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WELLBEING OVERVIEW AND SCRUTINY COMMITTEE

Wednesday 26 April 2017
3.00 pm
Warspite Room, Council House

Members:
Councillor Mrs Aspinall, Chair

Councillor James, Vice Chair

Councillors 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.

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Tracey Lee
Chief Executive

Wellbeing Overview and Scrutiny Committee

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. Chairs Urgent Business

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

4. Minutes (Pages 1 - 10)

To confirm the minutes of the meetings held on 25 January 2017 and 15 March 2017.

5. Integrated Fund Monitoring Report (Pages 11 - 26)

The Committee will receive the Integrated Fund Monitoring Report.

6. Integrated Commissioning Score Card (Pages 27 - 38)

The Committee will receive the Integrated Commissioning Score Card.

7. Update on GP Commissioning (Pages 39 - 44)

The Committee will receive an Update on GP Commissioning.

8. CQC Inspection Results (Pages 45 - 104)

The Committee will receive the CQC Inspection Results.

9. Tracking Resolutions (Pages 105 - 106)

The Committee will consider the tracking resolutions document.

10. Work Programme (Pages 107 - 108)

The Committee will receive the work programme.

Wellbeing Overview and Scrutiny Committee

Wednesday 25 January 2017

Present:

Councillor Mrs Aspinall, in the Chair.
Councillor James, Vice Chair.
Councillors Bowie, Mrs Bridgeman, Cook, Mrs Foster, Loveridge, Lowry (substitute for Councillor Dann), Dr Mahony, McDonald (substitute for Councillor Sparling), Tuffin and Tuohy.

Apologies for absence: Councillors Dann and Sparling.

Also in attendance: Pete Aley (Head Of Neighbourhood & Community Services), Dawn Aunger (Interim Joint Strategic Director Transformation and Change (Transformation)), Councillor Mrs Beer (Cabinet Member for Children and Young People), Alison Botham (Assistant Director for Children, Young People & Families), Councillor Bowyer (Leader of the Council), Councillor Mrs Bowyer (Cabinet Member for Health and Adult Social Care), Carole Burgoyne (Strategic Director for People), Councillor Downie (Cabinet Member for Safer and Stronger Communities), Matt Garrett (Head of Community Connections), Andrew Hardingham (Interim Joint Strategic Director for Transformation and Change, Finance), Ruth Harrell (Director of Public Health), Judith Harwood (Assistant Director for Education, Participation & Skills), Ross Jago (Lead Officer), Tracey Lee (Chief Executive), Craig McArdle (Director for Integrated Commissioning, NEW Devon CCG and Plymouth City Council), David Northey (Head of Integrated Finance), Giles Perritt (Assistant Chief Executive), Councillor Ricketts (Cabinet Member for Transport and Housing Delivery) and Lynn Young (Democratic Support Officer).

The meeting started at 3.00 pm and finished at 6.00 pm.

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

26. **Declarations of Interest**

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

27. **Chairs Urgent Business**

Councillor Mrs Aspinall advised members that Councillor Bowie was present in her capacity as Chair of the Place and Corporate Overview and Scrutiny Panel and had been invited to attend this meeting in that role.

28. **Budget Scrutiny**

Councillor Bowyer (Leader of the Council), Councillor Mrs Bowyer (Cabinet Member for Health and Adult Social Care), Carole Burgoyne (Strategic Director for People), Andrew Hardingham (Interim Joint Strategic Director for Transformation and Change (Finance)), David Northey (Head of Integrated Finance) along with senior officers presented the draft budget for 2017/18 which highlighted the following key areas –

(a) the Medium Term Financial Strategy (MTFS) had been approved by Council on 21 November 2016 and outlined measures to address the funding gap of £37 m over the next three years;

(b) the forecast budget gap for 2016-17 was £2.5 m, and it was acknowledged that some difficult decisions needed to be taken to address this gap;

(c) the Council had accepted a four year Revenue Support Grant (RSG) settlement from the Government which provided a level of certainty and would alleviate some budget pressure for future years;

(d) a modest increase in Council Tax was planned, however the increased cuts to Governments grants had exceeded the proposed increase, with the continuing demand for Council services such as Adult Social Care and Children's Social Care causing additional financial pressure;

(e) the Council faced a number of pressures to their budget (in addition to the loss of grants and funding) including –

- staff pension fund costs;
- significant demand for Council services;
- loss of the New Homes Bonus;
- pressure of the Living Wage;
- cost of the Apprenticeship Levy;
- cost of Housing Benefit Subsidy;

(f) the People Directorate recognised the complex and challenging financial circumstances they faced, and were trying to be innovative with the resources available to them.

The key areas of questioning from Members related to –

- the number of children currently in care, in particular those in residential care, and the measures being taken to reduce this number;

- the source of additional funding to support a higher number than anticipated of children in residential care;

- the level of support (both financial and training) offered to the Council's foster carers;

- the budget for Children, Young People and Families for the next financial year;

- what steps the Council were taking to retain the city's 'Dementia Friendly' status;

- the training opportunities available within the care sector in Plymouth;

- the number of staff who were currently absent due to long-term sickness, and the steps being taken to address this;

- the action being taken to deal with delayed discharges;

- the steps being taken by Public Health to improve the health of Plymouth's residents, particularly in light of budget cuts;

- the number of rough sleepers in the city and the steps being taken to address the issue of homelessness;

- the number of 16-17 year olds housed in bed and breakfast for a period longer than six weeks;

- what help was being offed to help educational organisations within the city with the apprenticeship levy;

- how schools were using the Pupil Premium;

- whether school governors were being fully supported;

- whether the risks associated with the need to make efficiency savings were known;

- the projected reduction in the workforce.

Agreed to –

(1) note the draft budget;

(2) express the Committee's significant concern on whether a sustainable, quality service and savings can be delivered in 2017/18 given rising demand and chronic underfunding of services by national government. As such recommend to Council to call upon national government to deliver a fair and sustainable settlement for the future of local social care.

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Wellbeing Overview and Scrutiny Committee

Wednesday 15 March 2017

Present:

Councillor Mrs Aspinall, in the Chair.
Councillor James, Vice Chair.
Councillors Mrs Bridgeman, Cook, Dann, Mrs Foster, Loveridge, McDonald (substitute for Councillor Tuffin), Sparling and Tuohy.

Apologies for absence: Councillors Dr Mahony and Tuffin (Councillor McDonald substituting)

Also in attendance: Councillor Darcy (Cabinet Member for Finance/ ICT), Councillor Mrs Beer (Cabinet Member for Children and Young People), Alison Botham (Assistant Director for Children, Young People & Families), Judith Harwood (Assistant Director for Education, Participation & Skills), David Northey (Head of Integrated Finance), Liz Cahill (Strategic Commissioning Manager), Emma Crowther (Commissioning Officer), Tracy Clasby (Livewell South West), Sarah Goodman (Livewell South West), Dave McCawley (CCG), Ross Jago (Lead Officer) and Helen Rickman (Democratic Advisor).

The meeting started at 3.00 pm and finished at 5.34 pm.

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

1. **Declarations of Interest**

The following declaration of interest was made by a councillor in accordance with the code of conduct in respect of items under consideration at the meeting -

Name	Minute Number	Reason	Interest
Councillor Mrs Foster	4	Member of the Adoption Panel	Personal

2. **Chairs Urgent Business**

Under this item the Chair advised Members that the next business meeting scheduled for 5 April 2017 had been delayed for two weeks to 19 April 2017 in order to receive a final update on the situation surrounding GP surgeries and the 40% of patients that had not yet re-registered.

3. **Minutes**

It was agreed that the minutes of the meeting held on 23 November 2016 were a true and accurate record.

4. **Children Services Budget and School Funding Reforms**

The Committee received the Children Services Budget and School Funding Reforms report presented by Councillor Darcy (Cabinet Member for Finance/ ICT), Councillor Mrs Beer (Cabinet Member for Children and Young People), Alison Botham (Assistant Director for Children, Young People & Families), Judith Harwood (Assistant Director for Education, Participation & Skills) and David Northey (Head of Integrated Finance).

The Panel heard that:

a) a full breakdown of the £43.5m revenue budget was provided to Members in the agenda paperwork; the budget was on target to deliver savings;

b) the Government had given permission to Local Authorities to charge schools for the Education Services Grant funding gap; officers were currently working with the Schools' Forum to discuss partnership working, specifically regarding statutory services;

c) both the Cabinet Member for Children and Young People and Council Officers were lobbying Government regarding better funding for Plymouth schools; Plymouth had received increased funding amounting to £0.058m whereas Coventry had gained £3.6m;

d) legacy pension costs were a significant portion of the school funding Education Services Grant; this pressure was increased in 1998 when the Council became a unitary authority and some schools within the area allowed headteachers and staff to take early retirement.

The Panel agreed that:

1. a cross party motion on notice regarding school funding (high needs block) would be submitted to the 3 July 2017 City Council meeting;

2. a five year projection of figures relating to the legacy pension costs associated with the schools funding budget would be provided to Members once available;

3. a performance review report relating to Children's Social Care would be submitted to the first meeting of the municipal year 2017/18 specifically including the management of contracts.

5. **Residential Placements - Supply and Quality of Provision**

The Committee received the Residential Placements – Supply and Quality of Provision report presented by Councillor Mrs Beer (Cabinet Member for Children and Young People), Liz Cahill (Strategic Commissioning Manager) and Emma Crowther (Commissioning Officer).

The Panel heard that:

a) 28 children were placed in residential placement providers in care; of the 28 placements Ofsted rated 20 as good/ outstanding, four had not been graded as they were new provision, three required improvement and one was inadequate. Officers worked closely with all providers and were supporting all to maintain their quality of provision or improve;

b) for several years Officers had been working hard to increase the number and quality of residential provision in Plymouth whilst focusing on a model of care based on a family home; each provider had a car to enable children to meet friends, allow parents to visit and have friends over for tea putting great emphasis on normal life;

c) a small number of Plymouth children requiring a residential placement were unable to be placed locally due to a variety of reasons however Officers worked closely with neighbouring authorities to share the scrutiny of placements;

d) there had been an uplift in the placement budget ensuring that the package of care provided for children was right for their needs.

Members congratulated Officers for their hard work surrounding residential care and commended the report.

6. **Update Following Child Sexual Exploitation Review**

The Committee received an update following the Child Sexual Exploitation (CSE) Review presented by Councillor Mrs Beer (Cabinet Member for Children and Young People).

Members were advised that –

a) the recommendations from the review had been raised with the Police and Crime Commissioner and an advocacy service to support victims had been set up;

b) young people in Plymouth that had been subject to CSE were currently required to travel to Truro or Exeter to be assessed; this was considered unacceptable and work was ongoing to try and find suitable premises in Plymouth;

c) a National CSE Awareness Day was scheduled for 18 March highlighting issues

surrounding CSE and encouraging everyone to unite against it.

It was agreed that –

1. regular updates from the Safeguarding Assurance Board would be provided to Members as well as confirmation that these meetings were being held quarterly;

2. Members of the Wellbeing Overview and Scrutiny Committee supported the Cabinet Member and Officers regarding the lack of an assessment centre for CSE in Plymouth;

3. a progress report on actions required of current Cabinet Members would be provided to Members at the next committee meeting.

7. **CAMHS update**

The Committee received an update on the Children and Adolescence Mental Health Service (CAMHS) from Liz Cahill (Strategic Commissioning Manager), Councillor Mrs Beer (Cabinet Member for Children and Young People), Tracy Clasby (Livewell South West), Sarah Goodman (Livewell South West) and Dave McCawley (CCG).

The Panel was advised that:

a) four key priorities included in the CAMHS transformation submission included crisis response, early intervention, children in care and specific service response; focus had shifted towards prevention and early intervention;

b) the third sector, schools and Livewell South West worked together to provide a variety of support to young people accessing the service;

c) some young people were using self-harm as a form of communicating distress and a lot of work from a variety of sectors was required the support these young people manage stress in a different way.

The Panel agreed that:

1. the number of children recorded as self-harming by the acute service team would be provided to Members as well as waiting time figures;

2. the number of children self-harming in Plymouth compared to the surrounding area would be provided to Members;

3. a Councillors guide to adolescent services and the process for dealing with CAMHS would be written and provided to Members to aid with relevant casework;

4. the number of children recorded as accessing treatment would be provided to Members;

5. Members would be provided with the Early Help Assessment Tool which enabled the holistic assessment of the needs of children.

8. **Tracking Resolutions**

Ross Jago (Lead Officer) advised Members that tracking resolutions listed on document had been completed.

9. **Work Programme**

Members agreed for the following items to be included on the work programme:

- end of life care (select committee review);
- transition of young people services to adults (select committee review);
- GP procurement (select committee review);
- update on Childrens and Adults safeguarding;
- Healthwatch.

The Chair advised Members that the 5 April 2017 meeting had been deferred to 19 April 2017.

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Northern, Eastern and Western Devon Clinical Commissioning Group

Plymouth Integrated Fund
Finance Report – Month 11 2016/17

Introduction

This report sets out the forecast financial performance of the Plymouth Integrated Fund for the month of February 2017 (month 11).

The report is in several sections.

- The first section details the performance of the Integrated Fund, including the section 75 risk share arrangements.
- The second section details the financial performance of the Western Planning and Delivery Unit (PDU) of the Clinical Commissioning Group (CCG).
- Appendix 1 which shows the Plymouth Integrated Fund performance and risk share.
- Appendix 2 which shows the PDU managed contracts financial performance.
- Appendix 3 which is a glossary of terms used in the report.

In summary, the Integrated Fund is forecasting to deliver against budget with a marginal risk share impact.

SECTION 1 – PLYMOUTH INTEGRATED FUND

Plymouth Integrated Fund Finance Position

The summarised financial performance of the Integrated Fund for both the CCG and the City Council is set out in **Appendix 1**. Both the Health and Local Authority elements of the Integrated Fund are forecasting to be overspent against budget by year end. There are risks in delivery of this position for both organisations.

The impact of the risk share in the year remains minimal, but the forecast at month 11 has exceeded the £50k tolerance and is now reflected at £88k. This is because there is an overspend forecast in each element of the fund and this triggers an adjustment relative to the risk share percentages.

Health Contribution to the Fund

Overall the Health contribution to the fund is forecast to be overspent against budget at £0.4m. Within this there are some pressures as identified, and the forecast includes an assumption about further cost recovery actions and agreements in the latter part of the year.

Acute Care

The CCG is forecasting an underspend of £0.4m for acute care for the Integrated Fund. This has improved slightly in month.

Community Services

This position has improved by £0.2m since last month, and reflects the mitigation of the risk in capital resources that was previously identified.

Placements

The overspend, as in previous months, is due to higher than planned numbers of clients and costs of care packages. The position has remained consistent and is forecast to be £0.6m over budget.

System Plan Agreement

This adjustment reflects the issue of the CCG budget having been set on the original plan of £29.2m deficit, as compared to the agreed system plan outturn of £42.2m. This results from the lengthy process to finalise the plan with the regulators, as described in previous reports, and should not impact on the risk share agreement.

Local Authority Contribution to the Fund

Children, Young People and Families

The Children Young People and Families Service are reporting a budget pressure of £0.306m a reduction of (£0.245m) in the month. The reduction is as a result of additional vacancy savings (£0.104m), reduced costs of legal agents (£0.015m) and a reduction in the cost of looked after children's placements (£0.126m).

The Service continues to face unprecedented pressures; care applications are up and the service are struggling to purchase cost effective placements to adequately meet demand. In the last 11 months, Plymouth has observed an increase in the number of children in care of 5.4%. The continued increase in numbers of children in care is in line with national and regional trends.

There are risks that continue to require close monitoring and management including the lack of availability of the right in-house foster care placements creating overuse of IFA's and the use of Residential Placements due to lack of foster care placement

sufficiency across the Peninsula. In addition, Court ordered spend continues on Parent & Child Assessment placements and there are still a small number of individual packages of care at considerably higher cost due to the needs of the young person.

The overall number of children in care at the end of February stands at 408 an increase of three in the month.

Strategic Co-operative Commissioning

The Strategic Co-operative Commissioning (SCC) service is now reporting an overspend on budget of £0.200m at month 11 – a decrease of (£0.247m) from last month. The main reasons for the change to the forecast are:

- (£0.154m) – Additional income from client contributions;
- (£0.136m) – A further reduction of Direct Payment client numbers, as well as additional clawback;
- (£0.129m) – A reduction to some of the commissioned contracts, for example Carers Support and Telecare.
- £0.144k – Movement in other Care Packages

As part of the transformation project for 2016/17, the SCC budget is making savings of over £5m (in order to contribute to the £9.214m Directorate target) with the activities and actions that will drive delivery forming part of the transformation programme. These have been achieved via savings around reduced client numbers, reviews of high cost packages and contracts.

Education, Participation and Skills

Education Participation and Skills are reporting a breakeven position at the end of month 11.

During 2016/17 the Education Participation and Skills budget had to make savings of £1.269m (in order to contribute to the £9.214m Directorate target) with activities and actions that will drive delivery forming part of the transformation programme. This has been achieved this year through EVRS, maximisation of grants and the transformation of services.

Community Connections

Reported savings have increased by (£0.033m) to (£0.081m) as a result of further staff savings through recruitment to a new structure and additional income recharging staff to grant projects.

Demand for emergency accommodation has increased from January to an average of 72 placements per night, however this is within the forecast range of 75 set last month.

Action is ongoing to limit the overall cost pressure through lower placements and prevention work.

Public Health

The Public Health department is on track to achieve a balanced budget and will continue to prepare plans to achieve the further reductions to the ring fenced grant in 2017/18.

SECTION 2 – WESTERN PDU MANAGED CONTRACTS

Context / CCG Wide Financial Performance at Month 11

This report sets out the financial performance of the CCG to the end of February 2017 (Month 11 management accounts).

The financial plan for 2016/17 is not yet approved by NHS England but negotiations are nearing conclusion with the national Arm's Length Bodies of the CCG share of the system wide control total negotiated between the 4 main providers within the Devon footprint. The CCG budget has therefore been set on the draft financial plan to deliver an in year deficit of £29m. In addition to this the brought forward deficit from 2013/14 to 2015/16 of £78.4m is repaid bringing the CCG to a planned cumulative deficit position of £107.4m.

Although the month 11 budget position remains in line with previous months, the forecast outturn at month 11 has been reported in line with the system wide control total, this is a departure from previous months as the CCG has been instructed by NHS England to reflect the full position rather than just that of the CCG as had been the case last month. This is a deficit position of £42.1m for the year following the release of the non-recurrent headroom reserve and a cumulative deficit of £120.5m.

Month 11 Summary financial position

	Planned Deficit £'000	Actual Deficit £'000	Variance £'000	Movement
Year to date in year position	25,747	37,806	12,059	1,097
B/fwd. deficit	71,854	71,854	0	0
Total In year Position	**97,601**	**109,660**	**12,059**	**1,097**
Forecast in year deficit	29,006	42,161	13,155	0
B/Fwd. deficit	78,386	78,386	0	0
Total Forecast Deficit	**107,392**	**120,547**	**13,155**	**0**

Year to date

The year to date financial position of the CCG reflects the move to the system wide gap as described above. This results in an in-year deficit of £37.8m (prior to the repayment of brought forwards deficits). Within the commissioning budgets there are some under and over spends which are detailed in the report below and significantly the year to date impact of the FNC national price change and continued growth in Independent Patient Placement (IPP) spend.

Forecast

The forecast outturn of the CCG is in line with the full system wide gap now falling to the CCG, as agreed by NHS England this month. In addition, the CCG has had to absorb cost pressures, the material issue being £3.5m due to the impact of FNC and IPP as described above. This has been offset through the partial release of contingency reserves and benefit within the CHC forecast in the forecast to meet the planned level of in year deficit.

System Wide Savings Plan

The CCG is reporting 58% achievement of the net CCG share of the System Wide Savings plan as at month 11 with a forecast achievement of 63%. This is following alignment with the system wide savings plan and the release of the system wide gap budget offset by the headroom and increased deficit.

Risk

The CCG financial position shows an improvement from month 9. The only remaining risk is £0.9m relating to capital funding but this is fully mitigated by expected capital from NHS England.

Western PDU Finance Position

Introduction

The total budget now stands at £317.6m which reflects of the system wide and individual NHS organisational control totals as described previously.

The Locality is currently forecasting an increased underspend against the budgets for the contracts that are managed in the West when compared to last month. This is a net position and includes some overspending and some underspending contracts. This represents an improvement from last month of £0.2m, and is mainly linked to an improvement in the Livewell Southwest position. The most significant variances to plan include:

- Acute Trusts. There has been a very limited movement in the Acute Trust forecasts in month 11 with the only movement being a £0.1m improvement in the forecast for South Devon Healthcare FT contract due to lower activity than expected.

- Community Contracts. The key risk identified previously for capital in the Livewell Southwest contract has now been mitigated, and there are no significant variances reported for Community and other categories.

The detailed analysis for the PDU is included at **Appendix 2**.

Acute Care Commissioned Services

Plymouth Hospitals NHS Trust

As explained in the context above, at the time of writing, the final contract value for Plymouth Hospitals NHS Trust is unconfirmed and the contract unsigned. The contract performance will still be reported on and scrutinised at the same degree of granularity and as such detail can be provided in this report.

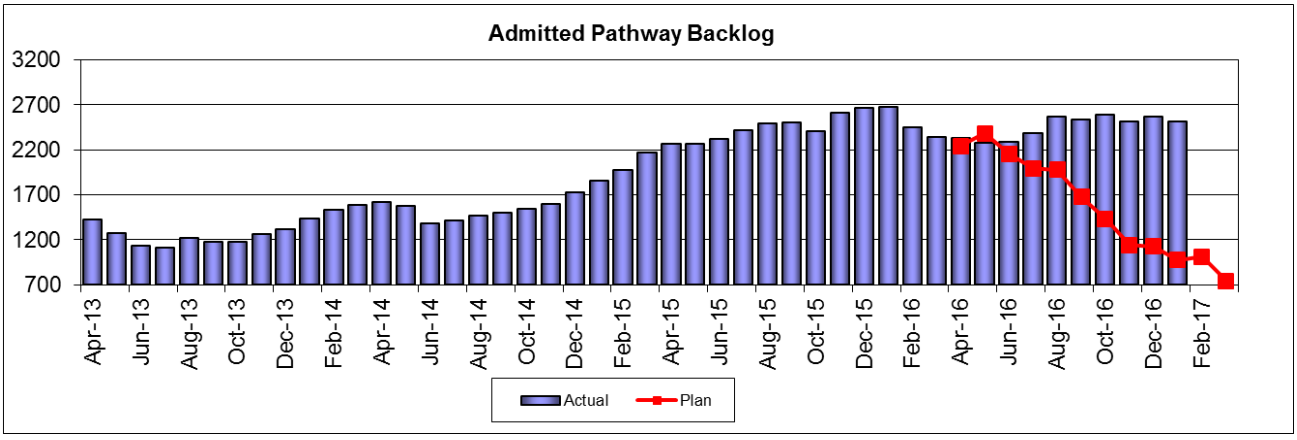
At this stage the budget allocation and forecast spend reflect the anticipated final contract value of £176.7m.

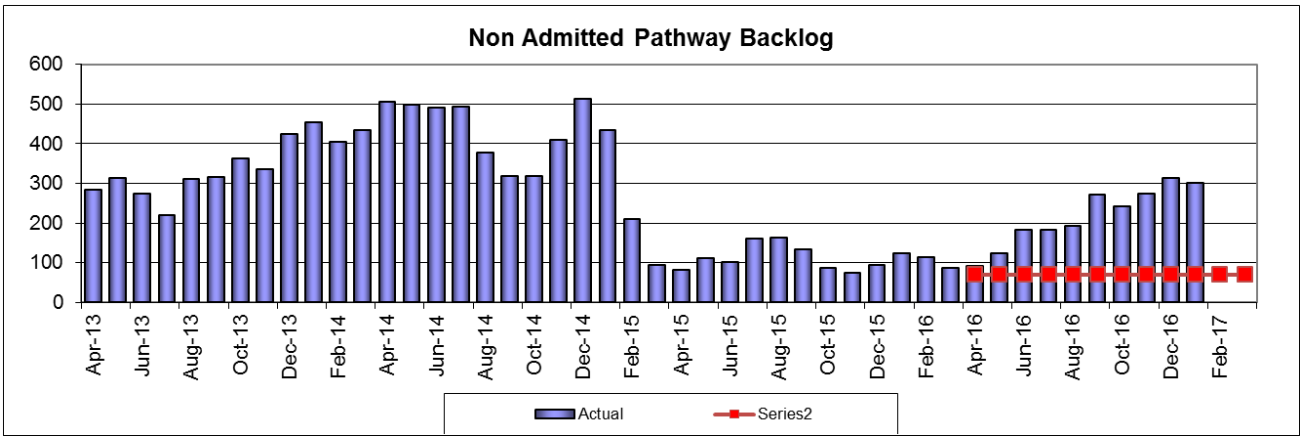
Capacity Constraint

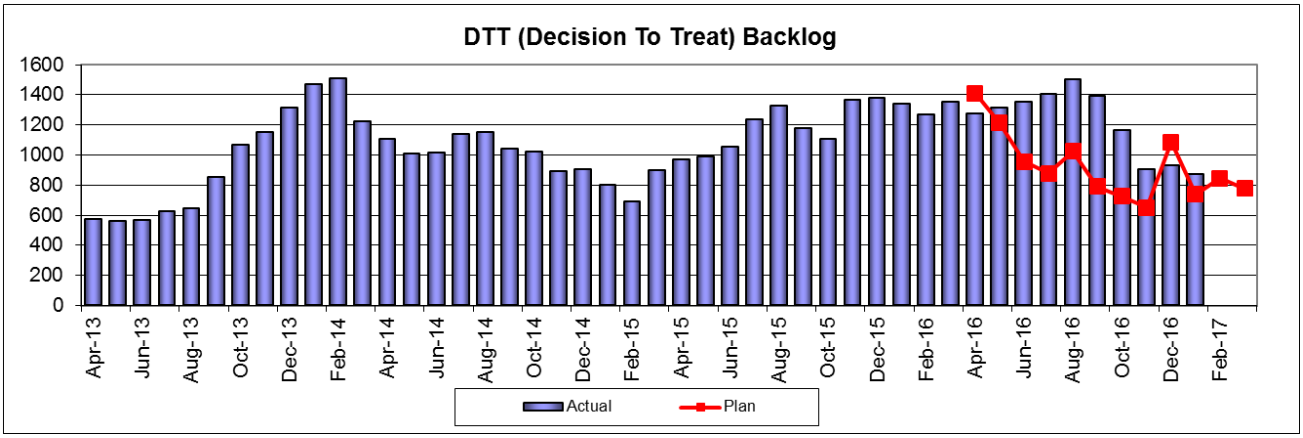
There are a number of specialities that the Trust has been unable to provide sufficient capacity to deliver RTT and match the demand in the system. The agreed level of capacity shortfall has been excluded from the contract, and the locality has been working with the Trust and other providers to bring appropriate levels of additional capacity online. This includes Care UK opening a 3rd theatre whilst they have already started providing General Surgery and Endoscopy, whilst PHNT have recently refurbished and increased the throughput of Tavistock theatre and have plans to bring modular theatres online in the coming months.

