**Oversight and Governance**
Chief Executive's Department
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Published 21 January 2020

# HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Wednesday 29 January 2020
3.00 pm
Warspite Room, Council House

**Members:**
Councillor Mrs Aspinall, Chair
Councillor Mrs Bowyer, Vice Chair
Councillors Sam Davey, 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. Apologies**

To receive apologies for non-attendance submitted by Councillors.

**2. Declarations of Interest**

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

**3. Minutes** **(Pages 1 - 8)**

To confirm the minutes of the meeting held on 9 October 2019.

**4. Chair's Urgent Business**

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

**5. Mapping of Corporate Plan to Scrutiny Committees** **(Pages 9 - 10)**

**6. Policy Update - for information only** **(Pages 11 - 16)**

**7. Primary Care Strategy and Plymouth Prospectus** **(Pages 17 - 54)**

**8. CQC Reports:**

8.a. Livewell South West **(Pages 55 - 60)**

8.b. Independence@Home Reablement Service **(Pages 61 - 76)**

**9. Update on Did Not Attend Appointments** **(Pages 77 - 84)**

**10. Fair Shares** **(Pages 85 - 98)**

**11. Performance and Corporate Plan** **(Pages 99 - 124)**

**12. Tracking Resolutions** **(Pages 125 - 126)**

**13. Work Programme** **(Pages 127 - 130)**

# Health and Adult Social Care Overview and Scrutiny Committee

## Wednesday 9 October 2019

**PRESENT:**

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

Also in attendance: Elaine Fitzsimmons (NHS Devon CCG), David Brown (University Hospital Plymouth NHS Trust), Councillor Kate Taylor (Cabinet Member for Health and Adult Social Care), Rachel Silcock (Strategic Commissioning Manager), Councillor Kate Taylor (Cabinet Member for Health and Adult Social Care), Ruth Harrell (Director of Public Health), Claire Turbutt (Advanced Public Health Specialist), Jo Watson (NHS Devon CCG), Anna Coles (Director of Integrated Commissioning), Ben Chilcott (NHS Devon CCG), Helen Foote (Plymouth City Council), Craig McArdle (Interim Strategic Director for Place) and Amelia Boulter (Democratic Advisor).

The meeting started at 2.05 pm and finished at 5.02 pm.

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

26. **Declarations of Interest**

The following declaration of interest was made by Councillor Tuohy in respect of minute 31, Health and Wellbeing Hubs, is a Board Member of The Wolseley Trust/Jan Cutting Living Centre.

27. **Minutes**

The minutes of the meeting held on 31 July 2019 were agreed.

28. **Chair's Urgent Business**

There were no items of Chair's urgent business.

29. **Mapping of Corporate Plan to Scrutiny Committees**

The Mapping of the Corporate Plan to Scrutiny Committees would be a standing item in the agenda. For information and to be used as a reference against the Committee's terms of reference.

30. **Winter Planning**

Elaine Fitzsimmons (NHS Devon CCG) and David Brown (University Hospital Plymouth NHS Trust) were present for this meeting and referred to the presentation in the agenda pack.

In response to questions raised, it was reported that:

(a) OPEL (Operational Pressures Escalation Levels) from 1 to 4 with 4 being the highest. The hospital were currently operating on OPEL 4 which meant that they were responding to a major incident. The fantastic work from staff the hospital meant that they would be imminently out of OPEL 4;

(b) to avoid future escalation to OPEL 3 or 4, the hospital were looking at systematic improvements such as improving the system of care at the weekends and same day emergency care by providing a high quality pathway for patients that do not require an overnight stay. By looking at each of the pathways could start to see where they were making a difference;

(c) resilient staffing was critical moving into the winter period and the hospital have more staff available than last winter. The hospital have a portfolio of services they have to provide and if they have staff shortages within urgent and emergency care then staff would be moved from other areas to ensure service continuity. The hospital's mission this winter was to continue to provide high quality emergency and urgent care as well as surgical care to patients;

(d) last year they worked as one system and nominated a chief operating officer to ensure the right levels of staffing were in place across the system. They were also reviewing the role GPs play and to ensure there were have enough out of hours GPs;

(e) they were looking at different options to bring people that may have recently retired back into work at short notice if required;

(f) the uptake of the flu vaccination were similar year on year. However the vaccination programme led by NHS England was focusing on the hard to reach groups but despite this the uptake was still around 70%;

(g) an on-line repeat prescribing function had been set up in Plymouth allowing patients to phone a separate number to receive their repeat prescriptions and this was starting to reduce the pressure on GPs;

(h) there was a co-ordinated approach to communications and how to get information out to the population on the different options available other than presenting at the GP practice and/or emergency department;

(i) the complex care response team has a good rate of accepting patients to be cared for at home but have had an arrangement that the patient would be seen by a GP before being referred to the team. This year they had invested additional money into highly trained nurses and paramedics for them to undertake the visit on the GPs behalf and this idea was shared at a recent GP forum and was received positively;

(j) they were undertaking a piece of work looking at high intensity users of the emergency department and doctor surgeries and trying to understand why they are using these services which were often not health related and how they could have been better supported within the community. GPs were also taking a proactive approach with the frail elderly patients.

The Committee noted the presentation and were:

- Assured that comprehensive work has been undertaken in relation to attempting to understand urgent care demand and building this into the local work plan.
- Assured that commissioners and providers continue to learn and build upon prior experience.
- Assured that planning for winter is being done in partnership with due regard to key risks and challenges to the system.

The Committee also agreed to be provided with a briefing report at the end of the winter period.

(Councillor Mark Deacon left after this agenda item).

31. **Health and Wellbeing Hubs**

Councillor Kate Taylor (Cabinet Member for Health and Adult Social Care) and Rachel Silcock (Strategic Commissioning Manager) were present for this item and referred to the report in the agenda. Councillor Kate Taylor thanked everyone involved in the development of the health and wellbeing hubs and to the staff and volunteers that were a credit to their communities.

In response to questions raised, it was reported that:

(a) communications relating to the health and wellbeing hubs would be shared with Councillors and apologies if this was not the case;

(b) they prioritised the hubs based on deprivation and need within the city and therefore hubs in the Plympton area had been delayed. However the Plympton community were engaged and were part of the hubs leadership programme to ensure that the community were ready to launch and undertake an active role;

(c) they were making the most of the community resources already available within the community and by working with the various groups within that community to enable them to the deliver the hubs in 2020;

(d) there were a suite of services for each of the health and wellbeing hubs and performance indicators were attached to the hubs. They were also looking across the whole system to ascertain what people gained from visiting the hubs and the services they received;

(e) they had looked at how other hubs had been evaluated and had found that good quantitative data around social prescribing and then qualitative as whole had worked well. They would like to take this approach in Plymouth however would be resource intensive but they have engaged with the Universities of Plymouth and Exeter to seek assurance that they were taking the right approach;

Agreed that:

1. A small group of this committee to review the programme with officers and agree a wider communication to elected members and to clarify the situation on external funding opportunities available.

2. The Committee notes and supports the delivery of this exciting programme of Wellbeing Hu

3. The Committee to review the performance of the Health and Wellbeing Hubs at a suitable time.

32. **Director of Public Health Annual Report**

Councillor Kate Taylor (Cabinet Member for Health and Adult Social Care), Ruth Harrell (Director of Public Health), Claire Turbutt (Advanced Public Health Specialist) were present for the item and referred to the report in the agenda.

In response to questions raised, it was reported that:

(a) there was a need to talk more about mental health to reduce the stigma and that mental health was no different to physical health. It was also well known to get support from supportive friends and colleagues around you;

(b) they were currently trying to understand why life expectancy in women was falling but do not have the answers but were looking across everything we do to try and identify what was causing the problem;

(c) unhealthy foods cheaper and easier to access in more deprived areas and obesity certainly an issue for different generations and Thrive Plymouth was working to tackle this;

(d) funding allocation to the NHS historically given based more on demand rather than need and that people in more deprived areas were less likely to seek medical attention when required which results in deprived areas receiving less funding. The CCG had recognise the lack of funding within the western locality and conversations were taking place to rebalance of funding across the locality.

The Committee agreed:

1. To note the content (including recommendations) of the Director of Public Health Annual Report.

2. To commit to considering what each partner organisation could contribute to these recommendations.

3. To consider our response, if any, to the national picture.

The Committee supported meetings taking place to address the fair funding for the city.

(Councillor Nicholson left during this item).

