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Published

WELLBEING OVERVIEW AND SCRUTINY COMMITTEE

Wednesday 23 November 2016
2.00 pm
Warspite Room, Council House

Members:
Councillor Mrs Aspinall, Chair

Councillor James, Vice Chair

Councillors Mrs Bowyer, Mrs Bridgeman, Cook, Dann, Mrs Foster, Loveridge, Dr Mahony, Sparling, Tuffin and Tuohy.

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

For further information on webcasting, attending Council meetings and how to engage in the democratic process please follow this link http://www.plymouth.gov.uk/accesstomeetings

Tracey Lee
Chief Executive

Wellbeing Overview and Scrutiny Committee

Agenda

1. Apologies

To receive apologies from Members for non-attendance.

2. Declarations of Interest

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

3. Minutes (Pages 1 - 6)

To confirm the minutes of the meeting held on 21 September 2016.

4. Chairs Urgent Business

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

5. Integrated Fund Monitoring Report - To Follow

The Committee will receive the Integrated Fund Monitoring Report.

6. Integrated Commissioning Scorecard (Pages 7 - 18)

The Committee will receive the Integrated Commissioning Scorecard.

7. Sustainability and Transformation Plan (Pages 19 - 72)

The Committee will receive the Sustainability and Transformation Plan.

8. Tracking Resolutions (Pages 73 - 90)

The Wellbeing Overview and Scrutiny Committee will monitor the progress of its previous decisions.

9. Work Programme (Pages 91 - 94)

The Committee will be asked to consider and approve the Work Programme.

Wellbeing Overview and Scrutiny Committee

Wednesday 21 September 2016

Present:

Councillor Mrs Aspinall, in the Chair.
Councillor Mahony, Vice Chair.
Councillors Mrs Bridgeman, Cook, Dann, Mrs Foster, McDonald, Tuffin and Tuohy.

Apologies for absence: Councillors James and Loveridge

Also in attendance: Councillors Beer, Mrs Bowyer and Downie, Peter Aley (Head of Neighbourhood and Community Services, PCC) Kristin Barnes (Democratic Support Officer, PCC), Carole Burgoyne (Strategic Director for People, PCC), Jerry Clough (NEW Devon CCG), Ruth Harrell (Interim Director for Public Health, PCC), David Northey (Head of Integrated Finance, PCC), Ross Jago (Lead Officer, PCC), Craig McArdle (Director of Integrated Commissioning, PCC), Jo Siney (Head of Special Educational Needs, PCC), Rob Sowden (Performance and research Officer, PCC), Dave Spencer (NEW Devon CCG), Superintendent David Thorne (Devon and Cornwall Police)

The meeting started at 5.00pm and finished at 7.10pm.

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

Please Note This Meeting was Webcast and can be Viewed at –
http://council.webcast.vualto.com/plymouth-city-council/home/?EventId=16311

9. **Declarations of Interest**

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

10. **Minutes**

The minutes of the meetings of;

a) Your Plymouth on 14 December 2016
b) Ambitious Plymouth on 1 February 2016
c) Caring Plymouth on 17 March 2016

Were agreed as a true and accurate record.

The minutes of the meeting of the Wellbeing Overview and Scrutiny Committee of 20 July 2016 were agreed as an accurate record, however, Cllr McDonald queried whether a request she had made regarding the redistribution of non-domestic rates had been responded to. It was agreed that the webcast for the previous meeting would be checked.

11. **Chairs Urgent Business**

Following discussions around the Sustainable Transformation Plan and proposed new models of care, Chair and Vice Chair had been in discussion with colleagues in Devon and Torbay and would report their findings back to the Committee towards the end of the year.

Chair had proposed a Select Committee Review into GP services in Plymouth. Membership was confirmed and the meeting would take place on 6 October 2016.

12. **Work Programme**

The Select Committee review on 6 October was added to the work programme.

13. **Tracking Decisions**

The decision had been made to combine the tracking of decisions from both scrutiny committees so that each knows the issues the other is considering and any crossover can be identified. Those items that were greyed out were considered complete.

Members of both committees would receive an updated version of the risk register with larger print in due course.

14. **Integrated Fund Monitoring Report**

The Committee received the Integrated Fund Monitoring Report, introduced by Councillor Mrs Bowyer and presented by David Northey(Head of Integrated Finance, PCC), Carole Burgoyne (Strategic Director for People), Craig McArdle (Director of Integrated Commissioning, PCC) and Jerry Clough(New Devon CCG) (as attached);

Integrated fund monitoring report.pdf

The Committee heard that;

a) NHS finances were under pressure in all areas. The intent of the integrated fund was to encourage greater collaboration between NHS organisations by setting a control total across all of those organisations rather than a total for each individual organisation. The CCG was working with all of its providers on a joint forecast outturn position;

b) the decision nationally to change the funding rate for free nursing care had increased cost pressures, there were a number of other cost pressures that could emerge, mitigating actions were in place to offset these pressures;

c) the system control total for the CCG was not yet set. Although this was an irritant it was not having any detrimental operational effect. The issue was between NHS England and NHS Improvement who needed to agree how the control total was apportioned between them;

d) a break even position was forecast for the end of the year;

e) savings of around £25 million were required to be made this year;

f) there was continued overheating in Children's placements and adult social care. The department needed to deliver savings of £9.2 million while managing budget pressures of £1.6 million. It was expected that these savings that these savings would be achieved and that the budget pressures were manageable;

g) it was hard to forecast the volume of pressure on the service but more sophisticated modelling meant this was improving. A number of initiatives were underway to offset the cost pressures of increasing volumes of work and being a part of the Integrated Fund assisted in meeting demand.

In response to questioning the Committee heard that;

a) payments for commissioned services would not be capped if they are over performing although the rate of pay for visits may change depending on the level of over performance;

b) the cost of home to school transport had increased following re-tendering but the department was confident that it was able to cover the increased cost pressure that resulted. This service was under constant review;

c) the £5 million contingency fund held by the CCG had been used up relieving the pressure caused by the new expectation to provide free nursing care. There was no further contingency available to offset additional pressures should they arise this financial year;

d) it was difficult to pinpoint the reasons that use of minor injuries services was rising. One reason could be pressure on primary care but this would not be the only reason.

The Committee <u>agreed</u> the following recommendations;

a) a briefing and training session for members of the committee on NHS financing would be provided;

b) a briefing on guardianship would be provided for members of the committee via email;

c) figures for the full year cost of the school transport service would be provided to members of the committee via email.

15. **Integrated Commissioning Scorecard**

The Committee received the Integrated Commissioning Scorecard (as attached) introduced by Councillor Mrs Bowyer and presented by Craig McArdle (Director of Integrated Commissioning, PCC), Rob Sowden(Performance and research Officer, PCC) , Dave Spencer(NEW Devon CCG), Jerry Clough (NEW Devon CCG) and Ruth Harrell (Interim Director of Public Health, PCC).

Integrated Commissioning Scorecard September 2016.pdf

In response to questioning the Committee heard that;

a) the purpose of the drive to increase the diagnoses rate for dementia was to meet the expected level of prevalence for a population;

b) a comprehensive programme of sexual health education formed part of the core work of Public Health to aid in the prevention and detection of sexually transmitted diseases;

c) a range of measures were underway to reduce referral to treatment waiting times including the use of private sector capacity and improving test reporting;

d) campaigns to increase carer's awareness of how to access services were ongoing and their efficacy was being tracked through the Carer's Strategic Partnership Board. Carers surveys were carried out every 2 years. The next cohort of carers were currently being identified and would be surveyed at the end of the year, the results of that survey would be ready next spring;

e) the befriending service within the city had been strengthened to try to combat social isolation. It was impossible to say how much of a factor social isolation was in the reported low happiness scores for the population in Plymouth;

f) the information in relation to low happiness was collected nationally, however, there was locally collected data which enabled targeted projects such as Thrive Plymouth;

g) alcohol related admissions have fallen in line with a national trend and as a result of an effort to improve joined up working across a number of disciplines;

h) the integrated approach has enabled issues to be highlighted that may otherwise not have been apparent.

The Committee agreed the following recommendation;

- national indicators relating to the happiness score would be removed from the data a local mechanism for providing that data would be developed.

16. **Welcoming City Action Plan**

The Committee received the Welcoming City Action Plan (as attached) presented by Councillor Downie, Superintendent David Thorne (Devon and Cornwall Police), Peter Aley (Head of Neighbourhood and Community Services, PCC)

In response to questioning the Committee heard that;

a) a number of indicators had been identified to monitor the success of the plan however it was felt that the qualitative data was also very important;

a) the intention of the plan was to encourage more collaborative working between organisations and the community. A lot of strong links were being established with previously hard to reach groups. A high degree of collaboration would also mean effective use of resources. A new Community Connections Service had been set up to work closely with neighbourhood police, schools and social inclusion and aid integration;

b) small community grants were now reaching a broader range of communities. A list of grants made would be made available on the Plymouth City Council website;

c) a peer review would be one of the methods used to measure success. Voluntary sector coordinators would be invited to form part of the working group.

The Committee agreed the following recommendations;

a) to receive an update on the action plan post February 2017;

b) members would be provided with a list of small budgets issued to diverse groups via email;

c) members would be provided with guidance on the "Members Room" for the third party reporting of hate crime.

17. **Special Educational Needs and Disability**

The Committee received a report on Special Educational Needs and Disability (as attached) introduced by Councillor Mrs Beer and presented by Jo Siney (Head of Special Educational Needs, PCC), Carole Burgoyne (Strategic Director for People, PCC) and Craig McArdle (Director of Integrated Commissioning, PCC);

In response to questioning the committee heard that;

a) the intention was to work towards a single delivery service by integrating commissioning and delivery;

b) the NEW Devon CCG had aligned their contracts to expire simultaneously in March 2017, allowing a full strategic review of review of future commissioning for the SEND services;

c) a technical working group was working to redesign areas of SEND provision in particular speech and language;

d) post 16 SEND provision remained a priority as it had been for the past 10 years, working to raise aspiration in young people with SEND to maximise independence and promote employability.

e) focussed work with Livewell Southwest around commissioning for the CAHMS service was ongoing. Funding had been received from the National CAHMS Enhancement as well as funding commitments that had been received from local schools. As of this September the CAHMS offer would be greatly enhanced with 500 additional counselling sessions available to schools, additional counselling for staff at The Zone, an online counselling scheme and an additional 26 workers across the CAHMS Service. This improved offer was made possible by the new integrated approach.

The Committee agreed the following recommendation;

a) the Committee would receive an update on SEND services at the end of the municipal year.

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

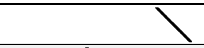
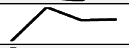
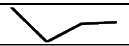
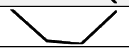
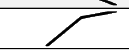
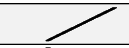
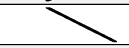
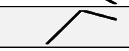
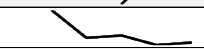
Referral to treatment waiting times – Reducing trend

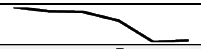
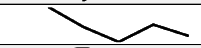
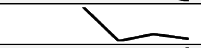
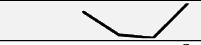
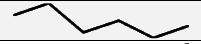
Performance against the 18-week referral to treatment waiting has decreased in the first part of 2016/17. However, local data is showing that performance in October has started to improve. This trend is expected to continue as a result of a comprehensive action plan that is in place overseen by the Western 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

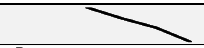
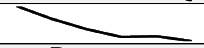
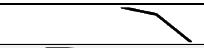
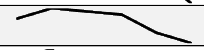
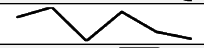
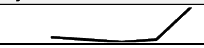
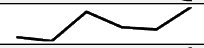
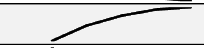
At the end of quarter two 84% of active providers of Adult Social Care have been rated as good or outstanding by the Care Quality Commission, this maintains the previous quarter's performance and is better than the England average. At the end of quarter two there were no providers rated as inadequate.

6. WELLBEING

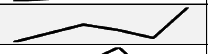
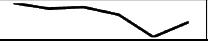
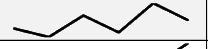
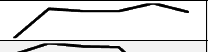
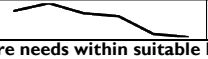
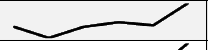
Source	Indicator	Measure	Most Recent Period	Benchmark England	First Value of Graph	Graph	Last Value of Graph	Trend
Sustain the improvement in healthy life expectancy and health inequality and reduce both all-age all-cause deaths and deaths due to cancer, stroke, heart disease and respiratory disease								
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	

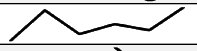
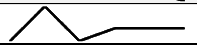
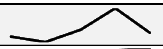
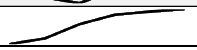
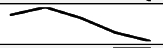
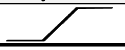
7. CHILDREN AND YOUNG PEOPLE

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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Report to Plymouth Wellbeing Overview and Scrutiny Committee
23rd November 2016
Wider Devon Sustainability and Transformation Plan (STP)

Recommendation
That the Committee:

- Notes the recent publication of the Wider Devon Sustainability and Transformation Plan
- Considers how the Committee can best be engaged in the Sustainability and Transformation Plan going forward

1. Purpose

The Devon Sustainability and Transformation Plan (STP) is a strategic framework that has been developed by NHS organisations in Devon working in partnership with Devon County Council, Plymouth City Council and Torbay Council. The framework for the development of joint strategic work programmes that covers the whole population of wider Devon, Wider Devon has a resident population of around 1,160,000 with just over half living in urban communities and just under half living in rural communities. The STP is the local plan to achieve the NHS 'Five Year Forward View' published in October 2014[1] and to address the challenges faced locally particularly those set out in the Case for Change[2].

The STP is designed to provide the overarching strategic framework within which detailed proposals for how services across Devon will develop between now and 2020/21. The purpose is that people residing in wider Devon will experience safe, sustainable and integrated local support. A key theme throughout the STP is an increased focus on preventing ill health and promoting people's independence through the provision of more joined up services in or closer to people's homes.

At the same time the STP is focused on closing the financial gap that exists, recognising that doing nothing is not an option and transformational change is essential to address the significant challenges faced by the local system. The partner organisations within the wider Devon system working together in relation to the STP are: NEW Devon CCG, South Devon and Torbay CCG, Plymouth Hospitals NHS Trust, Royal Devon and Exeter NHS Foundation Trust, Northern Devon Healthcare NHS Trust, Torbay and South Devon NHS Foundation Trust, South West Ambulance Service Trust, Devon Partnership NHS Trust, NHS

[1]Five Year Forward View https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[2]Success Regime Case for Change http://www.newdevonccg.nhs.uk/about-us/your-future-care/success-regime/case-for-change/101857

England, Circa 160 GP practices, Virgin Care, Devon County Council, Plymouth City Council, Torbay Council, Livewell Southwest CIC, Devon Doctors, Healthwatch (Devon, Plymouth and Torbay) and Care UK and Voluntary and Community Sector Organisations.

Plymouth Wellbeing Overview and Scrutiny Committee has previously received the Success Regime Case for Change and reports on the development of the Sustainability and Transformation Plan. A draft plan was submitted to NHS England in June with positive feedback. This draft has now been updated and was published on 4th November 2016 and is included as appendix 1.

2. STP overview

The STP is built around an aspiration to achieve, by 2021, a fully aligned sense of place, linking the benefits of health, education, housing and employment to economic and social wellbeing for communities through joint working of statutory partners and the voluntary and charitable sectors. In this context the partner organisations involved in the STP are united in a single ambition and shared purpose to create a clinically, socially and financially sustainable health and care system that will improve the health, wellbeing and care of the populations served.

In recognition of the growing physical and mental health needs of the population the STP sets out to achieve the 'triple aim' of the Five Year Forward View - to improve population health and wellbeing, experience of care and cost effectiveness per head of population. It also sets out to address key challenges as summarised below.

