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WELLBEING OVERVIEW AND SCRUTINY COMMITTEE

Wednesday 14 February 2018
2.00 pm
Warspite Room, Council House

Members:
Councillor Mrs Aspinall, Chair

Councillor James, Vice Chair

Councillors Mrs Bridgeman, Cook, Dann, Deacon, Loveridge, Dr Mahony, Tuffin, Tuohy and Vincent.

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

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

Tracey Lee
Chief Executive

Wellbeing Overview and Scrutiny Committee

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 - 4)**

To confirm the minutes of the meeting held on 13 December 2017.

5. Mental Health: **(Pages 5 - 54)**

6. Safer Plymouth Partnership: **(Pages 55 - 66)**

7. CQC Report: **(Pages 67 - 114)**

8. Integrated Commissioning Score Card **(Pages 115 - 124)**

This item is for information only. Relevant cabinet members and officers have not been asked to attend. If further information is required members are asked to contact the Chair and Democratic Advisor.

Suggestions for future scrutiny of issues arising from this item will be considered during the work programme item.

9. Integrated Finance Monitoring Report **(Pages 125 - 138)**

This item is for information only. Relevant cabinet members and officers have not been asked to attend. If further information is required members are asked to contact the Chair and Democratic Advisor.

Suggestions for future scrutiny of issues arising from this item will be considered during the work programme item.

10. Work Programme **(Pages 139 - 142)**

The Committee to receive the work programme.

Wellbeing Overview and Scrutiny Committee

Wednesday 13 December 2017

Present:

Councillor Mrs Aspinall, the Chair.
Councillor James, Vice Chair.
Councillors Mrs Bridgeman, Loveridge, Dr Mahony, Tuffin and Tuohy and McDonald (substituting for Councillor Dann).

Apologies for absence: Councillor Deacon and Dann

Also in attendance: Rob Sainsbury (Chief Operating Officer, Western Locality, NEW Devon CCG), Ruth Harrell (Director of Public Health), Rachel Silcock (Strategic Commissioning Manager), Claire Puckey (Dementia Friendly City Co-ordinator), Darren Stoneman (Senior Community Protection Officer), Anne Smith (Plymouth Argyle), Alison Botham (Assistant Director for Children, Young People and Families), David Northey (Head of Integrated Finance) Siobhan Wallace (Head of Service, Children, Young People and Families), Ross Jago (Lead officer) and Jamie Sheldon (Democratic Advisor).

The meeting started at 2.00 pm and finished at 4.30 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.

43. **Declarations of Interest**

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

44. **Chairs Urgent Business**

The Chair informed Committee Members that the Care Quality Commission watched the webcast of our primary care services meeting and were impressed with the scrutiny the Committee undertook

45. **Minutes**

Agreed that the minutes of the meeting held on 25 October 2017 are confirmed as a correct record.

46. **Sustainability and Transformation Partnership**

Rob Sainsbury (Chief Operating Officer, Western Locality, NEW Devon CCG) presented this item to the Committee.

The report was attached to the main agenda pack.

(Cllr Loveridge arrived part way through this item)

Key areas of discussion included -

(a) timescales for Accountable Care in Plymouth;
(b) Plymouth receiving a fair share of the budget;
(c) discussed the social services adaptation budget;
(d) the impact on community services from using this method of care;
(e) how the governance of Accountable Care System will work;
(f) how dependent we currently are on agency work staff and the strains this places on the budget.

Recommendations:

1. the Fair Share budget to be added to next year's work programme for the summer;
2. the governance of Accountable Care System is added to the work plan;
3. that the Committee have sight of the STP workforce plan.

47. **Health and Wellbeing Hubs**

Ruth Harrell (Director of Public Health) and Rachel Silcock (Strategic Commissioning Manager) presented the item to the Committee.

The presentation was included in the main agenda pack.

(Cllr Mahony arrived part way through this item)

Key areas of discussion included -

(a) will NHS England be providing any financial support to this project;
(b) how Health and Wellbeing Hubs will be marketed to residence and how will feedback be received;
(c) how areas are prioritised to reflect help required;
(d) whether the CCG will be providing any financial help.

The Committee recommended the Health and Wellbeing Hubs report to Cabinet.

48. **Dementia Friendly City**

Rachel Silcock (Strategic Commissioning Manager), Claire Puckey (Dementia Friendly City Co-ordinator), Darren Stoneman (Senior Community Protection Officer) and Anne Smith (Plymouth Argyle) presented this item to the Committee.

The presentation was provided in the main agenda pack.

Key areas of discussion included -

(a) how dementia in Plymouth is set to rise due to aging population;
(b) are there enough care homes in Plymouth to support the predicted rise;

(c) The Committee commended the team on the work to move Plymouth to a Dementia Friendly city.

49. **Torbay Children Services**

Alison Botham (Assistant Director for Children, Young People and Families) and David Northey (Head of Integrated Finance) presented this item to the Committee.

The presentation was provided and is included in the supplement agenda pack.

The Committee discussed -

(a) discussed whether the risk register will be included in Full Council papers for 29 January 2018;

The Committee supported the report going to Cabinet in principle and will take a view at Full Council.

50. **Re-referrals and child protection plans**

Alison Botham (Assistant Director for Children, Young People and Families) and Siobhan Wallace (Head of Service, Children, Young People and Families) presented this item to the Committee.

The report was included in the main agenda pack.

The Committee noted the update

51. **Recommendations from the General Practice in Plymouth Select Review**

The Chair shared with the Committee the recommendations made at the GP Select Review which were included in the supplement agenda pack.

Key areas of discussion the use of "Golden Handshakes" in Cornwall to attract GP's.

The committee agreed to -

1. to write to the Secretary of state to request that Plymouth is included in the areas able to provide further recruitment incentives;

2. explore Primary Care Co-commissioning and future plans for integrated Primary Care services.

52. **Integrated Commissioning Scorecard**

The Chair advised that this item together with the integrated finance monitoring report had been included on the agenda for information. As no issues had been identified for consideration prior to the meeting, no Cabinet Members or officers had been invited to attend.

53. **Integrated Finance Monitoring Report 2017-18**

The Chair advised that this item together with the integrated finance monitoring report had been included on the agenda for information. As no issues had been identified for consideration prior to the meeting, no Cabinet Members or officers had been invited to attend.

54. **Work Programme**

The Committee noted the Work Programme.

WELLBEING OVERVIEW AND SCRUTINY COMMITEEE

14 February 2018

PLYMOUTH CITY COUNCIL

Updates requested:

- Emotional and mental health in children
- The transition from children services to adult services
- Pathways to work for people with mental health
- Admissions to hospital due to mental health conditions / self-harm in adults
- Support when someone is discharged from the Glenbourne unit

Introduction

Children's and Young People's emotional health and wellbeing services are in scope of the Integrated Community Health, Wellbeing and SEND Support Services which are being re-procured locally and, at the time of writing this briefing, are about to go out to tender. These services include:

- Child & Adolescent Mental Health Services (CAMHS) - including Severe Learning Disability (SLD)
- Children's Speech and Language Therapy (cSALT)
- Public Health Nursing (health visiting and school nursing)
- Safeguarding and Looked after Children (LAC)
- The Children in Care (CiC) Team
- Associated Clinical and Administrative staff

Please note - Due to the current procurement process, commissioners/officers may be unable to provide the answers to specific questions if they are deemed commercially sensitive at this time.

For further information about the procurement go to:
https://www.newdevonccg.nhs.uk/children-and-young-people/procurement-102759

Emotional and mental health in children

- **CAMHS Local Transformation Plan (LTP) refresh**

NEW Devon CCG (Western Locality) has commissioned additional CAMHS capacity in Plymouth specifically to:

- Deliver an Eating Disorder service (staff are currently being recruited)
- Increase access to psychological therapies (e.g. Cognitive Behavioural Therapy)
- Provide additional support to Derriford Hospital (increased CAMHS nursing capacity)

There are significant challenges both locally and nationally in recruiting trained staff to these areas. The CCG is working with Livewell South West (LSW) to address this problem including training staff to meet local needs. In the short term, this has delayed additional service capacity starting as staff are trained and become fully qualified, but the long term benefits will be an increase in capacity across Plymouth.

The LTP refresh is attached at **Appendix 1.**

- **Update on emotional health and wellbeing support in secondary and special schools**

In October 2015, the Schools Forum agreed to fund an emotional health and wellbeing project to provide a core support offer across the secondary and special school system. The total budget allocated for the project was £1,223,664 which will end in August 2019. Schools Forum agreed to all recommendations from the original report, including for schools to enter into a commissioning and procurement partnership with the Local Authority and to develop a finance strategy to consider sustainability post 2019.

Good progress has been made to date and100% of schools now have a Mental Health (MH) Lead which is in line with the recommendation from Future In Mind. The update report taken to the SEND Steering Group in December 2017 is attached at **Appendix 2** for your information and contains details of achievements so far and recommendations for the future.

The transition from children services to adult services - CAMHS to Adult Mental Health Services

The NHS has annual and biannual Quality and Innovation (CQUIN) scheme. It is intended to deliver clinical quality improvements and drive transformational change. With these objectives in mind, the scheme is designed to support the ambitions of the 'NHS Five Year Forward View' and directly link to the NHS Mandate.

Whilst locally these are no-longer being used as part of the Sustainability & Transformation Partnership (STP) financial plan, there do remain national CQUIN's and for 2017-19 there is a 'Transitions' CQUIN with the following goal:

To improve the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services.

The initial stages of this CQUIN relate to planning and were achieved by the provider. Commissioners will be seeking evidence that the 'planning' is delivering actions. Further information about national and local CQUIN is attached at **Appendix 3**.

As well as a transition pathway being in place locally, from a system perspective, Plymouth has established a Preparing for Adulthood multi-agency working group. This group is overseeing the local response to the Children and Families Act and Care Act requirements around transition planning. A health and social care focus group (led by the Designated Clinical Officer for SEND) has been established to support the sector with reviewing the alignment of processes to improve the experience for young people and their families. This work will include mental health services and also those young people who are not eligible for transition to adult mental health services.

Pathways to work for people with mental health

Employment Support – this has many different funding streams and whilst not all are specific to Mental Health, people with mental health needs are included in this support offer.

New systems and services are currently bedding in and pathways will need to be revisited to ensure that they are working.

Work and Health Programme – Following changes to the benefit system there have also been changes to the support offer made by the Department for Work & Pensions (DWP).

The Work and Health Programme is the new contracted employment provision that will help people who have a disability, the long-term unemployed (LTU) and specified early access groups to find sustainable work. Providers will tailor their support to meet the individual participant needs and will provide 15 months (456 calendar days) of support.

It will help people who face additional barriers find work. It brings a different and refreshed energy and approach and will:

- utilise the expertise of private, public and voluntary sector organisations to provide targeted support for eligible customers
- deliver high quality support and experience, and utilise contacts to offer unique support to claimants
- have strong links to national and local employers to identify employment needs, carve out roles and provide bespoke training to enable better matching of skills to roles

Big Lottery - Building Better Opportunities

The Big Lottery Fund (the Fund) is matching funds from the European Social Fund (ESF) to provide joint investment for projects in England designed to tackle poverty and promote social inclusion for the most disadvantaged people in England. The Heart of the South West incorporates Devon, Torbay, Plymouth and Somerset, and will receive £13,770,000 of Building Better Opportunities funding. Here are the local projects:

- **Empowering Enterprise 18-24**
  A flexible programme to help 18-24 year olds who are NEET (Not in Education, Employment or Training) develop their employability and life skills, giving them the confidence to move into a positive outcome. The programme will engage over 600 of Devon's most socially-excluded young people. Petroc are leading 13 End to End partners to deliver this project across Devon, Plymouth and Torbay. Petroc are also working with Engagement Partners to enable them to identify young people who may be eligible to join the project, and Progression Partners who will work to develop and provide relevant progression pathways for these young people.
  Project outline
- **#Focus 5**
  The #Focus5 project provides in-depth support to young people aged 15-18 across the Heart of the South West Local Enterprise Partnership (LEP) area to move towards education, employment and training. Young people will work with a Key Worker to develop their own plan and can also access support from our Specialist Partners on the project. #Focus5 looks at the 5 key employability skills identified by employers as being gateways to employment: communication, customer service, organisation, problem solving, and team work. The project focuses on those who

are defined as most vulnerable and are most likely to become not in employment, education or training (NEET) or are already NEET. Project outline

- **Positive People**
  A project that helps participants manage tough times, get qualified and find work. Participants will receive help to identify their aspirations, master digital technology, search for jobs and access training. Advice is offered on apprenticeships, self-employment, benefits and financial matters. The project will also support participants with personal development, daily life and medical conditions. Services to help participants prepare for work include clubs and work trials to help gain experience. Continued advice and support is offered to participants who have found work. This project helps participants manage tough times, get qualified and find work. Participants receive help to identify their aspirations, use digital technology, search for jobs, and access training. Advice is offered on apprenticeships, self-employment, benefits and financial matters. Work trials help participants gain experience and prepare for work, while continued advice and support is offered to participants who find work. The project will also support participants with personal development, daily life and medical conditions. Project outline - (Somerset) and Project outline - (Devon, Plymouth and Torbay)

More information can be accessed via: https://www.biglotteryfund.org.uk/esf

NEW Devon CCG

Increasing Access to Psychological Therapies (IAPT) – this service, works with people experiencing mild to moderate depression or anxiety. One of the principle aims of this programme, when nationally initiated, was to support people to remain in work by tackling depression or anxiety early.

The IAPT service offers a range of workshops and one to one therapies. They have worked with some of the cities large employers such as Royal Mail and Bombardia Transport to offer work based sessions.

Last year, the IAPT service also provided monthly employment support workshops which included CV writing, applying for jobs, interview techniques and signposting to other support networks such as Job Centre, Remploy, Working Links and Money Advice Plymouth if clients were managing debt issues. The Provider is currently looking at ways of increasing uptake at these workshops and re-designing them to re-launch shortly.

First Episode Psychosis - part of the development for the First Episode Psychosis services is the inclusion of employment support workers using the Individual Placement Support model (IPS). Information on IPS can be found here: https://www.centreformentalhealth.org.uk/what-is-ips

The service has recruited an Employment Support Worker who is currently supporting 20% of the people on caseload. The interventions range from helping clients identify what kind or work (paid or unpaid) they are interested in undertaking, compiling CV's, practicing interview skills, finding out about courses and how to apply or visiting work places/placements. He is also support client who are in work to remain in their jobs as described in the case study below.

The Support Worker will complete IPS (Individual Placement and Support) training in March 2018, which is the recommended approach to be used with this client group. Following the training there will be a review of the support offered to ensure that it is in line

with the model but there are already good examples of where IPS has helped people back into work. A case study is available at **Appendix 4.**

Future - Nationally the recommended support for people with severe and enduring mental health conditions is through services which use the Individual Placement Support (IPS) approach and details can be accessed here:
https://www.centreformentalhealth.org.uk/what-is-ips

Initial funding is being made available by NHS England (NHSE) through a bidding process only open to areas which have exemplar IPS services. Plymouth is not one of those areas yet but it is anticipated that we will be able to bid in a second wave of funding which will subsequently be made available. We await further information.

Admissions to hospital due to mental health conditions / self-harm in adults

The admission pathway for adults experiencing an acute mental health crisis (including self-harm) starts within the community and involves community services delivering interventions aimed at averting admission and supporting alternatives, wherever possible. Integrated Commissioners have commissioned a community based Crisis Response Service, available from 0900-2100 to support speedy, same day access to assessment for those in crisis. This is being gradually introduced and has unfortunately been delayed because of an inability to recruit suitably trained and experienced staff (a national challenge).

A telephone support and triage service is available out of hours for individuals known to existing services. This is staffed by trained Mental Health Practitioners and manages upwards of 90% of calls without the need to consider referral for inpatient admission. If the risk of admission is higher than this service is able to manage, however, a direct referral to the community based Home Treatment Team can be made. The Home Treatment Team will work with the individual to support them if at all possible at home, but can and will facilitate admission where this is indicated.

Also available as a potential pathway to admission is the Psychiatric Liaison Service based at Derriford Hospital. This is an area that has been prioritised for investment locally and this service will be available to provide an assessment for individuals admitted to the Emergency Department 24/7, from March 2018.

Integrated commissioners are also currently commissioning a further evidence based range of alternatives to inpatient admission, most notably the availability of a ‘Crisis Café’ from April 2018.

It should be noted that despite an upward trend nationally for out of area placements for individuals requiring acute inpatient treatment, in Plymouth we have reduced the numbers of individuals going out of area significantly over the last 12 months, to the point where ‘clinically inappropriate’ placements are now a rare occurrence. Should an inpatient admission be required, the service at The Glenbourne Unit provides a range of therapies and treatments and aims to provide evidence based interventions that stabilise the individual’s mental health and enables timely discharge. The Glenbourne Unit is one of only four acute inpatient Mental Health units nationally to be rated as ‘outstanding’ by the CQC.

Support when someone is discharged from the Glenbourne unit

Within Plymouth, a designated Home Treatment Service is available 24/7 to both avoid hospital admission, but also support individuals on discharge from hospital. Support is based on individual needs and risk assessment and is provided dependent on the support package identified. Individuals discharged are followed up within 48 hours of discharge and the CCG sets a 95% target for the Provider for this.

APPENDICES

Appendix 1 – LTP Re-fresh

Appendix 2 - Update on emotional health and wellbeing support in secondary and special schools

Appendix 3 – Local & National CQUIN

Appendix 4 – First Episode Psychosis Service – Case Study

Appendix 5 – Adults in Contact with Mental Health Services

Author: David McAuley

Job Title: Interim Head of Commissioning

Department: NEW Devon CCG, Western Locality

Date: 14th February 2018

Support for Children and Young People's Emotional Health and Wellbeing

Devon, Torbay and Plymouth

2017-2022

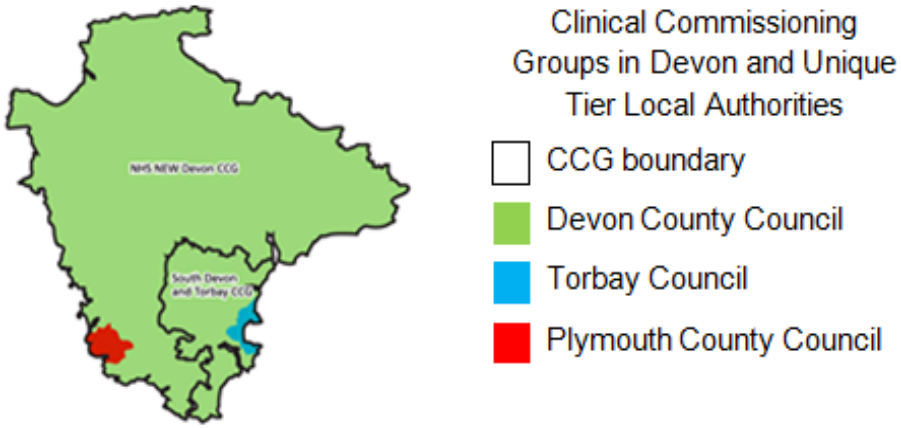
Local Transformation Plan Refresh

NHS organisations involved:
South Devon and Torbay Clinical Commissioning Group
Northern, Eastern and Western Devon Clinical Commissioning Group

Background

This Local Transformation Plan refresh has been used as an opportunity to bring together two Clinical Commissioning Groups and three Local Authorities to develop shared priorities across the geographical area of Plymouth, Devon and Torbay.

The map below shows the area that this plan applies to:



In this plan, 'Devon' will refer to this whole area.

The refresh provides information on the shared priorities for the Devon area. Although we share these priorities, how the support is delivered will need to be personal to you and the area you live in.

This plan has been written for you, as children and young people living in Devon. The way it is written and designed is based on what you have told us would work best for you. This is why there will be different styles of this plan available.

Our vision

As children and young people living in Devon, we want you to experience good emotional health and wellbeing. Research has shown five ways that are important to good emotional health and wellbeing. These are:

1) Being **connected** to those around you
2) Being **active**
3) Being able to **learn** new skills and interests
4) Being able to **give** to others by helping or supporting them
5) Being curious and **mindful** of the moment you're in

We will use these five ways to help you experience the best emotional health and wellbeing that you can. These five ways and your safety will be kept at the centre of the support you receive.

Each of you will have different experiences that will affect your ability to develop or maintain your emotional health and wellbeing. Some of these experiences will be positive, some will not. This means that the support you need must be built around you. It must be based on your experiences and who you are as a person.

No one service or person can be responsible for your emotional health and wellbeing. We all need to continue to work together to make sure your emotional health and wellbeing is supported. By everyone, we include you and those closest to you and everyone that may work or be involved with you. Our goal is that together we will build a system of support that will mean you can get the:

- ✓ right support
- ✓ at the right time
- ✓ in the right place
- ✓ from the right person

By the **right support,** we mean the support you need for your emotional health and wellbeing. This may mean: a specific 'talking therapy'; those around you doing things to support you; being able to read information online and trying different strategies by yourself; or going to a sports club, affordable gym or a local youth group. The support you need will be personal to you. It will be built around your strengths and needs. The support should be based in evidence or research.

By the **right time**, we mean that you receive the support you need at the time you need it. This means support will be available outside of 'office hours.' This means that your emotional health and wellbeing needs will not need to get worse before you get support. It also includes making sure that you receive the support you need in the right order and that you do not have to wait too long for any of the support you need.

By the **right place,** we mean in the best place for you. We want this to be as close to your home as possible. Your safety and that of anyone that you are working with must always be the most important thing when we think about the right place.

By the **right person**, we mean the person that is best to help you. The right person will depend on lots of different things such as who you want to be supported by and the skills the person needs to help you.

How will we do this?
We will build support around a framework called THRIVE. It was developed at the Anna Freud Centre in London. The framework is on the next page in Figure 1.

It will let us build support that focuses on supporting your emotional health and wellbeing so you can stay well, as well as providing support when you experience a challenge to your emotional health and wellbeing.

This framework tries to balance your emotional health and wellbeing needs with the type of support that you may need.

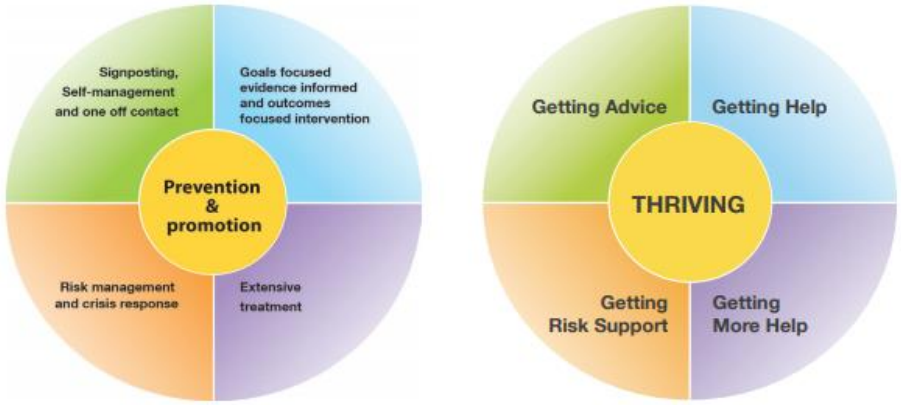


Figure 1: THRIVE framework, THRIVE Elaborated (2016)

Each part of the framework has a different focus:

Thriving: supporting the development of good emotional health and wellbeing by taking a preventative approach.

Getting Advice: the challenges you experience mean you need advice or information to manage your own emotional health and wellbeing.

Getting Help: the challenges you experience mean you need some specific support, likely to be time limited.

Getting More Help: the challenges you experience mean you need support that is likely long term, such as Eating Disorder or Early Intervention in Psychosis (EIP).

Getting Risk Support: the challenges you experience mean that you need crisis support, as your needs are such that you need immediate support to keep you safe.

The support you will be able to receive may be directly from a person or may involve digital technology. We will make sure all support is of good quality and safe.

You can find more information about the THRIVE framework at www.annafreud.org/media/3214/thrive-elaborated-2nd-edition29042016.pdf or www.implementingthrive.org/about-us/the-thrive-framework/

Everyone needs to be involved in building and delivering the support you may need. We cannot list everyone but this should give you an idea of who we mean:

- You
- Your family (everyone's family is different, so we mean the people that are important in your life)
- Foster carers
- Early Help workers
- GPs
- Schools and colleges
- CAMHS
- Social workers
- Local community groups
- Voluntary and independent groups

- Hospital nurses, doctors and consultants
- Police, fire and ambulance staff
- Educational psychologists
- Youth offending workers
- Clinical psychologists
- School nurses
- Health visitors
- Early years workers
- Therapists, like speech and language therapists, physiotherapists, occupational therapists
- Public Health, Local Authorities and Clinical Commissioning Groups

We have already started to build support around this framework, but we need to do more.

What do we want this support to do?
Challenges to your emotional health and wellbeing can have a negative impact on you and your family. This can be both immediate and long term. Impact can also be referred to as outcomes. We want you to achieve the best outcomes you can, so that more of you will have:

- Good emotional health and wellbeing
- Recovering emotional health and wellbeing needs
- Good physical health
- A positive experience of care and support
- Access to high quality support, as close to home as possible
- An understanding of emotional health and wellbeing

There has been a lot of information written around the impact of not supporting your emotional health and wellbeing. If you want to read more, we would recommend looking at a report called 'Future in Mind': www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

What else does this plan tell you?
We have described the support for your emotional health and wellbeing that we want to deliver for all of you aged 0-18 years who are living in Devon. The rest of this plan will tell you:

1) Some of what we know about your emotional health and wellbeing
2) What we did in 2016/17
3) What we want to do over the next five years

At the end of this plan, there are some appendices. Two of these appendices tell you:

1) How we will make this plan become a reality
2) The steps we will take to make the priorities become real

What we know of your emotional health and wellbeing
We collect a lot of information within different services and organisations. We need to use this information to understand what this means for your emotional health and wellbeing.

Public Health England, which works to identify what keeps people well and can make them unwell, has developed a framework (Figure 2, below) that identifies the positive and negative factors that can influence your emotional health and wellbeing.

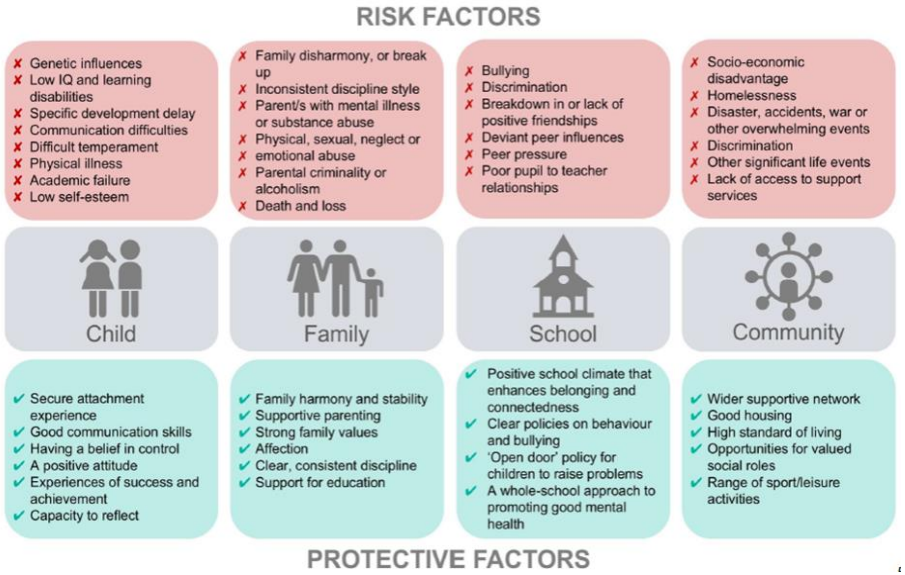


Figure 2: The Mental Health of Children and Young People in England, Public Health England (2016)

We used this framework to understand what this means for your emotional health and wellbeing living in Devon. This information is on pages 7 and 8.

Not all of the information that we want to know is available, but this is something we are working on. Some of the information is also not complete or may not be from a very reliable source. Appendix 3 has more details on where and how we got this information.

The information on pages 7 and 8 uses some acronyms. The acronyms and their meaning are:

- DCC: Devon County Council. This is one of the local authorities in Devon. The other two are Plymouth City Council and Torbay Council. The areas they cover are in their name. A local authority is responsible for services that you may need, for example, social care.

- STP: Sustainability and Transformation Partnership. You can read more about this in Appendix 1.

- CCGs: Clinical Commissioning Groups. They are responsible for buying health services in your area. The areas they buy health services for are in their names: South Devon and Torbay CCG and Northern, Eastern and Western (NEW) Devon CCG.