33. **Brexit - Verbal Update**

Jo Watson (NHS Devon CCG), Ruth Harrell (Director of Public Health) and Anna Coles (Director of Integrated Commissioning) were present for this item and provided a verbal update to the Committee. It was highlighted that:

(a) they were planning for potential no-deal Brexit and were looking at all the impacts. Two risk registers were submitted recently to Cabinet, one on the internal council risks and risks across the city and they were looking at the mitigations;

(b) after looking at the mitigations two issues highlighted related to our own suppliers on provision of social care and medicines;

(c) the Director of Public Health recently attended a Local Resilience Forum meeting and it was reported that in preparation for Brexit suppliers have been asked to order 6 weeks supplies on top of their normal supplies and this had been achieved for 80% of medicines;

(d) a commitment had been made that if supplies were unable to reach areas of the south west then the military would be drafted in to fly in supplies if necessary. All professionals have been asked to prescribe as usual and for patients not to over order.

In response to questions raised, it was reported that:

(e) they have been in discussions with social care providers since last February as part of business continuity to understand the potential implications with regard to EU nationals and possible impacts. Care providers have been having conversations with staff and to identify potential risks, providing support and information around the settlement process and whether EU nationals were likely to stay or leave;

(f) they were also looking at personal protective equipment (PPE) used largely in the social care market and ensuring sufficient supplies and identifying back up resources. There has been considerable engagement with the providers of social care and all commissioned services have been audited to ensure they were aware of the potential issues and be prepared as they could be and we feel that we were in good position to cope in the south west;

(g) if a medicine was not available then alternatives would be prescribed. They have introduced the serious shortage protocol to allow the community pharmacy to make the changes instead of the going back to the original prescriber to make the change thus enabling the pharmacist on the front line to make the change;

(h) important to note that there might be a slight delay for some patients receiving their medications, this was not ideal but pharmacists were generally aware of the issues that patients were facing and ensuring that their needs were met.

The Committee noted the verbal update on Brexit and requested a summary of the points raised to be circulated to members.

34. **Plymouth Integrated Fund Finance Report - Month 5 2019/20**

Ben Chilcott (NHS Devon CCG) and Helen Foote (Plymouth City Council) were present for this item and referred to the report in the agenda. It was reported that:

(a) currently between the CCG and the PCC they were declaring an in-year pressure of £1.271 million and majority of this pressure related to children's services at Plymouth City Council;

(b) the report also provides an overview of the integrated fund such as the services included, the section 75 agreement, financial framework and risk share agreement;

(c) the overall position for the CCG health budget was just under £1.9 billion and they were working towards a planned deficit of £29m with the month 5 position showing them on target to deliver that deficit however with significant risks emerging in-year. They were behind target of achieving £80 million savings and were in the process of pulling together a recovery plan.

In response to questions raised, it was reported that:

(d) Children Social Care and Education Overview and Scrutiny Committee would address the current overspend within the Children Services directorate;

(e) from a health perspective they know what the financial allocation would be for the next few years and were currently in the process of setting out the long term plan final submission in November 2019.
The plan sets out a do nothing gap with a series of over a short number of years a set of savings plans to bring the position back to balance;

(f) the council precept and allocated funding was subject to further consultation in the autumn.

The Committee noted the Plymouth Integrated Fund Finance Report – Month 5 2019/10 and to review the Long Term Plan at a future meeting.

35. **Devon Integrated Care System Performance Quarter One 2019/20**

The Chair deferred this item but requested that any questions the committee had in relation to the Devon Integrated Care System Performance Quarter One 2019/20 report be sent to Rob Sowden. Officers put forward a suggestion that when the Committee next receive the Winter Plan that the report should include performance.

36. **Work Programme**

The Committee noted the work programme and requested that the following items to be scheduled:

- Alliance Contract/Action Plan – how this item will be scrutinised;
- Marmot principles/review together;
- Food Justice – Cllr Mrs Bowyer to email the group to find a member;
- Mental health take place towards the end of the year;
- Long Term Plan.

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# MAPPING OF CORPORATE PLAN TO SCRUTINY COMMITTEES

| Overview and Scrutiny Committee | Current Areas of Responsibility | Map to Corporate Plan Priorities *(some appear across more than one committee)* |
|---|---|---|
| Brexit, Infrastructure and Legislative Change | Relevant policies in the Plymouth Plan<br>Response to Central Government's Policy Making<br>Capital Programme<br>Strategic Procurement<br>Corporate Property<br>Development planning<br>Strategic Highways<br>Economic Development<br>Heart of the South West Productivity Plan<br>Strategic Transport policies and strategies<br>Cultural Infrastructure<br>Climate change and sustainability<br>Reviewing impact of Brexit on the city<br>Proposing measures that Government should take to provide stability for the council and partners in light of Brexit<br>Exploring powers could be devolved from the EU directly to local authorities<br>Hear call-ins relevant to the role of the committee | • An efficient transport network<br>• A broad range of homes<br>• Economic growth that benefits as many people as possible<br>• Quality jobs and valuable skills<br>• A vibrant cultural offer<br>• A green and sustainable city that cares about the environment<br>• A strong voice for Plymouth regionally and nationally<br>• A welcoming city |
| Performance, Finance and Customer Focus | Relevant policies in the Plymouth Plan<br>Corporate Performance Monitoring<br>Financial Performance Monitoring<br>Annual Budget Setting Process<br>Medium Term Financial Strategy<br>Revenues and benefits<br>Homelessness<br>Communications<br>Human resources<br>Audit and Risk | • A clean and tidy city<br>• People feel safe in Plymouth<br>• A welcoming city<br>• Listening to our customers and communities<br>• Motivated, skilled and engaged staff<br>• Spending money wisely<br>• Providing quality public services |

| **Overview and Scrutiny Committee** | **Current Areas of Responsibility** | **Map to Corporate Plan Priorities** *(some appear across more than one committee)* |
|---|---|---|
| | Transformation<br>Bereavement Services and Register Office<br>Community Safety<br>Customer Services<br>Street scene and Waste<br>Parking<br>Hear call-ins relevant to the role of the committee | |
| Education and Children's Social Care | Relevant policies in the Plymouth Plan<br>Early Years Services<br>Schools, colleges and other educational settings<br>Child Poverty<br>Special Education Needs, behaviour and attendance, narrowing the gap in outcomes<br>Safeguarding Children<br>Cared for children<br>Youth offending<br>Adoption and Fostering<br>Corporate Parenting<br>Hear call-ins relevant to the role of the committee | • Improved schools where pupils achieve better outcomes<br>• Keep children, young people and adults protected<br>• Focus on prevention and early intervention |
| Health and Adult Social Care | Relevant policies in the Plymouth Plan<br>Integrated Commissioning<br>Hospital and community health services<br>Dental services, pharmacy and NHS ophthalmic services;<br>Public health services<br>Adult Social Care Services<br>Adult Safeguarding Services<br>Hear call-ins relevant to the role of the committee | • Keep children, young people and adults protected<br>• Focus on prevention and early intervention<br>• Reduced health inequalities<br>• A welcoming city |

# Health and Adult Social Care Overview and Scrutiny Committee

| | |
|---|---|
| Date of meeting: | 29 January 2020 |
| Title of Report: | **HASC Policy Brief** |
| Lead Member: | Councillor Kate Taylor (Cabinet Member for Health and Adult Social Care) |
| Lead Strategic Director: | Craig McArdle (Interim Strategic Director of People) |
| Author: | Sarah Gooding (Policy & Intelligence Advisor) |
| Contact Email: | Sarah.Gooding@Plymouth.gov.uk |
| Your Reference: | HASC PB 29012020 |
| Key Decision: | No |
| Confidentiality: | Part I - Official |

**Purpose of Report**

To provide Health and Adult Social Care Overview and Scrutiny Committee with the latest national picture in respect of policy announcements and legislation relating to health and social care.

**Recommendations and Reasons**

For Scrutiny to consider the information provided in regard to their role and future agenda items.

**Alternative options considered and rejected**

N/A

**Relevance to the Corporate Plan and/or the Plymouth Plan**

Delivery of the Corporate Plan and Plymouth Plan needs to take account of emerging policy and the legislative picture.

**Implications for the Medium Term Financial Plan and Resource Implications:**

N/A

**Carbon Footprint (Environmental) Implications:**

N/A

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

** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*

N/A

**Appendices**

**Add rows as required to box below*

| 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 | HASC Policy Brief | | | | | | | |
| | | | | | | | | |

**Background papers:**

**Add rows as required to box below*

*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 any 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 |
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**Sign off:**

| Fin | pl.19.20.205. | Leg | ALT/30508/17 | Mon Off | Click here to enter text. | HR | Click here to enter text. | Assets | Click here to enter text. | Strat Proc | Click here to enter text. |
|---|---|---|---|---|---|---|---|---|---|---|---|

Originating Senior Leadership Team member: Craig McArdle (Strategic Director for People).