RTT Compliance

Performance to month 10 is summarised in the following tables.







Contract Performance

The month 10 performance information showed a year to date over performance against the contract plan of £0.44m.

The main reasons for the contractual underperformance are summarised below.

2016/17 M10	Planned Spend	Actual Spend	Variance	Variance Activity	Variance Spend
	£000s	£000s	£000s		
Elective	31,765	30,483	- 1,282	-3.8%	-4.0%
Non Elective	49,587	50,331	744	1.8%	1.5%
A&E	7,232	7,431	199	4.0%	2.8%
Outpatients	25,508	26,445	937	4.2%	3.7%
Excluded Services	31,299	31,139	- 160		-0.5%
Penalties			-		
CQUIN	3,356	3,361	5		
Contract Adjustments			-		
Total	148,747	149,190	443		0.3%

The **Elective** position is £1.3m (4.0%) behind plan from a financial perspective but 3.8% behind plan in overall activity terms. The main contributors to this position are under performances within Upper GI surgery, Vascular Surgery, Orthopaedics, Cardiology, Clinical Oncology, Colorectal Surgery, Dermatology and General Surgery where the Junior Doctor Strikes, theatre cancellations and bed availability

have caused a reduction in capacity. The Trust have recently ceased to outsource activity to Care UK which has also resulted in a reduction of available capacity within elective, particularly in Orthopaedics. This position is marginally offset by over performances in Clinical Haematology and Endoscopy.

Non Elective has over performed overall, accountable to significant over performance demonstrated in Acute Medicine, Colorectal Surgery, General Medicine, Hepatobiliary & Pancreatic Surgery and Paediatrics. The extent of over performance witnessed is mitigated by material under performance within Diabetic Medicine, Geriatric Medicine, Nephrology and Upper GI Surgery. The year to date over performance is £0.74m which is over plan by 1.5% in financial terms and 1.8% in terms of activity.

In **Accident and Emergency** the Trust have seen 2,359 (4.0%) more patients than planned for so far this year. The majority of this over performance has occurred in month 7 and 8 and continued into months 9 and 10.

The overall position of an over performance of £0.94m (3.7%) on **Outpatients** masks a wide variation in performance at individual specialty level with over performances in ENT, Paediatrics, Dermatology, Colorectal Surgery, Orthopaedics and most significantly Ophthalmology. Clinical Haematology, Endoscopy and Pain Management, Trauma and Neurology are behind the year to date plan. Within this position there is also variation in the type of outpatient attendance where, first attendances account for £108k and procedures £886k. Follow ups have demonstrated an under performance amounting to £65k.

Referral Information

Referral information for month 10 of 2016/17 showed an overall decrease of 3.5% compared to the same period last year, with GP referrals being 4.4% below the equivalent 2015/16 volumes.

PHNT	Referral Source	2015/16	2016/17	Variance	%
Externally Generated	GP	47,196	45,108	- 2,088	-4.4%
	Dentist	140	155	15	10.7%
	Sub Total	47,336	45,263	- 2,073	-4.4%
Internally Generated	Consultant	13,376	14,034	658	4.9%
	Other	6,905	6,121	- 784	-11.4%
	A&E	2,980	2,743	- 237	-8.0%
	Sub Total	23,261	22,898	- 363	-1.6%
	Grand Total	70,597	68,161	- 2,436	-3.5%

The source data in this report is taken from the Provider data supplied under schedule 6 of the contract except where the Provider is stated as ‘Other’. Other Provider data is taken from DRSS Bookings.

Filters are applied to the Provider data to remove any non-consultant led activity, maternity activity and specialties which are not year on year comparable. NHS

England (including Specialised) activity is also excluded to provide a NEW Devon CCG view.

Performance Measures

The Trust is appraised against a number of nationally and locally defined key performance indicators. A summary of the key measures is included below:

PHNT Month 10 key performance			
Measure	**Target**	**This month**	**YTD**
RTT - Percentage seen within 18 weeks - admitted pathways	90%	69.5%	
RTT - Waits over 52 weeks	0	92	
Diagnostics - Percentage of patients waiting over 6 weeks - 15 key tests	<1%	6.8%	
Cancer - Percentage seen within 2 weeks - urgent referral to first seen	93%	92.1%	93.9%
Cancer - Percentage treated within 62 days - urgent referral to first definitive treatment	85%	75.0%	79.6%
Cancer - Percentage treated within 31 days - decision to treat to first definitive treatment	96%	96.2%	95.5%
Ambulance handovers - Number of handovers over 30 minutes	0	161	842
Ambulance handovers - Number of handovers over 60 minutes	0	7	39
A&E - Percentage of attendances seen within 4 hours	95%	79.5%	84.2%
Delayed transfers of care (acute) - bed days		1,682	9,500
Clostridium difficile - Number of hospital infections (avoidable)	35	0	1
MRSA - Number of hospital infections	0	1	2
Cancelled operations - patients to be offered another binding date within 28 days	0	26	248
Cancelled operations - urgent operations cancelled a second time	0	0	0

South Devon Healthcare Foundation Trust

The 2016/17 South Devon Healthcare Foundation Trust contract value for acute services has been set at £5.24m on a variable PbR basis, with a further £0.92m fixed contract for community services.

At month 10 the contract is over performing by £12k, this demonstrates a decrease in overspend of £47k compared to the reported £59k overspend in month 9. This is made up of underspends within elective activity (£132k) and excluded devices (£21k) and overspends within non elective admissions (£48k) and high cost drugs (£75k).

The contract also has a QIPP target of £147k which is being reported as undelivered and so represents a further £123k over performance so far this year.

Independent Sector

The IS performance remains in-line with the previous month.

London Trusts

There remain no significant movements within the London trusts. Significant over-performance due to high cost critical care patients remains at Guys and the Royal Brompton.

Livewell Southwest

The Livewell Southwest (LSW) Contract is blocked, with a single variable service (the Minor Injuries Unit). LSW produce a monthly performance/finance databook which allows both parties to shadow monitor the block contract and review key performance metrics.

We are currently validating activity data to understand the underlying activity position within this contract.

Care Co-ordination Team

Unfortunately an increase in referrals has resulted the PDU to amend its forecast underspend to a breakeven position. We are continuing to work with providers to reduce the overall number of spot purchased beds.

Primary Care Enhanced Services

Whilst the budgets and expenditure are reported in the Western PDU report, this is to ensure that all lines of expenditure for the CCG are reported in a PDU and there is integrity to the reports produced. There is, however, a separate governance structure for Enhanced Services that sits outside and alongside the two PDU structures to ensure there is segregation of decision making in primary care investments. The forecast expenditure is in line with budgets.

QIPP Savings Delivery

NORTHERN, EASTERN AND WESTERN DEVON CLINICAL COMMISSIONING GROUP

2016/17 FINANCE BOARD REPORT

FOR THE PERIOD FROM 01 APRIL 2016 TO 28 FEBRUARY 2017

Month 11 February	Year To Date			Current Year Forecast		
	Budget	Actual	Variance Adv / (Fav)	Budget	Forecast	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's	£000's
SAVINGS LEDGER REPORT						
NHS Royal Devon & Exeter Foundation Trust	-1,868	-861	1,007	-2,442	-1,657	785
NHS Plymouth Hospitals NHS Trust	-3,696	-1,419	2,277	-4,516	-2,986	1,530
NHS Northern Devon Healthcare Trust	-1,446	-728	718	-1,720	-1,254	466
Northern Devon Healthcare Community	-	-	-	-	-	-
NHS South Devon Healthcare Foundation Trust	-	-	-	-	-	-
NHS Taunton and Somerset	-	-	-	-	-	-
IS Nuffield Plymouth	-	0	0	-	-	-
Nuffield Taunton (NCA)	-	-	-	-	-	-
IS Nuffield Exeter	0	-	-0	-	-	-
Independent Sector (UKSH)	0	-	-0	-	-	-
Prescribing	-3,581	-3,630	-49	-3,995	-4,245	-250
Continuing Healthcare	-8,637	-9,893	-1,256	-10,000	-12,000	-2,000
Section 117	-	-	-	-	-	-
Individual Patient Placements Adult	-412	-460	-48	-449	-502	-53
Other Community Services	-1,192	-1,192	-0	-1,300	-1,300	-
Care Co-ordination Team	-474	-487	-13	-531	-531	-
Pay	-	-	-	-	-	-
System Gap	-17,772	-	17,772	-19,389	-	19,389
GROSS SAVINGS	-39,077	-18,670	20,407	-44,342	-24,475	19,867
TOTAL INVESTMENT	-	-	-	-	-0	-0
Contractualisation of system position	-9,924	-7,527	2,397	-10,826	-8,211	2,615
NET SAVINGS	-49,001	-26,197	22,804	-55,168	-32,686	22,482
IHAM Growth Miitgation	-12,833	-12,833	-	-14,000	-14,000	-
NHS England monitored QIPP	-61,834	-39,030	22,804	-69,168	-46,686	22,482

System wide savings plan

The above savings report has been aligned to the system wide savings plan with the balance of the system gap being held within the system gap reserve. In order to fund the opening system budget positions, the System leaders agreed to utilise the non-recurrent RTT reserve and the system investment reserve in the opening position. The commitments to reach the opening position over drew these reserves by £4.8m.

The stretch target required to recreate system reserves has now been mitigated through CCG and provider positions. The above year to date position is aligned to the system wide plan savings report for the CCG element of the plan. Overall the CCG is reporting 58% delivery of plan with 63% delivery forecast by yearend.

During month 11, the CCG share of the system wide savings plan has increased to £24.48m from £23.66m. This pressure is mitigated by an increase in the savings inherent in the contractualised block contract arrangements.

Also included in the contractualised savings are any additional benefits of the block contracts and also the fact that providers have absorbed the investment expenditure required for delivery. As part of the monitoring of the system wide savings plan, each Senior Responsible Officer (SRO) for the 6 work streams is required to sign off the forecast of the savings they are responsible for as a system. The CCG element of savings will be driven by and aligned to the SRO forecast.

Conclusion

In summary, the forecast outturn position for the Planning and Delivery Unit is underspent against plan. This incorporates the impact of the Integrated Fund, for which the risk share forecast is currently zero.

Ben Chilcott
Chief Finance Officer, Western PDU

David Northey
Head of Integrated Finance, PCC

APPENDIX 1

PLYMOUTH INTEGRATED FUND PERFORMANCE AND RISK SHARE

NORTHERN, EASTERN AND WESTERN DEVON CLINICAL COMMISSIONING GROUP

PLYMOUTH INTEGRATED FUND

2016/17 FINANCE BOARD REPORT

FOR THE PERIOD FROM 01 APRIL 2016 TO 28 FEBRUARY 2017

Month 11 February	Year to Date			Forecast		
	Budget	Actual	Variance Adv / (Fav)	Budget	Actual	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's	£000's
CCG COMMISSIONED SERVICES						
Acute	157,031	156,523	-508	171,039	170,596	-443
Placements	38,517	38,926	408	41,786	42,384	598
Community & Non Acute	69,367	69,159	-208	75,679	75,820	141
Mental Health Services	1,150	1,160	9	1,255	1,223	-32
Other Commissioned Services	13,205	12,558	-647	14,344	13,701	-643
Primary Care	44,384	43,317	-1,067	48,353	48,124	-230
Subtotal	323,654	321,642	-2,012	352,456	351,847	-609
Running Costs & Technical/Risk	-2,704	3,220	5,923	-69	6,498	6,568
System Plan Agreement				5,340		-5,340
CCG Net Operating Expenditure	320,951	324,862	3,911	357,727	358,346	619
Risk Share					88	88
CCG Net Operating Expenditure (after Risk Share)	320,951	324,862	3,911	357,727	358,434	707
PCC COMMISSIONED SERVICES						
Children, Young People & Families	31,304	31,585	281	34,150	34,456	306
Co-operative Commissioning & Adult Social Care	69,445	69,628	183	75,758	75,958	200
Education Participation and Skills	9,197	9,197	-	10,033	10,033	-
Community Connections	2,901	2,827	-74	3,165	3,084	-81
Subtotal	112,847	113,237	390	123,106	123,531	425
Public Health Commissioning	13,346	13,346	-	14,559	14,559	-
Recovery Plans in Development						-
PCC Net Operating Expenditure	126,193	126,583	390	137,665	138,090	425
Risk Share					-88	-88
PCC Net Operating Expenditure (after Risk Share)	126,193	126,583	390	137,665	138,002	337
Combined Integrated Fund	447,144	451,444	4,301	495,392	496,436	1,044

APPENDIX 2

PDU MANAGED CONTRACTS FINANCIAL PERFORMANCE

NORTHERN, EASTERN AND WESTERN DEVON CLINICAL COMMISSIONING GROUP

2016/17 FINANCE BOARD REPORT

FOR THE PERIOD FROM 01 APRIL 2016 TO 28 FEBRUARY 2017

Month 11 February	Year To Date			Current Year Forecast		
	Budget	Actual	Variance Adv / (Fav)	Budget	Forecast	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's	£000's
ACUTE CARE						
NHS Plymouth Hospitals NHS Trust	163,562	163,341	-221	178,002	177,761	-241
NHS South Devon Healthcare Foundation Trust	5,808	5,954	146	6,353	6,495	142
NHS London Contracts	1,483	1,833	350	1,623	1,842	219
NHS Imperial London	0	-	-0	0	-	-0
Non Contracted Activity (NCA's)	8,056	7,097	-960	8,813	7,742	-1,071
Independent Sector	12,546	12,194	-352	13,721	13,342	-379
Other Acute	-	17	17	-	32	32
Subtotal	191,456	190,435	-1,021	208,512	207,213	-1,299
COMMUNITY & NON ACUTE						
Livew ell Southw est	67,902	67,681	-221	74,075	73,834	-241
GPw SI's (incl Sentinel, Beacon etc)	1,617	1,657	40	1,764	1,808	44
Community Equipment	594	587	-7	648	640	-8
Ultrasound (Sonarcare)	234	214	-21	256	245	-11
Reablement	1,391	1,376	-15	1,517	1,500	-17
Other Community Services	235	234	-1	256	255	-1
Plymouth Integrated Fund - Risk Share	1	-89	-90	1	-	-1
Better Care Fund_Plymouth CC	7,384	7,378	-5	8,055	8,048	-7
Subtotal	79,357	79,038	-319	86,572	86,331	-241
MENTAL HEALTH SERVICES						
Mental Health Contracts	23	23	-	25	25	-0
Other Mental Health	912	909	-3	994	990	-4
Subtotal	935	932	-3	1,020	1,015	-4
OTHER COMMISSIONED SERVICES						
Stroke Association	140	146	6	153	159	6
Hospices	2,456	2,332	-124	2,679	2,551	-128
Care Co-ordination Team	7,064	7,064	0	7,692	7,692	0
Patient Transport Services	385	509	123	420	554	134
Wheelchairs Western Locality	1,970	1,720	-251	2,150	1,790	-360
Commissioning Schemes	175	178	3	191	191	-0
All Other	412	327	-85	449	338	-111
Subtotal	12,602	12,276	-326	13,734	13,275	-459
PRIMARY CARE						
Enhanced Services	6,942	6,942	-0	7,573	7,573	-
Other Primary Care	159	159	-	173	173	-
Subtotal	7,100	7,100	-0	7,746	7,746	-
TOTAL COMMISSIONED SERVICES	291,450	289,781	-1,669	317,583	315,580	-2,003

APPENDIX 3
GLOSSARY OF TERMS

PCC - Plymouth City Council

NEW Devon CCG – Northern, Eastern, Western Devon Clinical Commissioning Group

CYPF – Children, Young People & Families

SCC – Strategic Cooperative Commissioning

EPS – Education, Participation & Skills

CC – Community Connections

FNC – Funded Nursing Care

IPP – Individual Patient Placement

CHC – Continuing Health Care

NHSE – National Health Service England

PbR – Payment by Results

QIPP —Quality, Innovation, Productivity & Prevention

CCRT – Care Co-ordination Response Team

RTT – Referral to Treatment

PDU – Planning & Delivery Unit

PHNT – Plymouth Hospitals NHS Trust

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INTEGRATED HEALTH & WELLBEING

SYSTEM PERFORMANCE SCORECARD

APRIL 2017

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

Referral to treatment – Percentage seen within 18 weeks - Incomplete pathways – Increasing trend

Performance against the 18-week referral to treatment waiting has improved in quarter 3 (84.5% in December compared to 83.6% in September). Plymouth Hospitals NHS Trust is not achieving the 18-week referral to treatment standard. There have been capacity issues in a number of specialties in Plymouth Hospitals NHS Trust and referral reductions haven't been a large as planned. Additional capacity has been made available in recent months which should ease the pressure but the target is not expected to be achieved in 2017/18.

Accident and Emergency – 4 hour wait – Decreasing trend

Plymouth Hospitals NHS Trust is not achieving the 4hr wait in A&E target. This is mainly due to demand pressures including an increase in A&E attendances of 3.8% compared to the previous year. Plans are in place to achieve the target by Q4 2017/18.

Estimated diagnosis rates for dementia – Static trend

At the end of January 2017 the dementia diagnosis rate remains relatively static at 59%, compared to 60% at the end of quarter 3. The dementia diagnosis rate remains below the national target. The CCG (Clinical Commissioning Group) has raised concerns with NHS England with the expected number of people with dementia in our population (this may affect the calculated diagnosis rate). However, the CCG is also looking to work more closely with primary care to improve the pathway.

Number of carers receiving a statutory Carers Assessment – Reducing trend

The number of carers assessments completed fell in quarters 3 and 4 (193 and 191 respectively down from 293). This reduction is due to an increase in the number of carer 'reviews' undertaken, as large numbers of carers are now due a review having previously received an assessment. In quarter 3 107 carer reviews were done, meaning that overall work undertaken to support carers actually increased.

The biannual adult carer's survey has now ended and achieved the desired response rate of 35%. The final response was 41%, results will now be analysed and reported to committee when complete.

Annual Population Survey

The annual population survey gives us an estimated insight into how people feel about their own wellbeing in the city, it is a national survey run by the Office for National Statistics. It gives us our performance against the following indicators; Self-reported wellbeing - people with a low satisfaction score, people with a low worthwhile score, people with a low happiness score and people with a high anxiety score. The most recent results provide a mixed picture, with reductions in the percentage of respondents who report low satisfaction and low happiness. However, there has been an increase in the percentage of respondents with a feeling of low worthiness and high anxiety.

CHILDREN AND YOUNG PEOPLE

Children Social Care Re-referrals – Reducing trend

There were 1,209 referrals in quarter 4. 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 2017. Repeat referrals have continued a slight downward trend since October and as of the end of March 2017 stand at 31.7% against a target of 30%.

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

The overall number of child protection plans has been decreasing, at the end of quarter 4 there were 306 children subject to a child protection plan, down from 343 at the end of quarter 3. The percentage of children on multiple plans has increased slightly and stands at 29.6% at the end of March 2017. 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.

COMMUNITY

Delayed Transfers of Care – Increasing trend

Nationally, since August 2010, the number of delayed transfers of care has been increasing. Locally, performance is of concern with on average 18 people delayed at the end of each month between April 2016 and February 2017 (based on an end of month snapshot and delays attributable to Social Care only).

Since December recording changes have had an adverse effect on numbers of delays from Derriford hospital. In order to tackle the number of DTOCs, actions included in a plan being overseen by the Urgent Care Partnership include; Integrated Discharge Teams interpreting data and understanding reasons for delays with an aim to reduce length of stay, agreement on a new complex discharge pathway and additional social work capacity in the Integrated Hospital Discharge Team, the roll out of seven day working and additional step down beds.

A new whole system target has been agreed, which is to reduce the percentage of occupied hospital beds subject to delay to 3.5% during 2017/18. This target is in relation to all delays, not just those attributable to social care.

Preventing Homelessness – Decreasing trend

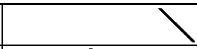
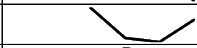
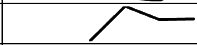
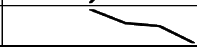
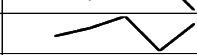
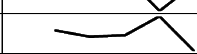
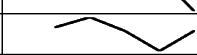
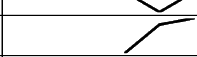
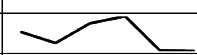
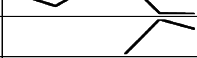
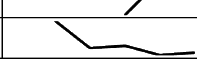
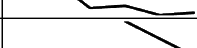
Between April 2016 and the end of December 2016 the number of households prevented from becoming homeless is 711, by the end of the year it is forecast that approximately 948 households would have been prevented from becoming homeless. This number is below the annual target, actions to improve performance include the review of initial point of contact procedures and the establishment of new community connections department, including locality working.

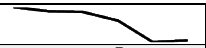
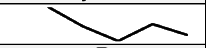
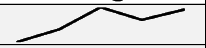
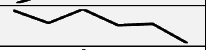
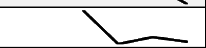
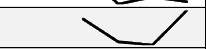
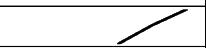
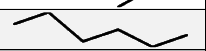
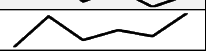
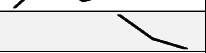
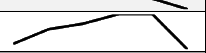
ENHANCED AND SPECIALISED

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

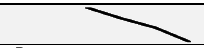
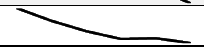
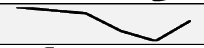
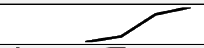
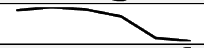
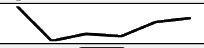
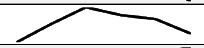
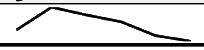
At the end of quarter 3 81% of active providers of Adult Social Care have been rated as good or outstanding by the Care Quality Commission, this is a reduction on the previous quarter's performance and is better than the England average. At the end of quarter two there were 4 providers rated as inadequate.