- People are living longer and will require more support from the health and care system. In excess of 280,000 local people, including 13,000 children, are living with one or more long term condition
- The system needs to respond better to the high levels of need and complexity in some parts of the population
- Some services such as stroke, paediatrics and maternity are not clinically or financially sustainable in the long term without changes to the way they are delivered across the system
- There is a difference of 15 years in life expectancy across wider Devon and differences in health outcomes – or 'health inequalities' – between some areas, particularly Plymouth
- Spending per person on health and social care differs markedly between the locality areas and is 10% less in the most deprived areas
- Mental health services are not as accessible and available as they need to be, driving people to access other forms of care with limited value from the intervention received. People with a mental health condition have poorer health outcomes than other groups
- There is an over reliance on bed based care - every day over 600 people in Wider Devon are medically fit to leave hospital but cannot for a variety of reasons
- The care home sector is struggling to meet increasing demand and complexity of need
- Almost a quarter of local GPs plan to leave the NHS in 5 years and there are significant pressures on primary care services. Some other services are particularly fragile due to high levels of consultant, nursing, social work or therapy vacancies
- Local health and social care services are under severe financial pressure, and health & social care services are likely to be £557m in deficit in 2020/21 if nothing changes.

The key focus of the STP will be on activities that will make the biggest difference to population health and financial recovery. Seven priorities have been identified. These priorities are:

- Prevention
- Integrated care
- Primary care
- Mental health
- Children and young people
- Acute hospital and specialist services
- Productivity

Once the STP is finalised the transformation programme will include more detailed work and planning around each of these areas. Already there has been progress in development of a more integrated care model and planning for the acute hospital and specialist services review is well underway.

3. Next steps

Already there has been work in 2016/17 on early improvements and efficiencies that can be made. The NEW Devon model of care work as described in 'Your future care' and the community hospital configuration work in South Devon and Torbay CCG are both currently subject to public consultation. The STP also confirms plans to review acute and specialist services.

In relation to the published STP document the next step is for this to be considered and endorsed by the Boards all the organisations involved. In providing a framework for a programme of transformation it is essential that there is ongoing dialogue with patients, volunteers, carers, clinicians and other staff, public, local voluntary and community sector, local authorities and political representatives and an engagement plan is being developed for the whole STP, with targeted involvement and consultation on specific aspects of the STP where applicable.

It is important to note that the STP is designed to build on and expedite progress with current plans as well as introducing new areas of focus. Work will also advance on the detailed planning in relation to each of the seven STP priorities listed in section 2 of this paper. In addition to noting the latest position on the Wider Devon STP, it would be useful to consider with the Committee how the Committee and other stakeholders and public can best be engaged in the STP going forward including a further report to Committee at its next meeting.

Report prepared by: Jenny McNeill, Associate, NEW Devon CCG
Wider Devon STP Lead: Angela Pedder, Chief Executive

Appendix: Wider Devon STP Published 4th November 2016

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Sustainability & Transformation Plan (STP)
Wider Devon

4th November 2016

Name of footprint and number: **Wider Devon (37)**
Region: **South**
Nominated lead of the footprint: **Angela Pedder, Lead Chief Executive**

Contact details
angela.pedder@nhs.net
l.nicholas@nhs.net

Organisations within Devon's STP footprint

Northern, Eastern and Western Devon Clinical Commissioning Group (CCG), South Devon and Torbay CCG, Plymouth Hospitals NHS Trust, Royal Devon and Exeter NHS Trust, Northern Devon Healthcare NHS Trust, Torbay and South Devon NHS Trust, South West Ambulance Service Trust, Devon Partnership NHS Trust, NHS England, Circa 160 GP practices, Virgin Care, Devon County Council, Plymouth City Council, Torbay Council, Livewell Southwest CIC, Devon Doctors, Healthwatch (Devon, Plymouth and Torbay) and Care UK.

The NHS in Devon understands its need to meet all relevant statutory obligations when undertaking a change programme and nothing in this report should be taken to commit the NHS to a particular decision without proper consideration of those obligations.

Content

Introduction and context	• Plan on a page • Introduction & context • Case for change • Vision
Triple Aim	• Triple aim (summary) • Our priorities (summary) • Critical decisions • Population health & wellbeing gap • Experience of care gap • Cost effectiveness gap
Governance	• Programme approach • Governance arrangements
Priorities	• Prevention & early intervention • Integrated care model • Primary care • Mental health & learning disabilities • Acute hospital & specialist services • Productivity • Children & young people
Enablers	• Workforce • Communications & engagement • Estate • Information management and technology (IM&T)

Plan on a page

Triple aim challenge :

- **Improve population health & wellbeing**
- **Experience of care**
- **Cost effectiveness per head of population**

Our commitment

Partners across the wider Devon health and care community are united in a single ambition and shared purpose to create a clinically, socially and financially sustainable health and care system that will improve the health, wellbeing and care of the populations we serve.

Over five years we will achieve clinical and financial performance and outcomes improvement by…..

2016/17

Phase 1 of clinical and financial recovery plan to reduce overspending 2016/17. Engage, design and consult on a new model of integrated care to ensure an equal spread of services across Devon and reduce reliance on bed-based care. Deliver early win initiatives to progress 1st phase financial recovery.

2017/18

Phase 2 to start planning and implementing the longer term clinically and financially sustainable models of care

Engage, design and consult on reconfigured new models of care for mental health, acute and specialist services to secure clinically sustainable services, reduce duplication and variation and improve user experience.

2018/19

Phase 3 Promote prevention and early intervention: Fully Implement the integrated care model

- Build equitable mental health and emotional well being capacity
- Mobilise new model of fully integrated health and social care, primary car and local community support in all localities and reduce bed stock
- Realign use of resources to achieve population and service equity
- Workforce redesign and capacity building to support care model delivery and to promote economic growth and resilience
- Commence specialist and acute reconfigurations implementation

2019/20

Capture the benefits of Reduced variations in care and provision, reduced health inequalities, enabling people to access services that achieve better outcomes. Also enable the care providers to better manage demand for their services – right care, right place

2020/21

Clinical and financial sustainability secured

Improvements in health/patient experience outcomes demonstrated

Key priorities	Prevention & early intervention	Integrated models of care	Primary care	Mental health	Children & young people	Acute hospital & specialist services	Productivity

Welcome to the Wider Devon Sustainability & Transformation Plan (STP) October 2016

Aspiration

The STP sets out our commitment to transforming care to deliver the best possible health outcomes for our local population; shifting our model of care so that more people are cared for in out of hospital settings - through prevention, more proactive care, and new models of care delivery – and reducing reliance on secondary care. We will take a place-based approach which links health, education, housing and employment to economic and social wellbeing for our communities through joint working of statutory partners and the voluntary and charitable sectors.

Framework

This Plan describes how people residing in wider Devon will experience safe, sustainable, integrated, local support by 2021. It shows how we will deliver a major programme of transformational change and improvement across wider Devon starting from 2016/17. This change will be enabled by engaging our communities, investment in technology, changes in workforce and ensuring that where estate is required, it is fit for purpose.

Challenges

The challenges we face are significant. Whilst we may all agree on the goal of achieving clinically and financially sustainable care services, there will be many views on how we get there.

We will be encouraging the community to work with us to jointly understand the challenge and develop solutions together.

Scope

The STP is a strategic plan that covers the whole of wider Devon, including its three local authorities and two clinical commissioning group areas. This plan necessarily focusses on a limited number of key transformational priorities which will deliver improvements to care services over the next 2-4 years in response to the significant financial and clinical sustainability challenges identified in the case for change.

We have identified seven high priority areas: Prevention; integrated care model; primary care; mental health; acute hospital and specialist services, children & young people and productivity. This STP does not replace the many other service plans already in development or delivery within the health and care system, but overtime will ensure all Plans align.

Growing needs

These ambitious plans will respond to the growing physical and mental health needs of people in their communities to ensure a future integrated network of support that is safe, sustainable and affordable and that enables people to live their lives well and independently.

Context and Approach

Context

Wider Devon has a resident population of around 1,160,000 within the 3 local authority areas of Devon County Council, Plymouth City Council and Torbay Council. Just over half of the populating live in urban communities, and the remainder in rural communities.

The NEW Devon CCG area has been part of a Success Regime since 2015 and, with South Devon & Torbay, both CCGs have come together to form a single strategic planning footprint with the local authorities in order to address together a common set of significant financial and service challenges around health and care.

Approach

This Plan is a work in progress that has been prioritised to provide a framework for focus on activities that will make the biggest initial difference to our population's health outcomes and financial recovery. There is a strong set of system governance arrangements in place that are enabling the 10 statutory organisations in Devon to work collaboratively to ensure the changes we make will benefit our patients and the health and social care system as a whole, not just individual organisations. At the heart of our Plan is a new model of integrated care that will reduce reliance on bed-based care and enable people to live healthy independent lives for longer, closer to where they live.

Whilst we will have one Plan for wider Devon, our approach will also ensure that local plans setting out how we deliver the common goals can be adapted to reflect local needs and existing services. We will be involving communities and our staff in doing this.

Wider Devon STP footprint

We will undertake a process of wide stakeholder engagement on the content of the STP and involve citizens and patients in its ongoing development. For this to be meaningful, it will be done both at the level of this overarching plan, and separately for the key areas of strategic change that we are proposing.

Case for Change

Services in Devon must change in order to become clinically and financially sustainable, and the key reasons for this are highlighted in the case for change published in February 2016:

- People are living longer and will require more support from the health and care system. In excess of 280,000 local people (23% of the population), including 13,000 children, are living with one or more long term conditions
- We need to respond better to the high levels of need and complexity in some parts of the population
- Some services such as stroke, paediatrics and maternity are not clinically or financially sustainable in the long term without changes to the way they are delivered across Wider Devon
- There is a difference of 15 years in life expectancy across wider Devon and differences in health outcomes – or 'health inequalities' – between some areas, particularly Plymouth
- Spending per person on health and social care differs markedly between the locality areas and is 10% less in the most deprived areas
- Mental health services are not as accessible and as available as they need to be which drives people to access other forms of care which doesn't always meet their needs. People with a mental health condition have poorer health outcomes than other groups
- There is an over reliance on bed-based care - every day over 600 people in Wider Devon are medically fit to leave hospital inpatient care but can not for a variety of reasons
- The care home sector is struggling to meet increasing demand and complexity of need
- Almost a quarter of local GPs plan to leave the NHS in 5 years and there are significant pressures on primary care services. Some other care services are particularly fragile due to high levels of consultant, nursing, social work or therapy vacancies
- Local health and social care services are under severe financial pressure, and health & social care services are likely to be £557million in deficit in 2020/21 if nothing changes

Our shared vision

Aim and Statement of Purpose

We will operate as an aligned health and care system, to be a major force and trustworthy partners for the continual improvement of health and care for people living in Devon, Plymouth and Torbay. We will address the NHS Five Year Forward View three key aims to improve population health & wellbeing, experience of care and cost effectiveness per head of population.

The Challenge for Wider Devon

Deliver better and more equal outcomes for more people and do it sustainably in a more joined up way harnessing the value of partners coming together to tackle problems as a collective. We will do this as efficiently as we can, within the financial resources available to us.

Mission

We will focus everything we do on improving:

- Our population's health & wellbeing
- The experience of Care
- The cost effectiveness per head of population

These mission statements underpin the NHS' Five Year Forward View and are referred to as the 'triple aims'.

Values

We will act, behave and be held to account for:

- Putting the patient/person first
- Operating without boundaries
- Working with speed and agility
- Strong teamwork
- Embracing innovation
- Relentless focus on population benefit and user experience

Strategic Objectives

We will deliver:

- Excellence in service delivery
- Improved health and well being for populations and communities
- Integrated care for people
- Improved care for people
- Empowered users who are experts in managing their care needs

Public engagement in developing our shared vision

Our plans are designed to deliver on a series of "I" statements developed by local people:

- I will take responsibility to stay well and independent as long as possible in my community
- I can plan my own care with people who work together to understand me and my family
- The team supporting me allow me control and bring services together for outcomes important to me
- I can get help at an early stage to avoid a crisis at a later time
- I tell my story once and I always know who is coordinating my care
- I have the information and help I need to use it, to make decisions about my care and support
- I know what resources are available for my care and support, and I can determine how they are used
- I receive high quality services that meet my needs, fit around my circumstances and keep me safe
- I experience joined up and seamless care – across organisational and team boundaries
- I can expect my services to be based on the best available evidence to achieve the best outcomes for me

From where we are	To where we want to be
From patients…	…to people
From care settings…	…to places and communities
From organisations…	…to networks of care and support
From what's the matter with you…	…to what matters to you
From illness management…	…to wellness support

Our aspirations against the Five Year Forward View three key aims

Improve population health & wellbeing	• Improve overall health by increasing focus on preventing or avoiding ill-health and proactively responding when required • Improve outcomes for people with mental health problems • Improve outcomes for people with two or more long term conditions • Address challenges of deprivation and funding inequality across wider Devon
Experience of care	• Reduce reliance on bed-based care and the associated harm to patients of long lengths of stay in hospital through investment in community, primary care and other supporting care services • introduce an innovative, fully integrated model of care that enables people to stay well and independent within their communities • Deliver consistently safe and high quality acute care by introducing clinically sustainable service configurations • Develop a well-trained, motivated and caring workforce that is empowered to deliver joined-up care and support to the communities they serve, including support to voluntary carers. • Develop a culture of safety and continuous service improvement
Cost effectiveness per head of population	• Reduce over-reliance on use of hospital beds to release around £90m • Invest in community, primary and social care services to support implementation of the integrated care model and improvements in care • Improve effectiveness of spend and productivity in all service areas to release around £300m (consisting of 2% annual provider efficiency and other additional efficiency gains) • Ensure progress towards equitable funding for the most deprived communities • Effective care market management and efficiency of spend

STP priorities and headline solutions

Devon's objectives for the Five Year Forward View (5YFV) focus on achieving financial and clinical sustainability and addressing key health and financial inequalities by 2021. The initial proposals below will be further developed and extended over time to make sure they achieve our key objectives

1 Prevention & early intervention

- Action to tackle the top five causes of death in under 75s
- Make sure all plans and priorities have a focus on preventing ill health
- Tackle place-based socio economic health determinants
- Build community resourcefulness
- Develop workforce skills in prevention

2 Integrated care model

- Promoting health through integration
- Empower communities to take active roles in their health and wellbeing
- Locality-based care model design and implementation
- Shift resources to community from hospital
- Health & Social care integration

3 primary care

- Developing integrated GP/primary care
- Delivering the GP forward view
- Supporting general practice development to be fit for the future
- Work towards delegated commissioning

4 Mental health & learning disabilities

- Ensure our services meet local needs
- Maximise the effectiveness of mental health spending to achieve better outcomes
- Improve mental illness prevention in primary care
- Improve provision for people with severe, long term mental illness and those who also have physical health problems

5 Acute hospital & specialist services

- Ensure clinical sustainability of services across wider Devon
- Review high priority services:
  - Stroke services review
  - Urgent and Emergency Care review
  - Maternity /Paediatrics/ Neonatal service review
- Review small & vulnerable specialties

6 Productivity

- Improve the cost-effectiveness of the care delivered per head of population
- Implement Carter's recommendations in 'Reducing Variations' report
- Rationalise the 'back-office' services
- Procurement efficiencies in clinical supplies and drugs
- Review spending on continuing health care (CHC)

7 Children & young people

- Ensure seamless support and access
- Ensure high quality, effective and rapid response of services
- Enhance effective collaboration between adult and childrens' services

Enablers

- **Workforce** Stability, Workforce Redesign, Workforce Development
- **Estates** Strategy
- Information: Digital Road Map
- **Communications** & engagement
- **Organisational Development**: Towards accountable care systems
- IM&T – improving clinical decision making

Critical decisions that deliver the plan

Financial recovery and meeting of future predicted increases in demand is predicated on implementing an integrated care model that is significantly less reliant on bed-based care. The changes we are proposing will result in a significant reduction in the number of acute and community beds needed across wider Devon by 2021 where up to 600 people are being cared for inappropriately at present. As we change the model of care these beds will no longer be required and this then releases resource to invest in improved care and achieve clinical and financial sustainability.