Please confirm the Strategic Director(s) has agreed the report? Yes

Date agreed: 17.01.2020

Cabinet Member approval: Kate Taylor *(Cabinet Member for Health and Adult Social Care)*

Date approved: 14.01.2020

# POLICY BRIEF

Health and Adult Social Care Overview and Scrutiny

29 January 2020

**The information contained within this brief is correct at the time of publication (Monday 20 January 2020).**

## HEADLINES

- General Election 2019 – the Conservatives won a majority with 365 MPs. Government ministers remain in post and continue to run their departments – a cabinet reshuffle is expected in February 2020.
- The provisional Local Government Settlement was published on 20th December 2019. The proposals include an additional £1.5bn for social care comprising £1bn additional grant for both adult and children's social care and a proposed 2% council tax precept for adult social care. These additional resources sit on top of the existing social care package, which will continue at 2019-20 levels.
- Chancellor's Budget set for 11 March 2020. The Budget will prioritise the environment, and build on recent announcements to boost spending on public services and tackle the cost of living. These include investing in new hospitals, training thousands of new police officers, funding vocational education and the biggest ever cash increase to the National Living Wage.
- A Queen's Speech was delivered on the 19 December 2019. The speech outlined the Government's intentions over the next Parliament and sets out 29 bills.

Headline announcements include;

- Priority to expedite the European Union (Withdrawal Agreement) Bill - implement in domestic law the Withdrawal Agreement which has been agreed between the UK and the EU.
- Immigration and Social Co-ordination Bill - points-based immigration system.
- Increase in the National Insurance threshold and an increase in the National Living Wage.
- Serious Violence Bill - new duties will require schools, police, councils and health authorities to work together and have plans in place to prevent and reduce serious violence.
- Domestic Abuse Bill - will establish a statutory definition of domestic abuse, including emotional, coercive or controlling behaviour and economic abuse. New duty to provide support to victims of DA and their children in refuges and other safe accommodation.
- Publish a National Infrastructure Strategy and prioritise investment in infrastructure and world-leading science research and skills and increase tax credits for research and development, establishment of a National Skills Fund.
- Environmental Bill will enshrine in law environmental principles and legally-binding targets, including for air quality. Target of net zero greenhouse gas emissions by 2050.

Measures relating to health and social care include:

### NHS Funding Bill and Long Term Plan

- Multi-year funding settlement for the NHS with a £33.9 billion increase in cash terms by 2023-24.
- Continue completing aims laid out in the NHS Long Term Plan and accelerate progress.
- Additional support through delivering 50,000 more nurses, with non-repayable maintenance payments of at least £5,000 per year for nursing, midwifery and some allied health professional students, 6,000 more doctors and 6,000 more primary care professionals in general practice.

- 40 new hospitals to be funded and built over the next 10 years on top of 20 new hospital upgrades announced in the summer.
- The NHS People Plan will ensure that qualified doctors, nurses and allied health professionals with a job offer from the NHS, and who have been trained to a recognised standard, will be offered fast-track entry, reduced visa fees and dedicated support to come to the UK.
- Free hospital parking for those in greatest need.
- 50 million more appointments in GP surgeries every year.

**Social Care Reform**

- Three-point plan for social care:
    - Additional £1 billion for adult and children's social care in every year of this Parliament. Consult on the 2 per cent precept that will enable councils to access a further £500 million for adult social care for 2020-21.
    - Cross party consensus on long term plan for social care reform
    - Nobody needing care will be forced to sell their home to pay for it.

**Mental Health Reform**

- Modernise the Mental Health Act by giving patients more autonomy, allowing them to set their preferences about their care and treatment in advance.
- Act on the recommendations of the Independent Review of the Mental Health Act through a White Paper in the New Year to reform the process of detention; specifically, the disproportionate number of people from black and minority ethnic groups detained under the Act.
- The Government will make it easier for people with learning disabilities and autism to be discharged and improve how they are treated in law.

**Medicines and Medical Devices Bill**

- Making it simpler for NHS hospitals to manufacture and trial the most innovative new personalised and short life medicines.
- Removing unnecessary bureaucracy for the lowest risk clinical trials, to encourage rapid introduction of new medicines. Implementing scheme to combat falsified medicines entering supply chains.

**Health Service Safety Investigations Bill**

- Will establish the Health Service Safety Investigations Body (HSSIB) with powers to conduct investigations into incidents that happen under the provision of the NHS.

**National Disability Strategy**

- The Government will publish a National Strategy for Disabled People in 2020 to support disabled people in all aspects and phases of their life.

Further details on all measures announced in the Queen's Speech can be found here.

## GOVERNMENT POLICY, LEGISLATIVE ANNOUNCEMENTS AND NEWS

**Department of Health and Social Care (18/12/2019)** All nursing students on courses from September 2020 will receive a payment of at least £5,000 a year which they will not need to pay back. Further details provided on the measures announced in the Queen's Speech (see above).

**Department of Health and Social Care (27/12/2019)** Free hospital parking for thousands of patients, staff and carers. Further details provided on the measures announced in the Queen's Speech (see above).

From April, all 206 hospital trusts in England will be expected to provide free car parking to groups that may be frequent hospital visitors, or those disproportionately impacted by daily or hourly charges for parking, including:

- blue badge holders
- frequent outpatients who have to attend regular appointments to manage long-term conditions

Free parking will also be offered at specific times of day to certain groups, including:

- parents of sick children staying in hospital overnight
- staff working night shifts

## OPEN CONSULTATIONS

| Date of publication | Performance, Finance and Customer Focus Overview and Scrutiny Committee | GOV |
|---|---|---|
| 20 December | Ministry of Housing, Communities & Local Government. Provisional local government finance settlement 2020 to 2021 Closes 17 January 2020 | Open consultation |

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# Health and Adult Social Care Overview and Scrutiny Committee

| | |
|---|---|
| Date of meeting: | 29 January 2020 |
| Title of Report: | **Primary Care Strategy and Plymouth Prospectus** |
| Lead Member: | N/A |
| Lead Strategic Director: | Jo Turl, Director of Commissioning (Western) – NHS Devon CCG |
| Author: | Mark Procter, Director of Primary Care – NHS Devon CCG<br>Paul Baker, Deputy Director of Commissioning (Primary care) – NHS Devon CCG |
| Contact Email: | D-CCG.CorporateServices@nhs.net |
| Your Reference: | N/A |
| Key Decision: | No |
| Confidentiality: | Part I - Official |

**Purpose of Report**

The attached report has been provided in response to the Committee's request to consider Primary Care services in Plymouth.

This strategy sets out our ambition and vision for general practice over the next five years. It describes how we will support our GP practices to provide accessible and coordinated care and ensure a skilled and motivated workforce to respond to the current and future needs of our population. We will continue to work with the public and service providers to ensure everyone understands the role they can play in achieving our collective vision.

GPs are the first point of contact with the NHS for most people and this strategy relates to those services provided by general practice. General practice is often described as the 'front door of the NHS'. Wider primary care providers include dentists, community pharmacists and optometrists. Around 90 per cent of interactions in the NHS take place in primary care.

Our vision for general practice is:

***General practice will offer their local community a wide and flexible range of information, support and services to enable people to live happy healthy lives.***

General Practice in Devon will be delivered from either a single practice or a network of practices typically covering a population of 30k – 50k. They will operate from modern buildings which have a range of co-located services and a multi-disciplinary workforce targeting care to specific needs including prevention and self-care, that have been identified using population health management methodology. These services will be accessed using a digital first approach.

Our patients will have the best outcomes if we work in a truly integrated way. This means each service being able to quickly and easily respond to requests from colleagues for advice or input to an individual

patient and, for individuals with more complex needs, working in partnership with a multi-disciplinary team of professionals.

Central to our vision are patients who take a much more active role in improving their own health, managing their own ill health and being better informed about which professional is best able to help them.

GPs are at the centre of patients' care, coordinating and overseeing other clinicians and healthcare providers, as well as providing care directly to patients. There will be a wide range of easily accessed and readily available alternatives to GP provided care.

Back office services will be delivered at scale across the practices with digital systems that enable improved efficiency and information sharing across practices and other health and care partners.

**Recommendations and Reasons**

The committee is recommended to note the report.