Overview of risk factors for your emotional health and wellbeing

Child

× **Physical illness and long-term conditions:**

- At least one in ten children in Devon STP is likely to have a long-term health condition such as asthma
- More young people aged 16-24 say their activities are limited due to disability or a long tem condition in Torbay compared to the national average; Devon, Plymouth and Torbay also have more young people saying they are 'limited a little'[1] than the rest of the country

× **Low academic achievement**

- Young people in Plymouth do not do as well at GCSE on average compared to national results[1]

× **Low self-esteem**

- School surveys suggest girls in poorer areas score lowest on self esteem[2]

× **Communication difficulties**

- There are rising numbers of children with speech, language and communication needs (SLCN), the second most common special educational need in Devon schools[1];
- In Plymouth the percentage with SCLN is higher than the national average
- The percentage of children identified with autism spectrum disorder has risen over time[4]

× **Learning disabilities**

- Schools in DCC and Torbay have a higher proportion of pupils identified with a learning disability than the national and regional average[2]

Family

× **Parents with poor mental health:**

- We don't have good or complete information about the number of parents with mental health problems in the STP
- In Plymouth, the Health Visitor Surveys have reported rising rates of mental ill health in parents which is worse in poorer areas[5]

× **Physical, sexual, neglect or emotional abuse:**

- Around 1 in 5 children have seen or heard domestic abuse; this would add up to 50,000 children in the STP
- Rates of looked after children (children in care) are higher in Plymouth and Torbay; even compared to similar local authorities[1]

× **Death and loss**

There is no suitable information available to show here

× **Family conflict or break-up**

There is no suitable information available to show here

× **Parental criminality, substance misuse or alcoholism**

There is no public information we can show here

× **Parents having difficulty managing child's behaviour and setting boundaries**

There is no suitable information available to show here

School and Peers

× **Bullying:**

- In school surveys, children and young people in schools across the STP have said they have concerns about bullying[6,7]

× **Peer pressure:**

- Amongst pupils in Plymouth and DCC secondary schools, more than 1 in 20 said they had been pressured by their boyfriend/girlfriend into having sex or doing other sexual things[2,7]

× **Exclusions from school**

- A higher percentage of children in Torbay are excluded from school than the national average. The most common reason for most being excluded was behaviour[1]

× **Lack of positive friendships**

- There is no suitable information available to show here

× **Drugs and alcohol**

- The Torbay and South Devon Children Count survey suggested that many young people in the areas were using illegal drugs[7]
- According to the What About Youth survey; 4-6% of 15-year olds across the STP said they had used cannabis in the past month[1]
- Hospital admissions due to alcohol in under-18s have been higher across Devon, Plymouth and Torbay than the national average[1]

Community

× **Socio-economic disadvantage**

- The Social Mobility Index looks at how well children from poorer backgrounds do as adults in the area (for example, in getting jobs and buying homes) [8]
- Plymouth, North Devon, Torridge and Mid Devon have the lowest scores on the Index in the STP
- Plymouth and Torbay have the highest levels of children living in poverty. However, in the Devon County Council area there are still some areas with high numbers of children growing up in poverty

× **Homelessness**

- Compared to the rest of the country, there are fewer homeless families in the STP. However, some housing is not of good quality and the cost of heating is also a concern[9] (fuel poverty)

× **Problems getting access to services (like health or leisure)**

- People living in some areas of Devon live a long way from major towns and cities and are in the bottom 10% nationally in terms of geographical access to services[9]

× **Discrimination**

- In some surveys, young people with special needs have told us that they cannot join in some activities or get access to the places that they want to go[10]

Overview of protective factors for your emotional health and wellbeing

Child

☑ **Experiences of success and achievement**

Each child or young person has their own individual successes and so it is hard to give any information here

☑ **Secure relationship with parents or carers**

There is no suitable information available to show here

☑ **Good communication skills**

- More children (especially in Torbay and Plymouth) are achieving the goals expected in communication and language in the Early Years Foundation Stage Profile (EYFSP)[11]. The profile helps to measure how very young children are developing

☑ **Having a belief in control, ability to think and reflect and a positive attitude**

- School children in Plymouth reported an increase in feelings of confidence and in control between 2014 and 2016[2]
- The percentage of children achieving at least expected scores across all learning goals in personal, social and emotional development in the EYFSP has increased across the STP over time[11]

Family

☑ **Family harmony and stability**

For many of these factors there is no suitable information to show

☑ **Supportive parenting**

- School surveys in Plymouth suggested an increase in the proportion of pupils saying parents like to hear their ideas[3]

☑ **Strong family values**

For many of these factors there is no suitable information to show

☑ **Affection**

For many of these factors there is no suitable information to show

☑ **Clear consistent discipline**

For many of these factors there is no suitable information to show

☑ **Support for education**

For many of these factors there is no suitable information to show

School and Peers

☑ **Positive school climate enhancing connectedness**

For many of these factors there is no suitable information to show

☑ **Clear policies on bullying and behaviour**

For many of these factors there is no suitable information to show

☑ **'Open door' policy for children to raise problems**

- School surveys in Plymouth suggested an increase in the proportion of pupils saying their teachers listen to them[2]

☑ **A whole school approach to promoting good mental health:**

- Plymouth and Devon currently have early help for mental health programmes which include support for schools and teachers

Community

☑ **Wider supportive network**

For many of these factors there is no suitable information to show

☑ **Good housing**

- The percentage of families who are homeless family is generally lower than average across the STP - but see Risk Factors above

☑ **Opportunities to learn and to do things that other people value**

- The percentage of young people not in employment, education or training has been decreasing over time in Devon[1]

☑ **Range of sport and leisure opportunities:**

- Our area has lots of green space, countryside and coastlines but there can be problems with getting to these areas – for example where public transport is not very good[9]

What you've told us about the support you need

We always try to listen to what you say you want. We have different ways to listen, including focus groups, face-to-face meetings, online surveys and conferences. Some of the key themes from this have been:

- Changes to crisis care so that you can get support before crisis point
- Focus on individual outcomes
- Improved transition
- Earlier help
- Focus on prevention
- Work with education
- Improve waiting times

This information has helped us to identify the areas that we need to focus on to support your emotional health and wellbeing. We know we need to do more to work with you in delivering the support you want.

This plan describes what we did during 2016/17 and what the priority areas are for 2017-2022.

We know that we need to reduce the negative experiences that will affect your emotional health and wellbeing, so other plans in Devon are focusing on reducing these. If you want to read these plans, please look at the websites for your local authority or CCG.

What we did in 2016/17

Between 2015 and 2020, the Government has promised to give the Clinical Commissioning Groups (CCGs) some additional money to improve support for your emotional health and wellbeing.

Every year the CCGs need to publish a document that describes how they have used this money to improve support for your emotional health and wellbeing and how they are working to deliver the targets in the Five Year Forward View for Mental Health. As the two CCGs are working together as part of the Devon Sustainability Transformation Partnership, this plan includes this information for 2016/17.

The previous CCG plans can be found using these links:

- NEW DEVON CCG: www.newdevonccg.nhs.uk/children-and-young-people/local-transformation-plan-for-mental-health-services-camhs-102753
- South Devon and Torbay CCG: www.southdevonandtorbayccg.nhs.uk/about-us/commissioning/our-plans/Pages/camhs-transformation-plan.aspx

Some of the changes during 2016/17 involved funding additional support and some involved changes to existing support. The following section (pages 10 to 11) lists

some of the new things we have done. In this section, where we use 'Devon', it refers to the Devon County Council geographical area. The map on page 2 shows the areas covered by the councils.

Devon: Redesigned the pathway for identifying and supporting the EHWB* needs of those of you who are Looked After. This will mean that if you are a 'Looked-After Child' and you need specialist support from CAMHS, you will receive this within 11 weeks of entering care.

Torbay, Plymouth and Devon: Investment to reduce waiting times for CAMHS.

Torbay: We started to redesign the pathway for support for those of you who are Looked After, but we did not finish. We will complete this in 2017/18.

Torbay and South Devon: Finalised plans for a community-based Eating Disorder Service that went live in November 2017.

Plymouth: Funding from a group of schools for a three-year project. Some of the achievements from the first year are: 100% of schools have a Mental Health Lead; 42 school-based staff have received mental health awareness training; 53 young people were trained as Peer Listeners; 24 staff from special schools have been trained in Level 1 Theraplay, MIM* and Group Theraplay; 20 staff from special schools have been trained in Level 2 Theraplay and Marschak Interaction Method; 1,636 children and young people accessed Kooth and, of these, 463 have engaged in online support; and 616 different children and young people have accessed face to face counselling.

Torbay, Plymouth and Devon: Through collaborative commissioning plans with NHS England, invested in additional CAMHS and Speech and Language Therapy support for those children and young people who are referred to the Youth Offending Teams.

Devon, Torbay and Plymouth: Successfully secured funding across the next three years to invest in increasing perinatal mental health services. This is a service for parents who need support from specialist mental health practitioners.

Torbay: Invested in an enhanced Crisis Resolution and Home Intervention Team. This team works 9am-10pm during the week and 9am-5pm at weekends.

Torbay and South Devon: Six thousand children and young people completed an online survey in their schools. This will tell us the challenges they face to their emotional health and wellbeing.

Devon: Started to pilot the use of Personal Health Budgets for some of you who Looked After. Our target is to have 40-50 personal budgets in place by March 2018. We currently have 43 young people accepted and five 'live' personal budgets underway. A personal budget is an agreed amount of money that can be spent to support your emotional health and wellbeing in a creative way.

Plymouth: CAMHS offer a consultation within six weeks when needs identified. This consultation is face-to-face.

Torbay, Plymouth and Devon: Funded CAMHS staff to attend CYP IAPT courses. For more information please see page 17.

Torbay and South Devon: Finalised plans for a pilot Creative Arts Project to work with some of you who were moving from year 6 to year 7 or who had just started in year 7. These projects started in June 2017.

Devon: Sixty-eight teaching assistants were trained to become Emotional Literacy and Support Assistants (ELSA). This included six days of training on loss, bereavement and family break up, managing emotions like anger and anxiety, active listening and reflective conversation skills and using social and therapeutic stories.

Devon: Attachment-based Mentoring offered to schools in Devon. This model has three parts: Attachment and relationships; Development; and Practical Support.

Plymouth: The CAMHS crisis service started to work extended hours: 8am-8pm.

Devon: The School Health Education Unit did a survey with 5,541 children to understand how they feel about their own health and wellbeing. This told us about some of the things that worry you and what support you think would help.

Torbay: Through joint funding between schools and Torbay Children's services, the Torbay Education safeguarding Service provides advice to schools.

Plymouth: 4,342 pupils from years 8 and 10 completed the health-related behaviour survey to tell us what life is like for them. Reference is: www.plymouth.gov.uk/sites/default/files/Child%20mental%20health%20and%20resilience%20summary%20report%202016_Final_v1.1.pdf

Here are some of the things we continued to support in 2016/17. This is not everything, just a few examples:

Devon: A community-based eating disorder for those of you who live in Northern and Eastern Devon.

Torbay: A CAMHS participation group for you and your families.

Devon: Early Help for Mental health. Over 300 schools in Devon have had training to help school staff support you with your emotional health and wellbeing. There is also face-to-face and online counselling available. For more details, see Appendix 4.

Torbay, Plymouth and Devon: Funding a Place of Safety for police to use. When they are concerned for the emotional health and wellbeing of a child or young person in a public place, they will take them to the place of safety for an assessment.

How did we spend the money we had?

The tables show how much funding the CCGs have made.

CAMHS (IN £'000)	14/15	15/16	16/17	17/18 plan
NEW Devon CCG	8,181	8,917	10,123	11,095
SDTCCG	2,709	3,163	3,723	3,752
TOTAL	**10,890**	**12,080**	**13,846**	**14,847**

2016/17	NEW Devon	SDTCCG
Core CAMHS	8,232	2,877
Transformation	1,891	616
Vanguard (non recurrent)	-	230
TOTAL	**10,123**	**3,723**

The CCGs are committed to supporting the transformation of Emotional Health and Wellbeing for Children and Young People.

The CCGs will be agreeing how they will spend future funding in line with the priorities of the Five Year Forward View and the wider transformation described in this plan.

What we want to do next

The next section outlines our priorities for supporting your emotional health and wellbeing. These are divided into two different sets:

- Priorities Set 1: Changes to the way support is developed and delivered
- Priorities Set 2: Support for your emotional health and wellbeing needs because of specific experiences

Priority 1.A: Support for your emotional health and wellbeing will be built and delivered around the THRIVE framework and its principles. The THRIVE framework was described on page 4. Through having one framework we will have a shared approach. Through working together, we can make it happen.

Priority 1.B: Families, schools, colleges, local communities and services will be able to develop and support resilience. Life can present challenges that we need to overcome. We all need to learn ways to do this. We want to support you in developing the knowledge, tools and skills to do this. This will mean that you have different ways to manage the challenges in your life.

While we support you to develop these skills, we also need to look at the challenges you face and work to overcome these. The framework on page 6 shows the risk and protective factors to your emotional health and wellbeing. Other areas of the Sustainability and Transformation Partnership and services within Health, Education and Social Care will support these, such as safeguarding and making sure you receive outstanding teaching. They are an important part of the approach to supporting your resilience.

We will also support your resilience by making sure that those around you have the tools, knowledge and support for their own resilience. Those around you can only support you if they are resilient themselves.

Our focus on resilience will be part of our preventative approach to emotional health and wellbeing. It is the focus of the 'Thriving' part of the THRIVE framework. The five ways to emotional health and wellbeing (see page 2) will be at the centre of this work.

Priority 1C: Your emotional health and wellbeing needs will be supported earlier in order to prevent enduring and serious mental ill health. We think we can do this by identifying your needs and supporting you as soon as possible.

We need to make sure that those you may talk to understand emotional health and wellbeing and have the confidence and skills to talk about this with you.

One of the key ways that we want to do this is through working with your schools and colleges. We know that you spend a lot of time at school and college. We also know that your emotional health and wellbeing will affect how you feel about being at school and how well you are able to do. Most of you have told us that you want your schools and colleges to be part of helping you but also that support should be provided in other places.

Priority 1D: Transitions. Transition is a term used when you move between support. We want you to experience an easy, planned transition no matter what support you are receiving. The Children and Young People's Work Programme in the Devon STP is going to lead on improving transitions. We will work with them.

Priority 1E: Working with you. We have described some of the ways that we have worked with you on pages 9, 10, 11 and 15. We need to do more. As you will be the people using the support, we want to co-design and co-produce the support for your emotional health and wellbeing.

Priority 1F: Deliver the targets of the Five Year Forward View for Mental Health. This will mean that for those of you who need support from specialist mental health services, you will receive the support you need. NHS England has set targets that the CCGs must achieve by 2020. These targets are in the 'Five Year Forward View for Mental Health.' You can read about this at www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf and www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf. Please see pages 15-18 for more details on what we have done so far and what else we need to do.

Priority 1G: You will receive effective support and help when in crisis but we will also focus on supporting you to prevent crises occurring. This priority links to the target in the Five Year Forward View around delivery of an effective 24/7 crisis response. Please see page 17 for more information around what we want to do.

Priority 1H: The support you receive for your emotional health and wellbeing will be evaluated

against outcomes that are the same wherever, however and whoever you receive support from.

Priority 1I: We will have processes in place that enable us to collect and evaluate data around the risk and protective factors for your emotional health and wellbeing so that we can identify where we need to target support for your emotional health and wellbeing. This also applies to Priority 1H, as the two priorities are different, but linked.

We collect a lot of information around what different services do. We collect a lot of information about what is happening for you in Devon.

We need to get better at collecting information that shows what difference the support you receive makes to you. We need to understand how it is improving outcomes for you.

We need to get better at using the data to understand your emotional health and wellbeing needs. This will help us know where we need to target support to you now but also where we could have put support at an earlier point.

We have started to think about this, and using information against the Risk and Protective Factors is one of the steps we have taken.

Priority 2A: We will make sure that if you have experienced abuse (sexual, physical, emotional and/or neglect) you will be able to access the support you need to support for your emotional health and wellbeing needs. This will be part of a wider system of support.

Priority 2B: We will make sure if your parent(s)/carer(s) experience mental ill health that your emotional health and wellbeing needs are supported. This pathway of support will begin during pregnancy.

Priority 2C: We will make sure that the emotional health and wellbeing needs of those experiencing physical ill health are supported. This will be part of a wider system of support for your physical health needs.

Priority 2D: We will make sure that the emotional health and wellbeing needs of those with Autism Spectrum Disorder are supported. This will be part of a wider system of support for autism spectrum disorder.

Priority 2E: We will make sure that those of you who are demonstrating 'challenging behaviour' receive the support you need for your emotional health and

wellbeing needs. This will be part of a wider system of support for those with challenging behaviour.

During 2016/17 and continuing into 2017/18, we talked with you and those closest to you around the changes that you would want to see within different services that you may use. This is because the contracts we have with people to provide some of this support will need to be renewed. We needed to understand what you would want from this new contract. This new contract is due to start 2019. This process is called procurement. When we were talking with you and your families around the changes that you wanted from these new contracts, you spoke a lot around these priority areas. We know that although you can access support, the support you receive is not as you want or need it to be. Everything you told us has been written up and published online. The final version of the report is being finalised. Once this is done, the link will be added to this plan.

These priorities will be focused on as part of the changes made through procurement. We will need to carefully plan any work that we do before procurement.

The Five Year Forward View for Mental Health
On page 4 we described the THRIVE framework that we want to build support around. The targets in the Five Year Forward View connect to the support that you are more likely to need within Getting More Help or Getting Risk Support. This support is likely to involve specialist mental health support. In your local area, Child and Adolescent Mental Health Services (CAMHS) provide this. If you live in Plymouth, Livewell Southwest (LSW) provides this support. If you live in Torbay, Torbay and South Devon Foundation Trust (TSDFT) provides this support. For those of you living in the rest of Devon, Virgin Care Limited (VCL) provides this support.

We will take each target in this document and tell you how we are doing. The targets we will talk about are those that apply to you as children and young people.

TARGET: By 2020/21, a Community Eating Disorder Service will be in place. For urgent referrals, you will start treatment within a week. For routine referrals, treatment will begin within four weeks.
If you live in Torbay or Devon (but not Plymouth), community-based eating disorder services have been commissioned so that these waiting times will be met. This model of care has been recommended by NHS England's commissioning guidance and includes specialist CAMHS practitioners, Consultant Psychiatrists, Dieticians and Community Paediatricians and Nurses all working together. Virgin Care Limited holds the contract for this support in these areas. They are a member of the Quality Network for Community CAMHS

Eating Disorders. This means that other CAMHS review the service and suggest areas for improvement. These plans will be shared with commissioners.

If you live in Plymouth, plans have been finalised for providing a similar service for you. New staff are being recruited. If you have an eating disorder and live in Plymouth, you do receive support. The changes that are being finalised will mean that the waiting times above are met and that all the requirements in the Five Year Forward View are met.

TARGET: By 2020/21, at least 35% of you with a diagnosable mental health condition will be receiving treatment from an NHS-funded service.
Our three CAMHS providers send data to the CCGs showing how many of you they are supporting. They also send data to NHS England as part of the Mental Health Minimum Dataset (MHMDS). At the moment, not all this data seems to be matching and we are working with NHSE to resolve this. We need to do this so that we can be sure that those of you who need support from CAMHS are receiving this.

TARGET: By 2020/21, we will have reduced the number of you who are admitted to a Tier 4 Unit, as the support you need will be delivered locally.
A Tier 4 Unit is a specialist mental health unit where you stay while you receive the support you need. These units are not always close to where you live. National and local evidence is showing that by changing the way we offer support to you where you live, we can help you to stay at home.

The data in Appendix 5 below shows how our admissions to Tier 4 have been reducing. This reduction matches changes to the way your local CAMHS teams deliver support in the community. This support is more intensive, works outside of normal CAMHS opening times and is often delivered in the home.

Some of the challenges to your emotional health and wellbeing needs will mean that you are best supported in a Tier 4 Unit. Your local CAMHS team makes sure that as soon as you are able to leave, they support you to return home.

TARGET: By 2020/21, we will be delivering a community based 24/7 crisis response.
This will help you to be supported at home when this is the best place for you to receive your support. If you have needed to be supported within a Tier 4 Unit, then this support should make your length of stay in a Tier 4 Unit as short as possible.

Locally, if you need an urgent or a crisis response from

CAMHS you are able to access support. There are differences to the way your CAMHS teams are commissioned to support your needs when you are in crisis or need support urgently.

The data in Appendix 5 shows you how many crisis or urgent referrals your CAMHS team receive. It also shows you how quickly they are able to respond to you.

Each of you will need different support when you are in a crisis. Some of you will need support led by CAMHS, some will need support led by Social Care. When we have spoken to you or your families, you tell us that most of the time you know when you are about to 'hit crisis.' We want to make sure that you receive effective support when you are in crisis but we also want to focus on supporting you before you 'hit crisis.'

There is not very much evidence that shows the best way to provide you with a 24/7 crisis response. Across the country, some areas are testing different ways of doing this. The results of these different ways of working should be ready in April 2018. In Torbay, we are testing an enhanced Crisis Resolution and Home Intervention Service, where you have an urgent and emergency mental health care plan in place within four hours. This enhanced service has been collecting a lot of data during 2017 that we are now able to learn from.

As part of our work within the Devon STP, we have a small group leading this work. This includes leads from CAMHS, Social Care, the local hospitals and those of you who have experienced crisis. We are in the process of collecting information so that we understand your needs before you are in crisis and what happens when you 'hit crisis.' Some of this information includes:

- When you are admitted to your hospital in crisis
- The reasons you are admitted
- The length of time you stayed in hospital
- Was there a delay in you leaving? Why?
- Who did you need support from to help you recover from crisis?
- What difference did the support make?
- At a point in time, how many of you are approaching crisis? How many of you are known to CAMHS, social care and both?
- What are the similarities and/or differences in those of you approaching crisis

TARGET: By 2020/21, there will be 1700 more trained therapists and supervisors. This is the target across the whole of England.
All our CAMHS are part of a CYP IAPT learning collaborative. This means they are 'signed up' to the principle of 'delivering well, delivering with.' This means that the support you receive is evidence based. CAMHS

staff work with you to make sure the support you receive is making a difference to you and that you are involved in working out the support that you need. Other services that may support your emotional health and wellbeing are also part of the CYP IAPT collaborative.

To make sure CAMHS staff are trained in the evidence-based support you need, NHS England have been part-funding staff to attend. The CCGs have funded the rest. In 2018, this changes and the CCGs will need to fund all the costs. We want to carry on supporting this training. We will work with CAMHS and others who need access to this training to make a plan that makes sure the right people are trained in the right support; but we need to make sure we can afford this. We will finalise our workforce plans during 2018. This plan will link to the workforce plan that is being developed under the STP.

In Appendix 5, you will see information that tells you how quickly your CAMHS team are able to see you. You can also see how many extra staff we have working in CAMHS and how many have attended CYP IAPT training.

TARGET: By 2020/21, 60% of you will receive treatment for Early Intervention in Psychosis within two weeks of referral. This target includes adults. Devon Partnership Trust, a specialist provider of mental health services for adults, provides this support. They offer a NICE-recommended, evidence-based treatment pathway for people aged 14+ who have Early Intervention in Psychosis.

It is likely that your local CAMHS team will be the first people to identify your need for support from this pathway. They have arrangements in place with Devon Partnership Trust so that you can receive the support you need from the Trust.

Summary

We hope that you feel this plan will provide the support you need for your emotional health and wellbeing.

We have tried to talk about this plan with as many people as we could, but we could not speak to everyone. We would like to hear your views and the views of those closest to you. If you want to ask a question or comment, please contact:

South Devon and Torbay CCG:

01803 652500
sdtccg@nhs.net

Northern, Eastern and Western Devon CCG:

01392 205205
D-CCG.CorporateServices@nhs.net

Appendix 1: How we will make this plan happen

Local changes

There have been some changes in the way your local organisations work. The organisations that provide support and/or have responsibility for buying support are now all working together across Devon. This is known as a Sustainability and Transformation Partnership (STP). The Devon STP has shared priorities that all these organisations have agreed to focus on. Your Emotional Health and Wellbeing is one of these priorities.

The Devon STP has responsibility for making sure that the support you need is of good quality, meets your needs and is affordable. The following is a list of some of the organisations involved in the Devon STP:

- Devon County Council
- Devon Partnership Trust
- Livewell Southwest
- Northern, Eastern and Western Devon Clinical Commissioning Group
- Northern Devon Healthcare NHS Trust
- Plymouth City Council
- Plymouth Hospitals NHS Trust
- Royal Devon and Exeter NHS Foundation Trust
- South Devon and Torbay Clinical Commissioning Group
- South Western Ambulance Service Trust
- Torbay and South Devon Hospitals NHS Foundation Trust
- Torbay Council

As we are all working together on the same priority, we are writing one plan that describes what we want to achieve across Devon for the next five years.

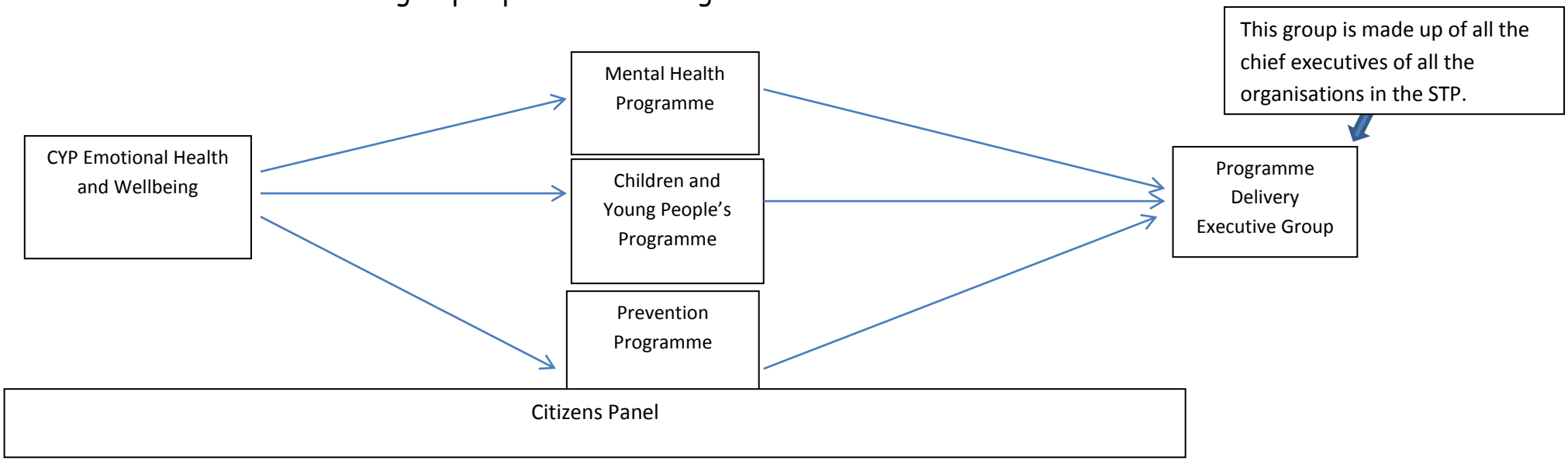
How will the Devon STP make this plan happen?

Under the STP there is a workstream called 'Children and Young People's Emotional Health and Wellbeing.' This group will have responsibility for making this plan happen. It is made up of leads from across Devon including: Education (including leads from Special Educational Needs); Social care; CAMHS; CCGs; Local Authorities; Public Health; Early Help; GPs; and Hospitals.

This group will work together and with others in their local areas to make the changes that need to happen. It reports to

three Programme Groups. They make sure we are doing what we need to be doing. Some of the changes we would like to make may need their help to make happen. If this is the case, we present our plans to the Programme groups. They can agree to this or they may need to ask the Programme Delivery Executive Group.

The chart below shows who this group reports to or the governance structure:



The reason that this work stream reports to three different programme groups is because of the approach we are taking. We are focusing on prevention all the way through to specialist mental health services.

The Mental Health Programme has a Citizens Panel that includes young people who have experienced challenges to their emotional health and wellbeing. The leads of the Mental Health Programme meet with this panel to discuss the work and to gain their views.