6. WELLBEING

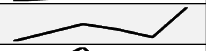
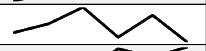
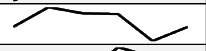
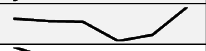
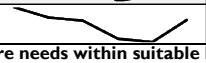
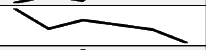
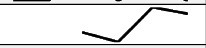
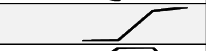
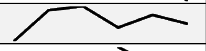
Source	Indicator	Measure	Most Recent Period	Benchmark England	First Value of Graph	Graph	Last Value of Graph	Trend
Sustain the improvement in healthy life expectancy and health inequality and reduce both all-age all-cause deaths and deaths due to cancer, stroke, heart disease and respiratory disease								
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	2015/16		5.3		4.2	
ONS	Self-reported well-being: % of people with a low worthwhile score	Percentage	2015/16		5.1		5.6	
ONS	Self-reported well-being: % of people with a low happiness score	Percentage	2015/16		11.5		9.4	
ONS	Self-reported well-being: % of people with a high anxiety score	Percentage	2015/16		22.9		22.4	
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	2014/15		33.2		33.2	N/A
Local - Carefirst	Number of carers receiving a statutory Carers Assessment	Count	2016/17 - Q4	N/A	247.0		191.0	
Local – Housing Options	Total Category 1 hazards removed CAT1	Number	2016/17 - Q3	N/A	63.0		94.0	
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	Jan-17	N/A	83.90%		84.90%	
PHNT	A&E 4hr wait	Percentage	Jan-17	N/A	86.90%		78.90%	
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 - Groin hernia	EQ-5D™ index	2015/16					No Data
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	Jan-17	N/A	59.4		59.3	
CCGOF	In hospital Falls with harm	Percentage	Jan-17	N/A	0.1		0.2	

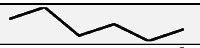
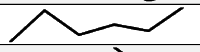
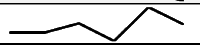
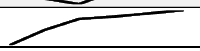
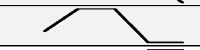
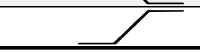
7. CHILDREN AND YOUNG PEOPLE

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	
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	2013 - 15		11.6		7.4	
PHOF	1.01i - Children in low income families (all dependent children under 20)	Percentage	2014		22.1		21.0	
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 - current method*	Percentage	2015/16		36.7		36.7	No Trend Data
PHOF	1.02i - School Readiness: The percentage of children achieving a good level of development at the end of reception	Percentage	2015/16		57.3		64.0	
PHOF	2.06i - Child excess weight in 4-5 and 10-11 year olds - 4-5 year olds	Percentage	2015/16		25.1		24.6	
PHE C&YP	A&E attendances (0-4 years)	Rate per 1,000	2015/16		338.9		487.5	
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 Q4		37.4		31.7	
PHE C&YP	Hospital admissions as a result of self-harm (10-24 years)	Rate per 100,000	2015/16		481.0		617.2	#N/A
PHE C&YP	Persons under 18 admitted to hospital for 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	2013/14 - 15/16		49.7		94.8	
PHE C&YP	Hospital admissions for mental health conditions	Rate per 100,000	2015/16		140.7		109.7	
Local - PCC	Number of children subject to a Child Protection plan	Count	2016/17 Q4		346		306	
Local - PCC	Number of looked after children	Count	2016/17 Q4		393		397	
Local - PCC	Number of Children in Care - Residential	Count	2016/17 Q4	N/A	23.0		28.0	
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	2015/16		16.1		15.4	

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 - Q3	N/A	233		198	
Housing	Average number of households in B&B per month	Number	2016/17 - Q3	N/A	26.0		39.0	
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	
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 - Q3	N/A	84.0		90.0	
NHSOF	IAPT Access Rate (PCH)	Percentage	Jan-17	N/A	1.2		1.2	
NHSOF	IAPT Recovery Rate (PCH)	Percentage	Jan-17	N/A	35.1		48.1	
ASCOF	Delayed transfers of care from hospital, per 100,000 population	Rate per 100,000	2016/17 - Q3		16.2		18.3	
ASCOF	Delayed transfers of care from hospital, per 100,000 population, attributable to Adult Social Care	Rate per 100,000	2016/17 - Q3		9.4		8.4	
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 - Q3	N/A	47		60	
ASCOF	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	Rate per 100,000	2016/17 - Q4		175.3		74.2	
ASCOF	Permanent admissions of younger people (aged 18-64) to residential and nursing care homes	Rate per 100,000	2016/17 - Q4		1.8		1.8	
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	2015/16		5.3		4.2	
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	

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	Jan-17	N/A	0.1		0.2	
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	2015		46.07		52.78	
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	
Local - PCC	Percentage of CQC providers with a CQC rating of good or outstanding	Percentage	2016/17 - Q4		82.0		81.0	
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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Update on GP care in Plymouth

Briefing for the Chair of the Wellbeing Overview and Scrutiny Select Committee

26 April 2017

This paper has been prepared by NHS England for the Chair of Plymouth's Wellbeing Overview and Scrutiny Committee. It provides an update on the closedown of four surgeries in the city and also the current position regarding the management of the Ernesettle contract sites at Ernesettle Medical Centre, Mount Gould Medical Centre and Trelawny Surgery.

The surgeries that have closed are:

- Hyde Park Surgery
- St Barnabas Surgery
- Saltash Road Surgery
- Cumberland Surgery

The first three were all independent practices, for which the previous providers handed back their contracts, having been unable to sustain the service themselves or to make alternative arrangements. The Cumberland Surgery was not commissioned by the NHS, but set up 'at risk' by the previous provider before its time-limited contract ended.

All four surgeries were kept open on a temporary basis by NHS England, at a significant premium in cost, so options for the future could be explored. Ultimately, the decision was taken in each case that the surgeries could not be sustained at standard contract rates, given their history and the move away from small practices towards primary care 'at scale'.

The emphasis over recent months has therefore been on the orderly closedown of all four surgeries. In each case, the current contracts ended on 31 March 2017.

Note: Homeless people who are cared for under a separate outreach contract were not directly affected by these changes. The contract was reprocured by Northern, Eastern and Western Devon Clinical Commissioning Group and awarded to Adelaide Street Surgery to provide continuity after 31 March.

Approach

The patients registered with each surgery needed to register with another practice – a process known as dispersal - to ensure continuity of care after 31 March.

NHS England may not itself transfer patients, as all have the right to choose the best alternative practice for themselves. Such individual decisions will typically be based on distance, opening times, staffing and facilities.

The approach to closure of a practice is well-established, with NHS England staff and the outgoing provider working together on a comprehensive 'exit plan' to identify and mitigate all risks.

The approach recognises that special help might be needed by vulnerable patients. These might include people with learning disabilities or who require ongoing medication, for example. See 'Measures taken', below, for details.

Re-registrations were tracked, by age group. This process continues post-closure.

Progress towards closedown

The table below shows the decline in the registered lists at each surgery:

	30.09.16	**31.03.17**
Cumberland Surgery	1721	482
Hyde Park Surgery	2850	763
Saltash Road Surgery	2098	311
St Barnabas Surgery	1444	299
Total	**8113**	**1855**

Age Breakdowns

	31.03.17		**31.03.17**
Cumberland Surgery		**Saltash Road Surgery**	
0-19	134	0-19	69
20-59	336	20-59	230
60-79	12	60-79	12
80+ -	0	80+	0
	482		311
Hyde Park Surgery		**St Barnabas Surgery**	
0-19	89	0-19	49
20-59	651	20-59	231
60-79	22	60-79	19
80+	1	80+	0
	763		299

This shows that more than three quarters of the patients had re-registered before the practices closed. Delays in data-returns mean that the true number is likely to be higher. There will also be patients who have moved away but not registered elsewhere, including students.

Past experience shows that many people will not re-register until they need treatment. Especially for younger adults, this might be a matter of many months after their own practice has closed. In this context, it is important to note that the great majority of those yet to find a new doctor are of working age, and therefore much less likely to be seen as vulnerable.

The age breakdown shows that all but one patient aged 80-plus had re-registered. People in this age bracket typically rely much more heavily on their practice than younger adults. Staff have attempted to contact the one remaining patient, who has just turned 80 years old, on several occasions by letter and telephone to offer support; it appears that the patient travels abroad.

NHS England's approach throughout has been pro-active, given the advantages for all people of being registered. Although anyone should be able to see a GP in an urgent situation, failing to register will mean that medical records are not immediately available, which can undermine patient safety.

NHS England also recognised that surrounding practices could not cope if every patient tried to re-register simultaneously. As a result, these practices were offered flexibility over the need to meet requirements such as providing health-checks for all new patients by 31 March.

To try to even out transfers of patients, NHS England's approach was:

- Not to urge all patients to re-register immediately when the decisions were taken in November about the four surgeries; Christmas was coming up and the contracts ran until 31 March, so there was no hurry
- To follow up this messaging with further reminders as the deadline drew closer

The great majority of patients affected lived within the catchment areas of at least five other surgeries. Many live closer to another surgery than to the one with which they were registered.

Measures taken

In preparation for the closedown, and in line with previous experience, the following steps were taken:

- A first letter was sent by NHS England in November 2016 to inform each patient that the current contract would end on 31 March 2017 and that they would need to find a new surgery. This stressed that there was "no great hurry for anyone to find a new

practice, but we would advise you to do so by March next year to ensure continuity of your care." The letter included contact numbers for more than 40 other surgeries that could take new patients; details of how to compare practices via NHS Choices; and phone, email and postal details for anyone who needed help or further information.

- A first reminder letter was sent in early January 2017, highlighting the closure date of 31 March and warning that continuity of care might be affected if patients did not re-register in a timely way. The practice list, link for NHS Choices and contact details for support were again included.

- A second and final reminder letter, stressing the short time to closedown, was posted out on 20 February.

- A letter was circulated in February to all health and social care organisations around Plymouth, informing them that the practices would close. The letter requested that they update patient records to ensure that results and other communications were no longer sent to patients of the closing practices after 31 March.

- All post was redirected to the NHS England office in Saltash to be returned to sender or redirected where appropriate.

- The numbers of patients registered at each surgery was monitored by age-group, with the emphasis on reaching any remaining people who were considered vulnerable

- NHS England maintained communication with all Plymouth GP practices, advising them of the numbers of patients yet to find a new doctor. Throughout this period, practices around Plymouth have kept their patient lists open and have registered all patients who were eligible.

- A full exit plan was drawn up with Access Health Care for bringing its contract to an orderly end and to provide all practicable help and support for patients in re-registering. As noted above, while the great majority of people are perfectly able to find a new practice, either themselves or with help from their families, there was special provision for people who might need extra support. For example:

    - Care homes were contacted to encourage and support re-registration

    - Local mental health and learning disability teams were contacted to help identify clients who might need further help to re-register and to support them through the process

    - Special arrangements were made for patients who were prescribed methadone, so interim care could provided if necessary

- Midwives and health visitors were contacted so mothers-to-be could be encouraged to register elsewhere

- Assigned social workers were contacted to help support vulnerable adults and children through re-registration

- Carers were identified, so they could be approached and provided with additional help

- Staff at all four surgeries actively encouraged patients to register elsewhere; whenever they came for appointments, registration (GMS1) forms were available to take away

- Posters about the need to re-register were displayed at each surgery, with walls otherwise bare to make it clear that closure was coming

- Local pharmacies also displayed the poster and liaised with Access Health Care regarding concerns for any patients; GMS1 forms were also provided to pharmacies

- Answerphone messages at each surgery included a message about forthcoming closure

- Information about the closure was printed on to prescription slips

As a further safety net, NHS England has a secure system in place to ensure that, for anybody who has failed to re-register, an electronic patient record/summary can be provided when they do find a new practice. This will support their new GP in providing diagnosis and treatment pending the arrival by post of the substantive medical record, which might take up to six weeks.

Update on the Management of the Ernesettle Contract Sites

The negotiations with the preferred bidder identified through the procurement process stalled very late in the process, so it was not possible to progress to signing a long term contract.

Access Health Care has now been awarded a further temporary contract for the running of the Ernesettle contract at the Ernesettle, Mount Gould and Trelawny sites, which previously also included patients who went to the Cumberland Surgery.

This has enabled NHS England to arrange for former Cumberland patients to remain on the Ernesettle contract pending re-registration with a practice of their choice. These patients – 482 as of 31 March – can therefore continue to use primary medical services run by Access Health Care at Ernesettle Medical Centre, Mount Gould Medical Centre or Trelawny Surgery.

Conclusion

The number of people who have yet to find a new doctor is low, and concentrated strongly in the group of working age

The patients identified as ‘vulnerable’ received individual support from the practice by linking with them and their relevant key workers. Access Health Care provided regular progress reports to NHS England regarding this process.

The number of re-registrations confirms NHS England’s analysis that there was capacity at the other practices across the city to take on all displaced patients

Analysis of information from NEW Devon CCG shows that patients registered at the four closing surgeries had not increased their attendance at Minor Injuries Units or at Derriford Hospital’s A&E Department

Finally, it is important to note that, in an emergency, any unregistered patient may access primary care under arrangements for ‘immediate and necessary’ care. They should nevertheless register as soon as possible to gain the benefits of ongoing care with a practice team.

SUMMARY REPORT

Plymouth Hospitals NHS
NHS Trust

Plymouth City Council's Wellbeing Overview and Scrutiny Committee

26th April 2017

Subject	**Plymouth Hospitals Trust's Care Quality Commission Re-Inspection July 2016**
Prepared by	Julie Morgan, Deputy Head of Quality Governance
Approved by	Greg Dix, Director of Nursing and Chief Operating Officer
Presented by	Bev Allingham, Deputy Director of Nursing

Purpose

The purpose of this report is to provide an overview of the key findings of the 2016 Care Quality Commission (CQC) inspection report which was produced further to our July re-inspection and the action being taken in response.

Decision	
Approval	
Information	
Assurance	●

Corporate Objectives

Improve Quality	Develop our Workforce	Improve Financial Position	Create Sustainable Future
●			

Executive Summary

Plymouth Hospitals NHS Trust was inspected by the CQC in July 2016 as a follow up to the comprehensive inspection that was carried out in April 2015. Whilst we have again been rated as 'Requires Improvement' overall for our services, the report clearly demonstrates significant improvements across the core services and this is clearly demonstrated in the comparison of ratings at Annex 1. An Action Plan has been developed in response to the Quality Report which addresses the 'Must Do' and the 'Should Do' areas for improvement; a copy of the Action Plan monitoring report is appended at Annex 2.

Quality Impact Assessment

Failure to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 results in the provision of services to patients that fails to meet essential standards of quality and safety.

Financial Impact Assessment

Failure to maintain compliance may incur financial penalties as part of any regulatory action taken by the CQC.

Regulatory Impact Assessment

Failure to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 may result in the issuing of a warning notice, imposition of a condition of registration, suspension or cancellation of registration, or under criminal law, a caution or prosecution.

Equality and Diversity Impact Assessment

Any equality and diversity issues identified in the report will be addressed in our action plan.

Environment & Sustainability Impact Assessment

Not applicable.

Conclusion and Recommendations

The Trust is delighted with the recognition of the improvements that have been made since the 2015 Inspection. Monthly updates of progress against the Action Plan are undertaken with the next external reports of progress planned for the end of April 2017. It is recommended that the Committee takes assurance from the progress that we have made and our plans to make further improvement.

DETAILED REPORT

Plymouth Hospitals NHS
NHS Trust

Plymouth City Council's Wellbeing Overview and Scrutiny Committee

26th April 2017

Subject	**Plymouth Hospitals Trust's Care Quality Commission Re-Inspection July 2016**
Prepared by	Julie Morgan, Deputy Head of Quality Governance
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Purpose

1 The purpose of this report is to provide an overview of the key findings of the 2016 Care Quality Commission (CQC) inspection report which was produced further to our July re-inspection and the action being taken in response.

Quality Report

2 Plymouth Hospitals NHS Trust was inspected by the CQC in July 2016 as a follow up to the comprehensive inspection that was carried out in April 2015. During the previous inspection we were rated as 'Requires Improvement' overall. The follow up inspection therefore focussed on those areas rated previously as 'Requires Improvement' and 'Inadequate' (see Annex 1). The CQC also inspected the Well Led domain at Trust level.

3 Whilst we have again been rated as 'Requires Improvement' overall for our services, the report clearly demonstrates significant improvements across the core services and this is clearly demonstrated in the comparison of ratings at Annex 1.

4 The CQC have aggregated the ratings from the previous inspection and given new overall ratings for each core service. Inspectors have reported a marked improvement and there are no more 'Inadequate' ratings.

5 Our ratings for each of the five domains assessed by the CQC is shown below:

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

6 Of the 18 domains rated as 'Requires Improvement' or 'Inadequate' for Derriford Hospital in 2015 we have improved in 14. Of particular note is the dramatic improvement

in Outpatients and Diagnostic Imaging. For Mount Gould Hospital we improved in the Safe Care domain from 'Requires Improvement' to 'Good'.

7 The report recognises many areas of outstanding practice including:

- There had been an outstanding response from the critical care teams and the hospital trust to areas of concern raised in the previous report.
- The audit processes used through the fundamentals of care audit and the departmental nursing assessment and assurance framework.
- The new role within the acute medical units and the short stay ward to enable medicines for patient discharges to be prepared more efficiently.
- Access for patients to receive care and treatment on the stroke pathway had improved since the last inspection.
- The multi-disciplinary working between the Specialist Palliative Care Team and the wider hospital and local community were outstanding.
- The use of prompt cards in outpatient areas to give staff easy access to phone numbers and processes involving safeguarding and the management of patients with complex needs.

8 Other positive feedback included:

- A positive incident reporting culture and staff were open and honest with patients and their relatives when anything went wrong.
- When people in outpatients and diagnostic imaging received care from a range of different staff, teams or services, this was co-ordinated well ensuring that all relevant teams were involved in the planning and delivery of care and treatment.
- Staff felt that senior managers were visible, approachable and accessible; they told the CQC that they felt respected and valued and spoke about an open culture.
- Improvements noted in the number of medical outliers, multiple patient ward moves and moves out of hours.

Action Plan

9 An Action Plan has been developed in response to the Quality Report which addresses the 'Must Do' and the 'Should Do' areas for improvement; a copy of the Action Plan monitoring report is appended at Annex 2.

10 Delivery of the completed Action Plan is subject to a process of internal and external monitoring and reporting. Further to the success of the arrangements established to govern delivery of the previous Action Plan, delivery of the new Action Plan is again being overseen by a CQC Post Inspection Project Group. Ongoing assurance is reported internally to Safety and Quality Committee at each meeting and externally to the CQC, NEW Devon Clinical Commissioning Group and to NHS Improvement until completion.

11 Any concerns with lack of delivery of actions or lack of desired impact of the actions will be escalated to Trust Management Executive and Trust Board as required.

Conclusion and Recommendations

12 The Trust is delighted with the recognition of the improvements that have been made since the 2015 Inspection. Monthly updates of progress against the action plan are undertaken with the next external reports of progress planned for the end of April 2017.

13 It is recommended that the Committee takes assurance from the progress that we have made and our plans to make further improvement.

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Annex 1: Comparison of Ratings

From this in 2015

Our ratings for this Derriford Hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & emergency	Requires improvement	Good	Good	Inadequate	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity & Gynaecology	Requires improvement	Good	Outstanding	Good	Good	Good
Children & young people	Requires improvement	Good	Outstanding	Good	Good	Good
End of life care	Good	Requires improvement	Outstanding	Good	Good	Good
Outpatients &Diagnostic Imaging	Inadequate	Inspected but not rated[1]	Good	Inadequate	Inadequate	Inadequate
Overall	Requires improvement	Good	Outstanding	Inadequate	Requires improvement	Requires improvement

Our ratings for Mount Gould Hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients &Diagnostic Imaging	Requires improvement	Inspected but not rated[1]	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Inspected but not rated[1]	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Plymouth Hospitals NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust	Requires improvement	Good	☆ Outstanding	Inadequate	Good	Requires improvement

to this in 2016

Our ratings for Derriford Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Medical care	Requires Improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Requires Improvement	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	☆ Outstanding	Good	Good	Good
Services for children and young people	Good	Good	☆ Outstanding	Good	Good	Good
End of life care	Good	Good	☆ Outstanding	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires Improvement	Good	Good
Overall	Requires Improvement	Good	☆ Outstanding	Requires Improvement	Good	Requires Improvement

Our ratings for Mount Gould Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires Improvement	Requires Improvement	Requires Improvement

Our ratings for Plymouth Hospitals NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires Improvement	Good	☆ Outstanding	Requires Improvement	Good	Requires Improvement

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Plymouth Hospitals NHS
NHS Trust

CQC Action Plan Monitoring

March 2017

Purpose

The purpose of this report is to update the Care Quality Commission (CQC), Clinical Commissioning Group and NHS Improvement with the progress that we are making in delivering the action plan designed to address the Requirement Notices arising from the CQC's inspection of Plymouth Hospitals Trust in July 2016.

The open actions in the action plan have been transferred into this action plan monitoring report which encompasses the outstanding actions (arranged by theme/core service), any arising actions and performance data that will allow us to monitor the impact of the actions that we are taking.

Ongoing monitoring of compliance with the closed actions is derived through the performance indicators included within this report. The report will be presented to, and monitored by, the Safety and Quality Committee.

Update March 2017

The table below gives an indication of progress with our actions. Further detail of the completed actions can be found in Annex 1.

Actions are marked as completed based on the updates provided by the action leads but are only marked as closed on receipt and review of appropriate evidence.

Action Status	Number of Actions	Percentage of total
Completed and closed on receipt of appropriate evidence	**18**	**24**
Completed – evidence to be submitted and reviewed	**16**	**21**
In Progress	**42**	**55**
Total:	**76**	**100**

Next Update

The next planned update will be on 28 April 2017.

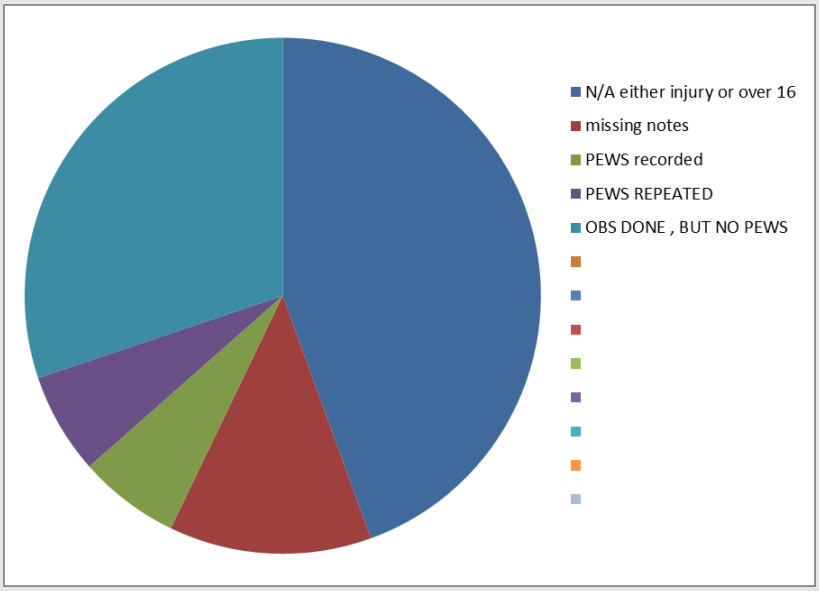
Urgent and Emergency

MUST DO: Formalise the recordings of meetings in the emergency department to ensure adequate assurance that the relevant persons are attending and discussions are held to identify learning points. Also ensure actions are recorded and allocated to a person who can progress the actions and progress is monitored. SHOULD DO: Review governance processes within the emergency department to ensure full integration between the medical and nursing teams.			
Planned action			
Ref	**Action**	**Lead**	**Deadline**
1.1	Commence Super Wednesday every third Wednesday of the month which will review governance framework / actions with a recorded auditable trail.	Matt Warner	28/02/17 - Complete
Update on Actions			
All governance and safety business meetings are agenda'd and minuted and held on the ED Clinical Governance shared drive that is accessible for the whole department – clinical / admin / managerial employees. This has been in place since November 2016 with the output reporting into the Care Group. Action complete January 18 2017.			

MUST DO: Review performance data in the emergency department to ensure it is accurately captured and reported, allowing adequate monitoring and scrutiny. (The data for patients who self-presented was inconsistently recorded. Data provided by the trust showed the initial assessment time from ambulance arrival was consistently within one minute. However, the manner in which the data was entered into the system failed to consider the time the patient was waiting before the nurse in charge took the handover.)			
Planned action			
Ref	**Action**	**Lead**	**Deadline**
1.2	Conduct review of admin process to enable accuracy of time of arrival ensuring that Receptionists are booking in time of arrival.	Tim Parham & Mary Coombs	01/02/17 - Complete
Update on Actions			
Team has completed admin review. This has identified further work to be carried out. A time, motion assessment will be completed with the help of Service Improvement.			

MUST DO: Ensure the paediatric early warning score is implemented fully and used consistently to ensure children are safely assessed and managed.

Current Performance



Comment on Current Performance

59 children attended on 15/01/17. In 28 cases PEWS was not applicable as the presentation was an injury and did not require observations, or the patient was 16 and over. 8 sets of notes were missing so unable to audit them. 4 patients had PEWS documented and all had repeat PEWS scores. 19 Cases had a set of observations recorded, but no PEWS.

Planned action

Ref	Action	Lead	Deadline
1.3	Audit current practice - provide education where required and sharing at team review.	Katherine Norton	31/01/17 - Complete

Update on Actions

January audit complete and plan to repeat this monthly.

MUST DO: Continue to work with commissioners and the local mental health service provider to ensure mental health patients arriving at the emergency department receive the care they require in a timely manner.

Planned action

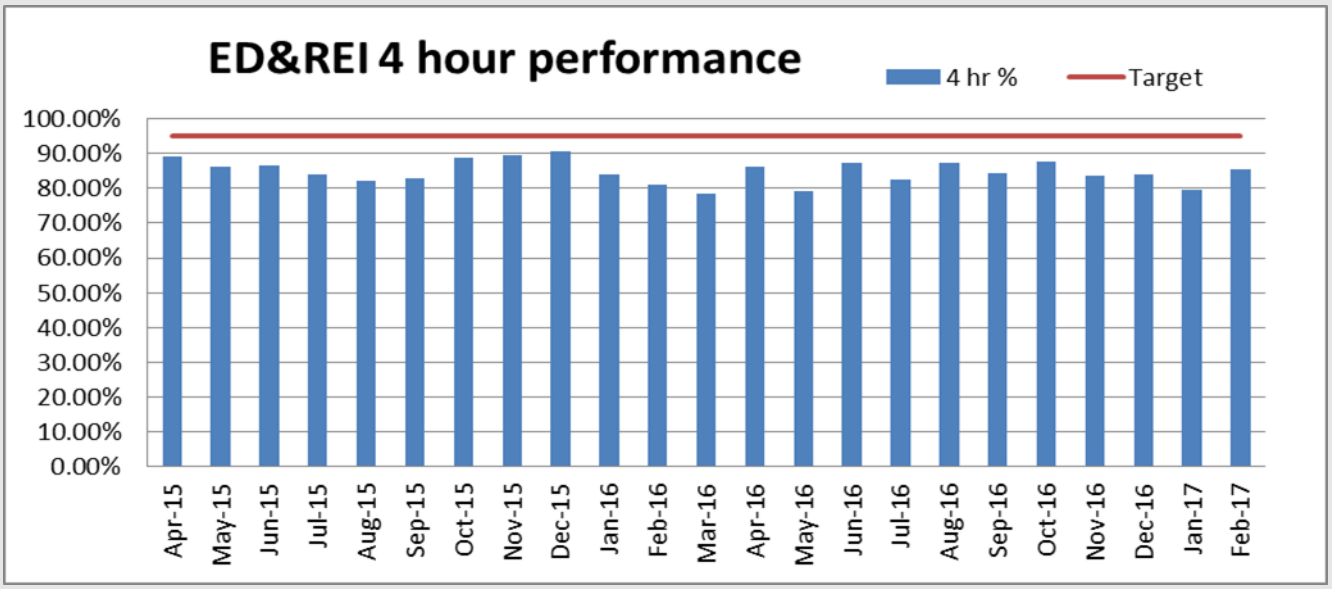
Ref	Action	Lead	Deadline
1.4	1.Continue ongoing local review of Mental Health Service. 2. Review Pathway. 3. Review Contractual issues.	Anne Hicks	30/06/17

Update on Actions

Commissioners and acute trusts to meet as part of service review and contractual delivery for 2017/18.

