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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Wednesday 19 June 2019
2.00 pm
Warspite Room, Council House

Members:
Councillor Mrs Aspinall, Chair
Councillor Mrs Bowyer, Vice Chair
Councillors Corvid, Deacon, James, Nicholson, Parker-Delaz-Ajete, Tuffin and Tuohy.

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

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Tracey Lee
Chief Executive

Health and Adult Social Care Overview and Scrutiny Committee

1. To Note the Appointment of Chair and Vice-Chair

The Committee will be asked to note the appointment of the Chair and Vice-Chair for the forthcoming municipal year 2019/2020.

2. Apologies

To receive apologies for non-attendance submitted by Councillors.

3. Declarations of Interest

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

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

To confirm the minutes of the previous meeting held on 21 March 2019.

5. Chair's Urgent Business

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

6. Terms of Reference **(Pages 7 - 18)**

7. CQC Report on Derriford's Emergency Department **(Pages 19 - 32)**

8. Disability Parking at Derriford Hospital **(Pages 33 - 38)**

9. A Long Term Plan (LTP) for Devon **(Pages 39 - 50)**

10. General Practice Update **(Pages 51 - 56)**

11. Integrated Care System Performance Report **(Pages 57 - 64)**

12. Integrated Finance Report **(Pages 65 - 76)**

13. Work Programme **(Pages 77 - 78)**

14. Tracking Decisions **(Pages 79 - 80)**

Health and Adult Social Care Overview and Scrutiny Committee

Wednesday 20 March 2019

PRESENT:

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

Apologies for absence: Councillors Loveridge.

Jo Beer (University Hospital Plymouth NHS Trust), Elaine Fitzsimmons (NEW Devon CCG) and Anna Coles (Director of Integrated Commissioning (Interim)), Ruth Harrell (Director of Public Health) and Gary Wallace (Public Health Specialist), Nicola Jones (NEW Devon CCG), Jo Watson (Deputy Director of Medicine Optimisation, NEW Devon CCG), Kevin McKenzie (Policy and Intelligence Advisor) and Amelia Boulter (Democratic Advisor).

The meeting started at 10.00 am and finished at 12.43 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.

61. **Declarations of Interest**

Councillor Mrs Aspinall declared a private interest with regard to minute 66, she is a panel member on the Mayflower Procurement Board.

62. **Minutes**

Agreed the minutes of the meeting held on 23 January 2019.

63. **Chair's Urgent Business**

The Chair requested that her concerns were noted regarding Brexit and the impact on health and adult social care.

64. **Winter Pressures**

Ian Tuffin (Cabinet Member for Health and Adult Social Care), Jo Beer (University Hospital Plymouth NHS Trust), Elaine Fitzsimmons (NEW Devon CCG) and Anna Coles (Director of Integrated Commissioning (Interim)) were present for this item and referred to the presentation within the agenda.

In response to questions raised, it was reported that –

(a) they saw a high demand in January and the beginning of February, however, this winter felt more organised and they now had a better handle on this;

(b) with the recruitment of Doctors, they find that once recruited they tend to stay because of the number of opportunities available to them. From a nursing perspective, the lack of a Nurse Consultant had impacted on the development of the nursing workforce, this was a key post and interviews for this post would be taking place soon;

(c) this winter they have been taken by surprise by the demand and this was reflected nationally. Unfortunately they do not have an immediate solution but they were analysing data to understand the causes of the demand and were looking at the flow;

(d) they were having discussions with GP practices to ascertain why patients were attending the emergency department as well as speaking to patients on why they had presented at the emergency department;

(e) they have appointed Dr Jonathan Cope, GP at Beacon Medical Group who understands the challenges around primary and acute and he was currently scoping a piece of work with GPs and consultants around opportunities around outpatient appointments and the huge opportunities to work in a more innovate ways;

(f) that were was a need to be more robust on communications to tell people that the hospital is full and the alternative options for people to be able to access the right help and support rather than presenting at the GP practice or at the Emergency Department.

The Committee noted the Winter Pressures update and requested a follow-up report in July 2019.

65. Access Healthcare - Substance Misuse Services

Ruth Harrell (Director of Public Health) and Gary Wallace (Public Health Specialist) were present for this item and referred to the report in the agenda. Officers provided assurance to the Committee on the importance of this service and that all of the patients that were provided the service by Access Healthcare continued to receive their medication.

In response to questions raised, it was reported that -

(a) the dispensing of blue prescriptions can only be prescribed by GP's that have undertaken the accredited training. There was an additional complication in the enormous rise in the cost of the drug and currently Public Health commission Harbour and Livewell and the CCG commissions the GP practices to administer the medication;

(b) the communication sent to patients indicated that they would still receive their medication as planned;

(c) that no one understands the causes that leads to substance misuse, however, 100 percent of substance misusers would have experienced either trauma, homelessness, offending, mental health problems and live in areas of deprivation;

(d) the Alliance were made up of partners who were subject experts looking to find solutions and prevention to substance misuse;

(e) Plymouth were trying to move in the right direction to address the wider determinants in health which included prevention whilst ensuring they were addressing the Marmot principles. Public Health was underfunded which has a massive impact on what they can deliver.

The Committee noted the update on the Access Healthcare, Substance Misuse Service and requested that a report on preventative measures against the Marmot principles is added to the work programme.

66. **Integrated Commissioning and Delivery - Next Steps**

Ian Tuffin (Cabinet Member for Health and Adult Social Care), Anna Coles (Director of Integrated Commissioning) and Nicola Jones (NEW Devon CCG) were present for this item and referred to the report in the agenda pack.

In response to questions raised, it was reported that –

(a) they were looking at demand across the service and the range of preventative services through the wellbeing hubs on offer to the public to alleviate the demand on services. and what we are saying to the general public that there are other services that can address your needs;

(b) mental health needs to be part of the wider community to access a wider workforce to support people. Currently mental health sits separately which creates delays within the system. They were in talks with the Police and have this as an ongoing agenda item to have the system oversight to ensure partners were working together to achieve the right outcomes;

(c) the health landscape was very complicated and the issues around trying to get a doctor's appointment or where to access the right services was important to the public. In the background a lot of work was being undertaken to alleviate the pressures within the system and for the public to be able to access the right services and at the right time.

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.

67. **Care Quality Commission Action Plan**

Ian Tuffin (Cabinet Member for Health and Adult Social Care) and Anna Coles (Director for Integrated Commissioning) were present for this item and referred to the report provided.

In response to questions raised, it was reported that they were working closely with partners to best look at the risk that may or may not exist with regard to Brexit. They have demonstrated good partnership working around the workforce challenges and were resilience planning to identify any risks.

The Committee acknowledge the CQC progress report and formally note the end of Plymouth's CQC Local Area Review process.

68. **Electronic Prescriptions**

Jo Watson (Deputy Director of Medicine Optimisation, NEW Devon CCG) was present for this item and referred to the report included in the agenda.

In response to questions raised, it was reported that –

(a) with regard to the national advertising of electronic prescriptions, there were some issues around the misunderstanding of the adverts but have been reassured by NHS England that the adverts had changed. It also reported that many pharmacies deliver on a private basis to patients;

(b) in Plymouth; the CCG had been investing early in pharmacy resource, not just Pharmacists within a GP practice but also Pharmacy Technicians. As part of the national contract for GP practices there was an expectation to invest in pharmacy resource, looking at poly pharmacy and ensuring patients were taking the medication that they need and looking at wastage.

The Committee noted the report on Electronic Prescriptions.

69. Health and Social Care Brexit Preparations

Councillor Ian Tuffin (Cabinet Member for Health and Adult Social Care), Kevin McKenzie (Policy and Intelligence Advisor) and Anna Coles (Director of Integrated Commissioning (Interim)) were present for this item and referred to the presentation in the agenda pack.

In response to questions raised, it was reported that nationally work was taking place to ensure that medication supplies were not impacted and ensuring all partners were working collaboratively so that the population receives the services and supplies as and when needed.

The Committee noted the Health and Social Care Brexit Preparations presentation.

70. 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.

71. 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.

72. Work Programme

The Committee noted the work programme and requested that the following items are added to the work programme for 2019 – 2020:

- Winter Pressures Update – June/July
- Alliance Action Plan (substance misuse) – June
- Update on GP recruitment - June
- Workforce Development Action Plan
- Select Committee on Mental Health (Cradle to Grave)
- Brexit report – impact on care – June

73. Tracking Resolutions

The Committee noted the progress against the tracking resolutions and highlighted the on-going issues around dental health.

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PLYMOUTH CITY COUNCIL
CONSTITUTION

PART D: OVERVIEW AND SCRUTINY FUNCTIONS & PROCEDURES

1. Overview and Scrutiny Functions

1.1. The aims of the Overview and Scrutiny process are to-

- add value to Council business and decision-making;
- hold the Cabinet to account;
- monitor the budget and performance of services;
- assist the Council in the development of policy and review the effectiveness of the implementation of Council policy;
- review relevant central government policy development and legislation to assess the impact on the City and make recommendations to Cabinet.

2. Role of Overview and Scrutiny Committees

2.1. The relevant scrutiny committee will:

- hear call-ins, Councillor's call for action and petitions;
- approve time limited select committees for issues within its remit;
- monitor performance against the relevant corporate priorities;
- receive finance and performance reports;
- agree recommendations to Cabinet, Council and partner organisations;
- agree appointments of co-opted representatives;
- monitor the forward plan;
- help Council and the Cabinet to develop policy by studying issues in detail through time limited Select Committees;
- review new and developing legislation to assess its impact on the city;
- consider and introduce schemes to involve the public in developing policy;
- work with national, regional and local organisations to promote the interest of local people.

3. Brexit, Infrastructure and Legislative Change Overview and Scrutiny Committee

3.1. Responsibility for

- Relevant policies in the Plymouth Plan
- Response to Central Government's Policy Making
- Capital Programme
- Strategic Procurement
- Corporate Property
- Development planning
- Strategic Highways
- Economic Development
- Heart of the South West Productivity Plan

- Strategic Transport policies and strategies
- Cultural Infrastructure
- Climate change and sustainability
- Reviewing impact of Brexit on the city
- Proposing measures that Government should take to provide stability for the council and partners in light of Brexit
- Exploring powers could be devolved from the EU directly to local authorities
- Hear call-ins relevant to the role of the committee

3.2. Partnership links

- Growth Board
- Joint Committee for Heart of the South West
- Heart of the South West Local Enterprise Partnership

3.3. **Membership -** All members of the Committee will adhere to the general rules of Overview and Scrutiny. There are nine members of the Committee including the Chair and Vice Chair.

3.4. **Chair** – The Chair will be from the group in administration.

3.5. **Vice Chair** – The Vice Chair will be from the opposition group.

3.6. **Urgent Decisions** – Urgent decisions will be reviewed by the Chair with relevant responsibilities

4. Performance, Finance and Customer Focus Overview and Scrutiny Committee

4.1. Responsibility for -

- Relevant policies in the Plymouth Plan
- Corporate Performance Monitoring
- Financial Performance Monitoring
- Annual Budget Setting Process
- Medium Term Financial Strategy
- Revenues and benefits
- Homelessness
- Communications
- Human resources
- Audit and Risk
- Transformation
- Bereavement Services and Register Office
- Community Safety
- Customer Services
- Street scene and Waste
- Parking

- Hear call-ins relevant to the role of the committee

4.2. Partnership links

- Health and Wellbeing Board
- Safer Plymouth
- Police and Crime Panel

4.3. **Membership** - All members of the Committee will adhere to the general rules of Overview and Scrutiny. There are nine members of the Committee including the Chair and Vice Chair.

4.4. **Chair** – The Chair will be from the opposition group.

4.5. **Vice Chair** – The Vice Chair will be from the group in administration.

4.6. **Urgent Decisions** – Urgent decisions will be reviewed by the Chair with relevant responsibilities

5. Education and Children's Social Care Overview and Scrutiny Committee

5.1. Responsibility for-

- Relevant policies in the Plymouth Plan
- Early Years Services
- Schools, colleges and other educational settings
- Child Poverty
- Special Education Needs, behaviour and attendance, narrowing the gap in outcomes
- Safeguarding Children
- Cared for children
- Youth offending
- Adoption and Fostering
- Corporate Parenting
- Hear call-ins relevant to the role of the committee

5.2. Partnership Links

- Plymouth Safeguarding Children's Board
- Plymouth Education Board
- Health and Wellbeing Board
- Regional Adoption Agency
- Children's Partnership

5.3. Membership - All members of the Committee will adhere to the general rules of Overview and Scrutiny. There are nine members of the Committee including the Chair and Vice Chair.

5.4. **Chair** – The Chair will be from the opposition group.

5.5. **Vice Chair** – The Vice Chair will be from the group in administration.

5.6. **Urgent Decisions** – Urgent decisions will be reviewed by the Chair with relevant responsibilities

6. Health and Adult Social Care Overview and Scrutiny Committee

6.1. Responsibility for -

- Relevant policies in the Plymouth Plan
- Integrated Commissioning
- Hospital and community health services
- dental services, pharmacy and NHS ophthalmic services;
- public health services
- Adult Social Care Services
- Adult Safeguarding Services
- Hear call-ins relevant to the role of the committee

6.2. Statutory Role with regard to undertaking all the statutory functions in accordance with Section 244, of the National Health Act 2006, (as amended by Health and Social Care Act 2012) regulations and guidance under that section.

6.3. Partnership Links

- Health and Wellbeing Board
- Plymouth Safeguarding Adults Board
- Integrated Commissioning Board

6.4. **Membership -** All members of the Committee will adhere to the general rules of Overview and Scrutiny. There are 9 members of the Committee including the Chair and Vice Chair. The Vice Chair is from the opposite political group to the Chair.

6.5. **Chair** – The Chair will be from the group in administration.

6.6. **Vice Chair** – The Vice Chair will be from the opposition group.

6.7. **Urgent Decisions** – Urgent decisions will be reviewed by the Chair with relevant responsibilities

7. Overview and Scrutiny Procedures

Conflicts of interest

7.1. Unless they have a dispensation, members of the Overview and Scrutiny

Committees cannot scrutinise decisions they were involved in taking and must leave the room when these decisions are scrutinised. Before they leave they can make representations and answer questions or give evidence if other members of the public would also have this right.

Procedure when a councillor resigns from a committee

7.2. A Councillor can resign from a Committee by writing to the Monitoring Officer.
7.3. A replacement member will be confirmed at the next Council meeting.