Appendix 2: The steps we will take to make the priorities happen

2017-18	2018-19	2019 onwards
Priority 1A: Implementing THRIVE		
Work with the specialists at the Anna Frued Centre to ensure we all have a shared understanding of the THRIVE framework. Develop actions plans of how together we will build support around the THRIVE framework. We will need to begin with understanding how 'THRIVE like' we are already.	Smaller local areas will meet and continue to develop and implement their action plans. They will become 'Local Communities of Practice' Devon wide events will be held to review how 'THRIVE like' support in Devon is becoming. Continue to implement best practice.	Continue to build and evaluate support around the THRIVE framework. Local action plans will become available once written.
Priority 1B: Support Resilience		
Talk to specialists in resilience and look at different resilience frameworks. Understand what we are doing now in supporting resilience in different areas. Review approaches in other areas such as Blackpool and Somerset. Share this learning with you and those that work with you. Create an action plan of how we will implement a resilience framework.	Smaller local areas will meet and continue to develop and implement their action plans.	Continue to implement and evaluate our action plans. Local action plans will become available once written.
Priority 1C: Early Support		
Review all our local approaches to support in school and other non- school settings to understand what has worked well. Review other approaches that have been tried in other areas.	Develop plans and begin implementation.	Continue to implement and evaluate our action plans. Local action plans will become

Understand the Green Paper that was released by the government in December 2017. This Green Paper focuses on the role that schools and colleges need to have to support your emotional health and wellbeing. Develop a shared framework that describes how support will be delivered.		available once written.
Priority 1D: Transitions		
Support the transition work and keep you informed.	Support the transition work and keep you informed.	Support the transition work and keep you informed.
Priority 1E: Working with you		
Review all our local approachs to understand what has worked well. Review other approaches that have been tried in other areas. Develop a shared approach and framework that describes how we will co-design and co-produce with you.	Agree the approach. Agree the accountability for involving children and young people. Develop an action plan.	Implement the action plan and evaluate progress. Local action plans will become available once written.
Priority 1F: Deliver Five Year Forward Targets		
See table below.	See table below.	See table below.
Priority 1G: Crisis Support		
See table below.	See table below.	See table below.
Priority 1H: Support delivered against outcomes		
	Review how other areas are doing this. Review our local approaches to this. Develop an action plan that will show how we will achieve this priority.	Implement the action plan and evaluate progress.
Priority 1I: Collecting and evaluating data		
	Review how other areas are doing this.	Implement the action plan and

	Review our local approaches to this. Develop an action plan that will show how we will achieve this priority.	evaluate progress.
Priority 2A–2E		
Review the information that you told us around the changes that you wanted. Review guidance and best practice in other areas. Use this information in the redesign of services across Devon.	Develop an action plan and start to work on these priorities.	New contracts will be awarded and we will be able to develop plans across the next three years.

2017-18	2018-19	2019 onwards
Five Year Forward View Target: Community Eating Disorder Service		
Plymouth: plans finalised and recruitment begun. Continue to monitor and review performance of the community eating disorder services in place.	Continue to monitor and review performance of the community eating disorder services in place.	Continue to monitor and review performance of the community eating disorder services in place.
Five Year Forward View Target: 35% will be receiving treatment from a NHS funded service		
Work with NHS England to understand these data discrepancies. Create a local data dashboard that is based on the Five Year Forward View. The information needed to complete this will be similar to the MHMDS. By comparing the data the CCG have and the data that CAMHS send in to complete this dashboard, we will identify where the differences are. Complete the trialling of a CAMHS online modelling tool. By using this tool, we will be able to work out how many more appointments CAMHS need to be able to offer, so that more of you can receive support from CAMHS if you need it. By knowing how many more appointments need to be offered, we can work out how many more specialist mental health practitioners we need. We will also be able to use this tool to	Based on the work completed in 2017 -18, we will identify what we need to do next to make sure that we reach this target. Actions plans will be available for you to see.	Target will be achieved by 2020.

know what evidence based support these practitioners will need to be trained in. This online modelling tool will be ready to use by January 2018.		
Five Year Forward View Target: Deliver a community based 24/7 crisis response		
Collect data and information to understand your needs when you are in crisis or approaching crisis. This will be our baseline that we will be able to show the impact of changes. Start to develop a new way of working so that we have pathway of support across all areas of Devon that will reduce admissions, support recovery from crisis and prevent crises occurring. We will be basing response times on the Expert Reference Guidance which recommends that you have a care plan in place within 4 hours of referral to the crisis team.	Finalise our plans and identify the funding needed. This plan will involve working with NHS England specialist commissioning. Implement plans.	
Five Year Forward View Target: CYP IAPT training		
Complete the trialling of a CAMHS online modelling tool. By using this tool, we will be able to work out how many more appointments CAMHS need to be able to offer, so that more of you can receive support from CAMHS if you need it. By knowing how many more appointments need to be offered, we can work out how many more specialist mental health practitioners we need. We will also be able to use this tool to know what evidence based support these practitioners will need to be trained in. This online modelling tool will be ready to use by January 2018. Develop a workforce plan based on the information above. Confirm the additional funding that will be needed to ensure the existing workforce is trained. Work with the workforce programme of the STP so that the training needs of the workforce are supported.	Based on the work completed in 2017 -18, we will identify what we need to do next to make sure that we reach this target.	

Appendix 3: Risk and Protective Factors Emotional Health and Wellbeing: Local Data

The overview aims to present a brief summary of factors that have been identified as important influences on your emotional health and wellbeing. Below each factor, the bullet points give further information about our local STP area, highlighting points such as:

- Risk factors where the prevalence may be higher within the STP than the national average, where reports suggest the risk factor is an existing concern, or where we know about a trend
- Protective factors where there may be assets to build on or improving outcomes within the STP
- Important areas where there is little available data e.g. on parental mental health

Much of the data presented may be a 'proxy measure' for the factor in the absence of specific information. In some cases there is much more detail about a risk factor than can be included in a summary. There are also influences on mental health and wellbeing that arguably are not appropriate or not possible to 'quantify' easily or summarise in a few indicators – for example 'strong family values' or 'secure attachment'.

Whilst some of the information in the overview comes from well-validated sources, such as school attainment or hospital admissions, other information is based on local reports and surveys – especially those carried out in schools. The Schools Health Education Unit (SHEU) recently carried out school surveys in Plymouth and in Devon County Council (DCC). In Torbay and South Devon, the Children Count survey analysis has not yet been published although there are some preliminary results available. This data may have various weaknesses and may not always be representative of the views of all CYP in the STP. However, it is included to provide an indication of factors that might need further investigation.

Similarly, the overview diagram is not intended to be a detailed needs assessment; there are existing analyses and needs assessment carried out by the various partnerships, commissioning groups and local authorities which make up the CCG; and these are the authoritative sources of in-depth local knowledge and challenges across this wide and varying geographical area. The main data sources used to create the overview are presented in the Data Sources box, the most comprehensive being the Public Health England Fingertips tool. You can look at this by: fingertips.phe.org.uk.

Data Sources

1. Public Health England (2017) Public Health Profiles [online] Available at: fingertips.phe.org.uk
2. Plymouth City Council (2016) Young People in Plymouth 2016 [online] www.plymouth.gov.uk/sites/default/files/Child%20sexual%20health%20summary%20report%202016_Final_v1.2.pdf www.plymouth.gov.uk/sites/default/files/Child%20mental%20health%20and%20resilience%20summary%20report%202016_Final_v1.1.pdf
3. Russell G, Collishaw S, Golding J, Kelly SE, Ford T (2015) Changes in diagnosis rates and behavioural traits of autism spectrum disorder over time. British Journal of Psychiatry Open 1 (2) 110-115; DOI: 10.1192/bjpo.bp.115.000976
4. Taylor B, Jick H MacLaughlin D (2013). Prevalence and incidence rates of autism in the UK: time trend from 2004–2010 in children aged 8 years. BMJ Open;3:e003219 doi:10.1136/bmjopen-2013-003219
5. Plymouth City Council (2016) Survey of Health Visitor Caseloads: www.plymouth.gov.uk/sites/default/files/HealthVisitorSurveyReport%202016_FINAL_v1.0.pdf
6. Torbay Health and Wellbeing Board (2017) Highlight Report: Mental Health prevention and early intervention www.torbay.gov.uk/DemocraticServices/documents/s42289/Mental%20Health%20Prevention%20and%20Early%20Intervention.pdf
7. Schools Health Education Unit (2017) Supporting the Health of Young People in Devon. A summary report of the Children and Young People Survey 2017. Schools Health Education Unit. Contact rachel.humphries@devon.gov.uk.
8. Social Mobility and Child Poverty Commission. The Social Mobility Index www.gov.uk/government/uploads/system/uploads/attachment_data/file/496103/Social_Mobility_Index.pdf
9. Devon County Council (2017) Joint Strategic Needs Assessment: Devon Overview [Online] Available at www.devonhealthandwellbeing.org.uk/jsna
10. Public Health Devon (2016) A Rapid Health Needs Assessment of Children and Young People living with Long Term Neurological Conditions and Associated Physical Disability in Devon www.devonhealthandwellbeing.org.uk/library/needs-assessments
11. Department for Education (2017) Early years foundation stage profile (EYFSP) results: 2017 www.gov.uk/government/statistics/early-years-foundation-stage-profile-results-2016-to-2017

Appendix 4: Early Help 4 Mental Health

The EH4MH programme is an emotional, psychological and social wellbeing service, aiming to improve resilience in children and young people. The programme is an important part of the early help system and supports the drive for prevention and early-intervention services which tackle mental health problems before they become more serious.

The programme has been in operation since September 2015 and encompasses two elements; direct support to children and young people (of secondary school age) through online and face-to-face counselling on a self-referral basis; and school support which aims to build the capacity of school staff to support pupils emotional health and wellbeing through a whole school approach.

Around 84% of Devon schools are working with the EH4MH programme (just over 300) and through this support; staff can access a range of training to enhance their knowledge, skills and confidence to manage low-level issues. As well as introductory courses in mental health, training also includes anxiety, bereavement, attachment patterns, self-harm and promoting resilience.

Schools can also access clinical supervision for staff and specialist consultation sessions; these can be used to discuss concerns, identify emerging mental health problems and develop solutions to better support the children and young people they are responsible for.

The programme is supporting cultural change, helping schools and staff to develop a common language around emotional health and wellbeing issues. In a recent survey with Devon schools (77 responded) 9 out of 10 said the EH4MH training has made a difference in their school.

In terms of direct support, Young Devon offers a range of therapeutic interventions across Devon including face-to-face counselling, mentoring and workshops in schools, working directly with pupils around issues impacting on their emotional health and wellbeing.

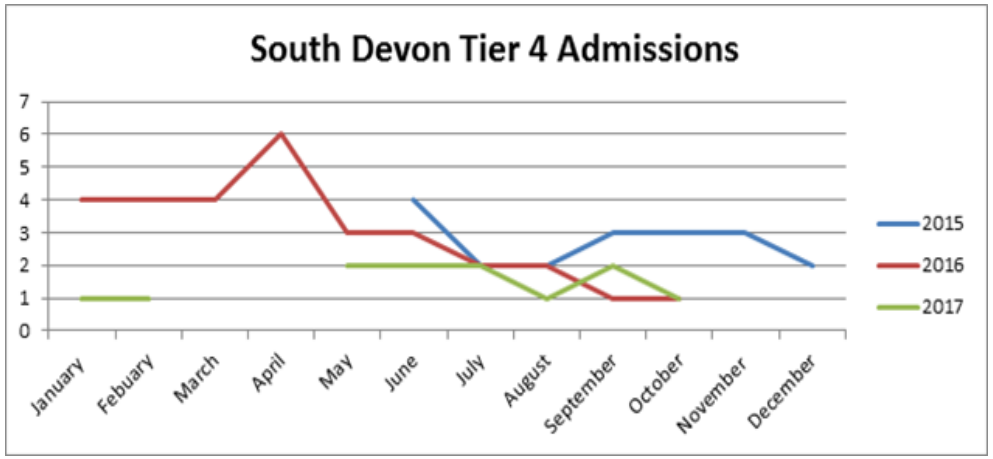
The online service 'Kooth' offers online Chat where children can speak directly to a counsellor, as well as messaging, live moderated forums and self-help materials (available up to 10pm in the evening 365 days a year). Kooth can also signpost to further support such as face-to-face support from Young Devon. 70% of Kooth log-ins are outside of office hours (9am-5pm) demonstrating how well this service fits in around young peoples' lives. To date, Young Devon has seen over 1,300 young people access their support services, and nearly 3,200 young people have registered and are using Kooth.

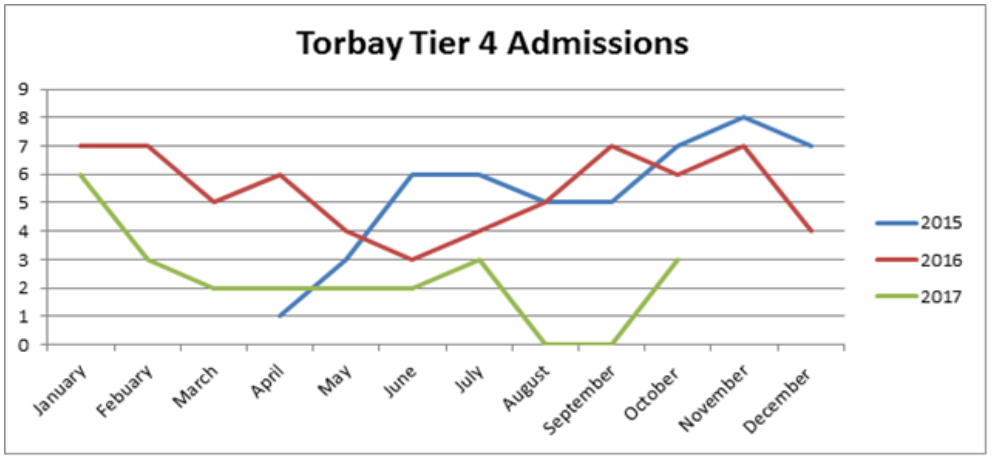
Visibility within schools has led to an increasing number of younger children seeking support through EH4MH, with 14-15 year olds the most prevalent age group accessing the direct support service. 50% of children and young people using Kooth heard about it at school; this demonstrates the success of the collaborative approach of the providers promoting services in schools.

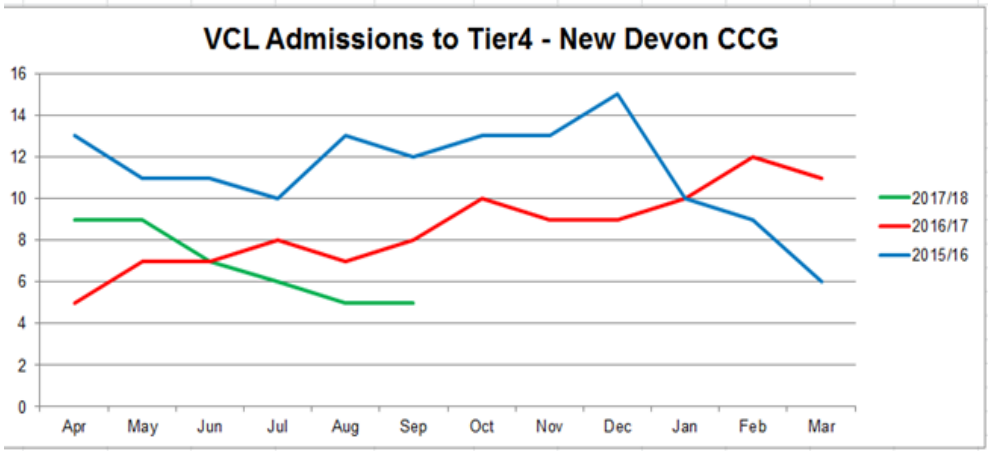
The programme is largely funded by Public Health Devon, with contributions from schools, CCGs and Devon County Council Social Care. The Social Care funding and the CCG funding are from the Better Care Fund.

Appendix 5: Local CAMHS data

Tier 4 admissions:







Livewell: 2016/17	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total number of referrals	145	170	146	136	122	159	186	210	153	169	171	204	
Total number of accepted referrals	129	148	133	123	114	146	161	185	138	165	168	186	1,796
% seen within 18 weeks RTT	96	97	96	89	96	94	95	95	90	91.5	92	92.4	
Median wait for treatments (weeks)	5.6	7.2	7.7	4.8	5.7	5.3	7	5.6	7.7	8.2	8.8	7.8	N/A

VCL: 2016/17	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total number of referrals	315	372	405	294	236	339	369	422	346	390	407	455	4,350
SDTCCG: Number of referrals	49	70	77	47	46	60	74	71	66	72	70	90	792
NEW Devon: Number of referrals	266	302	328	247	190	279	295	351	280	318	337	365	3,558
Total number of accepted referrals	185	221	242	194	151	231	253	293	244	287	280	320	2,901
SDTCCG: Number of accepted referrals	25	39	43	26	36	40	53	54	49	53	47	66	531
NEW Devon: Number of accepted referrals	160	182	199	168	115	191	200	239	195	234	233	254	
SDTCCG: % seen within 18 weeks RTT	89	89	92	94	92	95	99	96	94	94	94	95	
NEW Devon: % seen within 18 weeks RTT	83	91	91	89	87	88	90	92	95	93	93	94	
SDTCCG: Median wait for treatments (weeks)	8	6	5	6	6	5	5	6	7	7	6	5	
NEW Devon: Median wait for treatments (weeks)	8	8	6	7	8	8	6	5	6	7	6	7	

CYP IAPT evidence based support:

There are a number of different practitioners who have attended CYP IAPT training. These include staff within children's centres, family support workers, counsellors, workers from the voluntary and independent sector. The information below shows the courses that CAMHS staff across Devon have been on.

CYP IAPT Training Course	2015/16	2016/17
Cognitive Behaviour Practitioner	0	3
Cognitive Behaviour Supervisor	1	1
Parenting Practitioner	0	2
Parenting Supervisor	1	1
0-5 years Practitioner	0	1

0-5 years Supervisor	0	0
Children's Wellbeing Practitioner	0	1
Children's wellbeing Practitioner Supervisor	0	1
Systemic Family Therapist: Eating Disorder	0	1
Systemic Family Therapy Supervisor	0	0
Leadership	1	3
Systemic Family Practitioner: Conduct Disorder	2	0
Enhanced Evidence Based Practitioner	3	1
Supervisor	2	0

CAMHS Workforce:

Across our CAMHS services there are different practitioners including psychologists, psychiatrists, play therapists and many others. The information below shows that the whole time equivalents in each CAMHs service. You will see that each service has different numbers of staff. You cannot compare services by this, as each service covers a different size population. VCL has a larger workforce as it covers a larger area.

CAMHS	2015/16 (Whole Time Equivalents)	2016/17 (Whole Time Equivalents)
Livewell	47.7	71.6 (excludes medical and administrative staff)
VCL	116.45	135.22
TSDFT	38.2	39.1

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Appendix 2

Title: Update on emotional health and wellbeing support in secondary and special schools			
Date of meeting:	6 December 2017	**Report author:**	Shelley Shaw

SEND steering group

1. Background

- In October 2015 Schools Forum agreed to fund an emotional health and wellbeing project to provide a core support offer across the secondary and special school system.
- The total budget allocated for the project was £1,223,664 which will end in August 2019.
- Schools Forum agreed to all recommendations from the original report which included for schools to enter into a commissioning and procurement partnership with the Local Authority and to develop a finance strategy to consider sustainability post 2019.

2. Project Highlights

- 100% of schools have a Mental Health (MH) Lead – this is in line with the recommendation from Future In Mind
- Emotional Health and Wellbeing Key Note speech at the 2016/17 PLT training day
- 41% of schools (who responded to the request for information) have completed all 3 MindEd online courses
- 42 school based staff have received mental health awareness training
- 53 Young People were trained as Peer Listeners
- 100%[1] of secondary schools feel the MH Leads meeting is beneficial
- 24 staff from special schools have been trained in Level 1 Theraplay, MIM and Group Theraplay
- 20 staff from special schools have been trained in Level 2 Theraplay and MIM

[1] Of schools completing the evaluation questionnaire

- 1636 CYP accessed Kooth and of these 463 different CYP have engaged in online support
- 616 different CYP have accessed face to face counselling
- 77%[2] of schools reported an improvement in the communication between school and CAMHS
- School 27 joined in September 2017 and School 28 is engaged in some project elements
- Added value from the project is evidenced through grant funding for staff supervision, post 16 support from Plymouth Options and a successful Health Education England bid for Progeny Plus at £145,000.
- Improved system working evidenced through the development of the Emotional Health and Wellbeing Steering group, which brings together primary care, CAMHS, public health, MH network, schools, school nursing, and education psychology.
- Further co-commissioning opportunities developing between Schools and Plymouth City Council focused on Healthy Relationships and Substance Misuse.

3. Project Recommendations (as agreed by PLT Inclusion)

- Consideration for ongoing contract management process of service offers
- Sustainability planning – funding for the project ends in August 2019 but sustainability plans should be considered in 2017/18 to enable effective forward planning, these should be linked to Local Transformation Plans
- Schools to engage in Sustainability Transformation Partnership (STP) dialogue regarding implementation of the Local Transformation Plan (which may include the development of a collaborative framework)
- Understanding and addressing the underlying causes of poor emotional health and wellbeing, such as trauma, attachment, adverse childhood experiences and public health approaches to prevention such as resilience frameworks

[2] of MH Leads from secondary schools

- Continuation of exploring co-commissioning opportunities, such as the healthy relationships and substance misuse work streams through Commissioner engagement in PLT Inclusion
- Explore and review new ways of working, such as Wellbeing Practitioner role (being piloted in 2 schools) and systemic and multi family therapy as targeted interventions

END OF REPORT

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Appendix 3 – Local & National CQUIN

https://www.england.nhs.uk/wp-content/uploads/2016/11/cquin-2017-19-guidance.pdf

Annex A Chapter 5 Pages 61-78
https://www.england.nhs.uk/publication/cquin-indicator-specification/

Date/period Milestone relates to	Rules for achievement of Milestone (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1 2017/18	Sending and Receiving Providers to jointly develop engagement plan across all local providers. Sending and Receiving Providers to map the current state of transition planning/level of need and to submit joint report on findings to commissioners. Sending and Receiving Providers to develop implementation plan to address identified needs and agree with approach with commissioners.	31st July 2017	10% 15% 15%
Quarter 2 2017/18	Sending and Receiving Providers to update and assure commissioners as to implementation of joint plan to support better transition planning.	31st October 2017	10%
Quarter 3 2017/18	No Milestones		
Quarter 4 2017/18	Sending Provider to undertake Case note Audit assessing those who transitioned out of CYPMHS in Q4. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN.	30th April 2018	Up to 25%

Date/period Milestone relates to	Rules for achievement of Milestone (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	Sending Provider to undertake assessment of discharge questionnaires for those who transitioned out of CYPMHS in Q4. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN. Receiving Provider to undertake assessment of post-transition questionnaires of those who transitioned to AMHS or other relevant services from CYPMHS in Q3. Performance rewarded as per rules for partial achievement of the indicator; reward to be applied to all providers subject to this CQUIN. Sending & Receiving Providers to present to commissioners a joint report outlining overall CQUIN progress to date. Results to be submitted to NHS England via CQUIN Consolidated data Collection		Up to 10% Up to 10% 5%
Quarter 1 2018/19	Sending and Receiving Providers to refresh implementation plan in light of Year1 results and confirm arrangements with commissioners.	30th July 2019	5%
Quarter 2 2018/19	Sending Provider to undertake case note Audit assessing those who transitioned out of CYPMHS from Q1-Q2. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN. Sending Provider to undertake assessment of discharge	31st October 2019	Up to 15% Up to 15%

Date/period Milestone relates to	Rules for achievement of Milestone (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	questionnaires for those who transitioned out of CYPMHS in Q1-Q2. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN. Receiving Provider to undertake assessment of post-transition questionnaires of those who transitioned to AMHS or other relevant services from CYPMHS through Q4 2017/18-Q1 2018/19. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN. Sending & Receiving Providers to present results to commissioners.		Up to 15%
Quarter 3 2018/19	No Milestones		
Quarter 4 2018/19	Sending Provider to undertake case note Audit assessing those who transitioned out of CYPMHS from Q3-Q4. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN. Sending Provider to undertake assessment of discharge questionnaires for those who transitioned out of CYPMHS in Q2-Q3. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN. Receiving Provider to undertake	30th April 2019	Up to 15% Up to 15% Up to 15%

Date/period Milestone relates to	Rules for achievement of Milestone (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	assessment of post-transition questionnaires of those who transitioned to AMHS from CYPMHS through Q3-Q4. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN. Sending & Receiving Providers to present to commissioners a joint report outlining overall CQUIN progress to date. Results to be submitted to NHS England via CQUIN Consolidated data collection		5%

Appendix 4 - First Episode Psychosis Service – Case Study

Jenny (not real name) obtained a full time job with a large employer in the city, soon after being referred into the Insight team.

Jenny's care co-ordinator requested that the employment support worker meet with her prior to her starting her new job so that any worries or concerns Jenny had could be identified early and any reasonable adjustments could be made for her at the workplace. At this meeting, Jenny identified adjustments to the working environment and the type of support she would like, which included having a mentor through the first few weeks. As a result, the employment support worker contacted the team leader at the new place of work to pass on this information and to also book a time to meet with the team leaders and managers in person.

The employment support worker explained what the First Episode Psychosis Service do and how they would support Jenny. Jenny's worries about work were discussed, adjustments were planned and a buddy system (supportive managers who would coach her on what to do) were put in place. The employment support worker agreed to go out and meet with Jenny and her managers on a weekly basis for the first month to ensure everything was going smoothly. A practical and notable achievement during this time was to increase Jenny's allocation for sick leave so that should she have problems with her mental health there was no added pressure about breaching her sick leave entitlement.

During Jenny's time at work, there have been a few instances where she has had a slight deterioration in mental health. However, because of the work completed with Jenny and her team prior to starting her new job and in the first few weeks, the employer has contacted the employment support worker to let them know that they have sent Jenny home from work and that she will be coming in to speak with the team. They have not rushed Jenny back to work and have kept in contact with the team to find out if there is anything they can do to help and she has remained in meaningful employment.

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Adults in contact with mental health services in employment 2012/13

Proportion - %

Area	Count	Value	95% Lower CI	95% Upper CI
England	23,265	8.8	8.7	8.9
Fourth more deprived decile (IMD2015)	1,980	7.4*	-	-
Brent	130	9.1	7.8	10.8
Bristol	280	11.0	9.9	12.3
County Durham	215	6.0	5.2	6.8
Enfield	90	5.0	4.1	6.2
Gateshead	65	7.4	5.9	9.5
Greenwich	45	4.3	3.1	5.5
Leeds	490	12.1	11.1	13.1
Luton	40	6.8	4.8	8.7
Plymouth	75	6.3	5.1	7.8
Portsmouth	30	3.3	2.5	5.0
Sefton	45	2.6	2.0	3.6
Sheffield	115	6.3	5.2	7.4
Southampton	45	3.0	2.2	3.9
Wakefield	195	10.2	8.9	11.6
Wirral	120	6.8	5.7	8.0

Source: MHMDS, The Information Centre for Health and Social Care

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SAFER PLYMOUTH

Update – Wellbeing Overview & Scrutiny Committee

1. BACKGROUND

Safer Plymouth is responsible for the delivery of the Partnership Plan and priorities arising from annual Partnership Strategic Assessments (local and Peninsula) to ensure effective action and partnership collaboration to address community safety issues in Plymouth. This includes crime & disorder, substance misuse, and anti-social behaviour.

2. VISION

A city where people and communities feel safe and secure

3. PURPOSE AND VALUES

The purpose of Safer Plymouth is to realise its vision by working as One City to promote the following values:

- Democratic: making Plymouth a place where people can have their say and change things to ensure communities feel safe and secure;
- Responsible: taking responsibility for our actions, caring about their impact on feelings of safety and security, and holding others to account for delivering their bit towards this;
- Fair: championing honesty and openness and treating everyone with respect so that the whole community benefits from feelings of safety and security;
- Partners: working effectively together as strong community leaders to deliver our vision.

4. FUNCTIONS AND RESPONSIBILITIES

Safer Plymouth sets out the statutory framework for responsible authorities to work with other local agencies and organisations to develop and implement strategies to manage threat, risk and harm in their area Safer Plymouth will ensure:

- It works to the principles of meeting National Standards ("Hallmarks") of: Empowered and Effective Leadership; Intelligence led business processes; Effective and responsive delivery of structures; Engaged Communities; and Visible and constructive accountability:
- There is appropriate representation on the group.
- There is effective sharing of information.
- The preparation of annual strategic assessments (local and Peninsula) to assist in producing or revising the partnership plan.
- It informs integrated commissioning decisions
- It develops and monitors the Outcome Framework
- Views of Communities with regards to crime and disorder are considered
- A partnership plan to reduce threat, risk and harm is implemented
- They are cooperating with the Police and Crime Commissioner (P&CC) to tackle crime and disorder, having regard for the objectives in the Police and Crime Plan, responding to any request from the P&CC's for a report.

Safer Plymouth needs to remain flexible, and review these Terms of Reference in light of any new changes in legislation as and when required.

Safer Plymouth will ensure that it focuses on crime that causes the highest harm and affects the most vulnerable people and maintains a focus on victims.

Safer Plymouth recognise that there is often a balance to strike between communities' 'perception' of crime and the 'reality', and will ensure that there is meaningful and appropriate communication where this situation arises.

5. PRIORITIES AND THEMES

The Safer Plymouth board is supported by theme leads who operate and chair sub groups around their designated theme. The Sub groups contain specialists from a range of agencies across the City.

