Oversight and Governance
Chief Executive's Department
Plymouth City Council
Ballard House
Plymouth PL1 3BJ

Please ask for Amelia Boulter,
Democratic Support Officer
T 01752 305155
E democraticsupport@plymouth.gov.uk
www.plymouth.gov.uk
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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Wednesday 20 March 2019
10.00 am
Warspite Room, Council House

Members:
Councillor Mrs Aspinall, Chair
Councillor Mrs Bowyer, Vice Chair
Councillors Corvid, Hendy, James, Laing, Loveridge, Dr Mahony and Parker-Delaz-Ajete.

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

The meeting will be webcast and available on-line after the meeting. By entering the Warspite Room, councillors are consenting to being filmed during the meeting and to the use of the recording for the webcast.

For further information on attending Council meetings and how to engage in the democratic process please follow this link - Get Involved

Tracey Lee
Chief Executive

Health and Adult Social Care Overview and Scrutiny Committee

1. Apologies

To receive apologies for non-attendance submitted by Councillors.

2. Declarations of Interest

Councillors will be asked to make any declarations of interest in respect of items in the agenda.

3. Minutes **(Pages 1 - 6)**

To confirm the minutes of the last meeting held on 23 January 2019.

4. Chair's Urgent Business

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

5. Winter Pressures **(Pages 7 - 22)**

6. Access Healthcare - Substance Misuse Services **(Pages 23 - 26)**

7. Integrated Commissioning and Delivery - Next Steps **(Pages 27 - 36)**

8. Care Quality Commission Action Plan **(Pages 37 - 38)**

9. Electronic Prescriptions **(Pages 39 - 44)**

10. Health and Social Care Brexit Preparations **(To Follow)**

11. Integrated Finance Monitoring Report **(Pages 45 - 60)**

12. Integrated Performance Scorecard **(Pages 61 - 70)**

13. Work Programme **(Pages 71 - 74)**

14. Tracking Resolutions **(Pages 75 - 76)**

Health and Adult Social Care Overview and Scrutiny Committee

Wednesday 23 January 2019

PRESENT:

Councillor Mrs Aspinall, in the Chair.
Councillor Mrs Bowyer, Vice Chair.
Councillors Corvid, Hendy, James, Laing, Dr Mahony and Nicholson (substitute for Loveridge).

Apologies for absence: Councillors Loveridge and Parker-Delaz-Ajete.

Also in attendance: Councillor Ian Tuffin (Cabinet Member for Health and Adult Social Care), Andy Bickley (Independent Chair), Jane Elliot Toncic (Strategic Safeguarding Lead (Adults)), Kevin Baber (Chief Operating Officer), Amanda Nash (Head of Communications) and Julie Morgan (Head of Audit, Assurance and Effectiveness) from University Hospital Plymouth NHS Trust, Carole Burgoyne MBE(Strategic Director for People, Plymouth City Council) and Sonja Manton (Director for Strategy, South Devon and Torbay CCG and NEW Devon CCG) and Amelia Boulter (Democratic Adviser).

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.

50. **Declarations of Interest**

There were no declarations of interest made.

51. **Minutes**

Agreed that the minutes of the meeting held on 21 November 2018 were confirmed as a correct record.

52. **Chair's Urgent Business**

There were no items of Chair's urgent business.

53. **Report from Independent Chair, Plymouth Safeguarding Adults Board (PSAB)**

Andy Bickley (Independent Chair), Jane Elliot Toncic (Strategic Safeguarding Lead (Adults)) and Councillor Ian Tuffin (Cabinet Member for Health and Adult Social Care) were present for this item and referred to the report attached to the agenda.

In response to questions raised, it was reported that –

(a) his role as Chair was to challenge agencies and to seek assurance. There was very good engagement across the city and at the quarterly board meetings they were now looking at themes and how they collectively keep people safe;

(b) the Creative Solutions Forum reflects the exceptional leadership of different organisations across the city in particular around public health which highlighted a number of vulnerable people with acute and chronic drug and alcohol dependency who create a significant demand on services. The Forum was created as an open space for agencies to meet and discuss these cases to try and achieve a successful resolution;

(c) they commissioned Healthwatch to undertake extensive participation and engagement reviews to ensure that the Board were better sighted on the 'lived experience' of users and carers involved in the safeguarding process;

(d) they were looking at how to engage in a more preventative work to gain a better understating on vulnerability and safeguarding across all organisations to prevent people from being abused and/or at risk of being abused;

(e) assurance sits at the heart of what the Board undertakes on behalf of the community and there was a need to find innovative ways to ensure that recommendations from a serious case review were being delivered and that the Board were making a difference.

The Committee agreed -

1. To note the report and update from the Independent Chair, Plymouth Safeguarding Adults Board.

2. To receive the Healthwatch consultation results when available.

3. To explore how the Health and Adult Social Care Overview and Scrutiny Committee receive regular updates from the Plymouth Safeguarding Adults Board in the future.

4. To receive copies of the Creative Solutions Forum case studies.

5. To encourage all Members to attend the safeguarding training.

54. **Progress Update on CQC Action Plan**

Kevin Baber (Chief Operating Officer), Amanda Nash (Head of Communications) and Julie Morgan (Head of Audit, Assurance and Effectiveness) from University Hospital Plymouth NHS Trust were present for this item and referred to the report included in the agenda. It was highlighted that -

(a) the CQC visited the hospital in December 2018 to re-inspect progress against the two warning notices. It was reported that progress was concluding and would shortly be receiving the draft report;

(b) with regard to pharmacy and the capacity at a senior leadership level, it was reported that support had been provided to move the work programme forward and the team were now at establishment which was a significant achievement. The Pharmacy Board would start meeting on a weekly basis from next week;

(c) good progress had been made with diagnostic imaging but it was acknowledged that the changing of the culture would take some time;

(d) with regard to the overall action plan, 43% of the actions were now complete and it was reported that they now have the funds to build the new Emergency Department;

(e) there were challenges around mandatory training with a number of actions related to this which had resulted in a task and finish group to take this forward.

In response to questions raised, it was reported that –

(f) they were undertaking a piece of work to address whether the workforce within pharmacy was sufficient for the workload around dispensing and undertaking audits and checks. They were developing a business case to address the future staffing arrangement within pharmacy;

(g) the writing and dispensing of a prescription was complex and that patients that were fit for discharge in the morning would have to wait for their prescription to be signed off. There was an in day delay which kept patients in hospital and pharmacy would have a part to play in that;

(h) they do have challenges with the workforce and this was an on-going challenge for the hospital;

(i) they highlighted to the CQC their concerns around the staff survey results in pharmacy when they visited. The Chief Executive also had taken a huge interest in trying to resolve this;

(j) guidance and discussions on Brexit was being handled centrally with the major pharmaceutical companies and they were not expected to make any special provision or stockpiling of medicines.

The Committee noted the progress made so far and agreed to receive a written update report on the latest submission to the CQC.

55. **Missed Hospital Appointments**

Amanda Nash (Head of Communications) and Kevin Baber (Chief Operating Officer) from the University Hospital Plymouth NHS Trust were present for this item and referred to the report included in the agenda. It was highlighted that that the trust were in the top 25% for Did Not Attends (DNAs), however they were not complacent and continually making improvements.

In response to questions raised, it was reported that -

(a) patients that had problems with parking would not fall into this category and would find them another appointment;

(b) they follow national guidance in terms of the waiting list policy. The waiting list policy had been scrutinised externally and they were confident that there won't be any exceptions that would discriminate against any groups;

(c) we try and give as much notice as possible for an appointment, always try and give patients at least 2 weeks' notice;

(d) it was important to have a good understanding of why patients DNA and they were keen to undertake research on how this cohort was made up and barriers to not attending;

(e) they were exploring alternatives to attending the hospital for an appointment such as taking outpatient appointment closer to the patient by using the Cumberland Centre or Mount Gould.

The Committee notes that the University Hospital Plymouth NHS Trust is among the best performing trusts in the country for Did Not Attend (DNA) and the measures taken to further reduce DNAs and requested a follow up report in 6 months' time.

56. **Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS) Update**

Carole Burgoyne (Strategic Director for People, Plymouth City Council) and Sonja Manton (Director for Strategy, South Devon and Torbay CCG and NEW Devon CCG) were present for this item and referred to the report included in the agenda. It was highlighted that –

(a) the reports outlines the key developments in the Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS) journey;

(b) the NHS long term plan sets out the intent on how systems are to work together in new ways to improve the outcomes and offers to our population;

(c) they were expected across the wider Devon footprint to put forward a 5 year plan for our population on how we will address inequality and improve outcomes and this will be the opportunity to get the planning right with all of our partners and to ensure the right governance around this.

In response to questions raised, it was reported that -

(d) with regard to the Digital Strategy there were 4 areas of priority to become digitally enabled -

- one system – sharing of care records and only tell story once;
- technology together - shared infrastructure;
- digital citizen – access to appointments and self-care;
- harnessing information - using information to understand our population needs

(e) the plan needs to be co-designed to ensure that our communities have a say on the local priorities but the plan needs to realistic and with the support of this committee to assist with the conversation to shape the plan;

(f) they would use existing mechanisms to engage with communities and have infrastructure with our partners to get people together to work alongside councillors to share the plan and develop together;

(g) they were constantly in touch with partners around health and wellbeing on developing plans for the future.

The Chair on behalf of the Panel thanked Carole Burgoyne MBE for her contribution to the Committee and wished her a very happy retirement.

The Committee noted the contents of the report.

(This item was moved to facilitate good meeting management).

57. **Integrated Finance Monitoring Report**

The Chair advised that this item together with the integrated commissioning scorecard 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 for this item.

58. **Integrated Performance 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 for this item.

59. **Work Programme**

The Committee noted the work programme.

60. **Tracking Resolutions**

The Committee noted the tracking resolutions.

University Hospitals Plymouth NHS Trust

Winter Planning & Pressures Update

Jo Beer, Director of Winter & Partnerships UHP
Elaine Fitzimmons, Head of Commissioning – Urgent Care

Leading with excellence, caring with compassion

What did we predict:

1) No increase in demand but..
2) Increase in age, complexity and frailty – and number of patients needing admission
3) Bed Model: Need for additional medical beds which would impact on surgical capacity – linked to improvement plans to improve process, length of stay and outlier numbers
4) Workforce challenges across the system

What's new?

1) Increase in demand in January specifically – in the Western system:
   - Primary Care reporting increased demand but no metrics
   - NHS111/Devon Docs reporting Christmas demand every weekend in January and surges on Mondays and Wednesdays
   - 8% increase in ambulance conveyances for Plymouth system
2) Additional workforce challenges across the acute linked to the changing pension and tax systems reducing uptake of shifts to cover vacancies, escalation and sickness.
   Review of entire front door model planned.
3) Impact of sustained escalation on existing workforce
4) Increase in non-elective surgical demand

What are UHP doing?:

University Hospitals Plymouth NHS Trust

- **Quality and Safety:**
  Revised Fundamentals of Care audit - review of quality metrics and outcomes –despite very challenging circumstances the review shows normal variation in relation to clinical risk indicators. However, it does not show the loss of comfort, privacy and dignity that patients experience when in a crowded department. During significant waiting room crowding, additional nurse for waiting area to review/assess put in place

- **Space:** Expansion to current Emergency Department in progress

- **Workforce:** £2.5m investment in workforce: Recruitment ongoing – medical recruitment challenging; Recruitment to nursing posts good but appointees need development and training to assume full roles.

- **Considering every option** for securing additional medical staff **-** Escalated rates and incentive schemes for medicine and nursing/support workforce + agency on/off framework

- **Review** of all medical consultant job plans to provide medical cover to hot floor. This may impact elsewhere.

- **Nurse Consultant-** Re-advertised for 3rd time

- **Tests of change –** to support minor illness presentations - in progress with 2 existing GPs but they only work 2 days per week. Further test of change planned with NHS 111 and Devon Doctors

What are UHP doing?:

University Hospitals Plymouth NHS Trust

- **Command Centre:** Integration of site with Tactical Control to coordinate and triangulate capacity and demand: Improvements include transport utilisation, stranded, extended length of stay, delayed transfers of care, internal delays due to cardiology and imaging…with more to do. Live red to green dashboard has been developed and currently being linked to electronic referral system.

- **Relocation of Minors plan:**
  Our aim is to relocate minor illness/injury alongside primary care streaming and out of hours primary care support. This will enable us to change the 'front door' of minors. Space is a challenge and we are currently reviewing options…….