MUST DO: Continue to ensure the emergency department's four-hour performance improves, with an ultimate aim to achieve the 95% standard.

Current Performance



Putting Patients First Programme Dashboard:

PPF Programme Dashboard 090317.d

Comment on Current Performance

The average number of daily ED attendances fell to 249 in February, a small reduction on January and 18 per day lower than the same month last year. The % of those ED attendances triaged in the highest two categories decreased slightly to 42.5% in February, but this is 5.5% higher than the same month last year.

Planned action

Ref	Action	Lead	Deadline
1.5	1. Deliver Putting Patients First Programme. 2. Improve medical core staffing numbers. 3. Submit ED redesign business case for review and approval.	1. Dave Brown 2. Jo Beer 3. Anne Hicks	31/03/18

Update on Actions

The Regional A&E Delivery Board is responsible as a system to support the hospital in delivering the ED target.
We have reinvigorated the internal professional standards for the whole Trust from ED – complete.
We continue to work to agreed ECIP principles and endeavour to deliver an increased availability of beds (improvement governed through the PPF programme) to support flow through the emergency department as part of the ED action plan.
Significant progress has been made in relation to beds occupied by patients with a LOS >6 days. We have additionally shown an improvement in our volumes of Monday Discharges (Mondays have improved for previous quarter (144 to 150 per day) and Saturday discharges (we have seen on average 101 Saturday discharges in the last 3 months (up 7.7% on same period last year and 13.5% on previous quarter).
The DTOC tracking and CD discharge planning SALUS development began rolling out on 13th March 2017 starting with the Devon team.
The number of discharges has reached 110 on successive Saturdays and two weeks with 200+ weekend discharges.
Specifically in relation to the three actions above:

1. Rapid roll out of model ward (PPF) plan to complete all areas by the end of July 2017.
2. Increase in vacancies, increasing risk- to be reviewed.
3. Strategic Outline Case for ED presented to Trust Board by Ann Hicks, Service Line Director for ED, with approval to complete full Outline Business case given.

MUST DO: Ensure all equipment in all areas, and specifically the emergency department, is maintained in accordance with the trust's service schedule. Provide a system to adequately monitor and report on this.			
Current Performance			
Current performance cannot be measured at present due to an ongoing database (preventative maintenance scheduling) fault. A Fault report has been raised with the database supplier and we are awaiting resolution			
Comment on Current Performance			
Not applicable.			
Planned action			
Ref	**Action**	**Lead**	**Deadline**
1.7	Short term: 1.Complete rationalisation of servicing scheduling system on f2 database. On completion servicing schedules will reveal outstanding services on equipment in ED and these will be followed up. Completion will be dependent on quantity. 2. Follow up outstanding schedules for other departments. 3. Complete Technical Inspection of medical devices in ED. Long term: 4.Explore available databases on the market and purchase to enable better management of service schedules and other management information.	Jonathan Applebee	31/12/17 due to introduction of new database and annual round of service schedules/technical inspection
Update on Actions			
1. Rationalisation of service scheduling caused an ongoing database (preventative maintenance scheduling) fault which means that reports from this system are not reliable. Still awaiting resolution from supplier. However we have developed a work-around which has enabled us to complete rationalisation of service scheduling of all High Risk devices. 2. System should now be accumulating more accurate statistics for later reporting. Gaining timely access to High Risk equipment for servicing (e.g. in Critical Care, ED and Theatres) still an ongoing problem, due to high usage. Scheduled servicing in ED is up to date with 3 items due to be serviced this month. 3. Technical Inspection is now complete on levels 12 down to level 5 inclusive except for mop up of some isolated devices. Revisits to mop up taking place. 4. Truro visit and view of database done. Visit to Addenbrookes, Cambridge to see a mature development of possible future system taking place in March.			

SHOULD DO: Strengthen the nursing oversight of the whole emergency department, including majors, minors, resuscitation and the clinical decisions unit for each shift.			
Planned action			
Ref	**Action**	**Lead**	**Deadline**
1.8	1. Submit workforce plan as part of annual business planning to provide 24/7 band 7 cover. 2. Release admin duties from current band 7 stock by trialling a 3 month band 3 to undertake off duty rota on MAPS.	Tim Parham	01/04/17
Update on Actions			
1. The business plans are pending approval Trust wide with regards to staffing uplift and if approved a recruitment process will subsequently follow for a band 7 in a supernumerary role from 10:00-20:00. This role is aimed at having a view of the whole department and supporting areas where it is at its busiest. This may be working in triage, resus or			

assisting to prevent breaches.

2. The appointment of the band 3 is delayed as awaiting multiple health issue reports through Staff Health and Wellbeing

SHOULD DO: Ensure patients arriving at the emergency department by ambulance are protected from the elements as best as possible.

Planned action

Ref	Action	Lead	Deadline
1.13	Completion of agreed improvement works.	Andrew Davies	01/04/17 – Complete and closed

Update on Actions

The initial plans have now been reviewed and are not considered to be appropriate. The costs for this were prohibitive and also required planning permission, hence the reason it will now be considered as part of the scheme to develop ED. 30/03/17 Action closed and will be picked up in action ref 1.5 Submit ED redesign business case for review and approval.

SHOULD DO: Review the transfer team in the emergency department to ensure that when patients are transferred to a ward a clinically safe handover is completed in all cases.

Current Performance

Audit data ongoing.

Comment on Current Performance

No transfer related incidents documented.

Planned action

Ref	Action	Lead	Deadline
1.14	Completion of SBAR of Doctor prior to transfer.	Mary Coombes and Medic	28/02/17 - complete

Update on Actions

Spreadsheet commenced to record any transfer related incidents and if occurs will transfer to Datix for action. SBAR form has now been pre-printed on part B admission booklet.

SHOULD DO: Review the hospital's procedure for crowding in the emergency department to include the actions required by the wider hospital in order to support safe patient care.

Planned action

Ref	Action	Lead	Deadline
1.15	Head of Operations to complete review of Internal escalation plan.	Lee Johns	31/03/17 – Complete and closed

Update on Actions

New policy in draft and has been presented to OPDG Tuesday 14th March 2017. Policy produced in conjunction with Care Groups and is being tested live with ongoing developments. The policy is being developed with the CCG to align plans with the community.

SHOULD DO: Review plans to increase the space in the emergency department to consider how crowding can be reduced and patient flow improved within current financial constraints.			
Planned action			
Ref	**Action**	**Lead**	**Deadline**
1.16	Submit Strategic Outline Business case for review and approval.	Anne Hicks	30/06/17
Update on Actions			
Strategic Outline Case for ED presented to Trust Board by Ann Hicks, Service Line Director for ED, with approval to complete full Outline Business case given.			

SHOULD DO: Ensure wasted controlled drugs in the emergency department are disposed of in accordance with trust policy.			
Planned action			
Ref	**Action**	**Lead**	**Deadline**
1.18	Provide education to staff during team review and check knowledge by questioning of staff.	Fiona Veale	31/01/17 – Complete
Update on Actions			
Audit completed which found that the majority of staff are following the trust medication management policy with regard to the disposal of controlled medication. The one member of staff who was not complying with Trust policy was spoken to and informed of the correct procedure as written in the medical management policy.			

SHOULD DO: Review and upgrade computer systems in the emergency department to allow integration with wider hospital systems.(IT/CT issue).			
Planned action			
Ref	**Action**	**Lead**	**Deadline**
1.19	Work with IT to review collaboration of systems.	Dan Henning	31/03/17 - Complete
Update on Actions			
EDIS / SALUS / IPM remain isolated at present. This is an ongoing issue. The only effective solution would be the procurement of an electronic patient record with a cost of c£40m. Surgeon Commander Henning is working with IMandT to ensure systems are as integrated as they can be. He is working on a pioneering link between iCM and EDIS. Also introducing SALUS to CDU and effecting a wider rollout of ADF terminals into the main ED. This will be an ongoing piece of work.			

SHOULD DO: Ensure staff in the emergency department all have name badges which include the role they are in. Consideration should also be given to providing patients with a leaflet that details the different types of uniforms and what they designate.			
Planned action			
Ref	**Action**	**Lead**	**Deadline**
1.21	1. Provision of name badges to all staff to be checked at the beginning of team review. 2. Medical staff to wear named scrub tops.	Band 7s	28/02/17 – Complete and closed
Update on Actions			
The provision of name badges to all staff has been completed and checks undertaken at team review. All Consultants and Registrars have named scrub tops. The junior doctors have name badges with “Hello my name is ….” given to them just after they arrive.			

Medical Care

MUST DO: The provider must ensure that equipment stored on wards and in corridors does not obstruct or impede the access to and through fire exits.
Current Performance
 Walk Around Inspections.pdf
Comment on Current Performance
None

Planned action

Ref	Action	Lead	Deadline
2.1	1. Develop a forward plan and undertake Fire Safety Officer Walk arounds. 2. Run an awareness campaign related to the risk of obstructed fire exits. 3. Oversee and test through the above to ensure that all wards have appropriate risk assessments in place regarding their equipment storage arrangements.	Julie Richards	30/09/17

Update on Actions

1. Fire Safety team already undertake fire safety walkabouts to check compliance with fire safety, talk to fire wardens and staff and reports are sent to ward managers.

2. Regular remainders are issued through Daily Email and Vital Signs. Associate Director of Estates will contact service line leads.

3. Associate Director of Estates will ask Wards and departments to forward their risk assessments to her and keep a copy in their individual fire folders.

MUST DO: The provider must review the available storage to patients who self-medicate and retain their own medicines on the wards.

Planned action

Ref	Action	Lead	Deadline
2.2	Two pronged approach to be implemented: 1. As new lockers are required on a replacement basis the new locker will be the one of choice and purchase. 2. Agree an implementation strategy for a staged replacement programme via capital monies.	Bev Allingham	30/06/17

Update on Actions

The standard for the new patient lockers has been agreed. We have a plan to replace lockers through a staged capital management programme. More trial patient bedside lockers have now been requested as the models have changed since the last trials that we did. Trial locker being reviewed by ward managers week commencing 13th March, then we can assess them quickly and make a decision; then as new lockers are needed this will be the locker of choice. We will have determined the capital replacement programme in the next few months.

SHOULD DO: Encourage staff to report mixed-sex breaches.

Current Performance

Eliminating Mixed Sex Accommodation

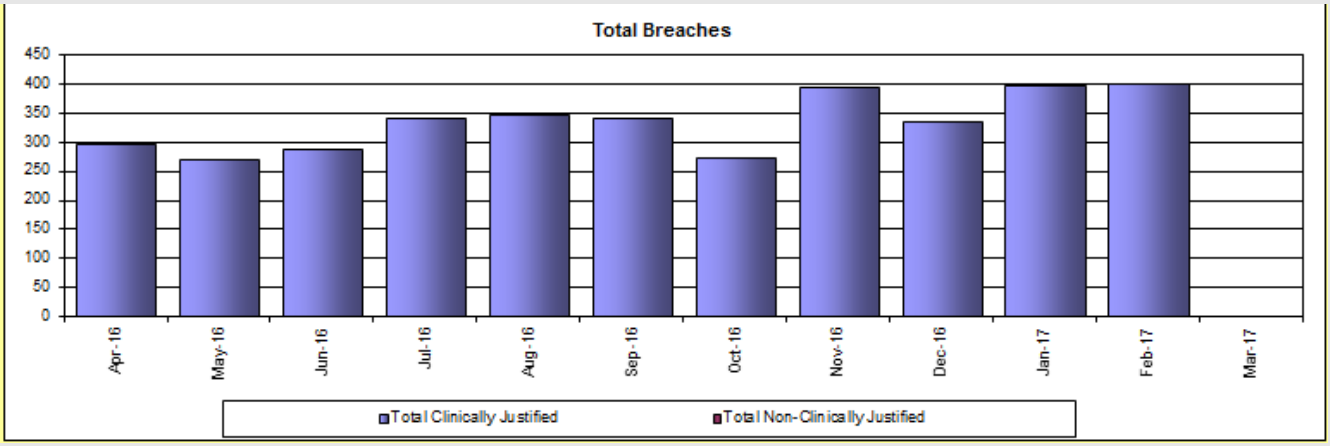


Figure represents the trust position as of Month 11: 2016/17

Comment on Current Performance

All breaches were clinically justified for the period April 2016 to February 2017.

Planned action

Ref	Action	Lead	Deadline
2.3	Publish awareness across the trust regarding the need to report mixed sex breaches.	Sam Rafferty	31/03/17 – Complete and closed.

Update on Actions

Communications via Vital Signs, Daily Email and Care Group communications.

SHOULD DO: The provider should plan to risk assess the impact of the location of the proposed cardiac catheter laboratory, reflecting on the patient journey and pathway.

Planned action

Ref	Action	Lead	Deadline
2.5	Produce a risk assessment related to the impact of the location of the proposed cardiac catheter laboratory; reflecting on the patient journey and pathway. Where any risk is identified, raise a service line level risk detailing the action to be taken to reduce the risk to its lowest level.	Venk Suresh	28/02/17

Update on Actions

The location now is within the Derriford campus at the NW quadrant close to Rowan's. This site will be inspected by CQC and will have dedicated access to emergency ambulance if required. Heads of Terms has been signed by both PHNT and Regents Park (private provider). Project groups are being established to ensure building and operations are developed to standard. The full contract is being led by procurement and is not yet signed. Risk assessment related to the impact of the location reflecting the patient journey and pathway will be inherent in this next phase.

SHOULD DO: The provider should review the environment regarding the safety of patients admitted to wards and departments living with mental illness and especially with the risk of self-harming.			
Planned action			
Ref	**Action**	**Lead**	**Deadline**
2.6	1. Conduct a review of inpatient wards for the presence of ligature points. 2. Provide fixtures and fittings that meet mental health standards whilst also meeting the PLACE requirements for all patients.	Head of Quality Governance	31/08/17

Update on Actions

A working group has been set up to review the new draft ligature policy which also includes a risk assessment process. The working group will review the policy and agree a roll out plan to assess clinical areas.

SHOULD DO: The provider should ensure that patient records are consistently completed and are kept up to date.

Current Performance

Data extracted from Meridian: Fundamentals of Care Audits for the period 1st April 2016 to 28th February 2017.

Figure 1 Has MUST Assessment Been Completed?

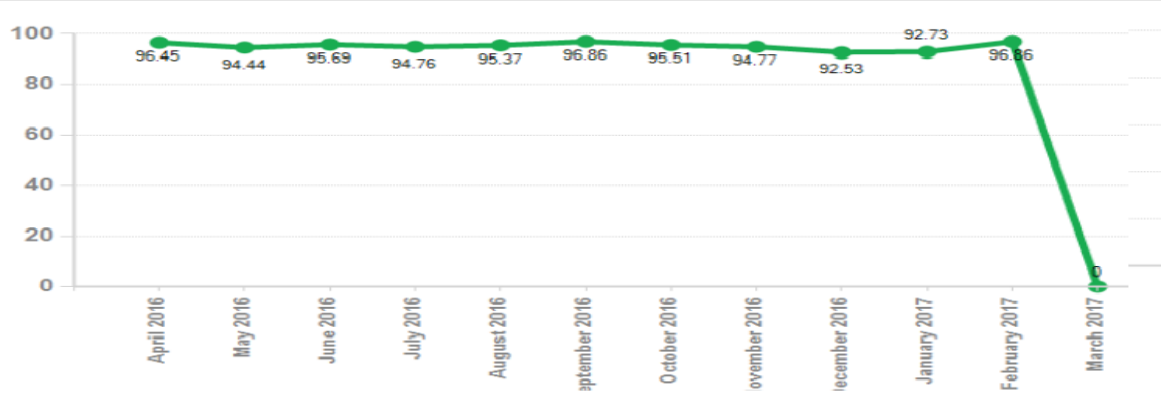


Figure 2 Has the Waterlow Score been completed on Admission?

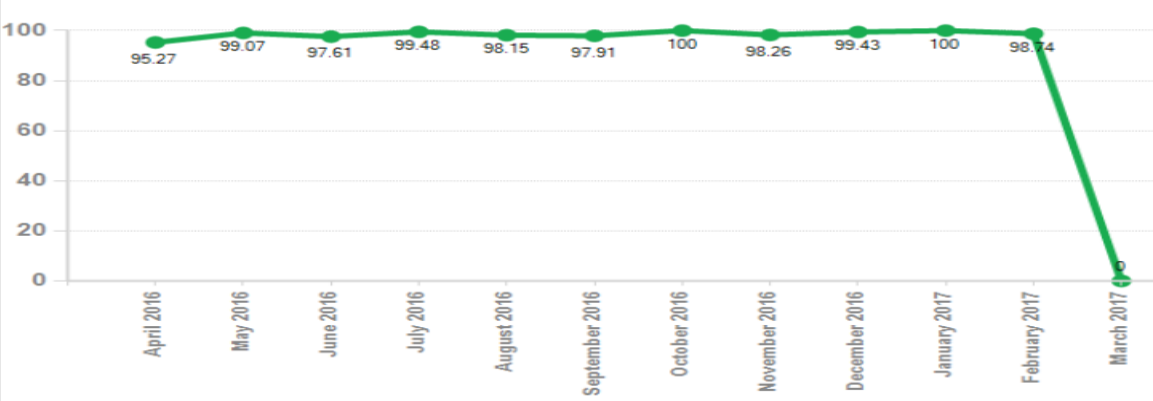


Figure 3 Has the Manual Handling Risk Assessment been completed and is it up to date?

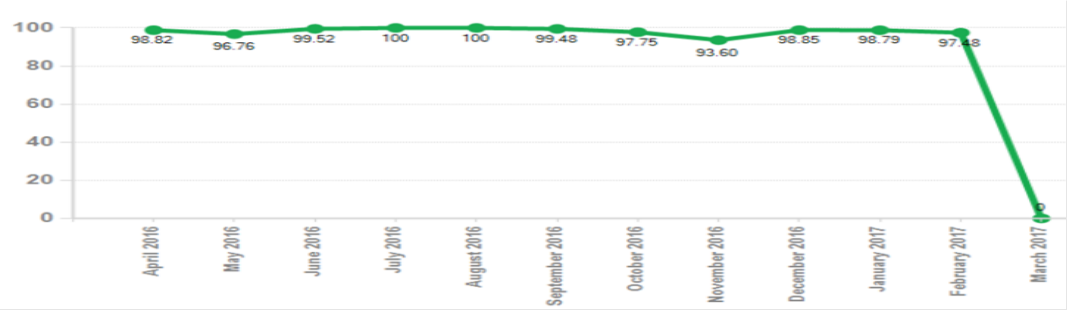
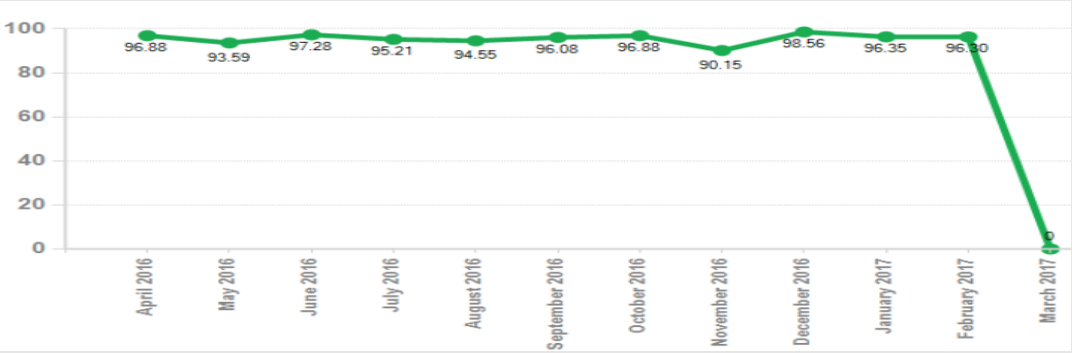


Figure 4 Has the Falls Care Plan been updated?



Comment on Current Performance
Benchmark for the above aspects of nursing practice is 95%. Waterlow risk scoring, manual handling risk assessments and falls care planning are at or above expected benchmark. MUST Screening has been slightly below benchmark since September 2016, but in February 2017 all benchmarks are above 95%.

Planned action

Ref	Action	Lead	Deadline
2.7	1. Complete a pilot of the new risk assessment booklet. 2. Roll out assessment booklet. 3. Matron led audit of risk assessment and care plan documents at 6 and 12 months intervals.	Sue Johnson / Sam Rafferty	30/06/17 – Complete and closed

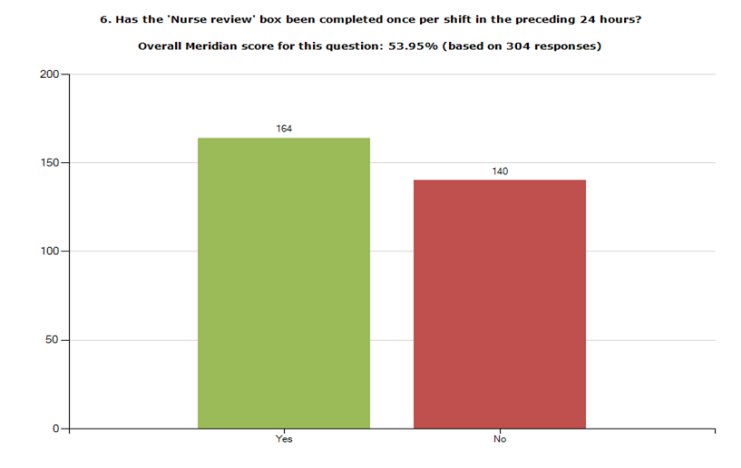
Update on Actions
1. Completed a pilot of the new risk assessment booklet. 2. Roll out of assessment booklet across the adult inpatient areas completed 3.Fundamentals of care audits embedded above show attainment above the 95% standard. The Heads of Nursing plan to review all ward areas with the Nursing Assessment and Assurance Framework (NAAF) audit in Autumn 2017.

SHOULD DO: The provider should ensure that where registered nurses were required to countersign the work of health care assistants this was consistently carried out. (Obs charts)

Current Performance

Data extracted from Meridian: Fundamentals of Care Audits for the period 1st April 2016 to 31st December 2016.

Figure 5 Trust wide Adult Inpatient Observations Audit 29/11/2017



Comment on Current Performance

53.95% compliance with regards the audit question asking 'Has the Nurse review box been completed once pre shift in the preceding 24 hours?

Planned action

Ref	Action	Lead	Deadline
2.8	1. Undertake a matron led campaign to raise awareness among registered nurses of the importance of countersigning healthcare assistants' written entries on observation charts. 2. Conduct an audit of observation charts and draw recommendations from it with associated action plan.	Sue Johnson / Sam Rafferty	30/06/17

Update on Actions

Heads of Nursing have arranged for a Matron from each care group to undertake an awareness campaign. Awareness campaign to be run to highlight the importance of countersigning all documentation, as well as obs charts, completed by HCAs, student nurses and preceptees. This will run as follows:

• To include countersigning of documentation in ward safety brief each day.

• List countersigning of documentation as an agenda item at the Ward Sisters meetings – demonstrating the 'gold standard' required.

• Communicate through Vital Signs and daily emails.

• Ensure HCA tutors emphasise the need for HCA to get their documentation signed by a RN. This should be highlighted at every stage of their training.

• Countersigning of documentation to be included on the mentorship courses and the preceptee programme.

• Screen Savers as a prompt to ward staff.

2. Adult observation audit undertaken on 29th November 2016. Results feed into a trust wide Quality Improvement Project – Deteriorating Patient. The next stage of this project is being considered and monitored via the Quality Improvement Committee. The observation audit will be repeated across the Trust on an annual basis. Once E' observations are implemented this will be easier to check and audit. In the meantime the actions highlighted above around an awareness campaign are in progress.

SHOULD DO: The provider should ensure that all chemicals are secured and not accessible to patients and visitors to wards and departments. Clinical waste including sharps bins should be sealed and dated correctly and removed from the wards promptly.

Current Performance

Data extracted from Meridian: Environmental Audits for the period 1st April 2016 to 28th February 2017

Question Text	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Benchmark
4. Does the ward appear generally tidy	98	96	97	96	100	100	100	100	100	100	100	95
47 Are areas tidy with equipment stored appropriately	95	93	97	89	100	100	100	100	100	100	100	95

Comment on Current Performance

Benchmark 95%: Overall the adult inpatient areas are exceeding or achieving the 95% target for compliance on 2 key questions in the environmental audits. Matrons undertake peer audits by inspecting each other's areas.