Themes are chosen based on the priorities selected from the strategic crime assessment carried out on a yearly basis. The current priorities and sub groups:

5.1 MODERN SLAVERY - Inspector Simon Hardwick, Devon and Cornwall Police

Context

Modern Slavery (MS) & Human Trafficking (HT) are identified as emerging areas of risk within the local Strategic Assessment, and as a result are a strategic priority for the Police & Crime Commissioner, and Devon & Cornwall police in terms of preventing crime and protecting the vulnerable. As a theme MS is subject of an Organised Crime Local Profile (OCLP) where clear recommendations for more effective partnership responses are outlined. These priorities and recommendations underpin the work of the Safer Plymouth MS thematic delivery group that utilises a 4P (PREVENT, PROTECT, PREPARE, PURSUE) approach to tackling the theme

Purpose

To prevent and protect vulnerable victims of crime, through an effective and connected partnership commitment to awareness raising, risk mapping, and proactive engagement and enforcement where MS is suspected.

Objectives:

- To **PREVENT** MS by ensuring effective information sharing across the partnership and engaging local stakeholders to support multi-agency prevention and enforcement.
- To **PROTECT** people from MS by raising awareness across service providers, developing effective geographic risk mapping, and identifying training needs across the partnership.
- To **PREPARE** for MS cases by developing guidance to assist in identifying and responding to MS cases, and to ensure opportunities for effective, multi-agency, proactive, engagement and enforcement are considered.
- To **PURSUE** those responsible for MS by ensuring victims are identified and supported in line with the NRM, and perpetrators subject of joined-up multi-agency enforcement

5.2 DOMESTIC ABUSE AND SEXUAL VIOLENCE – Chief Inspector Craig McWhinnie, Devon and Cornwall Police

Context

Domestic Abuse and Sexual Violence (DA&SV) have been identified as an area of priority from the Safer Plymouth Strategic assessment, it is also a priority of the Police and Crime Commissioner. Domestic Abuse and Sexual violence currently accounts for 12% of all violent crime in the City

Purpose

To identify and protect victims of domestic abuse and sexual violence, their children and families through partnership working. To raise awareness of DA&SV and increase confidence in victims to report crimes and incidents. To investigate the efficacy of current national perpetrator programmes to establish one for the City

Objectives:

- Services (public, private and voluntary) across Plymouth work together to respond to domestic abuse and sexual violence need. A mapping exercise is being undertaken currently to identify all the organisations in the City who are supporting victims and perpetrators of DA&SV to ascertain what is offered by the organisation and ensure there are shared outcomes, consistent terminology and identify the need in the City.
- The response to Domestic Abuse and Sexual Violence across the City is accessible to all, through the identification of barriers and mitigating factors, the availability of services and operating hours. The group will determine reporting requirements for future services.

- Victims of Domestic Abuse and sexual violence have access to high quality services and support particularly with regard to workforce development. The learning from Domestic Homicide Reviews will be incorporated into the delivery plan to ensure lessons learnt are acted on.
- People know how to report domestic abuse and sexual violence in Plymouth and are confident to report domestic abuse and sexual violence in Plymouth. Understanding the signs and symptoms of DA&SV through training and awareness raising, building confidence to improve reporting of DA&SV and improving methods to report crimes and incidents.
- The response to domestic abuse and sexual violence across the City incorporates a 'whole family' approach. This ensures improved working and information sharing between statutory and non-statutory organisations particularly between adult and children's services. A Healthy relationships programme is delivered in schools consistently across the City to ensure all pupils receive the same guidance.

5.3 PREVENT – Candice Sainsbury, Plymouth City Council

Context

The Counter-Terrorism and Security Act 2015 contains a duty on specified authorities to have due regard to the need to prevent people from being drawn into terrorism. This is also known as the Prevent duty.

Prevent is one aspect of CONTEST, the Government's counter-terrorism strategy. There are two core elements to this strategy:

- To provide practical help to prevent people from being drawn into terrorism and ensure they are given appropriate advice and support – this is undertaken via the Channel process, chaired by Plymouth City Council, which is a multi-agency panel that meets monthly to provide support to those identified at risk of being drawn into terrorist or extremist activity.
- To promote collaborative working with a wide range of sectors (including education, criminal justice, faith, health and the voluntary sector) where there are risks of radicalisation – this is undertaken through the Plymouth Prevent Partnership which meets on a quarterly basis and is aimed at supporting local partners and communities to share their experiences and discuss strategies for strengthening the city's response to preventing extremism

Purpose

Prevent aims to 'safeguard people and communities from the threat of terrorism' via the Channel process and local Prevent Partnership.

Specifically, the Channel process aims to identify individuals at risk of being drawn into terrorism and develop the most appropriate support plan for the individuals concerned, both through provision of mainstream services i.e. education, employment or housing and through mentoring support or diversionary activities.

The Prevent Partnership aims to support local communities and agencies to challenge and reject the message of extremism

Objectives:

The 2017/18 areas of focus for the Plymouth Prevent Partnership were identified based on the Counter Terrorism Local Profile as well as local priorities, with the following outcomes:

- Increased awareness of the importance of Prevent across key partners in Plymouth.
- Increased accessibility to Prevent (WRAP) Training for frontline staff, with a specific focus on those working in the fields of mental health and autism.
- Strong and active relationships have been established with communities identified as most vulnerable / at risk of being drawn into terrorism, as well as with key partnerships such as Plymouth Safeguarding Boards and Safer Plymouth.
- Closer links have been established between Safeguarding and Channel processes

5.4 WELCOMING CITY – Superintendent Craig Downham, Devon and Cornwall Police

Context

Plymouth seeks to deliver stronger, safer communities and good quality neighbourhoods as part of delivering its vision to become one of Europe's most vibrant waterfront cities where an outstanding quality of life is enjoyed by everyone.

The term 'community cohesion' is widely used to describe a state of harmony or tolerance between people from different backgrounds living within a community. The key measure of community cohesion is the percentage of people who believe people from different backgrounds get on well together in their local area. Currently available date indicates that community cohesion rates are poor across the City but not especially so amongst Black and Minority Ethnic Communities (BAME).

Whilst the majority (52.7%) of Plymouth residents agree that their local area is one where people from different ethnic backgrounds get on well together, there are variable levels of Community Cohesion across the city which need to be addressed.

Purpose

The brief for a Welcoming City emerged in response to the following drivers:

- **The Plymouth Plan** - The City will support strong and inclusive communities where people have a sense of belonging and ownership, feel safe and confident, with the opportunity to live, work and play in good quality sustainable neighbourhoods.
- **Safer Plymouth** - Plymouth is proud to be a welcoming city and continues to monitor levels of community cohesion.
- **Plymouth Fairness Commission (2014)**: Recommendation 42: The city engage in a consolidated effort to generate leadership on tackling discrimination in all its forms in the city, including; i. A city leadership workshop on discrimination, ii. A high profile public event committing city leaders tackling all forms of discrimination, iii. Roll out of evidence based, age appropriate school based programmes to address discrimination

Objectives:

If Plymouth is to fulfil its city vision of a 'vibrant waterfront city where an outstanding quality of life is enjoyed by everyone' we must continue to build our reputation as a welcoming, multicultural city where agencies and communities work together to promote the benefits of diversity and challenge unfair discrimination.

We aspire to be a fair city that supports strong and inclusive communities - where people have a sense of belonging and ownership, feel safe and confident, with the opportunity to live, work and play in good quality sustainable neighbourhoods.

We must work together to ensure that the needs of different communities of geography, identity and interest are respected, celebrated, and valued

5.5 CHILD SEXUAL EXPLOITATION – Tahira Rauf, NSPCC (managed through the PCSB)

Context

The Missing and Child Sexual Exploitation Group (MCSE) is appointed by the Plymouth Safeguarding Children Board (PSCB) and shall be made up of partner agencies of the Board

Purpose

The purpose of MCSE is to monitor and evaluate the effectiveness of the strategic and operational multi-agency response to Missing Children and Child Sexual Exploitation across Plymouth together with modern slavery and human trafficking.

Objectives

The MCSE has been appointed to undertake the following functions of the PSCB:-

- ensuring that current practice and interventions are informed by an evidence base and linked and mapped to national policy and developments;

- ensuring the focus is on prevention as well as response;
- ensure multi-agency practice is regularly reviewed and evaluated;
- ensuring that current and future multi-agency policies and procedures are appropriately designed to be responsive in meeting the demand that CSE, modern day slavery and human trafficking poses within the local community and when necessary develop new policies and procedures, for safeguarding and promoting the welfare of children;
- ensure that there is clear data and evidence supporting effective responses to the risk to children and young people of CSE and Missing Children and modern slavery and human trafficking;
- ensure frontline practitioners are adequately trained in how to identify and respond;
- ensure that the public receive key messages;
- ensure links to other groups of the PSCB and its Peninsula Local Safeguarding Children Boards

5.6 ALCOHOL HARM – Chief Inspector Rob Mooney, Devon and Cornwall Police

Context

Alcohol misuse is a significant public health challenge; it affects thousands of individuals, families and communities across the country and costs the NHS an estimated £3.5 billion each year. There is a clear defined link between life expectancy and alcohol abuse and its link to other forms of substance misuse.

The alcohol harm reduction group aims to ensure that the city remains a vibrant, welcoming place where the daytime and evening and night time economy is inclusive and welcoming to all. Significant work and collaboration in 2017 between the Police and the Evening and night time economy community, to improve our working relationship. Regular meetings are held in relation to current ongoing issues faced by both the Police and the community. The Best Bar None team have been recognised for their outstanding work in continuing to work to make the evening and night time economy area safer and inclusive for all, especially with the Ask Angela campaign.

The licensing team have relaunched the reducing the strength campaign aimed at supply of high strength alcohol to those with complex needs or are alcohol dependant.

Purpose

Within the ENTE arena, the group will focus on the viability of street safe scheme, night rangers and use of 3rd sector groups to ensure a safe and vibrant night out.

However, the group also needs to focus on reducing the impact of alcohol harm outside of the ENTE arena in order to understand and work to combat the binge drinking/preloading culture.

To look at the effect of alcohol harm in children and consider work that can be done in schools to encourage safe drinking.

To look at the effect of long term alcohol abuse and the relationship with alcohol in those members of the community with complex needs, in particular the rise in street drinkers and associated ASB and use of innovative initiatives to combat this.

Objectives

- To reduce alcohol related violence (excluding domestic abuse)
- To minimise the harm of substance misuse and reduce alcohol related crime and reduce alcohol related demand in and around the ENTE areas of Plymouth (Mutley Plain, North Hill, City Centre, Barbican and the East End)
- To understand the role that alcohol abuse plays in individuals with complex needs.
- To contribute to a positive and inclusive day/night time economy
- Identify gaps in current working practices and seek good practice in other cities.
- Reduce the rate of alcohol attributable hospital admissions
- Reduce levels of harmful drinking by adults and young people
- Reduce anti-social behaviour
- Reduce the number of children affected by parental alcohol misuse

5.7 CYBER CRIME AND FRAUD – Alex Fry, Plymouth City Council

Context

The annual cost of fraud in the UK is estimated to be around £196b. The average cost of cybercrime to a large UK business is £36,500 and to a small business it is £3100. Each year mass marketing mail scams, which often target vulnerable or disadvantaged consumers, cause approximately £3.5 billion worth of detriment to UK consumers. In Plymouth over 800 victims of scams have been identified. The average age of these victims is 72.

Doorstep crime and scams are identified as high priority areas in the Regional and Plymouth Trading Standards Strategic Assessments and in the Safer Plymouth Strategic Assessment as areas of concerning emerging crime

Purpose

To raise awareness of cybercrime and fraud amongst the public, businesses and organisations in Plymouth. To ensure a joined-up approach to the detection and investigation of cybercrime and fraud and in relation to the support of victims.

Objectives:

- To raise awareness of the crimes in Plymouth and inform potential victims on how to prevent it
- To bring together partner agencies and stakeholders to identify ways of working together to combat the crimes and better support victims. This includes improved sharing of intelligence and the training of relevant front-line workers
- To review the National Cyber Crime Strategy 2016-21 and other relevant guidance and ensure recommendations are implemented in Plymouth.
- To look at best practice examples nationally in relation to combatting fraud and cybercrime and assess whether they can be implemented locally.
- To review the implementation of the National Banking protocol and how it applies in Plymouth
- To develop a Doorstep Crime partnership with relevant agencies

5.8 COUNTY LINES – Rebecca Cheshire, Harbour Centre

Context

County Lines, the term used to refer to the activity of dangerous drug networks. Section 34(5) of the Policing and Crime Act 2009 defines this gang-related drug dealing activity as: "the unlawful production, supply, importation or exportation of a controlled drug which occurs in the course of, or is otherwise related to, the activities of a group that: a) consists of at least 3 people; and b) has one or more characteristics that enable its members to be identified by others as a group".

A county lines gang features these additional criteria:

- The gang / gang members are based in or have their origin within an urban city location;
- They have established a market in a county town, into which they supply drugs;
- They utilise a mobile phone number to facilitate drug orders from and supply to customers in the county town;
- Their criminality systematically exploits young and vulnerable persons.

Purpose

The main purpose of this project is to support Plymouth's response to emerging crime and exploitation linked to County Lines by strengthening professionals' understanding and responsiveness, increasing awareness with the public and providing visibility of support services to victims. The violence, vulnerability and exploitation linked to County Lines crosses over with that of Safer Plymouth themes of Modern Slavery & Human Trafficking, Domestic Abuse & Sexual Violence and Child Sexual Exploitation. The delivery of the County Lines objectives will therefore be closely aligned with the objectives of the related themes.

Objectives:

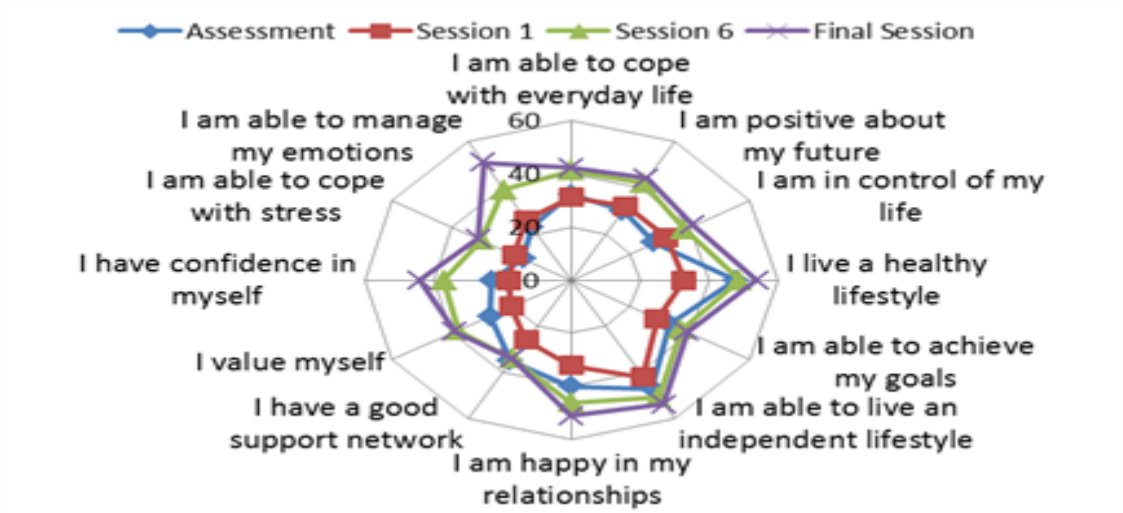
- A fuller understanding of Plymouth's current situation in regards to gangs, violence and vulnerability, specifically around: county lines, the internal drug market, local gangs and sexual exploitation.
- Professionals across all sectors and the general public will have increased awareness of county lines and its links to violence, vulnerability and exploitation, and its context within the strategic outcomes of the Plymouth Plan, Wellbeing Commissioning Strategy, and Children and Young People Commissioning Strategy.
- Professionals across all sectors will have increased awareness of approaches to identify risk and take action to prevent violence, vulnerability and exploitation of adults, children and young people, leading to increased timely access to early intervention and specialist support as required.
- Professionals across all sectors will have improved meeting and partnership mechanisms for information sharing, identification, early intervention and responding to county lines and its links to violence, vulnerability and exploitation.
- Vulnerable adults and young people will have increased awareness of about the dangers of recruitment into the illegal drugs trade and consequences of involvement, and will know where to go to get help.

6. COMMISSIONING PLAN

Since September 2016, Safer Plymouth has strengthened its links to other parts of Safer Communities and Integrated Commissioning and the Health and Wellbeing system, so that the Board can be influential in its community safety systems leadership role.
More specifically, integrated commissioning receives funding from the Police and Crime Commissioner which is channeled through the Western Planning and Delivery Unit (Plymouth City Council and NEW Devon CCG integrated commissioning team) as a grant for spending on local crime prevention and reduction initiatives. For 2017-18 and 2018-19 Plymouth has been awarded a total of £400,568 for each year.
A commissioning plan was created in February 2017 based on the evidence within the strategic crime assessment and feedback from theme leads. The following is a summary of initiatives being commissioned:

Service/Project	Impact/Outcomes
The Plymouth Domestic Abuse Service Provision of accommodation based support within a refuge and dispersed units; 1:1 referrals for support, Independent Domestic Violence Advocates; Multi Agency Risk Assessment Conference co-ordination and DASH training	Outcomes focus on improving the safety of victims and their families and encouraging them to engage with services and ideally move on from an abusive relationship, examples include: ▪ Over the past 18 months, in excess of 2,000 victims of domestic abuse have received support from the service ▪ 100% of service users engaging with the service are supported to minimise risk to their selves and others, as well as achieving other positive outcomes. ▪ Re-referral rate is below 20% ▪ 90% of victims exiting the service do so in a planned way ▪ Staff trained are satisfied – over the past 2 years approx. 500 professionals have received DASH training

Therapeutic counselling for victims of sexual violence Ensure that we support victims of sexual violence with access to therapeutic counselling services and that services users are better able to cope with the experience they have had and recover from it.	Since April 2016, this service has: ▪ Has supported approx. 300 people through the service ▪ Delivered in excess of 1,400 counselling sessions Outcomes for clients are monitored using a 'cope and recovery' mechanism. This is provided quarterly to commissioners to review. The following provides the most recent example of all service users during the 2nd quarter 2017/18 and shows positive outcomes in all areas for clients:



The Harbour Centre provides a community based drugs and alcohol treatment service. We support the delivery of service for those in contact with the criminal justice system	Nationally, Drugs and alcohol are identified as two of the key drivers of crime and disorder in the Home Office Modern Crime Prevention Strategy (2016). Individuals dependent on opioids and/or crack cocaine (OCUs) are responsible for an estimated 45% of acquisitive crime (shoplifting, burglary, vehicle crime and robbery). Around 40% of all violent crimes are alcohol-related. Drug and alcohol misuse are related to other issues such as child protection, impaired driving, anti-social behaviour and domestic abuse. When engaged in and completing treatment, people use fewer illegal drugs, commit less crime, improve their health, and manage their lives better. This makes a real contribution to community safety. Plymouth has a higher than the national prevalence of drug and alcohol dependent people. Our Plymouth service: ▪ Approx. 20% of all referrals into the service relate to CJS ▪ Performs better than the national average for waiting times for treatment ▪ Has a higher than national average engagement rate of prison releases into our service ▪ Overall, there was a reduction of 44% in the number of individuals who were recorded as re-offending in the two years following the start of treatment and a 33% in the number of offences.

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- One year's social and economic return (related to crime, health and social care as well as improvements in quality-adjusted life years) resulting from 2016-17 local investment in drug treatment is 33% return on investment

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Healthy Relationships programme

The Multi Agency Child Sexual Exploitation Group (MACSE) (sub group of the Safeguarding Children's Board) identified a need for quality assured earlier intervention and awareness work with children and young people in relation to CSE.

The Plymouth Domestic Abuse and Sexual Violence Partnership (sub group of Safer Plymouth) identified the need for earlier intervention and awareness work with children and young people in relation to Domestic Abuse via healthy relationships.

This work draws together these ambitions and the main purpose of the service is to develop a strategic approach to delivery of a 'Healthy Relationships Programme' in schools as an effective way of ensuring children and young people have access to information and skills to make informed decisions on the relationships they experience.

It will ensure an equitable offer to schools and provide quality assurance to the system.

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In collaboration with key stakeholders, we commissioned this service in August 2017.

The initial pilot has begun, which has included significant research, scoping of options and young person participation.

As an early intervention and prevention initiative this programme will ultimately contribute to the long term strategic outcomes as set out in the Plymouth Plan; Wellbeing Commissioning Strategy and CYP Commissioning Strategy:

- Delivering strong and safe communities
- Improvement in health and wellbeing
- People and communities feel safe
- Reducing harm
- Children are protected from sexual exploitation

As a commissioned service we have set the following outcomes and measures which will be monitored as the programme develops:

<table>
<tr><td>School community will have improved awareness of healthy relationships</td><td>Young People have increased awareness and report they can: (to be finalised with commissioner)
• Contextualize their own and others relationships
• Differentiate between positive and negative relationships including identifying signs and symptoms
• Understand how perpetrators groom young victims of DASV and CSE
• Understand and be able to identify pressures and expectations and to make informed decisions that prioritise their needs and are respectful to themselves and others
• Understand the meaning of consent within sexual relationships and understand the law including consequences of non-consensual sex
• Understand the impact on self and own health if engaging in risky or harmful sexual behaviour
• Interact and navigate safely online</td></tr>
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	Young people will have improved personal resources including resilience, confidence and self-esteem	Numbers of young people (male:female:describe myself in some other way): • with improved understanding of a healthy relationship • who know how to seek help or advice if they are in an unhealthy relationship • who would seek help or advice if they are in an unhealthy relationship
	Increased timely access to early intervention and specialist support as appropriately required	Number of young people Self-reported increase (priority group to be agreed with Commissioner)
Addressing Antisocial Behaviour, low level and emerging crime Plymouth City Councils Community Connections department works closely with partner agencies identifying/preventing/and responding to ASB and emerging issues. Enhanced joint working practices have been implemented between police colleagues and Community Connections via a Neighbourhood Problem Solving Group. This links with the police TIMS meetings and allows the early detection of emerging neighbourhood issues and the deployment of early intervention/ prevention activity.		• A rise in ASB in the City Centre by a group of young people has been targeted (Operation Greywild). Additional youth outreach will be put in place as well as diversionary activities and ASB escalation where appropriate. This will provide reassurance to the public, a reduction in ASB activity and options for perpetrators prior to escalation of ASB process. • PSPO's are under consideration for additional areas of the City (Mutley and North Hill) to reduce the levels of ASB and associated impact on communities, in particular linked with alcohol harm reduction. • Operation Plympton - outreach work is currently planned in Plympton where an issue with young people perpetrating ASB in the locality has been identified. Additional outreach youth work provision and ASB escalation response will be put in place to reduce the ASB and divert the young people into positive activities. This will reduce ASB in the area and give the public confidence to report issues.
Prevent The programme seeks to raise social and emotional competence and increase empathy amongst children by incorporating themes of: British values; celebrating and valuing local community; understanding different beliefs and diversity and promoting Plymouth as a great place to live and work.		A provider has been commissioned to deliver a pilot and create an innovative programme which will bring a new, exciting and fresh approach to teaching this topic directly to schools. It is expected that the programme will evidence: • Demonstrable change in social and emotional competence and increased empathy amongst children • Positive changes have been achieved in children's attitudes and behaviours • Children's understanding of different beliefs and values has improved • Increased perception of valuing and celebrating local community • An greater understanding of British Values amongst children and their community

Community Safety Awareness Raising Over the past 2 years, the partnership has delivered a number of events to improve public awareness of specific issues and available services as well as supporting workforce development	Examples of some of these initiatives: • Modern Slavery conference – a City wide event was arranged with guest speakers from the National Crime Agency, Gangmasters Licensing Authority, Devon and Cornwall Police, and RESTORE (victim perspective). 227 individuals attended from across more than 30 agencies made up of the statutory, non-statutory, and voluntary and community sector. 99% of attendees completing evaluation questionnaires (120) agreed that the event met their needs and enabled them to identify signs of modern slavery. • The Plymouth Prevent Partnership arranged and hosted a conference for approx. 120 attendees, increasing individuals ability to understand the PREVENT strategy in the city and their role with in this. • Operation Dalitron raises awareness of CSE issues in areas identified of being a particular risk to those vulnerable young people. I.e. Funfair, circus grounds. A multi-agency operation is planned for Easter including work with the communities in these areas raising awareness via CSE training and the provision of associated materials.
Regional services supporting Plymouth Alongside funding for CSPs, the Office for the Police and Crime Commissioner supports a number of activities across Devon, Cornwall and the Isles of Scilly for 2017/18	• Safeguarding Boards – contribution to Children's and Adults Boards including training and Serious Case Reviews; • Sexual Assault Referral Centres (SARCs) – 3 SARCS co-commissioned with NHSE. • Sexual Offence Lawyer Provision – to introduce a 3 year pilot, based in police stations to improve quality of investigations, experience for the victim and CPS processes. • Offender Diversion Scheme – exploring innovative offender management to lead to longer term behaviour change including a delayed charge and diversion scheme. • Youth Offending Service – aligned with redesign and current transformation of Youth Offending service and preventing and deterring crime offender management model. • Emerging Priorities fund – allocation of funding to projects on a case by case basis. • Victim support – victim care arrangements such as victim support, network and website and Restorative Justice.

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PLYMOUTH CITY COUNCIL

Subject:	CQC- Local System Review Report
Committee:	Wellbeing Overview and Scrutiny Committee
Date:	14 February 2018
Cabinet Member:	Councillor Lynda Bowyer
CMT Member:	Carole Burgoyne (Strategic Director for People)
Author:	Craig McArdle, Director-Integrated Commissioning
Contact details	Tel: 01752 307530 email: craig.mcardle@plymouth.gov.uk
Ref:	CQC
Key Decision:	No
Part:	I

Purpose of the report:

Plymouth Health and Wellbeing system was selected following a request from the Secretaries of State for Health and for Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of the review was to understand how people move through the health and social care system with a focus on the interfaces between services.

The local system review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on older people aged over 65. It also focussed on the interfaces between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

The review was conducted over a 6 week period with a week-long site visit from the 4-8 December 2017. The accompanying document presents CQC final Local System Review Report of the Plymouth System.

CQC presented their findings to the Plymouth System at a Local Summit on the 2 February 2018. Plymouth now has twenty days to complete an action plan that responds to the issues identified in the report. The Action Plan is designed to be owned by the Plymouth Health and Wellbeing Board.

Recommendations:

The recommendation is for the Wellbeing Overview and Scrutiny Panel to:

- Formally accept the CQC Plymouth Local System Review Report
- Agree to formally monitor the Action Plan and receive regular reports

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Plymouth

Local system review report
Health and Wellbeing Board

Date of review:
4-8 December 2017

Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and for Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives the Care Quality Commission (CQC) the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

The review team

Our review team was led by:

- Delivery lead: Ann Ford, CQC
- Lead reviewer: Rebecca Gale, CQC

The team included:

- Two CQC reviewers,
- One CQC strategy lead,
- One CQC deputy chief inspector (adult social care)

- One CQC head of legal services
- Two CQC analysts,
- One CQC manager for integrated care
- One CQC inspection manager (adult social care)
- One CQC inspector (pharmacist)
- One CQC Expert by Experience and;
- Five specialist advisors (two current directors of adult social services, one former director of social services, one clinical commissioning group board member and one GP).

How we carried out the review

The local system review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on **older people aged over 65**.

We also focussed on the interfaces between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system was functioning within and across three key areas:

1. Maintaining the wellbeing of a person in their usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/ or admission to a new place of residence

Across these three areas, detailed in the report, we have asked the questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?

We have then looked across the system to ask:

- Is it well led?

Prior to visiting Plymouth we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We asked the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (SOIR) and asked a range of other local stakeholder organisations for information.

We also developed two online feedback tools; a relational audit to gather views on how

relationships across the system were working, and an information flow tool to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care.

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as people who use services, their families and carers. The people we spoke with included:

- System leaders from Plymouth City Council (the local authority), the NEW Devon Clinical Commissioning Group (the CCG), Plymouth Hospitals NHS Foundation Trust, Livewell Southwest Community Interest Company (a social enterprise), the Health and Wellbeing Board (the HWB), the Overview and Scrutiny Committee and elected leaders.
- Health and social care professionals including social workers, GPs, discharge teams, therapists, nurses and commissioners
- Healthwatch Plymouth and voluntary, community and social enterprise sector (VCSE) services
- Independent care providers
- People using services, their families and carers at Improving Lives and the Elder Tree befriending service. We also spoke with people in A&E, hospital wards and at residential and intermediate care facilitates.

We reviewed 19 care and treatment records and visited 11 services in the local area including acute hospitals, community hospitals, intermediate care facilities, care homes, GP practices and domiciliary care providers.