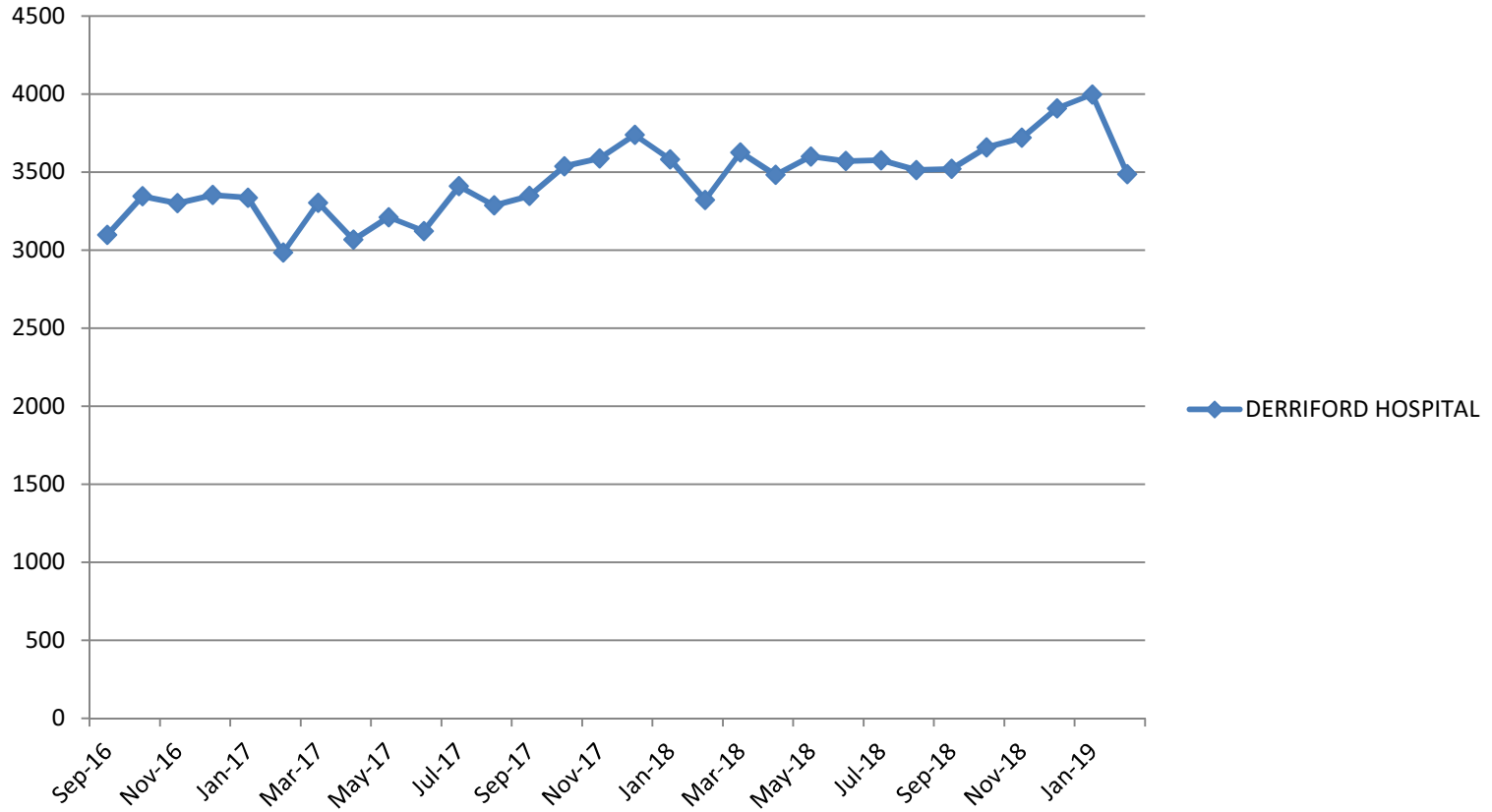
- **Imaging -** Additional Sunday Ultrasound for Surgical Assessment Unit in place

- **National Leadership Centre support**
  In place and working alongside Emergency Department and executive team

SWAST: Ambulance Handovers

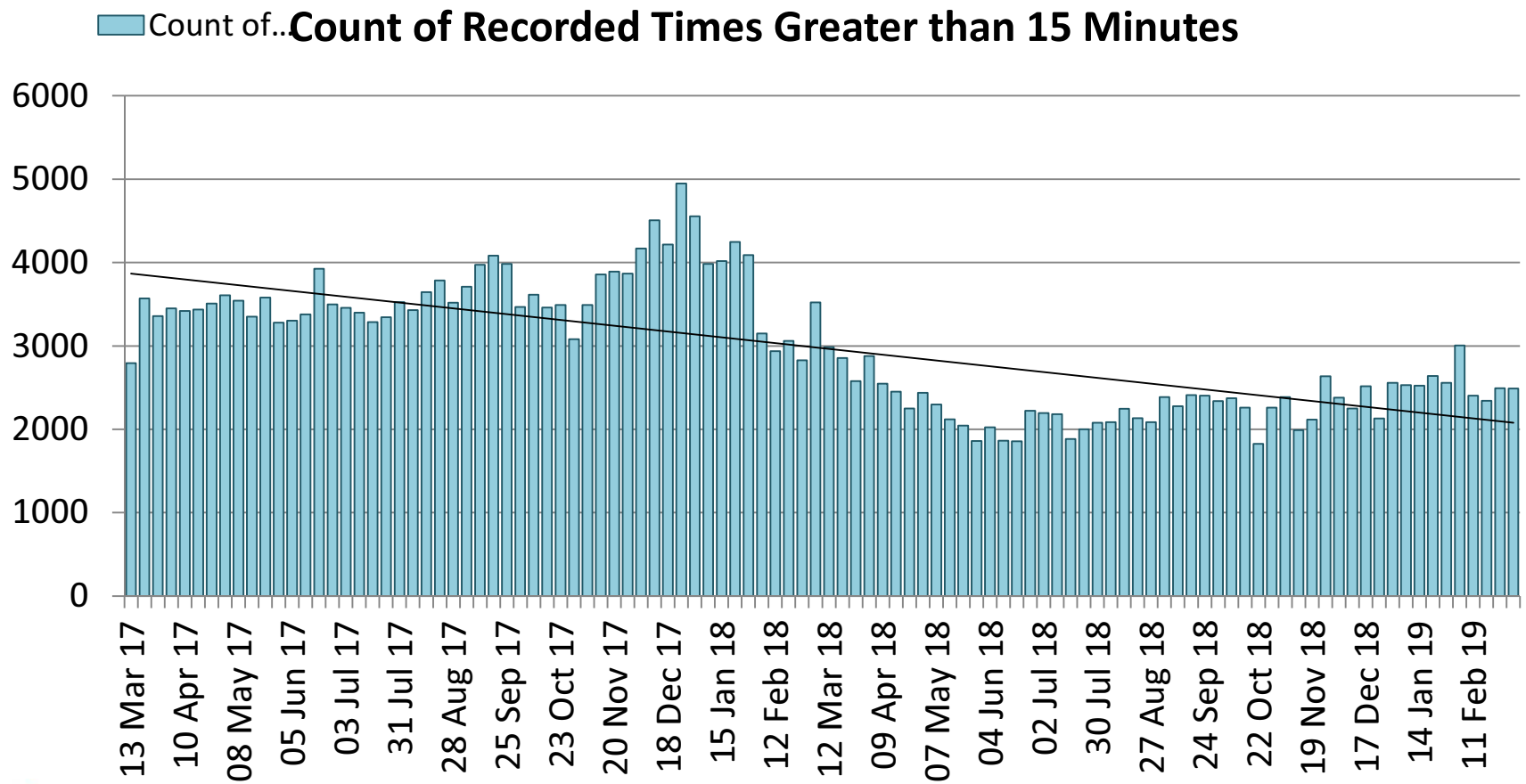
University Hospitals Plymouth NHS Trust

DERRIFORD HOSPITAL AMBULANCE HANDOVERS BY MONTH



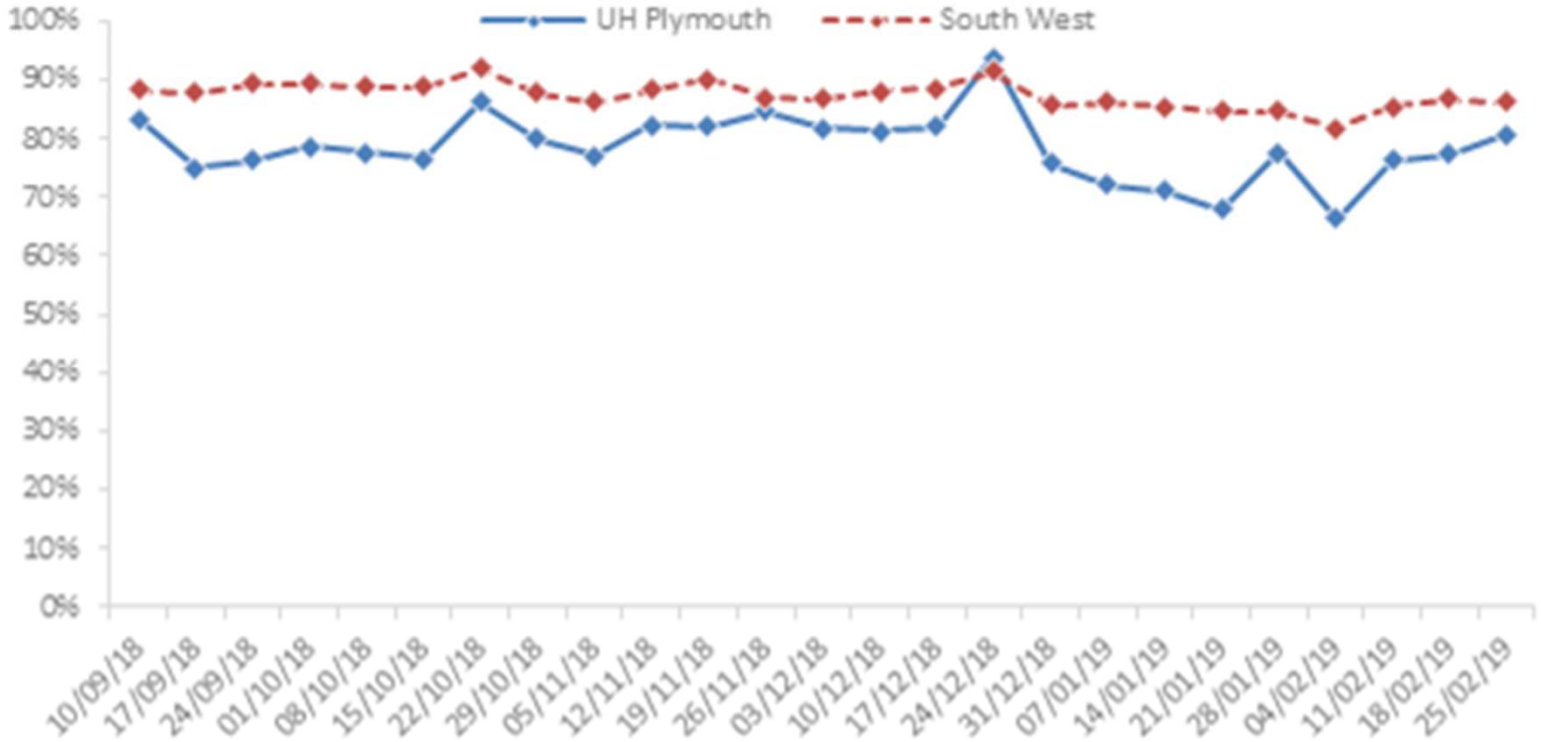
Ambulance Handover Trajectory

University Hospitals Plymouth NHS Trust



4 hour performance:

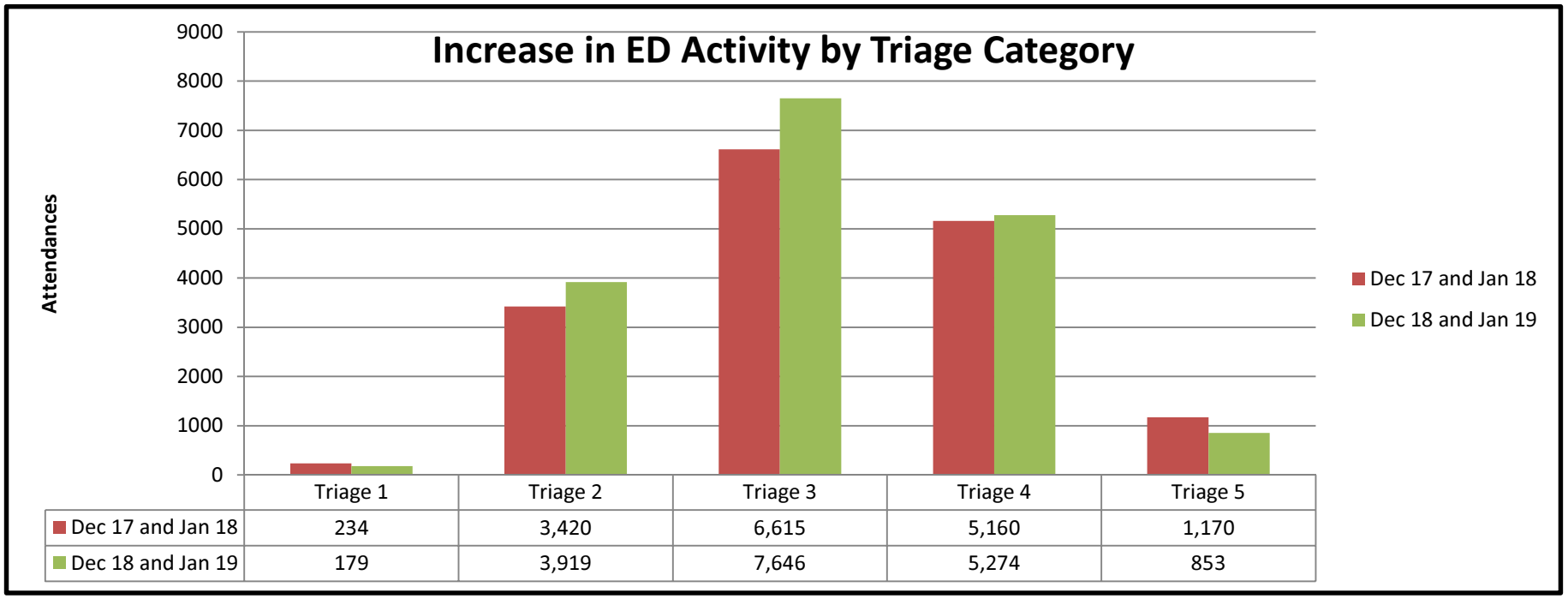
University Hospitals Plymouth NHS Trust



Comparing Winter 2018 and Winter 2019 – Triage

University Hospitals Plymouth NHS Trust

Largest movements in Triage categories 2 and 3 – Total movement of 1,530 in these two categories – 15% growth in triage 2 and 16% in triage 3 –
8% growth overall



	Triage 1	Triage 2	Triage 3	Triage 4	Triage 5
Dec 17 and Jan 18	234	3,420	6,615	5,160	1,170
Dec 18 and Jan 19	179	3,919	7,646	5,274	853

Comparing January 2019 to 2018 and 2017 – Attendances

University Hospitals Plymouth NHS Trust

	65+	75+	85+	Total Pts Aged 65+	Total Pts	% pts aged 65+
Jan-17	771	800	585	2,156	7,744	28%
Jan-18	887	888	649	2,424	8,099	30%
Jan-19	961	961	713	2,635	8,900	29%

Although there is no growth in the percentage of >65 attendances there is an obvious increase in volume so a proportionate increase in > 65s

The Bed Model

University Hospitals Plymouth NHS Trust

Used by UHPNT to understand future bed requirements.