Planned action

Ref	Action	Lead	Deadline
2.9	1. Conduct a review of COSHH storage facilities in both inpatient areas and departments. 2. Review the Matrons' Audit programme in terms of ensuring the sluice area is monitored for sharps bins being sealed and dated correctly and removed from the wards promptly. 3. Collaborate with SERCO for an independent quality check of sluice areas as part of SERCO cleanliness audits in terms of ensuring the sluice area is monitored for sharps bins being sealed and dated correctly and removed from the wards promptly.	Sue Johnson / Sam Rafferty	30/06/17

Update on Actions

1. The Quality Manager is seeking assurance from all Ward Managers that they have the appropriate COSHH storage facilities. This will be completed by 31st March 2017.

2. Request sent to Patient Safety Manager 30/01/2017 for advisory note to be added to Meridian. This will prompt the matrons to specifically score and comment on safe working practices within the sluice environment. Proposed that this is inherent in Question 4: Does the ward appear generally Tidy? Since January the Meridian Environmental Audit has been completed 13 times showing 100% compliance to the question "Are sharps bins not overfilled and are dated and temporary closure utilised." The link on Meridian around the sluice environment is not yet available; the Patient Safety Manager has been asked to provide confirmation of when this is likely to be live.

3. Feedback from PHNT SERCO link is that monitoring removal of full sharps containers from the sluice would not fit with the National Audit that has been developed for the Trust. Supervisors could be asked to add comments against the "Overall Tidiness" element under Sluice. The responsibility which sits behind each element would put this down to nursing responsibility. The audit completion reports will list all the comments but the completion of reports comes out individually after each audit has been submitted. To get an overall picture would require sifting through all the audit remedial action reports; which is not an efficient means of obtaining performance data on compliance. A decision needs to be made as to whether a previous plan to review the matrons audit should be reinvigorated or seek to close this line of enquiry and aim to keep with having the advisory note as detailed in sub action 2 above.

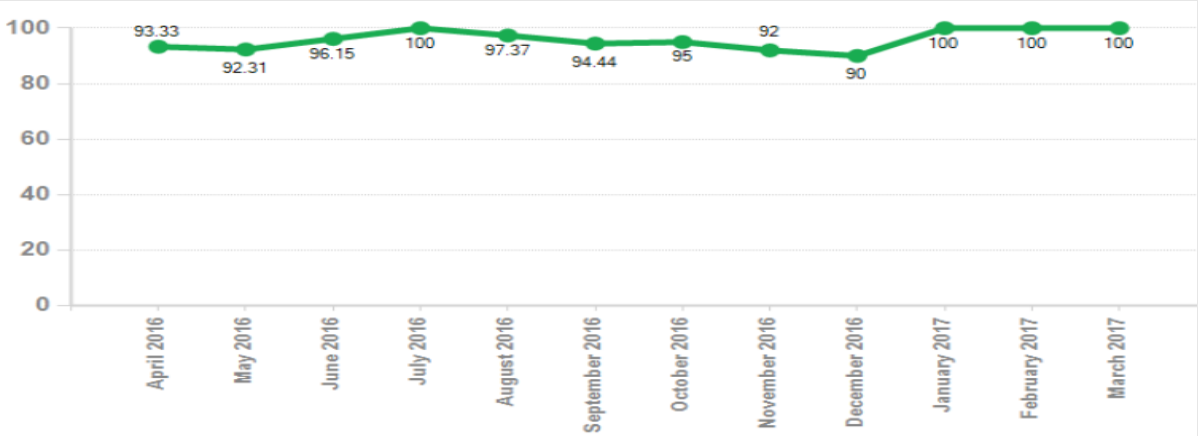
SHOULD DO: The provider should review the layout of wards which had six beds to a bay as in some areas this impeded access to hand washing facilities and clinical waste bins thus potentially compromising the control and prevention of infection.			
Planned action			
Ref	**Action**	**Lead**	**Deadline**
2.10	1. Undertake a review of the medical bed base requirements on each ward. 2. Risk assess the operational impact of reducing each bay to 5 beds against key performance indicators related to improved quality standards.	Joanne Beer	31/12/17
Update on Actions			
1.	Review of bed base requirements in progress.		
2.	Draft risk assessment written. To be presented to OPDG for approval.		

SHOULD DO: The provider should review the signage for the ambulatory care unit as it was not clear from the main hospital corridors.			
Planned action			
Ref	**Action**	**Lead**	**Deadline**
2.11	Undertake a review of way finding signage for the Ambulatory Care Unit from the main hospital corridors. Review to consider cost implications versus timing of the planned move of the Ambulatory Care Unit which will subsequently require further amendments to signage.	Stuart Windsor	30/04/17
Update on Actions			
Service Improvement Lead for Acute Care Co-ordination advised that the aim is for the Acute Care Unit to move into Orthopaedic Outpatients by April 17. There are some delays at the moment regarding confirmation of dates for relocation. The Facilities Programme Manager will work with the SI lead to ensure signage is changed to signpost the ACU in line with the timeline once dates are known. The paper outlining the plans should be presented to the OPDG in April.			

SHOULD DO: The provider should ensure that medicine trolleys are not left unattended when unlocked and that medicines are secured at all times.

Current Performance

Data extracted from Meridian: safe storage of medicines: 1st April 2016 to 16th March 2017



Comment on Current Performance
Overall the Trust is meeting the required benchmark for the safe storage of medicines.

Planned action			
Ref	**Action**	**Lead**	**Deadline**
2.12	1. Review the medicines' management policy pertaining to safe storage of medicines. 2. Review the medicines storage audit to ensure drug trolley security is monitored. 3. Conduct a matron led review of each ward's routine for stocking and cleaning drug trollies; and for undertaking drug rounds. 4. Undertake a matron led review of all wards to: - check the adequacy of supply of trolleys, - the condition of medicines trolleys to ensure they are fit for safe storage of medicines during drug rounds: e.g. all locking mechanisms are in good working order; - that keys are in the possession of the staff member undertaking the drug round.	Sue Johnson / Sam Rafferty	30/06/17

Update on Actions
1. Policy reviewed – Medicines Management Policy and Standard Procedures V9 June 2016 reviewed. Section 6; 6.3 page 26; Responsibility for Medication Cupboard/Trolley Keys. Action Completed.
2. Q13 of the safe storage of medicines asks the following: Are all drug trolleys: TETHERED to the wall and LOCKED if not in use OR ATTENDED by a Registered Nurse if in use? Action Completed.
3. Matrons will be asked to review their clinical areas; date to be confirmed. Their findings will be collated and shared. The Quality Manager has prepared an Excel Spreadsheet to collate findings of the matrons review of their areas; approval secured from Heads of Nursing to roll this out to matrons to populate.
4. The Quality Manager is awaiting response from the Ward Managers to confirm the adequacy of the trolleys and whether there are any problems with locking mechanisms or tethering to the wall.

Surgery

SHOULD DO: Review why surgery has received the most complaints.

Current Performance

Complaints by Care Group and Opened (Month and year) report extracted from Datix on 16th January 2017.

	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Full Year Total
Quality Governance	0	0	0	1	0	0	4
Clinical Support Services	3	3	3	0	1	3	19
Corporate Functions	1	1	0	0	1	0	6
Estates	0	0	1	0	1	0	3
Facilities	1	1	0	0	0	0	8
Medicine	27	24	18	19	13	22	240
Surgery	17	31	31	22	21	15	278
Trustwide	0	0	0	0	0	0	1
Women's and Children's	4	6	7	4	6	6	67
Total	53	66	60	46	43	46	626

Comment on Current Performance

During 2016 Surgery have received 278 complaints in comparison to Medicine's 240 complaints. 44% of the Trust's complaints are for the Surgical Care Group. 93 of the complaints within surgery relate to Access and Waiting in comparison to 38 for the Medical Care Group.

Planned action

Ref	Action	Lead	Deadline
3.1	1. Continue monitoring via the Surgical Care Group with the Patient Experience reports, looking for themes and local action. 2. Monitor Internal complaints though PALS.	Ian Wren	30/04/17 – Complete and closed

Update on Actions

The reasons for complaints within Surgery are discussed at the Care Group Governance Meeting with the Patient Experience Manager presenting a report which comments on the high number of patients raising concerns through PALs and through formal complaints about access and waiting times. Reviewing of complaints and PALs themes forms part of the forward work plan for the Care Group Governance Meeting and is part of the assurance framework when service lines present to the Care Group.

Work detailed in actions 3.2 and 3.3 aim to reduce the number of patients within the long wait categories of more than 40 and 52 weeks and bring the standards in line with the RTT of 18 weeks. Equally for outpatients, there continues to be follow-up backlogs mainly within Ophthalmology, Trauma, Orthopaedics and Rheumatology Service Lines. These risks are clearly stated on the Care Group's risk register (ID 5081, 5080, 5565, 5197).

SHOULD DO: Continue with the action plan to reduce their referral to treatment times in all surgical specialities. Continue to look at ways of reducing the number of patients who have been waiting for operations longer than 52 weeks.

Current Performance

Patients waiting >40 weeks for Treatment			
Specialty	22/02/2017	06/03/2017	09/03/2017
Neurosurgery	109	98	97
Plastic Surgery	27	23	27
ENT	9	2	2
General Surgery	7	6	7
Urology	5	5	3
Upper GI Surgery	5	5	5
Colorectal Surgery	5	10	3
Orthopaedics	4	4	4
Vascular Surgery	1	2	0
Cardiac Surgery	1	0	0
Hepatobiliary & Pancreatic Surgery	1	1	1
Pain Management	1	0	0
Maxillo-Facial	0	1	0
Dermatology	0	0	1
Grand Total	175	157	150

Comment on Current Performance

Referral to Treatment (RTT) has slightly improved, we are working with the national elective care programme and there are monthly meetings to review progress chaired by the Chief Nurse and Operating Officer. One or two areas are not on course to achieve the planned trajectory to 92%. The number of patients waiting more than 40 weeks has fallen below 200 (290 at the start of this year). Current performance shows a reduction from 175 on the 22nd February 2017 to 157 on the 6th March 2017 and 150 on the 9th March 2017.

Planned action

Ref	Action	Lead	Deadline
3.2	1.Deliver individual action plans. 2. Monitor delivery of plans via monthly Individual meetings, weekly RTT meetings and bi-monthly OPDG meetings.	Ian Wren	31/07/17

Update on Actions

Work continues with the commissioners particularly around Neurosurgery. An option appraisal is being completed for additional resources, including additional theatre and bed capacity and additional surgeons.

Additional theatre capacity is on line with Plym 3, Tavistock and a plan in place for Freedom 6 for March 2017, which is offsetting the risk from losing outsourced capacity. The Elective Care Intensive Support Team are developing more robust recovery plans, breaking improvements down into manageable trajectories. The Theatre Improvement Programme is focussing on all capacity.

The Neurosurgery business case has now been approved. This includes:

• provision of additional theatre capacity (1/2 theatre) following recruitment;

• an increase in the bed base for neurosurgery; and

• development of an extended recovery primarily for neurosurgery patients.

Also resilience around avoiding cancellation including offering patients choice about staying in recovery overnight or

waiting for a bed on the ward.

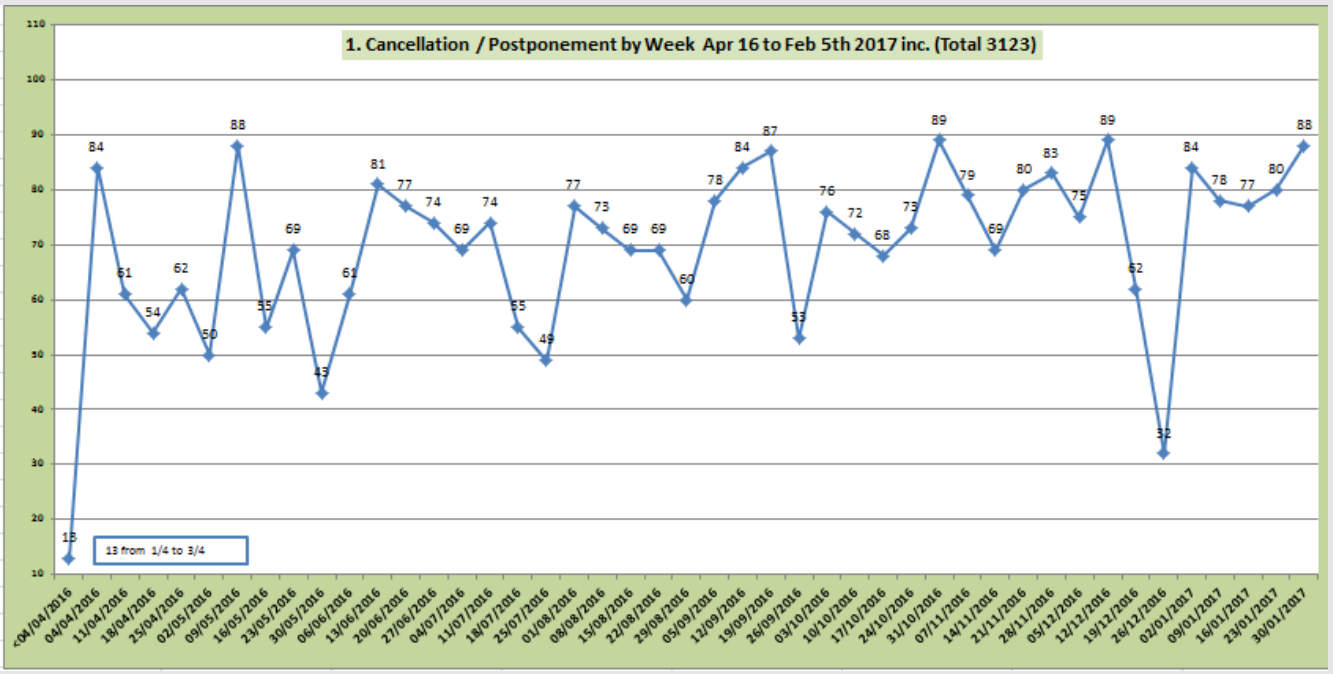
RTT trajectory plans are in place for 2016/17 and 2017/18 for each speciality. This is reviewed weekly in the Care Group and monthly with the Chief Operating Officer.

SHOULD DO: Continue to look at ways of reducing the number of cancelled operations and the numbers not re-booked within the 28-day time scale. Continue to look at ways of reducing the number of patients who have been waiting for operations longer than 52 weeks.

Current Performance

See previous section referring to 52+ week waiters.

Please see below for the current Theatre Improvement Plan. Cancellation Graphs Feb 16 v8



Comment on Current Performance

More detailed information is now available per specialty, by day-case and inpatient and by reason for cancellation. The data supplied for external monitoring includes the data for the Planned Investigation Unit, and other non-surgical procedure cancellations.

The cancellations due to bed pressures have significantly reduced and improvements are now being implemented to the patient reminder service.

Planned action

Ref	Action	Lead	Deadline
3.3	1. Define Service Line Improvement Project. 2. Establish mechanisms to monitor delivery of project via monthly report and working group. 3. Service lines to develop individual actions by Jan 2017.	Ian Wren	31/01/17 – Complete and closed

Update on Actions

Theatre Improvement Programme Actions relating to cancellations

Project	Action	Completion date
Cancellations	Disseminate updated cancellations by surgeon, review findings, establish trends & action plans for high cancellation specialties	Feb-17
Cancellations	Disseminate completed specialty packs. Work with SLM, SLD to review, establish action plans and start implementing potential changes to reduce cancellations.	Feb-17
Cancellations	Review NHS benchmarking data and report suitable performance information (IPM and current data)	Feb-17
Cancellations	Establish targets and KPI's for overall cancellations and each specialty and agree at next prog board	Feb-17
Cancellations	Review data numbers against through-put, discharges, breaches and correlate information.	Feb-17
Cancellations	Review Reminder service and establish current state (JF)	Complete
Cancellations	Gain agreement on performance team dashboard format using manually collated data (Cancellations, Delays, Late Starts, Late Finishes etc.)	Complete

- Disseminate updated cancellations by surgeon: weekly data now available. Weekly cancelled ops meeting with service lines to be arranged.
- Daily lunchtime meetings: happen daily at 1.30pm, these commenced in January.
- Review NHS benchmarking: Matron Cindy McConnachie is attending a meeting in London about this during March.
- Establish finalisation of theatre lists: Lists should be finalised by 1pm.
- Reminder service: Reviewed, additional staff member in post from February, therefore reminder service will roll out to all specialities who are currently not reminding patients. Weekly data now available following reminder calls which are undertaken 48 hours prior to date of surgery.
- Natsipps: We are setting up a project steering group to oversee implementation of NatSIPPS.
- Theatre communications : with effect from 13th Feb trialling new structure – Theatre Operations Manager in post working more closely with Site team with fixed daily meetings – planning 3 hours ahead for beds to improve sending times and start times.
- Recovery flow and processes: data being collected regarding times of patients within recovery.
- Recovery – expand ward level 1 capacity: additional level 1 bay going into Stonehouse ward from April 2017.
- Recovery PACU: trialling level 1 area in theatres w/c 20th Feb will prove trial of concept for PACU.

Surgical Breach meeting with Head of Operations reviewing the previous day's cancellations is established.

There are three themes with regards to cancelled operations:

• Operational issues and bed availability.

• Staffing.

• Medical and patient related cancellations (e.g. unfit for surgery on the day).

The initial focus was to resolve the operational and bed availability concerns and now this has shifted to on the day cancellations. The pre-alert programme has been strengthened whereby we are contacting patients prior to surgery to ensure that they know the date for their surgery and to confirm that there are no issues that would prevent them from having surgery on the day.

Performance targets are now set for each service line into the financial and performance improvement plan, with a target of 50% reduction in cancellations. Lunch time meetings in place between Theatre Management Team, Care Group Management and Operations lead reviewing the previous day's performance and initiating forward view of the next day's work.

SHOULD DO: Ensure that theatre lists are finalised at 3pm the day before the operations are due to take place.

Current Performance

In the daily 2pm meeting, theatre team leaders review the operating lists for the following day, including a review of whether the list is finalised, if the right staff are available (e.g. surgeon, anaesthetist, theatre staff), kit, information around the patient, order of the list, infection control issues etc.

Data from this, including finalised list data, is collated on a spreadsheet. Any feedback is given to service lines via email. Information from the spreadsheet will be collated into a run chart. Quarterly audit will be conducted.

Comment on Current Performance

Data on the number of lists finalised will be accessed from the run chart as described above.

Planned action

Ref	Action	Lead	Deadline
3.5	1. Conduct quarterly audit to assess compliance. 2. Present findings to the Service Lines to cascade down by Jan 17.	Ian Wren	31/01/17

Update on Actions

Internal audit review completed, report has been received and recommendations are being implemented.

Theatre scheduling policy is adequate however it needs strengthening to accommodate NATssips. There is currently variation on completing of theatre lists and local action plans need to be completed to address these issues.

Service Improvement are assisting with pulling together a run chart, the summary of which will be added to this document.

The plan is now to ensure that theatre lists are finalised by 1pm and not 3pm which will allow more time to resolve any issues. The 842 policy on scheduling has now been agreed and is expected to launch in March. At 8 weeks a surgeon should be allocated to a list, at 4 weeks patients should be booked onto a list and at 2 weeks the list should be finalised, having checked equipment issues etc. If the management team do not have assurance against these key measures then the list will be removed from local control.

Quarterly audits will commence in March.

SHOULD DO: Make sure chemicals and substances that are hazardous to health are secured and not accessible to patients and visitors in the Fal unit sluice area.

Planned action

Ref	Action	Lead	Deadline
3.6	Install locked cupboard. Key to be held with Band 6. (Fal Unit)	Jenny Pitt	31/12/16 – Complete and closed

Update on Actions

The only hazardous substance in the Fal sluice is actichlor tablets which have been removed and stored appropriately in the Postbridge sluice yellow metal (COSHH) cupboard. A notice has been put up in Fal sluice informing staff of the new storage location and instructing that they are not to store actichlor tablets in an unlocked cupboard. Quality Manager for Surgery has undertaken three spot checks of Fal and confirmed that there has been no actichlor or any other COSHH item found.

SHOULD DO: Make sure that all staff ideas are listened to and reasons given if they cannot be actioned.(Interventional Radiology)			
Planned action			
Ref	**Action**	**Lead**	**Deadline**
3.9	1. Implement Daily Team brief with Band 7 across all departments and theatres. 2.Encourage staff to raise questions via Ask Ann.	Kerri Richardson	30/04/17 - Complete
Update on Actions			
Daily team brief implemented at 08:30 which includes consultants, matron, nursing band 7, radiographer band 7 and other staff from the department. The team brief gives the opportunity to discuss issues from the previous day. There is also a Staff meeting held on CME mornings which is led by either the nursing band 7 or radiographer band 7, but due to shift patterns not all staff are able to attend. The actions have been completed and this is now routine which will be monitored by the matron for the area.			

Critical Care

SHOULD DO: Complete progress to allow the cardiac critical care service to contribute to the Intensive Care National Audit and Research Centre in order to obtain and learn from valuable benchmarking against other similar units.			
Planned action			
Ref	**Action**	**Lead**	**Deadline**
4.2	Investigate funding options to progress contribution to ICNARC.	Malcolm Dalrymple-Hay	Dependent on funding approval - hopefully 2017/18 financial year
Update on Actions			
This service development has been raised with local commissioners on a number of occasions but has not been agreed/funded. Formally raised in Business Planning for 17/18 in the expectation that this will be funded; feedback awaited.			

Maternity & Gynaecology

SHOULD DO: Should complete all outstanding refurbishments required on the delivery suite. This includes the remaining nine birth rooms, and the bathrooms and toilets which were shared between patients.

Planned action

Ref	Action	Lead	Deadline
5.2	1. Complete Room 5 refurbishment by end Dec 16. 2. Complete Room 14 refurbishment by end Jan 17. 3. Discuss room 6 and triage refurbishment in new financial year.	Sue Wilkins	31/12/17

Update on Actions

Areas already complete / refurbished:

- Delivery rooms 1, 2, 5, 12, 14 and 15
- The main bathroom (Op Snowdrop)
- Patient day room
- Snowdrop viewing room (8)
- Snowdrop room (9)
- Replaced communal corridor flooring across 80%
- Fixed wall protection along the communal corridors

Next and in priority order:

Shower room 4/072	Refurbishment will include a large shower cubicle (In progress this month)
Dirty utility	Replacement of all cabinetry and sink / taps / drainer and small tidy up
Clean utility	Replacement of all cabinetry and sink / taps / drainer and small tidy up
Bathroom (Op room 14)	Major refurbishment
Triage 4	Refurbishment / quotes being sourced
Triage 1, 2 & 3	Refurbishment / quotes being sourced
Delivery room 7	Birthing pool / quotes being sourced
Delivery room 11	This room had a tidy up, but needs a total refurbishment

Other areas awaiting updates:

Delivery 3	Fair condition
Delivery room 10	Fair condition – may be included as part of the Snowdrop Appeal
Bathroom (By Triage)	Needs refurbishing / Undecided as to the use of this room.

En suite toilet – all areas have been tidied, including painting radiators (Nov/ Dec 2016):

Between room 1 & 2	Fair condition
Between 5 & 6	Fair condition
Between 7 & 8	Fair condition
Between 9 & 10	Fair condition
Between 11 & 12	Has had a new toilet, sink and IPS / but hasn't had a total refurb / Fair condition
Between 14 & 15	Fair condition

SHOULD DO: Should provide more equipment to promote normalising birth and movement during labour and to aid pain relief.			
Planned action			
Ref	**Action**	**Lead**	**Deadline**
5.4	1 Agree procurement order for new dopplers - Complete. 2. Appoint normality midwife. 3. Discuss provision of equipment purchasing in 17/18 budget setting.	Sue Wilkins	31/12/17
Update on Actions			
Doppler purchased. Normality midwife advert was put out twice last year but there were no appointable applicants. The intention is to re advertise in Spring 17. EPR number applied for with intention of advertising at the end of March. Monthly meeting with finance team to discuss overall budget including equipment purchasing.			

Children and Young People

SHOULD DO: Consider staffing allocation to allow for management and supervision from senior staff in all paediatric areas.
Current Performance
Community Regular 3-4 monthly clinical supervision is in place and records kept for all Community children's nurses. Individual and group supervision monthly for therapists – records kept. Monthly supervision for Psychologists records kept. Ad hoc supervision for continence team – regular sessions to be established. Monthly safeguarding supervision provided for all staff by the safeguarding team. Ad hoc safeguarding supervision available and records kept in notes available from designated safeguarding supervisors. Individual senior staff receive supervision from peers external to the service line. **Acute** There is a Senior Band 7 or above available every weekday, office hours to provide support and supervision. Ward Managers work a predominately 4 day week, cross covering each other as necessary whilst covering the senior role for the floor. Ward Managers try to roster their band 6 to work on days when they are off.
Comment on Current Performance
Not applicable.
Planned action

Ref	Action	Lead	Deadline
6.1	1. Review allocation of supervisory time of ward manager role. 2. Ensure supervision is available for all staff across the community service line.	Anita Dykes / Sue Syers	30/04/17 - Complete

Update on Actions
Community: Monthly meetings now set for continence team; records to be kept. Closed action 9/2/17 SMT agree that minutes of supervision are available. **Acute**: Supervisory role of Ward Managers reviewed. 24/7 support from paediatric senior nurse in place if Ward Manager not available due to days off, annual leave etc. Matron available weekdays and Ward Managers also cross cover. Agreed at Post CQC inspection meeting 16/3/17 to close action.