To facilitate implementation of the care model and release funding to invest in more ambulatory care provision in community and home based settings the CCGs are currently publicly consulting:

- NEW Devon CCG is engaging on proposals for the overall strategic direction of travel and provision changes and on the components of new models of care. Public consultation on specific proposals to close a number of community hospital beds in the eastern locality commenced on 7 October 2016.
- In South Devon & Torbay implementation of the care model as set out in the Integrated Care organisation (ICO) business case is pushing ahead with consultation on community services transformation including proposals for closure of four community hospitals. This started in September 2016.

Proposals are in development for some changes to the acute care model across Devon's STP footprint to improve care and outcomes. There are a number of specialties that need to change to address future clinical sustainability issues, including: stroke, emergency services including A&E, paediatrics, maternity, neonatology and some smaller specialties. These may also require public consultation and preparations for undertaking the review will begin in October 2016.

We anticipate that we can make further progress over the five year period with developing the new care model and this may lead to further changes to how and where care is delivered. We are committed to fully engaging (and consulting as required) staff and communities on these proposals.

During the next phase of planning we will:

- Ensure that plans reflect the needs of local communities
- Engage fully with our stakeholders on future direction of travel and proposed changes to services particularly where this impacts on the number of beds available, community hospital closures, and changes to specific acute services.
- Formulate our change proposals and agree the future configuration of commissioning and provision functions to best support delivery.
- Ensure that implementation plans rapidly take shape to ensure we are ready for delivery in 2017/18

Health and wellbeing challenges we must address

There is a **real opportunity** to make significant improvements in the physical and mental health, wellbeing and care for the population and communities. This Plan is a work in progress and provides a planning framework that will evolve as we collate the evidence base and develop proposals for future improvements to the way we deliver care. We plan to **share our learning** to benefit communities beyond wider Devon.

The Public Health and Joint strategic needs assessment (JSNA)* key considerations underpinning the plan

An ageing and growing population	Giving every child the best start in life and ensuring children are ready for school	Complex patterns of deprivation linked to earlier onset of health problems in more deprived areas (10-15 life year life expectancy gap)	Balancing access to services in both urban and rural localities	Housing issues (low incomes / high costs/ poor quality in private rental sector)
Shifting to a prevention and early intervention focus	Poor mental health and wellbeing, contributed to by social isolation and loneliness	Poor health outcomes caused by modifiable behaviours	Ensuring services are resourced to meet the needs of people particularly those with long-term conditions, multi-morbidity, mental health and frailty	Unpaid care and the impact of caring on carers' health and wellbeing

* The Joint strategic needs assessment (JSNA) is an annual analysis of population health needs and demography undertaken by each local authority. It informs our understanding of the health of the population, disease and condition prevalence and causes of death. This helps us to plan health and care services for the future.

Health and wellbeing opportunities are based on our understanding of targeted population segments across the wider Devon

Health and Care Segmentation Devon 20/21

Population, Thousands | Total spend, £m | Spend per head

Devon STP	Mostly Healthy		Chronic conditions		SEMI		Dementia		Cancer		High needs			
Children 0 -15	Mostly healthy children 591		Children with chronic conditions 1,503		Children with SEMI 4,056		-		Children with cancer 12,733		Children with PD/LD 12,127		Vulnerable children 24,914	
	179.2	106.0	18.1	27.2	1.7	6.8	0.0	0.0	0.2	2.0	3.1	37.2	3.8	95.6
Adults 16-69	Mostly healthy adults 635		Adults with chronic conditions 1,553		Adults with SEMI 7,536		Adults with dementia 6,746		Adults with cancer 3,148		Adults with Phys. disabilities 13,292		Adults with Learn. disabilities 30,467	
	469.4	298.2	248.3	385.6	10.3	77.5	0.6	4.0	24.8	77.9	4.1	55.0	3.7	111.7
Elderly 70+	Mostly healthy elderly 1,802		Elderly with chronic conditions 3,414		Elderly with SEMI 12,758		Elderly with dementia 13,438		Elderly with cancer 4,466		Elderly with Phys. disabilities 19,667		Elderly with Learn. disabilities 32,469	
	29.1	52.4	129.9	443.4	1.8	23.2	10.5	140.5	37.5	167.5	16.3	319.7	0.43	13.8

This segmentation is based on forecast spend and population in a do nothing scenario. Opportunities have been identified based on the care segments to address the health and wellbeing gaps and public health and JSNA priorities

Sources: ONS subnational projections CCG level, Data returns from NEW Devon CCG, SDT CCG, RD&E, PHT, T&SD, NDH, Devon CC, Plymouth council, Torbay council, QOF 13/14, Carnall Farrar analysis

The care and quality challenges we must address

The case for change summary shows that care in Devon is generally high quality but is inconsistent and with variable outcomes. The principles and design features in this Plan will drive improvement in an integrated manner, delivering benefits of standardisation to reduce variation whilst ensuring our models are tailored to the clinical needs of individuals and communities. This will drive improved achievement of national performance standards, patient and staff experience, safety, service line resilience and clinical effectiveness and outcomes.

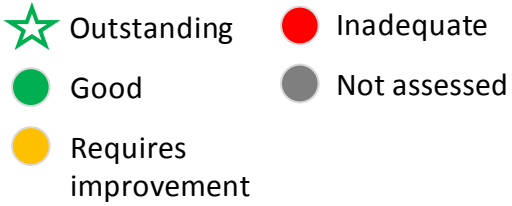
- Ensuring parity of esteem and equality of access for people with learning disability, poor mental health and looked after children
- Meeting national standards for primary, acute and specialist care with particular focus on child and adult mental health
- Achieving a minimum of good in Care Quality Commission (CQC) assessments in all services and making sure that services assessed by the CQC as inadequate or requires improvement are supported to improve rapidly and sustainably.
- Reduce harm associated with delayed discharge from bed based care
- Creating a whole system culture of continuous quality improvement and evaluation across the footprint, sharing best practice, learning and spreading the use of recognised improvement methodologies

To support a culture of high quality safe care and continuous improvement by:

- Supporting the whole system to reduce avoidable deaths, morbidity and harm
- Ensuring that people who are cared for in hospitals and residential settings are safeguarded, have personalised care plans and live in places where standards are high, and regularly monitored.
- Systematically learning from mistakes and sharing best practice
- Raising awareness and early identification of sepsis at all clinical interfaces
- Creating a positive culture of antibiotic guardianship in primary and secondary care, helping to reduce antimicrobial resistance and improve
- Safeguarding adults, young people and children through joined up safeguarding teams and processes

Key areas for care and quality improvement: comparison of CQC assessments of NHS providers

Care and quality gaps in the wider Devon heath and social care system will be addressed over the period of this plan. Current performance is variable across the system ranging from inadequate to outstanding. Our aim is to reduce variation.



CQC full inspection assessment	STP footprint	Devon Partnership NHS Trust	Northern Devon Healthcare NHS Trust	Plymouth Hospitals NHS Trust	Royal Devon & Exeter NHS FT	Torbay & South Devon NHS FT	Livewell Southwest CIC	South West Ambulance FT
Safe								
Effective								
Caring								
Responsive								
Well led								
Overall								
SHMI data								
Latest CQC inspection report		18.01.2016	11.09.2014	21.07.2015	09.02.2016	07.06.2016	19.10.2016	06.10.2016
SHMI Data		03/15-04/16	03/15-04/16	03/15-04/16	03/15-04/16	03/15-04/16	-	-

NB:Virgincare Childrens Services CQC assessment not available

Key areas for care and quality improvement: comparative performance of assessments and improvement opportunities

CCG & Local Authority Assessments	NEW Devon CCG	South Devon & Torbay CCG	Devon County Council	Plymouth City Council	Torbay Council
OFSTED children's services					
CCG assurance framework					

Staff and patient experience across NHS providers	RD&E	NDHT	TSDHT	PHT	DPT	England
Friends and Family Test (inpatient)	99.65%	99.95%	96.55%	99.18%	-	95%
Friends and Family Test (A&E)	95.65%	81.13%	97.1%	99.42%	-	87%
Friends and Family Test (Mental Health)	-	-	-	-	98.29%	88%
Harm free care	94%	95%	90%	96%	100%	94%
Staff survey score out of 4 Overall engagement increased in all areas	3.85	3.93	3.87	3.68	3.75	3.79 (acute) 3.75 (MH)

Source: NEW Patient Safety and Quality Scorecard in Development – Data from August 2016, England Data from August 2016
Ofsted Children's Services – Devon: Publication 03/15. Plymouth: Publication 01/2015; Torbay: Publication 01/2016
CCG Assurance Framework: 2015/2016 Data
Staff Survey: Data from 2015
Harm Free Care: August 2016 (RD&E), September 2016 (NDHT, TSDHT,DPT, England)

Drivers of the financial deficit

Whilst improving health, we also have to close a significant potential funding gap in health and social care funding over the next five years. If we do nothing this means the Devon STP footprint will have be £557m in debt by 2020/21 across the health and social care system. This includes the local authority adult and children's social care gap across the whole footprint

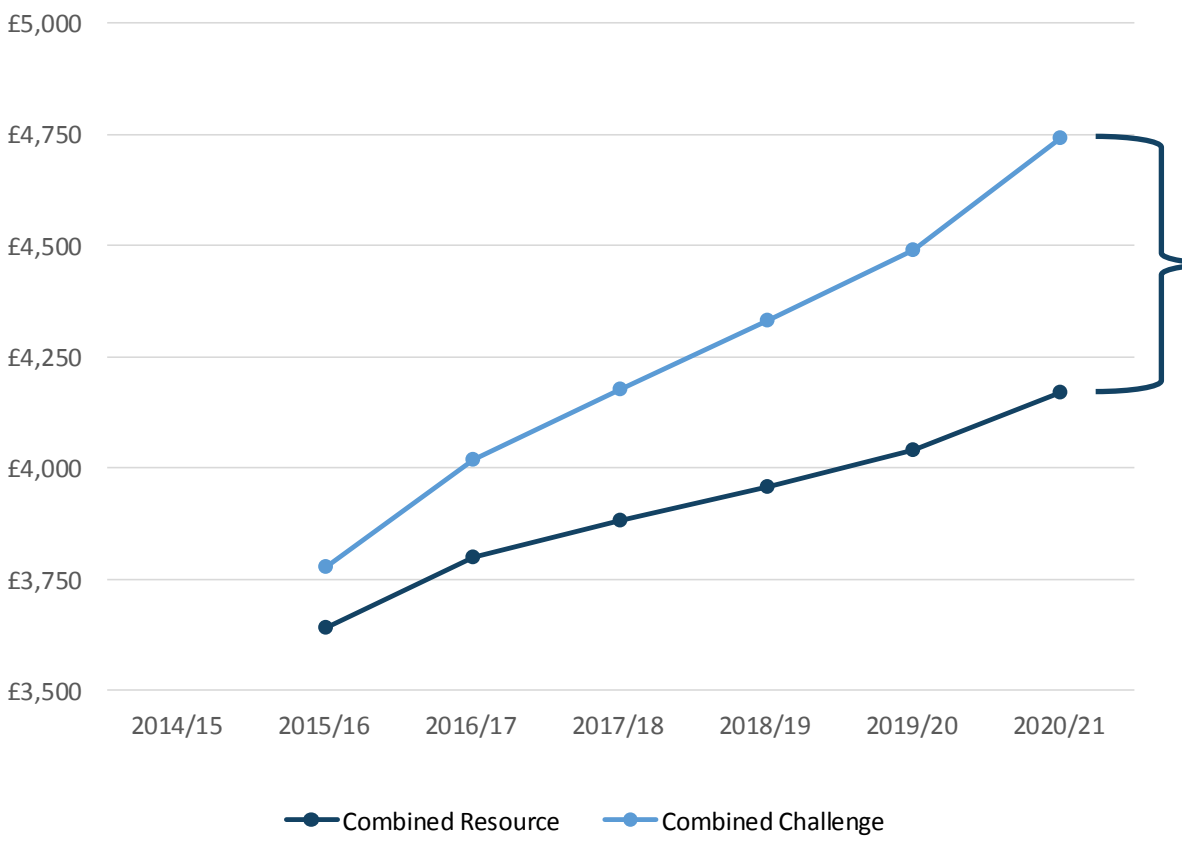
Deficit Drivers				
Independent sector care including CHC	Elective care and intervention rates	Community services	Length of Stay	Productivity
Devon spends significantly more on Continuing Healthcare (CHC) than other areas of similar size/population. Unit cost of independent care sector	We treat more people than other areas with similar populations	High levels of NHS & social care community services spending compared to peers	Excess length of stay in acute hospitals and non-elective admissions where patients would benefit if we had access to ambulatory or alternative community based models of care	Trust level productivity analysis confirms opportunities across staffing, procurement and agency spend.

We will be responding to our analysis of what people need by re-allocating resources to better meet the greatest needs of the population e.g. through shifting our resources out of hospital, reducing the amount spent on unnecessary bed-based care, improving efficiency and reinvesting in more innovative, integrated care models including investing in community assets that do more to prevent ill health, keep people out of hospital, treat them effectively when needed and enable them to recover rapidly and to stay in their own homes for as long as possible.

The financial challenges we have to address

A system-wide challenge of £557m is forecast by the year 2020/21

in £m



By 2021, without transformational change there will be a system deficit of £557m

NOTE: When the RAB effect is included, the total challenge amounts to £705m.

Addressing funding inequalities

- A vital element of our return to clinical and financial sustainability is that our available resources are distributed optimally to meet population need by the end of our programme.
- Our approach to the transformation of care, which is underpinned by population need, will both determine and drive resource distribution going forward.
- Analysis of CCG spend indicates sizable inequities in resource distribution across the wider Devon system. It highlights lower levels of spend in our more deprived areas, particularly in parts of Plymouth, and on mental health care.
- A further more comprehensive analysis will be undertaken which will include sources of funding – primary care, specialised commissioning and provider deficit support - not included in the initial analysis to confirm the scale of the inequities to be addressed.
- The output will be incorporated into the financial strategy to ensure our pathway to financial sustainability includes achievement of equitable population and care group resourcing.

Closing this financial gap will rely on six things to reduce demand and cost of delivering care, improve productivity and address inequalities

1. Delivery of the2016/17 savings opportunities and "business as usual" efficiencies in providers and commissioners is achieving savings in the region of £85m in 2016/17. These schemes form the building blocks for future years.

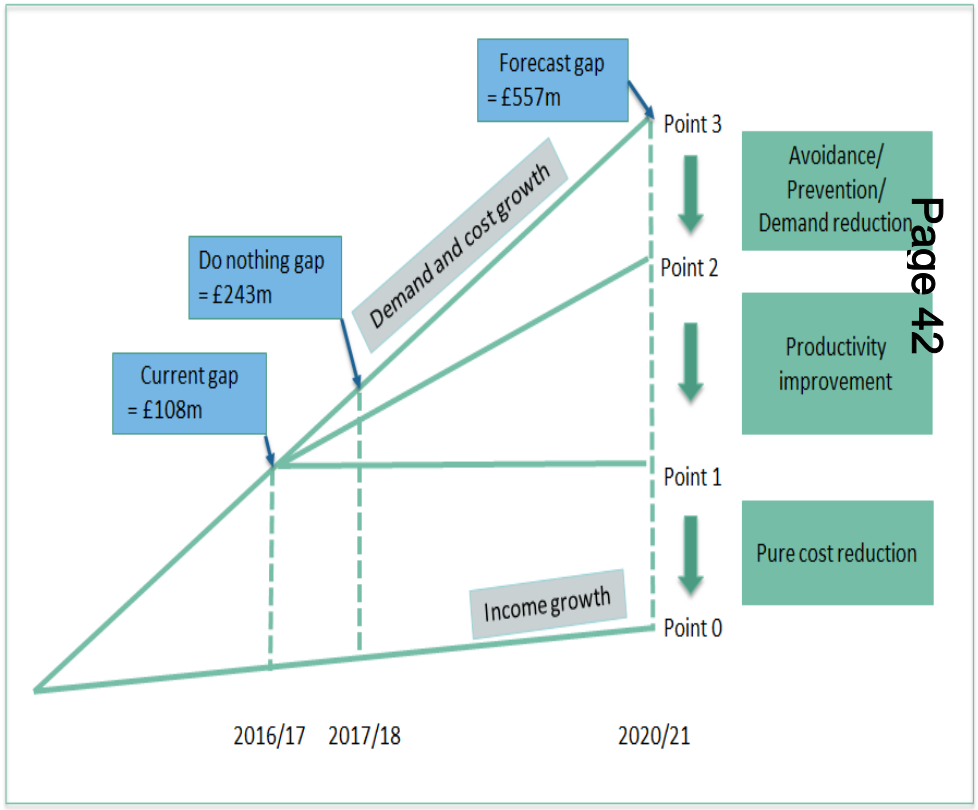
2. An assessment of investment in new and enhanced services and the expected impact on activity has been carried out. This will deliver the excellent care initiatives by reducing activity and shifting the setting of care closer to home.