Procedure when a committee member stops being a councillor

7.4. If a Committee member stops being a Councillor, a replacement member will be confirmed at the next full Council meeting.

Co-opted members of overview and scrutiny committees

7.5. Non-voting co-opted members can serve on an Overview and Scrutiny Committees or for a specific policy review.

7.6. Co-opted members cannot vote unless they have the legal right to do so.

7.7. The Overview and Scrutiny Committee that deals with education matters will appoint four (statutory) co-opted members (two parent governor representatives and two church representatives). One of the church representatives will be nominated by the Diocesan Board of Education for the Church of England diocese and the other will be nominated by the Bishop of the Roman Catholic diocese within the area.

Overview and scrutiny committee meetings

7.8. The annual calendar for Overview and Scrutiny Committee meetings is set by Council. If Overview and Scrutiny Committees need to have extra meetings, they set the dates themselves.

7.9. The Chair is responsible for the start times of committees in consultation with the Monitoring Officer.

7.10. The Monitoring Officer or the Overview and Scrutiny Committee Chair can decide to call a special meeting.

7.11. If a Committee has no business at one of its fixed meetings, the Monitoring Officer can cancel it after consulting the chair.

Substitutes, quorum and training

7.12. Members of the Committees can send other Councillors (who must belong to the same political group) as substitutes. Substitutes have the

powers of an ordinary member of the committee.

7.13. Substitutions must be for a whole meeting. A member cannot take over from their substitute or hand over to them part way through a meeting.

7.14. If a member wants to send a substitute, they must inform the Monitoring Officer before the meeting.

7.15. Substitutes cannot appoint substitutes of their own.

7.16. If a Councillor is a member of a Select Committee Review, once the group has started its work, no substitution is allowed.

7.17. The quorum for a meeting is three members

Chairs and vice-chairs of overview and scrutiny committees

7.18. Election of chair and vice-chair

7.19. Chairs and vice-chairs are appointed at the annual meeting of Council.

7.20. Resignation of chair or vice-chair

7.21. If a Councillor wants to resign as chair or vice-chair, they must write to the Monitoring Officer. A new chair or vice-chair will be confirmed at the Committee's next ordinary meeting.

Programme of work

7.22. The Overview and Scrutiny Committees set their own programmes of work. The Committees must also review anything they are asked to review by Council.

Call in

7.23. Items called in will be heard at a meeting of the relevant committee within 10 working days of the end of the call in period relating to that item.

Agenda

7.24. Any Councillor may place any local government matter (other than excluded matters – see below) which is relevant to the functions of the Committee or board on the agenda of a meeting. The Councillor will be invited to attend the meeting at which the item is to be considered and to explain the reasons for the request.

Considering matters

7.25. When considering a local government matter referred by a Councillor, the Committee will decide whether to:

- review or scrutinise a decision taken by the cabinet or cabinet member;
- make a report or recommendation to the Council or cabinet on how cabinet carries out its functions;
- review or scrutinise a decision taken by a Council body other than the cabinet or a cabinet member;
- make a report or recommendation to the Council or the cabinet on how a Council body other than the cabinet carries out its functions;
- make a report or recommendation to the Council or the cabinet on matters which affect the city or the inhabitants of the city;
- take no action.

7.26. The Committee will then report back to the Councillor who raised the local government matter about the decision and the reasons for the decision.

Excluded matters

7.27. The following matters cannot be considered by an Overview and Scrutiny Committee:

- any matter relating to a planning decision;
- any matter relating to a licensing decision;
- any matter relating to an individual or body if s/he/they have, by law, a right to a review or right of appeal ;
- any matter which is vexatious, discriminatory or not reasonable to be included in the agenda for, or to be discussed at, a Committee or board meeting .

7.28. The Monitoring Officer in consultation with the Scrutiny Officer and Chair (or Vice-Chair in the chair's absence) of the relevant Committee will determine whether a matter is an excluded matter.

Speaking on agenda items

7.29. Any member of the public and any Councillor who is not a member of the Committee can speak on an agenda item if the Chair agrees. The Chair will decide how long they can speak for (unless the meeting is for call-in).

Policy review and development

7.30. The overview and scrutiny Committees' role in developing the policy framework and budget is set out in paragraph 1.

7.31. In areas that are not covered by the policy framework and budget, the Overview and Scrutiny Committees can suggest policies for the cabinet or a cabinet member to develop.

7.32. The Overview and Scrutiny Committees can hold inquiries and consider future policy. This may involve appointing advisors, inviting witnesses, making site visits, holding public meetings, commissioning research or doing anything else which is necessary.

Select committee reviews

7.33. Overview and Scrutiny Committees may appoint time limited Select Committee Reviews to undertake pieces of scrutiny work as required and will be time specific.

Requests for reviews from full council

7.34. The Overview and Scrutiny Committees must review anything full Council asks them to review as soon as they can make space in their programme of work.

Requests for reviews from the cabinet

7.35. The Overview and Scrutiny Committees can (but do not have to) review items the Cabinet or a Cabinet Member asks them to review.

Reports on overview and scrutiny reviews

Select committees

7.36. The Overview and Scrutiny Committees may appoint Select Committees to undertake pieces of scrutiny work as required and will be time specific. The Chair of and members of Select Committee can be any member not excluded from scrutiny. Select Committees will be subject to rules of proportionality.

Committee/Select Committee Review report

7.37. At the end of each policy review, the Overview and Scrutiny Committee / Select Committee Review will send the report to the Cabinet or a Cabinet Member (if it is about executive responsibilities) or to Council (if it is about Council responsibilities) or to another organisation, as appropriate.

Minority report

7.38. For each policy review, there can be a minority report giving any dissenting views. The Cabinet, Cabinet Member or Full Council will consider the minority report at the same time as the Committee/ review report.

7.39. Each Overview and Scrutiny Committee / Select Committee Review member can vote for one report but no more than one. The report with the most votes will be the Overview and Scrutiny Committee / Select

Committee Review report.

Timing

7.40. If an Overview and Scrutiny Committee decides to send a report to the Cabinet, a cabinet member or Council:
- the Cabinet must, where practicable, consider it at its next ordinary meeting if it is about executive responsibilities;
- Council must, where practicable, consider it at its next ordinary meeting if it is about Council responsibilities.

Arrangements for cabinet to comment on reports to full council

7.41. When the Overview and Scrutiny Committee sends a report to full Council, the Monitoring Officer will send a copy to the Cabinet/Cabinet Member. Council must consider the Cabinet or cabinet member's comments on anything that affects the policy framework and budget.

Overview and scrutiny members' rights to see documents

7.42. Overview and Scrutiny members' rights to see documents are set out in the Access to Information Rules (see Part F).

Duty of cabinet members and officers to attend overview and scrutiny meetings

7.43. Overview and scrutiny meetings can require members of the Cabinet and senior officers to attend and answer questions about:

- their performance
- decisions they were involved in
- the extent to which they have followed the policy framework and budget

7.44. The Lead Scrutiny Officer will inform the Councillor or officer that they are required to attend, what it is about and whether they need to produce a report or provide papers.

Timing

7.45. The Councillor or officer must be given reasonable time to compile information.

Whipping

7.46. Political groups should not pressure their members over how they speak or vote at Overview and Scrutiny meetings.

Order of business at overview and scrutiny committees

7.47. The overview and scrutiny committee will consider:

- declarations of interest
- minutes
- anything that has been called in
- any Cabinet/Cabinet member's responses to the committee's reports
- anything else on the agenda

7.48. This procedure can be suspended if at least half of all the voting members are present and there is a simple majority in favour. It can only be suspended until the end of a meeting.

Witnesses at overview and scrutiny meetings

7.49. Witnesses should be treated with politeness and respect.

7.50. Witnesses will only be required to attend Scrutiny meetings where the law requires their attendance.

Items affecting more than one overview and scrutiny committee

7.51. If an item affects more than one Overview and Scrutiny Committee, the Chairs and Vice Chairs of the Committees will consider the creation of a Joint Select Committee to review it.

Minutes

7.52. At the first meeting when the minutes are available, the chair will move that the minutes are correct and sign them. The committees will not discuss anything arising from the minutes.

Gaps in these procedures

7.53. If there is a gap in these procedures, the Chair will decide what to do.

Care Quality Commission

University Hospitals Plymouth NHS Trust

Derriford Hospital

Quality Report

Derriford Road
Crownhill
Plymouth
Devon
PL6 8DH
Tel: 01752 202082
Website: www.plymouthhospitals.nhs.uk

Date of inspection visit: 15 April 2019
Date of publication: This is auto-populated when the report is published

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an unannounced focussed inspection of the emergency department at Derriford Hospital on 15 April 2019.

We did not inspect any other core services or wards at this hospital or any other locations provided by the trust. We did visit the day case recovery unit which was being used to provide additional overnight patient accommodation as part of the trust's escalation plan. During this inspection we inspected using our focussed inspection methodology. We did not cover all key lines of enquiry. We did not rate this service at this inspection.

The trust has one emergency department which provides a 24-hour, seven day a week service. It is a designated major trauma centre providing care for the most severely injured trauma patients from across the south west.

Our key findings were as follows,

- There were not enough available beds in the hospital to allow emergency patients to be admitted to a ward as soon as this was required. This had resulted in a crowded emergency department with patients receiving care and treatment in unsuitable environments.
- Initial clinical assessment (triage) of patients did not take place according to guidance produced by the Royal College of Emergency Medicine and the Royal College of Nursing. Self-presenting patients sometimes waited for up to an hour to be triaged. There was a risk serious medical conditions could remain undetected with a consequent delay in treatment.
- Some records of patient observations were not accurate.

However:

- Patients arriving by ambulance were assessed and treated quickly.
- There was a supportive and friendly culture within the department which was centred on the needs of patients.
- Innovative ideas had been used to prevent unnecessary admission to hospital.
- The emergency department had a committed and well-motivated leadership team.

We told the trust they must:

- Reduce crowding in the emergency department so patients do not have to wait on trolleys in unsuitable environments.
- Complete initial assessment (triage) of self-presenting patients in accordance with standards set by royal colleges.
- Accurately record first clinical observations made by emergency department staff.

In addition, the trust should:

- Improve and monitor the speed of response from senior specialist doctors when patients have been referred to them by the emergency department.
- Regularly monitor operational performance in the emergency department at a senior level and record issues, including how these are being addressed.

Professor Edward Baker

Chief Inspector of Hospitals

Care Quality Commission

Derriford Hospital

Detailed findings

Services we looked at
Urgent and emergency services

Detailed findings

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Our inspection team

The team included a CQC inspector, a consultant in emergency medicine and a specialist advisor in emergency nursing.

The inspection was overseen by Mary Cridge, Head of Hospital Inspection.

Urgent and emergency services

Safe	
Responsive	
Well-led	
Overall	

Information about the service

The emergency department (ED) is a designated major trauma centre and sees approximately 100,000 patients a year. It consists of a major treatment area with eleven cubicles and four side rooms, a resuscitation area with facilities for four patients, an ambulance assessment area with three assessment bays and a minor treatment area with four cubicles.

There are separate rooms for mental health assessment, eye examinations and application of plaster casts. A clinical decision unit provides 10 beds for patients who need a short period of observation while awaiting the results of major investigations such as computerised tomography (CT) scans. The unit also has a lounge for patients who are well enough to sit while waiting for test results.

Children have a separate treatment area with five individual treatment rooms and separate waiting areas for small children and adolescents.

We last inspected the emergency department in April 2018 as part of our ongoing inspection programme. The service was rated as requires improvement overall.

Summary of findings

Our key findings were:

- There were not enough available beds in the hospital to allow emergency patients to be admitted to a ward as soon as this was required. This had resulted in a crowded emergency department with patients receiving care and treatment in unsuitable environments.
- Initial clinical assessment (triage) of patients did not take place according to guidance produced by the Royal College of Emergency Medicine and the Royal College of Nursing. Self-presenting patients sometimes waited for up to an hour to be triaged. There was a risk serious medical conditions could remain undetected with a consequent delay in treatment.
- Some records of patient observations were not accurate.

However:

- Patients arriving by ambulance were assessed and treated quickly.
- There was a supportive and friendly culture within the department which was centred on the needs of patients.
- Innovative ideas had been used to prevent unnecessary admission to hospital.
- The emergency department had a committed and well-motivated leadership team.

Urgent and emergency services

Are urgent and emergency services safe?

As this was a focused inspection we have not inspected the whole of this key question. Therefore, there is no rating.

Environment and equipment

- The department had recently undergone a major refurbishment programme with newly built children's facilities, resuscitation area and ambulance assessment area. The latter was also known as the FLIC (front-loaded initial consultation) area and had opened four weeks before our inspection.
- The children's treatment area had secure access and ensured children were not exposed to the disturbing sights and sounds that sometimes occur in an adult emergency department.
- Senior staff had improved the medicines preparation areas since our last inspection. All were now secure and separate from patient areas.
- Most areas of the department had been designed to ensure staff had good visibility of patients. The exceptions were the four side rooms in the major treatment area which were used for patients with potentially infectious illnesses. Staffing levels for this area had been adjusted to ensure frequent observation of patients.
- Due to poor patient flow though the department there were not always enough cubicles or rooms for adult patients. As a result, some patients had to wait on trolleys in an open area in the centre of the department.
- As the department became busier trolleys were placed in a row with no space between them. It was difficult for nurses to reach some patients to undertake observations of vital signs, such as blood pressure and pulse rate.
- In the late evening during our inspection there was no room left in the centre of the department and one patient had to be placed next to the staff base. These areas were cramped, busy and noisy and did not provide a therapeutic environment for emergency patients.
- If it was not possible to move patients out of the ambulance assessment area, newly arrived ambulance patients sometimes waited in the central area. However, they had been fully assessed by an experienced nurse, had normal vital signs and were not in pain.
- All patients in the central area were observed by clinical staff at all times. Patients told us staff had explained why they were waiting there. Some of them felt uncomfortable in the area but they accepted ED staff were doing all they could to improve the situation.
- Although most patients were in the central area for less than an hour, some patients had to wait two or three hours before they could be moved to a ward. If they required further treatment or intimate care they were moved temporarily into a curtained cubicle.
- There was a designated room for seeing patients who required a mental health assessment. This had recently been modernised so it met the Psychiatric Liaison Accreditation Network quality standard requirements.
- An adjacent imaging department provided X-rays and scans. The department had its own CT (computed tomography) scanner next to the resuscitation area.
- We checked a range of specialist equipment, including adult and children's resuscitation equipment. It was clean, tamper-evident, clearly organised and well maintained. It had been checked daily to ensure it was ready for use.