Has been used by the Trust as part of winter planning and has underpinned the Winter Plan.

Model driven by two drivers –

- Admissions and length of stay

Expected winter problem has been reported both internally and externally since early summer 2018.

The Bed Model

University Hospitals Plymouth NHS Trust

What the model has told us we need – Medical beds

	Admissions		LoS		Beds	
	Elective	Non Elective	Elective	Non Elective	Required	Deficit
Jan-18	142	2400	4.24	7.28	626	-134
Feb-18	140	2238	4.57	7.21	643	-151
Mar-18	136	2415	3.28	6.97	600	-108
Apr-18	144	2246	3.68	6.32	531	-39
May-18	176	2454	3.69	6.24	555	-63
Jun-18	198	2360	3.78	5.96	534	-42
Jul-18	191	2387	3.18	6.36	550	-58
Aug-18	157	2302	3.52	6.56	546	-54
Sep-18	171	2186	3.82	6.70	550	-58
Oct-18	185	2365	3.42	6.13	528	-36
Nov-18	185	2330	3.24	6.28	548	-56
Dec-18	147	2360	3.46	6.24	532	-40
Jan-19	185	2539	3.56	6.50	596	-104

The Medical bed base used is 496, beds.

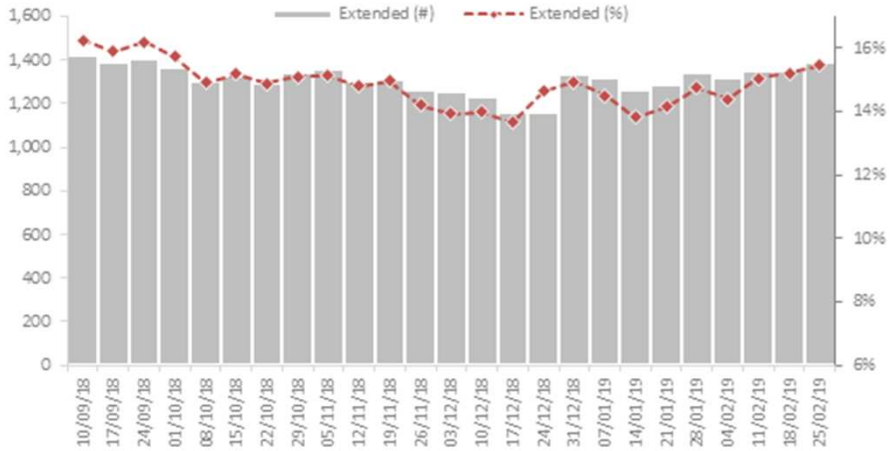
Although we have had 139 more medical arrivals in January compared to last January, the bed position has compared favourably because of decrease in medical LoS from 7.28 to 6.50.

If we compare January to December the contrast is stark – An additional 179 patients (6 a day), all staying an average of over 6 days – this equates to an extra two wards of patients!!

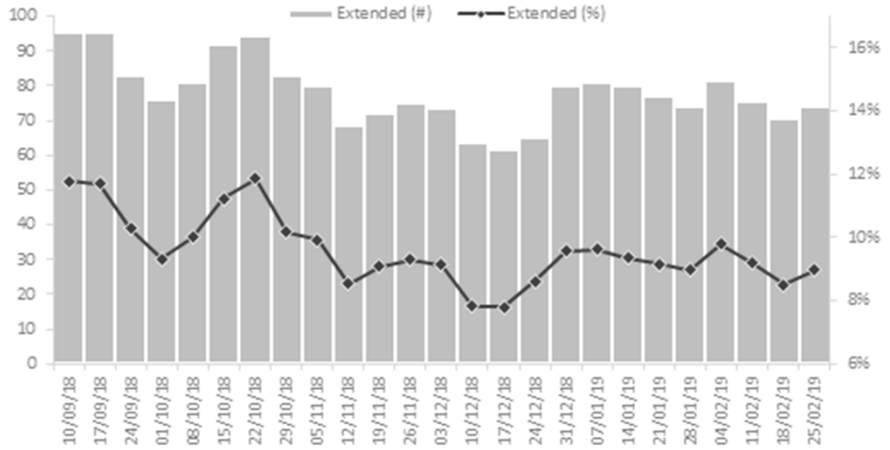
Extended Length of Stay

University Hospitals Plymouth NHS Trust

South

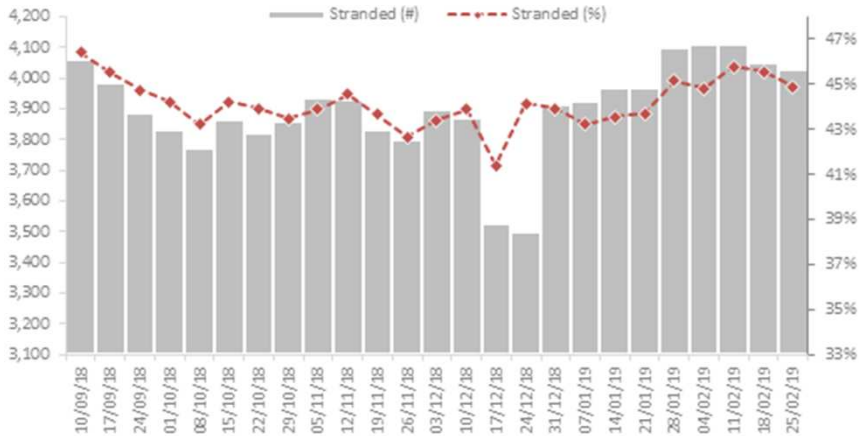


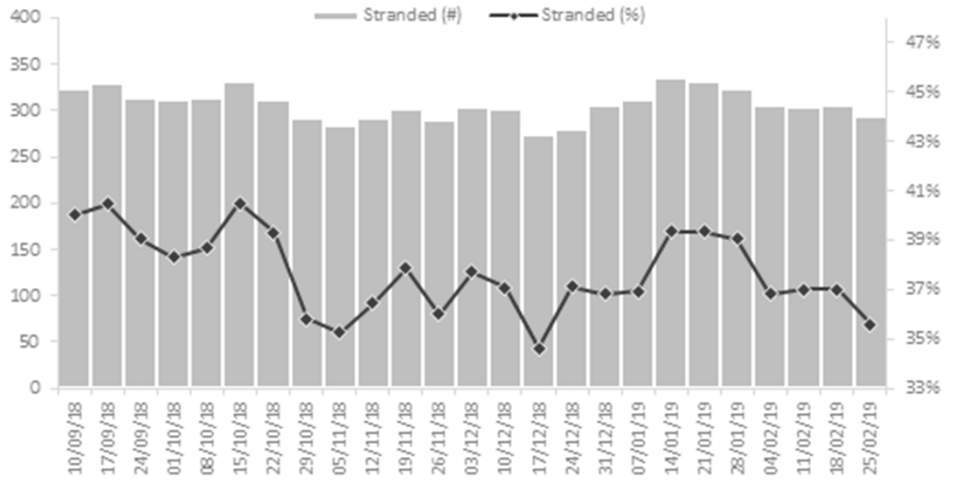
UHP



Stranded South

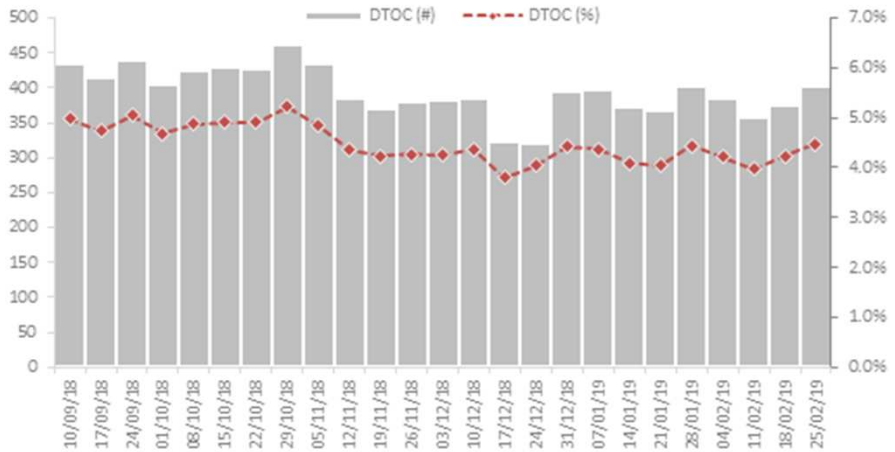
UHP



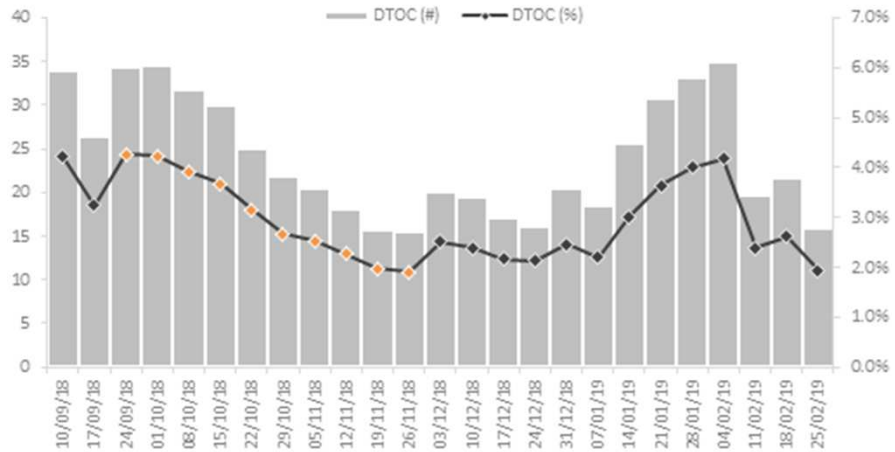


University Hospitals Plymouth NHS Trust

DToC South



UHP



Working to meet the Emergency 4 hour position:

External Challenges:

- **Primary & Community Care: (Workforce, ICM and Demand)**
- **Integrated Urgent Care: (Workforce and Demand)**
- **South West Ambulance Service Foundation Trust**

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PLYMOUTH CITY COUNCIL

Subject: Substance Misuse Service, Access Healthcare

Committee: Health and Adult Social Care Overview and Scrutiny Committee

Date: 20 March 2019

Cabinet Member: Councillor Tuffin (Cabinet Member for Health and Adult Social Care)

CMT Member: Ruth Harrell, Director of Public Health

Author: Gary Wallace, Public Health Specialist

Contact details: gary.wallace@plymouth.gov.uk 01752 398615

Ref:

Key Decision: No

Part:

Purpose of the report:
To describe the action taken to reallocate the patients affected by the Access Health decision to discontinue their Locally Enhanced Service (LES) contract for substance misuse patients.

Corporate Plan:
A Caring Council; people who are in need of substance misuse services are often those who are most at risk of poor health outcomes. Therefore, ensuring that treatment services are continued for those in need is contributing towards tackling health inequalities

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Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land: None

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Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management: None

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Equality and Diversity:

Has an Equality Impact Assessment been undertaken? No

Recommendations and Reasons for recommended action:
To note the contents of the report

Alternative options considered and rejected:

Published work / information: Not Applicable

Background papers:

Title	Part I	Part II	Exemption Paragraph Number						
			1	2	3	4	5	6	7

Sign off:

Fin	djn 18.19.249	Leg lt/32250/1203		Mon Off		HR		Assets		IT		Strat Proc	
Originating SMT Member - Ruth Harrell													
Has the Cabinet Member(s) agreed the content of the report? Yes													

1.0 Executive Summary

The Issue

Access Healthcare gave notice that they wished to discontinue their contract with Plymouth City Council to deliver their Locally Enhanced Services contract for substance misuse patients in November 2018 (meaning the contract would end on 15th February 2019). Initially information provided by Access Healthcare indicated that this would mean 171 patients would require re-allocation to another provider.

Action Taken

The notification came during a competitive tender process involving all the possible alternative providers, making it difficult to talk to them about future plans. Initially Livewell Southwest were looking to take on the patients but were unable to do so due to the price of some of the drugs patients were receiving. There was also a protracted period comparing patient lists to ascertain the exact number of patients requiring transfer, which eventually concluded that 111 patients met the criteria (the remainder being pain patients, or out of area patients). There are a very limited number of GP's and prescribers appropriately qualified to treat this group of patients. There are also complications around the costs of drugs and which organisation pays for them. Patient choice had to be provided and this is a group of highly complex patients with multiple physical and mental health needs, so it was a complicated and time consuming process.

Resolution

Livewell Southwest Complex Needs team and Adelaide Street and St Levans Surgeries agreed to take the patients and as of 1/3/19 all affected patients have been allocated to one of the alternative prescribers or are in receipt of a bridging prescription to allow the patient some time to choose which of the alternatives they would prefer. Patients are free to choose to change prescribers as part of the 'settling in' period and as a matter of principle.

Background

1.1 Plymouth City Council via ODPH commission Locally Enhanced Services (LES) in primary care for particular patient groups where services in addition to standard primary care is required;in this case substance misuse patients. The LES requires the GP to have some additional specialist skills and then pays (per patient) for them to deliver an enhanced level of care over and above 'normal' GP work. In the substance misuse LES there are two levels

a) Shared care, where the GP co-manages the person with input from the community specialist addiction service
b) GP managed care, where the GP manages the patient without ongoing input from specialist addiction services.

In addition to LES services Plymouth City Council ODPH also commission specialist addiction services from Livewell Southwest and Inpatient addiction services from Broadreach. In order to prescribe Controlled Drugs for addiction patients the prescriber must be qualified and then have further training in the specialism of addiction and patient care must be supported by appropriate care plans and risk management plans.