3. Additional productivity opportunities including rationalisation of estate and back-office will contribute to provider productivity.

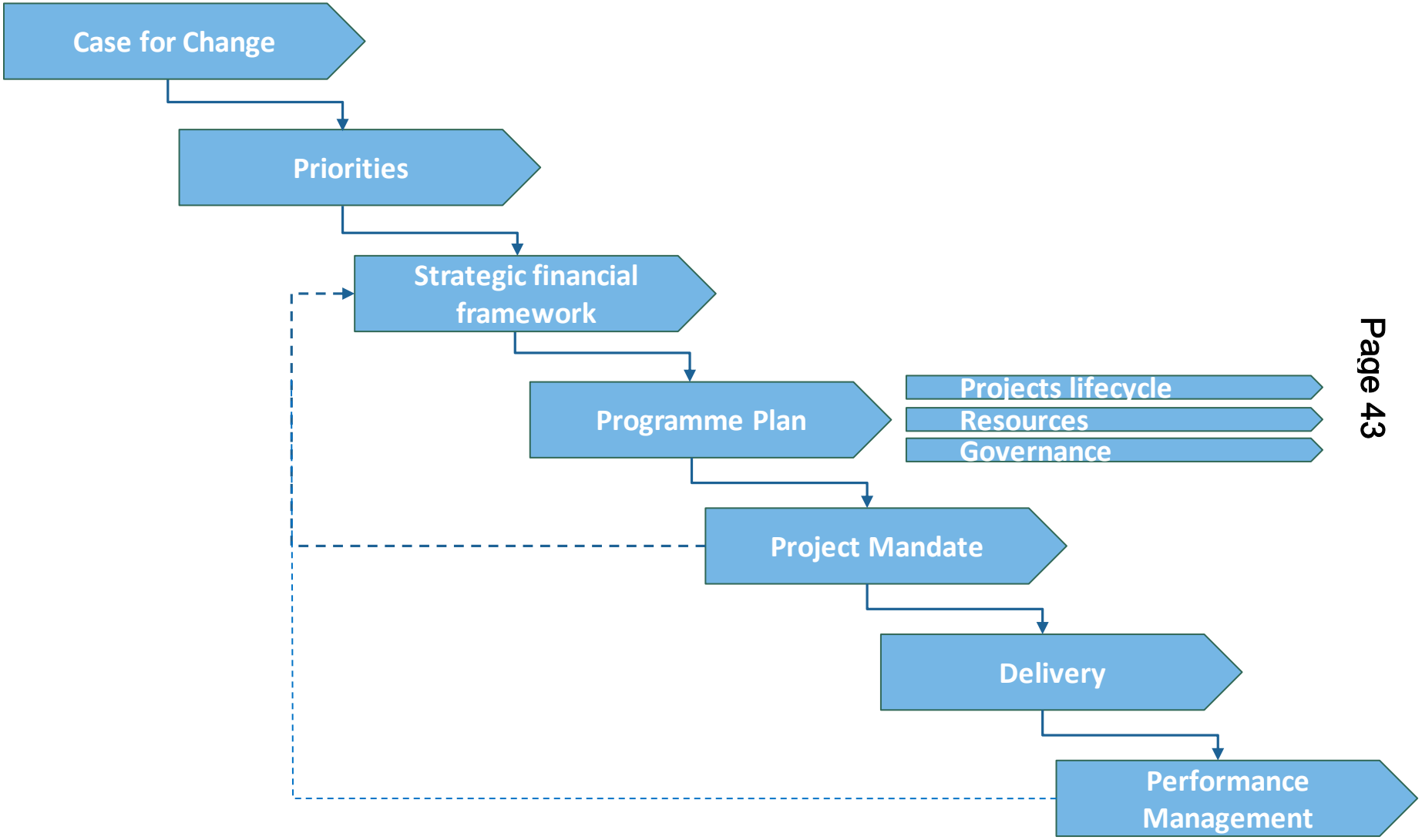
4. Examining the options that will ensure the clinical sustainability of acute services will help avoid forecasted cost pressures. Work on health promotion will help avoid the growth in demand for care services.

5. Delivering benefits of integrated local care, to ensure that reliance on expensive bed based care is minimised, and people retain their independence.

6. A detailed analysis of the distribution of resources, and a plan to address the current geographical and service inequities, particularly for mental health



Our STP programme management approach will ensure that there is clear line of sight from case for change through to delivery



Governance arrangements and system collaboration achievements

- Through the Success Regime, NEW Devon's partners have developed a strong ethos of system-wide working with commissioners, providers and local authorities coming together to agree a single system plan and financial control total for our 2016/17 plan. With the STP footprint including South Devon and Torbay, our system-wide co-design work to develop and implement our transformational change proposals from 2017/18 onwards will include partners across wider Devon.

- South Devon & Torbay have a strong track record of working collaboratively across the commissioner, providers and local authority boundaries. Torbay & South Devon Healthcare Foundation Trust is the first fully integrated care organisation in England and their local governance arrangements around this are well established.

- There is already significant health and local authority integration in both commissioning and provision across Devon. Adult social care is fully integrated with health provision in Torbay; Health and social care commissioning is fully integrated in Plymouth, along with a single integrated health & social care provider. In Devon County there are numerous examples of integrated provision and ambitious plans are in development to achieve extended scope and coverage of this as part of this Plan. There is increasing collaboration across the wider local authority agenda including housing, economic development and public health. NHS organisations are supporting and contributing to local authority proposals for a new combined authority – "The heart of the south west".

- These foundations provide a sound platform upon which to bring together both CCGs and three local authority areas to create strong and cohesive leadership of the STP agenda.

- The new STP-wide governance infrastructure (shown in appendix 1) will allow us to work together to extend our collaborative working and decision making across the whole STP footprint, under the leadership of a lead chief executive (Angela Pedder) and an Independent chair (Dame Ruth Carnall)

Our priorities

1. Prevention & early intervention
2. Integrated care model
3. Primary care
4. Mental health
5. Acute Hospital and specialised services
6. Productivity
7. Children, young people and families

Priority 1: Prevention & early intervention

Top five causes of death in under 75s

1. Coronary heart disease (CHD)
2. Trachea, bronchus and lung cancers
3. Accidents
4. Bronchitis, emphysema and other chronic obstructive pulmonary disease (COPD)
5. Cerebrovascular disease (stroke)

Prevention delivered through the new care model, will bring a renewed focus on prevention. To improve health and wellbeing and address health inequalities a long-term approach will be needed but we have identified some early priorities:

Smoking cessation
Alcohol misuse
Healthy eating
Moving more
Accident prevention - falls and fractures
Social connectedness and combatting loneliness
Mental health gap in access and outcomes
Addressing wider determinants of health - social, economic, environmental and cultural factors

See appendix for further information

Priority 1: Developing the prevention priorities

1

Our approach to prevention of ill health and encouraging independence and wellbeing is based on our identification of areas of significant local need and the potential to make both a health and financial impact across a large area. These priorities are better delivered together rather than in individual organisations as we will realise more cost and outcome benefits.

2

Based on key health and wellbeing challenge themes identified in our JSNAs as follows:

- Settings – place based health, care homes, workplace, housing
- Life-course – starting well, living well, ageing well
- Behaviours – smoking, eating, alcohol and physical activity and inactivity, DSVA
- Diseases and medical conditions – diabetes, hypertension, falls and fractures, sexual health
- Approach – making every contact count, complex individuals, universal proportionalism

Potential overlaps with wider work – place-based health, mental health, children and young people, planned care optimisation

3

The early priorities have been developed and further modelling and potential investment and cost savings are being scoped using the population segmentation undertaken. Early suggested priorities include:

1. Making every contact count and brief intervention training at scale
2. Test the new approach with an initial focus on the alcohol pathway from brief advice to acute alcohol liaison
3. Scale up lifestyle interventions through the new Devon Lifestyle service, Thrive Plymouth and ICO mode in T&SD
4. Focus on long-term conditions prevention and early intervention with a focus on co-morbidities in particular mental health and diabetes and hypertension
5. Develop further prevention and early intervention for pre-frail and frail to include isolation and falls prevention and the care home setting
6. Connect with the mental health and children and young people priorities to ensure a focus on emotional health & Wellbeing of children and young people

Priority 2: Promoting health through integration

In order to empower people, their carers and communities to take a more active role in their health and wellbeing we plan to:

1. Develop Integrated Personal Commissioning (IPC) to enable greater involvement in planning and choosing their care as a mainstream model of community based care for around 5% of the Devon population, including people with multiple long-term conditions, people with severe and enduring mental health problems and children and adults with complex learning disabilities and autism.

2. Expand personal health budgets and integrated personal budgets in line with the ambitions of the Five Year Forward View - including exploring the concept for maternity and end-of life. Our ambition in Devon is to use the Integrated Personal Commissioning programme to go further and faster than the national target and we aim to achieve 2,000 individual budgets by 2018. We are already well ahead of other systems in implementing IPC.

3. Achieve a step change in patient activation and self-care. The South Devon and Torbay urgent care vanguard has a framework in place which includes consideration of social segmentation, a strengths-based approach to behaviour change and the development and integration of directory of services. We also need to build on the Plymouth approach to integration, the Integrated Care in Exeter (ICE) project and One Ilfracombe.

4. Continue to work with Peninsula Urgent and Emergency Care network to develop a Peninsula-wide plan, leveraging collaborative opportunities. In parallel, we will develop detailed service models that meet local population needs. Our local delivery timeline is aligned with the emerging plan being developed for the Peninsula Urgent & Emergency Care Network.

5. Continue to develop our Better Care Funds to support our focus on prevention. They are already operating in a way that brings providers and commissioners together to determine how a single pooled fund can best be deployed to support improved flow of patients and how to keep people well and supported at home, or to return their own home as quickly as possible following a period of ill health, including support to their carers.

Priority 2: Integrated care model – promoting independence through a focus on joined up care provided locally

The best bed is my own bed

We will strengthen community health & care services so that they can both help people to avoid the need to access NHS and other provided care and respond swiftly when people become unwell. This means investing in more community-based services and associated technology so that they mirror the availability and reliability of hospital-based care. This includes enhancing our support to carers and delivering high quality end of life care, as well as building wider community support that can keeps people well.

Services closer to home

We also want to make sure that people do not travel further than they need to for care / treatment. Keeping people well and independent avoids the need to travel for care. The more community and primary care services we can provide in or close to people's homes the better.

High quality hospital care

Where people need to be admitted to hospital, we will make sure that they receive the best quality and experience of care, that we have caring and skilled staff to look after them and that we meet national quality/safety standards. New discharge to assess services will ensure people return to their normal place of residence quickly and safely and that care is coordinated around the person and their family.

What matters to me

Moving discussion from 'what's the matter with a person?' to 'what matters most to a person?' means that we will adopt a person-centred and asset-based approach to care, promoting networks of support, skills and attributes of individuals that increase people's self -confidence to manage their health and care for themselves. This approach will avoid unnecessary reliance on statutory services that can take away a person's independence and create more resilient communities. Patients will own their own digital, shared care plan.

Community-centred approach

Adopting a person-centred and community-centred approach to health and wellbeing helps to build community capacity and resilience which in turn helps provide support to reduce social isolation and loneliness and can contribute to reducing health inequalities for individuals and communities. Our voluntary and community partners are at the heart of our new care model. It is through the interaction of statutory services with local voluntary and community groups that we can improve people's health and wellbeing, reduce demand on health and care services and lead to wider social outcome improvements.

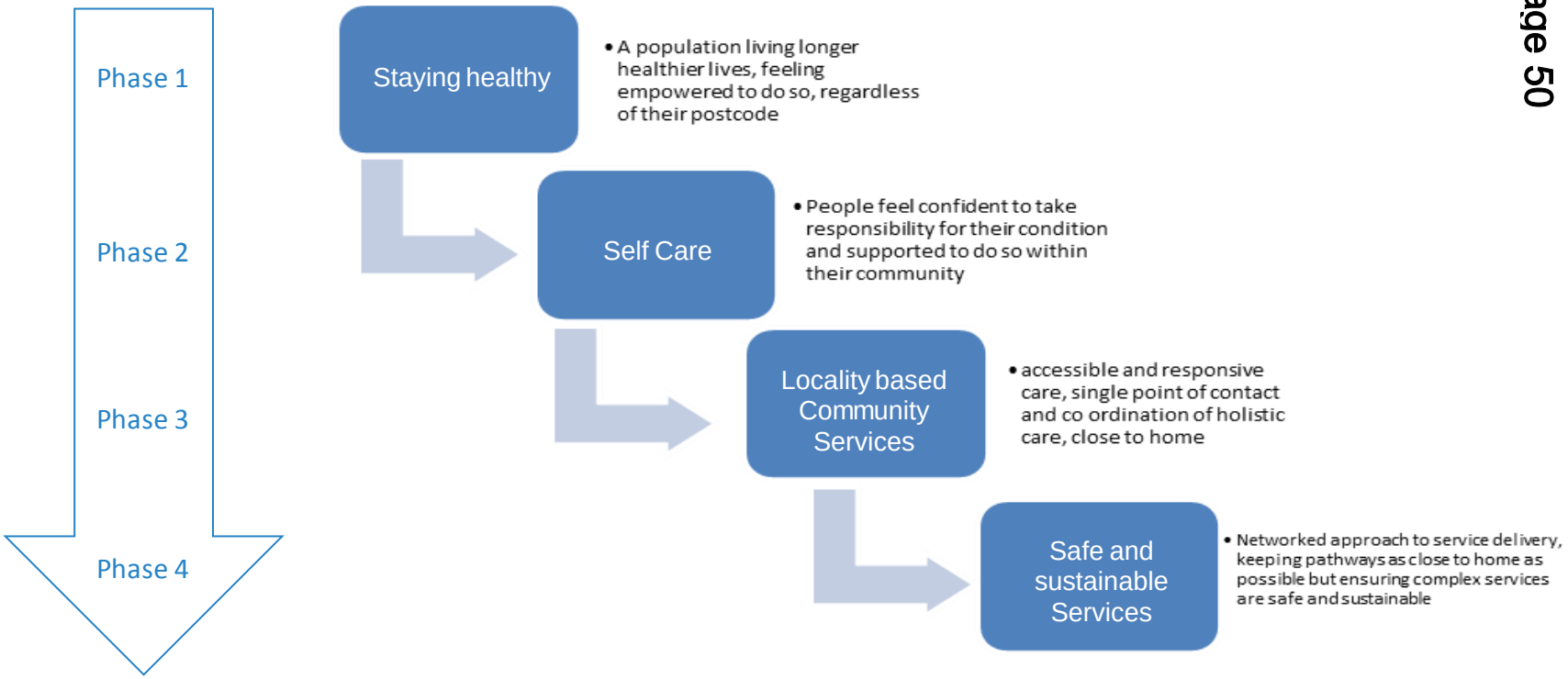
Making every contact count

Wellbeing is at the centre of our care model because it reflects the importance and necessity of focussing on prevention and early intervention. 'Making every contact count' encourages conversations based on behaviour change methodologies, ranging from brief advice and intervention, to more advanced behaviour change techniques. The aim is to empower healthier lifestyle choices and exploring the wider social determinants that influence all of our health. Patient activation measures can help us to understand where people are in terms of their level of knowledge and confidence to manage their own health. Activation measures have been linked to improved clinical outcomes and reduced costs of care.

