.8		24.6	
PHE C&YP	A&E attendances (0-4 years)	Rate per 1,000	2014/15		338.9		450.4	
Keep our Children and Young People Safe: ensure effective safeguarding and provide excellent services for children in care								
Local - PCC	Referrals carried out within 12 months of a previous referral (Re-referrals)	Percentage	2016/17 Q2		34.7		33.5	
Local - PCC	Reduction in the number of children with a "Child in Need" Status (As at 31st March)	Count	2015/16	N/A	1,776		2,118	
PHE C&YP	Hospital admissions as a result of self-harm (10-24 years)	Rate per 100,000	2014/15		425.5		473.6	
PHE C&YP	Hospital admissions due to alcohol specific conditions	Rate per 100,000	2012/13 - 14/15		92.5		53.9	
PHE C&YP	Hospital admissions due to substance misuse (15-24 years)	Rate per 100,000	2012/13 - 14/15		49.7		80.5	
PHE C&YP	Hospital admissions for mental health conditions	Rate per 100,000	2014/15		140.7		100.6	
Local - PCC	Number of children subject to a Child Protection plan	Count	2016/17 Q2		439		371	
Local - PCC	Number of looked after children	Count	2016/17 Q2		380		406	
Local - PCC	Number of Children in Care - Residential	Count	2016/17 Q2	N/A	22.0		27.0	
PHOF	2.08i - Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31st March	Percentage	2014/15		16.1		15.7	

8. COMMUNITY

Source	Indicator	Measure	Most Recent Period	Benchmark England	First Value of Graph	Graph	Last Value of Graph	Trend
Provide integrated services that meet the whole needs of the person by developing: • Single, integrated points of access • Integrated support services & system performance management • Integrated records								
PHOF	2.18 - Admission episodes for alcohol-related conditions - narrow definition	Rate per 100,000	2014/15		688.4		671.0	
PHOF	2.15i - Successful completion of drug treatment - opiate users	Percentage	2015		5.8		6.4	
PHOF	2.15ii - Successful completion of drug treatment - non-opiate users	Percentage	2015		23.2		38.5	
Housing	Number of households prevented from becoming homeless	Number	2016/17 - Q2	N/A	200		299	
PHOF	1.13i - Re-offending levels - percentage of offenders who re-offend	Percentage	2013		28.8		27.1	
ASCOF	The proportion of adults in contact with secondary mental health services living independently, with or without support	Percentage	2015/16		53.0		59.3	
Safer Plymouth	Number of reported domestic abuse incidents	Number	2016/17 - Q2	N/A	1,633.0		1,330.0	
Safer Plymouth	Number of reported domestic abuse crimes	Number	2016/17 - Q2	N/A	676.0		595.0	
Reduce unnecessary emergency admissions to hospital across all ages by: • Responding quickly in a crisis • Focusing on timely discharge • Providing advice and guidance, recovery and reablement								
ASCOF	Proportion of people still at home 91 days after discharge from hospital into reablement/ rehabilitation services	Percentage	2016/17 - Q2	N/A	86.0		88.0	
NHSOF	IAPT Access Rate (PCH)	Percentage	Sep-16	N/A	1.3		1.5	
NHSOF	IAPT Recovery Rate (PCH)	Percentage	Sep-16	N/A	38.8		46.0	
NHS quality premium	Discharges at weekends and bank holidays	Percentage	Aug-16	N/A	18.3		16.2	
ASCOF	Delayed transfers of care from hospital, per 100,000 population	Rate per 100,000	2016/17 - Q2		15.0		13.4	
ASCOF	Delayed transfers of care from hospital, per 100,000 population, attributable to Adult Social Care	Rate per 100,000	2016/17 - Q2		8.8		6.6	
Provide person centred, flexible and enabling services for people who need on-going support to help them to live independently by:• Supporting people to manage their own health and care needs within suitable housing • Support the development of a range services that offer quality & choice in a safe environment • Further integrating health and social care								
Housing	People helped to live in their own home through the provision of Major Adaptation	Number	2016/17 - Q1	N/A	47		68	
ASCOF	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	Rate per 100,000	2016/17 - Q2		128.1		240.5	
ASCOF	Permanent admissions of younger people (aged 18-64) to residential and nursing care homes	Rate per 100,000	2016/17 - Q2		1.8		4.9	
PHOF	1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate	Percentage Point	2014/15		65.6		66.8	
PHOF	1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	Percentage Point	2014/15		62.9		67.6	
PHOF	Self-reported well-being: % of people with a low satisfaction score	Percentage	2014/15		6.2		5.4	
ASCOF	Proportion of people who use services who have control over their daily life	Percentage	2015/16		74.7		79.0	
ASCOF	The proportion of carers who report that they have been included or consulted in discussions about the person they care for	Percentage	2014/15		74.6		67.3	
Safer Plymouth	Number of Reported Sexual Offences (inc Rape)	Number	2016/17 - Q1	N/A	153.0		126.0	