Assessing and responding to patient risk

- Patients arriving by ambulance as a priority (blue light) call were taken immediately to the resuscitation area. These patients were phoned through in advance so an appropriate team could be alerted and prepared for the arrival.
- Other patients arriving by ambulance were assessed by an experienced nurse as soon as they arrived. The assessment was needed to determine the severity of illness or injury and to prioritise the speed and type of treatment required. This is often known as triage.

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- Patients who walked into the department, or who were brought by families or friends, reported to the reception desk.Once initial details had been recorded patients were asked to sit in the waiting room while they waited to be assessed by a nurse.
- We observed the initial assessment of four patients (with their consent) and found it to be thorough and methodical. The nurse had completed training in triage and had been assessed as competent before undertaking the role.
- The triage process did not fully comply with standards set by the Royal College of Emergency Medicine and the Royal College of Nursing. These state " and should normally require less than 5 minutes contact". During our inspection the assessment often took 10 minutes to complete, which delayed other patients who were frequently arriving in the department, and some patients waited up to an hour for triage.
- During our inspection there were 14 patients waiting to be triaged at 7pm. None of them were assessed within 15 minutes. We observed four patients in detail. They waited between 48 and 58 minutes to be triaged and there was a risk their condition could deteriorate in this time. One patient was found to have a very low blood pressure and required immediate medical treatment. The matron was aware of this problem and was developing plans to change the assessment process.
- The National Early Warning Score (NEWS2) was used for adults. This was a quick and systematic way of identifying patients who were at risk of deteriorating. Clinical observations such as blood pressure, heart rate and respirations were recorded and contributed to a total score. Once a certain score was reached a clear escalation of treatment was commenced. We reviewed the NEWS charts of 21 patients and found all but two had patients had been monitored according to best clinical practice. However, delays in the triage of patients meant the first calculation of the NEWS was not always done quickly enough and opportunities for identifying deteriorating patients were potentially missed.
- Paediatric early warning scores (PEWS) were used for children. Different methods of scoring were used for different ages of children in accordance with best practice. Only two children required PEWS when we inspected the children's treatment area. However, both had been calculated correctly.
- If a patient had an early warning score of five or more, they were screened for sepsis (a critical medical condition resulting from a serious infection). We looked at the records of three patients with high scores and found they had all been screened correctly.
- Nurses in the department used a patient safety checklist. This was aimed at reminding nursing staff to undertake two-hourly safety checks of all patients in the major treatment area. We looked at the safety checklists of seven patients who had been in the department for four hours or more. Five of the seven checklists had been fully completed.
- The monthly records audit for March 2019 showed 91% of safety checklists had been completed correctly.
- Nursing staff told us there were new risk assessments for patients who attended as the result of a fall.We reviewed the records of two patients and found both had been assessed for the risk of further falls. Nurses had increased the frequency of observation to help reduce the risk.
- Risk assessments had taken place before patients were placed in the centre of the department. Most had been treated by an emergency department doctor, their condition was stable, and they were waiting to be admitted to a ward.

Records

- When ambulance patients arrived, emergency department staff would record the last set of vital sign observations made by the ambulance service. However, on the patient's record, they did not make it clear when the observations had been taken, or by whom. Therefore, it appeared the observations had been recorded during the initial assessment on arrival at the emergency department. This was misleading and was likely to lead to a delay in further observations of vital signs. We observed the same

Urgent and emergency services

practice during our last inspection in April 2018. We brought this to the attention of ED staff at the time and an action plan was put in place. However, very little improvement had taken place.

- We reviewed 21 patient records in total. All other aspects of the records were written and managed in a way that kept patients safe.

Nursing staffing

- A review of nurse staffing levels had been undertaken in 2018 although it was not clear whether an evidence-based staffing tool had been used. The review indicated 13 registered nurses were needed during the day and 11 at night.
- We reviewed staff levels for a random selection of nine days and nights between 9 January and 26 March 2019 and found these staffing levels had been achieved.
- The children's treatment area was separately staffed. There had been an increase in registered children's nurses employed by the department. Planned paediatric nurse staffing levels were increased in line with recommendations from the royal college at the beginning of September 2018. From the beginning of March 2019 this had been achieved, and there had always been a minimum of two registered children nurses on duty. This met guidance contained in the intercollegiate standards for children in emergency settings.
- Following a recent recruitment exercise there were very few vacancies for nursing staff. This meant the department did not have to employ temporary agency nurses.

Medical staffing

- There was a consultant in the department from 8am to midnight, seven days a week. There were two consultants in the department until 10pm.
- We looked at the rota for the month before our inspection and saw, when there were no consultants in the department, there was a senior middle grade (ST4 or above) on duty. For most nights there were two senior middle grade doctors in the department. There was a consultant on-call from home at night.
- Junior doctors spoke positively about working in the emergency department. They told us the consultants were supportive and accessible. There had been a well-organised induction programme. In-house teaching took place twice a week and was comprehensive and well organised.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

As this was a focused inspection we have not inspected the whole of this key question. Therefore, there is no rating.

Access and flow

- There were not enough available beds in the hospital to allow emergency patients to be admitted to a ward as soon as a bed was required. When we arrived, there were six patients lined up in the centre of the major treatment area, waiting to be admitted to a ward.
- Throughout our inspection there were never less than five patients in this space and by 7pm there were 10 patients. Most were waiting to be admitted to a ward, but no beds were available.
- There were arrangements in place to try and reduce the crowding in the department. For example, patients who had been urgently referred to specialist doctors by their GP went directly to a special assessment unit. However, by 4pm we found this unit was full and not able to accept any further patients. The result of this was that these patients were sent to the emergency department where they sometimes waited for several hours. ED staff told us the assessment units were often full by the middle of the afternoon.
- Low-risk patients waiting for a specialist doctor sometimes waited in the clinical decision unit. We observed a patient who had been waiting there for three hours to see a maxillo-facial surgeon (mouth, jaw, face and neck specialist). Nursing staff could not say how much longer the patient would have to wait.
- After assessment in the FLIC (front-loaded initial consultation) area, doctors could send frail and complex patients directly to the frailty unit. This was staffed by a multi-disciplinary team who worked closely with community teams to enable frail patients to be treated at home if it was safe to do so.

Urgent and emergency services

- There was an ambulatory emergency care (AEC) unit which provided urgent day case medical treatment. This helped to prevent unnecessary admission to a ward for patients with straightforward illnesses that could be treated quickly. The unit was open from 8am-8pm five days a week.
- The frailty and AEC units had a dedicated transport service that ensured patients could be brought back to the hospital at specific times if they needed follow-up treatment or urgent appointments. It also allowed frail patients to be returned home quickly so home support could be co-ordinated more effectively.
- The emergency department had a patient flow co-ordinator who monitored the progress of patients in the emergency department and made sure they did not “get lost in the system”. The co-ordinator informed clinical staff when the results of investigations had been received or if there were delays in admission to a ward.
- The Department of Health’s emergency access standard is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. Despite many initiatives, the trust had been unable to meet this standard since November 2016. During our inspection some patients had been in the department for up to nine hours. Most had been seen and treated by ED staff within one hour. Delays started to occur when they needed further specialist treatment or required admission to a ward. Once a senior doctor ED had decided that a patient needed further specialist treatment, the patient would be transferred to an assessment unit. However, the assessment units were often full and so referred patients had to wait in the emergency department.
- Figures from NHS England showed from January to March 2019, 64.4% of patients were admitted or discharged within four hours. This was worse than the national average of 77.2% for similar types of emergency departments. However, there had been gradual improvements during that period and 78.3% of patients spent less than 4 hours in the department in March 2019.
- The same figures showed the reasons for most delays were for patients waiting to be admitted to a ward. However, very few patients had waited more than 12 hours to be admitted.
- We attended a bed management meeting at 5pm where senior hospital managers made arrangement for the admission of patients to the hospital. Although they could identify empty beds for six of the patients waiting in the emergency department, the beds were not immediately available. It was not clear when the patients would be moved to a ward or where the remaining patients waiting in the emergency department would be treated.
- The bed management team used the national Operational Pressures Escalation system (OPEL). We were told the hospital was on Operational Pressures Escalation Level (OPEL) three. This refers to the number of beds available in the hospital and the number of patients needing to be admitted. OPEL provides a nationally consistent set of escalation levels, triggers and protocols for hospitals and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL 1: The local health and social care system capacity is such that organisations can maintain patient flow and are able to meet anticipated demand within available resources, to OPEL 4: Pressure in the local health and social care system continues to escalate, leaving organisations unable to deliver comprehensive care.
- The actions to be considered at OPEL 3 status include “Enact process of cancelling day cases and staffing day beds overnight if appropriate” and “Active management of elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases”.
- The trust’s escalation plan included the use of the day case operating theatres recovery area as additional overnight patient accommodation. The recovery area had room for 14 patients, and a maximum of 10 spaces initially could be used for overnight patients, with further escalation to 14 patients in the event of OPEL 4 status. The bed management team decided to put this part of the plan into action in order to allow patients in the emergency department to be admitted

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to a ward. Managers told us patients were selected to be moved to this temporary ward area according to agreed safety criteria. Most were due to be discharged from hospital in the next 24 hours.

- We were later told that discussion about reducing the next day's planned admissions would not take place until the following morning.
- Senior ED staff attended the bed management meeting. They reported that they had not been able to transfer patients to the medical assessment unit (MAU) for the previous two hours. There were currently six patients waiting to be transferred to the MAU. The bed management team decided that extra resources should be deployed to the unit to help with this problem.
- However, by 7pm the ED had still not been able to transfer any patients to the MAU. There were now 12 patients waiting to go there. We asked the hospital site manager why the extra resources had not helped the situation. We were told a consultant physician had been needed to decide which patients could go home and which needed to be transferred to specialist wards. It had taken longer than expected to find the consultant and so no patients had yet been moved out of the unit. The site manger had not been told why the consultant had not been available earlier in the day.

Are urgent and emergency services well-led?

As this was a focused inspection we have not inspected the whole of this key question. Therefore, there is no rating.

Vision and strategy for this service

- The leadership team were united in their aim to improve patient flow through the department. By reducing crowding in the department, they hoped to improve patient safety, the quality of treatment and staff satisfaction. They recognised there needed to be enhanced co-operation with other hospital teams to achieve this aim.
- The team wanted to make the service more patient centred and had created the concept of a "Hot Floor". This consisted of the emergency department (ED), the clinical decision unit, the medical assessment unit and the acute assessment unit (Ambulatory Emergency Care, Frailty Service, urgent treatment clinics and GP-led primary care). In order to bring these services together a Hot Floor Board had been formed, and was led by the lead clinician for ED.

Leadership of service

- The emergency department had a well-motivated leadership team. This consisted of the lead clinician, matron and two associate managers. Staff told us they trusted the leadership team and knew they would be listened to if they raised concerns. They thought leaders had the skills, knowledge, integrity and experience needed for their roles.
- Day-to-day leadership of the department was provided by the emergency physician in charge and the nurse-in-charge. They both had an overview of all patients in the department. We observed them supporting junior staff, leading the treatment of the sickest patients and dealing with the more complex situations that arose
- The clinical lead reported consistent support from the trust's chief operating officer and chief executive. For example, they had led an initiative to reduce the number of delayed patient discharges from the hospital. This had helped to increase the number of beds available on the wards for emergency patients.

Governance, risk management and quality measurement

- There was a well-structured clinical governance system in place with the production of information about the department's clinical quality performance. This was discussed at monthly governance and safety meetings and used to demonstrate effectiveness and progress. Items such as quality indicators, risks, incidents, lessons learnt, complaints, compliments and clinical audits were discussed.
- A safety newsletter was produced every two weeks to highlight clinical safety successes and problems. Plans to address any problems were described so staff were aware when clinical practice needed to change.

Urgent and emergency services

- We were told a consultant reviewed all deaths in the department and monthly mortality and morbidity meetings were held. Any issues arising were discussed during governance and safety meetings.
- Senior staff were aware of the risks in the emergency department and these were described on a risk register. The highest risk was a crowded department. It had been recognised many things contributed to this and so a separate 'crowding' risk register had been created. One of the consultants had responsibility for the risk registers. However, they were not present in the department when we inspected and so we were not able see the registers.
- We could not be certain operational performance was regularly monitored or how any weaknesses were addressed. Although the leadership team had an awareness of operational performance issues such as delays for triage and admission, the time taken during the handover of ambulance patients and the speed of urgent brain scans, they did not appear to be regularly monitored. We were told performance meetings were held but no minutes could be found during our inspection. Minutes of the most recent Hot Floor Board meeting (April 2019) stated performance metrics needed to be agreed.

Culture within the service

- There was a supportive and friendly culture within the department which was centred on the needs of patients. Staff formed a close-knit team who took pride in the care and treatment they gave to their patients.
- Attention to staff development was a feature of the department. Senior medical and nursing staff had specific responsibility for teaching and skills development and devoted a lot of time to it. This was appreciated by the staff we spoke with.
- There was a well-established wellbeing programme. This included a welcome pack for new staff and a champion of the week who was nominated by ED but did not necessarily need to be an ED employee. There were "away-day weekends", informal outings, and events were organised to support the ED charity of the year. The department had a private social media group as well as a page for learning. The wellbeing programme also included links to other activities such as yoga, walking and many other fitness, social and health groups. The programme featured strongly in feedback from the junior doctors we spoke with. They regarded it as an important aspect of working in the ED where the working life was invariably pressured.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- Reduce crowding in the emergency department so patients do not have to wait on trolley in unsuitable environments.
- Complete initial assessment (triage) of self-presenting patients in a timely fashion and in accordance with standards set by royal colleges.
- Accurately record first clinical observations made by emergency department staff.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- Improve and monitor the speed of response from senior specialist doctors when patients have been referred to them by the emergency department.
- Regularly monitor operational performance in the emergency department at a senior level and record issues, including how these are being addressed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.** 12(1) Care and treatment must be provided in a safe way for service users. Patients' clinical conditions were not always risk assessed in a timely fashion. For example, self-presenting patients were not triaged in line with national guidance when they arrived in the emergency department. Crowding in the emergency department meant patients had to wait on trolleys or beds in unsuitable environments.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance.** 17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements of this Part. When ambulance patients arrived, emergency department staff recorded the last set of vital sign observations made by the ambulance service. However, on the patient's record, it was unclear when the observations had been taken, or by whom.

This section is primarily information for the provider

Requirement notices

Therefore, it appeared the observations had been recorded during the initial assessment on arrival at the emergency department. This was misleading and there was a risk it could lead to a delay in further observations of vital signs.