**Alternative options considered and rejected**

NHS Devon CCG has provided the report at the committee's request, in compliance with regulation.

**Relevance to the Corporate Plan and/or the Plymouth Plan**

Content of this report is relevant to Plymouth Plan strategic objective one, Delivering a Healthy City.

Consideration of this report aligns with NHS Devon values of One Team and the City Council's Corporate Plan Co-operative and Democratic values.

**Implications for the Medium Term Financial Plan and Resource Implications:**

No implications for the City Council's financial planning are identified in this report.

**Carbon Footprint (Environmental) Implications:**

N/A

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

** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*

N/A

**Background papers:**

*N/A*

**Sign off:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Fin | **N/A** | Leg | **N/A** | Mon Off | **N/A** | HR | **N/A** | Asset s | **N/A** | Strat Proc | **N/A** |
| Originating Senior Leadership Team member: Jo Turl, Director | | | | | | | | | | | |

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|---|
| Please confirm the Strategic Director(s) has agreed the report? n/a |
| Cabinet Member approval: *n/a* |

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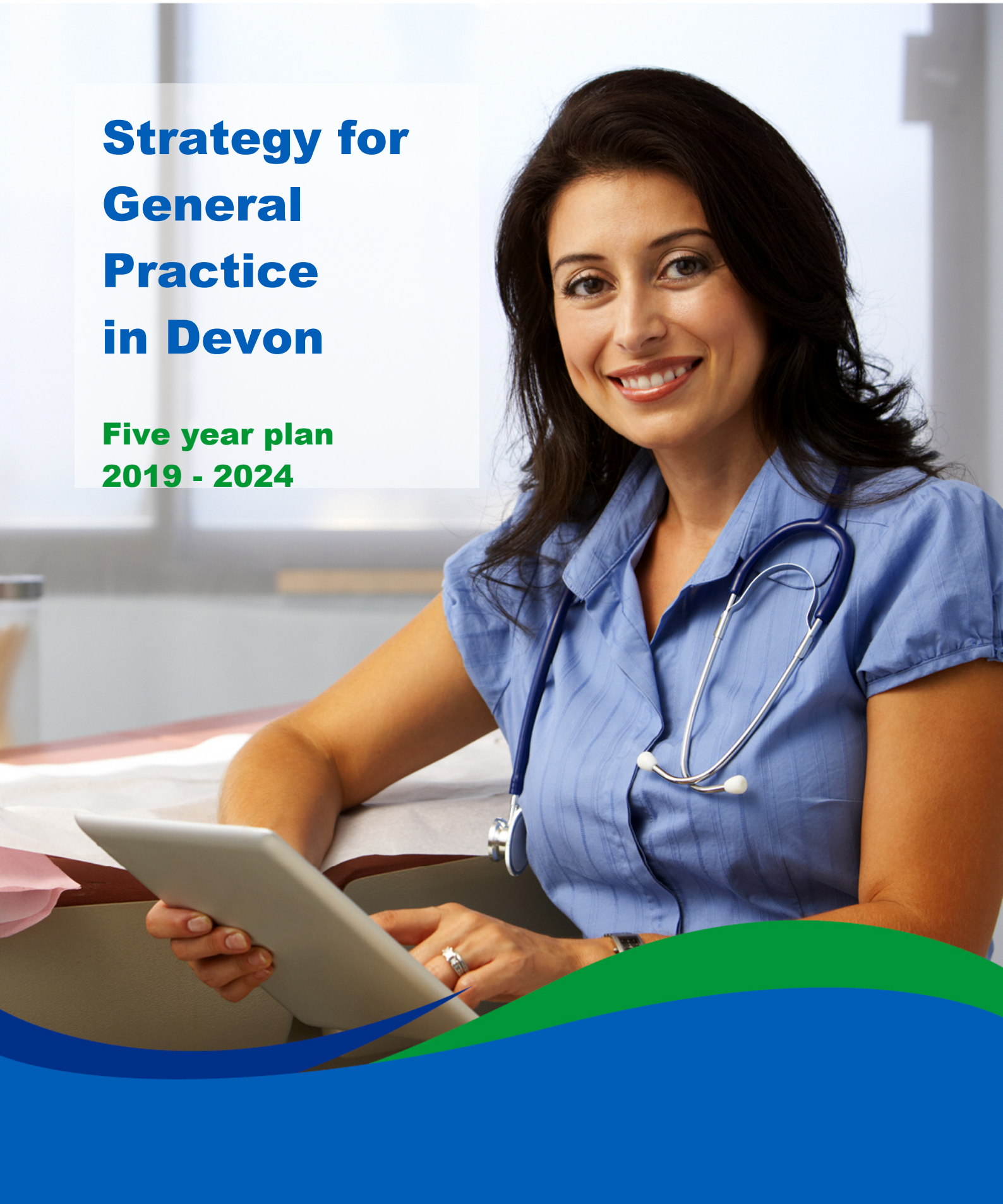
DRAFT

NHS
Devon
Clinical Commissioning Group

# Strategy for General Practice in Devon

## Five year plan
## 2019 - 2024



# Foreword

We are proud of the excellent primary care services we offer in Devon.

As a GP in Devon for more than 10 years, I see first-hand how my primary care colleagues provide high quality, caring and compassionate services for people in our area.

All Devon GP practices are rated as Good or Outstanding by the Care Quality Commission (CQC) and there are consistently high satisfaction rates in the annual GP Patient Survey locally.

All 127 Devon GP practices are part of one of the newly formed 31 Primary Care Networks and there is increasing joined-up working right across Devon as we head towards a new Integrated Care System.

Devon is leading the way in developing digital solutions for general practice. More than half a million people in Devon can now access online consultations with their GP practice, and Devon has the highest usage of the NHS App.

**Our vision is that primary care in Devon will offer each local community a wide and flexible range of information, support and services to enable people to live happy healthy lives.**

To do this, we must address a number of challenges. Increasing demand, difficulties in recruitment and retention, and funding that includes estates and IT are areas that need our attention.

This strategy is the baseline for joint working for the next five years. It outlines five priorities that will revolutionise general practice.

1. We will improve patient **access** to care through innovative technology

2. We will develop and retain an agile and engaged **workforce**, with a focus on multi-disciplinary teams to reduce pressures on services and improve outcomes for patients.

3. We will take a **population health management** approach to improve Devon's health and wellbeing, and reduce health inequalities

4. We will develop **Primary Care Networks** to provide more joined-up care close to home

5. We will modernise our **estates and infrastructure** to support and enhance services.

This document focuses on the future delivery of general practice, but primary care is formed of a much more diverse workforce than just those within GP practices. Involvement of all providers, including pharmacists, dentists, optometrists, allied health professionals and the voluntary sector, will ensure we have sustainable primary care in the future.

**Dr Paul Johnson**
Chair, NHS Devon CCG

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# Our vision

***General practice will offer their local community a wide and flexible range of information, support and services to enable people to live happy healthy lives***

General Practice in Devon will be delivered from either a single practice or a network of practices typically covering a population of 30k – 50k. They will operate from modern buildings which have a range of co-located services and a multi-disciplinary workforce targeting care to specific needs including prevention and self-care, that have been identified using population health management methodology. These services will be accessed using a digital first approach.

Our patients will have the best outcomes if we work in a truly integrated way. This means each service being able to quickly and easily respond to requests from colleagues for advice or input to an individual patient and, for individuals with more complex needs, working in partnership with a multi-disciplinary team of neighbourhood professionals.

Patients will be supported to take a more active role in improving and managing their own health and will be better informed about which professional is best able to help them.

GPs are at the centre of patients' care, coordinating and overseeing other clinicians and healthcare providers, as well as providing care directly to patients. There will be a wide range of easily accessed and readily available alternatives to GP provided care.

Back office services will be delivered at scale across the practices with digital systems that enable improved efficiency and information sharing across practices and other health and care partners.