Substance Misuse patients are amongst the most complex in the city. Most have multiple problems affecting both their physical health and their mental health, many also have behavioural problems making them difficult to place. In addition, they require prescriptions of Controlled Drugs to treat their addiction (which are issued on a blue prescription to distinguish it from drugs that are not controlled). Typically these are strong opiate drugs that can be substituted for heroin and enable people to achieve a degree of stability, to cease offending or sex work and to begin to address their problems. This is a recognised and well evidenced treatment and almost all patients gradually reduce over time and are eventually weaned off all drugs. Substitute prescribing also greatly reduces the chances of fatal overdose and reduces risks to families and children by removing the patient from the illegal drug market. Treating addiction patients also helps reduce inequality as drug addiction disproportionately affects our poorest communities.

1.2 Access Healthcare originally indicated they wished to reduce numbers of patients on the scheme and Livewell Southwest were asked to liaise to see if they could help in early October 2018. Whilst Livewell Southwest were willing to help, after a few weeks it became apparent that they could not take on the work because they were unable to claim payment in the same way as Access Healthcare could. Access Healthcare then gave notice on the contract. At this point a competitive tender process was underway for complex needs including substance misuse andAccess Healthcare were informed that it was not possible for commissioners to talk to potential alternative providers about future payment methods and structures as they did not know which services would win the tender, or if it would be necessary to return to the market. As soon as it was possible under commissioning procedures Livewell Southwest were asked if they could take over the prescribing for the patients and were assured about future payment.

1.3 A further complicating factor was that one of the prescribed medications (Subutex) had risen in price considerably and this would have had cost implications if patients on this medication were prescribed the drug through Livewell Southwest, rather than through primary care.

1.4 Once the complex needs tender was awarded in late January 2019 conversations with the winning Alliance took place about this issue. A patient list was requested from Access Healthcare and they supplied a list of 171 people who were on specific medications, which had to be matched with both the Harbour Centre database and the Livewell Southwest Case Management system, which was a lengthy exercise. Through this process Livewell Southwest were able to determine that 111 patients were eligible for the Substance Misuse LES scheme and needed to be found new, suitably qualified, prescribers. The remaining 60 patients remain with Access Healthcare; the majority were on these medications for other reasons (e.g. pain).

1.5 In the last week of the contract expiring commissioners asked Access Healthcare to extend for two weeks to allow the process to complete safely and they agreed to do this. Through a process of collaboration and negotiation it was agreed that Livewell Southwest would take the patients receiving the substitute drug Methadone and the two surgeries would take the patients receiving Subutex. This avoided creating an additional prescribing overspend for Livewell Southwest and a cost pressure for PCC since the Subutex patients were moved within primary care; so both the numbers receiving the drug and the associated costs and budgets stayed the same.

1.6 To summarise, this is a complex and difficult patient group to manage and Access Healthcare were finding it increasingly hard to balance the demands of this group with their mainstream GP work. They gave proper notice that they were ending the contract early (it expired on 1st April 2019 under normal circumstances) but there were a number of complicating factors. There are few qualified alternative prescribers and a competitive tender process was underway when the notice was given, which limited commissioners' ability to talk to services. There had been a huge increase in the cost of one of the controlled drugs, causing overspends and budget pressures, so patients had to be placed without exacerbating this. There was a complicated process to agree which of the original list of patients were eligible for the substance misuse LES, agreement was required for the two alternative surgeries to take patients from outside their catchment areas. Lastly, regard to patient choice was required and patients needed the opportunity to discuss their options. All the patients have now been allocated new prescribers and there has been no reported loss of prescription in the process.

PLYMOUTH CITY COUNCIL

Subject:	Integrated Commissioning and Integrated Delivery- Next Steps
Committee:	Health and Adult Social Care Overview and Scrutiny Committee
Date:	20 March 2019
Cabinet Member:	Councillor Tuffin (Cabinet Member for Health and Adult Social Care)
CMT Member:	Craig McArdle (Strategic Director for People)
Author:	Anna Coles, Director for Integrated Commissioning
Contact details	Tel: 01752 30 email: anna.coles@plymouth.gov.uk
Ref:	
Key Decision:	No
Part:	I

Purpose of the report:

Plymouth has a long and established record of cooperation and collaboration with a formal commitment to integration being set down by the Plymouth Health and Wellbeing Board in 2013, based around Integrated Commissioning, Integrated Health and Care Services and an Integrated System of Health and Wellbeing.

Since then there has been some significant progress and notable achievements towards achieving this aim. NEW Devon CCG and Plymouth City Council (PCC) formed an integrated commissioning function in April 2015 as part of their single commissioning approach. An integrated fund is in place with risk and benefit sharing agreements. Integrated planning and governance arrangements between the two organisations are in place.

Commissioners, informed and supported by clinicians and public health experts, have collectively developed an integrated commissioning approach through the development of four Integrated Commissioning Strategies, which direct all commissioning activity and deliver the Healthy City element of the Plymouth and South West Devon Joint Local Plan. This means our commissioners work across health and social care system. They have been co-located to enable closer working and delivery for a number of years. Also, in April 2015, the Local Authority transferred 173 Adult Social Care staff to Livewell Southwest (LWSW) to develop an integrated community health and care provider with a single point of access, locality-based services and improved discharge pathways from secondary care.

In July Cabinet approved Plymouth's Health and Wellbeing Strategic Commissioning Intentions 2018-20 which set out the next stages in Plymouth's Integration journey including the development of an Integrated Care Partnership.

This report sets out the next stages in the development of the Integrated Health and Wellbeing Programme in relation to Integrated Commissioning and Integrated Delivery.

The Integrated Commissioning paper sets out the next stages in the development of our arrangements with the CCG. This proposes the establishment of an Integrated Commissioning Executive and Joint leadership of integrated commissioning teams at a place based level. The paper also proposes an STP wide role for Population Health and Wellbeing. The Integrated Care Partnership sets out the approach to be taken in delivering our published Commissioning Intentions in relation to Community Health, Adult Social Care and Mental Health services, and sets out an opportunity to align to the re-procurement of the Mayflower Primary Care contract.

Recommendations and Reasons for recommended action:

Plymouth Health and Adult Social Care Overview and Scrutiny Committee are asked to note the progress in delivering Integrated Commissioning and Delivery and to use these developments to inform its future work programme.

Report Title:
Next Steps in the Development of Integrated Commissioning and Integrated Delivery.

Section One- Development of Integrated Commissioning
Summary of the direction of travel for integrating commissioning between NHS Devon CCG, Devon, Plymouth and Torbay Local Authorities in 2019/20.

1. Background

Over the last 2 years Local Authorities and NHS organisations across Devon, Plymouth and Torbay have been working to develop more effective ways of delivering integrated health, care and well-being services whilst also making best use of public resources. Collaborative arrangements are continuing to develop between partner organisations, both commissioning organisations and providers of services, to improve population health and enable access to modern, safe and sustainable services. Effective collaboration between organisations will also enable progress towards working as a self-improving system with increased maturity and delegated regulatory functions.

Integrating how the local NHS and the Local Authorities undertake their respective commissioning responsibilities is seen as a key component of:

- supporting increased collaboration,
- enabling the delivery of integrated services,
- making the most effective use of available funding
- and developing the means of self-improvement as a system.

This paper describes the planned arrangements for how Devon, Plymouth and Torbay Local Authorities and the NHS Clinical Commissioning Groups will operate to integrate commissioning through 2019/20.

2. Process to Date

A number of related work streams have been taking place over recent months involving a wide range of staff from partner organisations. For example,

- Intelligence leads from public health, social care and NHS have developed a common outcomes framework and been planning how to share knowledge, analyse data and provide integrated intelligence to inform planning, prioritisation and decision making.
- Staff with a role in planning in either Local Authorities or NHS CCGs have reviewed the current planning processes and begun designing how these can be adapted to facilitate a more integrated approach.
- Commissioning staff, including Heads of Service, senior officers and executives, have undertaken work to design joint processes, teams and meeting structures and, through doing so, have also increased their understanding of different ways of working and started developing a shared culture.

The proposed arrangements developed through this collaborative process take into account of the current position of the organisations, acknowledge and retain clear accountability and are designed in such a way as to enable implementation without significant re-organisation or disruption, whilst retaining the flexibility for further development.

3. Merger of the Devon CCGs

The merger of Northern, Eastern and Western Devon CCG and South Devon & Torbay CCG is an important step in the journey to create a single strategic commissioner for Devon as part of the CCG's ambition to better integrate health and care services to benefit our local communities. Together with delegated commissioning of primary care, the merger will enable the single NHS commissioner to work consistently and coherently with all local authorities across wider Devon as well as with local partners within each area.

From 1 April 2019, NHS Devon CCG will become a new statutory organisation serving a patient population of nearly 1.2 million people with a budget of more than £1.8 billion. The CCG will comprise a membership of 131 GP practices across Devon, Plymouth and Torbay and will be chaired by a GP with member representation as a core part of its governing body. Through its membership and staff, NHS Devon CCG will work with local communities and partner organisations to improve people's health and make sure they are able to receive high quality, local services.

4. Integrated Commissioning Arrangements

In summary the arrangements will consist of:

1. An Integrated Commissioning Executive who will lead strategic planning, resource allocation and incentivising the system to make progress on joint priorities, development of joint funding arrangements between the NHS and each local authority to support integrated commissioning and review progress against planned outcomes, service quality and cost effectiveness.

2. Joint leadership of integrated commissioning teams with responsibility for commissioning health, care and well-being services for the local population of different communities in the geographical areas across Devon, Plymouth and Torbay as well as supporting commissioning programmes across wider Devon for services or care groups where this will be more effective and efficient.

The following section provides a brief outline of the executive and team function. A detailed description is provided on the accompanying power point slides.

4.1 Integrated Commissioning Executive – Function

The Integrated Commissioning Executive meeting will provide a mechanism for joint planning and shared decision making by the relevant responsible senior officers who have the authority to act in accordance with the decision making framework of each partner organisation. It will be a meeting of executives rather than a joint committee of the statutory organisations or a new additional organisation. Each partner organisation will continue its own internal executive functions & meetings to manage the business of that organisation.

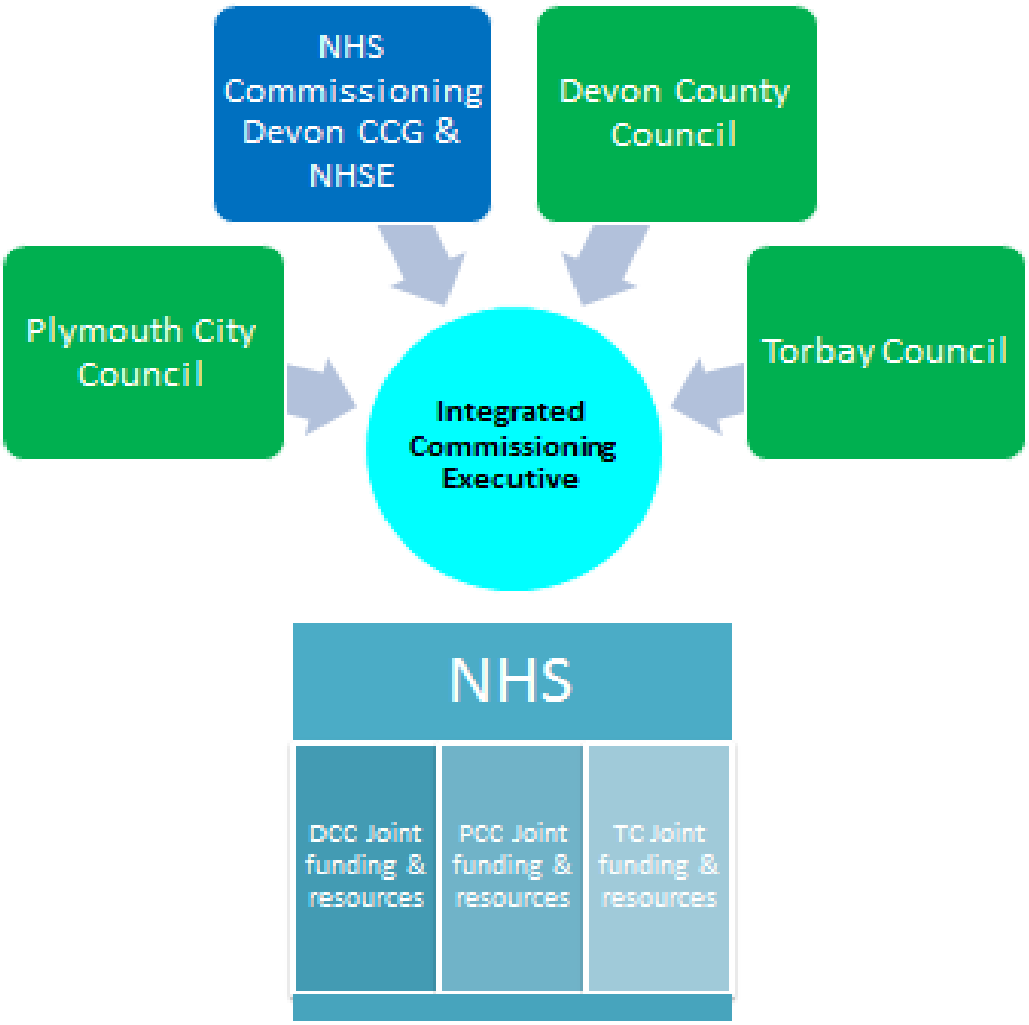

Diagram illustrating how executives / senior officers acting on behalf of the statutory organisations will operate through the integrated commissioning executive meeting.

The Integrated Commissioning Executive, through leadership of the commissioning process, will have a role in contributing to policy formulation or development of long term plans. However the responsibility for deciding and approving policies or long term plans rests with the appropriate bodies of respective organisations i.e. the Cabinets or Health & Well Being Boards of Local Authorities, CCG Governing Body and collectively through system governance mechanisms where statutory organisations are represented by leaders and chief executives i.e. STP Collaborative Board. The integrated commissioning executive will agree joint strategies or actions to implement agreed policies or long term plans, prioritising and deploying resources in accordance with the decision making frameworks of individual organisations, and reviewing impact and progress.