SUMMARY REPORT

Health and Adult Social Care Overview and Scrutiny Committee

19 June 2019

Subject	**Disabled Car Parking**
Prepared by	Director of Estates and Facilities
Approved by	Director of Site Services & Deputy Chief Executive
Presented by	Chief Executive

Purpose

To provide a briefing to the Committee on disabled car parking at University Hospitals Plymouth.

Decision	
Approval	
Information	●
Assurance	

Corporate Objectives

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

Executive Summary

1. The Trust currently has 101 disabled parking bays located on the main Derriford Hospital site. This represents just short of 6% of the total car parking capacity on the hospital. According to the Trust's Estates Return Information Collection (ERIC), the total and disabled car parking capacity has changed as follows:

	Total Spaces (Derriford Main Site)	Disabled Spaces	% Disabled Spaces
2011/12	2980	60	2.01%
2012/13	2980	94	3.15%
2013/14	2521	95	3.77%
2014/15	1661	69	4.15%
2015/16	1777	119	6.70%
2016/17	1795	127	7.08%
2017/18	1780	104	5.84%
2018/19	1744	101	5.79%

2. Of the 1744 total spaces, 1,100 are allocated to Public and Visitor parking, of which 99 are disabled spaces. Therefore 9% of the Public and Visitor parking capacity is dedicated for disabled users.

3. In 2015, the Trust invested £623k to create a dedicated disabled car park which is located adjacent to the main Outpatients Department. This provided the increase in capacity shown in the Table above. The car park was originally designed to provide 48 spaces, but following the development of the Bus Interchange scheme in 2017, the Trust lost spaces located on the entrance road adjacent to the main Outpatients Department. Some of these were re-provided in the disabled car park.

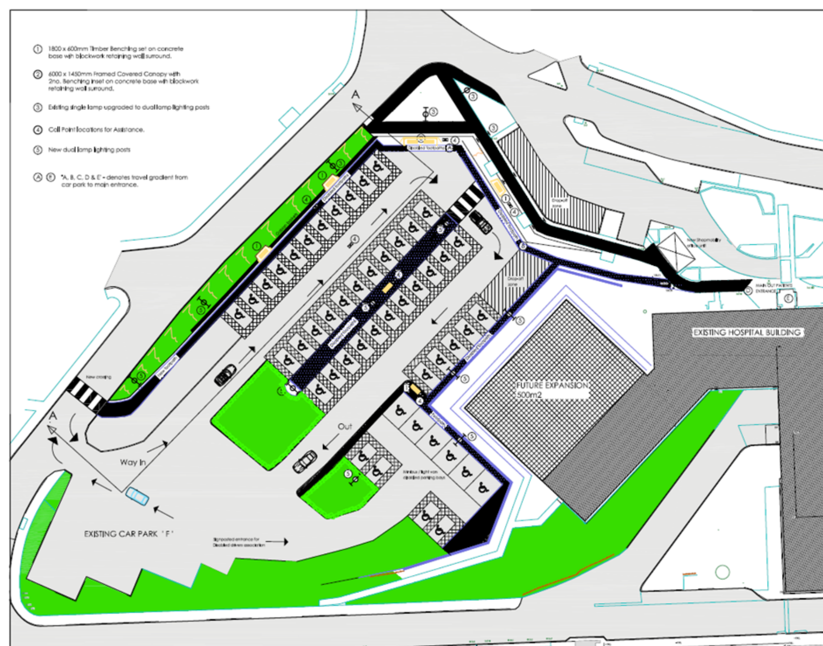
4. The dedicated disabled car park now contains 63 spaces. In order to fund this development, the Trust charges for disabled parking in this car park. In order to provide a reasonable adjustment to disabled car park users, the Trust offers 1 hour of free parking, compared to standard tariff:

Time	Standard Tariff	Disabled Car Park Tariff
0 – 15 mins	Free	Free
15 mins – 1 hour	£1.20	Free
1 – 2 hours	£2.40	£1.20
2 – 3 hours	£3.60	£2.40
3 – 4 hours	£4.80	£3.60
4 – 5 hours	£6.00	£4.80
5 – 6 hours	£7.20	£6.00
6 – 7 hours	£12.00	£7.20
Over 7 hours	£12.00	£12.00

5. Outside of the Disabled Car Park, the Trust offers visitors and patients who display a Blue Badge free parking for a maximum of 4 hours in any disabled or standard space within a non-barrier controlled car park. Blue Badge holders may also park in standard spaces within a barrier controlled car park, however under these circumstances they must they pay the standard tariff.

6. Staff who hold a Blue Badge are automatically granted a permit on application for one of the Trust's on site car parks. Depending on the nature of their disability, individual arrangements are put in place in terms of the car park or other location where these staff members park.

7. The disabled car park was designed working with a range of local organisations who represented a variety of views and needs. This included HealthWatch Plymouth, Plymouth Area Disabled Access Network (PADAN), and Plymouth Wheelchair Users Service Group (PWUSG). The original design is shown below.



8. The final design included a number of features that came out of the consultation, including:

- The use of a ticketless system to support those with upper body mobility limitations. The final system was based on the use of Automatic Number Plate Recognition (ANPR) on entry and exit. Payment is via machines which have been designed to be wheelchair friendly, or through the car parking desk in the main concourse.
- Rest points located along the route to the hospital entrance, and pedestrian routes through the car park that are suitable for wheelchair uses, or those using mobility buggies.
- Limited gradients that allow disabled people to access the main entrance from the car park on virtually level ground. This was challenging given the topography of the Derriford site.

9. In late 2017 the Trust relocated the Orthopaedic Outpatients Department into a modular building at the lower end of the disabled car park. This allowed the Trust to create a dedicated Acute Assessment Unit which is co-located next to the Emergency Department.

10. During construction, the barriers to the disabled car park were removed, and the access roadway realigned. During the construction period, free parking for disabled users has been provided.

11. The current ANPR system has not functioned well since being taken out of commission. Over the past 12 months the barriers have not been operational for approximately half of the time. During periods when the barriers are not functioning, they are left in the open position, and free parking is provided. The Trust is currently working with the equipment provider to rectify the issues, although these may require partial replacement.

12. The occupancy of the disabled car park is monitored by the Trust's car parking provider, Saba. During the week, occupancy is typically 85%, however there are periods when the car park is full. Saba carry out period checks on the blue badges being displayed.

13. Also in 2017, the Trust established a temporary Mobility Centre and buggy service to support the closure of the drop off area outside the main entrance as part of the Bus Interchange scheme. This was funded by the Trust and delivered by Saba. The service proved very popular, and in order to sustain it, the Trust has sought to make it volunteer led. The Trust has now recruited volunteer drivers, and once the buggy has been replaced, the service will recommence.

14. In August 2018 the Trust Board approved the updated Site Development Plan. Within this plan, the need to separate elective and emergency care was identified (in line with the NHS Long Term Plan), and a potential solution was outlined. This solution is based on the extension of the hospital building to the West, which would include the site of the disabled car park. If such a development were to take place then alternative disabled car parking provision would clearly be required, and would form part of the development brief.

15. Finally, there have been 115 contacts through PALS and 6 complaints that relate to parking since April 2018. In terms of themes the key issues raised are:

- Requests for parking refunds associated with cancelled or over-running appointments (31)
- Complaints and concerns about parking charges and Penalty Charge Notices (28)
- Parking capacity and delays to accessing car parks (17)
- Disabled parking capacity (12)
- Access times and availability of the Mobility Service (8)
- Inconsiderate parking by others (7)
- Issues relating to access to the site and drop off areas (6)
- Staff attitude (5)
- Disabled parking charges (3)

Quality Impact Assessment

There are no direct Quality Impacts associated with this briefing paper. As background context (from the Office for Disability Issues):

- General demographics:
    - There are over eleven million people with a limiting long term illness, impairment or disability in Great Britain.
    - In Great Britain, the most commonly-reported impairments are those that affect mobility, lifting or carrying.
    - The prevalence of disability rises with age. Around 6% of children are disabled, compared to 16% of working age adults and 45% of adults over State Pension age in Great Britain.
- Living standards:
    - A substantially higher proportion of individuals who live in families with disabled members live in poverty, compared to individuals who live in families where no one is disabled.
    - 19% of individuals in families with at least one disabled member live in relative income poverty, on a Before Housing Costs basis, compared to 15% of individuals in families with no disabled member.
    - 21% of children in families with at least one disabled member are in poverty, a significantly higher proportion than the 16% of children in families with no disabled member.
- Transport:
    - Around a fifth of disabled people report having difficulties related to their impairment or disability in accessing transport.
- Additionally, due to their disability, blue badge holders may require more frequent attendance at hospital than the general population, leading to increase cost of attendance for this group of patients.
- Hospital appointments for those that hold a blue badge may also take longer than the general population, due to issues associated with mobility. This could lead to increase cost of attendance for this group of patients.
- All patients are eligible for assistance with travel costs associated with hospital appointments and treatment through The Healthcare Travel Costs Scheme (funded separately by the CCG). Patients can receive support if the patient of their partner:
    - Receive Income Support
    - Receive Income-based Jobseeker’s Allowance
    - Receive Income-related Employment and Support Allowance
    - Receive Pension Credit Guarantee Credit
    - Are named on, or entitled to a NHS tax credit exemption certificate
    - Have a low income and are named on certificate HC2 (full help) or HC3 (limited help)
    - Are awarded Universal Credit
- This assistance extends to hospital parking charges, which may be reclaimed through the Cashiers Office. Therefore Blue Badge holders are equally entitled to means tested support which covers the cost of any car parking.

Financial Impact Assessment

There are no direct Financial Impacts associated with this briefing paper.

The Trust has previously invested £623k of capital to create a dedicated disabled car park.

Regulatory Impact Assessment

There are no direct Regulatory Impacts associated with this briefing paper.

According to the House of Commons Library Briefing Paper Number CBP 1360 (16 August 2018), Blue Badges and parking for disabled people in England:

- In terms of disabled parking provision at hospitals, NHS Hospital Trusts and Foundation Trusts are responsible for setting their own car parking policies and schemes for patients, visitors and staff. They are not currently required under law to make exemptions (e.g. for Blue bade holders). In October 2015 the Department of Health published updated non-mandatory guidelines on NHS patient, visitor and staff car parking principles, recommending the provision of concessions to groups that need them, such as disabled people.
- The Government's non-statutory Manual for Streets, published in 2007, advises that spaces for disabled people "need to be properly marked and meet the minimum space requirements":
    - It is preferable to provide these spaces in unallocated areas, including on-street, as it is not normally possible to identify which properties will be occupied by or visited by disabled people. It is recommended that spaces for disabled people are generally located as close as possible to building entrances. In the absence of any specific local policies, it is recommended that 5% of residential car-parking spaces are designated for use by disabled people. A higher percentage is likely to be necessary where there are proportionally more older residents. Local authorities should provide spaces on the basis of demand.
- Traffic Advisory Leaflet 5/95, published in 1995, states that on-street and off-street parking spaces for disabled people should not be further than 150 metres from major destinations (e.g. banks, Post Office, supermarket) for the visually impaired and wheelchair users; 100 metres for those who are ambulatory without a walking aid and not more than 50 metres for stick users.
- For off-street car parks whose primary purpose is shopping, recreation and leisure [the requirements are slightly lower for car parks for employees and visitors to business premises], the minimum number of disabled parking spaces is:
    - for car parks with less than 200 spaces: 3 bays or 6% of total capacity, whichever is greater; and
    - for car parks with over 200 spaces: 4 bays plus 4% of total capacity.
- In terms of the relevant dimensions for disabled parking spaces, the requirements are as follows:
    - On-street parking parallel to the kerb: within the marked parking space, a clear rectangular space should be provided, which is a minimum of 6600 mm long by 2700 mm wide (preferably 3600 mm). The extra width allows for an access zone on kerb or street side;
    - On-street parking at an angle to the kerb: the parking space should be a minimum of 4200 mm long by 3600 mm wide. It is recommended that kerbside parking bays should be sited where road gradient and camber are reasonably level, e.g. 1:50; and
    - Off-street parking: bays should be a minimum of 4800 mm long by 2400 mm wide with additional space: (1) where bays are parallel to the access aisle and access is available from the side an extra length of at least 1800mm, or (2) where bays are perpendicular to the access aisle, an additional width of at least 1200 mm along each side. Where bays are adjacent the same 1200 mm space can serve both sides. There should also be a 1200 mm wide safety zone at the vehicle access end of each bay to provide boot access or for use of a rear hoist.
- The requirements insofar as they relate to on-street parallel parking spaces only are also set out in legislation.

Equality and Diversity Impact Assessment

There are no direct Equality and Diversity Impacts associated with this briefing paper.

The provision of disabled car parking spaces, and access is covered through the Equality Act, with which the Trust must comply.

Environment & Sustainability Impact Assessment

There are no direct Environment and Sustainability Impacts associated with this briefing paper.

Key Recommendations

The Trust Committee is asked to:

1. Note the contents of this report.

Next Steps

None.

A LONG-TERM PLAN FOR DEVON

Health and Adult Social Care Overview and Scrutiny Committee

Date:	19 June 2019
Title of Report:	A Long-Term Plan (LTP) for Devon
Contact Email:	ross.jago@nhs.net
Your Reference:	LTP1 POSC
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report

On the 7 January the NHS long term plan was launched. The Plan set out how the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting. It also expressed the action the NHS will take to –

- strengthen its contribution to prevention and health inequalities,
- improve care quality and outcomes,
- tackle current workforce pressures and support staff
- upgrade technology and digitally enabled care across the NHS.
- put the NHS back onto a sustainable financial path.

The purpose of this agenda item is to discuss and influence the local response to the NHS Long Term Plan.

Recommendations and Reasons

That the Committee -

1. notes the progress to date and the proposed process, timescales, materials and levels of engagement for the development of Devon's Long-Term Plan;
2. endorses the robustness of the process before the engagement starts;
3. programmes additional consideration on the committee's work programme.

Alternative options considered and rejected

None.
Preparation of a local response to the long-term plan is a requirement upon the NHS.

Relevance to the Corporate Plan and/or the Plymouth Plan

By working with the health and care system to maintain oversight of the development and implementation of the Long Term Plan the committee is supporting the Democratic and Co-operative values of the Plymouth City Council, alongside objectives in the "Healthy City" Chapter of the Plymouth Plan.

Implications for the Medium Term Financial Plan and Resource Implications:
This update does not give notice of any required decision which may require expenditure or resource allocation.