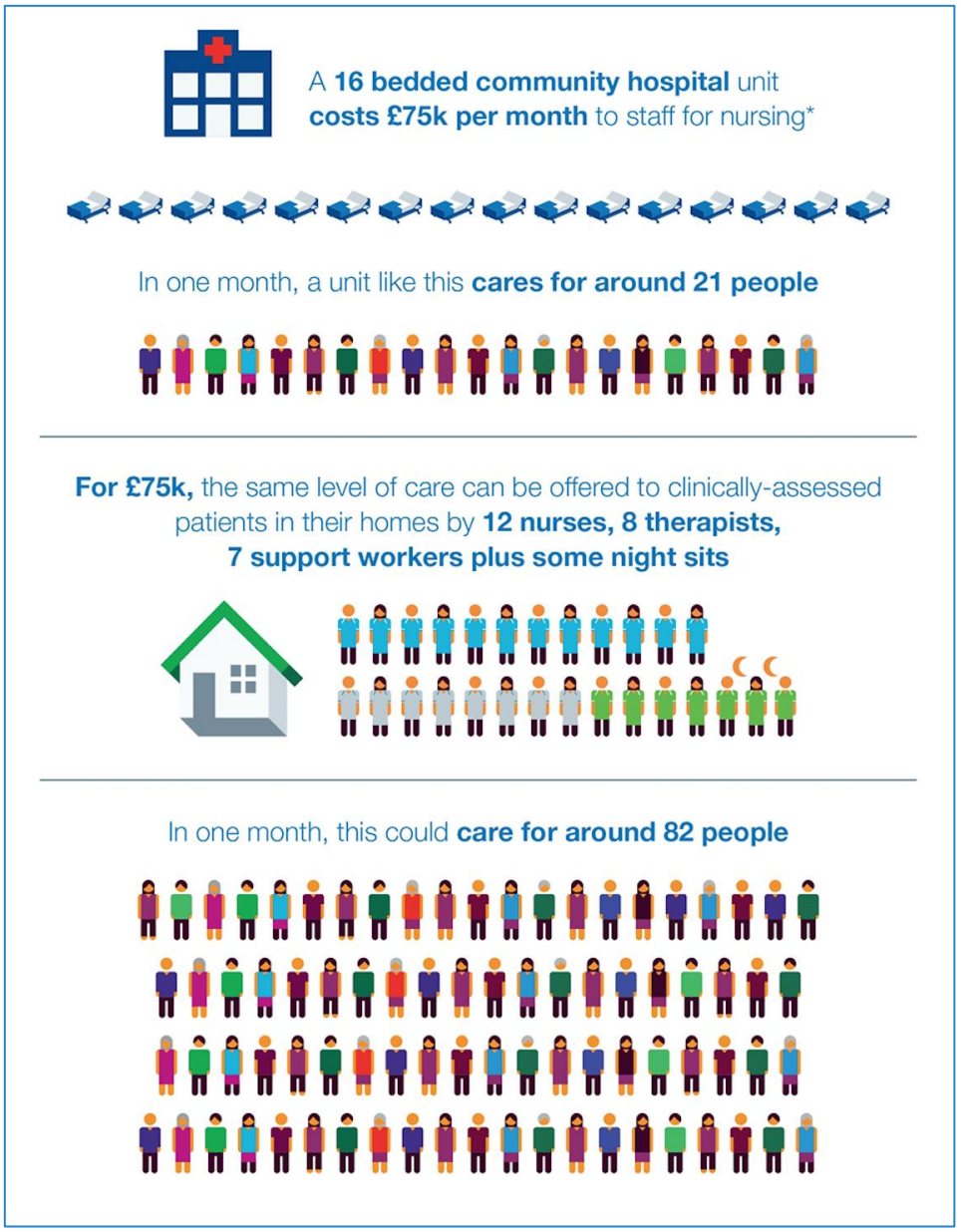
Priority 2: New models of care

The development and implementation of new models of care is fundamental in delivering the vision based on the drivers for change we have outlined earlier (on page 5). This transformation work is high profile and will realise a broad range of STP deliverables; increased focus on prevention, financial sustainability and quality of care.

Whilst the vision is consistent across the STP footprint, models of care will be tailored to meet the needs of localities. Models will maximise the use of non bed-based care and support people and carers as individuals, outcomes tailored to specific need. Development is at differing stages currently: In South Devon a full service model developed underpinned by a full engagement process and planned consultation. In the North there has been a focus on care closer to home and enhancing home-facing care services, the locality is engaging with a range of stakeholders to define the type and level of service required, location, and analysis on both financial and patient benefits. The diagram below supports us to analyse current configurations of service and work with stakeholders around which services and patient outcome should be achieved across the various phases:



Priority 2: The model allows investment to improve care capacity and delivery through reduced reliance on bed based care



Our modelling shows that the out of hospital model offers more care to people for the same cost.

Our proposals currently out to public consultation will help us enhance and increase care capacity closer to where people live.

*This is based on a daily £174/bed nursing cost in Eastern Devon (Referenced in PCBC finance appendix). This gives an annual nursing cost of £914K for a 16 bed site. Rounded down to £900k or £75K per month.

Priority 2: New model of care – a local approach

Our new model of care will have a local (place / community based) approach. In developing this we have considered the work of the King's Fund "Place-based systems of care" (Ham; Alderwick 2015) recognising that systems of care exist on different place-based footprints. The wider Devon STP area has a geographical and economic coherence based on the old shire county of Devon. Within this we have recognised material variation in care & quality, health & wellbeing outcomes; productivity, and finance and delivery performance. It is at this STP population level that we want to develop strategic plans including a financial strategy to achieve financial balance. However, these variations and inequalities can only change through action and delivery at the level at which they occur.

Public and user engagement in our vision is helping shape common design principles that will enable us to prioritise and tackle specific inequalities. Currently there are 4 localities – North, East, West and South (see below). As we develop our work and define the level of place we require to best deliver our strategy our current approach may change.

Northern Devon	Eastern Devon	Western Devon (including Plymouth)	South Devon & Torbay (1ST Integrated care organisation in England)
Northern Devon Healthcare Trust Vertical integration One Ilfracombe, One North Devon Devon Cares – domiciliary care service	Royal Devon & Exeter Foundation Trust Vertical integration ICE project	Whole system commissioning fund. Integrated health & social care provider	Health and social care integrated provision. Implementing new care model through the integrated care organisation

First phase of implementation of the integrated care model is underway across the STP footprint. We are pursuing changes to service delivery in all areas that focus on promoting independence, keeping people safe and well at home / in their own communities and reducing reliance on bed-based care. We have plans to reduce both acute and community hospital bed numbers which will enable additional investment in community & primary care and other local services to help deliver more care, more effectively to more people, closer to where they live and help them to maintain the highest level of independence.

Priority 2: Integrated care - wider planning

Integrated local planning will also take account of natural cross boundary flows. Most significant is the East Cornwall population served by Plymouth Hospitals NHS Trust. We are working with Kernow CCG to ensure our plans are appropriately aligned.

There is already an established track record of achievement which we will help to accelerate change

- The first Integrated Care Organisation (ICO) in England (acute hospital, community health and adult social care) is in South Devon & Torbay
- Fully integrated health & social care commissioning in Plymouth
- Integrated community health and social care community provider in Plymouth
- A high degree of vertical integration between acute and community health and social care services already delivering benefits in Northern Devon, including an emerging place-based approach in One Ilfracombe and other towns.
- Foundations established for similar care integration between acute and community health and social care in Eastern Devon
- Northern Devon Healthcare Trust is the first NHS Trust to provide domiciliary care. Operating across Northern and Mid Devon under the name of 'Devon Cares' and aims to bridge gap between health and social care provision into people's homes.
- Significant progress on integrated health & social care provision across Devon County
- A strong track record of population engagement on community services

Priority 3: Sustainable integrated primary care – the vision

Primary care will be an integral part of our new care model. We will prioritise broader integration of primary care into the wider care system in order to address some of their immediate challenges, around workforce sustainability, capacity and scale, 7 day working, IM&T and estate.

GPs will continue to be very much at the centre of patients' care, coordinating and other clinicians and healthcare providers, as well as providing care directly to patients. Partnership with patients, as well as fellow clinicians, to optimise health and wellbeing will be extended, as will pro-active identification and subsequent management of illness, and in particular long-term conditions.

We want to ensure we have high quality and sustainable primary care services which are integrated with social, voluntary, mental health, community and acute care across Devon. Primary care provision will be developed form a significant component of the integrated care model.

We recognise the need for practices to collaborate more formally than has been typical in the past, and we will provide support to make this happen, including investing in IM&T systems, workforce sustainability and premises where return on investment can satisfactorily be demonstrated. We will continue to commission integrated pathways of care that shift the focus of care from a bed-based model to one that is primary and community care focussed, and realign funding to enable this to happen.

We are developing a high level integrated primary care strategy for the STP that is capable of addressing the key challenges faced by primary care and incorporating the expectations of the GP Forward View. This will need to be translated at a local community level to agree changes that will respond to the varying needs of local communities and their different starting points. Whilst there is a significant focus on general practice we will also develop plans to better integrate other primary care providers especially pharmacy and optometry.

Engagement is key and we are working closely with both our CCG commissioning GPs and primary care provider representatives to co-design a sustainable future for the primary care sector that can make a vibrant, high quality and material contribution to our vision for fully integrated care.

Priority 3: Primary care – developing and delivering the strategy

The South Devon & Torbay Primary Care Strategy has been informed and supported by a Primary Care Stakeholder Survey. This sets out plans to proactively meet the challenges of future development including:

- Access and 7-day a week delivery
- Stakeholders and professional reputation
- Collaboration
- IM&T infrastructure
- Workforce sustainability
- Voluntary and third sector
- Education and leadership development
- Self -care
- Premises
- Patient and public participation
- Unplanned care
- Prescribing and medicines optimisation
- Funding flows
- Quality

The Northern, Eastern and Western Devon Primary Care strategy is in development. The priorities are first to support practices to work at scale, to work together and plan change together, working as part of a transformed multi-disciplinary fully integrated workforce. The CCG is working to overcome contractual and infrastructure barriers to better enable this.

In NEW Devon we need to build on the plethora of good practice but small in scale changes already in place to create a consistent and coherent set of change plans across the area.

We are working across the STP footprint to ensure that we make best use of the additional funding available to support the GP Forward View. We are aligning supported initiatives to specific local primary care challenges and our evolving integrated care model. We will support a programme of (consistent) shorter term and small scale service change and improvement at practice level to build capability and engagement and to help provide some immediate solutions to the most pressing issues.

We will work towards delegated commissioning to ensure change plans can fully align with the STP.

Priority 4: Transforming mental health & Learning disabilities

The national *Five Year Forward View for Mental Health* has set out the case for transforming mental health care across England by putting mental and physical health on an equal footing. There are benefits to this approach for people using mental health services and for the health and care system.

National priorities for all STPs are:

- High quality 7-day services for people in crisis
- Integrated approach to the delivery of physical and mental health care
- Promoting good mental health and preventing poor mental health
- Ensuring arrangements are in place for good mental health care across the NHS - wherever people need it

Our *Case for Change* highlights the fact that mental illness is relatively common in Devon and that people with serious mental illness experience poorer health outcomes than the general population. It is also identifies the need to prioritise high quality and accessible services for people with a mental illness - especially those who also have poor physical health - as well as prioritising the mental health needs of people with a physical health need. In addition more needs to be done to prevent mental illness and promote mental wellbeing. However, much less money is spent on mental health (when out-of-area placements are excluded) in Devon than in other similar areas of the country, and services are not as comprehensive as they need to be to ensure the best outcomes for people.

We believe that mental health should have equal priority with physical health and that everyone who needs mental health care should get the right support, at the right time. We have included mental health throughout our STP - in terms of prevention, integrated care and specialist services – so that mental health is an integral part of our system. We will design and deliver clear pathways of care that meet people's mental and physical health needs. We have developed a set of local priorities to transform mental health care in Devon and these, along with the national requirements, will be addressed through our transformation programme.

Priority 4: Transforming mental health – seven priorities

1. Ensuring safe and sustainable services and addressing gaps in service provision

Clear, evidence-based pathways of care will be established for all main mental health conditions – from prevention and primary care through to secondary care, specialist care and supported recovery.

The interface between primary and secondary care will be transformed so that people can have the most appropriate care in the right setting.

Mental health will be an integral and equal part of the new model of care in order to ensure improvements in the wellbeing, support and experience of people with dementia and their carers in wider Devon.

We will strengthen plans for suicide prevention and publish our plans in accordance with national requirements.

2. Making acute and crisis care more resilient; 24 hours a day, seven days a week

We will create a more effective and robust care pathway for people experiencing a mental health crisis. We will ensure sufficient Crisis Resolution and Home Treatment Team capacity and effective step-up and step-down options to ensure that we can provide alternatives to hospital admission and ensure discharge from hospital is timely.

We will develop greater community resilience to support people with mental health needs, for example through increasing the availability of peer support programmes.

We will set out a plan of service development and improvement to achieve these aims. This will be agreed and regularly reviewed against a set of performance indicators.

3. A life course approach to care

We will develop a mental health outcomes strategy that prioritises prevention, early intervention and recovery across wider Devon that will create a framework for achieving :

- A seamless and integrated experience for everyone, regardless of their age
- Access to mental health services that are timely, proactive and effective
- Empowerment and self-help as essential principles of a remodelled mental health system
- Commissioning additional Individual Placement Support roles for those with severe and enduring mental illness
- Delivering integrated physical and mental health services

Priority 4: Transforming mental health – seven priorities

4. Achieving equity of access and national standards

We will achieve equitable access to mental health services that meets national standards for people across wider Devon, including:

- Treatment for Children and Young People
- Access to perinatal mental health support
- Early Intervention in Psychosis
- Increased access to Psychological Therapies
- Diagnosis of dementia and effective support through regular care plan reviews
- Annual physical health checks
- Access to Individual and Placement Support to find employment
- Core 24hr psychiatric liaison services where needed
- Meeting urgent care response standards
- Further reduction in out-of-area placements and care

5. Treating people with complex care needs in Devon

Enhanced expertise, services, and facilities in Devon that meet people's needs locally and reduce placements out-of-area:

- Reducing the number of people receiving specialist mental health care out-of-area; improving provision for intensive rehabilitation and specialist dementia care; improving s117 aftercare commissioning and enhancing community pathways to maximise recovery or provide onward support following hospital admission
- Extending clinically-led individual placement commissioning and considering models of provision needed to return people to Devon
- Piloting a commissioning model for specialised Secure Care and identifying opportunities to shift resources from hospital care to community pathways, aligned with Transforming Care Partnerships
- Commissioning specialist community eating disorder services and ensuring that commissioners and providers join the national quality improvement and accreditation network for community eating disorder services (QNCC ED)

6. Recruiting and retaining staff

Enabling health and care staff in the wider workforce to meet people's mental health needs with the appropriate support of mental health professionals .

Creating a balanced and flexible workforce, of the right size and with the right skills, that is well led and appropriately rewarded.

Embedding a health and social care system in which mental health and learning disability are everyone's business.

7. Increasing access to mental health support and services for children and young people

Working with our schools and Local Authorities to develop systems that support emotional wellbeing, resilience and positive mental health whilst transforming the delivery of mental health services for children and young people through our CAMHS transformation plans.

Priority 4: Living well with learning disabilities

We want people in Devon with a learning disability to live well and we are developing an

Drivers behind our work in the field of learning disability include:

1. Tackling health inequalities: The Confidential Inquiry into the Premature Deaths of People who have Learning Disabilities (CIPOLD) in 2013 showed that on average "women with a learning disability were dying 20 years before women in the general population and men, on average, 13 years earlier."

   - In order to address this we have developed nursing liaison roles across primary, acute and neurological services, however we need to ensure that as a community of health and social care providers we have a legal and moral duty to consider the needs of this population **in all our plans and pathways** and make the reasonable adjustments required to help people access the services they need.