Membership

The Integrated Commissioning Executive meeting will be a meeting of 'decision makers', with authority held by individual executives who will operate within the respective schemes of delegation and remain accountable through the governance mechanisms of their individual organisations.

Membership will comprise those senior officers with responsibility for commissioning services and managing resources on behalf of their organisations including those jointly deployed through pooled fund arrangements. Therefore it is proposed that the core membership will include:

- Devon CCG Accountable Officer
- Local Authority Directors from Devon, Plymouth and Torbay with DASS responsibility
- Devon CCG Director of Commissioning

Other relevant Devon CCG Executives, CCG clinical membership representative, Local Authority Officers and System Leadership roles will attend and inform decision making according to the agenda. In terms of the latter, it is proposed that an additional system role is created to provide dedicated leadership capacity for Population Health and Well Being with the role to be undertaken by a Director of Public Health on rotational basis in a part time capacity.

Directors of Children's Services will be invited to attend as needed to enable whole population planning and alignment of the priorities of local children and young people's plans with the wider Devon whole system plan or where improvement in service delivery requires action at executive level across services for adults and children.

4.2 Integrated Commissioning Team Function

The integrated commissioning teams will:

i. Develop local plans to support the system wide priorities in addressing the needs of the population and service delivery requirements that are specific to the local area.
ii. Work with partners, providers and the local population to design appropriate support and services that improve the experience of users and efficiency of service provision.
iii. Create the conditions to enable partners to deliver integrated care services for individuals and to support the development of healthy communities.
iv. Review the quality of service, progress on outcomes for the local population and financial productivity and performance.

The teams will include commissioning staff from both NHS Devon CCG and each Local Authority, managed through joint leadership arrangements. This will not require staff to transfer employment between partner organisations. The teams will manage the deployment of joint funds in accordance the agreements made at Executive level between the CCG and each local authority. It will commission services to promote well-being and prevention and deliver integrated health and care services including primary and secondary care, physical and mental health for the local population. The integrated teams will also identify when it is appropriate or likely to be more effective and efficient for staff to operate collectively with other teams and providers working across wider Devon.

5. Implementation and Review

The integrated commissioning arrangements as set out will commence in April 2019. The work programme 2019/20 will include aspects of both delivery and further development. Key tasks include:

- Delivery of the Operating plan for 2019/20 and supporting development of a Long Term Plan for wider Devon
- Agreeing a commissioning finance plan including allocation against priorities, resource distribution and incentives
- Delivery of commissioning plans, transformation schemes and reviewing the impact of these
- Creating the conditions to enable local partnership development inc. finance, performance, delivery of Integrated Care Model, local & system transformation
- Continue developing commissioning capabilities, including planning cycle, outcomes framework, intelligence, change capability
- Determine future approach with relevant providers to integrated or delegated Commissioning arrangements, e.g. commissioning individual care and support packages to service level commissioning and delivery.

The Integrated Commissioning Executive will review the effectiveness of the arrangements operating during 2019/20 and draw learning to inform how these should be further developed. In addition, adaptation of the planning processes will also take account of the ongoing work to develop a system

governance framework that supports effective collaboration and democratic accountability including collaboration between the three Local Authority Health & Well Being Boards and Scrutiny Committees. The planned integrated commissioning arrangements are deliberately flexible, maintaining the agility to adapt and take opportunities for further development as required for future years.

Section Two- Development of Integrated Delivery through the Integrated Care Partnership

1) Introduction

In 2018 NHS NEW Devon CCG and Plymouth City Council published their strategic ambitions for delivering Integrated Care in the Plymouth System. These intentions set out a number of priorities, including commissioning an Integrated Care Partnership (ICP) for Adults and Older People. Since the original paper was produced the ambitions around an ICP have evolved, in line with the developing Integrated Care Model, Primary Care Networks and the Long Term Plan.

2) Background and Context

2.1) Strategic Direction

In 2014, Plymouth's Health and Wellbeing Board articulated a vision based around three pillars of integration: Integrated Commissioning, Integrated Health and Care Services and an Integrated System of Health and Wellbeing.

In 2015, Plymouth took the first step in delivering Integrated Health and Social Care Services with the Council's Adult Social Care service transferring to Livewell Southwest (LSW) to create an Integrated Community Health and Social Care partnership. Since then, LSW and University Hospital Plymouth (UHP) have worked very closely together to manage people's care from an acute setting back into the community.

Plymouth's Strategic Health and Wellbeing System Commissioning Intentions 2018-20 articulated that, in order to ensure joined-up whole person care and to take the next step towards an Integrated Health and Care Service, an Integrated Care Partnership (ICP) for adults and older people would be commissioned. The intention was for the ICP to eventually bring together Core Community Health, Adult Social Care, Acute, Local Mental Health Services and, potentially, certain Primary Care Services.

However, in recent months the scope of the ICP has changed and Commissioners are no longer looking to integrate acute services at this time. This is as a result of the need to strengthen and focus on Community Services shaping these around emerging Primary Care Networks and the network of Wellbeing Hubs. However alignment of Community and Acute Services remain an ongoing priority as does integrating pathways of care between the two settings.

2.2) Devon STP Integrated Care Model for integrated out of hospital care

In parallel to Plymouth Commissioning Intentions, the Devon STP has developed a blueprint for an Integrated Care Model (ICM) for integrated out of hospital care. The aims of the ICM are to:

- Promote health through integration.
- Empower communities to take active roles in their health and wellbeing.
- Locality-based care model design and implementation.
- Shift resources closer to home, or in people's own homes.
- Health and social care integration**.**

Locally there are some initiatives already underway in in the Western locality:

- Prevention of need and/or demand
    - Wellbeing hubs in Plymouth
    - Social prescribing in Plymouth; Life Chances bid including social prescribing across Devon
    - Supporting primary care in the implementation of the frailty index as per core contract

- Integration of services and improved pathways of care:

    - Single lead provider for end of life care co-ordination
    - Improving Revision of the D2A services in the locality
    - Commencement of the community diabetes delivery plan
    - Integration of respiratory services (five key areas)
    - Embedding the acute assessment unit as a core service
    - Leg ulcer procurement
    - Mental health initiatives including IAPT and the Crisis Cafe
    - Enhanced care in care homes

- Medicines optimisation initiatives including repeat prescription hub and pain management improvements

Despite this progress, community and primary care services remain challenged with high levels of demand, as evidenced by increased attendances and admissions at University Hospital Plymouth. There is a need to make a further step change and achieve greater integration across the community, including ensuring the integration of physical and mental health to deliver fully on the ambition of parity of esteem. As such the local emerging Integrated Care Model recommends integrated community services wrapped around primary care so that care is delivered in a more timely and seamless way closer to peoples' homes.

2.3) Primary Care

Within the Western System, especially Plymouth, Primary Care remains fragile with a high number of G.P vacancies. However the recent guidance around Primary Care Networks and the five year deal for Primary Care sets out a clear framework for greater integration of community health services and general practice.

At the same time the need for NHS England to re-procure the Mayflower practice, following failure to find a long term provider through previous processes, has provided an opportunity to ensure greater alignment between primary care and community services and deliver on the vision within the Long Term Plan.

2.4) Mental Health

The original intentions signalled the intention to ensure locally responsive mental health services and the recent Complex Lives Contract has further strengthened this approach. The Long Term Plan has

also signalled community mental health teams being aligned with primary care networks. Integrating physical and mental health at a local level thus remains a priority. However there is also a need to ensure sustainable and clinically safe mental health services across the wider Devon STP and there remains a need for mental health services to be managed collaboratively across the wider Devon system.

3) Proposed Commissioning Approach

Community Health and Social Care (Plymouth) Services and Mental Health Services are presently delivered by Livewell Southwest through two separate Contracts. The proposal would be to bring these separate services together into a single integrated contact with the services then wrapped around Primary Care Networks and Wellbeing Hubs. This would have the advantages of bringing together physical and mental health thereby supporting parity of esteem as well as strengthening primary care and ensuring care is delivered closer to home. The need for NHSE to re-procure the Mayflower practice, following failure to find a long term provider through previous processes, has prompted consideration of aligning this primary care contract to the ICP. Commissioners are now discussing these proposals with the market and this engagement will feed through into the final procurement strategy.

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PLYMOUTH CITY COUNCIL

Subject:	Care Quality Commission Action Plan
Committee:	Health and Adult Social Care Overview and Scrutiny Committee
Date:	20 March 2019
Cabinet Member:	Councillor Tuffin (Cabinet Member for Health and Adult Social Care)
CMT Member:	Craig McArdle (Strategic Director for People)
Author:	Anna Coles, Director for Integrated Commissioning
Contact details	Tel: 01752 308949 email: anna.coles@plymouth.gov.uk
Ref:	CQC
Key Decision:	No
Part:	I

Purpose of the report:

In 2017/18, at the request of the Secretaries of State for Health and Social Care and for Housing, Communities and Local Government, the Care Quality Commission (CQC) undertook a programme of 20 reviews of local authority areas to look at how well do older people move through the health and social care system, with a particular focus on the interfaces. This 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 local system review of **Plymouth** was undertaken in December 2017 and was followed by a local summit and the development of a system action plan. The Action Plan was developed in partnership with the Social Care Institute for Excellence and with oversight from the Department of Health and was signed off by the Chair and Vice Chair of the Health & Wellbeing board.

CQC was subsequently asked in October 2018, to report on 9 of the first 12 local authority areas subject to review by conducting a monitoring exercise to establish how local systems have progressed since their review. On 10 October, Ian Trenholm, Chief Executive of the Care Quality Commission wrote to key partners in the Plymouth Health and Wellbeing System, informing us of their intention to review the progress made against the Action Plan following the System Review last December.

With the support and cooperation of the Health and Wellbeing system CQC concluded their required monitoring exercise of **Plymouth** and the attached supporting draft slide deck contains a summary of key areas of progress since the local system review.

The finalised slide deck was shared with the Department of Health and Social Care and formally concludes the CQC review process.

Recommendations and Reasons for recommended action:

- Health and Adult Social Care Overview and Scrutiny Committee are asked to acknowledge the CQC progress report and formally note the end of Plymouth's CQC Local Area Review process.

PLYMOUTH CITY COUNCIL

Subject:	Primary Care Prescriptions
Committee:	Health and Adult Social Care Overview and Scrutiny Committee
Date:	20 March 2019
Cabinet Member:	Councillor Tuffin (Cabinet Member for Health and Adult Social Care)
CMT Member:	Craig McArdle (Strategic Director for People)
Author:	Jo Watson, Deputy Director, Medicines Optimisation, NHS South Devon and Torbay & Northern, Eastern and Western Devon CCGs
Contact details	Tel: 01752 398800 email: jo.watson3@nhs.net
Ref:	
Key Decision:	No
Part:	I

Purpose of the report:

This report is provided to OSC to update members on ways in which people can (a) request and receive prescriptions from their GP practice and (b) request and receive medicines dispensed against these prescriptions.

The report is purposefully brief. Whilst there is a significant amount of regulation in relation to these areas, the paper focuses on prescribing and dispensing of medicines in primary care (general practice and community pharmacy) from the perspective of the user (the patient). It is recommended that the information is the paper is noted by OSC and used to inform questions to raise and discuss at the meeting in order to gain further clarity on specifics as required.

Corporate Plan

N/A

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land

This paper does not contain a proposal requiring with resource implications; rather it is a paper for information and to prompt questions and discussion.

Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management:

None

Equality and Diversity

Has an Equality Impact Assessment been undertaken? Not for this paper

Recommendations and Reasons for recommended action:

It is recommended that OSC note the content of this paper and raise questions for further clarification.

Alternative options considered and rejected:

Published work / information:

- National legislation
- NHS England contracts with general practice and community pharmacy
- GP practice and community pharmacy policies and standard operating procedures

Background papers:

None

Title	Part I	Part II	Exemption Paragraph Number						
			1	2	3	4	5	6	7

Sign off: N/A

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Originating SMT Member													
Has the Cabinet Member(s) agreed the contents of the report? ~~Yes~~ / No* please delete as necessary													

Introduction

1.0 This paper uses common terminology surrounding prescriptions, for ease this is a brief glossary:

- Acute prescription = one off or initial prescription, usually from a GP practice, although could be from other providers such as dentists. Common examples would be an antibiotic prescription.
- Repeat prescription = a medicine which has been agreed for longer term use between the prescriber and patient, common examples are medicines for long term conditions.
- Primary care prescriptions = medicines prescribed by GP practices or dental practices.
- Secondary Care prescriptions = medicines prescribed by hospitals
- Repeat dispensing = different to repeat prescriptions: a batch of repeat prescriptions are given to the patient and their chosen pharmacy to allow for a specified number of months of prescriptions to be collected at regular intervals.
- Electronic prescriptions = can be acute or repeat prescriptions, the prescription is sent electronically to the dispenser, there is no paper form required.
- Medicines optimisation = medicines optimisation is defined as 'a person-centred approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines'.

Medicines are a vital part of modern health care, the NHS in England spends around £18 billion on medicines, 410 million repeat prescriptions are generated each year, this represents 66% of all primary care prescriptions. Given the scale of medicines use it is important that patients can easily request and receive medicines.

1.1 Prescribing and medicines optimisation is integrated into primary and secondary care and, although medicines use is only one aspect of health care, prescribing is a huge subject in its own regard. This paper does not pertain to the full scope of medicines optimisation by any means, but rather seeks to set out key points from the perspective of people (patients) in requesting and receiving prescriptions and dispensed medicines.

Much of this subject is driven by national regulation and policy; some specifics are driven by local developments including the specific ways in which each GP practice and community pharmacy deliver their services.

Prescribing in general practice

1.2 Prescriptions are supplied to patients by general practice for either acute or repeat use. Historically prescriptions were printed on paper forms, however, increasingly electronic prescriptions are used and this step change is driven by national policy and legislation changes.

1.3 The process for a patient to obtain an acute prescription from a general practice is generally: GP or other prescriber (prescribing nurse, prescribing pharmacist etc) issues a one-off prescription following a consultation. Occasionally, acute prescriptions may be issued by GP practices following advice from other prescribers (e.g. outpatient hospital letters etc).