The Plymouth Context

Demographics

- 16% of the population is aged 65 and over
- 96% of the population identifies as white
- Plymouth is in the top 20-40% most deprived local authorities in England

Adult social care

- 78 active residential care homes:
  - Two rated outstanding
  - 62 rated good
  - 9 rated requires improvement
  - Two rated inadequate
  - Three currently unrated
- 22 active nursing care homes:
  - One rated outstanding
  - 11 rated good
  - Seven rated requires improvement
  - 2 rated inadequate
  - 1 currently unrated
- 18 active domiciliary care agencies:
  - 2 rated outstanding
  - 7 rated good
  - 3 rated requires improvement
  - 6 currently unrated

Acute and community Healthcare

Hospital admissions (elective and non-elective) of people of all ages living in Plymouth were almost entirely to Plymouth Hospitals NHS Trust

- Received 97% of non-specialist admissions of people living in Plymouth
- Admissions from Plymouth made up 53% of the trust's total admission activity
- Rated requires improvement overall

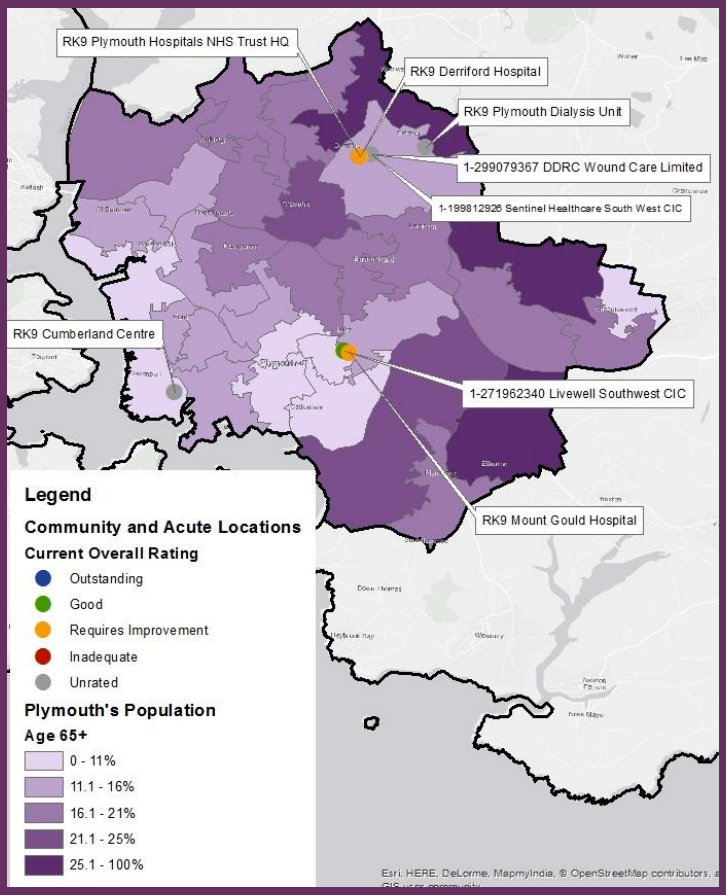
Community services are provided by Livewell Southwest

- Rated good overall

GP Practices

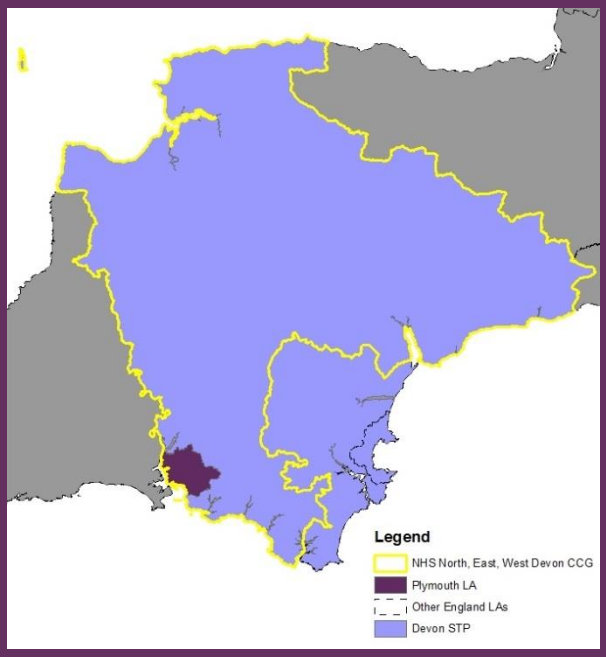
- 32 active locations
  - 30 rated good
  - 2 unrated

All location ratings as at 01/12/2017. Admissions percentages from 2016/17 Hospital Episode Statistics.



Map 1: Population of Plymouth shaded by proportion aged 65+.

Also, location and current rating of acute and community NHS healthcare organisations serving Plymouth.



Map 2: Location of Plymouth LA within Devon STP.

NHS North, East .West Devon CCG is also highlighted.

Summary of findings

Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- Plymouth is on a journey to integration. There was a compelling vision for integration within Plymouth, developed in collaboration with system partners and local people and linked to the Devon-wide Sustainability and Transformation Plan (STP). The strength and commitment of Plymouth's leadership meant this strategic vision had the potential to be realised, but only if it was translated at ground level and if the wider current challenges facing the system are addressed.

- Plymouth was part of the north, east and west NEW Devon Success Regime, one of three in the country, owing to the area's significant financial pressures. These pressures continued to be felt at the time of our review. It was reported that Plymouth Hospitals NHS Trust (PHNT) had one of the largest Cost Improvement Plans in the country at £40 million for 2017/18. There were significant capacity issues within primary care and continuing healthcare performance was poor. People's experiences of the care system were variable and these challenges meant there was a risk improvements could not be sustained.

- The ambitions of the Devon-wide STP had been translated into the local *Plymouth Plan* and there were clear lines of communication and accountability between the two. Both officers and political leaders within the system had strived hard to ensure the voice of Plymouth was heard within the STP structures. Plymouth had been recognised by the STP for their approach to integrated commissioning, the way they had involved the public in developing their strategic vision and commissioning plans and the effectiveness of their Health and Wellbeing Board (HWB). This meant there was a clear framework to secure improvements for people who use services.

- There was a shared ambition among system leaders to progress with vertical integration of service delivery to include primary care, community, acute and social care. The challenges will be to ensure staff are engaged in the process and can articulate the strategic vision, and to ensure that positive approaches and ways of working that have been established within the current system are not lost in the change process.

Is there a clear framework for interagency collaboration?

- There was a clear framework for interagency collaboration. Relationships amongst system leaders were positive and there were examples of effective partnership working. However, it was widely recognised that some cultural and organisational barriers remained and that

significant organisational development work was required to overcome these if full integration of service provision was to become a reality.

- Since 2015, the local authority and the Western Locality of Northern Eastern and Western (NEW) Devon CCG had a pooled budget of £462 million to deliver integrated health and wellbeing services. There were four corresponding integrated commissioning strategies, which system partners were all signed up to. While they were reviewed every six months, they had remained consistent to provide clarity and stability.

- There was evidence of risk sharing at an STP and a local level. The Devon-wide STP was working to a system-wide control total which meant if PHNT's Cost Improvement Programme was not addressed, the entire STP was at risk. The risk share arrangement outlined in the Section 75 agreement between the local authority and NEW Devon CCG had been nationally recognised as innovative.

- System leaders were aware of the shared challenge to reduce the causes of delayed transfers of care. They had committed to resolving these issues through the establishment of the System Improvement Board (SIB) in October 2017, which provided a system-level view of performance. This fed into the Devon-wide System Performance and Delivery Group (SPDG) had been established to provide a shared view of performance and high-level scrutiny to drive improvement.

How are interagency processes delivered?

- There were strong governance arrangements in place with clear lines of accountability and communication between system partners within Plymouth and with the Devon-wide STP. However, some governance arrangements had been recently implemented and their impact had not yet been realised in terms of improvements in performance.

- In 2015 the local authority had transferred their adult social care staff to Livewell Southwest (LWSW), a social enterprise, to create an integrated health and social care community provider with the aim of providing a whole-person response to community support. Multidisciplinary teams were now based in four localities across Plymouth working in an integrated way to deliver positive outcomes for people.

- Plymouth's journey to integration had been underpinned by extensive public engagement and co-production. Health and social care providers and voluntary sector organisations described their relationships with commissioners as positive and collaborative.

- The challenge for this system was to continue to drive forward the strategic ambition while remaining focused on delivering improvements against current performance pressures. The

prevention and early intervention commissioning intentions for hospital admission avoidance remained underdeveloped due to a reactive response to external reviews and sub-optimal performance in parts of the system

- There were some missed opportunities to learn and improve as a system. For example, Plymouth was consistently in a state of escalation and this had become normalised. There was a lack of evaluation at a system level to identify what actions by services or individual staff led to the level of escalation being reduced.

What are the experiences of frontline staff?

- System leaders and senior managerial staff were visible and engaged. Staff were aware of how to escalate concerns within their organisations and across organisations.

- Frontline staff were committed to providing high-quality and person-centred care. There were some particularly innovative and energised staff working within the system who were leading and contributing to system improvements. However, there was a dependence on specific, critical individuals. Leaders should ensure plans are in place for succession and to mitigate any risk of these individuals leaving and that changes and improvements are embedded and sustained.

- While we found examples of staff working in an integrated way to deliver positive outcomes for people, the system remained fragmented in parts and organisational structures were a barrier. Staff did not always know which services were available and there was a lack of trust or understanding in the capability of those services newly established or those outside of their respective organisations. This was supported by the findings of our relational audit.

- While frontline staff were aware of the system's performance in relation to delayed transfers of care, there was not a shared level of responsibility to reduce them, but an acceptance they were the symptom of a pressurised system. This was particularly apparent in the acute hospital. The system needs to ensure that staff are not normalising sub-optimal performance.

- Most frontline staff across the health and social care sector we spoke with were positive about their relationships with commissioners. They described them as collaborative and supportive.

What are the experiences of people receiving services?

- The experience of people receiving health and social care services in Plymouth was varied. We received mixed feedback from people using services and from carers we spoke with. They were complimentary about individual staff, but told us they had had negative

experiences of discharge from hospital.

- If people received reablement services they were more likely to remain independent and remain at home, additionally if they were under the care of a LWSW locality-based team they were likely to only have to tell their story once.

- There were significant pressures within primary care, and GP provision in terms of numbers was poor in parts of the city. This meant people could not always access a GP when they needed one which placed an additional burden on other services within the system.

- There were services commissioned to prevent unnecessary admissions to hospital, however, some were working below capacity and could be better utilised. This meant some people were admitted to hospital unnecessarily.

- There were also missed opportunities to better utilise the services and contribution of the voluntary and community sector in terms of maintaining people at home and avoiding hospital admission.

- If a person went into crisis, they were more likely to be admitted to hospital and experience longer lengths of stay due to delays in the assessment processes for both health and social care.

- People were receiving direct payments and personal health budgets, but we were told it was difficult for people to access information about services available, particularly if funding their own care.

- Performance in relation to continuing healthcare (CHC) was poor. Large numbers of people were waiting for assessments for considerably longer than the expected 28 days. Furthermore, the conversion rate was low, meaning a large number of people referred for an assessment did not receive funding because they did not meet the eligibility criteria. System leaders told us that a high number of inappropriate referrals impacted on the CHC team's ability to respond to the backlog.

Are services in Plymouth well led?

Is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high quality care and support?

As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, interagency and multidisciplinary working and the involvement of people who use services, their families and carers.

Plymouth was well on its journey to integration and some positive progress had been made to date.

We found there was strong system leadership with a clear strategic vision for the future, which was aligned to the wider Devon STP. There was a real commitment among both officers and political leaders to deliver together, and the challenges and pressures faced by the system were well understood by all. Relationships at a system level were positive and there was evidence of effective partnership working. However, some cultural and organisational barriers existed and were impacting on service delivery in parts of the system. It was widely recognised that some organisational development work was required to engage staff at all levels and ensure they were able to articulate the strategic vision and work together to achieve it. Should the wider system challenges be addressed with a clear focus on the here and now as well as transformational change, there was the potential for the strategic vision to be realised.

There had been extensive public engagement in the development of the city's strategic vision and service design. Wider system partners, including health and social care providers as well as voluntary sector organisations felt they had collaborative relationships with commissioners and there was a commitment for the system to learn and improve together.

Strategy, vision and partnership working

- There was strength in the leadership and a shared, system-wide commitment to serve the people of Plymouth well. While there was recognition that some relationships had been challenging and organisational structures had created barriers to integrated working, there was a commitment to overcome these. Findings from 160 respondents to our relational audit showed some issues still existed around organisational cultural issues, trust, and understanding about what services could offer. System leaders need to ensure staff at all levels across health and social care are included in the vision and understand their role in delivering it.

- The system was on its journey to integration. In 2013 the HWB set the ambition to develop

an integrated system of population-based health and wellbeing to tackle inequalities and improve outcomes for residents across the city. The HWB continued to take a leadership role, setting ambitions and agreeing strategic approaches. This strategic vision for an integrated health and social care system within Plymouth pre-dated the development of the STP and system leaders had worked hard to ensure local priorities and challenges were well understood at an STP level from a political, commissioner and provider perspective. There was representation from Plymouth across the STP structures.

- Leadership was strong among officers and political leaders; positive relationships were leading to effective partnership working. Political leaders and shadow leaders were united in their support of the strategic vision and priorities for the city and the NEW Devon footprint, despite political and financial pressures, which was encouraging to see. This meant there was a shared commitment to ensuring people received better quality care.

- The Devon STP, encompassing the local authority areas of Plymouth, Torbay and the rest of Devon, set out ambitious plans to improve health and care services to ensure they are clinically and financially sustainable in the future. It also provided the framework for an Accountable Care System with a single strategic commissioner and four Local Care Partnerships (LCPs) based on a place-based model of care and a network of acute hospitals by 2020/21. One of these LCPs would cover the Western Locality of NEW Devon CCG, including Plymouth.

- The strategic vision and priorities of the Devon STP had been translated into a local strategic framework. The '*Healthy City'* chapter within, '*The Plymouth Plan'* set out the objectives for health and social care, focusing on prevention and early intervention as well as considering the wider determinants of health such as, housing, transport and the environment. This strategic framework was underpinned by four integrated commissioning strategies. The focus was very much on prevention and living well. There had been significant investment across the city to develop 309 extra care housing units for older people, with a further 80 due to complete by February 2019. However, there was an absence of end of life care within the strategic plans at both an STP and local level. This was highlighted by some voluntary sector organisations we spoke with during our review.

- Although system leaders embraced the STP and were committed to delivering the strategic objectives of the STP and *Plymouth Plan,* some system partners felt the STP had hindered progress in some areas. The STP had been slow to develop a primary care strategy and this had impacted on Plymouth's ability to respond to what was an immediate risk within the system due to commissioning arrangements being the responsibility of NHS England.

- Partners had not only succeeded in having a joint plan for the Better Care Fund (BCF)

signed off and approved by NHS England without any conditions, they had also submitted a bid to be part of round one BCF graduation. Plymouth was not one of the seven areas selected for the first tranche, but intended to apply again should the opportunity arise. The Improved Better Care Fund (iBCF) submission for Plymouth outlined a long list of schemes, which all met with the three national conditions imposed on related monies.

- System leaders were aware of the shared challenge to reduce the causes of delayed transfers of care. They had committed to resolving these issues through the establishment of the SIB and the joint appointment of an 'Interim Director of Integrated Urgent Care' by LWSW and Plymouth Hospitals NHS Trust (PHNT). Unverified data showed recent improvements had been made, but delays remained higher than average and wider system pressures, including primary care capacity and workforce put the sustainability of these recent improvements at risk.

- A system level plan for winter had been produced and staff and providers throughout the system were able to articulate how they had been asked to contribute. For example, care providers and voluntary, community and social enterprise sector (VCSE) organisations had been asked to provide information on their capacity.

- The system worked collaboratively with providers, housing partners and VCSE organisations. The feedback we received from these organisations supported this view. They were positive about how commissioners engaged them in developing the vision and strategy and they felt like system partners. There were a variety of fora they could attend, including system design groups at both a local and STP level. However, some VCSE organisations also reported they felt underutilised and that commissioners could be more proactive in their approach. System leaders should ensure VCSE organisations are included in strategic plans to increase future capacity.

Involvement of people who use services, families and carers in the development of strategy and services

- Plymouth's journey to integration had been underpinned by extensive public engagement and co-production. Providers had systems in place within their individual organisations to engage with people and obtain feedback, including a partnership committee at LWSW and a patient council at PHNT. The system's approach to involving people in service design and delivery was positively commented on by many people who use services and staff we spoke with during our review and it had also been recognised at the STP level. For example, the 'Plymouth Sofa' visited different parts of the city to facilitate conversations about what was important to people and a series of 'I' statements were also developed.

- For each of the four integrated commissioning strategies, a system design group (SDG)

had been established. These created opportunities for all stakeholders (including providers, people who use services and carers) to collaborate, review, design and implement structures and pathways. Annual surveys and quality reviews across service provision were undertaken as part of the contract management process, which involved site visits and speaking with people who used services. The feedback from these surveys and reviews helped inform future commissioning plans and identify areas for improvement.

- Healthwatch Plymouth had been commissioned by the local authority to lead a public consultation for the development of ten health and wellbeing hubs across the city where people could access information, signposting and self-management advice and activities. These hubs were at the planning rather than delivery stage and people were being consulted in their design from the outset. The consultation had concluded and Healthwatch had produced a comprehensive outcome report for commissioners prior to our review (published November 2017).

- We received positive feedback from VCSE organisations about their relationship with commissioners and involvement in strategic development to support local people. Not all were represented on Plymouth's HWB, but they described their involvement in SDGs at a local and STP level. However, some felt underutilised in the delivery of services. The system had commissioned a number of VCSE organisations to deliver services on their behalf. For example, Improving Lives ran the city's carers' hub and were commissioned to carry out carers assessments in collaboration with LWSW.

- Work was also being undertaken to develop and build upon community assets. The Plymouth Octopus Project (POP) had received investment from the local authority to go out into communities and help connect like-minded people, projects and organisations to create networks and increase social capital in local areas.

Promoting a culture of inter-agency and multidisciplinary working

- There was a shared ambition and commitment to move to a model of vertical integration which would see integration of statutory community and acute healthcare service provision as well as commissioning. The system had begun to lay the foundations for this and the integrated commissioning arrangements which saw a pooled budget of £462 million since 2015 between the local authority and Western Locality of NEW Devon CCG, meant they were further ahead than other areas of the country (and the Devon STP) in terms of the transformation agenda. This pooled budget extended beyond health and social care to include the wider determinants of health and wellbeing, such as public health, housing, leisure and community safety budgets.

- In 2015 the local authority transferred their adult social care staff to LWSW to create an

integrated health and social care community provider with the aim of providing a whole-person response to community support. Multidisciplinary teams were now based in four localities across Plymouth working in an integrated way.

- While there had been some ambitious steps made to encourage a culture of inter-agency and multidisciplinary working, some of these were relatively new and needed to be further embedded as relationships were fragmented in parts. This was supported by the findings of our relational audit where two of the lowest scores were on the statements: “Poor communication creates misunderstanding and ill-formed decisions” and “Opportunities are missed and problems caused as a result of limited knowledge about other organisations”.

- The Acute Assessment Unit at Derriford Hospital had been opened the week before our review. This saw LWSW and PHNT staff co-located and working together to prevent unnecessary admissions to hospital through primary care streaming, the Acute GP service and the frailty unit. The Acute GP service had been in operation for some time, but was generally working at 60% capacity despite attempts to engage staff in the Emergency Department at Derriford Hospital to encourage referrals directly from A&E. Some organisational development work needs to be undertaken to break down organisational barriers, strengthen relationships and ensure there is a shared understanding about staff roles and responsibilities and how they fit into the wider system. Should work progress to form a fully integrated service delivery model, the system needs to ensure staff are fully engaged, from the outset and led by a collaborative leadership.

- There was a shared commitment among system leaders to tackle the challenges faced jointly. PHNT and LWSW had recently made a joint appointment of an ‘Interim Director of Integrated Urgent Care’ to objectively review the system’s capacity and to remove barriers to facilitate more effective working.

- More work was required to ensure all providers felt like system partners. While care providers were positive about their relationships with commissioners, they were less so in relation to secondary care providers, who they felt did not understand the limitations of what their services were able to provide.

Learning and improvement across the system

- Although there was evidence of learning and improvement within individual parts of system, there was not a single, co-ordinated approach to ensure that lessons and key messages were shared widely across among system partners, but rather a fragmented approach. This meant there were some missed opportunities to evaluate and learn as a system to prevent incidents from reoccurring.

- The system had been the subject of several external reviews in the past year, including the Emergency Care Improvement Programme. This is a clinically led programme provided by NHS Improvement to provide practical advice and support to improve patient care and flow. Plymouth had produced comprehensive action plans in response to these reviews, which were ratified and monitored by the SIB. However, system leaders acknowledged these had often looked at pressure points within the system in isolation, which had led to a fragmented, reactive response.

- Due to the pressures in relation to flow, the system was regularly in escalation and this had become normalised among staff at all levels. System leaders recognised there was good communication in relation to escalation, but less so about when they were de-escalating. There should be more evaluation of the contributing factors that lead to de-escalation, whether that the actions of particular teams or wider system partners. This should be communicated widely to encourage learning and improvement. In addition, the system should proactively look to other areas within the STP where performance is better to understand this.

- At the time of our review, a “yellow card” system had recently been implemented within primary care. It enabled GPs to easily flag an issue of concern, such as outpatient departments asking GPs to do unnecessary investigations in the community. These were then escalated to the CCG who monitored for themes and action as necessary. Staff who had used the system reported they had received limited feedback to issues they had reported, but commissioners told us plans were being developed for cascading information. The yellow card system was not routinely being used to flag near misses, such as medication errors on discharge, nor was it accessible to social care providers. Therefore, opportunities were missed to identify common themes across the health and social care interface.

What impact is governance of the health and social care interface having on quality of care across the system?

We looked at the governance arrangements within the system, focusing on collaborative governance, information governance and effective risk sharing.

There were robust governance arrangements across the health and social care interface to assess, monitor and mitigate risks. There were clear vertical and horizontal lines of reporting between organisations and up to system level arrangements and the STP. The SIB had been established shortly before our review, but was effective at providing a shared view of performance across the system and driving improvement. However, data used to monitor flow was based on traditional performance indicators rather than universal outcome measures.

Risk sharing agreements and information governance agreements were in place. However, a lack of integrated records systems was a barrier to providing fully integrated care across the system

Overarching governance arrangements

- There were robust governance arrangements in place to support the planning and delivery of integrated care, particularly since the establishment of the SIB. The STP set out the strategic vision, delivery plans and provided an oversight of performance via the Devon-wide A&E Delivery Board, the STP's System Performance and Delivery Group (SPDG) and the Western SIB in Plymouth. There were clear lines of accountability and communication from the local level through to the STP board with horizontal and vertical reporting structures to ensure the correct groups were sighted on performance and quality issues.

- While each organisation within Plymouth had its own reporting structures and boards, two partnership groups had been established to encourage inter-agency working; the SIB to focus on the "here and now" in relation to system flow performance, national targets and financial improvements and the Taking Change Forward group to deliver on the transformation agenda.

- The SIB was established in October 2017 and had taken on the responsibilities of the Local A&E Delivery Board. The SIB included commissioners, providers and regulators, who met fortnightly to direct activity and seek assurance activities were having an impact and leading to improvements. A snapshot view of performance was provided by the System Flow Performance Framework, which included system flow indicators from the community and acute providers, NHS constitution targets and the escalation status of the system. The SIB provided performance updates to the Health and Wellbeing Board.

- Plymouth's HWB had been nationally recognised in a study commissioned by the Local Government Association in 2016 as a good example for being effective, having clarity of purpose and committed leaders. It was the driving force behind the vision and strategy and saw itself as the lead in terms of governance. While the HWB and system leaders recognised it had become "distracted" by the STP, work was ongoing to refocus its role. Both the HWB and the Overview and Scrutiny Committee provided a high level of challenge around specific pressures within the system, such as the system response to the fragility of primary care. They were reassured recent changes within the system would lead to performance improvements, but they did not have evidence of impact yet.

- There was a transparent approach to sharing of management information across the health and social care interface, facilitated by the SIB where some agreed performance metrics

were presented. However, some services were unable to evaluate their activity performance and how it impacted on the wider system. For example, intermediate care and reablement teams told us they did not know how many people currently in hospital were waiting for an intermediate care bed, only those who were referred to them so they could not predict demand. This meant some people in hospital may have been waiting longer than necessary if there were delays in their referral being submitted.

Risk sharing across partners

- There was a shared view of operational and financial risks across the system. However, while there was a shared strategic risk register, operational risks were often contained within organisational-level risk registers. We were advised plans were in place to develop a risk register between LWSW, PHNT and the CCG. However, the system needs to go further to include care providers for it to be truly system-wide.

- The Devon-wide STP was working to a system-wide control total which meant if PHNT's Cost Improvement Programme was not achieved it would impact on the STP income, which in turn would impact on the overall STP system control total.

- Locally, there was a risk-share arrangement outlined in the Section 75 agreement between the local authority and NEW Devon CCG. This had received national recognition as being an innovative approach. Commissioners and financial officers felt this had had a positive impact on relationships and their ability to respond to system pressures collectively. We observed a high level of trust between the two organisations.

- Feedback from external reviews carried out in early 2017 identified that a lack of risk-sharing between the acute and community sectors was affecting Plymouth's ability to respond to a consistently escalated system. System leaders were open and transparent about these findings during our review and were taking strategic steps to resolve them. A joint bid between LWSW and PHNT resulted in a £1 million grant to support the development of the Acute Assessment Unit (AAU) at Derriford Hospital, which opened the week before our review. It had also recently been agreed for the management of the Minor Injury Units to be transferred from LWSW to PHNT to provide greater connectivity and improve performance against the four-hour A&E target. It was hoped these changes would lead to demonstrable improvements in coming months.

- The recent establishment of the SIB provided a single point of escalation for system risks. It was responsible for resolving any issues in the best interests of the people of Plymouth, not individual organisations. All risks were considered shared risks and while leaders were able to articulate how the system had responded to specific issues or pressure points, this approach was reactive.

Information governance arrangements across the system

- There was a joint information sharing agreement in place between all partners in the STP (including Plymouth City Council, NEW Devon CCG, LWSW and PHNT) to support people who moved through the health and social care system. Plymouth was meeting the national conditions around better data sharing between health and social care and had NHS numbers recorded against more than 95% of adult social care records.

- Staff throughout the system reported information sharing across the health and social care interface needed to improve and it was regularly described as a barrier to integrated working and ensuring people experienced seamless care. Integrated multidisciplinary teams working within Plymouth's four localities could all access the same system, as could other LWSW services, such as the Community Crisis Response Team (CCRT). However, GPs and secondary care could not access these community health and social care records and vice versa. We were told this could lead to risk-averse decision making and unnecessary hospital admissions.

- While there was positive intent amongst system partners to share information, current operating systems differed between organisations and prevented frontline staff from sharing accurate, up to date information in a timely way. This meant people often had to tell their story more than once and experienced unnecessary delays.

To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?

We looked at how the system is working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource.

We found there were strategic plans at organisational levels and STP level which aligned the workforce to future demand. It was clear what needed to be done and by whom, with a focus on developing teams rather than just individual professional groups. However, there was not a single, coherent workforce plan for Plymouth. Workforce was one of the most significant risks faced by the system with recruitment and retention challenges across every sector. The situation within primary care was felt most acutely and due to commissioning arrangements, this was being progressed at the STP level, which created its own challenges.

There were some examples of innovative approaches to responding to workforce capacity, looking at new roles and models of care. The system needs to ensure it works together as one, sharing good practice while preventing the burden from being felt elsewhere.

System level workforce planning

- Workforce capacity was a significant challenge for the system. There were a range of workforce strategies across the system at organisational level (Plymouth City Council, PHNT, LWSW) which outlined what needed to be done and by whom. However, there was no overall, coherent strategy for Plymouth. System leaders should work with partners to pull together existing plans, making sure priorities are aligned to address system-wide challenges and that strategic plans are supported by data and timescales for delivery.

- Although the system faced significant workforce challenges across every sector, the situation within primary care was at a tipping point. There was a shortage of 25 whole time equivalent GPs across 32 practices, equating to a 15.3% vacancy rate, and several practices had handed back their contracts or were at risk of doing so (some owing to difficulties with recruitment). Furthermore, it had been estimated that between 25% and 35% of GPs and practice nurses would be retiring within the next five years. The majority of the practices across NEW Devon CCG deemed vulnerable were in Plymouth (11 in total). Some workforce planning and action was taking place at an STP level due to national funding flows and recruitment initiatives to attract staff to the western peninsula. NHS England (NHSE) was the commissioner for primary care across the whole of NEW Devon CCG. NHSE had and is continuing to develop a range of initiatives to improve recruitment to Devon and Cornwall and recognised that there were particular pressures in some locations including Plymouth.

- System leaders within Plymouth acknowledged that the STP had been slow to develop a primary care strategy. The system needs to work closely with NHS England as the commissioner of primary care to take this forward at a pace, considering the fragile situation in the city.

- Plymouth had recently been successful in securing approximately £120k in funding from Health Education England, specifically for training and education in relation to new models and roles within primary care. However, it had taken some time for these monies to be released to the system, which was a source of frustration for commissioners and providers in primary care. This delay had impacted on the system's ability to plan and respond to what was a critical situation.