**Our five pillars**

**1.** We will improve patient **access** to care through innovative technology

- People can access care from an appropriate service when they need it
- Improve patient experience and outcomes, empowering people to take control of their own health
- Improve extended and consistent access to primary care services
- Digital first approach to delivery of services

**2.** We will develop and retain an agile and engaged **workforce**, with a focus on multi-disciplinary teams to reduce pressures on services and improve outcomes for patients

- GPs and primary care teams are resilient, and have manageable and appropriate workloads
- Primary care can attract and retain the staff it needs
- Integrated community and primary care multidisciplinary teams delivering care

**3.** We will take a **population health management** approach to improve Devon's health and wellbeing, and reduce health inequalities

- People receive care targeted to their specific needs, including improved prevention and self-care
- Reducing the health inequality gap
- Reduce unwarranted variation and accurate disease prevalence where Devon is an outlier

**4.** We will develop **Primary Care Networks** to provide more joined-up care close to home

- Working with all practices as part of Primary Care Networks
- Implementing leadership development programmes

**5.** We will modernise our **estates and infrastructure** to support and enhance services

- Co-located premises with community and voluntary sector services
- Primary care deploys its resources effectively to achieve the best possible outcomes for patients

# The benefits of working in this way

## For Patients

**Co-ordinated services** where patients only have to tell their story only

**Access** to a wide range of services and professionals
- in the community
- In a single coordinated appointment

**Access to appointments that work around their life**
- shorter waiting times
- convenient appointments
- different ways of accessing appointments using technology

**Patients feel in control and have responsibility*:***
- **More influence** for people, providing them with more involvement and decision-making opportunities over how their health and care is planned and managed
- Patients given support to take responsibility for access to **personalised care** and with a focus on self-care and prevention, living healthily, recognising what matters to the person and how their individual strengths, needs and preferences can support better outcomes

## For general practice and other providers of care

**Greater resilience across general practice** by making the best use of shared staff, buildings and other resources, they can help to balance demand and capacity over time

**Better work/ life balance** with more activity routed directly to appropriate professionals such as clinical pharmacists, social prescribers, physiotherapists

**More satisfying work** with each professional able to focus on what they do best, spending time with patients where most needed

**Improved care and treatment for patients** by expanding access to specialist and local support services including social care and the voluntary sector

**Greater influence** in the wider health system, leading to more informed decisions about where resources are spent

Attractive to **new people to come and work** in general practice in Devon, with greater retention of workforce

## For the whole health and care system

**Coordinated care** through collaboration and cooperation across organisational boundaries and teams with shared accountability

**A range of services in a community setting**, so patients don't have to default to hospital services

**A more population-focused approach** to Devon wide decision-making and resource allocation, drawing on primary care expertise as central partners

**Resilience** across the health and care system

Providing services **that are affordable**

# Background

This strategy sets out our ambition and vision for general practice over the next five years (2019-2024).

It describes how we will support GP practices in Devon to provide accessible and coordinated care, with a skilled and motivated workforce who can respond to the current and future needs of our population.

GPs are the first point of contact with the NHS for most people and this strategy relates to those medical services provided by general practice. General practice is often described as the 'front door of the NHS'. Wider primary care providers include dentists, community pharmacists and optometrists. Around 90 per cent of interactions in the NHS take place in primary care.

This strategy defines how a series of actions and enablers in general practice will positively impact on pressures faced by the wider system. For example, this strategy sets out how we will improve access for patients, which in turn can help reduce inappropriate ED attendances locally. By reducing vacancies in primary care and finding solutions for recruitment and retainment, we can help reduce inappropriate referrals in to secondary care.

# Drivers for change

## National

The NHS Long Term Plan sets a direction of travel for primary care services.

GP practices face many challenges. Nationally, one in six GP posts are vacant. Practices are finding it increasingly difficult to recruit and retain GPs and are seeing this trend extend to other members of the team, such as nurses and practice managers.

There have been increases in NHS funding, but people's needs for services are growing faster.

The new GP Contract has been positively received by many providers in that it addresses some long-standing issues, such as the costs of clinical indemnity.

The introduction of Primary Care Networks (PCNs) is the biggest transformation in more than a generation to the way family doctors work. General practices across Devon will begin working together formally within local PCNs.

As they develop, Networks will recruit multi-disciplinary teams, including pharmacists, physiotherapists, paramedics, physician associates and social prescribing support workers, freeing up GPs to focus on the sickest patients.

PCNs will support each other while offering more specialist care services to patients and taking on a wider range of health professionals. New larger sized business models (Networks, Federations, Super Partnerships) are emerging but traditional practice model (small multi-partnerships) still dominate.

## Local

NHS Devon Clinical Commissioning Group has a population of 1.2 million people, living across Devon, Plymouth and Torbay, with an annual budget of £1.8 billion.

The population of Devon is expected to increase by more than 33,000 by 2024, the equivalent of the town of Exmouth. The number of people in Devon aged over 75 years old is expected to rise by more than 20% in the next five years, with the number of people aged over 85 years old expected to rise by more than 11%.

Devon's Long Term Plan describes the challenges the county's health and care system is facing:

- While more people are living longer, it is often in ill-health.
- Preventable illnesses are increasing.
- There are persistent inequalities in life expectancy and health outcomes.
- The population is growing, and the proportion of older people is set to increase, and this will increase the demand for services
- Vital health and care jobs are unfilled, and numbers of working age adults will reduce in future.
- There are continuing pressures on hospital beds.
- There is unwarranted variation in clinical outcomes across wider Devon.

More about the population of Devon can be found in the Joint Strategic Needs Assessment produced by each local authority. Devon has varying levels of deprivation areas and there are differences in health outcomes across the county.

Devon's health and care partners have worked together to produce a Long Term Plan for Devon (Better for You, Better for Devon). It will ensure that Devon's health and care system supports people to live healthier lives, improves physical and mental health outcomes for children, adults, older people and families, promotes wellbeing and reduces health inequalities across the whole of Devon.

This strategy for general practice will form part of the wider Long Term Plan for Devon, with each of the aims and objectives linking directly to the wider aims of the Devon Plan.

**Delegated commissioning of primary care medical services**

The CCG is a clinically led organisation and all GP practices in Devon form part of our membership. They share with us the views of all the health care professionals within the surgeries as well as those of the community teams with whom they work. Devon practices voted to support the move to delegated commissioning for primary care medical services. In April 2019, the newly formed Devon CCG took over this responsibility from NHS England.

# Improving the quality of care

We are supporting practices to improve quality of patient care and in working to reduce variation. Quality and safety is a responsibility of all healthcare organisations, whether commissioner or provider in nature. We view quality as comprising the following components:

- clinical effectiveness,
- patient experience
- patient safety

We will be open and transparent about the quality of primary care in the area and, where appropriate, will publish robust and reliable quality-focussed information.

We will work with partners to triangulate information and knowledge where appropriate to do so, and would expect this to include NHS England, the Care Quality Commission and Local Authorities. This information will include prescribing, referrals and emergency department attendances data.

Work has been undertaken to establish useable quality-focussed tools that identify actual, emerging and possible areas of concern, so that remedial action can be taken on a proactive basis. We will explore how best to extend this to include General Practice.

We will be looking to develop a new series of indicators that measure quality in general practice, based on business intelligence data and analysis. This will include a review of public health data, Care Quality Commission (CQC) data, Quality and Outcomes Framework (QOF), Quality and Equality Impact Assessments (QEIA), yellow card, serious incident/significant event analysis, patient feedback and complaints and the nationally-run GP Patient Survey.

This data will be formally monitored by the CCG's Quality Committee.

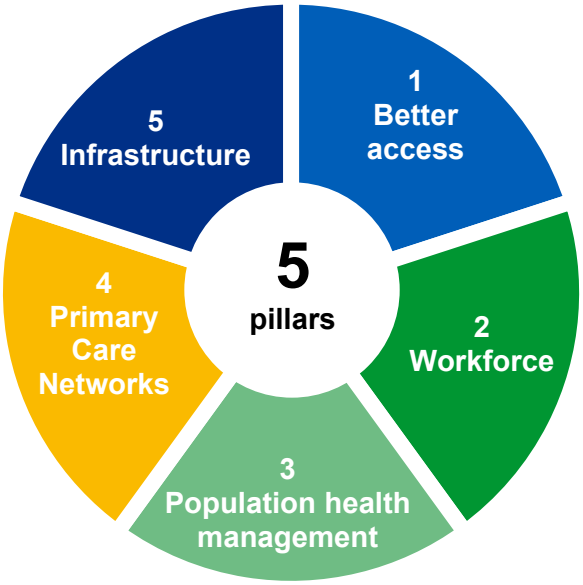
## What we will do

We will work with practices, PCNs and localities to benchmark outcomes and learn from best practice.

We will implement a comprehensive system of practice and network reviews, including site visits, to learn from best practice and support practices which continue to benchmark poorly we will include involvement of contractor professional representatives where that is either agreed between us or felt by either party to be required.

We will review the sustainability of single-handed practices in Devon during the first year of this strategy to understand the issues they face and ensure we have plans in place to address any risks to provision of services identified.