1.4 The process for a patient to obtain a repeat prescription from a general practice is either:

- Patient ticks their prescription counter foil and returns it to the GP surgery. The surgery will then process a prescription in due course (normally 2-3 working days from request).

- Patient returns their prescription counter foil to their pharmacy; the pharmacy then sends on to the GP surgery.
- Patient leaves a prescription counterfoil with their regular pharmacy and liaises with their pharmacy to indicate what they want next time; many pharmacies refer to this as 'managed repeats'.
- A batch of repeat dispensing prescriptions is supplied to the patient by the prescriber for dispensing at the patient's chosen pharmacy at stipulated intervals.
- A repeat prescription is ordered from the GP practice via an online log in i.e. patients are provided with username and password by the GP practice to order repeat medicines.

1.5 Considerations for patients may include the following:

- How they prefer to order their medicines: One patient's preference for online ordering may be entirely different to another patient's preference for ordering using a paper counterfoil.
- Ensuring they order and receive only the medicines they need. Nationally and locally medicines waste is a huge issue; excess medication in the home may present patient safety risks and financial waste.
- Whether they consent to using the electronic prescription service, or whether they want to use paper prescriptions.

Dispensing of medicines by community pharmacy

1.6 NHS prescriptions can be dispensed by community pharmacies or dispensing practices, there are no dispensing GP practices within Plymouth, however there are dispensing GP practices within NEW Devon CCG (for example in more rural areas such as Wembury and Yealmpton). The choice of pharmacy where a prescription is dispensed rests entirely with patients and/or their carers or family; prescribers do not 'direct' prescriptions to a particular pharmacy. Patients do not have to use the same pharmacy each month (although many do use a 'regular' pharmacy) and patients can change their 'nominated' pharmacy either by asking the GP practice or a pharmacy.

1.7 Prescriptions can be sent to dispensers either as a paper prescription, signed in ink by a prescriber, or an electronic prescription sent once a prescriber's electronic signature has been added.

1.8 Dispensers (usually community pharmacies) supply medicines in accordance with the prescribed directions (drug, daily dose, quantity etc) and most commonly patients collect their medicines from the dispenser. However, there are a range of other options.

- The dispenser has the prescription in advance, prepares the medicines, keeps the medicines until the patient comes to collect.
- The dispenser is provided with the prescription and the patient waits while the medicine is dispensed.
- The prescription is delivered, either by the dispenser's own delivery driver, or by post or courier. Delivery services are not funded by national or NHS contracts and are entirely private arrangements between patient and dispenser.
- Many patients will use other dispensers such as an "appliance contractor". Appliance contactors dispense items such as colostomy appliances, catheter appliances, tracheostomy appliances. Appliance contractors generally deliver appliances using mail or couriers.

1.9 Considerations for patients may include the following:

- Which pharmacy they choose to use, for example do they choose a local pharmacy they can walk in to, or do they prefer a pharmacy that operates a 'mail order' delivery system.
- What time of day they want to access pharmacy services, e.g. some pharmacies are open until 11pm, others 6pm, some open Sundays, others do not.
- Have the patient's own needs changed, e.g. working hours or have new prescriptions such as colostomy appliances started?
- Does the patient wish to change their pharmacy? Patients can change pharmacy at any time, this choice rests entirely with the patient.

Recent initiatives to improve prescribing and medicines optimisation for patients

1.10 All those responsible for prescribing and dispensing are concerned with providing high quality services that are accessible and represent good value for money. Initiatives to improve recently include:

- Reducing waste to ensure only those items needed are dispensed.
- Supporting practices with 'best practice' advice on repeat prescriptions.

Recommendations

1.11 It is recommended that OSC:

- Notes the content of this paper
- Raises any questions in relation to the content of this paper to be answered and/or discussed at the meeting.

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PLYMOUTH CITY COUNCIL

Subject:	Integrated Finance Monitoring Report
Committee:	Health and Adult Social Care Overview and Scrutiny Committee
Date:	20 March 2019
Cabinet Member:	Councillor Tuffin (Cabinet Member for Health and Adult Social Care)
CMT Member:	Craig McArdle (Strategic Director for People)
Author:	Helen Foote, Finance Business Partner Integrated Finance
Contact details	Tel: 01752 305471 email: helen.foote@plymouth.gov.uk
Ref:	
Key Decision:	No
Part:	

Purpose of the report:

This report sets out the projected financial outturn for the Integrated Finance S75 Agreement Between Plymouth City Council and N.E.W. Devon CCG.

This report sets out the financial performance of the Plymouth Integrated Fund for the period to the end of October and the forecast for the financial year 2018/19. 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.

Corporate Plan

This report is fundamentally linked to delivering the priorities within the Council's Corporate Plan. Allocating limited resources to key priorities will maximise the benefits to the residents of Plymouth.

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land

Robust and accurate financial monitoring underpins the Council's Medium Term Financial Strategy (MTFS) and the financial integrity of the Integrated Fund. The Council's Medium Term Financial Forecast is updated regularly based on on-going monitoring information, both on a local and national context, as is the CCG's financial position.

Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management:

The reducing revenue and capital resources across the public sector has been identified as a key risk within both organisations' Strategic Risk registers. The ability to deliver spending plans is paramount to ensuring the Council can achieve its objectives to be a Pioneering, Growing, Caring and Confident City.

Equality and Diversity

Has an Equality Impact Assessment been undertaken? No

This report monitors our performance against our approved budget 2018/19. As part of the budget setting process, EIA were undertaken for all areas.

Recommendations and Reasons for recommended action:

The Committee is recommended to note the contents of the report.

Alternative options considered and rejected:

Published work / information:

Background papers:

Title	Part I	Part II	Exemption Paragraph Number						
			1	2	3	4	5	6	7

Sign off:

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Originating SMT Member Craig McArdle													
Has the Cabinet Member(s) agreed the contents of the report? Yes													

Plymouth Integrated Fund
Finance Report – Month 9 2018/19

Introduction

This report sets out the financial performance of the Plymouth Integrated Fund for the period to the end of December and the forecast for the financial year 2018/19.

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.

SECTION 1 – PLYMOUTH INTEGRATED FUND

Integrated Fund - Month 9 Report 2018/19

As highlighted in previous months, the pressures for health are mainly focussed on the variable use of the independent sector acute contracts. For Plymouth City Council there are pressures in residential, domiciliary care and children's packages.

The report highlights an overspend position against budget for health of £3.4m at this stage in the year. For the Council, the forecast overspend of £4.1m is reflected at this stage without assuming further recovery.

The overall fund position is reflected in Appendix 1, and shows an overall forecast overspend of £7.4m, before corporate contingencies.

Plymouth City Council Integrated Fund Monitoring – Month 9

Service	Latest Approved Budget M9	Latest Year End Forecast	Variation at Month 9	Variation at Month 8	Change in Month
	£m	£m	£m	£m	£m
Children, Young People & Families	37.153	41.217	4.064	4.533	(0.469)
Strategic Cooperative Commissioning	78.401	78.401	0.000	0.101	(0.101)
Education Participation and Skills	101.106	101.106	0.000	0.000	0.000
Community Connections	3.784	3.784	0.000	0.026	(0.026)
Director of People	0.295	0.295	0.000	0.000	0.000
Public Health	16.048	16.048	0.000	0.000	0.000
Sub Total	**236.787**	**240.851**	**4.064**	**4.660**	**(0.596)**
Support Service Recharges	14.473	14.473	0.000	0.000	0.000
Disabled Facilities Grant (Capital)	2.298	2.298	0.000	0.000	0.000
Total	**253.559**	**257.622**	**4.064**	**4.660**	**(0.596)**

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

The Children Young People and Families Service are reporting a budget pressure of £4.064m at month 9, an increase of £0.030m in the month. The changes include the following:

- The assumption on minimising the pressure through a reduction in LAC has been removed £0.358m. It should be noted that the majority of the young people discharged are to other permanent arrangements such as Special Guardianship Orders, Child Arrangement Orders and Care Leavers that often require ongoing financial support albeit at a lower rate. The expected saving have been outweighed by the additional cost of new placements coming online as most of these packages have come in at a higher rate.
- The assumption for placements to stepdown has been adjusted down by £0.483m from (£0.670m) to (£0.187m) in line with savings already achieved and a review of the cohort of children who are likely to stepdown by year end. The service have realised savings of £1.471m in the first nine months through step down and step out of placements.
- However, the joint funding assumption with regard to health contribution for young people's placements has increased from (£0.304m) to (£0.404m) an increase of (£0.100m).
- Additional actions equating to (£0.500m) have been put in place to mitigate the above with robust plans to deliver by year end.
- Placements cost and volume overall have increased by £0.210m within the month this can be attributed mainly to two high cost placements one of which was extended due to the court of protection.
- An additional £0.079 of legal agents costs for court work.
- Additional partner funding of (£1.000m) of has been allocated in month 9 to offset part of the underlying additional placement costs.

The cost of the care is particularly high due to the level of support needed to keep young people safe, such as specialist residential care placements with high levels of

staffing. A number of very costly care packages are the result of Court of Protection orders that place a duty on the Council to provide specialist care.

This increasing financial demand on Children's Services is not just a local issue, but is seen nationally and is a culmination of rising demand, complexity of care, rising costs and the availability of suitable placements. Robust plans are in place to deliver £4.655m savings this year, delivering over £3.000m to date, although the Service has identified a savings plan £1.647m that will not be achieved this year.

The following actions are being taken to minimise the overheating budget.

- Tightening of the front door for LAC - Action only HOS Children's Social work and Permanence can give consent for anyone to be accommodated and in her absence Service Director will cover.
- Fortnightly placement review to ensure step down of high cost placements
- Review of staying put arrangements and financial remuneration
- Maximize contribution from partners - Health and Education Action Complete required Health tool for all Residential placements. Review elements of contracts to ensure Education element is recharged correctly
- Service Director persistently raising matter of budgetary pressures at all staff meetings to ensure only essential expenditure and actions taken in a timely manner.
- Maximise local residential placements to avoid higher out of area associated costs.
- Director & Finance Review all Financial Assumptions

There are risks that continue to require close monitoring and management:

- Significant increase in cost and volume of young people's placements since budget setting autumn 2018.
- Lack of immediate availability of the right in-house foster care placements creating overuse of IFA's.
- There are still a number of individual packages of care at considerably higher cost due to the complex needs of the young people.
- Regional wide commissioning activity did not bring about the anticipated holding and reduction of placement costs in both the residential and IFA sectors.
- There are 35 Residential placements with budget for 36. However, there has been a 10.16% increase in the average weekly cost.
- There are 137 Independent Fostering Agency Placements with budget for only 119.
- There are 19 Supported Living Placements with budget for 15 we have seen a 55% increase in the average cost due to a small number of young receiving significant wrap around packages.
- A region wide lack of placements due to an increase in demand for placements, both national and regionally continues to impact negatively on sufficiency
- There has been a 6% increase in looked after children in the financial year, which compares with an 11.3% increase in the South West Region March 2017- March 2018.

The overall number of children in care at the end of December stands at 414, a reduction of 7 in the month.

The number of children placed with independent fostering agencies stands at 137 against a target budget of 119 placements. Residential placements stands at 35 against a target of 36 budgeted placements with a number of these placements being high cost due to the complex nature of these children's needs. There are currently 3 young people placed in 'welfare' secure.

The In-House Foster Care placements have 159 including connected carer's placements against a target budget of 186 placements. There are no In House Parent & Child Assessment Placement, 1 court ordered Independent foster care placements and 1 high cost Residential placements. We currently have 19 Supported Living Placements with budget for 15. However, 30% of the placements are at a substantially high cost due to the complex nature of the placement.

Ongoing work continues all placements are reviewed regularly in order to reduce the pressure on cost and volume where appropriate.

Commissioning arrangements to increase the supply of local placements continues. The Peninsula residential framework tender has just closed, with 29 bidders. A contract award report will be presented to Cabinet in December. The Plymouth Caring in Partnership residential block contract continues to be developed – 3 beds have been added to the contract since March 2018, with a new solo home currently being registered. The Peninsula fostering contract began on 1st April 2018 and is embedding, with a wider group of providers engaged.

Strategic Co-operative Commissioning

The Strategic Commissioning service is forecasting to come in on budget at year end. This is a favourable movement of (£0.101m) from month 8.

There will continue to be management actions to reduce the pressure on the care packages in year, with continued "deep dives" taking place into the areas that are still overheating.

Education, Participation and Skill

Education, Participation and Skills budget is forecast to balance to budget at year end.

Community Connections

Community Connections is reporting a balanced budget at Month 9, a favourable variation of (£0.026m) from month 8.

Average B & B numbers for April to December have reduced from 53 to 52 placements per night, although there was a reduction in Housing Benefit income claimed at the start of the year due to the change across to the universal credit system.

There is still a possible variation of £0.026m but with an assumption that this will be mitigated by year end, with a further reduction to average placements by 3 from the current 52 to 49 per night. The service is targeting to reduce placements with use of alternative properties provided through existing contracts, as well as use of additional contracted staff to target single occupancy stays.

The service is dedicating more resource to encourage clients to complete universal credit claims to increase the Housing Benefit received. Action is still ongoing to limit the overall cost pressure through lower placements and prevention work, as well as capitalisation of equipment that will help to bring spend back to budget.

Public Health

Public Health is expected to come in on budget for 2018/19 despite a reduction in the Public Health grant received in 2018/19 of £0.405m from 2017/18. This will be contained by a variety of management actions, mainly around the contracts that are held within the department, as well as using approximately £0.500m of grant that was carried forward from previous years.