2. There is a need across all commissioned services to maximise the independence of people who have a learning disability. Furthermore we need to support opportunities for people to develop real friendships that will reduce the number of people experiencing loneliness.

   - This can be achieved through more robust outcomes based commissioning that utilises reviews to help set new goals to help people to progress.

3. Transforming care for people who have a learning disability and/or autism who have behaviours that challenge. This aims to bring people placed in hospital back into the community, prevent admissions to hospital, and to make sure that people have every opportunity to live a good life

   - In order to address this we have developed a new Transforming Care plan that spans the whole STP area and **also includes children and young people**. In order to make sustainable change happen action needs to be undertaken in a number of areas.

Priority 4: Devon-wide transforming care partnership plan

Our vision is to create a place where children and adults with a learning disability live in the community of their choice, with the people they want, and with the right support, and are happy, healthy and safe

This plan is for people of all ages living in Devon, Torbay and Plymouth who have a learning disability and / or autism, who display behaviour that challenges, including behaviour from a mental health condition

We are succeeding when:

All people placed out of the area are returned to their own community	No-one remains in hospital for longer than they need to be	People and their carers have a better quality of life and are helped to be as independent as possible	All people on our risk register have been offered a personal budget and have an individually designed service	There is a lifelong pathway for people	We have a range of providers offering choice to people who have their own budgets

The current model

- Too many people in inpatient care, out of area
- People fit into services rather than services being built around them
- Over-referral to long term residential care

The new model

- Choice of local housing, care and support
- Individually designed services funded through personal budgets
- Short term inpatient care

Things to do now

- Engage service users on our vision
- Check our data and finance information
- Implement our project plan and engage key stakeholders in our working groups
- Develop our wider communication plan
- Get all the people and organisations involved working together

Things to do in the longer term

A single pathway.
Increase the choice of local housing, care and support.
Develop co-designed care and support plans with robust outcomes.
Personal budgets and direct payments.
Support for people, parents and carers.
Effective short breaks and crisis arrangements for people with complex needs.

Benefits of our new model of care

People are cared for and supported in the best place for them.
Care and support is arranged around people not where they live.
People get just the right help to be as independent as possible, without being too dependent on services.
People are able to lead active lives in the community.

Priority 4: Transforming mental health resources

We understand that transforming mental health care in Devon and addressing our priorities will require additional resources. National guidance requires an increase in baseline spending on mental health by at least the overall growth in allocations in order to deliver the Mental Health Investment Standard.

In order to make a start toward increasing resources and improving access to services, mental health services in Devon have been proactive in securing additional revenue and capital funding through national funding opportunities such as: increasing access to psychological therapies, and improving health based places of safety for people experiencing mental health crisis.

In order to secure and then sustain the priorities for improvements in mental health care in Devon we will through our STP:

- Review our spending on mental health services as a proportion of the total system
- Review how we currently use our resources to ensure they are directed toward evidence based and effective interventions, providing supporting at an early stage and ensuring safe and sustainable services.
- Realise the benefits of increasing mental health interventions that reduce activity in other parts of the system, such as reduced attendances, admissions or length of stay in hospitals, and reinvest these savings to continue to fund these enhanced mental health services in future.

Priority 5: Acute hospital and specialist services

- The NEW Devon case for change identified concerns about quality and/or sustainability of some acute hospital and specialist services. It prioritised stroke, maternity, paediatrics and neonatology and emergency and urgent care for urgent review. A similar analysis undertaken in Torbay and South Devon confirmed similar priorities for review.
- Medical leaders in Wider Devon also identified a number of clinically and financially vulnerable services where clinical sustainability was causing some concern. The causes of this vulnerability can include national staff shortages or low patient numbers, which make it difficult for clinical staff to keep their skills up to date and where action may be necessary to maintain reliable services.
- An overarching programme for the review of acute and specialist services has been established. The programme will be led by the STP Clinical Cabinet chair and a nominated Lead Chief Executive. The objectives of the review will be to optimise the quality and timeliness of acute hospital and specialist care by making services more resilient with better outcomes and improved affordability. This will allow us to meet the increased demand for hospital-based services and support services – does this need clarifying so it doesn't contradict earlier statements about not needing so much hospital inpatient capacity?
- The unique geography of Devon will not limit access to time critical services and that proposed changes are affordable within the allocated system funding

The services prioritised for review in the first phase of this programme are:

- Stroke services (including hyper-acute and stroke rehabilitation).
- Maternity (including consultant-led and midwife-led care), paediatrics and neontaology, to be reviewed together given their inter-dependency.
- Urgent and emergency services, focusing particularly on the acute hospital provision of accident and emergency and co-dependent services.

The 'vulnerable' services for review include:

- Breast services (surgery and radiology)
- Ear, Nose and Throat
- Interventional radiology
- Histopathology
- Neurology
- Interventional cardiology
- Vascular surgery

Scope and content of subsequent phases is currently being developed

Priority 5: Acute hospital & specialist services – specialised commissioning

Specialised Commissioning - services currently commissioned by NHS England

- Leaders within the wider Devon STP recognise that unifying a commissioning approach to services with Specialised Commissioning is critical to a sustainable Plan over the next five years. Both CCGs are exploring how specialised services can be commissioned differently to integrate pathways, develop local service alternatives and to crystallise opportunities for consolidation as part of reconfiguration plans
- Specialised Services within the South West Peninsula are delivered in a number of Trusts. The transformation programme for specialised services will be integrated with the Devon STP acute and specialist services review work programme
- Plymouth Hospitals NHS Trust will be the lead centre for trauma, cardiac surgery, neurosurgery and level 3 neonatology in the STP footprint
- For specialised mental health the aim is to:
  - eliminate unnecessary admissions out of the South West of England
  - establish a South West tertiary mental health care models pilot with budget circa £70m (this will be undertaken as part of the mental health work programme)

Reinvestment and collaboration

- The STP partners will seek permission to develop plans that would reinvest specialised commissioning efficiencies where our plans control demand and produce service alternatives that reduce demand for specialised interventions
- We will also work in conjunction with national and regional service networking arrangements to develop, share and implement best practice and align our plans as appropriate across neighbouring STP areas – for example, Cancer Alliance, strategic clinical networks; urgent & emergency care network.

Priority 6: Productivity – cost effectiveness of care per head of population

Objective

Each provider has had their pay and non-pay costs and spend benchmarked against similar sized and types of NHS organisations. This has enabled us to identify with a view to implementing productivity opportunities across providers in Devon.

Expected impact

- Significant reductions in pay and non-pay costs by 2020/21 across four providers in Devon (RD&E, Plymouth, NDHT, T&SD)
- Achieve operational productivity as good as top quartile performers in provider peer groups

Key workstreams

- Improving **Pay** productivity within
  - Medical staff
  - Nursing staff
  - Scientific, Therapeutic & Technical (ST&T) staff
  - Other non-clinical staff
- Improving **Non – pay** productivity within
  - Clinical supplies and drugs
  - Estates
  - Agency

Milestones

- High level productivity opportunity agreed by Finance Working Group (FWG)
- Providers to reconcile with Carter benchmarking analysis and to develop plans to target opportunities

Team

- Finance Working Group
  - consists of Directors of Finance from all providers in STP
  - chaired by Andy Robinson, STP Director of Finance

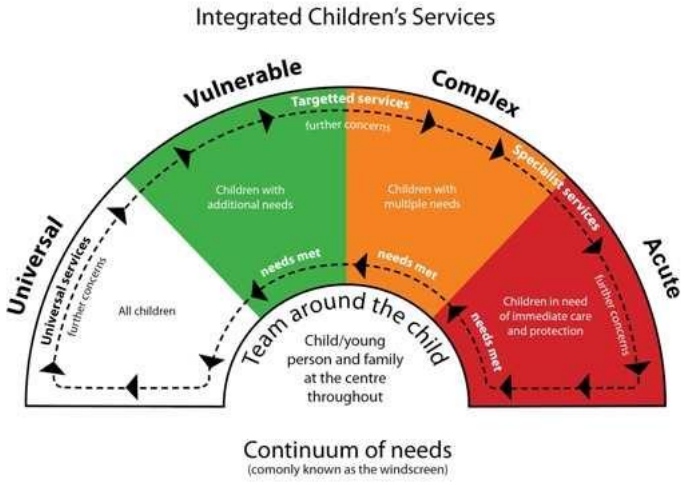
Priority 7: Children, young people and families

It is our aim to ensure we are 'doing the right thing at the right time' to support children, young people and families (CYP) across wider Devon. Support is area-based, seamless and has an integrated pathway approach that builds resilience and early support to CYP and their families. To do this we need to:

- Help families and practitioners understand and access Early Help in their community.
- Ensure that children and young people are able to access whole person support in the right place throughout their journey. This means ensuring that staff have the best skills to help them to thrive and to provide support through key transition points.
- Ensure that children and young people stay healthy, with intervention starting earlier, both in terms of access to the right people who have the skills and of expertise to their support needs.
- Commissioners and providers will co-produce a model of care across universal and specialist services that spans health, social care and education; and ensures that adult and children's services work together to prepare young people for adulthood.
- Ensure that mechanisms are in place to enable effective communication, sharing data and enabling timely access to the right pathway.
- Strengthen access to senior paediatric expertise, linked to GP practices, for urgent and non-urgent needs.
- Provide a rapid access clinic for non-emergency cases, led by paediatricians.
- Triage quickly and effectively to ensure that children and young people can access the right care appropriate to their needs and in doing so avoid unnecessary attendances and admissions whilst ensuring that their parents/carers also receive appropriate support.

We know that some CYP may need more targeted and specialist support. Therefore we need to:

- Ensure that our consistent arrangements also comply with statutory responsibilities for children with Special educational needs (SEND) their parents/carers and also young carers.
- Provide a local offer available for children under the SEND reforms, that enables them to achieve the outcomes and goals identified through their ECHP. We must support children and young people, including those with complex needs and the most vulnerable, with multi-agency co-ordinated care, as close to home as possible.
- Support children and young people with emotional well-being and mental health services in supportive communities that can build resilience and that provide access to early help that delivers prevention and early intervention. Transformation of CAMHS will ensure timely crisis responses; specific pathways for eating disorders and self-harm; specific support to cared for children.
- Evidence effective transition planning for children and young people and their families, offering more personalised care through the use of Personal Budgets.
- Facilitate access to health assessments for children in care and services which are responsive to their needs; ensuring that we are safeguarding these vulnerable CYP.



Key enabling plans

1. Workforce
2. Communications & engagement
3. Estates
4. IM&T

Enablers: Developing the workforce strategy

Opportunities

The creation of employment opportunities are key drivers of health, wellbeing, economic growth, resilient communities and the delivery of quality care. Our new models of care will create the opportunity to think and work differently, creating a flexible workforce across health and social care which is capable of responding to the changing needs of people and to address many of the problems our staff and service users currently describe.

Our workforce strategy also creates the opportunity to work with schools and colleges as well as our traditional links with universities to create new roles such as care apprentices creating more career opportunities and choice for young people locally . The STP area is one of 11 national pilot sites for the new assistant nurse roles: 76 places will be available from January 2017. This innovative scheme is the only one in the country which had included the care home sector in the pilot.

Implementation of the proposed changes in this Plan will have a major impact on the existing workforce. Our workforce will be supported to develop new skills and capability. Initial analysis indicates:

- Re-provision of up to £60m per year to deliver the new care delivery arrangement interventions could provide for between 1,000 and 1,500 redesigned roles, representing retraining of 4 - 6% of the current workforce or recruiting new staff.
- High-level estimates indicate a requirement for 900 staff to undertake different roles (these were based on traditional roles and ways of working, and require development) and many of these roles would be filled by staff relocating their work and expertise from existing services.
- Significant training and support will be needed to as staff move to new roles, working in new ways in the new models of care. An extensive OD programme is being established to underpin these changes.
- There will be challenges in recruitment in several areas such as domiciliary workers, social workers, health care assistants, primary care and senior medical staff in small specialties.
- Primary care workforce development is a key area for attention given the Devon GP age profile and the key role primary care will play in our future integrated model of care.

Workforce leads in all the partner organisations in the STP are working together to address these issues and have developed this high level shared system-wide work plan.

Enablers: Developing the workforce strategy – early actions

- Produce an agreed strategic workforce Sustainability Transformation Plan (STP) which addresses the priorities identified that spans 10 years ahead but focus on the medium to five year plan.
- Build and develop key relationships with the agreed workforce representatives from across the whole system in an ongoing way to achieve effective engagement, understanding and collaboration in delivering the workforce objectives
- Systems leaders will ensure sign-up to an implementation plan, with clearly identified achievable steps informed and agreed by the models of care and clinical cabinet, tested and assured through agreed modelling.
- Ensure workforce plans encompass the whole system for the long-term with the vision of the future integration landscape described and workforce mapped
- Agree and deliver system workforce benefits, for example, by exploring a joint values-based recruitment and retention strategy (one Devon, one workforce) that is inclusive across all statutory organisations with a focus on maximising use of the local labour force
- Explore opportunities for flexible education packages and career pathways which enable hybrid roles which can rotate within all partner organisations, working as required to support new care models (for example an Integrated Apprenticeship programme)
- Develop system wide approaches to shared flexible staff learning interventions prioritising initiatives that deliver greatest benefit to staff and patients.
- Set up and roll out pilot for assistant nurse role
- Develop the Community Education Provider Networks (CEPN) to plan inter-professional learning (with support from Academic Health Science Network)
- Develop systems that ensure Education and continuing professional development is accessible to the whole workforce
- Consider development of shared broad based integrated training delivery opportunities (e.g. key common statutory training) across partner organisations that improve scale and efficiency of provision.
- Share best practice in care delivery practice that will support the existing workforce to implement the new care model
- Maximise the impact of the new employment deal by working collaboratively across the STP on its implementation

Enablers: Stakeholder communication and engagement (SC&E) embedded within, and integral to the STP Programme

In a change programme of this size, scope and length it is critical that staff, patients, public and stakeholders understand the context, purpose and benefits of any change as well as feeling able to influence and be involved in the decision-making process.

Current focus

Strategic

- Development of a system-wide stakeholder communications and engagement plan to support delivery of the STP
- Provision of expert SC&E advice to STP Programme Board informing strategic approach
- Representation from three Healthwatches to advise on public engagement at Programme Board
- Development of strategic narrative and key messages aligned to, and reinforcing the Devon vision
- Patient and public involvement assurance mechanism in place via NEW Devon Patient and Public Engagement Committee and SD&T Engagement Committee
- Developing approaches to co-production / planning with citizens and communities

Tactical

- Embedding SC&E within each STP Working Group (eg: the Clinical Cabinet)
- Establishing the governance structure to monitor delivery of SC&E Plan (including resourcing)
- Development of core SC&E processes, channels and protocols – ensuring consistency, evaluation and use of feedback received
- Stakeholder mapping and analysis

Operational

- Patient and public engagement working with clinicians on STP groups
- Weekly internal communication channels established
- Media protocol in place
- Daily calls between commissioner and provider comms leads

Key achievements to date

- ✓ NEW Devon case for change launched in February to more than 10,000 staff and public
- ✓ Widespread and extensive SD&T engagement in developing new model of care for community services
- ✓ A growing awareness of the need for change by the public and staff
- ✓ Key stakeholder events held in Plymouth, Torbay, Barnstaple and Exeter
- ✓ Flow of feedback from events influencing the development of STP vision and approach. SD&T survey informing IM&T and wider primary care strategy implementation
- ✓ Health and wellbeing scrutiny, Health and Wellbeing Boards and Member of Parliament briefings commenced
- ✓ Public and patient representatives influencing design of new models of care
- ✓ Clinicians and SC&E team co-designing/delivering communication and engagement activity
- ✓ Increased alignment of SC&E across New Devon and South Devon CCG footprints
- ✓ South Devon and Torbay CCG completed a nine month engagement programme which informed the "Into the Future" consultation proposals, published on 31 August
- ✓ NEW Devon CCG launched a formal consultation (7 October 2016) on proposals to achieve consistent, integrated community services.
- ✓ Stakeholder engagement forum event held on 20 October

Enablers: Developing the Estates Transformation Strategy

Strategic Aim	Provide a **transformed and innovative estate portfolio** which delivers **excellent, quality, well maintained and economical buildings and facilities** which are **efficient and responsive** to the changing needs of the new model of care population and local communities of Devon.