Carbon Footprint (Environmental) Implications:
None arising from this report.

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:
None arising from this report.

Appendices

Ref.	Title of Appendix	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	**2**	**3**	**4**	**5**	**6**	**7**
A	Briefing report (mandatory)							

Background papers:

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are unpublished works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of background paper(s)	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	**2**	**3**	**4**	**5**	**6**	**7**

Sign off:

Fin	N/A	Leg	N/A	Mon Off	N/A	HR	N/A	Assets	N/A	Strat Proc	N/A
Originating Senior Leadership Team member: Penny Harris, Director of Strategy (NHS Devon)											

PLYMOUTH CITY COUNCIL

Devon
Clinical Commissioning Group

A LONG-TERM PLAN FOR DEVON

Recommendation

That the Committee -

1. notes the progress to date and the proposed process, timescales, materials and levels of engagement for the development of Devon's Long-Term Plan;
2. endorses the robustness of the process before the engagement starts;
3. programmes additional consideration on the committee's work programme.

1. Purpose

1.1 On the 7 January the NHS long term plan was launched. The Plan set out how the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting. It also expressed the action the NHS will take to –

- strengthen its contribution to prevention and health inequalities,
- improve care quality and outcomes,
- tackle current workforce pressures and support staff
- upgrade technology and digitally enabled care across the NHS.
- put the NHS back onto a sustainable financial path.

1.2 The purpose of this agenda item is to discuss and influence the local response to the NHS Long Term Plan.

1.3 Plymouth City Council, its Councillors and officers, are key partners in shaping and delivering Devon's system plan. The broadened scope of this NHS Long Term Plan, particularly in seeking to strengthen action on prevention and inequalities, provides real opportunities for councillor contribution. This in turn can ensure a clear and credible plan that councillors feel not only takes account of the needs of the communities they represent, but also how they can contribute to improving population health and well-being and the delivery of health and care services in Devon. In doing this the plan is to engage all Councils across Devon, the public and the voluntary sector. This has been built into the process described in this paper.

2. A description of the overall process and timescale

2.1 As a reminder The NHS Long Term Plan, published in January 2019 sets out how the NHS will:

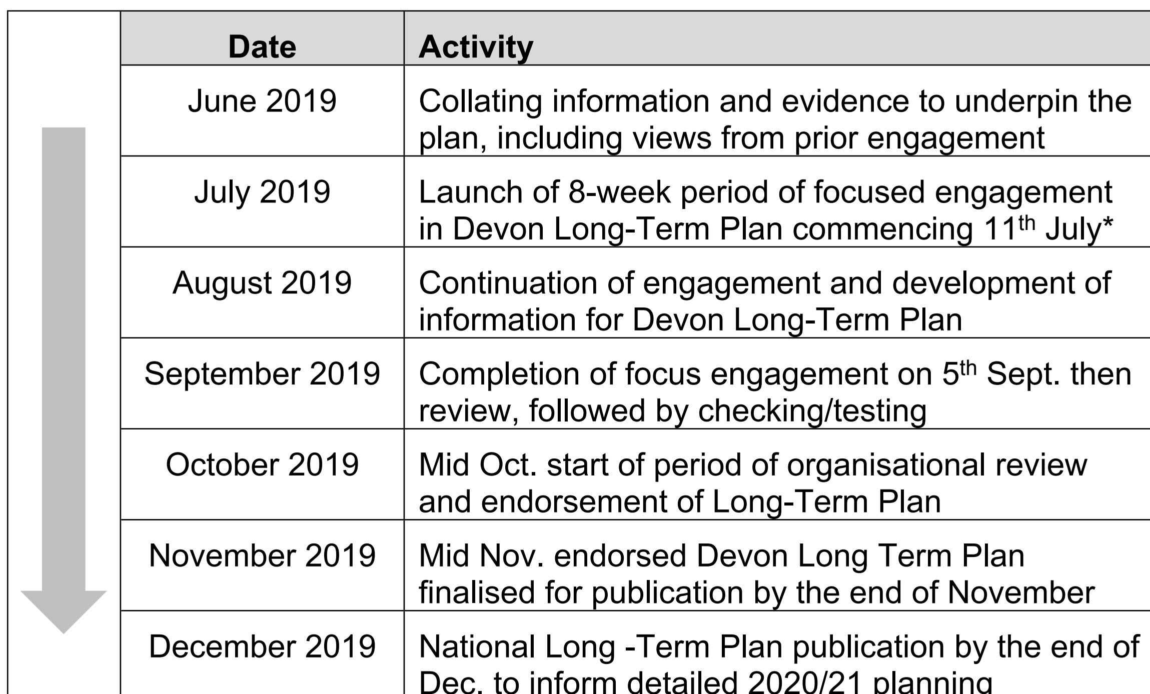
- Move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting
- Strengthen its contribution to prevention and health inequalities
- Improve care quality and outcomes
- Tackle current workforce pressures and support staff
- Upgrade technology and introduce digitally enabled care across the NHS
- Put the NHS back onto a sustainable financial path
- Support every system to become an Integrated Care System by April 2021

2.2 Each system (current Sustainability and Transformation Partnership area) is expected to develop its plan by autumn 2019. National planning guidance is expected to be published soon setting out the framework and timescales for development and submission of local system plans. Therefore, the following sections are indicative at this stage.

2.3 The process as outlined below is designed to ensure that our local system plan is developed through:

- Involving local communities and delivery partners in its development
- Using evidence of population need to inform priorities and targeted action
- Building upon the existing agreed system plans and strategies
- Defining how outcomes will be delivered and how local and national good practice initiatives will be adopted consistently across the system
- Outlining how financial stability and sustainability will be achieved.

2.4 The overarching timescale for developing Devon's Long-Term Plan is set out in the table below.



Date	Activity
June 2019	Collating information and evidence to underpin the plan, including views from prior engagement
July 2019	Launch of 8-week period of focused engagement in Devon Long-Term Plan commencing 11th July*
August 2019	Continuation of engagement and development of information for Devon Long-Term Plan
September 2019	Completion of focus engagement on 5th Sept. then review, followed by checking/testing
October 2019	Mid Oct. start of period of organisational review and endorsement of Long-Term Plan
November 2019	Mid Nov. endorsed Devon Long Term Plan finalised for publication by the end of November
December 2019	National Long -Term Plan publication by the end of Dec. to inform detailed 2020/21 planning

2.5 The development of the Long-Term Plan timeline is aligned with essential work to agree common Health and Wellbeing themes and priorities across Plymouth, Devon and Torbay. The three Health and Wellbeing Strategies (the *Plymouth Plan Part 1* in Plymouth) are key documents that evidence population need and are the building blocks

of our Long-Term Plan. This incorporates population health and wellbeing priorities into the plan from the start.

2.6 The overall process is effectively broken down into the following phases:

Phase 1: Preparation and set up: This has included establishing the team and governance arrangements for the Long-Term Plan as well as early briefings and engagement with organisations and key stakeholders.

Phase 2: Developing the evidence base: Building on information and work already undertaken, actions are underway to ensure a strong evidence base for the Long-Term Plan including:

- Current and projected health needs of the whole Devon population and the key health challenges
- A review of prior engagement and messages from the forthcoming engagement to ensure the voices of local people in the plan
- An assessment of health and care demand, how this may change within the life of the Long-Term Plan and key points for attention
- A baseline review to check the maturity of current strategies, plans and performance in the context of the new Long-Term Plan requirements
- An outline of best practice locally and in other areas and opportunities to be explored further for the Long-Term Plan
- A description of constraints and opportunities in relation to finance, workforce, digital and other key resources for a sustainable plan

Phase 3: Engagement and co-creation: With a clear purpose to engage in the key topics in the NHS Long Term Plan and to consider the challenges and opportunities to address the local priorities for health, wellbeing and care. The plan for this phase is described in more detail in the section below. As shown in the timeline, focused engagement for the Long-Term Plan will commence in July 2019.

Phase 4: Developing the plan: The plan development will take account of the national requirements, the evidence base and messages from local engagement as described above. It is expected that the national Long-Term Plan framework will set out foundation NHS priority areas to be addressed in plans in the next two years, which indicatively are:

- Person-centred care
- Primary care networks
- Reducing pressure on urgent and emergency services
- Mental health
- Cancer
- Elective/planned care waiting times
- Integrated Care System development (ICSs)
- Workforce and digital

Phase 5: Testing, approvals and publication: Approval for the draft system plan will be sought through the collective system groups, including system leaders and collaborative board and subject to statutory organisations individual governance arrangements as determined by respective partners. In addition, it will be tested for

robustness and subject to a process of approval and external assurance through NHS England and Improvement prior to publication and development of a supporting implementation framework the end of 2019.

3. A description of the plans for engagement at Locality and STP wide levels

3.1 The engagement plan sets out the scope, content and approach to engagement; the methods or channels to be used; the collation of views and feedback; and the audiences and groups for engagement.

3.2 It is important to note that there has already been a range of engagement relevant to the Long-Term Plan:

- NHS national Long-Term Plan engagement in 2018
- Healthwatch national survey on the Long-Term Plan
- Devon STP programme engagement e.g. mental health, maternity etc

3.3 Given the need to build on existing system plans, a review of the themes arising from this prior engagement is underway and will form part of the refreshed local evidence base.

3.4 In addition, Healthwatch is currently engaging people in Devon, Plymouth and Torbay including holding six focus groups on the following points:

- Making it easier for people to access support closer to home and via technology
- Doing more to help people stay well
- Providing better support for people with cancer, dementia, heart and lung disease

3.5 Responses on these topics will be formulated in a Healthwatch report which is due in early June 2019 to contribute to the Devon Long Term Plan.

3.6 The engagement is planned to take a two-Tier approach.

Tier 1 – Strategic engagement (Devon-wide)

3.7 Engagement in the Long-Term Plan will need to be system-wide on some of the key challenges it faces, for example developing digital capabilities and recruiting and sustaining a flexible workforce. The areas of focus system-wide, are;

- Understanding how technology can better support individuals to stay well
- Creating a sustainable workforce fit for the future
- What the NHS can do to help people stay well, live better

Tier 1 – strategic engagement (Devon-wide)	
Activity:	Engagement to be delivered by:
Devon Virtual Voices Panel – 1500 members (x 2 surveys for 8 weeks)	Devon CCG
Focus groups: Devon-wide recruitment:	Devon CCG

1. Digital 2. Workforce 3. Helping people to stay well and live better for longer *One focus group on each topic.*	
Generic survey (15 questions) – hosted on CCG website and supported by social media and marketing activity (drive quantitative feedback) – paid for advertising online, weekly theme.	Devon CCG
Devon Referral Support Services (DRSS) tele-survey – DRSS speak to 1500 per day, they will ask each caller 2 questions regarding planned outpatient appointments (to test their views on the use of digital to support planned care)	Devon CCG Devon Referral Support Service
MPs (Devon-wide) A session with Devon MPs will be set up to brief them on process and timeline	Devon CCG
Health and Wellbeing Boards (x3) H&WBB will work with the three public health teams in Devon, Plymouth and Torbay to address issues and challenges in chapter 2 of the LTP and provide recommendations and priorities back.	H&WBB Devon + Public Health Devon H&WBB Plymouth + Public Health Plymouth H&WBB Torbay + Public Health Torbay

Tier 2 Locality

3.8 Engagement will also be planned in the Northern, Eastern, Southern and Western Localities.

3.9 Locality based engagement will provide the opportunity engage in the delivery of integrated care to better address the key challenges that are specific to that area. Each locality (Local Care Partnership) will agree how they will engage on priorities and topics from within the Long-Term Plan using the data and tools provided that illustrate the local challenges and opportunities. This will identify clear themes from the locality-based engagement to inform the Devon Long-Term Plan.

4. The executive arrangements for progressing the development of the plan including the role and function of the Health and Wellbeing Board

4.1 The Long-Term Plan development is being led through the Devon Sustainability and Transformation Partnership which is chaired by Dame Suzi Leather, with Phil Norrey in the role of interim Chief Executive. Each constituent NHS and Local Authority organisation[1] will be key partners in both the development and delivery of the Long-Term Plan.

4.2 Health and Wellbeing Boards, in their role of ensuring the delivery of improved health and wellbeing outcomes for the population, reducing inequalities, and promoting integration will play a key role in the development and delivery of the NHS Long Term Plan and will be engaged and invited to endorse that the final Long-Term Plan addresses the priority needs of the population.

4.3 Scrutiny Committees will continue to be engaged throughout the process in the context of their role in matters relating to the commissioning, planning, provision and operation of health services, and the scrutiny of public health and social care, to review the engagement and emerging plans in this important context.

4.4 In accordance with the national guidance, Devon's Long-Term Plan will be subject to a review and assurance process led by NHS England/Improvement to ensure that the local Long-Term Plan meets the necessary national requirements and expectations before the final Long-Term Plan is signed off and published at the end of 2019.

4.5 In relation to this timeframe, it is proposed that Plymouth Health and Adult Social Care Overview and Scrutiny Committee considers this item on the following dates:

- ***19 June 2019***
  Report of progress and engagement process and timelines.

- ***9 October 2019***
  Report of themes from engagement accompanied by circulation to Members of emerging draft Long-Term Plan content.

- ***4 December 2019***

  Submission of final Long-Term Plan following approvals and sign off by organisational boards, including Health and Wellbeing Boards and following review and assurance by NHS England/Improvement.

4.6 In relation to the Health and Wellbeing Board's in Devon, Plymouth and Torbay, it is proposed a joint working arrangement is implemented to develop a common set of Health and Wellbeing priorities; and review of the implementation of the Long-Term Plan, insofar as it relates to the Devon STP geography in aggregate.