Plymouth City Council Delivery Plans

Between People Directorate and Public Health, over £11.5m of savings are being delivered during 2018/19, which includes savings of over £6m of savings brought forward from 2017/18 which were delivered as one-off savings. It is forecast that all savings will be achieved - breakdown shown below:

Plymouth City Council	Year To Date			Current Year Forecast		
Month 9 - December 2018	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	3,491	3,491	-	4,655	4,655	-
Strategic Cooperative Commissioning	3,596	3,596	-	4,794	4,794	-
Education Participation & Skills	1,040	1,040	-	1,386	1,386	-
Community Connections	494	494	-	659	659	-
Additional People Savings (apportioned to depts above)	-	-	-	-	-	-
Public Health	56	56	-	75	75	-
	8,677	8,677	-	11,569	11,569	-

Integrated Fund Summary

Health are reporting a forecast unplanned overspend of £3.4m for services commissioned for patients registered with Plymouth GP practices whilst the Local Authority are reporting an unplanned overspend of £4.1m.

This position reflects a deterioration in the health position of £1.6m, largely due to investments to support STP Partners as part of a coordinated system approach to managing the system financial position.

The risk share adjustment that results from the respective health and local authority positions at month 9 indicates that an adjustment of £351k would be transacted, with a flow of funding into the local authority.

SECTION 2 – BETTER CARE FUND (BCF)

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

The table below provides a summary of the different types of the BCF, how they are funded, how the fund was spent in 2017/18 and how the fund is planned to be spent in 2018/19.

Note that parts of these plans are still under review and subject to change.

NHS Northern, Eastern and Western Devon Clinical Commissioning Group				
Plymouth City Council				
Better Care Fund				
	2017/18		2018/19	
	£000's	£000's	£000's	£000's
Source	**CCG**	**ASC**	**CCG**	**ASC**
BCF	17,701	2,126	18,044	2,298
iBCF_a		764		5,343
iBCF_b		5,800		3,660
Total BCF	17,701	8,690	18,044	11,301
Application	**CCG**	**ASC**	**CCG**	**ASC**
Intermediate Care	9,156	5,149	9,443	5,149
Social Care Support		3,396		3,452
DFG		2,126		2,298
Social Care Support (iBCF_a)		764		5,343
Meeting ASC Needs		1,449		2,160
Reducing NHS Pressure	3,351		1,500	
Stabilising SC market		1,000		
	12,507	13,884	10,943	18,402

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."*

SECTION 3 – WESTERN PDU MANAGED CONTRACTS

Context / CCG Wide Financial Performance at Month 9

This report sets out the outturn financial performance of the CCG to the end of month 9 of 2018/19.

The CCG plan for 2018/19 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 submitted Financial Plans for 2018/19 set out forecast deficits to 31st March of £20.0m and £5.0m for NEW Devon CCG and South Devon & Torbay CCG respectively. The challenge is significant both for each of the organisations and for the STP as a whole. The CCG plans require the delivery of a £78.597m savings programme in order to meet the respective positions agreed with NHS England. £70.847m of this challenge relates to NEW Devon CCG and the balance of £7.750m with South Devon & Torbay CCG.

The CCG is reporting forecast delivery of 96.8% against this plan at this stage.

Delivery of the required savings plan is the main financial risk and challenge to the CCGs, however there are other risks in relation to out of area placements and within the independent sector contracts. These are subject to continued focus, priority and joint working across the local community and wider STP foot print to mitigate or reduce the potential impact as a result.

Western PDU Finance Position

Introduction

This report previously described emerging risks within the acute independent sector contracts and these risks continue. The Western PDU are reporting a forecast overspend of £2.5m for the contracts that are managed within the PDU.

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

Acute Care Commissioned Services

University Hospitals Plymouth NHS Trust

The 2018/19 contract plan for University Hospitals Plymouth has been set in accordance with the principles agreed by the Devon STP. The overarching agreement is for flat cash contracts, where the 2018/19 contract value is based upon the 2017/18 contract value with minor adjustments agreed for specific areas. Whilst growth and inflationary pressures have been identified the system expectation is that

these will be dealt with through demand management, efficiencies and cost reductions.

The 2018/19 contract value has been agreed at £192.9m for NEW Devon and £4.7m for SD&T CCG. These values include the recent contract variations for RTT support and the Plymouth Orthopaedic Partnership.

Contract Performance

2018/19 M09	NEW Devon CCG					Torbay and South Devon CCG				
	Planned Spend	Actual Spend	Variance	Variance Activity	Variance Spend	Planned Spend	Actual Spend	Variance	Variance Activity	Variance Spend
	£000s	£000s	£000s			£000s	£000s	£000s		
Elective	30,353	26,247	-4,106	-6.4%	-13.5%	1,028	875	-153	-4.9%	-14.8%
Non-Elective	53,879	53,722	-157	4.2%	-0.3%	789	865	77	6.8%	9.7%
A&E + MIU	10,358	10,304	-54	-0.8%	-0.5%	135	209	74	83.2%	54.5%
Outpatients	25,306	24,299	-1,007	-4.1%	-4.0%	663	608	-55	-4.5%	-8.2%
Excluded Services	16,434	17,214	780		4.7%	226	255	29		12.8%
Penalties	-	-363	-363			-	-15	-15		
Drugs & Devices	10,052	10,635	583		5.8%	341	315	-25		-7.5%
CQUIN	3,256	3,286	30		0.9%	78	70	-8		-10.0%
Contract Adjustments	-6,537	-	6,537			300		-300		
Total	143,101	145,344	2,243		1.6%	3,558	3,182	-376		-10.6%

Expenditure on Elective Care is 13.5% behind financial plan for NEW Devon and 14.8% for SD&T, representing a combined underspend of £4.3m to month 9 with £1m of this variance occurring in month. The primary drivers of underperformance for NEW Devon include:

1. Orthopaedics – Underperforming by 25.1% worth £1.85m
2. Cardiology – Underperforming by 32.2% worth £643k
3. ENT – Underperforming by 24.5% worth £419k

We have been notified that there have been delays in processing the activity data from the newly operational Plymouth Orthopaedic Partnership which has significantly worsen the Orthopaedic position this month. We expect that this will be corrected in time for the month 10 reporting.

Non-Elective activity is 4.2% ahead of plan compared with a 0.3% under performance in financial terms for NEW Devon. This is after the contract was increased to reflect historical growth trends and includes the activity and spend taking place within the Acute Assessment Unit (AAU).

Accident and Emergency, which includes MIU activity which has been varied into the UHP contract, is ahead of plan by 0.1% or 128 attendances which is an improvement of 361 attendances since month 8, reducing the adverse variance to 0.2% in month 9. The Torbay and South Devon proportion of this part of the contract is small, it should be noted that the activity variance of 83.2% remains exceptionally high.

Outpatient activity and spend has continued to fall behind plan during month 9. Activity is 4.1% or 0.9m behind plan for NEW Devon. Outpatient procedures are ahead of plan by £0.32m whilst new and follow-up attendances are underperforming by £1.4m. At specialty level there are over performances in Plastic Surgery (£85k or

21%), Paediatrics (£103k or 8%), Trauma (£126k or 25%) and Dermatology (£157k or 20%). However, these are offset by significant underperformances in Hepatology (£181k or 18%), Neurosurgery (£171k or 16%), Gynaecology (£169k or 20%) and Clinical Haematology (£156k or 17%).

NEW Devon Passthrough Drugs and Devices are overspent by 5.8% or £0.58m, which is driven by passthrough drugs. Whilst South Devon and Torbay have an underspend of 7.5%, giving a combined overspend of 5.4% or £0.56m.

The plan has an adjustment for system savings; this number reflects the differences between the PbR activity plan and the agreed system wide contract value and for NEW Devon is worth £8.7m. Any activity savings will fall into the reporting at the points of delivery in which they occur, therefore this line will show as a constant overspend all year. As at month 9 this shows an overperformance of £6.5m.

Overall, contract reporting illustrates an over performance of £1.9m for both Devon CCGs. However, a significant contributor to over performance is in respect of the £6.5m STP contract adjustment. Ignoring these adjustments so that we can consider the contract variance against the agreed activity plan, contract reporting would indicate an under performance of £4.3m.

South Devon Healthcare Foundation Trust

The 2018/19 South Devon Healthcare Foundation Trust contract has been set in accordance to the contracting principles agreed within the Devon STP. The fixed contract value is £5.991m.

Despite having agreed a fixed contract value we will continue to monitor and report on the variances against the agreed activity plan. As at month 9 the activity data shows an underperformance of £0.4m. This primarily driven by underperformances within non elective and passthrough drugs.

Independent Sector & London Trusts

This month the Independent Sector position has improved by £0.4m. This is driven by a reduction in the volume of work that has been going through the Care UK contract in recent months; particularly in hip and knee replacements because of CCG demand management programmes.

At the same time the Orthopaedic work that Care UK previously undertook has been transferred into the Plymouth Orthopaedic Partnership which commenced on the 13th October. University Hospitals Plymouth (UHP) host the Partnership and so this activity has transferred into the UHP contract. As the overall UHP contract is of a fixed financial value this activity has now been fixed, at a level that reflects the continued delivery of the demand management work described above.

Whilst Orthopaedics were the main specialty provided by Care UK, they do also provide other services such as Ophthalmology and Gastroenterology and these

services will continue to be provided by Care UK and be commissioned directly with the CCG.

A further risk of £0.35m is presenting within our variable London provider contracts.

Livewell Southwest

The Livewell Southwest (LSW) Contract has been set in accordance to the agreed STP contracting principles which focus on delivering flat cash contracts.

For LSW this means a fixed contract value of £77.3m for 2018/19.

Discharge to Assess beds

There is pressure in the cost of the Intermediate Care (Discharge to Assess) beds in the West, however, work focussed on the discharge pathway has significantly reduced the number of beds in use and the length of stay, such that the system is planning to move into financial balance in this financial year.

Primary Care Prescribing

Month 9 shows a £156k overspend for the Western area. Overall the CCG is forecasting that our year to date QIPP target has been achieved but are reflecting the QIPP yet to be achieved within our risks. This is prudent based on the information to M07 and will be reconsidered as more data becomes available.

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

The overall Integrated Fund is forecasting a year end overspend of £7.4m at this stage. Within this position the Council is forecast to overspend by £4.1m whilst the health position is forecast to be £3.4m overspend with risks continuing to emerge.

Ben Chilcott
Associate Director of Finance (Western)

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	119,889	120,693	803	159,852	160,857	1,005
Placements	27,419	26,340	-1,078	35,792	34,374	-1,418
Community & Non Acute	37,705	37,727	22	50,273	50,310	37
Mental Health Services	27,426	27,442	16	36,568	36,589	21
Other Commissioned Services	11,858	11,772	-85	15,810	15,696	-114
Primary Care	34,738	34,679	-58	46,087	46,032	-55
Subtotal	259,034	258,653	-381	344,383	343,859	-525
Running Costs & Technical/Risk	3,280	4,618	988	3,516	7,398	3,881
CCG Net Operating Expenditure	262,314	263,271	606	347,899	351,256	3,357
Risk Share					351	351
CCG Net Operating Expenditure (after Risk Share)	262,314	263,271	606	347,899	351,607	3,708
PCC COMMISSIONED SERVICES						
Children, Young People & Families	27,865	30,912	3,048	37,153	41,217	4,064
Strategic Cooperative Commissioning	58,801	58,801	0	78,401	78,402	0
Education, Participation & Skills	75,830	75,830	0	101,106	101,106	0
Community Connections	2,838	2,838	-	3,784	3,784	-
Director of people	221	221	-0	295	295	-0
Public Health	12,036	12,036	-	16,048	16,048	-
Subtotal	177,591	180,639	3,048	236,788	240,852	4,064
Support Services costs	10,855	10,855	-	14,473	14,473	
Disabled Facilities Grant (Cap Spend)	1,724	1,724	-	2,298	2,298	-
Recovery Plans in Development	-	-	-	-	-	-
PCC Net Operating Expenditure	190,169	193,217	3,048	253,559	257,623	4,064
Risk Share					-351	-351
PCC Net Operating Expenditure (after Risk Share)	190,169	193,217	3,048	253,559	257,272	3,713
Combined Integrated Fund	452,484	456,488	3,654	601,459	608,879	7,421

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 University Hospitals Plymouth NHS Trust	145,276	145,276	1	193,701	193,701	0
NHS South Devon Healthcare Foundation Trust	4,713	4,713	-0	6,284	6,284	-0
NHS London Contracts	1,281	1,490	209	1,709	2,005	297
Non Contracted Activity (NCA's)	6,880	6,880	-0	9,174	9,174	-
Independent Sector	8,355	10,241	1,887	11,139	13,607	2,467
Referrals Management	1,936	1,936	-	2,581	2,581	-
Other Acute	17	7	-10	23	13	-10
Cancer Alliance Funding	192	192	-0	246	246	-0
Subtotal	168,650	170,736	2,086	224,857	227,611	2,754
COMMUNITY & NON ACUTE						
Livewell Southwest	33,105	33,105	0	44,140	44,140	-0
GPwSI's (incl Sentinel, Beacon etc)	1,251	1,251	0	1,668	1,668	-
Community Equipment Plymouth	486	486	-0	648	648	-
Peninsula Ultrasound	214	203	-10	285	285	-
Reablement	1,138	1,138	-0	1,517	1,517	-
Other Community Services	192	192	0	256	256	-
Joint Funding_Plymouth CC	6,533	6,533	-0	8,711	8,711	-
Subtotal	42,918	42,908	-10	57,225	57,224	-0
MENTAL HEALTH SERVICES						
Livewell MH Services	24,793	24,793	-	33,059	33,059	-
Mental Health Contracts	20	20	-0	26	26	-
Other Mental Health	823	824	1	1,097	1,097	-
Subtotal	25,636	25,637	1	34,182	34,182	-
OTHER COMMISSIONED SERVICES						
Stroke Association	120	120	-0	159	159	-
Hospices	2,096	2,065	-31	2,795	2,751	-44
Discharge to Assess	4,960	4,960	0	6,613	6,613	-
Patient Transport Services	1,741	1,741	-0	2,321	2,321	-
Wheelchairs Western Locality	1,350	1,410	60	1,800	1,880	80
Commissioning Schemes	143	121	-22	191	159	-32
All Other	817	751	-65	1,089	979	-110
Subtotal	11,226	11,167	-58	14,968	14,862	-106
PRIMARY CARE						
Prescribing	41,615	41,731	116	55,156	55,312	156
Medicines Optimisation	231	231	0	307	307	-
Enhanced Services	7,150	7,150	-0	9,533	9,533	-
GP IT Revenue	1,913	1,913	0	2,550	2,550	-
Other Primary Care	3,204	3,204	0	4,272	4,272	-
Subtotal	54,112	54,228	116	71,818	71,974	156
TOTAL COMMISSIONED SERVICES	302,542	304,677	2,134	403,050	405,854	2,804

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

UHP – University Hospitals Plymouth NHS Trust

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PLYMOUTH CITY COUNCIL

Subject:	Integrated Performance Scorecard
Committee:	Health and Adult Social Care Overview and Scrutiny Committee
Date:	20 March 2019
Cabinet Member:	Councillor Ian Tuffin
CMT Member:	Craig McArdle (Strategic Director for People)
Author:	Robert Sowden, Performance Advisor
Contact details	Tel: 01752 305407 Email: Robert.sowden@plymouth.gov.uk
Ref:	
Key Decision:	No
Part:	I

Purpose of the report:

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.