SHOULD DO: Ensure height and weight measurements of children are readily available for staff prescribing medications.
Current Performance
Audit data not yet available.
Comment on Current Performance
Not applicable.
Planned action

Ref	Action	Lead	Deadline
6.2	Remind staff in all paediatric areas to record the height and weight of children via newsletter and email and audit compliance.	Anita Dykes / Heather Jarvis	30/03/17 - Complete

Update on Actions
Community: Email to staff sent to remind them that children should be weighed at each appointment and if prescribing. SMT have agreed that this will be added to the yearly records audit for monitoring. Next due April / May. Closed 10/02/17.

Acute: Staff reminded via email reminder. Height and Weight Question being added to Paediatric Fundamentals of Care Audit. Fundamentals of Care change request submitted so compliance can be audited.

SHOULD DO: Ensure only current medicine guidance is available in all paediatric areas. (BNF)

Planned action

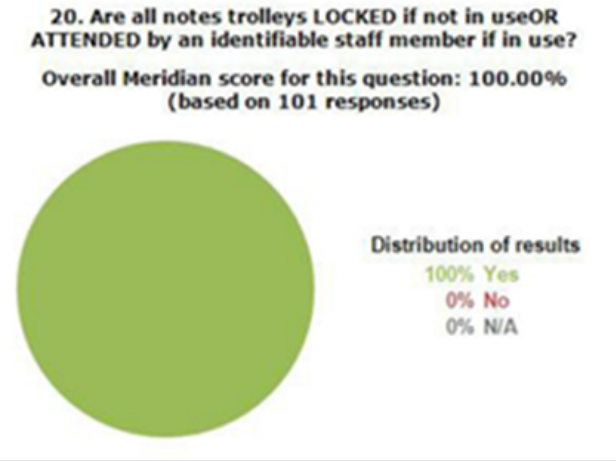
Ref	Action	Lead	Deadline
6.3	Ensure all out of date BNF-C are removed from circulation.	Anita Dykes	28/02/17 - Complete

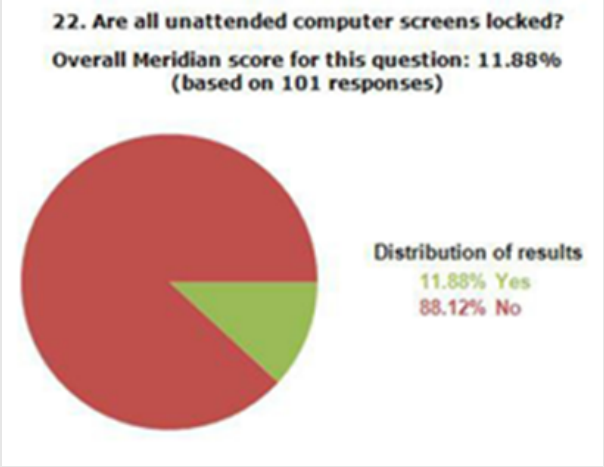
Update on Actions

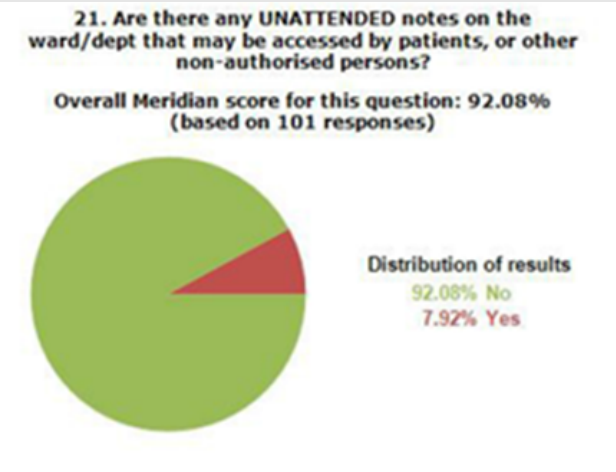
All removed from CDC. All removed from Level 12 and Plym by Paediatric Pharmacist.

SHOULD DO: Ensure patient details in children's and young people's services are kept confidential and that only authorised personnel are able to access details of care. (Patient details were displayed on an electronic board where visitors could view it which could compromise a child's privacy.)

Current Performance







Monitored via Matrons Audit on Meridian for Acute Paediatrics. Charts display results for the period 01/08/16-27/03/17.

Comment on Current Performance

None.

Planned action

Ref	Action	Lead	Deadline

6.4	1. Review the placement of electronic screen to ensure privacy. 2. Ensure patient notes are not left in clinic rooms unattended / accessible to members of the public. 3. Ensure patient identifiable information is not visible.	Anita Dykes	30/06/17

Update on Actions

Community: Staff reminded to close computer screens when not in use and ensure clinic doors are kept closed if notes are in them unattended. This will be monitored via 3- 6 monthly spot checks - first walk around confidentiality audit is due imminently.

Acute: Placement of screens reviewed by Matron. Woodcock's nurse screen could potentially lead to information being visible to other patients or parents so this will be moved. New works request to be submitted by 30/3/17. To be highlighted to staff in the next newsletter. Audit continues.

SHOULD DO: Make sure the equipment log is up to date with all servicing of equipment.

Planned action

Ref	Action	Lead	Deadline
6.5	1. Create a ward log of equipment. 2. Identified lead to manage the equipment. 3. All equipment added to one database to be maintained.	Anita Dykes / Sue Syers	28/02/17 – Complete

Update on Actions

Community: All equipment checked and now up to date and on one database. Ongoing checking process in place and monitored by specific staff. 9/2/17 – closed – database will be monitored by Service line governance group.

Acute: Link nurses identified for paediatric wards and equipment. Log obtained from MEMs, cross checking in place.

Actions complete.

SHOULD DO: The oxygen cylinder for use in emergencies, kept at the Child Development Centre, should be portable and safe for staff to move.

Planned action

Ref	Action	Lead	Deadline
6.6	Investigation and purchase of suitable trolley for the equipment	Sue Syers	31/01/17

Update on Actions

Some issues with identifying a suitable trolley. We cannot use a normal resuscitation trolley unless we have it stocked in line with the rest of the Trust which would not be required. The current equipment is portable and is stored in a carry bag. Specific trolley identified and has now been authorised for purchase but it is a non-standard item and is awaiting approval to be added to the system as a new product request. Once approved it can be ordered. There is a trolley for use if needed in the interim.

SHOULD DO: Consider how to raise an alert to potential safeguarding issues if parents or their children do not book appointments that have been professionally advised.

Current Performance

Policy is in place and algorithm is available to staff to ensure understanding of process. The safeguarding team monitor reported incidents when children are not brought or not opted into services and communicate with multi-agency partners as needed. Systems and processes are in place. Audit data not yet available.

Comment on Current Performance
All incidents where policy is not followed should be reported. Staff do report repeated failure to be brought to appointments to the safeguarding team so that they can liaise with community health colleagues as needed.

Planned action

Ref	Action	Lead	Deadline
6.7	This is incorporated in the DNA/Was not brought policy currently in use. Conduct audit of compliance with policy.	Alison O'Neill	31/05/17

Update on Actions

DATIX is monitored regularly and no incidents have been noted.

Staff do report regularly to the safeguarding team children who do not attend and do not opt into offered services.

Due to staffing issues the audit of policy has not commenced as yet. An audit of children who are not brought or whose parents do not opt into offered services is planned.

SHOULD DO: The Trust should consider how they manage and mitigate the risk to lone workers.

Planned action

Ref	Action	Lead	Deadline
6.8	1. Agree purchase of monitored lone worker devices. 2. Purchase and implement use of devices.	Andrew Davies (purchase) / Brigitte Price	28/02/17

Update on Actions

Community: The Trust has now purchased these devices and we are in the process of allocation. Data for staff currently being provided for Skyguard to upload onto their systems. Training planned for April.

Acute: Not relevant.

SHOULD DO: The trust should consider in-house provision of physical intervention trainers to ensure appropriate staff in the children and young people's service are fully trained.

Planned action

Ref	Action	Lead	Deadline
6.9	Develop a business proposal for internal training team.	Matron Brancher (Safeguarding) & Sophie King Clinical Educator CYP	May 2017 to go to Care Group leadership team with proposal for internal trainers

Update on Actions

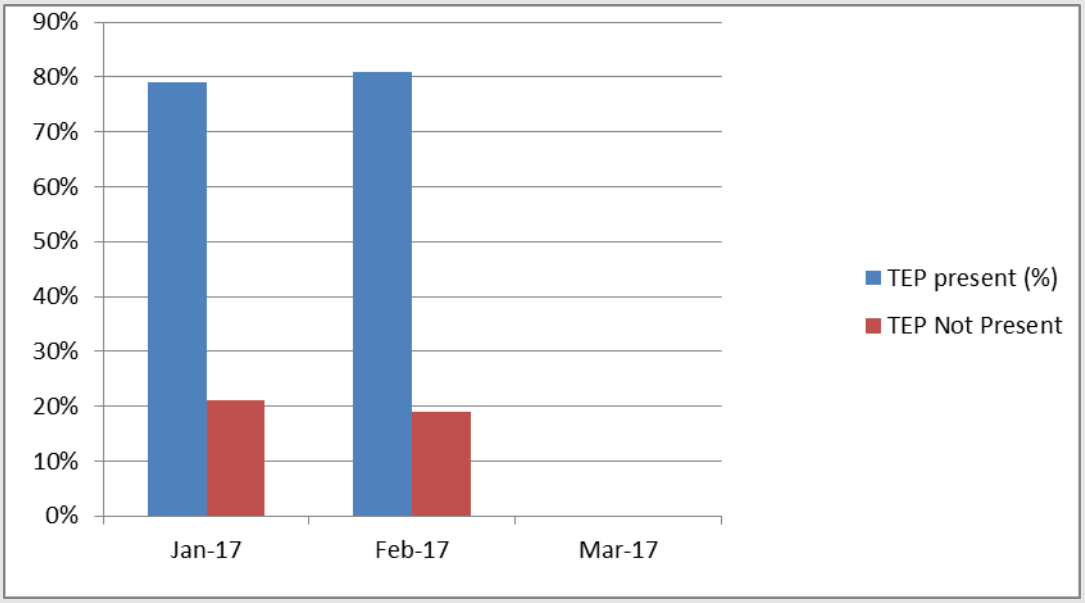
As an interim measure CYP has outsourced external training provision for 2017 regarding Physical Interventions training; this also includes Maternity staff and staff working with children in other areas of the Trust e.g. E.D., Paediatric Radiographers etc. Training for all maternity and paediatric staff in PI takes place in Block Week Training. Physical Intervention training continues. The Clinical Educator has been supported to undertake GSA regulated PI training to support the wards and Trust in further developing PI training in house and reduce reliance on outside trainers. Business Plan has been developed and submitted and is awaiting approval.

End of Life Care

MUST DO: Ensure audit programmes associated with end of life care are carried out in line with the plan and that actions and improvements are reviewed.

Current Performance

Retrospective audit of all emergency calls continues and quarterly reports are presented to both the End of Life and Resuscitation Committees. January – February 2017 report highlighted that TEP presence in medical notes = 79-81% of those patients who had a call for the emergency team to attend. For those patients deemed 'not for resuscitation' 100% of patients had the rationale documented for the decision and 86-93% of patients/relatives had been involved in the resuscitation decision process and discussion.



The revised Meridian TEP audit was piloted on x 20 patients in December 2016 on Healthcare of the Elderly wards and results are much clearer and demonstrate very good compliance with TEP completion.

Our organisation's (CQC) TEP Action Plan is to concentrate on exemplar areas within the organisation to ensure there is excellent TEP completion compliance prior to rolling out the audit across the organisation. Healthcare of the Elderly and Brent wards have been chosen as the exemplar areas.

Comment on Current Performance

See above.

Planned action

Ref	Action	Lead	Deadline
7.1	1. Meridian tool to be revised and rolled out across the Trust. 2. Results to be uploaded to service line dashboard. 3. Agree plan for reporting improvements and results.	J Williams	30/04/17

Update on Actions

Healthcare of the Elderly and Brent wards will implement the Meridian TEP audit April 2017. Results will be displayed on service line dashboards.

SHOULD DO: Ensure that local audits for the 'Last days of Life Care Plan' are put in place to provide evidence or any changes needed in practice.
Current Performance
Last Days of Life Local Audit completed December 2016. Compared with local audit 2015 and National Audit 2016. 14 sets of notes reviewed from the first patients to have died in May 2016. All 14 pts were non-cancer. 42% of patients >3 co-morbidities.
Comment on Current Performance
Local Audit completed. When compared to the National Audit March 2016 there seems to be an overall general improvement in care for patients dying within the acute trust
Planned action

Ref	Action	Lead	Deadline
7.2	To complete local Audit Dec 16. Results (produced annually) to be presented to and monitored by EOL Committee.	A Munton	31/01/17 – Complete

Update on Actions
Audit complete. Plan to be presented to EOL Committee April 17 and integrate with overall EOL plan.

SHOULD DO: Ensure the ongoing completion of plans in place to develop rooms for privacy for patients at the end of life and suitable environments for private discussion and the delivery of bad news.
Current Performance
Matrons completed baseline and work in progress to provide suitable BBN rooms
Comment on Current Performance
Matrons / Sisters to contact Planning regarding sisters offices to be redecorated.
Planned action

Ref	Action	Lead	Deadline
7.3	Work with Estates, HON and Matrons to identify suitable private rooms for BBN and guiding principles for BBN if room not available.	Matrons, Estates and HON	31/08/17

Update on Actions
The majority of Matrons have completed baseline assessment. Requires further work to make current facilities more suitable for patients and carers. Raised within Nursing and Midwifery Operational Committee.

SHOULD DO: Ensure improvements identified by the end of life 'quality improvement in the environment' project have timescales for completion which will enable patients and families to have a better experience.
Planned action

Ref	Action	Lead	Deadline
7.4	Plan agreed. Room redecoration to commence Feb 17 (two rooms over two weeks) with completion expected within 6-8 months; this will be under review to assess for impact on capacity.	K Lyth	31/10/17

Update on Actions
Funding agreed. Plan to commence 2 rooms at one time from Feb 17. Work commenced, work intermittently stopped due

to operational pressures. Now resumed and escalation process implemented.

SHOULD DO: Continue to explore options to increase space for multi-faith prayer and facilities for ablutions prior to prayer.			
Planned action			
Ref	**Action**	**Lead**	**Deadline**
7.5	Arrange multi faith meeting to discuss possible options. Review opportunities to redesign space available within Chapel and surrounding offices/rooms to accommodate requirements for Friday prayers and ablutions. Work with estates to implement plan.	P Snell	30/04/17
Update on Actions			
Identified a temporary way forward prior to implementing a permanent solution. The proposal is to purchase some free standing screens to create a prayer area for Jumah prayers on Fridays only (the prayer room will continue to be used during the rest of the week.) This can be achieved within the next month, once the type is decided. Further temporary proposal to adapt the existing toilet and ablution facility, to incorporate 2 or 3 sinks in the existing room, and possibly to remove the toilet facility in line with CQC requirement. The leader of the Muslim congregation suggested the facility is adequate for weekday usage and that on Fridays many of those worshipping carry out their ablutions elsewhere before arriving whilst others can continue to use the existing facility. Actions in progress.			

Outpatients and Diagnostic Imaging

MUST DO (Derriford): The provider must make sure that medical records are stored securely overnight in the oncology outpatients department.
Current Performance
To be assessed via quarterly case note audits once records have been relocated.
Comment on Current Performance
Not applicable at this time.
Planned action

Ref	Action	Lead	Deadline
8.1	Relocate Oncology Medical Records into expanded Oncology OP in March 2017 with all records to be stored in there overnight and with swipe access to new facility.	Denise Roddy	31/03/17

Update on Actions
Relocation project currently being reviewed.

SHOULD DO (Derriford): The provider should translate the vision and values of the organisation and service lines into clear, credible, and well defined objectives for outpatients which are regularly reviewed and remain relevant and achievable.
Planned action

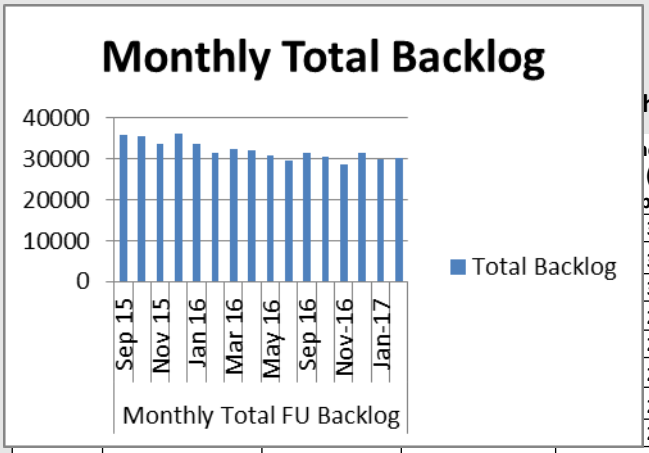
Ref	Action	Lead	Deadline
8.2	1. Local objectives will be set through the annual business planning process. 2. Outpatient Forum to consider the objectives generically for outpatients as an agenda item.	Sue Johnson	30/06/17

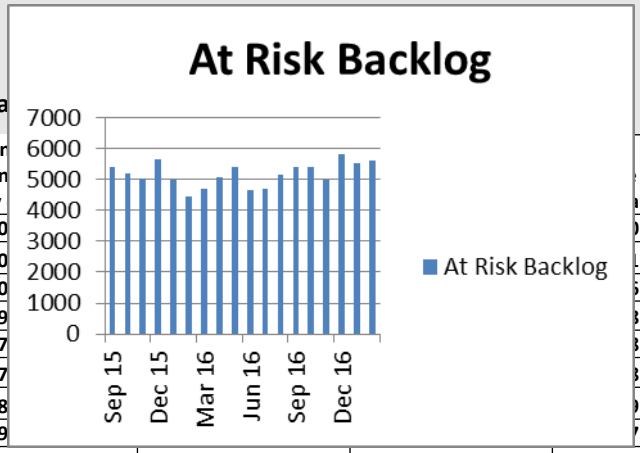
Update on Actions
This was considered at the Outpatient Forum on 22 February 2017 and it was felt that this was only really a concern for main outpatients which supports a broad range of service lines rather than outpatient clinics that sit within their service lines e.g. fracture clinic.

MUST DO (Mount Gould): Take action to reduce the numbers of patients waiting past their to be seen date on follow-up and pending waiting lists.

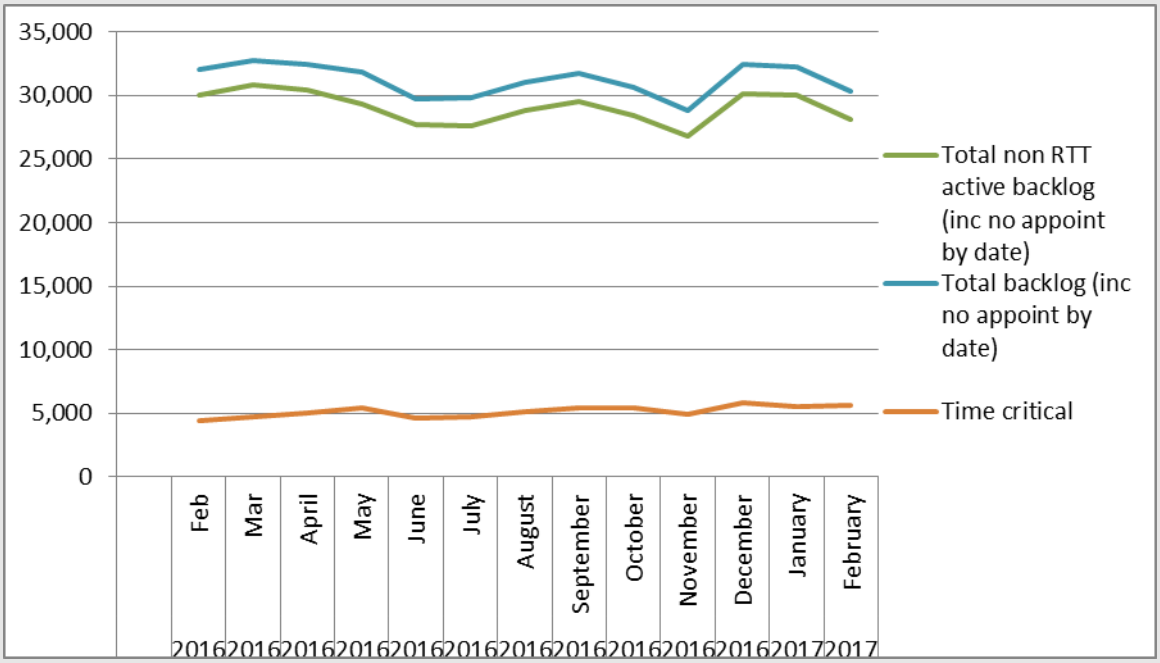
SHOULD DO (Derriford): The provider should continue to make improvements on the follow up backlog waiting list to meet people's needs.

Current Performance



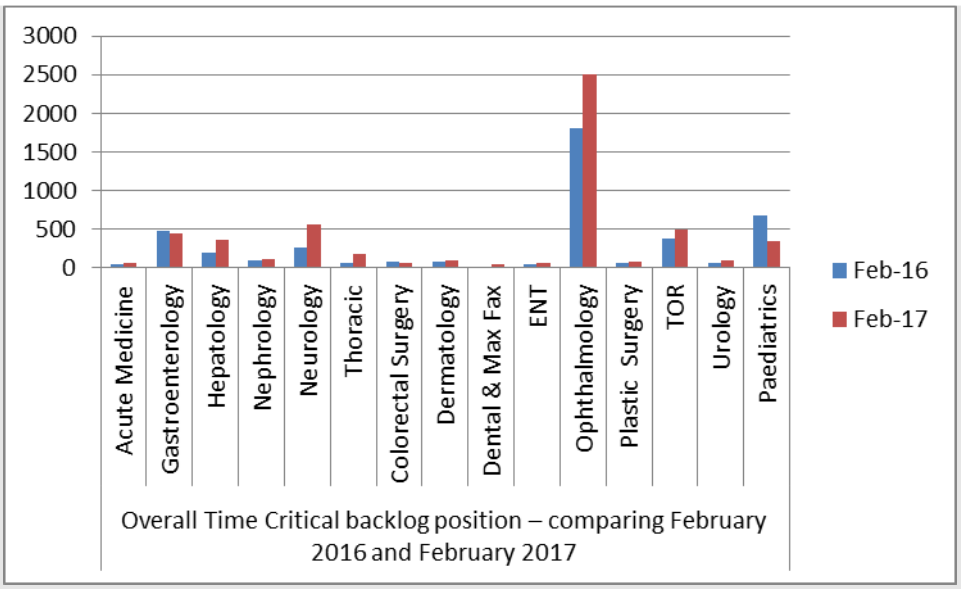


2016	October	28,349	94	**28,443**	2,137	**30,580**	**5,417**
2016	November	26,619	181	**26,800**	1,976	**28,776**	**4,974**
2016	December	29,901	185	**30,086**	2,336	**32,422**	**5,806**
2017	January	27,642	161	**27,803**	2,211	**30,014**	**5,538**
2017	February	27,920	200	**28,120**	2,224	**30,344**	**5,602**



Tables below show comparison between February 2016 and February 2017 of overall backlog and time critical backlog.

Source: FBM



Comment on Current Performance

The end of February saw a small increase in the follow up backlog; there were 30,132 patients past their 'see-by-date', a rise of 289 on the previous month and 5,602 patients are flagged as being at clinical risk, a rise of 64 on the end of January.

The profile of length of wait past see by date has improved in the last 12 months across all time parameters with a reduction in the number of the longest waiting patients. There has also been a reduction in the patients waiting longer than a year past their see by date. At the end of February there were 564 patients waiting longer than one year compared to 1,215 patients at the end of February 2016.

Planned action

Ref	Action	Lead	Deadline
8.3	1. Continue to reduce the longest waiting patients by lowering the threshold of the managed discharge programme, where clinically appropriate to do so, from the current + 52 weeks to 9 months and then a further reduction to 6 months. 2. Develop a plan across the high volume service lines of patients currently on the waiting list to determine if the patients can be managed in primary care, managed via a shared care model with both primary and secondary care or if they need to remain within secondary care. 3. To develop a plan with the high volume service lines for developing alternative approaches to follow up care, e.g. Patient Initiated Care (PIC). 4. Work with Ophthalmology to transfer some of the follow up of cataract operations to a community setting, to free up hospital capacity to contribute to seeing high risk backlog patients. 5. Where alternative methods of follow up cannot be introduced for clinical reasons each service line will develop a plan as to how they will reduce the number of backlog patients. 6. Review any incidents recorded on Datix related to the follow up backlog.	Sue Cook	30/09/17

Update on Actions

The end of February saw an increase in the number of patients waiting in the overall and the time critical backlogs, however, the competing priorities for the limited capacity continues to impact on the Trust's ability to reduce the backlog

and time critical figures substantially further.

Long wait patients (52+ weeks)

The Trust continues to manage this group of patients to achieve the internal standard of having no patient wait longer than one year past the see by date, consistent with the 52 weeks RTT standard. The progress made over the last 18 months has seen the number reduce from c1,800 to 564 and 39% of these patients had an appointment date at the end of February.