# Our five pillars

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# 1 Better Access

We have worked closely with local providers to identify and develop solutions that allow patients to access care through alternative methods, including community pharmacists, voluntary sector and by using new technology.

In Devon, the 2019 NHS Patient Survey found that 81% of patients were satisfied with the type of appointment they were offered by their GP practice. For those who weren't satisfied, 11% went to A&E, 5% called NHS 111, 9% went to a pharmacist and 33% didn't end up seeing or speaking to anyone. The remaining 42% contacted another service, waited for a different day, or took advice online or from a friend/family member.

The extended access directed enhance service is now part of network level contracts from 2019/20 with the CCG commissioned extended access moving into network contracts in 2020/21. Where opportunities exist, the CCG will encourage PCNs to deliver extended access at a larger scale to make best use of resources but considering patient demographics and geography.

The current model of provision includes 7-day and 24-hour (24/7) access to general practice. The out-of-hours service provides care where a level of need is identified that is most appropriately met by General Practice, but which cannot wait until mainstream General Practice is next available.

Local data and feedback to suggest there is appetite for weekend provision of medical services is variable. Therefore, we will ensure that limited resource is deployed in way that matches demand and is not driven by perceived need alone.

## What we will do

We will ensure needs of patients requiring urgent primary care are met appropriately and routine appointments are available in the evenings and at weekends where there is demand or a need (building on overall high levels of patient satisfaction with appointment availability in Devon currently).

## Impact measures for better access

We will use the following measures to show the impact of the initiatives included in this section on access to general practice:

- Patients with an urgent clinical need will have access to a consultation on the day and patients with a non-urgent need will be offered a consultation within 7 days.
- Directly bookable GP appointments will be available via all PCNs – the percentages to be made available will be agreed during the planning of each year.
- Improved patient survey results demonstrating improved satisfaction with access, with a 5% increase year-on-year in satisfaction rates across the access sections in the national GP Patient Survey.
- Improved Friends and Family test responses demonstrating improved satisfaction with access – the percentage of improvement will be agreed during the planning of each year.

# Digital First in primary care

Digital is an essential enabling function to allow for radical transformation in service delivery and patient care by creating greater efficiency, better quality and improved safety. The importance of a digital enabling strategy to deliver modern general practice in a challenged NHS has never been clearer. No viable future health and care system is possible without digital innovation, design and support throughout. The vision is to 'Support citizens and clinicians by using information and technology seamlessly, safely, quickly and innovatively', Devon's digital strategy is designed to transform health and care with clear priorities for digital transformation supported by four workstreams:

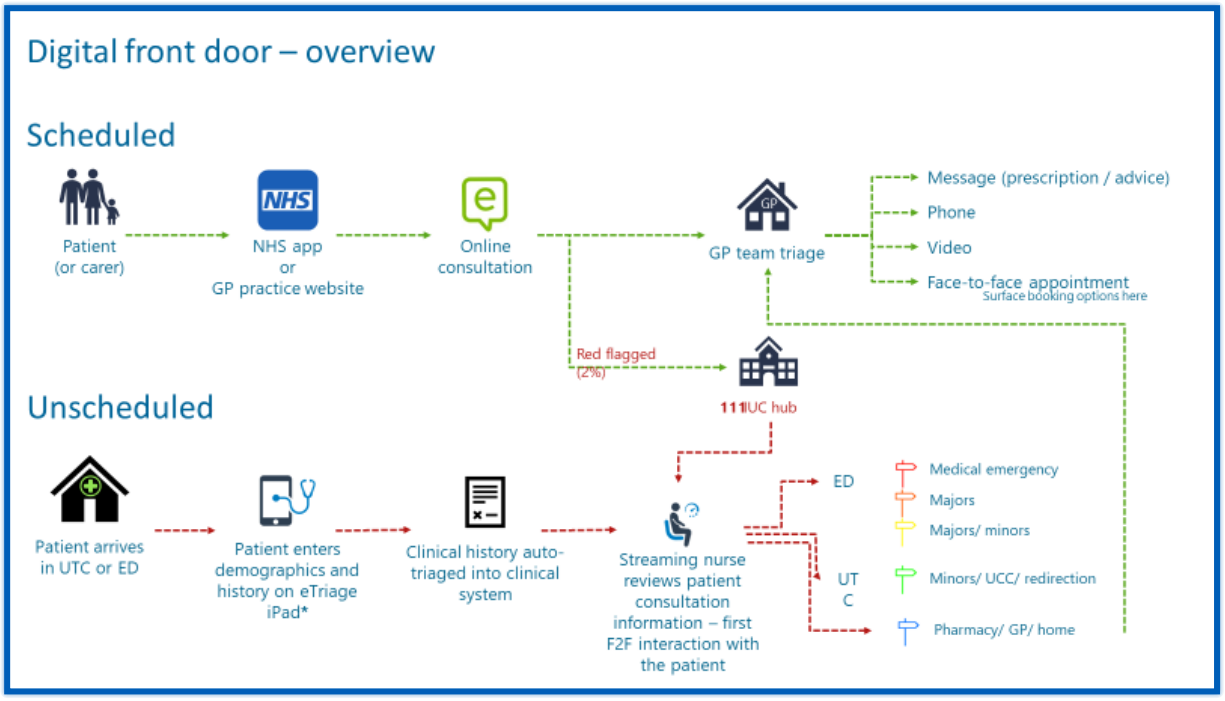
- Feels like one system: A shift to shared, consolidated and integrated records
- Technology together: Shared infrastructure and technical design
- The digital citizen: Increasing access to services and self-care online
- Harnessing information: Advances in data analytics, intelligence and governance

## What we will do

We will adopt a 'digital first' approach. Where possible, the first contact with general practice services will be digital, there will be digital connectivity between organisations.

Everyone can expect that their personal and medical history is available wherever they touch health and care systems. They will be supported digitally for self-care and technology will be doing some of the routine work previously undertaken by staff.

We are committed to helping develop an end-to-end digital patient journey through scheduled and unscheduled care, sharing our learning and understanding. The model we will adopt in Devon is shown in the diagram below:




## What we will do

Devon will continue to lead the way in digital innovation. The Digital Accelerator project will be expanded in scope to cover the whole of Devon, allowing quicker access to primary care by delivering online consultations and better utilisation of resources. To facilitate this, new workforce models will be developed for GPs and other clinicians to deliver online services, scalable across the county and beyond.

We will enable GP practices to embrace and embed the functionality of the NHS App, supporting patients to access self-care, clinical advice, book appointments, order repeat prescriptions, access their medical records, choose preferences for data sharing and organ donation.

Promoting digital activation amongst all groups of patients including a digital guidebook developed by Healthwatch to help patients navigate the NHS and the potential for Digital Drop in surgeries at practices run by the voluntary sector

# The Digital Patient

## NHS App

The NHS App will become the digital front door to the NHS, offering a gateway for patients allowing them to access self-care and clinical advice, book appointments, order repeat prescriptions, access their medical records, choose preferences for data sharing and organ donation. Devon has the highest use of the NHS App nationally, with more than 4,000 downloads to date.

93% of GP practices in Devon are live on the NHS App, providing a simple and secure way for people to access a range of NHS services on their smartphone or tablet.

| | %eligible live GP pop registered for NHS App | Total App registrations | GP registered pop aged 13+ years (Live Practices) | Total GP registered patients aged 13+ years | % Live practices | % GP pop registered for POL | GP pop registered for POL | Total POMI patient size |
|---|---|---|---|---|---|---|---|---|
| Devon | 0.50% | 5,467 | 1,053,876 | 1,103,292 | 93% | 26.69% | 324,814 | 1,216,834 |

*NHS Digital figures for NHS App in Devon November 2019*

The NHS App will help practices meet their targets for registering patients to GP online services as set out in the GP contract. The app doesn't change the online services that are already available. It's a new way of accessing them that can encourage uptake.