Recommendations:

The recommendation is for the Health and Social Care Overview and Scrutiny Panel to:

- To note the contents of the report

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INTEGRATED HEALTH & WELLBEING

SYSTEM PERFORMANCE SCORECARD

DECEMBER 2018

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.

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- Community
- Enhanced and specialist

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

2. COLOUR SCHEME – BENCHMARK COLUMN

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

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

For the rest of the indicators:

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

3. TREND GRAPHS

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

4. COLOUR SCHEME - TREND COLUMN (RAG)

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

5. PERFORMANCE BY EXCEPTION

WELLBEING

Referral to treatment (RTT) – Percentage seen within 18 weeks

Nationally it has been agreed that RTT position at the end of March 2019 should be no worse than the March 2018 position and the focus should be on reducing the number of long waiters, specifically those waiting over 52 weeks. An improvement trajectory has been agreed to reduce the number of people waiting 52 weeks or more by March 2018.

Estimated diagnosis rates for dementia

In November the dementia diagnosis rate improved to 57.5%, up from 55.8% in October, the NEW Devon CCGs dementia diagnosis rate does remain 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 and achieve the national target of 66.7% by March 2019.

Excess Weight in Adults, 4-5 year olds and 10-11 year olds

The most recent data (2016/17) saw a slight increase in the percentage of children aged 10-11 that are classed as overweight (31.7%), this is however significantly lower than the England average (34.2%). We continue to worry about the percentage of children aged 4-5 who are classed as overweight, latest data shows that Plymouth is significantly worse. This is also the case for Adults classed as overweight, in Plymouth the latest data shows Plymouth has 67% of adults who are overweight or obese; this compares to the England figure of 61.3%.

We are working to tackle this by giving children the best start in life (e.g. breast feeding, weaning and parenting advice), making schools health-promoting environments (e.g. Healthy School Quality Mark), managing the area around schools through fast food planning policy, and working with partners to raise awareness of the risk factors of unhealthy diets and physical inactivity (Thrive Plymouth). Since 2006/07 when the National Child Measurement Programme (NCMP) began, Plymouth has consistently exceeded the target of taking valid measurements from 85% of eligible children.

COMMUNITY

Health and Social Care System

The Health and Social Care system remains challenged with an increase in the number of older patients who are more likely to require onward care due to the complexity of their needs.

Accident and Emergency four hour wait

University Hospitals Plymouth is not achieving the four hour wait in Accident & Emergency (A&E) target. This is due to demand pressures including an increase in A&E attendances.

Provisional data suggests there was an average of 285 attendances per day during December, this increase on the November figure of 281 and is greater than December 2017 (270). Following a successful hard reset which resulted in an improvement in performance; a second hard reset was repeated in October and a number of actions put in place to improve performance including: dedicated medical leadership; embedding internal professional standards; establishing a full capacity protocol; establishing a paediatric escalation protocol; implementing Front Loaded Initial Care Assessments, embedding fit to sit; creating physical capacity by moving minors to fracture clinics and expanding paediatric space.

Emergency admissions aged 65 and over

Emergency admissions aged 65+ continue to increase. The increase in emergency admissions over winter 17/18 was especially for older people. This was due to the level of respiratory admissions linked to the flu and the cold weather. There was also an increase in the Summer which has been shown to correlate with the hot weather. Whilst admissions fell slightly during Autumn 2018, numbers have begun to increase although levels in December 2018 were not has high as the previous year.

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

Following the Care Quality Commission (CQC) review of the health and social care system we have been delivering against a CQC action plan, an outcome of which was to reduce Delayed Transfers of Care (DTOC). Our progress on delivering this action plan has been shared with the CQC as part of a monitoring exercise into areas that were the subject of a review.

A number of actions have been in place with a view to improve performance in length of stay and DTOC. Actions include the establishing of executive lead escalation arrangements across health and social care systems and the daily review of long stay patients by integrated discharge teams.

Performance for the whole of quarter three is not yet available. Performance has however improved again in October and November 2018, the average number of delayed days across these two months is 849, this compares to the monthly averages of 1,081 in quarter two and 1,269 in quarter one. We have continued to reduce the number of delays attributable to adult social care, improving our national ranking from 142nd (of 152) at the end of 2017/18 to 83rd at the end of October 2018, current performance is better than the national average.

Long term admissions to Residential Care and Nursing Care

We continue to have fewer long term admissions than local authorities in our comparator groups, this despite long term admissions to residential and nursing care for older people (65+) increasing in 2018/19. Last year (2017/18) there were 261 long term admissions in the whole year, equating to a rate of 547.3/100,000. Between April and December 2018 there have been 238 long term admissions for older people meaning we are on a trajectory to have approximately 80 more admissions this year than last. The Hard resets at Derriford Hospital have contributed to an increase in people going through the discharge to assess process with an outcome of going into residential care.

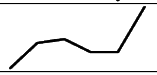
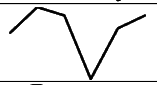
ENHANCED AND SPECIALIST

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

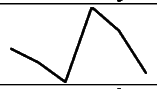
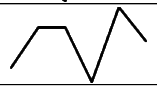
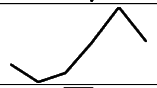
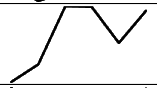
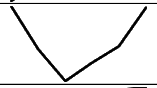
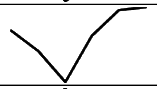
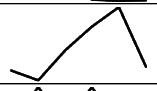
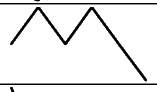
At the end of quarter three the percentage of residential and nursing homes that are rated by CQC as good or outstanding remains steady at 80%. The number of homes that are outstanding rose from seven to eight (7% to 8%), the number of homes that are good fell from 72 to 70 (74% to 72%). At the end of quarter three there are two care homes with a CQC rating of inadequate, this was zero at the end of quarter two.

The QAIT (Quality Assurance and Improvement Team) are undertaking a specific project to target providers requiring improvement 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 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
2.12 - Percentage of adults (aged 18+) classified as overweight or obese	Percentage	2016/17		66.5		67.0	
Child excess weight in 10-11 year olds	Percentage	2016/17		34.4		31.7	
Child excess weight in 4-5 year olds	Percentage	2016/17		24.0		26.3	
2.14 - Smoking Prevalence in adults - current smokers (APS)	Percentage	2017		24.1		18.4	
CCGOF Referral to Treatment waiting times (patients seen within 18 weeks on incomplete pathway (%)	Percentage	Nov-18	N/A	79.5%		79.9%	
NHSOF Estimated diagnosis rates for Dementia	Percentage	Nov-18	N/A	58.9%		57.5%	
The proportion of people who use services who feel safe	Percentage	2017/18		73.4		72.0	
The proportion of people who use services who say that those services make them feel safe and secure	Percentage	2017/18		93.3		90.0	
Overall satisfaction of people who use services, with their care and support	Percentage	2017/18		65.6		73.0	

7. COMMUNITY

Indicator	Measure	Most Recent Period	Benchmark	First Value of Graph	Graph	Last Value of Graph	Trend
2.15i - Successful completion of drug treatment - opiate users	Percentage	2017		7.0		5.3	
2.15ii - Successful completion of drug treatment - non-opiate users	Percentage	2017		30.8		26.3	
Proportion of people still at home 91 days after discharge from hospital into reablement/ rehabilitation services	Percentage	2018/19 - Q3		82.0		83.3	
Improving Access to Psychological Therapies Monthly Access rate	Percentage	Nov-18		1.50		1.77	
Improving Access to Psychological Therapies Recovery rate rate	Percentage	Nov-18		35.40		52.30	
A&E four hour wait	Percentage	Dec-18		84.30%		84.20%	
Emergency Admissions to hospital (over 65s)	Count	Dec-18	N/A	1,313		1,361	
Rate of Delayed transfers of care per day, per 100,000 population	Rate per 100,000	2018/19 - Q3		26.0		10.5	
Rate of Delayed transfers of care per day, per 100,000 population, attributable to Adult Social Care	Rate per 100,000	2018/19 - Q3		11.9		2.4	
Long-term support needs met by admission to residential and nursing care homes, per 100,000 population (aged 65+)	Rate per 100,000	2018/19 - Q3		138.0		140.1	
Long-term support needs met by admission to residential and nursing care homes, per 100,000 population (aged 18-64)	Rate per 100,000	2018/19 - Q3		2.4		1.8	
Proportion of people who use services who have control over their daily life	Percentage	2017/18		83.4		80.0	

8. ENHANCED AND SPECIALIST

Indicator	Measure	Most Recent Period	Benchmark	First Value of Graph	Graph	Last Value of Graph	Trend
In hospital Falls with harm	Percentage	Nov-18		0.24		0.48	
Percentage of CQC providers with a CQC rating of good or outstanding	Percentage	2018/19 - Q3		79.0		80.0	

HEALTH AND ADULT SOCIAL CARE OVERVIEW SCRUTINY COMMITTE

Work Programme 2018 - 19

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
13 June 2018	Health Landscape		To give the committee a better understanding of the current health landscape for Plymouth.	IT, CB, CM, RH
	Integrated Commissioning 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 Finance 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 July 2018	Emergency Department		To receive an update on waiting times.	Kevin Baber
	Healthwatch Annual Report		Annual Report and overview of 2017 – 18	Karen Marcellino
	CQC Action Plan Update			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.	-
26 Sept 2018	CQC Reports for Derriford			
	Update on Never Events (Plymouth Herald report on 13 August 2018)			
	Western System -Winter Plan		To include the plans from the NHS as well as looking at flu vaccinations for staff.	NHS, CCG
	Flu Jabs for Front Line staff – how this is promoted and uptake			

	STP Mental Health and Wellbeing Strategy			
25 Oct 2018	Livewell SW CQC Report			
	UHP Progress Update on two warning notices			
	Director of Public Health Annual Report			
	Planned Care Programme Update			
	Integrated Finance Monitoring Report			
	Integrated Commissioning Score Card			
21 Nov 2018	Dental Access			
	Workforce Development Strategy to include UHP			
	CQC Action Plan			
	Integrated Finance 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.	-
23 Jan 2019	Update from the Chair of the Plymouth Safeguarding Adults Board		Update and Annual Report.	
	Update on STP, ICS and Fair Share			
	Monitoring of missed hospital appointments			
	UHP Progress Update on CQC Action Plan			
	Integrated Finance 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.	-
27 March 2019	Access Healthcare – Substance Misuse Services			
	Winter Pressures			
	CQC Action Plan			
	Electronic Prescriptions			

	Integrated Care Partnership			
	Health and Social Care Brexit Preparations			
	Integrated Finance 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				
	NHS 111 Update			
	Loneliness			
	Care Need Assessments	June 2019		
	Workforce Development Strategy Update	July 2019		
	Update on Did Not Attends	July 2019		

Select Committee Reviews				
	End of Life Care		Member request	
	Urgent Care			

Cross scrutiny items				
2019	Joint Mental Health Select Committee		Joint Select Committee with Education and Children's Social Care	

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Health and Adult Social Care Overview and Scrutiny Committee

Minute No.	Resolution	Target Date, Officer Responsible and Progress
21 November 2018 Dental Access - Minute 43	The Committee agreed - 1. To explore whether Plymouth City Council can support recruitment campaigns to attract Dentists to the area. 2. That all Councillors attend training to become Dental Champions. 3. To be updated on progress of the potential set-up of a new practice in the city centre to ease pressure within the system. 4. To explore and discuss with Health Education England the potential for the Peninsula Dental School to increase the number of students. 5. That a link to the Plymouth on Line Directory is sent to Committee Members.	**Date:** Jan 2019 **Officer:** Amelia Boulter **Progress:** 5 - email circulated to Members on 28.11.18. Meeting with Public Health to go through recommendations.
23 January 2019 Report from Independent Chair, Plymouth Safeguarding Adults Board (PSAB) - Minute 53	The Committee agreed - 1. To note the report and update from the Independent Chair, Plymouth Safeguarding Adults Board. 2. To receive the Healthwatch consultation results when available. 3. To explore how the Health and Adult Social Care Overview and Scrutiny Committee receive regular updates from the Plymouth Safeguarding Adults Board in the future. 4. To receive copies of the Creative Solutions Forum case studies. 5. To encourage all Members to attend the safeguarding training.	**Date:** Jan 2019 **Officer:** Amelia Boulter **Progress:** Progressing
23 January 2019 Progress Update on CQC Action Plan - Minute 54	The Committee noted the progress made so far and agreed to receive a written update report on the latest submission to the CQC.	**Date:** Jan 2019 **Officer:** Amelia Boulter **Progress:** Progressing
23 January 2019 Missed Hospital Appointments - Minute 55	The Committee notes that the University Hospital Plymouth NHS Trust is among the best performing trusts in the country for Did Not Attend (DNA) and the measures taken to further reduce DNAs and requested a follow up report in 6 months' time.	**Date:** Jan 2019 **Officer:** Amelia Boulter **Progress:** Added to work programme

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