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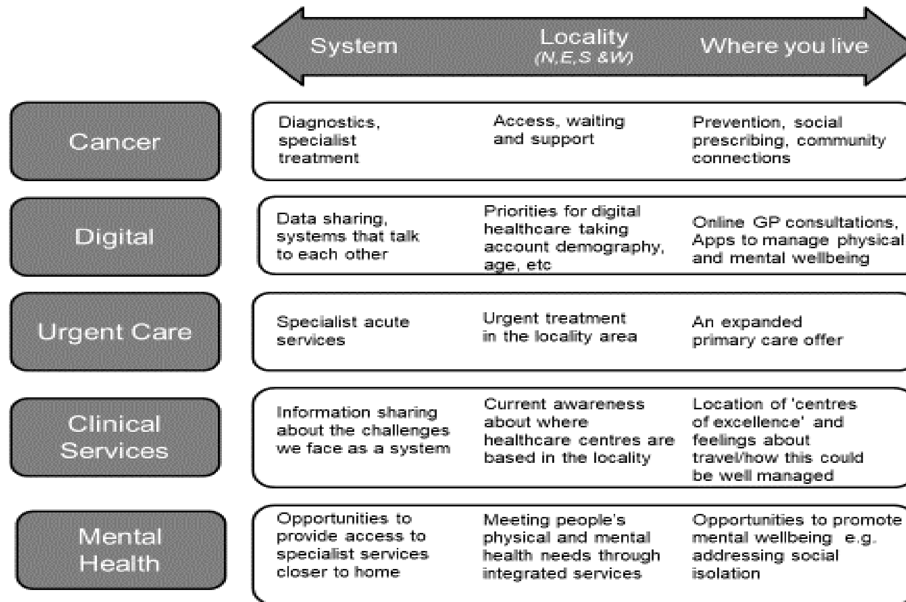
[1] Constituent *organisations* in the Sustainability and Transformation Partnership are set out on STP website

5. A description of which issues might be best considered at which level

5.1 To determine which issues might best be considered at which levels it is also clear that different elements of the same issue may be considered at different. While the detail of the content is still being developed, the diagram below illustrates the nature of the engagement and influencing opportunities that may take place system level to where they live.



Members will be encouraged to engage at all levels to shape and influence the Long-Term Plan.

6. Intentions for the likely methods and material used to support engagement

6.1 There is a range of engagement opportunities that exist, and each locality will be able to use ones are the most appropriate for their audiences. However, Local Care Partnership (LCP) need to ensure that the engagement gathers both quantitative (data) and qualitative (verbal feedback/words). Some of the ways this can be done:

Quantitative	Qualitative
Surveys (online or hard copy)	Focus groups
Social media i.e. Facebook and Twitter polls	Public meetings
Feedback forms and QR marketing	Social media
Staff surveys, intranets	Attendance at existing meeting i.e. community groups (place – market town, parish or neighbourhood)

6.2 It is recommended that they have a blended mix of activities as not all approaches will suit every individual or group, it depends on who, what, where and when.

Using our engagement channels Devon-wide (Devon CCG):

Devon Virtual Voices

6.3 This is an online panel of people who have specifically signed up to being surveyed about health and social care. By the end of June our panel will be up to 1500 and membership is screened based on a representative sample of Devon. We expect to receive a response rate of 45/50% for each survey issued.

6.4 Individuals can self-select areas of interest or preference when they join, meaning we can target them with chapter specific surveys as well as the generic.

6.5 We will issue two surveys to the panel:

- Week 1 (8 July) – welcome to the panel and short survey (theme: digital)
- Week 4 (29 Aug) – generic survey (no more than 10 questions)

Focus groups

6.6 Recruitment to focus groups will be Devon-wide, but this will specifically target different representative groups to make the attendance mixed – geographic, demographic, psychographic etc. There would be no-more than 15 people in each focus group.

6.7 Proposed focus groups include:

- Digital: how technology can better support individuals to stay well
- Workforce: how can the NHS create a sustainable workforce
- Wellness agenda: what can the NHS do to help people stay well, live better for longer

Using social media

6.8 We will use social media in two ways. Firstly, we will run paid for advertising on social media to promote all surveys and drive people to complete them. This worked very well during our Better Births engagement. We will do themed weeks to ensure our communication is targeted and aligns to specific groups. This engagement plan will be supported by a full PR and communications plan.

6.9 The second element of social media will be to target specific groups and forums that already exist – and a list is being compiled the ones that will be relevant to specific chapters. This will enable online focus groups with online communities.

Hard to reach groups

6.10 Working with the Devon Joint Engagement forum there will be some targeted work with the members of the committee, linking in with similar forums in Torbay and Plymouth.

7. Next steps

7.1 The introductory briefings and engagement will continue with key stakeholders and materials and plans for engagement will be finalised in the lead up to launch of the Long-Term Plan engagement on 11 July 2019.

7.2 Healthwatch will receive and review all engagement responses and provide invaluable independence in preparing the engagement report. As indicated the engagement outputs, as well as themes from prior engagement, will form a key part of the Long-Term Plan developing evidence base which will provide a comprehensive and transparent approach to planning.

7.3 Through an iterative process the content of the Long-Term Plan will be drafted following engagement and emerging content of the draft plan will be both informed by and shared with members.

It is proposed the emerging content is shared with members in October 2019, with further updates as this develops and is signed off with the final draft plan being reviewed by the Health and Wellbeing Boards' and organisational and regulator governance processes ahead of publication.

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GENERAL PRACTICE UPDATE

Health and Adult Social Care Overview and Scrutiny Committee

Date:	19 June 2019
Title of Report:	General Practice Update
Author:	Mark Proctor, Director of Primary Care
Contact Email:	ross.jago@nhs.net
Your Reference:	GPP / 001
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report

This report is in response to the request from the Plymouth Health and Social Care Overview and Scrutiny Committee for a further update on General Practice in Plymouth following the Select Committee sessions held in November.

Recommendations and Reasons

The Committee is asked –

1. to note the report;
2. schedule a further update in line with the Committee's recommendations in November 2018 (Selection Committee minute 13 (4, 5, 6) refers).

Alternative options considered and rejected

None. As a relevant NHS body, NHS Devon CCG has a duty to attend before a local authority when required (provided reasonable notice has been given) to answer questions the local authority believes are necessary to carry out its health scrutiny functions.

Relevance to the Corporate Plan and/or the Plymouth Plan

By working with NHS bodies to maintain oversight of primary care services in Plymouth the committee is supporting the Democratic and Co-operative values of the Plymouth City Council, alongside objectives in the *"Healthy City"* Chapter of the Plymouth Plan.

Implications for the Medium-Term Financial Plan and Resource Implications:
This update does not give notice of any required decision which may require expenditure or resource allocation.

Carbon Footprint (Environmental) Implications:
None arising from this report.

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

None arising from this report.

Appendices

Ref.	Title of Appendix	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	**2**	**3**	**4**	**5**	**6**	**7**
A	Briefing report (Part 1)							

Background papers:

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are unpublished works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of background paper(s)	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	**2**	**3**	**4**	**5**	**6**	**7**

Sign off:

Fin		Leg		Mon Off		HR		Assets		Strat Proc	
Originating Senior Leadership Team member: N/A											
Please confirm the Strategic Director(s) has agreed the report? N/A Date agreed: 10/06/2019											
Cabinet Member signature of approval: N/A Date: 10/06/2019											

NHS
Devon
Clinical Commissioning Group

Briefing – GP Care in Plymouth

This briefing sets out updates in relation to –

- NHS Devon merger and delegated commissioning
- Mannamead Surgery
- Local recruitment campaigns/ initiatives around workforce.
- CCG level data for Plymouth including, GP numbers, waiting times
- OOHs availability in Plymouth

1. NHS Devon Clinical Commissioning Group (CCG) launched on 1 April 2019

1.1. The CCG is made up of 131 member GP practices, all of which are rated either good or outstanding by the CQC. We serve a patient population of nearly 1.2 million people with a budget of more than £1.8 billion.

1.2. Creating one CCG for the county is an excellent opportunity to take NHS care in Devon into an exciting future and the CCG will now have a powerful single voice in the commissioning of health services.

1.3. The CCG will work with its NHS and local authority partners, patient groups and local people to design and develop services that improve the lives of people across Devon.

2. Delegated Commissioning

2.1. On 1 April 2019, NHS Devon took on delegated responsibility for the commissioning of general practice from NHS England. The CCG will continue to link with NHS England colleagues where their expertise adds value to ensure it discharges its responsibilities efficiently and effectively.

2.2. The CCG will use this additional responsibility to benefit local patients and Devon GP practices, it gives the CCG the ability to commission primary, community, mental health, and acute care services to meet patients' needs in a more joined-up way.

3. Recruitment / Workforce

3.1. Our goal is to facilitate recruitment and retention by easing workload, creating flexibility in careers and empowering general practice in tailoring services to meet local need and learning from the GP retention support sites.

3.2. The CCG has participated in the international recruitment for GPs with NHS England. Four international GPs have been recruited to date. There is investment in portfolio careers for GPs with Devon Doctors Ltd through NHS England funding. Investment in GP coaching to support retention is also in place through the LMC with NHS England funding. This progress will continue in 2019/20.

3.3. A scheme to entice back primary care workforce that have left the profession will be launched in the early part of 2019, is initially focusing on GPs by offering flexible working and alternative employment arrangements. For nursing we are looking at a Nursing Portfolio Career. There is also -

- trialling of a pilot nursing rotational role planned through primary, secondary and social care with the final rotation as primary care to encourage retention;
- launch of the new GPN preceptorship course to offer a non-academic route to practice;
- work with universities to support student entry to primary care.

3.4. A workshop took place on the 2nd May 2019 to explore the practicalities of developing and offering portfolio roles, the main discussion points were –

- how to join up thinking on recruitment across the system;
- the strategic development of portfolio careers;
- identifying priorities from Health Education England projects;
- sharing knowledge of portfolio careers.

3.5. Some areas in Devon are already developing or have developed portfolio careers and we will work to capture how this has been achieved and what has been successful. We have also identified that clinical directors of Primary Care Networks will be key partners in developing portfolio careers within networks.

3.6. We continue to with the Devon Community Education Provider Network and Health Education England to develop primary care training hubs to support the GP training as well as the broader primary care workforce.

3.7. We will attend the London BMJ recruitment fayre in October providing a presence for both Devon and Plymouth across the two-day event.

4. GP Numbers in Plymouth

		Mar-19
GPs	Headcount	250
	FTE	174.82
Nurses	Headcount	124
	FTE	84.28
Allied Health Professional	Headcount	108
	FTE	67.83

5. Waiting Times

5.1. Waiting time data is available at the Devon CCG level and is provided in the table below.

Time from Booking Date to Appointment Date

	NEW Devon CCG	National
GP practices included	87	6,391
Count of appointments	462,320	23,077,849
% Same day	41%	42%
1 Day	7%	7%
2 to 7 Days	21%	20%
8 to 14 Days	14%	14%
15 to 21 Days	7%	8%
22 to 28 Days	6%	5%
More than 28 Days	5%	4%

6. OOHs availability in Plymouth

6.1. Appointments at practices are available out of hours and at weekends at GP practices in Plymouth as part of the national improved access programme.

6.2. A full out of hours service is also provided from Derriford Hospital, in the north of the city, seven days per week. A complement of GP's who provide treatment centre appointments, home visiting and carry out some telephone triage.

6.3. In addition to the out of hours service at Derriford Hospital an urgent care facility is available in the Devonport Area in the south west of the City. Plymouth also receives out of hours services thorough the Devon Urgent Care provider offering 24/7 access to urgent care services.

6.4. A programme to deliver a network of wellbeing hubs is also being implemented by the health and care system across Plymouth giving families easier and earlier access to health advice and support.

7. New health and wellbeing hubs

7.1. Wellbeing hubs are set to open across neighbourhoods as part of an initiative designed to focus on prevention and make services easier to access in neighbourhoods.

7.2. Two of the hubs were opened on Friday 23 March 2018 by Simon Stevens, Chief Executive of NHS England. These were the Jan Cutting Healthy Living Centre and Four Greens.

7.3. The wellbeing hubs are a joint scheme run by Plymouth City Council and the CCG.

7.4. A bid was also made to ministers for £13 million to fund the roll out of these hubs and to launch a new city centre health hub. This would include NHS dentistry from our medical school, sexual health testing and directly employed GPs as well as mental health support.

Opening timetable

Phase 1	Estimate Opening
Jan Cutting Healthy Living Centre	OPENED March 2018
Four Greens	OPENED October 2018
Improving Lives, Mannamead	OPENED November 2018
Stirling Road Surgery	OPENING SHORTLY; Summer 2019
Cumberland Centre	OPENED March 2019
Rees Youth Centre, Plympton	OPENING SHORTLY; SUMMER 2019
Phase 2	
Efford	(March 2020) – Dependent on preferred option
Estover	(March 2020) – Dependent on preferred option
Southway	(March 2020) – Dependent on preferred option
City Centre (Colin Campbell Court)	TBC
Stonehouse	TBC
Derriford Hospital	In planning opening date to be confirmed
Mount Gould Local Care Centre	March 2020

8. Contract Handbacks in Plymouth

8.1. As of March 31, 2019, there were no contracts handed back in Plymouth over the preceding twelve months. However, the CCG received a contract handback on the 1 April from Mannamead Surgery. We are working with this practice to secure the future care for patients.

8.2. NHS Devon Clinical Commissioning Group has appointed an interim provider at Mannamead Surgery to take on the running of the surgery from 1 July 2019.

8.3. Mannamead Surgery will merge to become part of the Mayflower group. We are about to start a formal process to find a long-term provider for The Mayflower Medical Group, and to secure services in the long-term.

Health and Adult Social Care Overview and Scrutiny Committee

Date of meeting:	19 June 2019
Title of Report:	Integrated Care System Performance Scorecard
Lead Member:	Councillor Kate Taylor (Cabinet Member for Health and Adult Social Care)
Lead Strategic Director:	Craig McArdle (Interim Strategic Director of People)
Author:	Rob Sowden, Performance Adviser
Contact Email:	Robert.sowden@plymouth.gov.uk
Your Reference:	
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of 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.

The Integrated Care System (ICS) has been designed to deliver leadership of a shared vision for population well-being, single system plan and care model. It will look to ensure collaboration between statutory partners as well as to set a direction, framework and culture around the delivery of health and social care services. The performance outcomes framework has been designed to allow us to monitor how the ICS is delivering care to the people of Plymouth and the rest of the ICS geographical area.

Recommendations and Reasons

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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DEVON INTEGRATED CARE SYSTEM PERFORMANCE

QUARTER 4 2018/19

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.

The Integrated Care System (ICS) has been designed to deliver leadership of a shared vision for population well-being, single system plan and care model. It will look to ensure collaboration between statutory partners as well as to set a direction, framework and culture around the delivery of health and social care services. The performance outcomes framework has been designed to allow us to monitor how the ICS is delivering care to the people of Plymouth and the rest of the ICS geographical area.

2. BENCHMARKING

Benchmarking information provided in this report is sourced from a variety of places with national performance based on the most recently published data, the time period for this data will vary depending on the source.