Developing a skilled and sustainable workforce

- Health Education England South West had provided the Devon STP with £861k to spend on workforce transformational activities, which had been prioritised by the STP as essential to the health and social care system. System leaders were working to develop and future

proof the workforce through initiatives at a local and regional level as well as with education institutions. We found examples of innovative approaches to growing a workforce and developing new roles and new models of care. For example, healthcare providers, including LWSW and PHNT, worked closely with a local medical and healthcare college recently set up for pre-GCSE students keen to a pursue a career in healthcare.

- Plymouth was facing significant recruitment and retention pressures in relation to staff across health and social care. However, while vacancy rates of adult social care staff across Plymouth stood at 8.7%, LWSW currently had a vacancy rate of less than one per cent. LWSW had developed a variety of programmes to help grow, support and retain their workforce. For example, scholarships to support staff to obtain degrees, the development of the nursing associate role and protected time for training additional to regulated training. System partners should work together to share initiatives and good practice to support wider improvements.

- Plymouth's substantive GPs cared for 2,364 patients per whole time equivalent GP on average compared with 1,950 on average for the whole of NEW Devon CCG. To reduce workloads and increase capacity, the CCG and GP federations were exploring non-GP scenarios, such as the roles of allied health professionals (pharmacists, advanced practitioners, nurse practitioners and medical associate professionals). In some parts of the city primary medical and community pharmacy models and workforce had been brought together, but recruitment and retention pressures also existed with pharmacists. Plans were in place to ensure every practice had some social prescribing support by early 2018. We saw an example of one GP federation that had employed a multidisciplinary team, including advanced paramedic practitioners to respond to demand for urgent appointments. Although innovative, this had wider implications for the system. South West Ambulance Service NHS Trust (SWAST) reported it had lost 14% of its advanced paramedic practitioners to primary care, but it should be noted this figure covers a much larger area than just Plymouth.

- Skills for Care workforce estimates for 2016/17 showed that the staff turnover rate for social care in Plymouth was 35%, which was higher than the comparator and England averages (24% and 28% respectively). Seventy two per cent of new appointments were made to people who were already working in the social care sector in Plymouth, which meant the system was retaining skills and experience, however a high turnover meant people did not receive continuity of care.

- Vacancy rates in social care were higher than average at 8.7%, compared to a regional average of 6.9% and an England average of 6.6%. Plymouth was part of the 'Proud to Care South West' campaign consisting of 16 local authorities promoting a career in the care sector. The local authority also supported providers with recruitment, for example by

hosting recruitment fairs and providing links with City College Plymouth's social care faculty.

- The local authority supported care providers to develop their workforce. Examples of training provided by or commissioned by the local authority included, leadership training, medicines management workshops, safeguarding and the development of health and wellbeing champions. Providers we spoke with were positive about these initiatives.

Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?

We looked at the strategic approach to commissioning and how commissioners are providing a diverse and sustainable market in commissioning of health and social care services.

Commissioning strategies, underpinned by needs assessments, focused on prevention and were aligned to the wider Devon STP. The system had developed an integrated commissioning function with a pooled budget. Services were commissioned across the health and social care interface, but commissioning practices remained predominantly reactive to pressure points within the system. There was awareness among commissioners at all levels where improvements were required and work was in train to make these. Plymouth did not face the same social care market issues felt elsewhere in the country or compared to the rest of the Devon STP area, but the system needs to ensure there is sufficient capacity and resilience to cope with an increase in demand.

Strategic approach to commissioning

- The HWB set the strategic ambition of system integration, including integrated commissioning. New Devon CCG and the local authority formed this integrated commissioning function as part of the pooling of budgets in April 2015. The local authority and the CCG commissioners were co-located to commission jointly across health and social care and this was well-regarded by local system partners, as well as those at STP level. Commissioning teams themselves described how it was much easier to "get things done" working in an integrated way.

- Commissioning plans were focused on prevention, place-based models of care designed to keep people well at home working to the principle of "the best bed is your own bed". There were four integrated health and social care commissioning strategies, underpinned by Joint Strategic Needs Assessments as well as advice from clinicians and public health specialists. These aimed to reduce inequalities, improve people's outcomes and experience of care and ensure the sustainability of the health and wellbeing system. However, due to current pressures within the system commissioning activity in relation to

hospital admission prevention had been reactive.

- SDGs, involving commissioners, providers and the public, had been established to convert the four commissioning strategies into project plans and deliverable outcomes. Some staff and stakeholders (providers and VCSE organisations) commented that the absence of a specific focus for older people and end of life care within the strategies made it difficult to articulate joint goals.

- The Devon-wide STP outlined ambitious proposals to form one strategic commissioner with four Local Care Partnerships. While system leaders within Plymouth were supportive of this direction of travel, the system was further ahead than its counterparts in relation to integrated commissioning and it was not clear what a strategic commissioner would mean in practice.

Market shaping

- The response to the System Overview and Information Request (SOIR) stated the commissioning strategies set the direction of travel so providers could use them to plan and deliver the services required. However, there was no externally-facing Market Position Statement which signalled to current and future providers what future requirements would be and to encourage innovative approaches. This should be developed as a matter of priority to ensure there is capacity in the market otherwise improvements made to increase flow elsewhere in the system will not be sustained.

- Plymouth did not have social care market capacity challenges seen elsewhere in the country, but there were some quality issues in nursing care and capacity issues with some specialist care. Sixty-eight per cent of care home beds and 67% of domiciliary care packages were partially or fully funded by the local authority or NHS. As of December 2017, 79% of residential homes in Plymouth were rated as good and 12% were rated as requires improvement which was better than comparator areas and the England average (18% and 15%, respectively). However, 9% of Plymouth's nursing homes were rated as inadequate, which was higher than an average of 2% in comparator areas and the England average of 3%. The percentage of domiciliary care providers rated as good or outstanding was higher than average and none were rated as inadequate.

- The system needed to assure itself there was capacity and resilience in the market should performance improvements lead to an increase in demand. Traditional contractual arrangements meant domiciliary care providers were not paid a retainer to keep packages of care open should a person be admitted to hospital. This arrangement may impact on continuity of care for the person and the capacity of providers to recruit and retain staff. Furthermore, should flow improve elsewhere in the system, this may lead to further delayed

transfers of care if packages were not available.

- Plymouth's iBCF submission statement had identified stabilising the social care market as a priority and as a result reported it had increased the rate of pay for domiciliary care. The current hourly framework rate for home care was £14.87, an increase from £14.76 the previous year. According to the response to the SOIR, a Care Home Business Improvement Partner, employed by the Integrated Commissioning team, offered support and a collaborative approach to the care sector regarding fees in a bid to secure a sustainable and viable market. Although care providers we spoke with understood the financial constraints of the local authority, they did not feel the current rate of pay was sufficient to attract and retain the right quality of staff and ensure business viability. The Association of Directors of Adult Social Services (ADASS) 2016/17 budget survey report highlighted there was national variation in the price paid for care and that councils overall had been unable to meet the desired 2016/17 UK Homecare Association (UKHA) benchmark of £16.70.

Commissioning the right support services to improve the interface between health and social care

- The integrated commissioning team commissioned a variety of support services to improve the interface between health and social care. There was a joined-up approach to commissioning preventative initiatives, bringing together public health and iBCF budgets to expand social prescribing and establishing health and wellbeing hubs to reshape existing services rather than procuring new ones. The public health prevention budget was small, but low-level services, such as befriending, had been retained.

- However, there remained a targeted, reactive approach to wider system pressures, which meant hospital admission prevention commissioning was underdeveloped. There was good uptake of personal budgets for health and social care, but there needed to be better use of voluntary sector organisations. The British Red Cross were in discussion with commissioners to increase their offer to support people with the discharge process.

- There were a variety of services commissioned from health and social care providers to prevent admissions to hospital and to facilitate timely discharges, but their effectiveness was hindered by workforce challenges, complex pathways and assessment delays. Emergency admissions for over 65s in Plymouth had been persistently higher than national averages since 2014, and there were a high number of delayed transfers of care. However, the system was aware of where the challenges were and the improvements required, including how it commissioned services.

- There was wide recognition that the discharge to assess pathway had not achieved the expected outcomes for people. Commissioners were working with providers to remodel the

service and ensure the right wrap around support from therapists and GPs was commissioned. Contracts had also been drawn up to commission the out of hours GP service to provide an enhanced visiting service to care homes by Christmas 2017.

- Published data in relation to continuing healthcare (CHC) showed that NEW Devon CCG's performance in quarter one for 2017/18 was poor. High numbers of people were waiting in a community setting for longer than 28 days for an assessment and conversion rates were low. System leaders reported that a lack of understanding amongst staff about the appropriate use CHC funding, the framework and eligibility criteria led to a high number of inappropriate referrals; 91.2% did not meet the criteria and this impacted on the CHC team's ability to respond to the backlog. There needs to be a system wide response to ensure there is a shared understanding and agreement of how the CHC framework should be applied so only appropriate referrals are made, people are not left waiting too long for an assessment and the backlog is resolved.

Contract oversight

- There were comprehensive systems in place to monitor the performance of commissioned services, but there was sometimes a varied response to quality issues. Commissioners were able to provide examples of how they evaluated the quality of service provision and performance dashboards were in use across the health and social care sector. These were being used to improve activity and hold providers to account, for example ensuring timely reviews of people receiving reablement services.

- The Quality Assurance and Improvement Team (QAIT), supported care homes to improve quality and practice, arranging training where required. Although the system was able to demonstrate some positive outcomes, 20% of adult social care services in Plymouth were found to have deteriorated following a CQC re-inspection compared to 15% in similar areas and 12% nationally. Furthermore, only 19% were found to have improved, which was lower than a comparator and England average of 37%.

- The local authority was described by CQC inspectors as more reactive than proactive in managing struggling services; only focusing on those rated as inadequate by CQC rather than those rated requires improvement. Feedback from the relational audit also included comments about commissioners not responding quickly enough to those providers who were financially challenged to prevent them from failing financially.

How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting people's independence?

We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high quality care and promote people's independence.

We found there were robust controls and governance arrangements in place to provide assurance that available resources were being used in the most effective manner. Plymouth's financial situation was challenging with both the acute trust and CCG running large deficits, coupled with a funding gap of approximately 10% compared to the rest of Devon. The pooled budget arrangements facilitated open and transparent lines of communication between organisations and clear reporting structures meant system leaders were able to provide assurance they were aware of how resources were being used.

- There were robust governance arrangements in place to provide assurance around how resources were being used across the system. The system faced some significant financial challenges; it was reported that PHNT had one of the largest Cost Improvement Programmes nationally at £40 million and the CCG was running a planned deficit of £57.2m for 2017/18. Plymouth also faced an inequity challenge whereby funding per head of population was approximately 10% less in western Devon compared to eastern and northern Devon. There was also inequity in the public health budget compared to similar areas. System leaders were realistic about how and when this may be resolved and, in the meantime, ensured there were sufficient controls to effectively manage the current resource.

- Governance structures were designed to provide assurance. Since the pooling of budgets between the local authority and the CCG in 2015, the fund has been hosted by the CCG, with the fund manager being employed by the CCG and the deputy employed by the local authority. The pooled budget of £462 million was managed through an Integrated Commissioning Board. Financial officers worked closely with commissioners to measure the effectiveness of investments. There were a series of dashboards that tracked both budget and activity on a daily basis providing real time financial information.

- There were clear lines of reporting between the two organisations and up to their respective boards as well as the SIB. The Overview and Scrutiny Committee also fulfilled its function to provide challenge around the system's financial status.

- The iBCF funding was included within the pooled budget in its entirety and was being used to drive forward next phase of the 'One System, One Aim' programme of activity. The system was meeting requirements of the iBCF funding by providing quarterly update reports to the Department for Communities and Local Government.

- Our analysis showed that there were more residential beds per population aged 65+ in Plymouth compared to comparator areas and the England average with a 2% increase in the number between April 2015 and April 2017. There were a similar number of nursing beds per population aged 65+ in Plymouth compared to comparator areas and the England average. The number of nursing beds had reduced by 8% between April 2015 and April 2017. Rates of admission to residential and nursing care homes to provide long term support for older people had declined in 2016/17 to 461 per 100,000 from 513 per 100,000 the previous year and were below the England average and that of similar areas. Avoiding permanent admissions is a good measure of delaying dependencies.

Do services work together to keep people well and maintain them in their usual place of residence?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in usual place of residence

Are services in Plymouth safe?

There was a demonstrated commitment at all levels across the system to proactively maintain people in their usual place of residence; prevention and early intervention were the focus of the strategic vision. However, it was widely acknowledged by system leaders, frontline staff and stakeholders that the focus had been on acute, bed-based care due to pressures within the system and the prevention agenda relating to hospital admission prevention was underdeveloped. Current systems and practices were working well for the majority of people, but more needed to be done to ensure there was a shared view of who in Plymouth was at risk of hospital admission and that recently implemented initiatives were embedded. This will help mitigate the risk posed by the current capacity issues within primary care.

- There were a variety of systems and practices in place to support people to stay safe at home, but some were in their infancy and needed embedding. An Admission Avoidance Project Board had been established and was responsible for monitoring the progress of project delivery plans. It was widely recognised Plymouth's hospital admission prevention agenda was underdeveloped, but work was in progress to shift the focus from acute, bed-based care to the community.

- The Adult Safeguarding Health Needs Assessment provided an in-depth analysis in relation to the people in Plymouth who were in need of care and support and may be unable to protect themselves from harm. There was a multi-agency response to people deemed to be vulnerable through risk management meetings which included partners from health to housing. Frontline staff across the system were able to describe the process for reporting safeguarding concerns and other incidents. We were told the recent introduction of a

webform to report safeguarding concerns provided greater assurance, but both staff and stakeholders commented they often had to follow-up on referrals. They felt that there was limited feedback on any themes or lessons learned which could be cascaded widely across health and social care for future improvement.

- There was not a system wide risk stratification tool to provide a single view of those who were at most risk of a hospital admission. Individual teams or professionals had separate tools. A risk stratification tool had been agreed at STP level, but was yet to be rolled out in Plymouth at the time of our review. Five weeks before our review, LWSW had established locality multidisciplinary team (MDT) meetings attended by GPs, social workers and the LWSW MDT team for the area to discuss those people deemed to be at risk. The GPs we spoke with during our review were positive about these meetings and commented how LTC Matrons were effective at identifying and responding to deterioration in a person's condition.

- Most older people living in care homes in Plymouth were supported to remain safe and well in their usual place of residence and were less likely to attend A&E or be admitted to hospital with conditions which could be treated in the community. Our analysis of Hospital Episode Statistics (HES) data showed that between October 2015 and September 2016, admissions from care homes in Plymouth as a result of decubitus ulcers was higher than similar areas at 220 per 100,000 aged 65+, compared to 165 per 100,000 aged 65+ across comparators, and the England average of 161 per 100,000 aged 65+. However, the system has conducted its own analysis using information from Dr Foster and the NHS safety thermometer which showed Plymouth's observed rate of admission due to ulcers compared to the expected rate was below the national average. In the 12 months preceding our review, performance had improved and the data showed Plymouth's rate of admissions due to ulcers was in the lowest quintile nationally. A wellbeing clinic for leg ulcers had been piloted by LWSW and a bid had been submitted to commissioners. The pilot had demonstrated some positive outcomes. For example, one person had suffered from an ulcer for over two years and healed within eight weeks following input from the LWSW team. The bid outlined proposals to work with and provide training to practice nurses and care homes to support them in leg ulcer management.

- Our analysis of HES data in the first quarter of 2017 showed the rate of A&E attendances for people aged 65+ was 9,129 per 100,000; lower compared to similar areas with a rate of 12, 532 per 100,000 and the England average of 10,534 per 100,000. Data collected by the system showed the number attending A&E daily had remained fairly consistent between April 2017 and October 2017, with an average rate of between 271 and 292 people daily. However, these figures had increased since the previous year where the average daily attendance figures ranged from 256 to 276 during the same period.

- There were concerns throughout the system that capacity issues within primary care would see this number rise further. For example, performance figures for a GP practice with a patient list size of 21,000 people and a critical shortage of GPs had led to 14.8% increase in A&E attendances between April and August 2017 compared with the same period the previous year for those patients. This meant more people were accessing acute care, placing an increased burden on PHNT.
- The Minor Injuries Unit (MIU) at The Cumberland Centre was well utilised, seeing approximately 120 people a day. Staff reported they had seen an increase in attendees as a result of the lack of primary care capacity. There was an expectation for the MIU to continue to reduce the burden on Derriford Hospital's A&E department. Therefore, the system should assure itself it has the resource and capability to respond to deteriorating individuals appropriately. During our visit, staff told us they did not have the necessary medications to respond to a cardiac event and, as they were deemed a 'safe space' by the ambulance service, calls to 999 were not categorised as high priority. This placed people at risk of harm if the service was unable to respond appropriately to medical emergencies.

Are services in Plymouth effective?

There was a system wide commitment from staff at all levels to proactively maintain people in their usual place of residence. There had been some innovative work undertaken to design a service model which aimed to improve flow and prevent unnecessary hospital attendances or admissions. We found some positive examples of staff working in an integrated way to achieve good outcomes for people. However, parts of the system remained fragmented and work was required to bring staff from different organisations together to share information, increase their understanding of services available and ensure they were accessible to all. While staff were well supported and had the right skills. a lack of shared IT systems across organisations was a barrier to providing truly integrated, seamless care.

- We received positive feedback from people who use services and their carers about the support they received from VCSE organisations, including the Elder Tree befriending service and Improving Lives. However, if multiple organisations were providing support, it was not clear who was co-ordinating it. We also heard it was not always easy to access information and advice about services available. The Plymouth Online Directory (POD) provided a comprehensive list, but this was only accessible via the internet. Arrangements were in place to provide information to people in the format they required, including printing documents for people in libraries. The Plymouth Contact Centre provided information over the telephone and staff signposted people. Adult Social Care Outcomes Framework (ASCOF) data for 2016/17 showed 77% people over 65 in Plymouth found it easy to find information about support, which was in line with the average for similar areas and England at 75%.

- VCSE organisations felt they could be better utilised to support people to stay at home, especially if like-minded organisations worked together to come up with a combined offer. We were given powerful examples of where organisations had come together to respond to specific cases, such as supporting a homeless person at end of life to die in their preferred place of care. The System Design Groups (SDGs) provided a forum to collaboratively plan future service delivery, but it was felt there needed to be a more structured approach to responding collaboratively to individual cases.

- Although frontline staff in health and social care services had the right skills and were provided with regular training and development, they described a lack of understanding of services available as a barrier to support the effective transition of people. We found knowledge amongst staff varied and with the recent implementation of new initiatives, there needed to be some proactive and joined-up communication from system leaders.

- There had been a considerable about of work undertaken in recent years to remodel the system, reduce duplication and encourage holistic assessments of individuals. In 2015 local authority adult social care staff were transferred to LWSW, which led to integrated, multidisciplinary teams working together within four localities across the city. People who were under the care of these teams had a crisis prevention plan in place which could be accessed by all LWSW staff. However, when a person moved between organisations this information did not go with them.

- Services designed to improve flow through the system and to keep people at home were evidence based. There was a single telephone number for all community health and social care professionals, as well as paramedics, which they could access for advice and a response to a person at risk of going into crisis. All frontline staff we spoke with were aware of this single contact point and we were given multiple examples of how it had successfully prevented hospital attendances and admissions. Teams accessible via this number were provided by LWSW and included:
    - Community Crisis Response Team (CCRT) - a MDT which responded within two hours and could provide packages of care up to six weeks.
    - Acute GP Service (based at Derriford Hospital providing advice to GPs on clinical options)
    - Acute Care at Home Team (a nurse-led service which could provide intravenous antibiotics in the community)

- Data collected by the system showed the Acute GP Service received 766 referrals in October 2017 and 47% resulted in an admission avoidance. This was a similar figure to the previous year's performance. However, the service was currently working at 60% capacity, which meant it was not being fully utilised.

- There was no single point of access for care providers. If they identified a person may need additional support to stay safe and well at home, they had to go via a health professional or the local authority's contact centre for low-level equipment. This was a missed opportunity which may also be placing an additional burden on some parts of the system and should be reviewed as a priority.

- Our review of case files showed some positive examples of integrated working by staff delivering community services. However, the lack of digital interoperability impacted on the ability of staff to share information effectively, especially between organisations. This often led to duplicated assessments and could contribute to delays.

Are services in Plymouth caring?

Staff at all levels demonstrated a clear will and commitment to provide person-centred care and there were some innovative initiatives in place. Personalisation was high on the agenda and articulated within strategic plans and delivery plans. It was hoped that the development of 10 health and wellbeing hubs in early 2018 would improve the accessibility of information to people including professionals, as well as encouraging a more co-ordinated response to people's needs. Carers assessments had increased, but we received some mixed feedback about the support available, particularly in relation to respite care.

- ASCOF outcome data for 2016/17 showed the average quality of life score for people receiving social care in Plymouth (68) was higher than the national average, and the fourth highest when compared to its 15 comparator local authority areas where scores ranged from 54 to 71. Our review of case files showed some positive examples of person-centred care, supporting people to achieve their goal to remain independent at home.

- Plymouth's voluntary sector was dynamic, providing a range of services designed to maintain and improve people's health, wellbeing and independence. While organisations felt they could be better utilised in relation to the prevention agenda, they reported positive engagement with commissioners and the development of the 10 health and wellbeing hubs across the city in 2018 was hoped to lead increased activity.

- There were some examples of innovative practice, demonstrating a commitment to people being at the centre of service delivery. Plymouth was awarded the Dementia Friendly City of the Year in 2017, encouraging businesses and staff from across the city to receive dementia training and increase awareness. Community Connectors had been in operation for a year, connecting housing services to community teams to take a holistic approach to problem solving. These initiatives were linked to 'creative solution forums' where people who were vulnerable and resisted support from services were considered in terms of

alternative approaches. However, services were not imposed on people and our review of case notes showed examples of where a person's decision to no longer receive community care was respected.

- The local authority continued to commission low-level services, such as a befriending service, recognising the role this played in preventing social isolation and loneliness. Some people we spoke with during our review had been using this service for over 15 years and stressed the important role it played in maintaining their health and wellbeing. Plans were in place to extend the provision of social prescribing such that all GP practices would have this support from early 2018. Some VCSE organisations felt they were almost acting as social workers for some people, so the system needs to ensure these hubs do not blur the lines of accountability.

- As part of our review, we spoke with a carers group, supported by Improving Lives. They described challenges in accessing respite care, particularly in an emergency due to a lack of available placements in the community. Commissioners acknowledged it could be challenging if a person had complex needs. Our review of case files showed mixed experiences for carers. In one there was evidence of respite care being arranged, but in another there was no evidence of a carers assessment being completed despite it being identified that they felt in need of support. The response to the System Overview and Information Request (SOIR) reported that a collaborative approach between LWSW and Improving Lives to improve services for carers had seen the number of carers assessments increase from 549 in 2015/16 to 909 the following year and, correspondingly, the number of personal budgets for carers increase from 210 in 2015/16 to 704 in 2016/17.

- Data provided by the system showed the proportion of people in receipt of funded care in the form of a direct payment in Plymouth was slightly lower than the national average at 23% (575 people) compared to 28%. NEW Devon CCG was on track to achieve a target to have 1,740 personal health budgets (PHB) in place by March 2018. At the time of our review, 7.13 people per 50,000 were in receipt of a PHB compared to an England average of 5.82 per 50,000. However, it should be noted these figures apply to the whole of the CCG area, not just Plymouth.

Are services in Plymouth responsive?

We found some positive examples of staff working in an integrated way to achieve good outcomes for people. However, the capacity issues within primary care were placing an additional burden on the wider system. There was a risk of people not being seen at the right time, in the right place and by the right person.

- GP Patient Survey data for 2016/17 showed 64% people in Plymouth felt supported to

manage their long-term condition. This had improved from 62% the previous year, but was still below comparator and England averages. Our review of case files showed evidence of responsive, coordinated assessments. In one case file, the CCRT had been carrying out regular reviews on a person and appropriately escalated a skin integrity concern to their GP and the district nurses.

- The system faced significant capacity issues within primary care, which meant people could not always access a GP when they needed one; GPs we spoke with told us it was not uncommon for the waiting time for a routine appointment to be four weeks. There had been several closures and practices handing back their contracts to NHS England over recent months, affecting approximately 32,000 patients. While we were provided with assurance these practices were being staffed by regular locums, some people with long-term conditions were changing practices for consistency of care. The impact of these closures was felt by other practices stretched beyond their limits.

- A March 2017 national data set on provision of extended access to GPs outside of core contractual hours showed that none of the 29 GP practices in Plymouth surveyed (there are 32 in total) offered full provision of extended access over the weekends and on weekday mornings or evenings compared to the England average of 22.5% and the average across Plymouth's comparators of 23.2%. However, NHS England, the commissioner for primary care told us no funding was available for full provision until April 2018, so this was the reason for the low score. Our data showed 76% of GP practices provided partial extended hours provision outside of core hours and 24.1% provided no extended provision at all. NHS England told us 10 practices had opted out providing any extended provision outside of core hours, a total of 31%. This was considerably higher than comparator averages and the England average at 11.5% and 12.3%, respectively. NHS England, the commissioner for primary care, confirmed out of hours provision was available and this was provided by Devon Doctors.

- GPs' reported workloads had increased dramatically in recent years as had the complexity of the people's conditions. There were high levels of deprivation in parts of the city and a high number of refugees and asylum seekers saw some GPs using translation services every session, which was time consuming and resource intensive. We were provided with a copy of a letter written by a group of GP appraisers to the Lead Appraisal Team outlining their concerns about GPs' increasing workloads and the risks this posed.

- There were some systems in place to support people to remain at home following a change in circumstance. Domiciliary care providers were able to increase packages of care for a limited time without having to obtain approval from the brokerage team and the CCRT could also arrange emergency packages of care from the reablement service to prevent a

hospital admission. However, while these teams could provide a rapid response to prevent a crisis, staff reported discharging them could be problematic due to long waits for routine community therapy input. There was a falls team, but people could only be referred by a GP or consultant for an undiagnosed medical reason. For slips, trips and falls people were referred to the community therapy team after a second incident and could experience waits of several weeks. A review was underway, driven by staff, to respond to some of these issues and how community and acute teams worked together.

- However, the system's ability to respond out of hours was impacted by the availability of some services. The system's BCF submission demonstrated a commitment to implementing the high impact change model, including the provision of seven day services. Whilst the CCRT operated seven days a week, it was not open 24 hours a day and referrals were not accepted after 3pm at weekends. There were plans for the recently opened Acute Assessment Unit to be open at weekends, but recruitment challenges meant it was uncertain when this would be achieved. Therefore, at the time of our review, people were not always being seen in the right place at the right time.

Do services work together to manage people effectively at a time of crisis?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management

Are services in Plymouth safe?

There was a shared view of risks to service delivery which may impact on the system's ability to respond to people in crisis and keep them safe. While A&E attendances were lower than in similar areas, emergency admissions were higher than national averages and on an upward trajectory. Some people experienced delays if they were transferred by ambulance and people over 65 experienced longer lengths of stay, both of which put them at greater risk of harm.

- Once a person was in crisis and transferred to hospital, systems, processes and practices did not always safeguard people from unnecessary admissions and long lengths of stay which put them at risk of avoidable harm. In one case file we reviewed a person was admitted in July 2017 due to a series of falls (this was their fourth admission). They were transferred to Mount Gould for rehabilitation, but a further fall resulted in a fractured hip and head injury. The person was readmitted back to Derriford Hospital. From a review of this person's records we found that there had been missed opportunities to maintain them at home and delays in their transfer of care had placed them at risk of deterioration.

- The number of ambulance handovers at Derriford Hospital's A&E taking more than 30 minutes had steadily increased since April 2015, peaking at 406 (11%) in November 2017. A total of 334 hours, approximately 10 hours per day, were lost by South Western Ambulance Service NHS Trust (SWAST) to Derriford delays lasting more than 15 minutes in November 2017. This was considerably higher than other hospitals accessed by SWAST. This put the people waiting to be admitted to A&E and also those who may need assistance in the community at risk of harm should they be waiting for long periods.

- Fewer people attended A&E in Plymouth compared to other areas, and while they were less likely to be admitted compared to similar areas, admission rates were higher than national averages and had increased. Our analysis of HES data in the first quarter of 2017 showed the rate of A&E attendances for people aged 65+ was 9,129 per 100,000 compared to similar areas with a rate of 12,532 per 100,000 and the England average of 10,534 per 100,000. The emergency admission rate for people aged 65+ in Plymouth was 6,434 per 100,000 compared to a rate in similar areas of 7,343 per 100,000 and the England average of 6,391 per 100,000. Unverified data provided by the system showed there had been a 10.8% increase in the number emergency admissions for people aged 65+ across the western locality in 2017/18 due to an increase in acuity and pressures in primary care.