The managed discharge process continues to be implemented to remove long wait patients from the waiting lists where clinically appropriate to do so in conjunction with GP practices to ensure the continuity in care management. Patients are offered the opportunity to remain on the waiting list should they wish to and if they choose to remain on the waiting list they are prioritised for a face to face or a virtual appointment. Dermatology, Gastroenterology, Cardiology and Thoracic Medicine continue to manage patients via this process. Neurology also manages a selected group of patients through this process.

The threshold for the managed discharge process has been lowered from +52 week to 40 weeks within Gastroenterology, Dermatology and Neurology.

Time Critical (high risk) patients

The end of February saw a small increase in the number of time critical patients. As at 28th February 2017, 45% of the 5,602 time critical patients had been given a clinic date. 69% (3,874) of the time critical patients in backlog fall within a 3 month timescale with 22 patients having waited over a year, compared to 125 patients at the same time last year. As previously identified, the competing priorities for limited capacity continues to impact on the Trust's ability to reduce the number of time critical patients further.

The number of 'time critical' patients is higher compared to last year. There have been significant improvements made within Gastroenterology and Paediatrics over the last 12 months. The service lines with the largest volume of time critical patients, i.e. Ophthalmology, Neurology and Paediatrics are developing recovery plans to reduce the number of time critical patients.

The 'time critical' numbers are contributed to by patients who DNA. At the end of February there were 496 patients within this category who have been offered an appointment but have not attended, 348 of these patients are backlog time critical patients and remain on the waiting list within the backlog until they attend a further appointment. The Trust has been developing a local policy for follow up DNA's. The clinical sign off of this policy has taken longer than initially first anticipated as it is now being discussed at clinician level in the individual service lines.

Of the backlog 'time critical' patients there are 111 patients at the end of February where the booking teams are unable to book appointments as the patients are still awaiting investigations or a review of results.

Future Plans

Having made improvements through the robust systems of prioritisation and ensuring capacity is maximised, the Trust has reached a point where a further step improvement is required to continually significantly reduce the overall backlog and time critical numbers which is beyond the process improvement of the current systems and practices.

The large volume service lines have quantified the opportunity for joint working with primary care (mainly general practice) by reviewing patients on the follow up waiting list to determine if they can be managed in primary care, managed via a shared care model with primary and secondary care or if the patients need to remain in secondary care. Following on from this review of patients, a pilot with 6 GP practices has commenced to sample 150 patients per practice in Respiratory Medicine, Neurology and Paediatrics (50 patients per speciality). The review of patients is expected to be completed by mid - May and meetings arranged shortly after to gain clinician to clinician agreement as to which patients can return to primary care. The pilot will then be reviewed with regards to the potential of rolling out this process to all backlog patients in other GP practices.

The returning of patients to primary care will be managed through an organised structured process similar to the current managed discharge programme for the over 52 week wait FU patients.

Creating clinic capacity through identifying alternative working arrangements will help to secure the required capacity to ensure that time critical patients can be seen in the required timescales. This will not always be possible due to sub specialism i.e. not all capacity will be transferable to meet the specific needs of particular patient groups.

In addition to this work the Ophthalmology service have been working up a proposal to change the pathway so that patients who have a first, final and second, final cataract operation are followed up by a community optometrist; the service specification is expected to be completed by the end of April 2017. The Ophthalmology service has also

completed a pilot for virtual eye clinics for glaucoma and diabetic patients and 60% of patients reviewed were discharged back to primary care. The implementation plan for the roll out is expected to be completed by the end of April 2017. This would have the benefit of vastly improving the review time of these patients and help reduce the overall backlog due to the more timely response.

A review in urology of patients within the backlog with a booking category of 'Do Not Book' has been completed which has identified administrative and clinical issues around how patients are managed whilst on the waiting list. As a result of this review, work is about to begin to deliver changes in process to manage these patients in a more effective way to ensure they are removed from the waiting list at an appropriate time. This review of process is also to start five other high volume service lines.

Incidents related to FU backlog

In the last 6 months there has been one incident recorded on Datix in Ophthalmology related to the backlog in follow up .

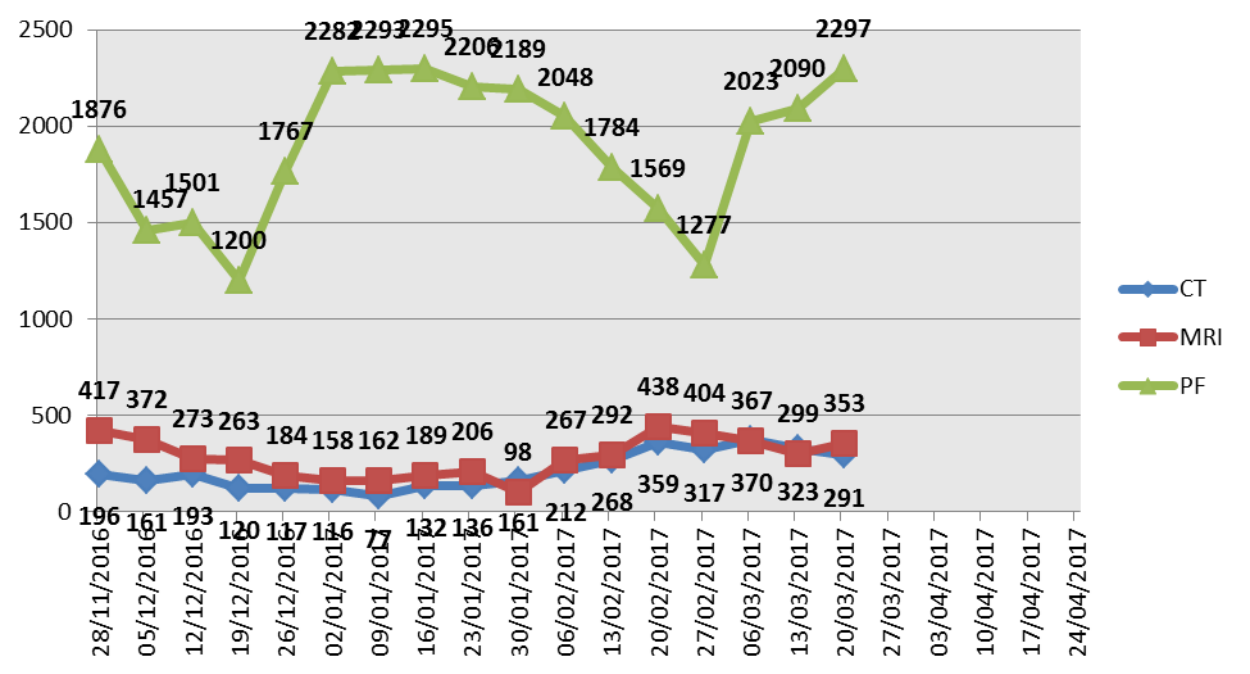
SHOULD DO (Derriford): The provider should minimise risk and harm caused to patients through excessive waits on the reporting of images.

Current Performance

The Planned outcome will be to meet the national targets for reporting. Provision of assurance will be a review of weekly performance. As part of the Service Line Strategy and assurance provision the Consultants Job Plans will be very transparent around reporting capacity. Once this has been completed (April 2017) an improved Capacity v Demand analysis can take place of reporting capacity to enable planning of the service demands going forward. Various staff members allocate exams to be reported to reporting consultants and this is overseen by operational management. Work has been undertaken to formulate this into a Standard Operating Procedure (SOP).

Comment on Current Performance

At present there are 4.08 WTE gaps in the Radiologist workforce. The reporting capacity lost through this is provided through outsourcing to 3rd party providers. Outsourcing of reporting is also used regularly to meet the additional images taken to meet the 6/52 standard when outsourcing of exams is performed. A weekly report is gathered and provided and shared with all imaging staff so reporting length of waits is communicated with both patients and referring clinicians including GP's. Below is a graph of all outstanding unreported diagnostic scans. Plain film reporting has deteriorated over the past few weeks and we are working to find a solution to the backlog. Of the 2297 noted above over 85% are at less than 7 days old. Around half of these are IP or ED attenders. We are working on a way of improving the process and timeliness of the auto reporting.



Planned action

Ref	Action	Lead	Deadline
8.4	The Service Line will review the process for images awaiting reporting weekly and then monitor performance through weekly data charts.	Mark Walker	30/06/17

Update on Actions

At present, imaging has a process where Images awaiting reporting are pushed to Reporters by the admin and clerical team who have vision of the reporters' annual leave and other absence. This is reviewed daily and longer than normal waiters are chased or removed from the relevant reporting Silos and subsequently reassigned. During times of reduced capacity outsourcing is used as a result to deliver timely exam turnaround times. A SOP has now been written to provide the service line with continuity of actions around allocation. A further 3rd party for external reporting is also being sought to improve further resilience for the reporting.

SHOULD DO (Derriford): The provider should put process in place that ensure all diagnostic images that required documented evaluations have one.

Current Performance

Service Line	Last audited	Number audited	Written evaluation present?	Status
Pain	April-16	15	60%	Ongoing
Cardiothoracics	--	0		**Not started**
Dental & Max Fax	May-16	30	80%	Ongoing
General & UGI	--	0		**Not started**
Neurosurgery	Apr-16	15	93%	Ongoing
Plastic Surgery	Mar-17	30	65.5%	Audit ref: CA_2015-15-079 Rolling audit default audit tool not used
Trauma & Orthopaedics	Nov-16	50	90%	Ongoing
Urology	Jan-17	30	100%	Ongoing

Comment on Current Performance

For those who have performed initial audits, the results have been extremely variable and follow up audits with action plans to improve will be required. These actions are an important way of reducing this known risk to our patients.

Planned action

Ref	Action	Lead	Deadline
8.5	The Radiology Service Governance Manager will perform an audit of service lines who should be documenting all auto reports in the patients notes.	Mark Walker/Kylie Glynn/Brent Drake	30/06/17

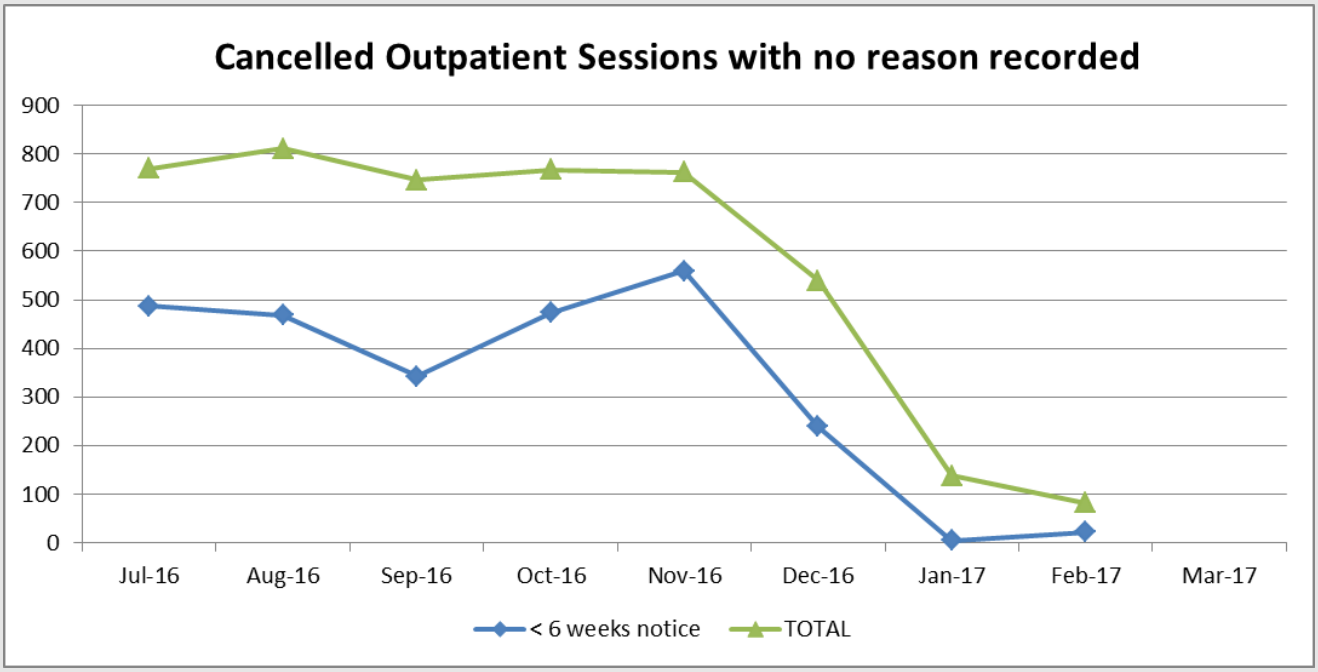
Update on Actions

The Radiation Protection Committee Chair has written to the Care Groups to ensure that audits are now performed with completion within the next two months and this action is placed on the associated service line risk register. Audits which have not commenced will be chased and enforced by a member of the Executive team who sits on the RPC board.

MUST DO: Reduce the number of clinics cancelled and capture the reasons why.
SHOULD DO: Ensure staff comply with annual leave policy when cancelling sessions with less than six weeks notice to patients.
(Derriford and Mount Gould)

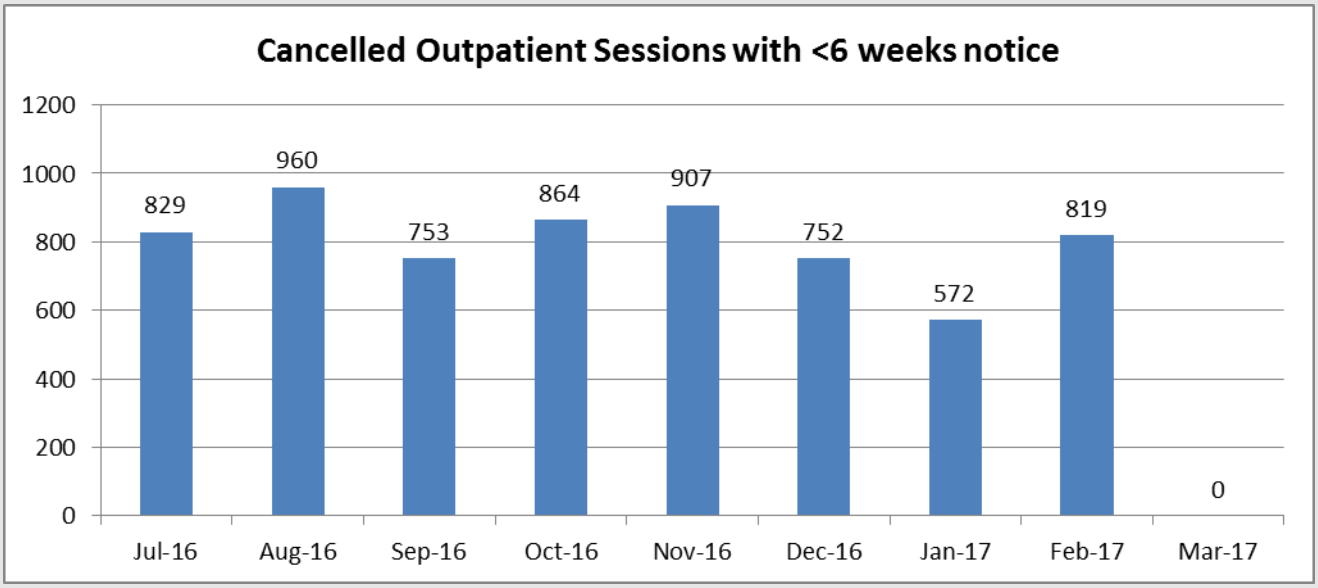
Current Performance

Graph 1: Completeness of "reason for cancellation" recording



	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
< 6 weeks notice	487	469	342	474	559	239	5	22
>6 weeks notice	283	342	404	294	204	300	133	60
TOTAL	**770**	**811**	**746**	**768**	**763**	**539**	**138**	**82**

Graph 2: No. of Outpatient Sessions Cancelled with <6 week notice



[Note: excludes short notice cancellations due to sick leave, special leave & capacity not required)

Comment on Current Performance

Graph 1 shows how the level of sessions with no cancellation reason recorded has been reasonably consistent but, following a notice to all staff in November that this was now mandatory, an improvement in performance has been seen since December 2016 with best performance to date being seen in February 2017; 82 with no reason recorded which equates to 5.7%.

Graph 2 shows that the total number of outpatient sessions cancelled with < 6 weeks notice has ranged from 752 to 960 during the months of July 2016 to December 2016. An improvement was seen in January 2017 but February 2017 has seen a return to previous levels.

Planned action

Ref	Action	Lead	Deadline
8.6	1. Amend Access Policy to make recording of clinic cancellation reason mandatory.	Sam Sheridan	31/01/17 – complete & closed
	4. Publicise number of clinics cancelled with < 6 weeks notice at Service Line Level - understand reasons why and develop actions to combat areas where cancellations are not reasonable e.g. due to annual leave.	Jacqui Beer	31/03/17
	5. Agree escalation policy for sessions cancelled with < 6 weeks notice as they happen - reporting mechanism required.	Graeme Hemsley	28/02/17

Update on Actions

The Access Policy has been amended to make recording of the clinic cancellation reason mandatory.

The need to record the reason for cancellation of Outpatient sessions is also being emphasised at the monthly RTT meeting where all Service Line Management Teams attend. Information showing levels of unrecorded reasons and those cancelled with < 6 weeks notice is being publicised on a regular basis along with the iPM Users involved.

The current report shows which specialties still have some data quality issues (see table below).

Specialty	6 Weeks Plus	Less than 6 weeks	Grand Total
Paediatrics	23	2	25
Anaesthetics	8		8
Diabetic Medicine	8		8
Neurosurgery	2	3	5
Uro - Gynaecology		5	5
Obstetrics	4		4
Neurology	4		4
Clinical Immunology	2	1	3
Rheumatology	2		2
Thoracic Medicine	1	1	2
Audiological Medicine		2	2
Cardiology		2	2
Clinical Haematology	2		2
Gastroenterology	1	1	2
Maxillo Facial Surgery		2	2
Clinical Oncology	1		1
Clinical Biochemistry	1		1
Gynae - Hysteroscopy		1	1
Nephrology		1	1
Orthodontics	1		1
Pain Management		1	1
Grand Total	60	22	82

Paediatrics is still showing as having the most clinics cancelled without a reason recorded. This has been investigated and is due to the fact that the majority of these clinics were cancelled back in the autumn of 2016 before the mandate was established.

A new report has been set up to monitor the issue in-month to ensure all are recorded accurately prior to the month end

reporting.

Now that the data quality is improving we can review the reasons each month with more confidence.

The table below shows the data of all cancelled sessions with < 6 weeks notice for February 2017. Currently we are classifying the following reasons as acceptable for short notice cancellation: Sick leave, Special leave & Capacity not required. The data is now being shared with the Service Lines to review. "Annual leave" is the largest cohort and work is underway with the key Service lines to understand why this is happening; anecdotally we are being told that the correct notice is being given but there is a delay in recording this on iPM.

Canc Reason	Total
Annual Leave	303
Clinic Profile Change	102
External Duties	49
Management Commitments	65
No reason Given	22
Study Leave	55
Support Staff Unavailable	142
Take Commitments	70
Theatre - Awaiting new Consultant	1
Theatre - Consultant unavailable - Annual leave	2
Theatre - Consultant unavailable - Other	3
Theatre - See Comments	4
Theatre - Session entered in error	1
Grand Total	819

The escalation policy has been drafted and been out to consultation with the Care Groups. It is hoped that this will be agreed and signed off by OPDG before the end of March 2017.

SHOULD DO (Mount Gould): Consider reviewing risk registers, to enable risks to be captured by site.

Planned action

Ref	Action	Lead	Deadline
8.7	Risk Management Review Group to consider the feasibility of adding offsite locations to Datix to enable risks to be captured by site.	Steve Mumford	Complete and closed

Update on Actions

We have enabled the 'Unit' field to the Risk Register module of Datix (as set up on the Incident module) which allows new risks to be captured by site. The list of offsite locations detailed under the 'Unit' field have been reviewed and updated. The list now contains the following offsite locations:

- Cumberland Centre
- Derriford Hospital
- Kingsbridge Hospital
- Launceston Hospital
- Liskeard Community Hospital
- Mount Gould Hospital
- Plymouth Dialysis Unit
- Royal Cornwall Hospitals Trust (Treliske)
- Scott Hospital
- Stratton Hospital
- Tavistock Hospital.

SHOULD DO (Mount Gould): Consider reviewing cleaning audits carried out by external companies in relation to the environment in the outpatient, diagnostic imaging and pain management. Review its systems and process which give assurance that services delivered by external companies are carried out in a way that keeps people safe.

Current Performance

To be determined.

Comment on Current Performance

To be determined.

Planned action

Ref	Action	Lead	Deadline
8.8	1. Implement appropriate measures into the Inter Trust Agreements in the new contracting round for 17/18. 2. Implement requirement for quarterly contract monitoring reviews where we look at quality of care, risks and issues, incidents and manage patient feedback etc.	Chris Rapson	30/03/17

Update on Actions

Requirement for Quarterly reviews has been built in to new Inter Trust Agreements and agreed with other providers. Specific schedules for all services still to be completed. Agreement for 1st Quarterly review to take place in April 17. Working to finalise list of attendees from each organisation

SHOULD DO (Mount Gould): Consider reviewing secretarial staff numbers to help clear the typing backlog of Mount Gould clinic letters. Ensure the digital dictation system is fully implemented to help reduce typing delays at Mount Gould Hospital.

Current Performance

Graph 1: No. of letters awaiting typing at end of each month with > 5 days delay

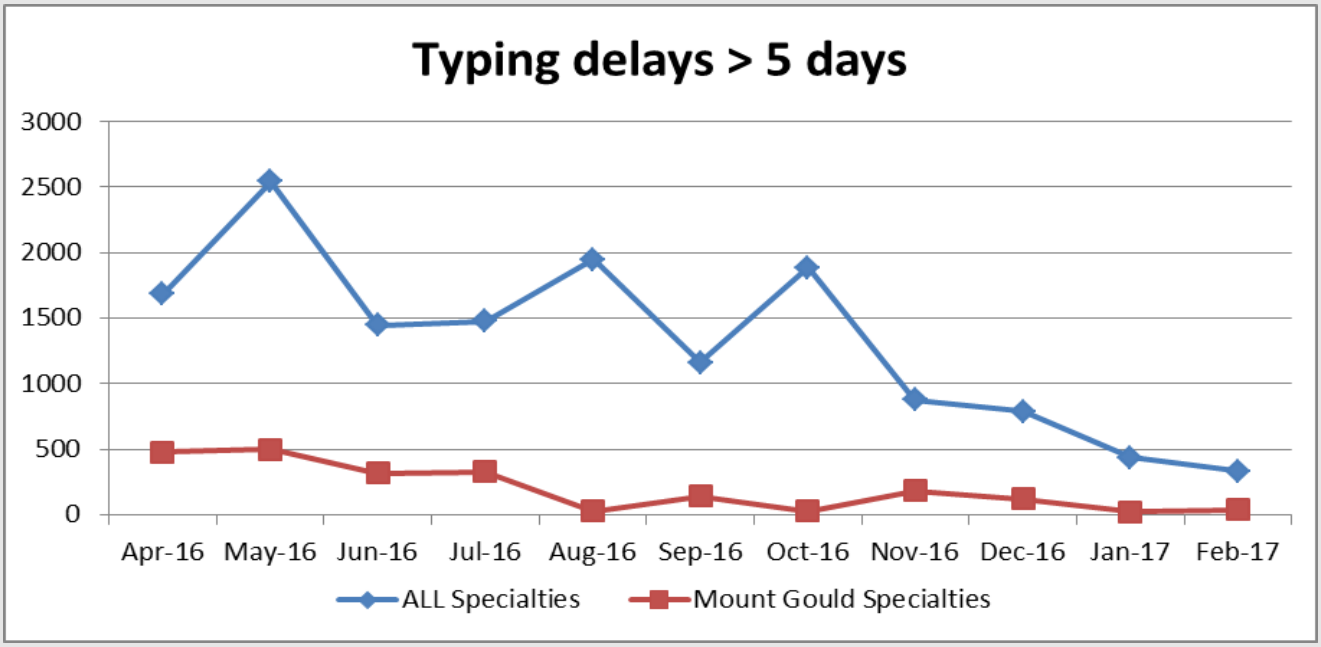


Table 1: No. of letters awaiting typing at end of each month with > 5 days delay for specialties that have some clinics at Mount Gould Hospital

Mount Gould Specialties	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Endocrinology & Diabetes	1	0	0	20	0	2	0	4	0	0	0
ENT	0	9	14	0	11	0	11	0	0	0	0
Health Care of the Elderly	1	3	47	5	0	0	0	0	22	12	0
Neurology	279	157	124	172	2	93	2	31	5	5	0
Ophthalmology	27	82	86	81	0	0	0	8	4	3	0
Orthopaedics & Trauma	27	63	2	0	0	28	0	7	3	0	27
Pain Management	0	0	0	41	0	0	0	92	62	0	0
Rheumatology	0	137	0	0	13	15	13	9	0	0	0
Thoracic Medicine	142	38	46	9	1	2	1	12	3	5	14
Upper GI HPB	0	8	0	0	0	0	0	20	21	0	0
Upper GI OG	0	0	0	1	0	0	0	0	0	0	0
TOTAL Mount Gould Specialties	**477**	**497**	**319**	**329**	**27**	**140**	**27**	**183**	**120**	**25**	**41**

Information on digital dictation usage to be developed.

Comment on Current Performance

Typing delays

Graph 1 shows that the number of letters with a typing delay of greater than 5 days has been reducing since May 2016. In May 2016 the number was 2,541 compared to end of February 2017 when the number was 332; a reduction of 2,209 delays.