3. TREND GRAPHS

Each indicator is accompanied by a trend graph showing where possible the latest four values, values that represent the whole of the Integrated Care System area which includes Plymouth, Devon and Torbay. 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. PLYMOUTH PERFORMANCE BY EXCEPTION

OUTCOME: More people will be living independently in resilient communities

Adult Social Care User Survey

Outcome indicators relating to the safety and social isolation of users of adult social care services are based on an annual survey of service users.

The fieldwork for the 2019 survey was undertaken between February and April 2019 and in total we received 510 completed questionnaires, a total of 1,732 were sent out. This equates to a response rate of 29.4% and ensures our results are statistically robust.

There has been a decline in the percentage of service users who feel safe (66% down from 72%) and the percentage who have responded that they have as much social contact as they want (45% down from 50%). Analysis of these results is underway and an action plan is being developed to respond to some of the issues identified.

OUTCOME: More people will be choosing to live healthy lifestyles and less people will be becoming unwell

Adult Smoking Prevalence

Smoking prevalence in Plymouth is significantly higher than the England average. We will continue to invest in the services and roll out Making Every Contact Count (MECC) to ensure that as many brief interventions take place as possible that encourage people to stop smoking and support them in doing so. We will continue to focus our resources on those with the most complex support needs and work with University Hospitals Plymouth to embed MECC within their organisation. We will also continue to take a system approach to tobacco control so that action takes place to disrupt and minimise the supply of illegal and illicit tobacco in the city, and to ensure that tobacco sales are appropriately restricted by age and advertising restrictions are adhered to.

Excess weight in adults/ Fruit and Vegetable Consumption

Excess weight in Plymouth is higher than the national average. We continue to focus on giving children the best start in life, making schools health-promoting environments, 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 through Thrive Plymouth. In April 2019, we renewed our Bronze Sustainable Food Cities award as part of our journey towards Silver. This includes promoting healthy eating and healthy weight through a range of initiatives, such as Sugar Smart, Healthy Start and working with our community and voluntary sector to tackle food poverty in the city.

Dementia Diagnosis Rate

In April 2019 the diagnosis rate has increased to 56.3%, up from 55.7% in March. The diagnosis rate remains below the target of 67%.

Consultant capacity has been increased. Link workers are now in place with relevant care homes and a series of actions have been undertaken to reduce home visit rates via offering more appointments at Mount Gould. Reports have also been developed on length of wait for head scans leading to more efficient booking of follow up appointments

OUTCOME: More care will be available in the community and less people will need to visit, or be admitted to hospital

Long term support needs of people 65+ met by admissions to residential or nursing care

Historically we have in Plymouth had a lower rate of adults who require long term adult social services delivered within a residential or nursing home. In 2018/19 the number of people admitted to homes increased from 261 to 305. The improvement in the management of patient flow in the hospital system which has improved our delayed transfers of care performance has had an impact on numbers admitted.

OUTCOME: People will have far greater control over health services and will be equal partners in decisions about their care

Social Care Quality of Life

The Social Care Quality of Life indicator is another borne of the annual adult social care survey and takes into account people's responses to questions relating to control, personal care, food and nutrition, accommodation, safety, occupation and dignity. Based on our results the 2019 Social Care Quality of Life in Plymouth is 19.1, down from 19.7 in 2017/18.

Overall Satisfaction of people who use services with their care and support

Satisfaction among long term users of adult social care services continues to be higher than the national average. In the 2019 survey the percentage of users who were either 'Extremely' or 'Very' satisfied was 70.6%, compared to an average of 63.7%. Those least satisfied are people aged 18-64 and receiving a service in either a home or in the community, the action plan to improve service user experience will reflect this.

OUTCOME: People will go into hospital when necessary and will be discharged efficiently and safely with the right support in their community

Delayed Transfers of Care

The rate of DTOC in Plymouth continues to exceed national expectations, and work continues to improve hospital flow and discharge and thus reduce delayed transfers of care and length of stay. Actions include the now established escalation of care arrangements across health and social care systems and the daily review of long stay patients by integrated discharge teams. The management of patients with complex needs is working well at the hospital and the process to discharge people from hospital has remained stable despite pressure at the front door of the hospital.

5. OUTCOMES FRAMEWORK SCORECARD

Devon ICS Strategic Outcomes Framework													
			STP in Context			Local Authorities			STP Localities				
Outcomes	**Measures**	**England**	**Actual**	**Trend**	**STP Chart**	**Devon**	**Plymouth**	**Torbay**	**East (RDEFT)**	**North (NDHT)**	**West (PHNT)**	**South (TSDHT)**
More people will be living independently in resilient communities	ASCOF 1E: Proportion of adults with learning disabilities in paid employment	6.0%	8.6%	▲		8.6%	5.6%	3.8%				
	ASCOF 1F: Proportion of adults with mental health needs in paid employment	7.0%				8.0%	7.0%	1.0%				
	ASCOF 4A: Proportion of people who use services who feel safe	69.7%				68.8%	66.4%	70.6%				
	ASCOF 4B: Proportion of people who use services who say that those services have made them feel safe and secure	86.5%				80.8%	89.8%	83.9%				
	Fuel poverty	11.4%	10.9%	▼		10.9%	11.8%	10.8%	10.6%	10.9%	11.2%	10.7%
	Self-reported wellbeing (low happiness score)	8.2%	7.8%	▼		6.9%	7.9%	8.7%				
	ASCOF 1Ii - The proportion of people who use services who reported they had as much social contact as they would like	4580.0%				42.8%	44.8%	43.1%				
	ASCOF 1Iii - Proportion of carers who reported that they had as much social contact as they would like	35.5%				27.9%	26.6%	34.4%				
More people will be choosing to live healthy lifestyles and less people will be becoming unwell	Adult smoking prevalence	14.9%	14.7%	▲		13.5%	18.4%	14.8%	11.9%	15.3%	16.8%	15.5%
	Alcohol-related admissions	2224	1981	▼		1711	2159	2248	1620	1904	1816	2044
	Physically active adults	66.3%	70.7%	▼		72.8%	68.7%	70.7%	76%	69%	70%	70%
	Excess weight in adults	62.0%	64.7%	▲		67.2%	67.2%	59.8%	57%	66%	62%	64%
	Fruit and vegetable consumption	54.8%	60.1%	▼		62.3%	57.2%	60.7%	60%	64%	62%	62%
	Life expectancy at birth (males)	79.6	79.4	▼		80.4	79.0	78.7	80.2	79.5	80.4	79.7
	Life expectancy at birth (females)	83.1	83.1	▼		84.2	82.2	82.8	84.3	82.9	83.6	83.8
	Life expectancy gap (males)	9.4				5.6	8.5	9.4				
	Life expectancy gap (females)	7.4				4.5	6.3	4.3				
	IAF 102a: 10-11 classified overweight /obese	33.9%	29.9%	▼					29.5%			30.9%
	Dementia diagnosis rate	67.9%	59.2%	▼					59.7%			59.1%
People who do have health conditions will have the knowledge, skills and confidence to better manage them	Proportion of people who are feeling supported to manage their condition	79%	82.9%	◀▶		85.1%	76.0%	82.1%	85.5%	84.7%	78.1%	84.0%
	Hospital admissions for self-harm (aged 10 - 24)	421	653.3	▼		593.7	706.1	949.2	480.4	818.2422329	662.4	845.5936263
	IAF 126b: Dementia post diagnostic support	77.5%	77.1%	▼					77.2%			76.8%
	Percentage of people that received an NHS Health Check of those offered	46.5%				77.7%	52.9%	87.9%				
	IAF 127b: Emergency admissions for ambulatory care sensitive conditions	2408.5	2331.0	▼					2185.0			1996.0

Devon ICS Strategic Outcomes Framework

			STP in Context			Local Authorities			STP Localities			
Outcomes	**Measures**	**England**	**Actual**	**Trend**	**STP Chart**	**Devon**	**Plymouth**	**Torbay**	**East (RDEFT)**	**North (NDHT)**	**West (PHNT)**	**South (TSDHT)**
The healthcare system will be equipped to intervene early, and rapidly, to avert deterioration and escalation of health problems	Cancer diagnosed at stage 1 or 2	52.2%	53.4%	▼		56.1%	54.2%	49.9%	58.1%	53.2%	56.1%	52.1%
	Mortality rate from preventable causes	181.5	188.7	▲		161.0	207.3	197.7	164.2	180.25	165.7	178.1
	Suicide rate	9.6	10.8	▼		10.5	9.2	15.7	10.3	12.8	9.5	13.15
	OIS 1.10: One-year survival from all cancers	72.3%							73.6%			74.3%
	OIS 1.4: Myocardial infarction, stroke and stage 5 chronic kidney disease in people with diabetes	100							89.6			112.5
More care will be available in the community and less people will need to visit, or be admitted to, hospital	ASCOF 2Ai: long-term support needs of people 18-64 met by admission to residential or nursing care homes per 100,000 population (LOW IS GOOD)	14.0	16.8	▲		17.7	11.7	22.8				
	ASCOF 2Aii: long-term support needs of people 65+ met by admission to residential or nursing care homes per 100,000 population (LOW IS GOOD)	586	471.0	▼		494.3	637.5	446.9				
	Deaths in usual place of residence	46.6%	53.4%	▼		53.2%	54.5%	53.4%	53.0%	51.8%	55.2%	52.9%
	IAF 127f: Hospital bed use following emergency admission	498.9	397.0	▲					427.5			366.7
People will have far greater control over health services and will be equal partners in decisions about their care	ASCOF 1A: Social-care related quality of life	19				19	19.7	19.4				
	ASCOF 3A: Overall satisfaction of people who use services with their care and support	65.0%				67.9%	72.0%	69.2%				
	ASCOF 3B: Overall satisfaction of carers with social services	39.0%				37.6%	33.6%	37.9%				
	ASCOF 1C(2A): proportion of people who use services receiving direct payments	28.5%	27%	▼		33.3%	22.4%	26.7%				
	IAF 128b: Patient experience of GP services	83.8%	88.6%	▼					89.0%			87.4%
	OIS 2.1: Health-related quality of life for people with long-term conditions	73.7%	72.7%	▼					73.8%			72.0%
	OIS 2.15: Health-related quality of life for carers, aged 18 and above	79.7%	79.7%	▼					80.8%			79.7%
	OIS 2.16: Health-related quality of life for people with a long-term mental health condition	51.9%	52.4%	▼					52.0%			49.5%
	OIS 2.2: Proportion of people who are feeling supported to manage their condition	59.6							63.20			62.40
People will go into hospital when necessary and will be discharged efficiently and safely with the right support in their community	ASCOF 2Bi: the proportion of people 65+ discharged from hospital who remain at home 91 days afterwards	82.9%	79.1%	▼		82.6%	80.4%	70.7%				
	ASCOF 2Bii: the proportion of people 65+ discharged from hospital who are offered reablement services.	2.9%	4.1%	▲		1.8%	3.9%	6.5%				
	ASCOF 2Ci: delayed transfers of care from hospital in year per 100,000 population	1.3	17.5	▲		16.8	15.7	7.9				
	ASCOF 2Cii: delayed transfers of care from hospital in year attributable to social care per 100,000 population	4.3	5.2	▼		4.3	2.1	1.9				

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Northern, Eastern and Western Devon
Clinical Commissioning Group

Plymouth Integrated Fund

Finance Report – Month 12 2018/19

Introduction

This report sets out the financial performance of the Plymouth Integrated Fund 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 12 Report 2018/19

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

The report highlights an outturn overspend position against budget for health of £4.2m. This deteriorated in month 12 due to system management agreements. For the Council, the overspend was £2.7m which represented a small improvement on the previous month's forecast.

The overall fund position is reflected in Appendix 1, and shows an overall overspend of £6.9m, before corporate contingencies, and resulted in a risk share impact of £158k.

Plymouth City Council Integrated Fund Outturn – Month 12

Service	Approved Budget M12	Year End Outturn	Variation at Month 12	Variation at Month 11	Change in Month
	£m	£m	£m	£m	£m
Children, Young People & Families	37.168	41.174	4.006	4.064	(0.058)
Strategic Cooperative Commissioning	83.729	83.476	(0.253)	0.000	(0.253)
Education Participation and Skills	101.106	101.106	0.000	0.000	0.000
Community Connections	3.784	3.739	(0.045)	0.000	(0.045)
Director of People	0.295	(0.705)	(1.000)	(1.000)	0.000
Public Health	16.048	16.048	0.000	0.000	0.000
Sub Total	**242.130**	**244.838**	**2.706**	**3.064**	**(0.355)**
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	**258.902**	**261.610**	**2.706**	**3.064**	**(0.355)**

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 year end outturn adverse position £4.006. There has been a favorable reduction of (£0.058m) in the month.

The overall year end variation position can be attributed to the cost and volume of looked after children's placements £3.866.

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 have been as a result of Court of Protection orders that have placed 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.

Ongoing or one off savings plans have delivered £2.714m of the CYPF targeted £4.655m savings this year, leaving a deficit of £1.941m at year end.

The Service through business as usual have continued to hold expenditure wherever possible through the quarterly budget review exercise, holding vacant positions and grant maximization this has offset the overall pressure by (£1.801m).

The Service continue to keep the pressure on going into the new financial year by carrying on with the following actions to address the pressures in the system.

- Looked After Children - only one point of contact for all new entrants;

- Fortnightly placement review to ensure step down of high cost placements
- Maximize contribution from partners including Health and Education
- Maximize local residential placements to avoid higher out of area costs.

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

Strategic Co-operative Commissioning

The Strategic Commissioning service is reporting an under spend of (£0.253m) for 2018/19. This is a significant achievement given the cost and volume pressures in the system especially around residential & nursing care and supported living.

As part of the MTFS for 2018/19, Strategic Commissioning have achieved savings of £2.546m as well as £2.248m of savings brought forward from 2017/18 that were realised from one off savings and needed to be achieved in this financial year.

Work will continue into 2019/20 to review all cost and volume impacts on the department spend with management actions to minimise all administration costs where possible.

Education, Participation and Skill

Education, Participation and Skills balanced to budget at year end.

As part of the MTFS for 2018/19, Education Participation and Skills has made savings of over £0.699m as well as £0.687m of savings brought forward from 2017/18 that were previously realised from one off savings.

There was an added pressure of £0.159m due to Adult Community Meals, however, £0.130m of this was offset by grant maximisation.

Community Connections

Community Connections has finished the year (£0.047m) under budget.

Average B & B numbers for the year have been reducing and finished with an average of 46 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. This presented a £0.351m overspend within 2018/19.

This reduction has been achieved by the service with use of alternative properties provided through existing contracts as well as use of additional contracted staff to target single occupancy stays.