- Our analysis of HES data showed that in the first quarter of 2017, 37% of people aged over 65 had a hospital stay lasting longer than seven days, which was higher than similar areas with an average 33% and the England average of 32%. The length of stay had remained consistently higher than average since 2014. If people were admitted to hospital from a care home, they were likely to have significantly longer lengths of stays at 49% staying longer than seven days compared to the England average of 36%. Longer lengths of stay put people at avoidable risk of harm.

- There was a system-level escalation procedure to manage risks to service delivery; the Operational Pressure Escalation Levels (OPEL) framework. Between April 2017 and October 2017 PHNT was consistently at OPEL 3 or 4 status (the highest of escalation) and this had become normalised amongst staff. We were told it was not uncommon for there to be several escalation calls a day involving system partners.

- The locally developed, 'Shackleton Plan' was an innovative approach adopted by domiciliary care providers to support people to stay safe at home during times of increased demand or staff shortages. This had been triggered five times within two years and saw providers working together, with the support of commissioners, to deliver packages of care during challenging periods, including winter.

- There was a shared view of risks to delivery of services to people in crisis and these were monitored closely. Dashboards regarding flow, safeguarding and incidents were provided daily to system leaders. Derriford Hospital historically had a higher than expected number of falls with harm and work had been ongoing to investigate this. Data provided by the system following our review showed the number of falls with harm at Derriford Hospital was in the lowest 25% nationally; in November 2017, it was 0.9%.

Are services in Plymouth effective?

During a crisis, frontline staff demonstrated an awareness of assessing a person holistically, but a lack of digital interoperability impacted on how effectively they could share information with colleagues. There were multiple pathways available once a person was in crisis and work was required to increase staff understanding and confidence in the capabilities of different services to ensure the whole system was working effectively considering the pressurised state of the system.

- Our review of case files showed holistic assessments of people's needs and multidisciplinary input. The CCRT staff had been upskilled to enable them to assess the whole person, so that they were able to respond appropriately to any identified issues or risks. The aim of this was to prevent the person from having to tell their story more than once. However, the extent to which people we spoke with felt involved and aware of their plan of care varied.

- Services designed to improve flow through the health and social care system were evidence based. However, there were multiple pathways, provided by different staff groups and a lack of trust or knowledge by staff meant they were not always being used effectively. People in crisis could be routed to the Community Crisis Response Team (CCRT), the Acute Assessment Unit (AAU) where they could be seen by a GP or Advanced Nurse Practitioner, or the frailty service in an attempt to prevent their admission. If admission was deemed necessary, there continued to be multiple pathways; the medical assessment unit (MAU), the clinical decision unit (CDU), the short-stay ward or hospital wards.

- It was widely recognised some organisational development work was required to increase staff's trust in the capability of services available. Staff we spoke with described a "risk averse" culture of decision making and we were given examples of where people who needed best interests decision meetings or Deprivation of Liberty Safeguards assessment had been admitted rather than undertaking these in the community despite the people being medically fit. Findings from our relational audit showed one of the lowest scores was on the statement: "People take organisational risks where it had the potential to serve wider system goals without fear of criticism or failure". Data collected by the system showed

during times of escalation some community services were working under expected capacity. Work needs to happen at pace to improve understanding and communication between staff.

- Due to pressures within the acute care system, Plymouth had a significant number of outpatient appointment cancellations. Data collected by the system showed that in September 2017, 82% of people received treatment within 18 weeks of referral, but there were 163 operations cancelled on the day of admission or after for non-clinical reasons. This meant people experienced delays in treatments, placing them at an increased risk of crisis as a result of missed early interventions.

- There was limited interoperability between records systems to allow staff to share accurate, real time information. While there were plans in place to address this and staff reported it was better than it had been, it remained disjointed. In one case file we reviewed, a person had been referred to A&E by the out of hours GP due to raised potassium levels. As staff were unable to access the person's record at their registered GP to see what was deemed to be a 'normal' range, the person was transferred to the AAU and then admitted for treatment. Staff were not clear if the Acute Care at Home team could provide the necessary treatment and this option, which may have prevented an admission, had not been explored.

Are services in Plymouth caring?

Frontline staff understood the importance of involving people and their families in decisions about their care. Some case files we viewed clearly documented the discussions had with people, but we were told by some people and their carers during our review that they were not always aware of what the plan of care was or that they had been involved in the decision making process.

- Our review of case files showed assessments of care were centred on the needs of the person and took into account social factors, as well as health. Some people we spoke with at Derriford Hospital were complimentary about the care they had received and knew the plan for their care. However, others told us they were not aware what was happening.

- Since February 2017 the Plymouth Carer's Hub run by Improving Lives has had a presence within Derriford Hospital to provide advice, support and signposting to carers of patients in the hospital about local services and help available to them.

- Staff we spoke with demonstrated an awareness of dementia care and it had been recognised some parts of the hospital (A&E and the AAU) were not as dementia friendly as they could be, but there were processes in place to manage this. Providers, VCSE organisations and carers raised some concerns about support for people with dementia

when they went into crisis, including the environment on hospital wards and staff skills.

Are services in Plymouth responsive?

People living in Plymouth did not always receive the services needed at the right time during times of crisis, particularly out of hours. There were some responsive community-based services, but if people arrived at A&E they were increasingly likely to be admitted to hospital and stay in hospital for too long. It was hoped that the newly opened AAU would reduce some of the pressures on the hospital, but it was too soon to measure its impact.

- People were often seen in multiple places and experienced a disjointed pathway. We looked at eight people's records during our visit to Derriford Hospital and all were moved within the hospital several times after admission. All but one person went from A&E to the MAU before going onto a ward; some stayed on three different wards.

- There were some examples of proactive and rapid responses to people in a crisis. Plymouth Community Homes had installed emergency telecare alarms in 1,400 properties; the CCRT provided advice to paramedics attending falls; and people attending majors within A&E received a Front Loaded Initial Care (FLIC) assessment by a clinician in an attempt to identify the most appropriate pathway as quickly as possible. On 5 December 2017 the AAU had seen 28 people and only admitted two.

- In July 2017 South West Ambulance Service (SWAS) treated 49% of 999 calls without transferring the person to hospital and 14% of calls were resolved with telephone advice; both these figures were higher than the England average. However, some care providers we spoke with gave us examples of where they had had to wait for several hours for an ambulance to attend after a fall or other incident.

- Between 2014/15 and 2016/17 PHNT failed to meet the national four hour A&E target of 95%, falling from 91% to 84%. Unverified data, collated by the system showed performance had improved in August 2017 when 90% of people were seen within four hours. However, this was not sustained and in November 2017 in the week commencing 18 November performance decreased to 65% on two days. On the Monday, Tuesday and Wednesday of that week A&E attendances were similar (280, 298 and 307, respectively). However, the number of four hour breaches increased from 49 on the Monday, to 79 on the Tuesday and 106 on the Wednesday. PHNT needs to scrutinise this data to determine what is causing these downturns in activity.

- During the same week in November when A&E performance dipped, corresponding performance data for the hospital avoidance schemes such as Acute Care at Home, the CCRT and Acute GP service showed they did not start meeting their expected activity targets until the Wednesday. This meant seven day services were not fully operational and

those designed to prevent hospital admissions were not being utilised effectively during periods of increased demand.

- Older people in Plymouth were more likely to end up being admitted to hospital than national averages and to stay in hospital longer. Between 2016 and 2017, bed occupancy at PHNT was consistently above the optimal target of 85%, peaking at 89%. Some hospital staff reported they cared for people who should not have been admitted. Examples given included failed packages of care, a fall with no injury and some low-level antibiotic treatment.

Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/or admission to a new place of residence

Are services in Plymouth safe?

The number of people over 65 in Plymouth who were readmitted to hospital following discharge was consistently below average, including those who were discharged to care homes. Providers reported they received comprehensive discharge summaries most of the time and our review of records supported that. However, the level to which providers trusted the information was poor and we were given examples of when people had experienced unsafe discharges.

- VCSE organisations, providers and carers of people who use services told us about their experiences of discharges, some of which they felt were poorly managed and organised with risks not always fully mitigated. For example, a person being discharged and left on their doorstep with no key; another was discharged to a care home at 2am and left in the car park; and others where people with considerable care needs were discharged with no, or insufficient, packages of care.

- Medicines management was not optimised across the system to support timely and safe discharges. While work had been undertaken to facilitate more effective information sharing between hospital and community pharmacists, processes within the acute setting needed improving. Medicines were not being requested early enough in the discharge process and approximately 100 people's medicines per month were being sent to them via courier after discharge; a costly response. There had been no analysis to determine which wards were generating this activity in order to encourage learning and improvement. This put people at risk of avoidable harm due to delays in receiving their medication and medication errors.

- The number of older people in Plymouth requiring emergency readmission once discharged from hospital was consistently below comparator and England averages. Our analysis

showed that throughout 2016/17, Plymouth's emergency readmission rates occurring within 30 days of discharge for people aged 65+ ranged from 15% to 17%, compared to the England average of 19%. This indicated people were only discharged from hospital when they were medically fit and were less likely to be readmitted due to inappropriate discharges.

- The same applied to people from care homes. Our analysis of HES data showed that in the first quarter of 2017 emergency readmission rates occurring within 30 days of discharge for people aged 65+ from care homes in Plymouth was lower (at 15%) than similar areas and the England average (21% and 20% respectively). Performance had fluctuated, but had been consistently better than average since 2014.

- Fourteen out of the 20 Registered Managers of care providers who responded to our survey reported they received discharge summaries at least 75% of the time, mostly in paper format or via secure email. However, six respondents received discharge summaries less than 75% of the time. Fifteen respondents reported receiving discharge summaries within 24 hours, but two responses relating to domiciliary care providers stated they never received summaries within 24 hours. Not receiving timely discharge summaries puts people at risk of unsafe and inappropriate care, which may lead to readmission.

Are services in Plymouth effective?

There had been a considerable amount of effort at a system level to address the issues in performance in relation to delayed transfers of care, both in the acute and community setting. A number of external reviews had made a series of recommendations and these were being acted upon. The appointment of an Interim Director of Integrated Urgent Care and recent changes to the system model were having a positive impact. Reablement services were achieving good outcomes for people, but the number of delayed transfers of care remained high.

- Readmission rates were consistently below average and people in Plymouth were more likely to receive a reablement service than in other areas. Analysis of ASCOF data for 2016/17 showed 4.1% of older people received a reablement service compared to similar areas and the England average (3.6% and 2.7%, respectively). Where people did receive reablement, it had good outcomes; 85% of people over 65 were at home 91 days after discharge from hospital to a reablement service.

- The number of delayed transfers of care was consistently, and significantly, higher than average. There had been a sudden increase in December 2016 and while there had been a decline between April 2017 and September 2017 from 32.1 days to 27 days per 100,000 population (aged 18 and over), this was more than double the comparator average of 11.9 and England average of 13 days. Data collected by the system showed performance had

improved and was on the right trajectory, but it was still off the national target of 3.5% (5.6% in October 2017).

- The high impact change model for managing transfers of care identifies a series of changes that can support the reduction of delays and the system was in the process of implementing some of these. For example, a multidisciplinary, integrated discharge team comprising LWSW and PHNT staff had recently been established at Derriford Hospital and community teams were being encouraged to do more in-reach to facilitate the discharge of people on their caseloads. At the time of our review there was one Trusted Assessor working between Derriford Hospital and providers commissioned to provide discharge to assess beds, but plans were in place to recruit more.

- Facilitating timely discharges and reducing length of stay should be considered a shared responsibility, not a delegated one. The Tactical Control Centre (TCC) at Derriford Hospital provided an oversight of capacity within the community to facilitate complex discharges and there were daily meetings to discuss transfers of care where ongoing support was required. However, staff across all levels of the system felt the absence of some senior clinical and operational staff at these meetings meant they were not as effective as they could be. The integrated discharge team and Discharge Case Managers (DCMs) were seen as a positive, but this had also encouraged a lack of clinical ownership in relation to discharges. Our review of case files showed estimated discharge dates were not being discussed early enough and there was a lack of urgency among clinical staff; delays were an accepted part of the system.

- Some care providers told us they had to proactively contact the hospital to find out when an existing client may be ready for discharge. Both families and care providers gave examples of when the first contact they had was to be told the person was being discharged that day. Registered Managers of care providers who responded to our survey commonly felt that the discharge summaries supplied were sufficient for their service to make a decision on whether they could support the placement; however 15 out of 20 respondents were less positive about whether they trusted them. Where the Trusted Assessor had strong links with care providers, we were told they were beginning to trust their assessment for package of care re-starts. However, it was recognised there was more work to be done.

Are services in Plymouth caring?

It was acknowledged by staff across the system that people, their families and carers or advocates were not involved early enough in the discharge process. Our conversations with people, their families and carers supported this view as experiences varied. People, especially those funding their own care, found information difficult to access and while some voluntary sector organisations were effectively supporting people to be discharged home, more could be done.

- Our review of case files showed a person-centred approach was adopted and people's preferences were documented. However, some records showed conversations with people, their families and carers were not being started early enough. People told us it was difficult to access information, particularly if they were arranging the care themselves. There was a choice policy in place, but it had not been ratified and not all staff could refer to it.

- Staff were committed to providing compassionate and high-quality care. However, some carers and providers gave examples of where people had experienced very poor discharges which had been undignified and unsafe.

- The British Red Cross had been commissioned to provide support with the discharge process by ensuring people returned to safe, warm homes with the essentials supplied. The organisation was in talks with commissioners to see how this service could be expanded. There was recognition among voluntary organisations and system leaders, that they could do more.

- According to the response to the SOIR, 52.8% of people died in their usual place of residence in 2015, which was slightly higher than the national average of 46%. Data in relation to standard continuing healthcare (CHC) was poor with a low referral to service provision conversion rate. As at November 2017, the number of outstanding disputes was 152 across NHS NEW Devon CCG. People were not only waiting a long time for an initial assessment, but were also waiting too long for their appeal to be heard. Data provided by the system following our review, showed there had been a considerable improvement. As of 17 January 2018, there were 27 outstanding appeals across NEW Devon CCG, 11 of which related to Plymouth. We were assured all people were receiving care while waiting for the outcome of their appeal.

Are services in Plymouth responsive?

There were multiple pathways to facilitate discharges from the acute setting and support people to remain as independent as possible. However, delays in assessments across the system meant people's support needs were not regularly reviewed, leading to longer lengths of stay in inappropriate settings. Recent performance data collected by the system showed performance had improved, but it was unclear if there was capacity within the market to cope with an increase in demand. People referred for continuing healthcare (CHC) were experiencing significant delays and this needs to be acted on as a matter of urgency.

- The process for reviewing people's support needs was not always timely and was contributing to delays in the acute and community settings. Published data in relation to delayed transfers of care between February and April 2017 showed the majority of delays

were attributable to the NHS with 'awaiting completion of assessment' and 'awaiting further non-acute NHS care' reported as the main reasons for delay in Plymouth. 'Awaiting completion of assessment' accounted for an average daily rate of 13.8 days per 100,000 population, compared to an average of 2.2 days in similar areas and 2.5 days nationally. 'Awaiting further non-acute NHS' accounted for an average daily rate of 8.1 days per 100,000 population, compared to an average of 1.8 days in similar areas and 2.6 nationally.

- Unverified data provided by the system showed there had been an improvement in performance. In November 2017, the total number of delayed days had decreased from 27 per 100,000 in September 2017 to 18.3 per 100,000. Delays in assessment were the biggest contributing factor in an acute setting, and awaiting package of care in a person's own home was the main cause of delay in community settings.

- There were multiple pathways available to support people to return home and remain as independent as possible; reablement, intermediate care, discharge to assess one (home-based), discharge to assess two (bed-based) and discharge to assess three (complex, bed-based care). Reablement services were achieving good outcomes for people, but delays in reviews and assessments across each of these pathways meant some people were not being rehabilitated or discharged within expected timeframes. In one case file we reviewed, the person was receiving a reablement service but it was not clear when it started, when it was due to end or what the person's goals were.

- Consistent themes had been identified by external reviews, one of which was the fact too many people were spending too long in intermediate care. Data collected by the system supported this. As of 13/10/2017 there were 126 people who had been in spot-purchased, discharge to assess beds for more than the target of six weeks; 49 for more than 20 weeks. Those in spot-purchased beds did not have the dedicated MDT input of those in block-purchased beds which led to delays in assessment and rehabilitative input. The system had recognised the current discharge to assess pathways were not working as effectively as they could be. A thorough analysis had been carried out to diagnose the issues and plans were underway to remodel the pathways, shifting the focus to Home First and reducing a cultural reliance on bed-based care.

- The delays in assessments were widely understood by system leaders and recent efforts had shown these had gradually come down. However, the system needs to assure itself that it has the capacity within community based services and the social care market to cope with increased demand and activity should flow continue to improve elsewhere in the system.

- Significant improvements were required in relation to standard continuing healthcare (CHC)

to ensure staff understood the eligibility criteria and made appropriate referrals so there was a timely use of the framework and people's rights to care were being met. While it was positive the system had achieved their commitment not to conduct any CHC assessments in an acute setting, published data showed a high number of people waited a long time for an assessment. It should be noted that this data does not just describe the situation in Plymouth, but relates to the whole NHS NEW Devon CCG area. In quarter one of 2017/18 the number of people waiting longer than 28 days for their assessment was 54.3 per 50,000 compared to the England average of 10.2 per 50, 000. Furthermore, the conversion rate for standard CHC was 13% compared to an England average of 25% meaning fewer people who were referred for CHC funding were deemed to meet the eligibility criteria. We were told the CHC team received a high number of inappropriate referrals and educating staff and improving their understanding was cited as a priority. The system were aware of their performance and data collected as part of the SIB's ongoing monitoring of performance showed in October 2017 there was a backlog of 253 people waiting in Plymouth for an assessment, with an average waiting time of 227 days. A high number of inappropriate referrals was impacting on the CHC team's ability to meet expected assessment targets.

- The Department of Health's analysis of activity showed between October 2015 and September 2016 the proportion of older people discharged over the weekend in Plymouth was similar to comparator areas at 18%. Performance data collected by the system showed this had increased to 20.7% in October 2017. However, social care providers were less likely to accept discharges over the weekend and the lack of seven day services across the system meant this figure was unlikely to increase significantly.

Maturity of the system

What is the maturity of the system to secure improvement for the people of Plymouth?

- Our review showed Plymouth is striving to make improvements in the way that people move through the health and social care interface. The positive intent was clear amongst the system leadership, but in reality people's experiences varied. If the system continues on the current trajectory with the further development of the western locality, the improvements in flow from secondary care to the community and the potential vertical integration of service provision, people should enjoy a responsive, effective, caring and safe journey through the system. However, the lack of primary care provision, poor prevention and inadequate CHC arrangements may compromise these improvements.

- The system had a clearly articulated, long-established vision of integration, translated into local commissioning strategies. Leaders were consistent in their description and commitment to the vision with whole system buy-in. Plymouth needs to drive this forward to ensure there is a community, home-based focus.

- Governance arrangements in Plymouth were strong across health and social care and closely linked to the Devon STP. System leaders were well represented at STP level to ensure the voice of Plymouth was heard. The System Improvement Board (SIB) was effective, and had begun to think about developing a set of integrated performance metrics shared across the system. This work should continue at pace even if the role of the SIB changes in the future.

- Relationships at a system level were positive and there was strong political consensus. However, some cultural challenges existed between organisations and these need to be overcome if the vision for vertical integration in service delivery is achieved. The system had a good track record of public engagement and they need to ensure this continues as they move forward with the integration agenda.

- There was evidence of engagement with the current local provider market, but there is an opportunity to develop a more strategic approach to include the anticipated future need and attract potential providers. This applies to health and social care providers.

- There was a shared understanding of resources. The system had an integrated budget in place, but future funding flows were fragile. The current financial position was vulnerable at both a local and STP level due to shared risk agreements.

- There was an STP level workforce strategy, but not a single, coherent strategy for Plymouth.

- There was a lack of system-wide digital interoperability, but integrated teams within the community had joint records and there was a shared use of NHS numbers.

- There was a shared commitment to the prevention agenda and investments had been protected. However, the implementation and effectiveness of the agenda was underdeveloped and budgets were vulnerable considering the current financial position.

Areas for improvement

We suggest the following areas of focus for the system to secure improvement

- System leaders need to drive forward the strategic ambition while remaining focused on delivering improvements against current performance pressures. Attention should be given to commissioning for prevention and early intervention as performance is sub optimal in these areas.
- As the system moves towards further integration, work needs to be undertaken to ensure that staff are fully engaged, on board from the outset and led by a collaborative leadership.
- Organisational development work needs to be undertaken to break down any organisational barriers, strengthen relationships, improve communication and ensure there is a shared understanding among staff of their role in achieving the strategic vision at an operational level.
- Due to the fragile primary care situation, the system needs to work with NHS England at pace to avoid the sustainability of the wider system improvement being put at risk.
- System leaders should develop a coherent workforce strategy for Plymouth.
- Continuing healthcare (CHC) performance needs to be addressed as a matter of urgency to ensure people are assessed and given an outcome in a timely way.
- The system needs to undertake more evaluation of the actions taken by teams and individuals during times of escalation and this should be shared with system partners to encourage learning and improvement.
- The local authority needs to ensure it continues to fulfil its statutory obligation under the Care Act 2014 and provide assurance there is capacity of good quality services within the domiciliary care market to cope with an increase in demand.
- Commissioners need to consider how the practicalities of not paying a retainer to domiciliary care providers and how the current rate of pay may impact on continuity of care for the person and the capacity of providers to recruit and retain staff.
- The activity data for services designed to prevent admissions should be reviewed to ensure they are being used effectively, particularly during times of escalation.

- The system should assure itself that the Minor Injuries Unit has the resources and capability to respond to deteriorating individuals appropriately.

- The system should consider expanding the single access point currently available to community health and social care staff to independent care providers.

- There should be a review of how the “yellow card” reporting system is used and who it is accessible to, to ensure common themes across the health and social care interface are identified.

- The system should continue to review performance data in relation to pressure ulcers to assure themselves there are no gaps in commissioning.

- The system should progress with the review into the number of falls in hospital with harm to determine the root causes.

INTEGRATED HEALTH & WELLBEING

SYSTEM PERFORMANCE SCORECARD

DECEMBER 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

Estimated diagnosis rates for dementia

NEW Devon CCGs dementia diagnosis rate remains below the national target. The CCG has raised concerns with NHSE 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. A new Dementia Advisor Service has just been procured with a role to work closely with primary care and GPs, which will be much more visible than the previous service. This will help with diagnosis rates as GPs will have services to work with them to support people through diagnosis and afterwards. This will start in April 2018

Referral to treatment - Percentage seen within 18 weeks

Nationally the NHS has acknowledged that the 18-week referral to treatment standard is not being met or likely to be met in 2017/18. The national mandate to temporarily stop all elective surgery during the period of heightened activity as a result of the flu outbreak has also had an impact on performance. Locally we have tried to maintain throughput in the hospital and have focused the stopping of elective surgeries on routine operations whilst prioritising Cancer treatments.

In hospital falls with harm

This is expressed as a % of the total patients surveyed as part of the NHS safety thermometer. There are on average around 800-900 surveyed each month in Plymouth Hospitals NHS Trust. December's figure of 0.36% would equate to three patients having fallen in hospital and experienced harm as a result of that fall. Plymouth Hospitals NHS Trust has consistently had a lower rate of falls with harm compared to the national average for the last two years.

CHILDREN AND YOUNG PEOPLE

Timeliness of Children's single assessments

Single assessment performance is now showing a positive direction following decline over previous months. The backlog of assessments over 45 working days has now been addressed and new assessments performance is reported at 90% within quarter four. Forecasted performance is to finish the year at over 70%.

Number of Children in Care

Children in care numbers have increased by 8 to 411 which, at a rate per 10,000 (78) is below the statistical family group but above England.

COMMUNITY

Delayed transfers of care from hospital per 100,000 population, whole system (delayed days per day)

In quarter three the daily bed delay attributable to ASC rate is at 22.7/100,000 so remains off target, but is an improvement on the rate for quarter two (26.0). The rate of these delays that are attributable to Adult Social Care is also improving, during quarter three the rate is 10.50 compared to 11.90 in quarter two.

Our system remains challenged with an increase in the number and proportion of patients who are complex need, impacted on by winter pressures. The continued improvement programme in place includes the appointment of an Interim Director of Integrated Urgent Care, the development of an Acute Assessment Unit to assist in preventing unnecessary admissions. This is also being supported by the review of the current Discharge to Assess (D2A) offer which includes a single Trusted Assessor being in post and the recruitment of additional social workers dedicated to support hospital discharges.

Accident and Emergency 4 hour wait

Plymouth Hospitals NHS Trust is not achieving the 4hr wait in A&E target. This is linked to an increase in demand over the last year as both the number of A&E attendances and emergency admissions have increased. The recent flu outbreak has also contributed to a winter surge that has been much greater than seen in recent years. This has resulted in a high bed occupancy which has restricted flow through the A&E department. A number of schemes are in place to reduce the level of A&E attendances/ emergency admissions and to reduce the bed pressure by reducing the level of delayed transfers.

Emergency admissions aged 65+

There has been a 10.8% increase in emergency admissions in 2017/18 across the Western Locality for patients aged 65+. This is linked to the operational pressures in PHNT. The ageing population will be contributing to this increase but a number of other causes are at play including the pressures on primary care.

Improving Access to Psychological Therapies (IAPT) – Access rates

Livewell Southwest achieved the IAPT access rate in 2016/17 and is on track to achieve it again in 2017/18. However, monthly performance does remain variable.

Average number of households in B&B

Increasing demand means that there continues to be a pressure regarding households accessing B&B temporary accommodation. The average number of B&B stays for the whole of quarter three was 57, an increase from 53 for quarter two. In December the monthly average fell to 50 which is positive, although it is noted that the Christmas period often has a positive impact on numbers in temporary accommodation.

People helped to live in their own home through the provision of Major Adaptation

By providing major adaptations through a DFG (Disabled Facilities Grant) we are helping people with disabilities to live at home. Interventions including a pilot to install stair lifts at the request of Occupation Therapists have helped increase the number of home adaptations provided during quarter three, thus increasing the number of people helped to live at home. The gap between actual performance and the department's target has closed meaning progress against target has improved, we are now on a trajectory to provide a similar number of major adaptations to that provided in 2016/17 and considerably more than in 2014/15 and 2015/16.

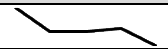
ENHANCED AND SPECIALIST

Percentage of CQC providers with a CQC rating of good or outstanding

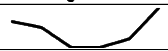
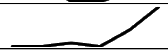
At the end of quarter three the percentage of residential and nursing homes that are rated by CQC as good or outstanding has fallen from 79% (end of Q2) to 73%. Within this the number rated as outstanding has increased from one to four, however the number rated as good has fallen from 76 (end of Q2) to 68 at the end of quarter three. The number of homes requiring improvement increased from 17 to 21 and number inadequate remains unchanged.

In recognition of the higher percentage of homes with a rating of Requires Improvement commissioners are working with the CQC towards a more collaborative approach between the CQC and commissioners. The QAIT (Quality Assurance and Improvement Team) are undertaking a specific project to target these providers (along with those rated as Inadequate) in the form of supportive workshops over the next 12 months. If necessary these workshops will be ongoing with learning shared across the whole care home sector. The team continue to request and monitor action plans from homes that have been rated as Requires Improvement or Inadequate and provide support visits and advice and information.