We are not able to separate letters for patients who attended Mount Gould hospital accurately so the graph also shows the position for all specialties who have some activity at Mount Gould as a proxy. It can be seen that this number has also reduced from 497 in May 2016 down to 41 at the end of February 2017; a reduction of 456 delays.

Table 1 shows these numbers broken down by specialty (where some activity occurs at Mount Gould) and demonstrates that the 2 specialties with the greatest number of delays in April 2016 (Neurology & Thoracic medicine) have improved significantly. Now only very low numbers exist in a few specialties and this is being monitored weekly to manage.

The wider Trust position is also being actively managed. The table below shows the 6 specialties that contribute to 92% of the delays.

Urology	152
Thoracic Medicine (Junior)	45
Neurosurgery	37
Orthopaedics & Trauma	27
Maxillo Facial Surgery	23
Cardiology	21

Use of Digital dictation

Digital dictation has been rolled out across the organisation with, based on the original scope of the project, only 1 clinician not taking advantage of the new technologies. Work is in progress to develop an automated way of assessing whether all currently employed clinicians are using the technology.

Planned action

Ref	Action	Lead	Deadline

8.9	1. Review current secretarial staff numbers at Service Line level.	Sam Sheridan	30/06/17
	2. Create a methodology to assess level of secretarial staff needed to carry out required functions within Trust standard timescales.	Sam Sheridan	30/06/17
	3. For Service Lines with backlogs of typing (>5 days), create an action plan for improvement which may involve Transformation Team input to redesign processes.	Jacqui Beer/Louise Shalders	30/06/17
	4. Report any clinicians not yet using the digital dictation system to the Medical Director.	Jacqui Beer	31/03/17 – Complete with monitoring ongoing
	5. Support those individuals to switch to required technology.	Sam Sheridan	31/03/17 – Complete with monitoring ongoing

Update on Actions

Review of secretarial staff numbers

Due to lack of engagement from the Service lines with regard to this work, a slot has been reserved at the Operational Performance & Delivery Group meeting on 11th April 2017 to gain agreement on a way forward.

Action plans for Typing delays

Despite the improvement already seen, work continues to identify specialties where the number of > 5 day delays remains too high. The Transformation Team have worked with Gastroenterology and Hepatology to review processes and staffing levels, the result being zero typing delays as at the end of November 2016; this remains the case through to the current time. This work is planned to be rolled out across more specialties as part of the Elective Care Transformation Programme.

Update on specialties with the remaining backlogs:

Urology – due to absence but being actively managed by sharing workloads

Thoracic Medicine - short term issue relating to absences

Neurosurgery – been improving for last 2 months

Orthopaedics – short term issue relating to annual leave

Maxillo-Facial Surgery - short term issue relating to absences

Cardiology - been improving for last 2 months

Use of Digital dictation

Support has been provided to the Service Line with the non-Users. The one remaining non-User has now agreed to commence use of the new Digital Dictation system from the 1st April 2017 following return of a device which is being repaired.

Staffing and Training

MUST DO: Ensure safeguarding training for staff in the emergency department and across all areas is completed to ensure trust compliance targets are met.

Current Performance

Area	Month	Level 1	Level 2	Level 3
ED	March 2017	100.00%	95.12%	86.71%
ED	February 2017	100.00%	100.00%	84.9%
ED	January 2017	100.00%	100.00%	88.65%
ED	October 2016	100.00%	95.00%	78.42%
Trust wide training	March 2017	98.20%	90.66%	84.86%
Trust wide training	February 2017	97.8%	90.2%	83.2%
Trust wide training	January 2017	97.86%	90.39%	84.52%
Trust wide training	October 2016	97.62%	90.34%	75.47%

Comment on Current Performance

Training at all levels continues to be monitored and reported on at departmental and organisational level. Local Safeguarding Children's Board trainers have been accommodating in allowing increased numbers of staff to be trained at level 3. Safeguarding team continue to monitor training figures and encourage staff and individual practitioners compliance.

Planned action

Ref	Action	Lead	Deadline
9.1	1. Identify staff who are non-compliant and send reminders regularly to individuals and to managers as appropriate - Complete 2. Contact LSCB trainer to agree that we can book more staff onto each course to try to improve compliance - Complete. 3.Safeguarding team to direct staff who have completed the basic course previously to other more specialist Level 3 courses with more capacity available - Complete. 4. Working with LSCB lead trainer, arrange further review of training spaces available to allow PHNT to access any free places between now (Nov 2016) and March 2017. 5.In liaison with LSCB lead trainer, on completion of review of current places available at level 3 LSCB training, they will consider provision of more basic courses with half the spaces available to health staff. This will increase the amount of spaces available for Level 3 basic safeguarding training in the New Year.	Alison O'Neill Named Nurse Safeguarding	Improvement expected month on Month with 100% compliance aim by April 2017

Update on Actions

Training department and safeguarding team have been working at ensuring accuracy of recording staff at the right level of training need and this has improved over the last 12 months. There have been amendments to training status to ensure staff are allocated to the correct level. This will continue to be monitored regularly. Staff who are not compliant have been reminded via practice educators or individually as appropriate. Trust safeguarding training report is reviewed at the Safeguarding Steering group bi-monthly.

A review of the Trust target will be undertaken at the next Safeguarding Steering Group in May to determine whether this should be re-set.

SHOULD DO: Use clearer processes in order to be able to identify and evidence, at all times, the percentage of staff across the trust who were compliant with mandatory and role specific training. This would also provide greater safety assurance at service line, care group and trust levels that governance information was reliable and valid.

Current Performance

Trustwide:

	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Basic Life Support	83%	85%	85%	86%	86%	84%	83%	83%	84%	86%	84%	84%
Manual Handling	91%	91%	92%	92%	91%	92%	92%	91%	91%	91%	91%	91%
Trust Update	84%	85%	85%	86%	86%	86%	86%	86%	86%	86%	87%	88%
Child Protection	91%	92%	92%	92%	92%	92%	91%	91%	92%	92%	92%	92%

Maternity:

ILS and BLS: 91% in date

Manual handling: 92% in date

Child protection: 86% in date

PROMPT: 99% attendance

Neonatal life support: 65% in date (48 midwives are booked for training, 12 are awaiting availability of training)

Water birth training: 18% in date – it is anticipated that 90% of staff will be trained by end of 2017. At least 1 member of staff is trained at evacuation of the pool on every shift.

Aseptic non touch technique: 92% in date.

Comment on Current Performance

A full review of mandatory training has been undertaken by the L&OD department to ensure that all aspects of mandatory training are relevant to the staff member undertaking them as well as giving assurance around compliance. HR Business Partners are supporting Care Groups with plans to improve mandatory training compliance performance within Service Lines.

Planned action

Ref	Action	Lead	Deadline
9.2	Trustwide: 1. A reminder of how to access training information will be sent to all managers and the senior management team. Maternity & Gynaecology: 2. Practice Development Midwife will publish the training matrix percentage of staff in training in the maternity newsletter on a quarterly basis. 3. Practice Development Midwife will send all training matrix to Matrons and clinical risk manager on a quarterly basis.	1. Bill Chapman 2&3. Sue Wilkins	1. 31/01/17 - Complete 2&3. 30/04/17

Update on Actions

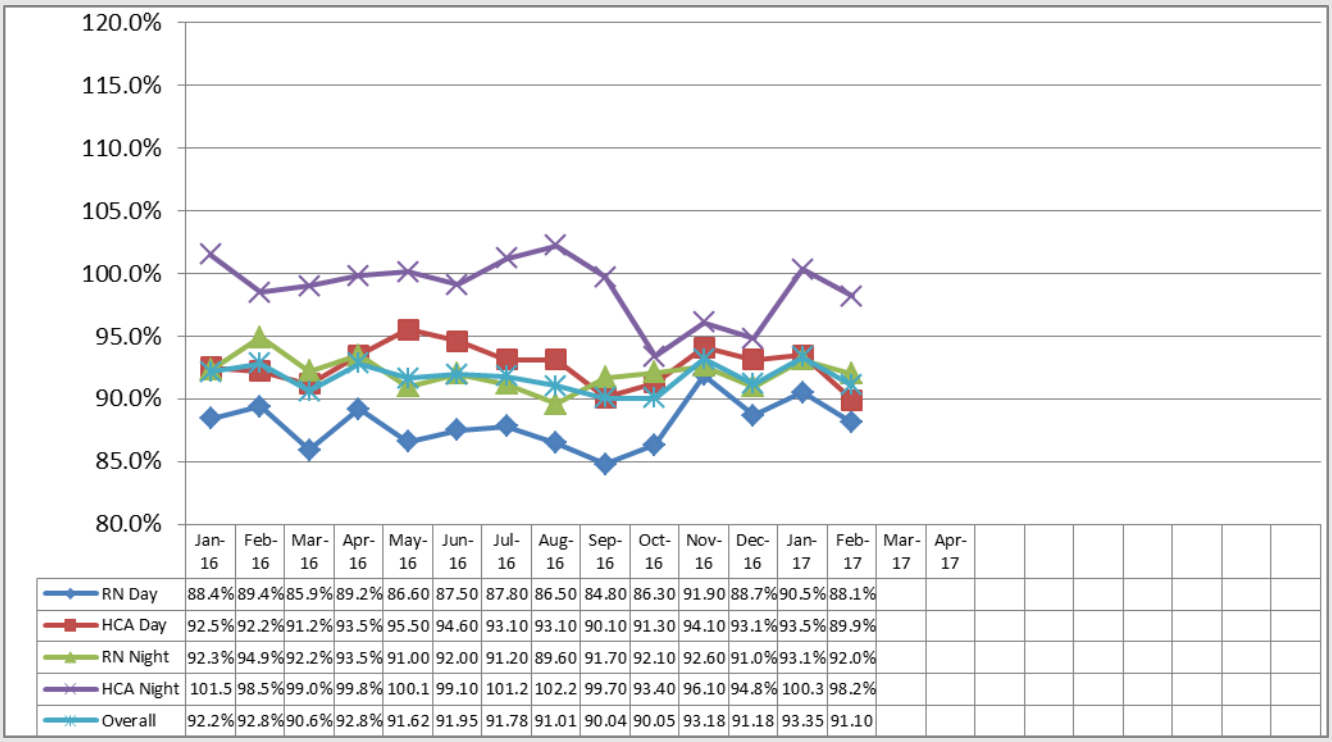
Action 1 complete.

Maternity training matrix due end April17 then every quarter moving forward.

SHOULD DO: The provider should ensure that all wards and departments are adequately staffed.

Current Performance

Fill rates for February 2017:



	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
RN Day	88.4%	89.4%	85.9%	89.2%	86.60	87.50	87.80	86.50	84.80	86.30	91.90	88.7%	90.5%	88.1%		
HCA Day	92.5%	92.2%	91.2%	93.5%	95.50	94.60	93.10	93.10	90.10	91.30	94.10	93.1%	93.5%	89.9%		
RN Night	92.3%	94.9%	92.2%	93.5%	91.00	92.00	91.20	89.60	91.70	92.10	92.60	91.0%	93.1%	92.0%		
HCA Night	101.5	98.5%	99.0%	99.8%	100.1	99.10	101.2	102.2	99.70	93.40	96.10	94.8%	100.3	98.2%		
Overall	92.2%	92.8%	90.6%	92.8%	91.62	91.95	91.78	91.01	90.04	90.05	93.18	91.18	93.35	91.10		

	Feb-17
RN Day shift	88.1
HCA Day shift	89.9
RN Night shift	92.0
HCA Night shift	98.2
Overall	91.10

Comment on Current Performance

The monthly safer staffing figure for February 2017 is 91.10 % overall which is slightly down on the previous month's safer staffing figure. This continues to reflect the current vacancy rate and the challenges with filling vacancies across the South West. NHSI are visiting the Trust this month to test the new nursing ward dashboard which forms part of the model hospital; our staff will be able to influence how staffing levels are reported nationally. Staffing levels and patient acuity and dependency continues to be recorded in real time using the Safe Care system and is reviewed continuously throughout the twenty four hour period and via staffing meetings. The current nursing workforce position has remained stable over the last 6 months and an establishment review is about to commence.

Planned action

Ref	Action	Lead	Deadline
9.3	Immediate and Ongoing 1. Continue to actively recruit to all vacant posts utilising financial incentives where approved by the executive director. 2. Manage all department staffing rosters using Healthroster. 3. Maintain daily use of safecare acuity and dependency to ensure safe staffing in real time. 4. Implement safe care on Postbridge by end Jan-17 to give	Bev Allingham	31/12/17

	visibility to the staffing on Postbridge when it is opened as an inpatient area. Complete. 5. Implement Safe care in theatres to provide visibility of the non-medical staffing in each theatre to assess the safety of the staffing and any gaps. 6. Review individual areas to see if it is possible to safely and effectively introduce additional non-registered roles. This will mean a change to the skill mix requiring agreement by Director of Nursing and agreement at ERP before recruitment. 7. Work towards delivering the trust Recruitment and Retention plan; making revisions where gaps are identified. 8. Research and investigate how best to cross fertilise staff within different specialist departments. Long Term 9.Respond to any changes in bed base or bed modelling with appropriate staffing solutions.		

Update on Actions

The level of vacancies in the Trust remained static between January 2017 and February 2017. Minor budget changes have meant that the percentage vacancy rate has decreased marginally from 8.71% to 8.69%. It should also be noted that our overall levels of staff in post have increased by over 172 FTE staff in post over the past 12 months. Rolling annual turnover to the end of December 2016 is at 11.00% compared to 11.77% for the year to December 2015.

The 12 month rolling average to end February 2017 shows that sickness has increased over the past 12 months to 4.14% (from 3.9% from the same period in 2016) against a target of 3.5% and the key staff areas with the highest levels of sickness are professional and technical staff and additional clinical services (HCAs).

We continue to review our processes in order to provide further reductions in recruitment timeframes and have been working with OHWB to reduce the Occupational Health Lead times. This will also provide significant assistance when recruiting the preceptees for 2017 for which we are currently forecasting greater numbers than in 2016.

Final work is underway to complete the rebranding of our advertising via the website and social media. On Twitter, we have introduced a 'Job of the Week' tweet which has seen a good response and have continued to offer and support department advertising through social media.

We have had an extremely successful Open Day for Medicine on the 21st January which appointed 50 new Nursing staff and our latest Open Day on the 11th March 2017 for Surgery and Medicine which appointed another 26 new nursing staff. After our attendance at the ODP event in Swindon, we also invited and ran an Open Day for ODPs and Scrub Nurses which resulted in appointing 8 new staff into Theatres. We will also be attending the Nursing Times Event on the 30th March as part of our regional initiative to introduce nurses to the County in partnership with RD&E, DPT and Torbay. Further internal PHNT open days are now being scheduled.

We continue to recruit in small numbers with 4 EU nurses joining in late February. We are providing interviews for a further 4 candidates on Friday 17th March and reviewing future intakes and the Radiography intake over the next few months.

Actions Completed and closed

Ref	Core Service	Requirement	Action Taken
1.6	Urgent & Emergency	Review the storage of intravenous fluids in the emergency department to prevent tampering.	Added locks to cupboard.
1.13	Urgent & Emergency	Ensure patients arriving at the emergency department by ambulance are protected from the elements as best as possible.	The initial plans have now been reviewed and are not considered to be appropriate. The costs for this were prohibitive and also required planning permission, hence the reason it will now be considered as part of the scheme to develop ED.
1.15	Urgent & Emergency	Review the hospital's procedure for crowding in the emergency department to include the actions required by the wider hospital in order to support safe patient care.	New policy in draft and has been presented to OPDG Tuesday 14th March 2017. Policy produced in conjunction with Care Groups and is being tested live with ongoing developments. The policy is being developed with the CCG to align plans with the community.
1.17	Urgent & Emergency	Progress the work to install an adequate area for the preparation of medicines in the resuscitation area of the emergency department.	Completed and in use.
1.21	Urgent & Emergency	Ensure staff in the emergency department all have name badges which include the role they are in. Consideration should also be given to providing patients with a leaflet that details the different types of uniforms and what they designate.	The provision of name badges to all staff has been completed and checks undertaken at team review. All Consultants and Registrars have named scrub tops. The junior doctors have name badges with "Hello my name is ...." given to them just after they arrive.
2.3	Medicine	Encourage staff to report mixed-sex breaches.	Published awareness across the trust regarding the need to report mixed sex breaches.
2.7	Medicine	The provider should ensure that patient records are consistently completed and are kept up to date.	Completed a pilot of the new risk assessment booklet. Roll out of assessment booklet across the adult inpatient areas completed Fundamentals of care audits embedded in this report show attainment above the 95% standard. The Heads of Nursing plan to review all ward areas with the Nursing Assessment and Assurance Framework (NAAF) audit in Autumn 2017.

Ref	Core Service	Requirement	Action Taken
3.1	Surgery	Review why surgery has received the most complaints.	An analysis of the 2016 complaints has been completed. The reasons for complaints within Surgery are discussed at the Care Group Governance Meeting. Reviewing of complaints and PALs themes forms part of the forward work plan for the Care Group Governance Meeting and is part of the assurance framework when service lines present to the Care Group.
3.3	Surgery	Continue to look at ways of reducing the number of cancelled operations and the numbers not re-booked within the 28-day time scale. Continue to look at ways of reducing the number of patients who have been waiting for operations longer than 52 weeks.	Theatre Improvement Programme in place.
3.6	Surgery	Make sure chemicals and substances that are hazardous to health are secured and not accessible to patients and visitors in the Fal unit sluice area.	The only hazardous substance in the Fal sluice is actichlor tablets which have been removed and stored appropriately in the Postbridge sluice yellow metal (COSHH) cupboard. A notice has been put up in Fal sluice informing staff of the new storage location and instructing that they are not to store actichlor tablets in an unlocked cupboard.
8.6 (part)	Outpatients	Reduce the number of clinics cancelled and capture the reasons why. Ensure staff comply with annual leave policy when cancelling sessions with less than six weeks notice to patients.	The Access Policy has been amended to make recording of the clinic cancellation reason mandatory.
8.7	Outpatients	Consider reviewing risk registers, to enable risks to be captured by site.	We have enabled the 'Unit' field to the Risk Register module of Datix (as set up on the Incident module) which allows new risks to be captured by site. The list of offsite locations detailed under the 'Unit' field have been reviewed and updated.

Actions Completed and evidence to be submitted

Ref	Core Service	Requirement	Action Taken
1.1	Urgent & Emergency	Commence Super Wednesday every third Wednesday of the month which will review governance framework / actions with a recorded auditable trail.	All governance and safety business meetings are agenda'd and minuted and held on the ED Clinical Governance shared drive that is accessible for the whole department – clinical / admin / managerial employees. This has been in place since November 2016.
1.2	Urgent & Emergency	Review performance data in the emergency department to ensure it is accurately captured and reported, allowing adequate monitoring and scrutiny.	Team has completed admin review. This has identified further work to be carried out. A time, motion assessment will be completed with the help of Service Improvement.
1.3	Urgent & Emergency	Ensure the paediatric early warning score is implemented fully and used consistently to ensure children are safely assessed and managed.	January audit complete and plan to repeat this monthly.
1.10	Urgent & Emergency	Review the paediatric unit in the emergency department to ensure it is adequately secure to keep children safe.	Implemented Spot Checks on door lock.
1.11	Urgent & Emergency	Ensure patients in the minors' waiting area in the emergency department are observed so any deterioration can be quickly responded to.	Triage nurse increased awareness of minor patients to team.
1.12	Urgent & Emergency	Ensure all patients awaiting X-ray in the emergency department who are not escorted have access to the portable call bell in accordance with the department's standard operating procedure.	Ensured that Porters are aware of the need to attach portable call bells to all trolleys when patients are awaiting X-ray.
1.14	Urgent & Emergency	Review the transfer team in the emergency department to ensure that when patients are transferred to a ward a clinically safe handover is completed in all cases.	Spreadsheet commenced to record any transfer related incidents and if occurs will transfer to Datix for action. SBAR form has now been pre-printed on part B admission booklet.
1.18	Urgent & Emergency	Ensure wasted controlled drugs in the emergency department are disposed of in accordance with trust policy.	Medicines management to be repeated at team review in the near future. Fiona Veale to complete questionnaire for staff to check knowledge.
1.19	Urgent & Emergency	Review and upgrade computer systems in the emergency department to allow integration with wider hospital	EDIS / SALUS / IPM remain isolated at present. This is an ongoing issue. The only effective solution would be the procurement of an electronic

Ref	Core Service	Requirement	Action Taken
		systems.(IT/CT issue).	patient record with a cost of c£40m. Surgeon Commander Henning is working with IMandT to ensure systems are as integrated as they can be. He is working on a pioneering link between iCM and EDIS. Also introducing SALUS to CDU and effecting a wider rollout of ADF terminals into the main ED. This will be an ongoing piece of work.
1.20	Urgent & Emergency	Ensure computer records are adequately secured when computers are left unattended to prevent unauthorised access.	Screen savers come on automatically.
3.9	Surgery	Make sure that all staff ideas are listened to and reasons given if they cannot be actioned.(Interventional Radiology)	Daily team brief implemented at 08:30. There is also a Staff meeting held on CME mornings. The actions have been completed and this is now routine which will be monitored by the matron for the area.
6.1	Children and Young People	Consider staffing allocation to allow for management and supervision from senior staff in all paediatric areas.	Community: Monthly meetings now set for continence team; records to be kept. Closed action 9/2/17 SMT agree that minutes of supervision are available. Acute: Supervisory role of Ward Managers reviewed. 24/7 support from paediatric senior nurse in place if Ward Manager not available due to days off, annual leave etc. Matron available weekdays and Ward Managers also cross cover.
6.2	Children and Young People	Ensure height and weight measurements of children are readily available for staff prescribing medications.	Community: Email to staff sent to remind them that children should be weighed at each appointment and if prescribing. SMT have agreed that this will be added to the yearly records audit for monitoring. Acute: Staff reminded via email reminder. Fundamentals of Care change request submitted so compliance can be audited.
6.3	Children and Young People	Ensure only current medicine guidance is available in all paediatric areas. (BNF)	All removed from CDC. All removed from Level 12 and Plym by Paediatric Pharmacist.
6.5	Children and Young People	Make sure the equipment log is up to date with all servicing of equipment.	Community: All equipment checked and now up to date and on one database. Ongoing checking process in place and monitored by specific staff. Database will be monitored by Service line governance group.

Ref	Core Service	Requirement	Action Taken
			Acute: Link nurses identified for paediatric wards and equipment. Log obtained from MEMs, cross checking in place.
7.2	End of Life Care	Ensure that local audits for the 'Last days of Life Care Plan' are put in place to provide evidence or any changes needed in practice.	Audit completed, Plan to be presented to EOL Committee April 17 and integrated with overall EOL plan.

Wellbeing Overview and Scrutiny Committee and Corporate and Place Overview and Scrutiny Committee

Tracking Resolutions – 2016 - 2017

Wellbeing Overview and Scrutiny Committee			
Minute	**Resolution**	**Target date, Officer responsible and Progress**	
15.3.17 Children Services Budget and School Funding Reforms Minute 4	1.a cross party motion on notice regarding school funding (high needs block) would be submitted to the 3 July 2017 City Council meeting; 2. a five year projection of figures relating to the legacy pension costs associated with the schools funding budget would be provided to Members once available; 3. a performance review report relating to Children's Social Care would be submitted to the first meeting of the municipal year 2017/18 specifically including the management of contracts.	Date: Officer: Progress:	April 2017 David Northey/ Judith Harwood Information requested.
15.3.17 Update Following Child Sexual Exploitation Review Minute 6	1.regular updates from the Safeguarding Assurance Board would be provided to Members as well as confirmation that these meetings were being held quarterly; 2.Members of the Wellbeing Overview and Scrutiny Committee supported the Cabinet Member and Officers regarding the lack of an assessment centre for CSE in Plymouth; 3.a progress report on actions required of current Cabinet Members would be provided to Members at the next committee meeting.	Date Officer Progress	April 2017 Alison Botham Information requested.

Wellbeing Overview and Scrutiny Committee			
Minute	**Resolution**	**Target date, Officer responsible and Progress**	
15.3.17 CAMHS Update Minute 7	1.the number of children recorded as self-harming by the acute service team would be provided to Members as well as waiting time figures; 2.the number of children self-harming in Plymouth compared to the surrounding area would be provided to Members; 3. a Councillors guide to adolescent services and the process for dealing with CAMHS would be written and provided to Members to aid with relevant casework; 4.the number of children recorded as accessing treatment would be provided to Members; 5.Members would be provided with the Early Help Assessment Tool which enabled the holistic assessment of the needs of children.	Date	April 2017
		Officer	Liz Cahill
		Progress	Information requested.

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	Children Services Budget and School Funding Reforms		Children and Young People Focused Session	
	Residential Placements - Supply and Quality of Provision		Children and Young People Focused Session	
	Update Following Child Sexual Exploitation Review		Children and Young People Focused Session	
	CAMHS update		Children and Young People Focused Session	

Date of meeting	Agenda item	Prioritisation Score	Reason for consideration	Responsible Officer
26 April 2017	Integrated Fund monitoring Report		Standing Item	
	Integrated Commissioning Score Card		Standing Item	
	Community Safety Partnership		Items which required scheduling before the end of the municipal year.	
	CQC Inspection Results		Items which required scheduling before the end of the municipal year.	
	GP Procurement Update		Items which require scheduling before the end of the municipal year.	
Items to be scheduled				
	SEND Update			
	Homelessness			
Select Committee Reviews				
March/April				