Strategic Objectives	Economical and Efficient Estate	Transformed and Innovative estate portfolio	Well maintained and Responsive	Excellent and Quality Environment
	Support the on-going viability of the NHS by minimising the cost of property and waste and by maximising commercial opportunities for income generation and the use of one public estate.	In collaboration with local communities and partners, deliver changes to the estates portfolio to facilitate the delivery of the integrated service model.	Deliver a safe, statutory compliant and responsive estate by utilising new technologies, innovation and best practice to transform the way Facilities Management (FM) services are delivered.	Invest available resources wisely, delivering an environment of the highest possible quality to maintain the quality of services.

	Drivers for Change	Estates Plans/Solutions
1.	Delivery of the new model of integrated care and reduced need for bed based care. Developing mental health care services, fully integrated with primary and acute care services.	Build on the Local Estates Strategies (LES) by developing a system wide estates strategy. Disposal of poor quality buildings and re-investment in new and re-configured buildings to provide community multi-disciplinary centres and local health and well-being centres. Smaller acute Hospitals
2.	Future population increase and provision of services at the heart of the community.	Locally based affordable rural services with integrated General Practice and community care, provided through multispecialty centres. Partner working and co-ordination between NHS and Local Authorities, to forward plan effectively, and release land to create new opportunities for housing. New Care facilities and building in town centres linked with re-generation.
3.	Pockets of deprivation, levels of high-risk behaviours and multiple conditions.	Re-use of existing estate for preventative and public health services.
4.	Vanguard deliverables.	Development of urgent care centres (and, potentially, new locations).
5.	Ageing population – increased pressure on the whole care system.	Increased private sector care home provision and use of telemedicine to reduce face-to-face appointments. Co-located facilities and partnership working with voluntary services.
6.	Meeting the challenges of the General Practice Forward View (GPFV), the Five Year Forward view (5YFV) and System Transformation Plan (STP). Delivery of the Lord Carter review.	Development of health hubs with GPs operating at scale and within multi-disciplinary centres. Fewer individual GP practices and development of new estate and conversion of existing estate to deliver fit-for-purpose facilities. Partnership working to develop a system wide plan for 'One Public Estate' Reducing the cost of the estate; rationalisation of leases, disposal of buildings in poor condition. Partnership working across all sectors in the region to deliver upper quartile EFM performance, and reduction in running costs. To include new and different funding models and commercial partnership
7.	Reduced Capital resources for investment in the estate	Make use of capital received from disposal of assets for system-wide re-investment in new buildings and facilities to support the re-configured service model.

Enabling through technology – the local digital roadmap

Implementation of the proposed new care model requires new ways of working which will be enabled through technology and information sharing. Data and digital technology has the power to support people to live healthier lives and be less reliant on care services, as well as ensuring the provision of health and care is both high quality and sustainable. A local digital roadmap has been developed in collaboration with Kernow STP and sets out the shared vision, goals and plan required to deliver health and social care IT solutions across the South West Peninsula. To achieve this ambition locally there are four key areas of focus namely:

- Build the foundations: health and care organisations need to reach digital maturity
- Leverage the capability: connect all the digitally mature organisations
- Leverage existing capabilities: identify what can be achieved ahead of 2020
- Exploit the opportunities: enable citizen access.

Good progress is being made in terms of sharing the GP record in accordance with robust information sharing agreements.

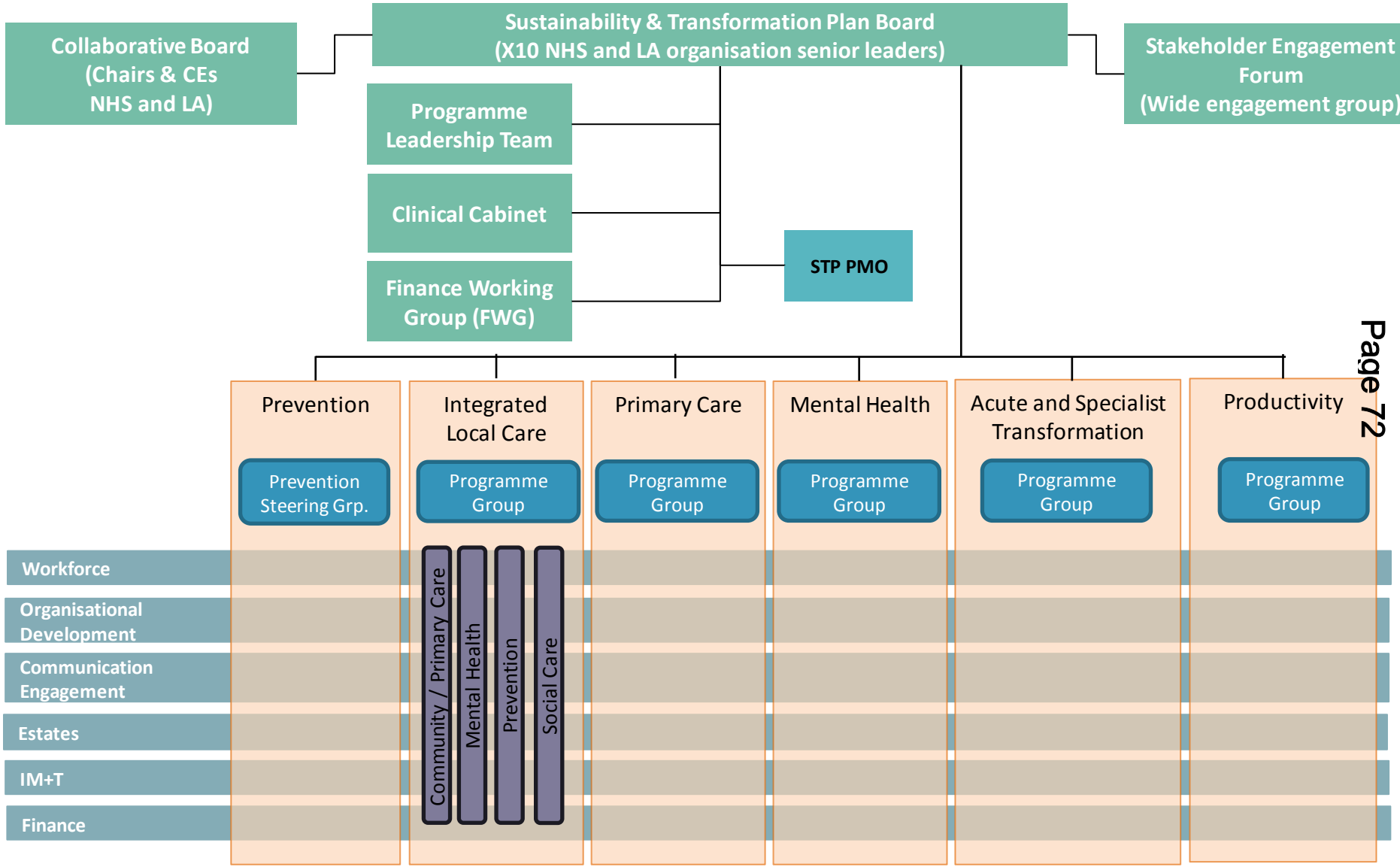
The next three areas in the local digital roadmap considered to deliver greatest alignment and impact on the seven priorities are:

1. Delivery of the integrated digital health and care record
2. Shared care plan
3. Supporting self care/prevention, including the patient held portal.

These will require significant additional resourcing over and above the current allocation.

STP priority	Digital maturity	System wide bed manage-ment	Integrated digital record	Self care	Information Sharing Framework	GP record availab-ility	Child protection informatio n system	Secure email (care homes)	Virtual consult -ations	Secure hotspots for health and care workers	End of life wishes & shared care plan patient portal
Prevention				✓	✓			✓			
Care Model		✓	✓	✓	✓	✓		✓		✓	
Primary care				✓	✓	✓					✓
Mental Health			✓	✓	✓	✓			✓	✓	✓
Children & young people	✓		✓		✓	✓	✓		✓		
Acute hospital and specialist care	✓	✓	✓		✓						
Productivity	✓	✓	✓		✓						

Programme architecture to design and develop and deliver system wide plans



Place based design and delivery arrangements. Co-production with citizens & communities – NHS and LA

Wellbeing Overview and Scrutiny Board and Corporate and Place Overview and Scrutiny Board

Tracking Resolutions – 2016 - 2017

Wellbeing Overview and Scrutiny Committee			
	Resolution	**Target date, Officer responsible and Progress**	
20.07.16 Plymouth City Council Corporate Plan Minute 4	The Committee noted the report and agreed the following recommendations; 1. the Welcoming City Action Plan will be available for scrutiny. 2. Scrutiny members would take an active role in the consultation on budget setting priorities.	Date: Officer: Progress:	September 2016 Kristin Barnes (Democratic Support Officer) Relevant officers have been advised. The Welcoming City Plan is scheduled to come before the Wellbeing Overview and Scrutiny Committee on 21 September 2016 - **Complete**
20.07.16 Success Regime and Sustainable Transformation Plan Minute 5	The Committee agreed to – 1. support the strategic direction of the Sustainable Transformation Plan. However, it should not impact on the programme of change in Plymouth and Health and Care Organisations in Devon should be encouraged and supported to keep pace with the shift to new models of care. 2. delegate to small working group to monitor progress of the Sustainable Transformation Plan and bring back to the committee proposals which have a significant impact and/or risk to services and people in Plymouth. 3. report on progress against opportunities for	Date: Officer:	March 2015 Ross Jago (Lead Officer)

Wellbeing Overview and Scrutiny Committee			
	Resolution	**Target date, Officer responsible and Progress**	
	accelerated implementation of service delivery and quality improvement as part of the integrated fund monitoring report.	Progress:	Chair and Vice Chair have met with scrutiny colleagues from across the Devon area. New models of care are being consulted upon throughout the Devon area. Minute 5 (1) will be dealt with through standing item on the Integrated Fund Monitoring Report.
20.07.16 Integrated Commissioning Action Plans Minute 6	The Committee agreed to – 1. review the action plan aim *"Deliver and integrated education, health and care offer: ensure the delivery of integrated assessment and care planning"* at the next meeting of the committee. 2. request that the integrated commissioning scorecard will made available as a standing agenda item. 3. establish a Select Committee review on the Urgent Care System.	Date:	March 2016
		Officer:	Kristin Barnes (Democratic Advisor)
		Progress:	1. the action plan aim *"Deliver and integrated education, health and care offer: ensure the delivery of integrated assessment and care planning"* will be considered at the meeting of 21 September. 2. Integrated Commissioning Scorecard has been added as a standing item on the agenda. 3. Select Committee review into Urgent Care is on the Work Programme.

Wellbeing Overview and Scrutiny Committee			
	Resolution	**Target date, Officer responsible and Progress**	
20.07.16 Medium Term Financial Strategy Minute 7	The Committee agreed that - 1. Improvements were required to the MTFS to make visible how risks and opportunities were being identified through scenario planning and to make the management of risk more explicit. 2. The corporate strategic risk register should be emailed to members as soon as possible 3. Mitigation plans for the "overheating" in Adult and Children's Social Care as to be made available as part of the Integrated Fund Monitoring Report.	Date: Officer: Progress:	September 2016 Andrew Hardingham / Carole Burgoyne 7 (1) Officers have been tasked with highlighting levels of risk within the Medium Term Financial Strategy. This will be considered at the 22nd September 2016 consideration of the MTFS. (2) The corporate risk register has been emailed to members. If members require further updates this can be arranged as officer briefings or as a work programme item. (3) The Integrated fund monitoring report will be subject of ongoing scrutiny.
21.09.16 Integrated Fund Monitoring Report Minute 14	The Committee agreed the following recommendations; a) a briefing and training session for members of the committee on NHS financing would be provided; b) a briefing on guardianship would be provided for members of the committee via email; c) figures for the full year cost of the school transport service would be provided to members of the committee via email.	Date: Officer: Progress:	November Ross Jago A. A briefing has been organised for the 17th November. B. Yet to be actioned C. Yet to be actioned

Wellbeing Overview and Scrutiny Committee			
	Resolution	**Target date, Officer responsible and Progress**	
21.09.16 Integrated Commissioning Scorecard Minute 15	The Committee agreed the following recommendation; National indicators relating to the happiness score would be removed from the data a local mechanism for providing that data would be developed.	Date: Officer: Progress:	March Ross Jago Officers are currently reviewing how this data may be obtained.
21.09.16 Welcoming City Action Plan Minute16	The Committee agreed the following recommendations; a) to receive an update on the action plan post February 2017; b) members would be provided with a list of small budgets issued to diverse groups via email; c) members would be provided with guidance on the "Members Room" for the third party reporting of hate crime.	Date: Officer: Progress:	 Ross Jago / Pete Aley a) Added to the committee work programme b) Details have been sent to members c) Details have been sent to members

Wellbeing Overview and Scrutiny Committee			
	Resolution	**Target date, Officer responsible and Progress**	
21.09.16 Special Educational Needs and Disability Minute 17	The Committee agreed the following recommendation; a) the Committee would receive an update on SEND services at the end of the municipal year.	Date:	21.09.16
		Officer:	Kristin Barnes (Democratic Support Advisor)
		Progress:	SEND has been added to the Work Programme

Place and Corporate Overview and Scrutiny Committee			
	Resolution	**Target date, Officer responsible and Progress**	
27.07.2016 Plymouth City Council's Draft Corporate Plan 2016-19 Minute 4.	The committee agreed that – 1. It should be explicit within the Corporate Plan that the move to increased digital accessibility is based on an approach of digital be preference; 2. A focus on fly-tipping should be added to the priority activity on littering; 3. The Corporate Plan Performance Framework is made available as a standing item on the committee; 4. Net yield and occupancy rates from the Council's Commercial Estate and information on stalled sites will be monitored by the committee through the most appropriate mechanism; 5. A report on the UK's withdrawal from the European Union and the Impact on and response by the City Council to be provided to the committee at a future meeting.	Date: Officer: Progress:	August 2016 Ross Jago (Lead Officer) Information has been fed back to officers for inclusion into the Corporate Plan where appropriate. The Corporate Plan will be considered at full Council on the 19 September 2016.
27.07.2016	The committee agreed that –	Date:	August/September 2016

Place and Corporate Overview and Scrutiny Committee			
	Resolution	**Target date, Officer responsible and Progress**	
Medium Term Financial Strategy Minute 5.	1. A Select Committee Review will be held in early September 2016 on the Plan for Waste; 2. A joint Select Committee Review will be held, at the most appropriate time, to enable pre-decision scrutiny of the budget, efficiency proposals, the next iteration of the Medium Term Financial Strategy, consultation feedback on the proposals and the findings from the Select Committee Review on waste, prior to decisions being taken by Cabinet and Council.	Officer:	Ross Jago (Lead Officer) and Helen Wright (Democratic Advisor)
		Progress:	• the Select Committee Review on the Plan for Waste was held on 31 August 2016. Recommendations will be submitted to the Select Committee Review on the Medium Term Financial Strategy on 22 September 2016. • a Joint Select Committee Review on the Medium Term Financial Strategy has been arranged for 22 September 2016.
27.07.2016 Plymouth Plan/Local Joint Plan Minute 6.	The committee agreed that the Lead Officer, in consultation with the Chair and Vice Chair will prepare a consultation response on behalf of the committee.	Date:	August/September 2016
		Officer:	Ross Jago (Lead Officer)
		Progress:	There were no further comments from Members of the committee therefore a response was not made. Minutes supporting discussion at the meeting will be forwarded to the Plymouth Plan team.

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11th November 2016

Dear Councillor Aspinall

Re: Primary Care Commissioning in Plymouth

Thank you for your letter of 14th October 2016, following the Wellbeing Select Committee held on 6th October. This is the formal response requested in that letter. Please see the response to each recommendation in turn.