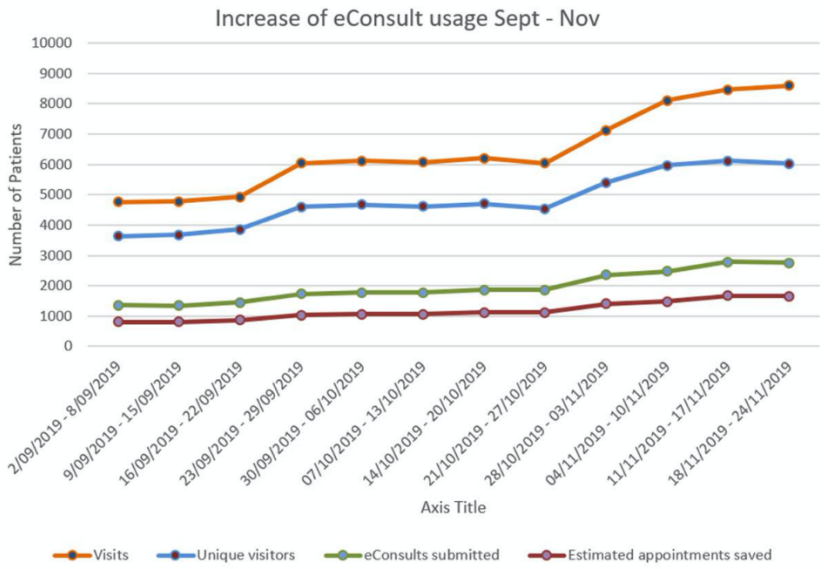
Most people can verify their identity through the NHS App, rather than having to visit the practice. This is more convenient for patients and saves time for practices. More patients booking appointments online can also save practices time and money.

Making more specialist appointments available online, improving access, can also help towards Quality and Outcomes Framework and Enhanced Services targets.

## Online consultations

Access to clinical advice and capacity to meet demand are constant challenges facing general practice. Online consultation platforms aim to provide convenient access to clinical advice for patients while providing efficiency savings for clinicians.

Devon is leading the way with online consultations. Every month, more than 5,500 people consult with their GP online to get healthcare advice and treatment more quickly. This has saved more than 3,000 unnecessary face-to-face appointments.




*eConsult figures reported via digital accelerator project September 2019 – November 2019*

As well as being a more convenient and faster access to general practice, online consultations have several benefits:

- Reduced administrative workload for practice staff
- Improved communication between patients and practices
- Reduced travel for patients
- Expanded health knowledge for patients
- Increased information sharing and operational efficiencies for practices
- Increased patient satisfaction and reduction of missed appointments
- Improved access to care services

## What we currently do

**Online consultations in Plymouth**
Patients in Plymouth have a digital first option for services in a selection of the city's GP practices. The project, which is one of a number of nationally funded Digital Accelerators, is looking at the challenges faced during adoption of new technology, implementation and creating change. It is exploring new ways of working for clinicians to help increase capacity. The project will:

- Drive and increase online consultation at practices.
- Trial and implement a multidisciplinary care 'Hub and Spoke' model which can provide additional capacity for practices.
- Utilise the principles of crowdsourcing from an available network. They will have the capacity to deliver flexible, remote working to support practices under pressure, to free up GPs to focus on the patients who require a face-to-face consultation.
- Provide a full blueprint that can be adapted and implemented into any practice within the UK.

## Impact Measures for Digital First

- Full adoption of a digital front door model using eConsult by all practices with 5% of consultations taking place through eConsult by March 2020 and 20% by March 2025
- In accordance with national targets, all practices will have enabled the NHS App by June 2020 – the target level of patient usage and activations will be agreed during each planning cycle
- In accordance with national targets, all patients will have the right to effective online and video consultation by April 2021
- In accordance with national targets, all patients will have online access to their full record from April 2020
- In accordance with national targets, all practices will be offering and promoting electronic ordering of repeat prescriptions and using electronic repeat dispensing for all patients for whom it is clinically appropriate by April 2020
- There will be an increase in the percentage of appointments available for online booking agreed during each planning round building on the 25% of appointments are available by July 2019.
- A 5% year-on-year increase in patient satisfaction with online access, measured in the GP Patient Survey

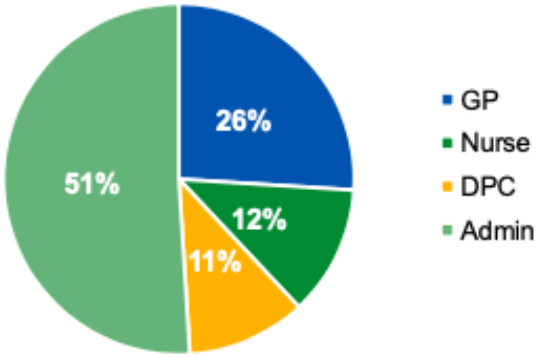
# 2 Workforce

The key element to delivery of this general practice strategy, is recognition of the need to develop and retain an agile and engaged workforce. In ensuring delivery of high-quality care, we recognise the importance of excellent training and development for our workforce. Our focus is on providing the appropriate support for our workforce from recruitment through to retirement.

In general practice, the biggest workforce challenges are on GP and practice nursing roles. Current training data indicates that there are not enough students currently in training to replace those who are likely to retire over the next 20 years. Unless the numbers of people in training increase substantially, up to 50% of our current workforce in Devon could be lost by 2035.

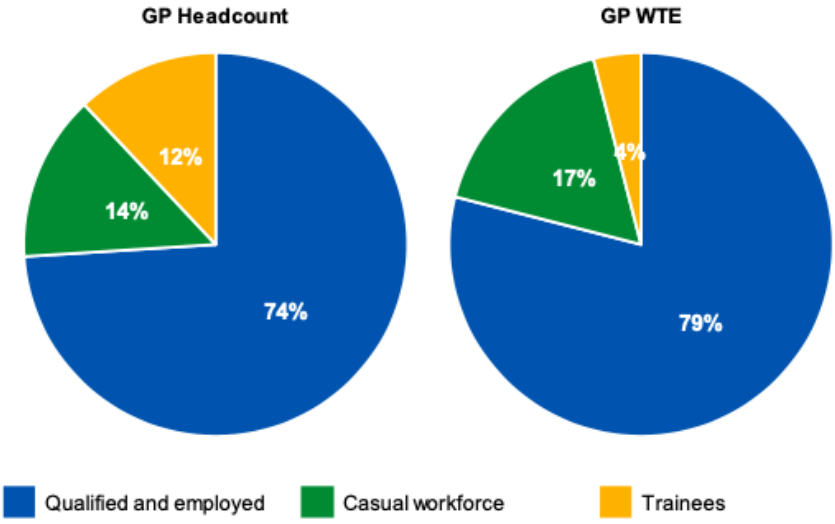
The continued challenges in recruiting GPs has highlighted that greater reliance on other clinical roles must become a priority.  Only 23% of the clinical workforce relates to non-GP roles and this must increase significantly to ensure a sustainable service for the future.

**Roles in primary care** (general practice, nurse, direct primary care and administration)




## GP workforce

There are approximately 660 whole-time equivalent (WTE) GPs in Devon. Sessional GPs (locums) represent 4% of the overall full-time equivalent (FTE). However, this group represents 14% of the overall headcount. This could potentially be an untapped resource. Understanding why this group prefer locum working and providing alternative solutions is vital to creating greater stability within this workforce group. The projected growth of GPs is limited over the period of this strategy to the difficulty in recruitment.



# Nursing workforce

There are approximately 400 nursing staff in general practice in Devon. Primary care has generally been attractive to experienced mid-career nurses. We are committed to developing a stronger pipeline by encouraging practices to recruit post-graduation nurses in to general practice. This approach will be supported by working closely with the Devon Training Hub to ensure these new recruits are able to fulfil the full remit of duties required in practice as quickly as possible.

In Devon practice nurses account for 74% of the overall nursing workforce FTE, but 78% of the overall headcount. The majority of these nurses work part time and could represent an untapped resource. Advanced Nurse Practitioners represent 20% of the current workforce and the majority work full time. The combined Nurse Specialist and External Nurse group (representing 6% of the nursing workforce), are recognised as the specialists in chronic disease management and mental health.

Some of the newer roles such as Physician Associates and Nursing Associates have yet to fully embraced by general practice. Both roles support the wider clinical staff group and provide an opportunity for practices to introduce varied roles into their current workforce models. The opportunity for these to be joint roles across primary and secondary care is being explored to increase collaboration across the sectors and optimise the available funding channels.

# Support staff

Support staff vacancies are amongst the lowest of the staff groups. Over the next five years, there will be opportunities for closer working and sharing of resources to support the system with its challenges. These opportunities will see more teams working on behalf of the wider system rather than for a single organisation and this may include teams being centralised or co-located.

## What we will do

We will work closely with partners, including the Academic Health Science Network, both Exeter and Plymouth Medical Schools, Plymouth and Exeter Universities and the Devon Training Hub, to take forward emerging action plans drawn up in response to our improving understanding of anticipated workforce needs and also barriers to commencing a career within primary care settings.

This will include actions to address career attractiveness, recruitment to and retention within associated professions, and the offering of opportunities that vary from the traditional models.