9. ENHANCED AND SPECIALIST

Source	Indicator	Measure	Most Recent Period	Benchmark England	First Value of Graph	Graph	Last Value of Graph	Trend
Create Centres of Excellence for enhanced and specialist services								
CCGOF	CCGOF Incidence of healthcare associated infection (HCAI) - MRSA	Count	2015/16	N/A	4		2	
CCGOF	CCGOF Incidence of healthcare associated infection (HCAI) - C-Difficile	Count	2015/16	N/A	32		42	
CCGOF	CCGOF Incidence of healthcare associated infection (HCAI) - Cat 2,3 & 4 new pressure ulcers	Count	2015/16	N/A	174		51	
CCGOF	In hospital Falls with harm	Percentage	Sep-16	N/A	0.0		0.1	
Ensure people are able to access care as close to their preferred network of support as possible								
NHSOF	Health-related quality of life for people with long-term conditions	EQ-5D™	2015/16		0.70		0.71	
EOL Profile	DiUPR, Persons, All Ages (%)	Percentage	2014		44.96		52.11	
Provide high quality, safe and effective care, preventing people from escalating to, or requiring, urgent or unplanned care								
PHOF	2.24i - Injuries due to falls in people aged 65 and over	Rate per 100,000	2014/15		2,233.8		1,960.7	
CCGOF	CCGOF Referral to Treatment waiting times (patients waiting over 18 weeks on incomplete pathway (%) (PHNT)	Percentage	Aug-16	N/A	85.0		83.5	
Local - PCC	Percentage of CQC providers with a CQC rating of good or outstanding	Percentage	2016/17 - Q2		82.0		84.0	
Local - PCC	Satisfaction among Adult Social Care clients resident in Residential/ Care homes	Percentage	2015/16	N/A	77.0		81.0	

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HEALTH AND WELLBEING BOARD

Work Programme 2016 - 2017

Date of meeting	Agenda item	Reason for consideration	Responsible
30 June 2016	~~Plymouth ICB Commissioning Intentions~~	~~To consider alignment against the Plymouth Plan~~	~~Jerry Clough / Carole Burgoyne~~
	~~Success Regime~~	~~To consider an update and any resultant actions from the Success Regime~~	
	~~Sustainable Transformation Plan~~	~~To consider an update and any resultant actions from the Sustainable Transformation Plan~~	
	~~Growth Board – People, Communities and Institutions Update~~	~~To consider an update from the Growth Board~~	~~Judith Harwood / Kelechi Nnoaham~~
~~**22 September 2016**~~	~~Plymouth ICB Commissioning Intentions~~	~~Standing Item – (if required)~~	~~Jerry Clough / Carole Burgoyne~~
	~~Alcohol Dashboard Update~~	~~To consider progress against performance measures.~~	~~Kelechi Nnoaham / Laura Juett~~
	~~Children and Young Peoples Partnership Update~~	~~To consider an update and any resultant actions from the Children's Partnership.~~	~~Judith Harwood~~
	~~Director of Public Health Annual Report~~		
	~~The Plymouth Report (JSNA)~~		
26 January 2017	Health Protection Annual report		
	Plymouth Plan		
	NHSE to present on GP forward view (Future of Primary Care)		
	Plymouth Report		
23 March 2016	Plymouth ICB Commissioning Action Plan Update		

Date of meeting	Agenda item	Reason for consideration	Responsible
Date to be Confirmed	Success Regime and Sustainable Transformation Plan	To consider any updates and any resultant actions from the Success Regime and Sustainable Transformation Plan as necessary.	
	Supported living		
	Proposals for the direction of Mental Health Service.		
	The board to receive reports form the adults and children's safeguarding boards		
	Plan for sport		
	Health and wellbeing hubs		
	Special educational needs		