1. ***This committee considers that the services delivered for the Cumberland surgery are essential in the battle against Health Inequalities which Plymouth City Council is committed to addressing.***

NHS England appreciates the value the City Council, patients and the public place on the primary care and minor injuries services delivered in Devonport as part of addressing health inequalities in Devonport. However, the Cumberland Surgery does not provide the same range of comprehensive primary care services to patients as other local practices in the same area, such as extended hours, or avoiding unplanned admissions through targeted support and care plans for patients who might otherwise be admitted unnecessarily to an acute hospital.
The minor injuries service at the Cumberland Centre will not be affected by this decision and NEW Devon CCG are working to re-procure the Homeless service which is currently managed from the Cumberland Centre, by April 2017.
NEW Devon CCG is in the early stages of exploring a Health and Wellbeing Hub model which will use the Cumberland Centre campus as a focus point. This will be a step forward for the people of Devonport in addressing a wider set of issues which contribute to the health inequalities in the area.

2. ***The committee takes seriously its duties under the NHS Act 2006 (as amended) and strongly recommends that to NHS England that all attempts are made to re-procure the current service being delivered through the Cumberland surgery.***

NHS England has taken the difficult decision not to re-procure the current primary care service at the Cumberland Surgery, which as you know was not established by NHS England in the first place. The decision about the Cumberland Surgery was made taking into account its own circumstances and the feedback from patients. The common factors included:

- The underlying level of viability, given that the previous providers had been unable to sustain any of the surgeries which we are not re procuring, despite their best efforts.
- The relatively small size of the practices, which make them unattractive to would-be providers who would have to take on the financial risk (at a value of £76.44 per patient per year).
- The likelihood that, even if a would-be provider was found and was able to meet the necessary criteria, that provider would not be able to keep the doors open for long.
- The fact that young doctors increasingly prefer to be salaried or to work as locums, working within larger practices, which makes it particularly hard for small practices to recruit.
- The availability of alternative GP services, with most patients having the choice of 20 or more other surgeries located within two miles.
- Where patients live, with significant numbers closer to other surgeries than to the one where they are registered.
- The direction of travel set out in the national policy blueprint, the General Practice Forward View, which recognizes the pressures on general practice and points towards a future in which surgeries increasingly operate ‘at scale’ rather than as separate, small businesses (see appendix 1)

Many of these issues are common across the South West as NHS England has sought to sustain general practice.

Taking all the above factors into account, NHS England’s conclusion in each case is that there is no realistic prospect of attracting a new provider that would be able to sustain the individual practices in the face of rising workload and increasing financial pressures.

However, NHS England and NEW Devon Clinical Commissioning Group, which commissions other local services, recognise the Cumberland Centre as a special case because of the deprived population it serves. Work is therefore now under way

to look at how local services might be enhanced from this site, with the objective of creating a Health and Wellbeing Hub.

Other points to note about the Cumberland Surgery are that:

- It was set up ‘at risk’ by LiveWell South West as part of its single contract that
- also spanned Ernesettle, Mount Gould and Trelawny surgeries. This means it was never commissioned by the NHS, given the existing commitment to build the new Devonport Health Centre next door.
- Devonport Health Centre is now open and, with 5,600 registered patients against a capacity of at least 9,000, has more than enough space to absorb more patients from the Cumberland Surgery.
- Unlike most other surgeries in the area, the Cumberland Surgery has not signed up to open extended hours, or to provide special support to help vulnerable patients avoid admission to hospital, which is part of a core offer we encourage all practices to deliver to patients.
- Other services at the Cumberland Centre, including the minor injury unit, are not affected by this decision.
- The outreach service for homeless people, which has been headquartered at the Cumberland Centre, will be re-procured by NEW Devon CCG to provide continuity of care after the current contract expires on 31 March 2017.

3. ***NHS England should work in conjunction with the Clinical Commissioning Group, Plymouth City Council, Peninsula Medical School and providers adjacent to the Cumberland surgery to investigate how sustainable services to tackle health inequalities in this area may be delivered.***

NHS England and partners within the Clinical Commissioning Group, the City Council and the Peninsula Medical School are committed to tackling health inequalities in Devonport. We will work together to address the inequalities in all current and future work with existing providers, and where opportunities arise, for example through procurements, we will investigate how sustainable services to tackle health inequalities can be delivered.. This commitment can be demonstrated through our work with the nearby community of Barne Barton. This should mean that we secure a provider to set up a GP service for the community of Barne Barton, and there will also be a Community Pharmacy to provide an additional service to this more isolated community.

Furthermore, NHS England is collaborating with the CCG on the re-procurement of the Outreach Service – specifically for homeless people.

We know that the Public Health team at Plymouth City Council are keen to work with the CCG and the third sector to develop Health and Wellbeing Hub, which will be able to tackle access to a range of support services for communities such as Devonport. The CCG are currently looking at innovative models to provide better access to urgent care within the community and again the Cumberland Centre is ideally placed to launch this service delivery model.

4. ***The Committee recognizes that whilst NHS England have accepted flaws in the consultation and engagement process, this committee must put on record its dissatisfaction with the process following submissions from patient groups during the course of this meeting***

NHS England acknowledges there were two main areas that caused concerns with regard to the engagement process. With this in mind NHS England has already made some changes to the engagement process, recognising the need to respond to these issues as soon as these were known. The two areas and our responses are as follows:

1) The letters alerting patients of St Barnabus Surgery, Hyde Park Surgery and the Cumberland Surgery to the engagement process, and containing information about drop in sessions at the surgeries were sent out later than anticipated which meant that patients felt they had no notice of the drop in sessions. Further feedback concerned the timing of the letters and concentrated on the fact that letters were sent during peak holiday periods.

   NHS England used an agent to send letters to patients, and unfortunately they were unable to work within the timescales set by the local team in the South West. This meant there was a delay in sending out the letters which we recognise was unacceptable.

   Subsequent letters have been sent out from our local office, meaning we have more control over delivery, and can make sure that patients are the first to know of our decisions. With regards to the timing of the letters, we agree it was regrettable that the letters were sent out in August at the end of the summer holidays, however we were clear that the engagement period would last for four weeks ending on 24th September. We were also clear that there was more than one method of patients being able to give their views, as patients could write, email or phone us as well as attending the drop in sessions.

2) The first drop in sessions were well attended despite feedback that the notice period for these sessions was too short. This led to criticism that the drop in sessions were chaotic and disorganised. We took this feedback seriously, internally reviewed our processes and as a result sent more staff to subsequent

sessions. As an example we were able to send four members of staff to the Cumberland Surgery drop in session on 25th August 2016.

As a result of the engagement process 430 people responded by coming to drop-in meetings or contacted us via phone, email or post. All feedback was collated and analysed as part of the decision-making process.

Detailed responses were also received from Healthwatch Plymouth and from the Cumberland Patient Participation Group among others. We were also able to use the specific feedback received at the Overview and Scrutiny Meeting when making our final decisions.

The broad themes from the engagement process were as follows;

- Patients did not wish to lose their relationship with the GP and valued good access to a practice and not waiting a long time for an appointment.
- Another practice might be larger, with longer waits to speak with receptionists or for appointments.
- Patients were concerned about the distance to other practices, the lack of direct bus services the cost of travel including taxi fares.
- Patients felt they might lose valued services.
- Patients did not wish to lose their relationship with staff who were more than clinicians, knew them well and enabled patients to see the same doctor each time.
- Some patients did not want to register with other surgeries, because of past experience.
- Patients valued the continuity of care in managing long term health conditions and worry that they would not get the same level of care at any other GP surgery.
- Patients did not wish to lose their relationship with the GP, and valued good access to a practice and not waiting a long time for an appointment.
- Patient felt another practice might be larger, with longer waits to speak with receptionists or for appointments.

5. ***With regard to St Barnabas and Hyde Park surgeries; that committee, via the Chair, receives information on how future proposals reflect the engagement and consultation that has taken place and includes an impact assessment on surrounding surgeries***

The decision has been taken that St Barnabas and Hyde Park surgeries will not be re-procured for the reasons set out in our response above to your second recommendation, and also in the light of the patient feedback received, as described in the response to the fourth recommendation above.

In the areas surrounding both practices there are 20 different GP practices within a two mile radius of each surgery. Investment has been made across Plymouth at a number of GP practices to either enlarge or improves premises, therefore the impact on any individual practice is expected to be diluted as a result of the large number of GP practices in the area. There is a positive impact for those surgeries as an increased number of patients will result in increased income, which will help to secure a more sustainable set of GP practices for the population of Plymouth. We will be working closely with all practices, as well as patients, to ensure a smooth transition for patients.

6. ***NHS England should consider "lessons learnt" from the recent consultation experience and in future all proposals should be accompanied by an extensive communication plan which advises all patients of alternative services and how to access them.***

It has been helpful to receive your feedback which enables us to build learning into any future engagement and communication with patients about service change. I think it is helpful to re iterate the NHS England requirements around engagement. The NHS England guidance on engagement is set out in the 'Statement of Arrangements and Guidance on Patient and Public Participation in Commissioning' (December 2015).This extract explains duties under Section 13Q of the Health and Social Care Act 2012 and includes an important example:

Where public involvement is required, NHS England has a broad discretion as to how it involves the public. However, this is not an absolute discretion: it must ensure that its arrangements are fair and proportionate.

Fair

The courts have established guiding principles for what constitutes a fair consultation exercise. These principles (known as the Gunning principles) were developed by the courts within the context of what constitutes a fair consultation and will not apply to every type of public involvement activity. However, they will still be informative when making plans to involve the public.

The Gunning principles are that the consultation:

- Takes place at a time when proposals are still at a formative stage. If involvement is to be meaningful, it should take place typically at an early stage. However, it is often permissible to consult on a preferred option or decision in principle, so long as there is a genuine opportunity for the public to influence the final decision.
- Gives the public sufficient information and reasons for any proposal to allow the public to consider and respond.

- Allow adequate time for the public to consider and respond before a final decision is made.
- The product of the public involvement exercise must be conscientiously taken into account in making a final decision.

Proportionate

It is almost always possible to suggest that more can be done or that an exercise can be improved upon, particularly with hindsight. However, NHS England needs to balance its duty to make arrangements to involve the public with its duty to act effectively, efficiently and economically. Therefore, the arrangements for public involvement and activities flowing from those arrangements need to be proportionate.

NHS England should also consider the potential impact on other services, which may not be commissioned by NHS England (e.g. ambulance services), and issues for patients beyond the clinical services themselves such as accessibility, transport links and ambulance availability.

For example:
A small GP practice in an urban area is likely to close due to the retirement of the lead partner and difficulties relating to the condition of the practice premises. The patient list can be dispersed to a neighbouring GP practice two streets away. The public involvement duty would be engaged, but carrying out an extensive public involvement exercise in relation to the changes may be disproportionate. Local commissioners arrange to write directly to all current patients of the practice informing them of the planned change, and ensure that clear notices are displayed on noticeboards at the surgery and local community venues, and that information is included on the practice website. They talk to the patient participation groups of both surgeries about the impact of the proposed changes and arrange a drop-in session at the practice for patients to find out more. Specific efforts are made to reach those who may be easy to overlook, including seeking advice from the local community and voluntary services about the impact on groups in the local community that experience the greatest inequalities.

When considering the way forward for all affected practices in Plymouth, NHS England was very clear that options should not be closed off for those surgeries that, in its preliminary view, should not be procured. However, the decision-making process was timetabled so any of these surgeries could still be added into the procurement process following the patient engagement exercise, to try and find a new provider for 1 April 2017.

The process undertaken locally has been overseen by a group that includes representatives NEW Devon CCG, Plymouth City Council and Healthwatch

Plymouth, along with an independent GP. Devon Local Medical Committee and other GPs have also helped shape the proposals.

The approach to direct patient engagement has been two-fold:

- For Ernesettle, Mount Gould and Trelawny patients, a survey was set up so they could consider issues such as opening hours, types of staff and levels of service. The online survey ran until Friday 23 September, supplemented by paper copies that were available from the surgeries. Results are now being analysed so service specifications can be finalised for phase two of the procurement. Considerable, similar feedback had already been gathered from people in Barne Barton, as part of the abortive procurement process in 2015.
- For St Barnabas, Hyde Park and Cumberland the brief was to try to understand what impact the loss of their surgery would have on individual patients and if there might be any other viable options than closure and dispersal of the registered list.

All patients registered at the affected practices will be receiving letters this week giving them the news of the decision made to close the surgeries and providing information on all the other GP practices in Plymouth. In addition there is a telephone number and email address where patients can contact our team at NHS England if they have questions or need help registering at another GP practice. With the support of the existing contract holder the most vulnerable patients will also be supported to move to a new GP Practice of their choice.

I can confirm that we were clear during the engagement process that NHS England wanted to listen to patients views, but recognise that sending out lists of alternative services at that point in the process could have been misconstrued as meaning a decision had been made before the results of the engagement were known.

7. ***Plans for the future of Primary Care services are considered at the Health and Wellbeing Board to check alignment against the Plymouth Plan (HWB Strategy)***

The GP Forward View is the blueprint for developing sustainable primary care in Plymouth. This means that, when commissioning primary care for Plymouth for the future, NHS England will work with partners such as the City Council to

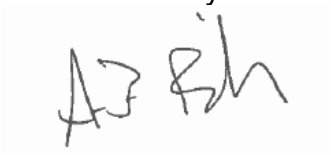
- Encourage innovative and extended services that offer maximum benefits for patients.
- Make best use of capacity and of good buildings that already exist.
- Develop GP services at a scale that can cope with the financial and workload

pressures.and tackle inequalities.

- Make best and fairest use of taxpayers' money.
- It will be helpful as we develop our plans, in combination with the CCG, for the future of primary care services to work with the Health and Wellbeing Board and ensure alignment against the Plymouth Plan (HWB Strategy).

I look forward to a continued close working.

Yours sincerely



Amanda Fisk
Director of Assurance and Delivery
NHS England South West (Devon, Cornwall and Isles of Scilly)

c.c. Julia Cory, Head of Primary Care, NHS England
Ross Jago, Plymouth City Council

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WELLBEING OVERVIEW SCRUTINY COMMITTE

Work Programme 2016-2017

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

For general enquiries relating to the Council's Scrutiny function, including this committee's work programme, please contact Helen Wright, Democratic Support Officer, on 01752 307903.

Date of meeting	Agenda item	Prioritisation Score	Reason for consideration	Responsible Officer
~~**20 July 2016**~~	~~Plymouth City Council Corporate Plan~~			
	~~Success Regime and Sustainable Transformation Plan~~			
	~~Integrated Commissioning Action Plans / Performance Scorecard~~			
	~~Integrated Fund monitoring Report~~		~~Standing Item~~	
~~**21 September 2016**~~	~~Integrated Fund monitoring Report~~		~~Standing Item~~	
	~~Integrated Commissioning Scorecard~~		~~Standing Item~~	
	~~Welcoming City Action Plan~~			
	~~Integrated Commissioning Aim: *Deliver and integrated education, health and care offer: ensure the delivery of integrated assessment and care planning*~~			
	~~*Community Item (if forthcoming)*~~			
23 November 2016	Integrated Fund monitoring Report		Standing Item	
	Integrated Commissioning Score Card		Standing Item	
	Sustainability and Transformation Plan			
	Community Item (if forthcoming)			
9 January 2017				
15 February 2017	Integrated Fund monitoring Report		Standing Item	
	Integrated Commissioning Score Card		Standing Item	
	Community Item (if forthcoming)			

Date of meeting	Agenda item	Prioritisation Score	Reason for consideration	Responsible Officer
5 April 2017	Integrated Fund monitoring Report		Standing Item	
	Integrated Commissioning Score Card			
	SEND Update			
	Community Item (if forthcoming)		Standing Item	
Items to be scheduled				
	CQC Inspection Results			
	Community Safety Partnership			
Select Committee Reviews				
November	Urgent Care			

SCRUTINY PRIORITISATION TOOL

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

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

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