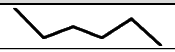
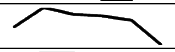
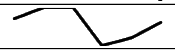
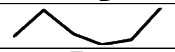
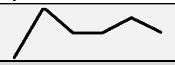
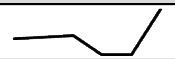
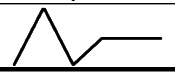
6. WELLBEING

Indicator	Measure	Most Recent Period	Benchmark	First Value of Graph	Graph	Last Value of Graph	Trend	Comments
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								
CCGOF Referral to Treatment waiting times (patients seen within 18 weeks on incomplete pathway (%)	Percentage	Dec-17	N/A	84.8%		81.3%		High is good
NHSOF Estimated diagnosis rates for Dementia	Percentage	Dec-17	N/A	59.6%		60.1%		High is good
In hospital Falls with harm	Percentage	Dec-17	N/A	0.24		0.36		Low is good

7. CHILDREN AND YOUNG PEOPLE

Indicator	Measure	Most Recent Period	Benchmark	First Value of Graph	Graph	Last Value of Graph	Trend	Comments
Keep our Children and Young People Safe: ensure effective safeguarding and provide excellent services for children in care								
Referrals carried out within 12 months of a previous referral (Re-referrals)	Percentage	2017/18 Q3		33.5		28.2		Low is good
Number of children subject to a Child Protection plan	Count	2017/18 Q3		371		338		Low is good
Number of Children in Care	Count	2017/18 Q3		406		411		Low is good
Number of Children in Care - Residential	Count	2017/18 Q3	N/A	27.0		39.0		Low is good
Timing of Children's Single Assessments (% completed within 45 working days)	Percentage	2017/18 Q3		94.9		70.6		High is good

8. COMMUNITY

Indicator	Measure	Most Recent Period	Benchmark	First Value of Graph	Graph	Last Value of Graph	Trend	Comments
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								
Number of households prevented from becoming homeless	Count	2017/18 - Q3	N/A	299		175		High is good
Average number of households in B&B per month	Count	2017/18 - Q3	N/A	32.0		57.0		Low is good
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								
Proportion of people still at home 91 days after discharge from hospital into reablement/ rehabilitation services	Percentage	2017/18 - Q3	N/A	88.0		84.0		High is good
Improving Access to Psychological Therapies Monthly Access rate	Percentage	Dec-17	N/A	1.17		0.90		High is good
Improving Access to Psychological Therapies Recovery rate rate	Percentage	Dec-17	N/A	35.80		47.40		High is good
A&E four hour wait	Percentage	Dec-17	N/A	84.36%		79.29%		High is good
Emergency Admissions to hospital (over 65s)	Count	Dec-17	N/A	1,387		1,371		Low is good
Discharges at weekends and bank holidays	Percentage	Dec-17	N/A	18.22%		19.09%		High is good
Rate of Delayed transfers of care per day, per 100,000 population	Rate per 100,000	2017/18 - Q3		16.4		22.7		Low is good
Rate of Delayed transfers of care per day, per 100,000 population, attributable to Adult Social Care	Rate per 100,000	2017/18 - Q3		7.9		11.9		Low is good
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								
People helped to live in their own home through the provision of Major Adaptation	Count	2017/18 - Q3	N/A	59		77		High is good
Long-term support needs met by admission to residential and nursing care homes, per 100,000 population (aged 65+)	Rate per 100,000	2017/18 - Q3		125.9		116.7		Low is good
Long-term support needs met by admission to residential and nursing care homes, per 100,000 population (aged 18-64)	Rate per 100,000	2017/18 - Q3		1.8		2.4		Low is good

9. ENHANCED AND SPECIALIST

Indicator	Measure	Most Recent Period	Benchmark	First Value of Graph	Graph	Last Value of Graph	Trend	Comments
Provide high quality, safe and effective care, preventing people from escalating to, or requiring, urgent or unplanned care								
Percentage of CQC providers with a CQC rating of good or outstanding	Percentage	2017/18 - Q3		84.0		73.0		High is good

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Plymouth Integrated Fund
Finance Report – Month 09 2017/18

Introduction

This report sets out the financial performance of the Plymouth Integrated Fund for the year to date and the forecast for the financial year 2017/18.

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 identifies the Better Care Fund, which is a subset of the wider Integrated Fund, but has specific monitoring and outcome expectations.
- The third 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.

A risk is emerging that the risk share will have an impact in the current year as the Council budgets are still forecasting an £0.8m overspend. When the risk share methodology is applied to the outturn of the CCG element of the Plymouth fund, which is also forecast at £0.8m, it results in a risk share charge from the Council to the CCG of £0.1m.

The position continues to be managed with recovery plans and is expected to improve by year end.

SECTION 1 – PLYMOUTH INTEGRATED FUND

Integrated Fund - Month 9 Report 2017/18

The impact of the risk share across the Integrated Fund is now reflected, and at this stage, should both organisations return their currently forecast outturns, this would result in a £0.1m risk share impact between organisations. The system remains under significant pressure and there is continued focus on managing and delivering an improvement to the current forecasts. The areas of particular pressure include Looked after Children in Care, Intermediate Care in both Health and Social Care, Continuing Healthcare, and Prescribing.

The overall fund position is reflected in Appendix 1.

Plymouth City Council Integrated Fund

As in previous months, the integrated fund for Plymouth City Council (PCC) is shown as gross spend and now also includes the Support Service Recharge costs for the People directorate and Public Health department along with the capital spend for Disabled Facilities Grant, which is funded from the Better Care Fund.

Children, Young People and Families

Children, Young People and Families

The Children Young People and Families Service are reporting a budget pressure of £0.458m.

The overall CYPF overspend can be attributed to the increased cost and volume of looked after children's placements. The national and local context for children's placements is extremely challenging, with increasing difficulties in securing appropriate, good quality placements. Despite these increased costs, the department has made significant off setting savings in year with good progress through the management-challenge sessions and budget containment meetings.

Early in-year monitoring identified the increasing costs of placements, with increases effective during 2017/18 showing 16.59% uplifts. The department has been working throughout the year to contain and cover from other savings; however as we have reached the third quarter a budget virement has been agreed of £1m, effectively increasing the children's services budget for the current year. This cost pressure has been identified going forward into future years and as such the MTFS additional funding has been increased from the original £2m to £3.2m.

High demand and limited supply of placements, a tightening of Ofsted requirements, as well as initiatives such as the introduction of the National Living Wage, have all led to an increase in the unit costs of placements. We have seen an average cost increase for placements of 16.59%.

The overall number of children in care at the end of the month of December stands at 411.

Strategic Co-operative Commissioning

The Strategic Commissioning service is forecasting a year end overspend against budget of £0.430m at month 9, no change from month 8.

Strategic commissioning will have achieved its target of delivering over £5.2m of savings in the current year.

Within the overspend reported of £0.430m there is a pressure of £0.485m within Supported Living with client numbers increasing: domiciliary care are also showing a budget pressure of £1.011m. Both of these areas of additional spend have been offset by additional income.

Within ASC over the last 12 months they have:

- Provided services for 4,782 adults receiving social care packages.
- Paid for over 1,294 people to be cared for in residential and nursing homes.
- Provided a total of 617,765 hours of domiciliary care provided to those living in their own homes per year, with an average of 11,880 hours per week.
- Supported 3,488 people with a community based package of care.
- Supported 698 people via a direct payment.

The strategic commissioning department are continuing to undertake management reviews of all areas of expenditure and all assumptions around care packages etc to minimise this over spend, with a target of a breakeven position by the end of the financial year

Education, Participation and Skills

Education, Participation and Skills are again reporting a balanced budget position at Month 9.

Community Connections

Community Connections is reporting a balanced budget position at Month 9, a reduction of £0.212 in the month. Although the B&B numbers are still high, work is being done within the department to bring the budget back to balance by the end of the financial year.

Public Health

Although the 17/18 Public Health ring-fenced grant was cut by a further £0.398m for Plymouth City Council, the Directorate is on track to achieve a balanced budget. However, it should be noted that there are pressures with achieving some income targets and there is increasing demand for activity led services.

Plymouth City Council Delivery Plans

Between People Directorate and Public Health, over £10m of savings will need to be delivered during 2017/18, which includes savings of over £2.8m brought forward from 2016/17 which were delivered as one-off savings. At the moment, it is expected that all savings will be achieved - breakdown shown below:

Plymouth City Council	Year To Date			Current Year Forecast		
Month 9 - December 2017	Budget	Actual	Variance	Budget	Actual	Variance
			Adv / (Fav)			Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's	£000's
Children, Young People & Families	2,087	2,087	-	2,783	2,783	-
Strategic Cooperative Commissioning	3,922	3,922	-	5,229	5,229	-
Education Participation & Skills	1,069	1,069	-	1,425	1,425	-
Community Connections	408	408	-	544	544	-
Additional People Savings (apportioned to depts above)	-	-	-	-	-	-
Public Health	111	111	-	148	148	-
	7,597	7,597	-	10,129	10,129	-

Western Locality of CCG Integrated Fund

The integrated fund for the Western Locality is now reflecting a forecast unplanned overspend before the use of corporate contingencies of £0.8m.

As reported last month, the pressure for the Independent Sector contracts remains, but Continuing Healthcare has improved marginally, improving the overall position. There remains some pressure on Intermediate Care, and this has not yet crystallised into the position and remains on our risk profile. There are also cost efficiency expectations for Individual Patient Placements and Section 117 packages of care.

Independent Sector:

The Year to Date and the Forecast are now more accurately reflective of the updated risk, following a review of both, including the forecast delivery of QIPP in year. The forecast overspend is identified at just under £0.7m CCG wide, and of which £0.5m relates to Plymouth (and impacts on the Integrated Fund).

This also now reflects the up to date position with regard to Neurosurgery as highlighted in last months report.

Intermediate Care:

The pressure in the cost of the Intermediate Care (Discharge to Assess) beds in the West remains above plan. The forecast assumes a recovery programme bringing the pressure back into financial balance. The level of bed usage in place at this point, if remaining static for the remainder of the year, would indicate an overspend of £1.2m, which is a significant improvement on the previously reported forecast. Included within the assumption of breakeven is an assumed benefit from the use of the iBCF resources.

This is an area of significant focus on transformation and recovery, and is reported in detail to the Western System Improvement Board on a bi-weekly basis.

Continuing Healthcare:

The CCG wide Continuing Healthcare budget for 2017/18 is £80.3m. At month 9, the forecast spend for the year is very marginally above this level. There remains a significant risk that this position may deteriorate further.

The key risk for this cohort of patients is that the numbers receiving Continuing Healthcare has plateaued and this may impact on the delivery of the overall cost reductions.

IPP and Section 117:

For IPP a risk share continues to be agreed with Livewell Southwest, and performance is good when compared to the same period last year.

For section 117 packages of care a plan is being developed to manage the cost of packages of care as a pooled budget. This will be run in parallel in the current year, and the CCG will continue to work with Livewell Southwest in the delivery of the planned efficiency targets.

Primary Care Prescribing:

The West has the greater opportunity in terms of savings from Primary Care Prescribing, and therefore has the greater share of the cost efficiency target. The PDU is currently on target to achieving this target. The level of risk this month remains high as a result of the withholding of Category M savings centrally, and the impact of NCSO (No Cheaper Stock Obtainable). The volatility of these make it difficult to accurately predict a forecast for the CCG at this stage, both the CCG and the Integrated Fund are reported at break even, with the risk being held at CCG level.

Efficiency Programmes:

FOR THE PERIOD FROM 01 APRIL 2017 TO 31 DECEMBER 2017

Month 09 December	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						
Independent Sector	-2,625	-916	1,709	-3,500	-971	2,529
Prescribing	-6,375	-6,375	-	-8,500	-8,500	-
Continuing Healthcare	-4,960	-4,209	751	-8,000	-8,000	-
IPP	-1,779	-2,322	-542	-3,000	-3,000	-
Running Costs	-1,994	-1,828	166	-2,788	-2,257	531
GROSS SAVINGS	-17,733	-15,650	2,083	-25,788	-22,729	3,059
QIPP Reported to NHSE						
Contractualised 16/17 FYE	-8,370	-8,370	-	-11,160	-11,160	-
Social Care	-3,500	-3,500	-	-7,000	-7,000	-
Technical Accounting	-1,500	-1,500	-	-2,000	-2,000	-
TOTAL SAVINGS REPORTED TO NHSE	-31,103	-29,020	2,083	-45,948	-42,889	3,059
Additional System Savings						
Headroom Release	-2,722	-2,722	-	-3,629	-3,629	-
Investment Release	-1,050	-1,050	-	-1,400	-1,400	-
TOTAL SYSTEM SAVINGS	-26,505	-24,422	2,083	-39,817	-36,758	3,059

The above savings report feeds into the system wide savings plan, excluding the contractualisation of 16/17 full year effect, although this forms part of the position reported to NHS England.

Overall the CCG is reporting 93% delivery of plan year to date with 93% delivery forecast by yearend, with the main shortfall on independent sector both year to date and forecast as plans continue to be worked on.

Integrated Fund Summary

Both parties to the fund are experiencing ongoing pressures reflected in forecast overspends that require management to return the position to balance. The forecasts reflect the position before the impact of corporate contingencies. There is a relatively small impact forecast for the risk share at this stage.

SECTION 2 – BETTER CARE FUND (BCF)

Better Care Fund (BCF) and Improved Better Care Fund (iBCF)

The table below shows the total BCF for 2016/17 and 2017/18, along with the distribution between CCG and PCC.

	2016/17	2017/18 Estimated
	£m	£m
PCC Capital (Disabled Facilities Grant)	1.954	2.126
PCC Revenue	9.087	8.852
CCG Revenue	8.310	8.856
Sub Total BCF	**19.351**	**19.834**
iBCF (see below)	0.000	0.764
iBCF (see below)	0.000	5.800
Sub Total iBCF	**0.000**	**6.564**
Total Funds	**19.351**	**26.398**

As part of the resource settlement for 2017/18, PCC were awarded amounts from the Governments iBCF. The first amount was £0.764m which forms part of the PCC revenue settlement. The Government then awarded additional monies, as part of the £2billion to support social care nationally, at the Spring Budget of which PCC will receive:

2017/18 £5.800m
2018/19 £3.660m
2019/20 £1.815m.

These funds are being paid to the Local Authority and come with conditions that they are *"to be spent on adult social care and used for the purposes of meeting adult social care needs, reducing pressures on the NHS - including supporting more people to be discharged from hospital when they are ready - and stabilising the social care provider market."*

A report was taken to Cabinet in July that showed the 2017/18 additional funding and allocations to specific areas and projects. This report was approved and the schemes are now being worked up with more detail. A summarized expenditure plan is included below:

	2017/18
	£m
Priority One - Meeting Adult Social Care Needs	1.400
Priority Two - Reducing Pressures on the NHS	3.351
Priority Three - Stabilising the Social Care Market	1.000
Sub Total	**5.751**
Contingency	0.049
Sub Total iBCF	**5.800**

This is not recurrent money and so overall investments will seek to be a 'bridging' resource to implement the STP new models of care or deliver efficiencies.

SECTION 3 – WESTERN PDU MANAGED CONTRACTS

Context / CCG Wide Financial Performance at Month 9

This report sets out the financial performance of the CCG to the end of December 2017 (Month 9 management accounts)

The CCG plan for 2017/18 has been produced in conjunction with our main acute providers within a wider System Transformation Plan (STP) footprint encompassing South Devon and Torbay CCG (SD&T CCG).

The CCG's planned deficit for 17/18 is £57.1m. This is an improvement from its original plan of £21.4m following proposals developed through the Capped Expenditure Process (CEP). NHS England has confirmed that the plans submitted under the CEP will be used to review the CCG's performance and accordingly the CCG is reporting against this revised plan. In addition to this the CCG has a brought forward deficit from 2013/14 to 2016/17 of £120.5m making the planned cumulative deficit £177.7m.

Although the plan has been updated, NHS England has also confirmed they will continue to measure overall performance against the control total of £17.4m deficit. The current forecast would represent an overspend of £39.7m to the control total.

The updated CCG plan sits within an overall plan for the STP which has a deficit of £61.5m with a savings plan of £168.2m. The plan is based on an agreed set of block contracts with the main providers which de-risks this element of the CCG's commissioning budget and delivers savings within those contracts of £11.2m.

As of Month 9 the year to date and forecast outturn positions are in line with the current plan.

Western PDU Finance Position

Introduction

The Locality is forecasting to marginally (£0.5m) overspend budget at this stage in the year, and this is also reflected in the year to date position. In general the main pressure is for the Independent Sector provider contracts, and this is explained more fully in the report.

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

Acute Care Commissioned Services

Plymouth Hospitals NHS Trust

The contract value for Plymouth Hospitals NHS Trust is agreed at £180.9m, however, the contract remains unsigned whilst the system wide plan is being reviewed by system regulators. 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.

The forecast now reflects some of the planned variations to contract resulting from the work plan of the Western System Improvement Board, and is currently set at £186.0m.

Contract Performance

The month 8 performance information showed a year to date overperformance against the contract plan of £1.14 m.

The main reasons for the contractual overperformance are summarised below.

2017/18 M08	Planned Spend	Actual Spend	Variance	Variance Activity	Variance Spend
	£000s	£000s	£000s		
Elective	26,127	22,862	- 3,265	-10.6%	-12.5%
Non Elective	45,079	45,063	- 16	2.7%	0.0%
A&E	6,487	6,834	347	3.5%	5.3%
Outpatients	21,069	20,846	- 223	-0.7%	-1.1%
Excluded Services	25,096	23,605	- 1,491		-5.9%
Penalties	- 253	-	253		
CQUIN	2,730	2,770	40		
Contract Adjustments	- 5,494	-	5,494		
Total	120,841	121,980	1,139		0.9%

The **Elective** position is £3.27m (12.5%) behind plan from a financial perspective but 10.6% behind plan in overall activity terms.

Non Elective has overperformed by £44k in month 8 resulting in a total underperformance year to date of £16k. Whilst the financial variance is minor, the volume variance shows that 2.7% (660) more patients have been seen than were planned for.

In **Accident and Emergency** the year to date overperformance totals £347k, this is significant at 5.3% over plan. In activity terms the overperformance percentage is lower at 3.5% which indicates that the complexity or volume of care has increased.

Outpatients has underperformed in month 8 to a value of £147k. This now gives an overall underperformance of £223k. Outpatient procedures are over plan by £574k,

whilst first attendances and follow ups are behind plan. Overall, there have been 1282 fewer outpatient attendances than had been planned for.

The plan has an adjustment for system savings; this number reflects the difference between the PbR activity plan and the agreed system wide plan and for NEW Devon is worth £8.24m. Any activity savings will fall into the reporting of the points of delivery in which they occur, so it is likely that this line will show as an overspend all year. At month 8 this is an overperformance of £5,494k.

South Devon Healthcare Foundation Trust

The 2017/18 South Devon Healthcare Foundation Trust contract value for acute services has been set at a total of £6.07m. £5.15m of this accounts for the acute contract which is on a variable PbR basis, with a further £0.92m fixed contract for community services.

At month 8, this contract is forecast to underspend budget by £0.1m.

Independent Sector & London Trusts

The monitoring information to date indicates a small forecast underspend against plan for the London Trusts.

Within the Independent Sector at Month 9, a significant overspend remains at Care UK, of which a significant degree of additional performance within Orthopaedics accounts for the bulk of this. At Nuffield Plymouth, there is a large overspend within Spinal Surgery but this is being partially offset by underperformances within other specialties. A similar situation with regards to spinal surgery is now present within Mount Stuart and, to a lesser extent, Duchy Hospital. Assumptions have been made in regard to budgetary management as well as in the delivery of QIPP during the latter part of the year in informing a forecast overspend of £0.8m.

Livewell Southwest

The Livewell Southwest (LSW) Contract is blocked. LSW produce a monthly performance/finance databook which allows both parties to shadow monitor the block contract and review key performance metrics.

Discharge to Assess beds

Despite the service redesign and additional support to maintain a 6 week timeframe for Intermediate Care, the system has been forecast to significantly overspend. A huge amount of focus on pathways of care has been put in place recently, and this is driving a change in the cost of bed usage. The position is improving, but still remains a risk. The forecast has been set to breakeven unit the outcome of this pathway design process is known. This pressure remains a key focus of scrutiny through the Western System Improvement Board.

Primary Care Enhanced and Other 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 outturn expenditure is in line with budgets.

Conclusion

In summary, the outturn position for both the Integrated Fund and the Western Planning and Delivery Unit is forecast to overspend plan at this stage in the year, with a predicted consequential impact on the risk share. There are pressures in the system around Looked After Children in Care, Intermediate Care in both Health and Social Care, and Continuing Healthcare, with emerging risks around Primary Care Prescribing.

Ben Chilcott
Chief Finance Officer, Western PDU

David Northey
Head of Integrated Finance, PCC

APPENDIX 1

PLYMOUTH INTEGRATED FUND AND RISK SHARE

Month 09 December	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	133,168	133,651	483	177,071	177,634	563
Placements	31,245	31,053	-192	40,971	40,674	-297
Community & Non Acute	41,783	41,787	3	55,711	55,727	16
Mental Health Services	20,484	20,484	-	27,312	27,312	-
Other Commissioned Services	6,725	6,720	-5	8,932	8,926	-7
Primary Care	4,689	4,861	173	6,414	6,392	-23
Subtotal	238,094	238,557	463	316,412	316,664	253
Running Costs & Technical/Risk	4,135	4,073	-62	13,308	13,848	540
CCG Net Operating Expenditure	242,229	242,630	401	329,720	330,513	793
Risk Share					133	133
CCG Net Operating Expenditure (after Risk Share)	242,229	242,630	401	329,720	330,646	926
PCC COMMISSIONED SERVICES						
Children, Young People & Families	26,537	26,882	345	35,382	35,842	460
Strategic Cooperative Commissioning	58,140	58,463	323	77,520	77,950	430
Education, Participation & Skills	76,222	76,222	-	101,629	101,629	-
Community Connections	2,915	2,915	-	3,887	3,887	-
Director of people	162	162	-	216	216	-
Public Health	11,943	11,942	-1	15,924	15,923	-1
Subtotal	175,919	176,585	667	234,558	235,447	889
Support Services costs	12,321	12,321	-	16,428	16,428	-
Disabled Facilities Grant (Cap Spend)	1,595	1,595	-	2,126	2,126	-
Recovery Plans in Development	-	-	-	-		-
PCC Net Operating Expenditure	189,834	190,501	667	253,112	254,001	889
Risk Share					-133	-133
PCC Net Operating Expenditure (after Risk Share)	189,834	190,501	667	253,112	253,868	756
Combined Integrated Fund	432,063	433,130	1,068	582,832	584,514	1,682

APPENDIX 2

WESTERN PDU MANAGED CONTRACTS FINANCIAL PERFORMANCE

Month 09 December	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	140,107	140,107	-0	185,962	185,962	-
NHS South Devon Healthcare Foundation Trust	4,810	4,827	17	6,385	6,313	-72
NHS London Contracts	1,325	957	-368	1,759	1,709	-50
Non Contracted Activity (NCA's)	7,046	7,046	0	9,354	9,354	-
Independent Sector	10,191	10,851	660	13,524	14,355	830
Referrals Management	2,015	1,884	-131	2,674	2,499	-176
Other Acute	18	17	-1	24	23	-1
Cancer Alliance Funding	760	760	0	1,014	1,014	-
Subtotal	166,272	166,449	177	220,695	221,227	532
COMMUNITY & NON ACUTE						
Livewell Southwest	37,151	37,151	0	49,535	49,535	-
GPwSI's (incl Sentinel, Beacon etc)	1,213	1,213	-	1,618	1,618	0
Community Equipment Plymouth	486	486	-	648	648	-0
Peninsula Ultrasound	192	198	6	256	285	29
Reablement	1,138	1,138	-	1,517	1,517	-0
Other Community Services	192	191	-1	256	255	-1
Joint Funding_Plymouth CC	5,483	5,483	-0	7,311	7,311	-0
Subtotal	45,855	45,861	6	61,140	61,168	28
MENTAL HEALTH SERVICES						
Livewell MH Services	20,336	20,336	-	27,115	27,115	-
Mental Health Contracts	19	19	-	26	26	-
Other Mental Health	758	746	-12	1,010	990	-20
Subtotal	21,113	21,101	-12	28,151	28,131	-20
OTHER COMMISSIONED SERVICES						
Stroke Association	115	120	5	153	159	6
Hospices	2,010	2,010	-0	2,679	2,679	-
Discharge to Assess	4,900	4,899	-0	6,533	6,533	0
Patient Transport Services	1,671	1,671	0	2,228	2,228	0
Wheelchairs Western Locality	1,350	1,350	0	1,800	1,800	-
Commissioning Schemes	143	143	0	191	191	-
All Other	641	600	- 41	861	830	-31
Subtotal	10,828	10,793	-35	14,445	14,420	-24
PRIMARY CARE						
Prescribing	43,479	43,479	0	57,971	57,971	-
Medicines Optimisation	183	148	-35	244	202	-42
Enhanced Services	6,555	6,555	-0	8,740	8,740	-
GP IT Revenue	2,241	2,240	-0	3,311	3,311	-
Other Primary Care	761	761	0	1,171	1,171	-
Subtotal	53,218	53,183	-35	71,437	71,395	-42
TOTAL COMMISSIONED SERVICES	297,287	297,387	100	395,868	396,342	474

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

WELLBEING OVERVIEW SCRUTINY COMMITTE

Work Programme 2017-2018

Please note that the work programme is a 'live' document and subject to change at short notice.

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

Date of meeting	Agenda item	Prioritisation Score	Reason for consideration	Responsible Cabinet Member / Officer
9 August 2017	Reprocurement of Sexual Assault Referral Centres (SARC)	5 (High)	Member request due to announcement of re-procurement process	Cllrs Downie / Mrs Beer / Mrs Bowyer / NHS England / Office of the Police and Crime Commissioner
	Acute Services Review	6 (High)	Member request – Aligned to Sustainability and Transformation Plan and outcome of review.	Sustainability and Transformation Plan – Kevin Baber (Plymouth Hospitals NHS Trust)
	Integrated Commissioning Action Plans / Performance Scorecard	-	Standing Item – Written briefing only. Members to advise the Chair if matters arising require presence of an officer / or addition to work programme.	-
	Integrated Fund monitoring Report	-	Standing Item – Written briefing only. Members to advise the Chair if matters arising require presence of an officer / or addition to work programme.	-
25 October 2017	Plymouth Education System	5 (High)	Member request as a result of monitoring reports and changes to Education Funding – to include Special Educational Needs & Disability (SEND) Update	Cllrs Mrs Beer / Judith Harwood
	CQC Review / Delayed transfer in care	6 (High)	Member request as result of announcement of CQC Targeted review	Cllr Mrs Bowyer / Carole Burgoyne / Craig McArdle
	Integrated Commissioning Action Plans / Performance Scorecard	-	Standing Item – Written briefing only. Members to advise the Chair if matters arising require presence of an officer / or addition to work programme.	-
	Integrated Fund monitoring Report	-	Standing Item – Written briefing only. Members to advise the Chair if matters arising require presence of an officer / or addition to work programme.	-
13 December 2017	Sustainability and Transformation Partnership	3 (Medium)	Member request	Sustainability and Transformation Plan - Plymouth Hospitals NHS Trust / NEW Devon CCG (Craig McArdle)

Date of meeting	Agenda item	Prioritisation Score	Reason for consideration	Responsible Cabinet Member / Officer
	Health and Wellbeing Hubs		Member request	
	Dementia Friendly City		Member request – evaluate the impact	
	Torbay Children's Services	5 (Low)		Cllr Mrs Beer / Carole Burgoyne / Alison Botham
	Social care re-referrals and the reduction in child protection plans	2 (Low)	Member request – due to review of Integrated Commissioning Performance Scorecard	Cllr Mrs Beer / Alison Botham
	Integrated Fund monitoring Report	-	Standing Item – Written briefing only. Members to advise the Chair if matters arising require presence of an officer / or addition to work programme.	-
	Integrated Commissioning Score Card	-	Standing Item – Written briefing only. Members to advise the Chair if matters arising require presence of an officer / or addition to work programme.	-
14 February 2018	Mental Health	3 (Medium)	Member Request – to include Pathways to work and emotional and mental health in children / admissions to hospital due to mental health conditions / self-harm	Cllr Mrs Beer / Bowyer and NEW Devon CCG (Craig McArdle)
	Safer Plymouth Partnership		Member request	
	Integrated Fund monitoring Report		Standing Item – Written briefing only. Members to advise the Chair if matters arising require presence of an officer / or addition to work programme.	-
	Integrated Commissioning Score Card		Standing Item – Written briefing only. Members to advise the Chair if matters arising require presence of an officer / or addition to work programme.	-
	Care Quality Commission		Member request (review outcomes and improvement plan)	
11 April 2018	Age Appropriate Dwellings		Member request	Councillor Nicholson/Councillor Ricketts Paul Barnard (Assistant Director for Strategic Planning and Infrastructure and Councillor Wigens (Chair of Planning Committee)
	Healthwatch			Karen Marcellino
	Staff Survey		Staff survey results	
	Workforce Plan (STP)			
	Safeguarding Adult and Children Board		Update and Annual Report	

Date of meeting	Agenda item	Prioritisation Score	Reason for consideration	Responsible Cabinet Member / Officer
	Integrated Fund monitoring Report	-	Standing Item – Written briefing only. Members to advise the Chair if matters arising require presence of an officer / or addition to work programme.	-
	Integrated Commissioning Score Card	-	Standing Item – Written briefing only. Members to advise the Chair if matters arising require presence of an officer / or addition to work programme.	-
Items to be scheduled				
	Homelessness to be reviewed by Place and Corporate Overview and Scrutiny Panel		Reviewed at meeting held on 1 November 2017	
20 September 2017	**Torbay Children's Services**	5 (High)	Member request – Due to announcement of planned state intervention	Cllr Mrs Beer / Carole Burgoyne / Alison Botham
25 October 2017	Plymouth Education System		Member request – to review the steps being taken to improve attainment levels of pupils, particularly for Key Stages 3 and 4, engaging with the Plymouth Education Board; Business Case including a full assessment of risks.	Item went to 25.10.17 wellbeing meeting
	Better Care Plan		Assess issues of sustainability in the context	
New Municipal Year	Accountable Care System (STP)			
	Capitated Fair Shares Position Statement (STP)			
Select Committee Reviews				
29 Nov 17	Primary Care Services			
Mar/Apr 2018	End of Life Care		Member request	
TBC	Urgent Care			
18 and 19 Jan 2018	Budget Scrutiny			
28 Feb 2018	GP Select Committee – Update			

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