Director of People

The People Management & Support budget recorded a £1m underspend due to a one-off balance sheet adjustment

Public Health

Public Health has 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 has been 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 have been 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 Delivery Plans	**Outturn**		
Month 12 - March 2019	Budget	Actual	Variance (Adv) / Fav
	£000's	£000's	£000's
Children, Young People & Families	4,655	2,714	(1,941)
Strategic Cooperative Commissioning	4,794	4,794	0
Education Participation & Skills	1,386	1,386	0
Community Connections	659	659	0
Public Health	75	75	0
	11,569	9,628	(1,941)

Integrated Fund Summary

Health are reporting a final outturn position of an unplanned overspend of £4.2m for services commissioned for patients registered with Plymouth GP practices whilst the Local Authority are reporting an unplanned overspend of £2.7m.

This position reflects a deterioration in the health position of £0.7m from the position reported in month 11. The reason for the deterioration in the CCG financial position was due to the cumulative effect of a number of relatively smaller changes in year end contractual positions. The largest of these was a system agreement that resulted in an increase in unbudgeted acute sector spend in the west.

The risk share adjustment that results from the respective health and local authority positions at month 12 indicates that an adjustment of £157k will be transacted, with a flow of funding into the CCG.

SECTION 2 – BETTER CARE FUND (BCF)

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

The table below shows the total BCF and IBCF for 2018/19, and the distribution between CCG and PCC.

2018/19 BCF & IBCF	**PCC**	**CCG**	**Total**

	£m	£m	**£m**
BCF Capital (Disabled Facilities Grant)	2.298	0.000	**2.298**
BCF Revenue	9.425	8.619	**18.044**
Sub Total BCF	**11.723**	**8.619**	**20.342**
IBCF (part of Councils RSG funding)	5.344	0.000	**5.344**
IBCF (other)	2.160	1.500	**3.660**
Sub Total BCF	**7.504**	**1.500**	**9.004**
Total Funds	**19.227**	**10.119**	**29.346**

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 12

This report sets out the outturn financial performance of the CCG for 2018/19.

The CCG outturn position was breakeven for both organisations. These positions were achieved after planned deficits of £20.0m for North East and West Devon CCG and £5.0m of South Devon and Torbay CCG were delivered which lead to the release of Commissioner Sustainability Funding being released worth a further £25m collectively.

The CCG plan for 2018/19 was 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 plans required the delivery of a £78.59m savings programme in order to meet the respective positions agreed with NHS England. £70.85m of this challenge relates to NEW Devon CCG and the balance of £7.75m with South Devon & Torbay CCG. The CCG's delivered 96% against the plan.

Delivery of the required savings plan was the main financial risk and challenge to the CCGs, however there were other risks in relation to out of area placements and within the independent sector contracts which materialised. These were managed by a combination of continued focus, priority and joint working across the local community and wider STP foot print.

Western PDU Finance Position

Introduction

This report previously described emerging risks within the acute independent sector contracts and these risks have materialised in year. The Western PDU have reported an overspend of £4.0m 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 £197.4m for NEW Devon and £4.7m for SD&T CCG. These values include the recent adjustments for the RTT support, Plymouth Orthopaedic Partnership and the STP realignment variation orders.

Contract performance

2018/19 M12	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	41,651	36,363	- 5,288	-4.4%	-12.7%	1,414	1,220	- 194	-4.0%	-13.7%
Non-Elective	72,216	72,268	52	2.0%	0.1%	1,015	1,051	36	5.9%	3.5%
A&E + MIU	14,364	13,953	- 411	-1.8%	-2.9%	177	284	107	93.7%	60.5%
Outpatients	33,661	32,445	- 1,216	-3.7%	-3.6%	884	832	- 52	-2.9%	-5.9%
Excluded Services	21,809	23,447	1,638		7.5%	300	295	- 5		-1.7%
Penalties	-	- 458	- 458			-	- 21	- 21		
Drugs & Devices	13,346	14,278	932		7.0%	453	411	- 42		-9.3%
CQUIN	4,355	4,450	95		2.2%	103	92	- 11		-10.7%
Contract Adjustments	- 8,716	-	8,716			399		- 399		
Total	192,686	196,746	4,060		2.1%	4,745	4,164	- 581		-12.2%

Expenditure on Elective Care is 12.7% behind financial plan for NEW Devon and 13.7% for SD&T, representing a combined underspend of £5.4m to month 12 with £0.3m of this variance occurring in month. The primary drivers of underperformance for NEW Devon include:

Orthopaedics – Underperforming by 18.1% worth £2.0m
Cardiology – Underperforming by 31.5% worth £828k
Neurosurgery – Underperforming by 38.9% worth £641k

Non-Elective activity for NEW Devon is 6.8% ahead of plan and 0.1% over performance in financial terms. This is after the contract was increased to reflect

historical growth trends and includes the activity and spend taking place within the recently formed Acute Assessment Unit (AAU).

Accident and Emergency, which includes MIU activity which has been varied into the UHP contract, is behind plan by 0.8% or 950 attendances which is a fall of 583 attendances since month 11. The adverse variance for spend is 2.1% or £304k. The Torbay and South Devon proportion of this part of the contract is small, it should be noted that the activity variance of 93.7% remains exceptionally high.

Outpatient activity and spend has continued to fall behind plan during month 12. Activity is 3.7% or £1.2m behind plan for NEW Devon. Outpatient procedures are ahead of plan by £0.5m whilst new and follow-up attendances are underperforming by £1.8m. At specialty level there are over performances in Plastic Surgery (£159k or 21%), Endoscopy (£180k or 30%), Trauma (£172k or 25%) and Paediatric Neuro Disability (£148k or 15%). However, these are offset by significant underperformances in Orthopaedics (£209k or 15%), Gastroenterology (£234k or 25%), Ophthalmology A&E (£221k or 18%) and Pain Management (£183k or 24%).

NEW Devon Passthrough Drugs and Devices are overspent by 7% or £0.9m, which is driven by passthrough drugs. Whilst South Devon and Torbay have an underspend of 9.3%, giving a combined overspend of £6.4m.

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.

Overall, contract reporting illustrates an over performance of £4.1m for NEW Devon and a £0.6m under performance for South Devon CCG. However, a significant contributor to the NEW Devon over performance is in respect of the £8.7m 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 £4.7m.

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 11 the activity data shows an underperformance of £0.6m. This primarily driven by underperformances within non elective and passthrough drugs.

Independent Sector & London Trusts

This month the Independent Sector position has steadied with no forecast movement. This is continuation of the reduced volumes of work which has been

going through the Care UK contract in recent months; particularly in hip and knee replacements because of CCG demand management programmes.

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 £0.4m 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 £71.2m 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 delivered financial balance within the financial year.

Primary Care Prescribing

Month 12 shows a £1.6m overspend for the Western area which reflects deterioration of £0.3m in month. The position has moved on the basis of the nationally produced forecasting methodology which is become more robust as we approach the end of the year.

Overall the CCG is forecasting that our year to date QIPP target was achieved.

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 delivered a year end overspend of £7.0m. Within this position the Council overspent by £2.9m whilst the health position was a £4.1m overspend after the application of the risk share.

Ben Chilcott	***David Northey***
Associate Director of Finance (Western)	***Head of Integrated Finance, PCC***

APPENDIX 1

PLYMOUTH INTEGRATED FUND AND RISK SHARE

99P	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	162,780	164,435	1,654	162,780	164,435	1,654
Placements	35,980	35,255	-725	35,980	35,255	-725
Community & Non Acute	49,681	50,336	654	49,681	50,336	654
Mental Health Services	36,370	36,288	-81	36,370	36,288	-81
Other Commissioned Services	18,326	18,101	-225	18,326	18,101	-225
Primary Care	46,247	46,790	543	46,247	46,790	543
Subtotal	349,384	351,204	1,821	349,384	351,204	1,821
Running Costs & Technical/Risk	2,461	4,885	2,424	2,461	4,885	2,424
CCG Net Operating Expenditure	351,844	356,089	4,245	351,844	356,089	4,245
Risk Share					-157	-157
CCG Net Operating Expenditure (after Risk Share)	351,844	356,089	4,245	351,844	355,932	4,088
PCC COMMISSIONED SERVICES						
Children, Young People & Families	37,168	41,174	4,006	37,168	41,174	4,006
Strategic Cooperative Commissioning	83,729	83,475	-253	83,729	83,475	-253
Education, Participation & Skills	101,106	101,106	-0	101,106	101,106	-0
Community Connections	3,784	3,739	-45	3,784	3,739	-45
Director of people	295	-705	-1,000	295	-705	-1,000
Public Health	16,048	16,048	-	16,048	16,048	-
Subtotal	242,131	244,837	2,706	242,131	244,837	2,706
Support Services costs	14,473	14,473	-	14,473	14,473	-
Disabled Facilities Grant (Cap Spend)	2,298	2,298	-	2,298	2,298	-
Recovery Plans in Development		-	-	-	-	-
PCC Net Operating Expenditure	258,902	261,609	2,706	258,902	261,609	2,706
Risk Share					157	157
PCC Net Operating Expenditure (after Risk Share)	258,902	261,609	2,706	258,902	261,765	2,863
Combined Integrated Fund	610,746	617,697	6,951	610,746	617,697	6,951

APPENDIX 2
WESTERN PDU MANAGED CONTRACTS FINANCIAL PERFORMANCE

Month 12 March	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	198,078	198,078	0	198,078	198,078	0
NHS South Devon Healthcare Foundation Trust	6,284	6,294	10	6,284	6,294	10
NHS London Contracts	1,709	1,976	267	1,709	1,976	267
Non Contracted Activity (NCA's)	8,374	8,374	-0	8,374	8,374	-0
Independent Sector	11,139	14,164	3,025	11,139	14,164	3,025
Other Acute	23	17	-5	23	17	-5
Cancer Alliance Funding	182	182	-	182	182	-
Subtotal	225,788	229,085	3,297	225,788	229,085	3,297
COMMUNITY & NON ACUTE						
Livewell Southwest	46,346	46,345	-0	46,346	46,345	-0
GPwSI's (incl Sentinel, Beacon etc)	1,668	1,626	-42	1,668	1,626	-42
Community Equipment Plymouth	648	640	-8	648	640	-8
Peninsula Ultrasound	285	260	-25	285	260	-25
Reablement	1,517	1,500	-17	1,517	1,500	-17
Other Community Services	256	256	-0	256	256	-0
Plymouth Integrated Fund - Risk Share	-	-58	-58	-	-58	-58
Joint Funding_Plymouth CC	6,211	6,231	20	6,211	6,231	20
Better Care Fund_Devon CC	-	-	-	-	-	-
Subtotal	56,931	56,800	-131	56,931	56,800	-131
MENTAL HEALTH SERVICES						
Livewell MH Services	32,870	32,870	0	32,870	32,870	0
Mental Health Contracts	26	25	-1	26	25	-1
Other Mental Health	1,259	1,141	-118	1,259	1,141	-118
Subtotal	34,155	34,037	-118	34,155	34,037	-118
OTHER COMMISSIONED SERVICES						
Stroke Association	159	159	-0	159	159	-0
Hospices	2,795	2,678	-117	2,795	2,678	-117
Discharge to Assess	6,613	6,610	-3	6,613	6,610	-3
Patient Transport Services	2,321	2,313	-8	2,321	2,313	-8
Wheelchairs Western Locality	1,800	1,703	-97	1,800	1,703	-97
Commissioning Schemes	191	157	-34	191	157	-34
All Other	855	855	-0	855	855	-0
Subtotal	14,734	14,473	-261	14,734	14,473	-261
PRIMARY CARE						
Prescribing	54,468	56,106	1,638	54,468	56,106	1,638
Medicines Optimisation	295	242	-53	295	242	-53
Enhanced Services	7,620	7,895	275	7,620	7,895	275
GP IT Revenue	4,249	4,086	-163	4,249	4,086	-163
Other Primary Care	6,413	5,968	-446	6,413	5,968	-446
Subtotal	73,045	74,296	1,252	73,045	74,296	1,252
TOTAL COMMISSIONED SERVICES	404,653	408,691	4,038	404,653	408,691	4,038

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

HEALTH AND ADULT SOCIAL CARE OVERVIEW SCRUTINY COMMITTE

Work Programme 2019 - 20

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
19 June 2019	Update on Primary Care			Mark Procter
	CQC Report on Derriford's Emergency Department			Ann James
	Disability Parking at Derriford Hospital			Ann James
	Integrated Performance Report			Rob Sowden
	Integrated Finance Report			David Northey
31 July 2019	Care Needs Assessments			Craig McArdle
	Mental Health Progress Update			Lin Walton/Jo Turl
	Adult Social Care – Future Direction			Craig McArdle
	Workforce Development Strategy			David McAuley
	Update on Did Not Attends			Amanda Nash
	Integrated Performance Report			Rob Sowden
	Integrated Finance Report			David Northey
9 Oct 2019				
	Integrated Performance Report			
	Integrated Finance Report			
4 Dec 2019				
	Integrated Performance Report			
	Integrated Finance Report			
29 Jan 2020				
	Integrated Performance Report			
	Integrated Finance Report			
25 Mar 2020				

	Integrated Performance Report			
	Integrated Finance Report			

Items to be scheduled				
	NHS 111 Update			
	Loneliness			
	Plymouth Safeguarding Adults Board Update			
	Winter Pressures Update			
	Alliance Action Plan (Substance Misuse)			
	Brexit Report – impact on care			
	Preventative Measures against the Marmot Principles			

Select Committee Reviews				
	End of Life Care		Member request	
	Urgent Care			

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

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 - completed.	**Date:** Jan 2019 **Officer:** Amelia Boulter **Progress:** 5 - email circulated to Members on 28.11.18. Meeting with Public Health to go through recommendations.
20 March 2019 Access Healthcare – Substance Misuse Services Minute 65	The Committee noted the on Access Healthcare Substance Misuse Service and requested that a report on preventative measures against the Marmot principles is added to the work programme.	**Date:** March 2019 **Officer:** Amelia Boulter **Progress:** Added to the Work Programme
20 March 2019 Work Programme	The Committee noted the work programme and requested that the following items are added to the work programme for 2019 – 2020: • Winter Pressures Update – June/July • Alliance Action Plan (Substance misuse) – June • Update on GP Recruitment - June • Workforce Development Action Plan • Brexit Report – impact on care	**Date:** March 2019 **Officer:** Amelia Boulter **Progress:** Added to the Work Programme

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