We will undertake a capacity and capability analysis which will identify any skills gaps and shortages to inform development needs and also enable us to work effectively with training providers to provide an effective pipeline of skills in readiness to meet future requirements. Where skills gaps are identified, we will consider first the opportunity to improve service delivery through digital solutions while also enabling our clinicians to work at the top of their licence.

Our aspiration will be to first stabilise, then future-proof workforce, embracing new and different roles and associated qualifications, including associate physicians, revised nursing roles and varying the application of pharmacists' skillsets.

Access to accurate data is vital to supporting us in identifying and forecasting workforce challenges. From the data currently available, we have established that more individuals want to work more flexibly, achieving a greater work/life balance. We are working closely with practices to improve the accuracy of the data submitted through the National Workforce Reporting Tool so that we have a clearer picture of vacancies across general practice.

# Developing new roles

The current general practice workforce is continually evolving to incorporate new roles, which not only aim to deliver the new GP contract, but also provide the most appropriate care for our patients.

As we continue to skill mix the teams providing care, more patients attending their general practice will have the opportunity to see an expanded multi-disciplinary team with advanced training in diagnosis and treatment in their specialist areas. This signals a fundamental change in how patients will experience general practice, consulting with a broader team that is better suited to meeting patient needs.

These new care teams will include clinical pharmacists, physician associates, physiotherapists, paramedics and social prescribers. This will improve access to care, enhance patient safety and streamline patient pathways, ensuring that holistic care is delivered more efficiently.

## What we will do

**Establishing Primary Care Network teams**

Each PCN will, over the next three years, expand the multi-disciplinary team comprising:

- Clinical pharmacists (from 2019/20)
- Social prescribing link workers (from 2019/20)
- Physiotherapist (from 2020/21)
- Physician associates (from 2020/21)
- Community paramedics (from 2021/22)

# Recruitment and retention

As challenges to recruit and retain a resilient workforce continue, it is vital we utilise the current workforce in the most effective way to meet the needs of our population.

Where practicable, tasks and activities will be digitalised, allowing the workforce to focus on the delivery of patient care. Specialist knowledge and skills will be utilised in the areas of greatest need by teams who can react and adapt to a changing environment.

## What we currently do

**Plymouth Trailblazer scheme**
Devon CCG and HEE have funded for four sessions of Post-CCT GP Fellow time so the Trailblazer Scheme can be piloted in Plymouth. Newly qualified GPs who accept a substantive contract in a practice within the highest 20% deprivation index can apply for these post-CCT sessions.

The fellow sessions are used for private study, coaching, peer support groups, structured teaching sessions, and general reflection time, they work 4-8 clinical sessions, with two protected sessions.

For this pilot, the Trailblazer fellows have access to VTS sessions focused on subjects most relevant to inner city medicine including:

- Health inequalities
- Personality disorder
- Functional illness/chronic pain
- Substance misuse
- Asylum seeker mental health

## What we will do

Working in partnership with the PCNs we will:

- Attend local, regional and national job fayres promoting Devon as a place to work
- Continue to build on the success of the GP retainer scheme
- Make the GP fellowship scheme available across Devon
- Expand the portfolio and rotational working opportunities to staff working in general practice
- Work with the PCNs to develop a range of flexible working approaches
- We will continue to participate in the international recruitment of GPs initiative
- We will continue with supporting implementation of the 10-point practice nurse plan
- Continue with the NHS England retention scheme
- Expand the GP post training fellow pilot to cover the whole of Devon

## Impact measures for workforce

We will identify a range of measures to monitor the impact of the workforce initiatives. These measures will cover:

- Robust workforce data available from and about general practice workforce
- Reduction in stress related absences
- Better staff retention and positive feedback from staff surveys
- Reduced vacancies
- Reduced time to fill vacancies
- Appropriate use of the skill mix in wider multi-disciplinary teams, with an increase of Allied Health Professionals AHPs completing tasks within general practice
- A steady programme of funded estates developments which enable integrated working
- Fewer requests to the CCG for support via the resilience fund in relation to workforce issues, which is one of our current indicators of a practice that is struggling
- Better sharing and adoption of good practice in services
- Each PCN will have a five year workforce plan by December 2020 (with next 12 months plan in place by March 2020)
- Increase number of trained staff coming directly into general practice after completion of the graduate scheme

To set measures for all of these we need a clear base line.  Targets will be set in each annual business plan.

# 3 Population Health Management

A Population Health Management (PHM) approach will help to address Devon's complex and multifaceted health and wellbeing challenges. It will increase the understanding of how and why different health and social care services are used and provide a richer understanding of the underlying needs for services across organisational boundaries.

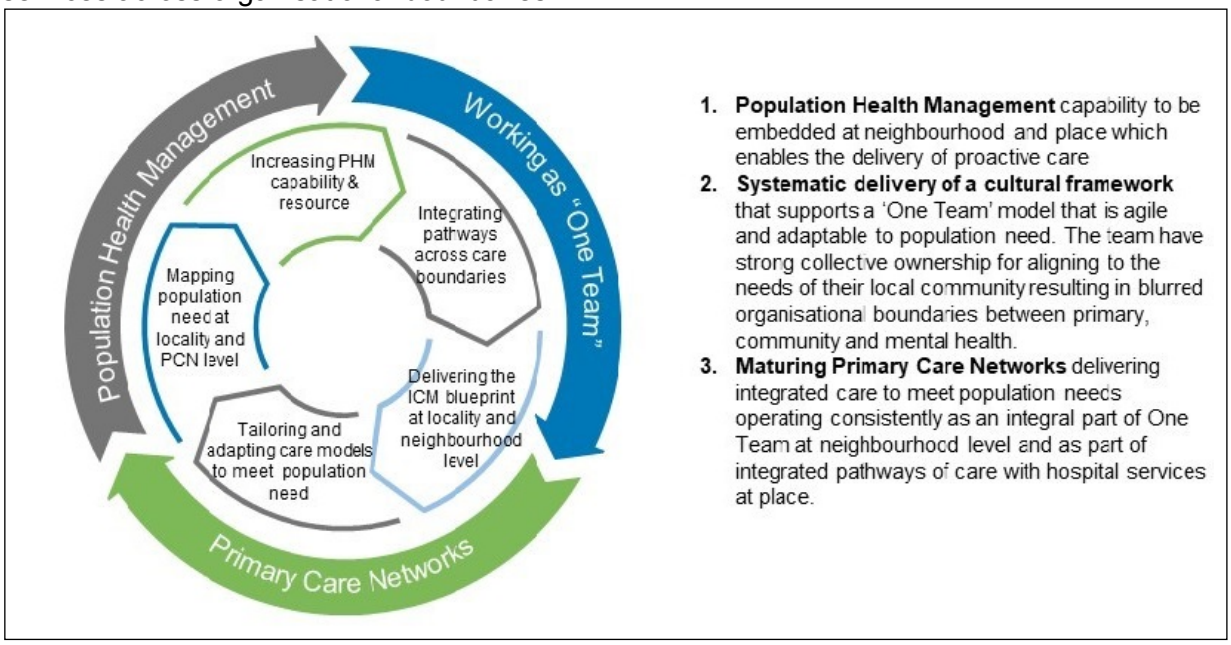



**Diagram 1: Population Health Management Approach**

Population Health Management will focus on:

- Infrastructure to ensure the basic building blocks of population health management are in place.
- Opportunities to improve care, quality, efficiency and equity throughout Devon.
- Care models focused on proactive interventions to improve health and reduce inequalities.

The expected outcomes and benefits are:

- Increasingly evidence-based decisions that inform the most efficient allocation of resources to prevent illness, improve care and lower costs.
- Financial improvement and improved health outcomes through prevention, early detection and intervention.
- Better monitoring and evaluation of the impact of interventions to improve outcomes or reduce inequalities, and upscaling to maximise benefits.

Through participation of partners, the opportunity of data linkage across organisations and staff capacity building. Taking a systematic approach to population health management will support effectiveness of Primary Care Networks and the Integrated Care Model. Participating in Wave 2 of NHS England's Population Health Management Development Programme will enable the development of technical capabilities and infrastructure. They will be used as the platform and driver for the local programme focused on delivery of the priorities for Devon and national commitments. The local programme will embed PHM approaches and targeted interventions within integrated care teams, using these teams as the central mechanism for changing practice and culture across the system.

## Harnessing the power of information

The proliferation of data and information captured within the GP IT Systems and the potential to connect that with other datasets from across our system gives us an opportunity to develop solutions to these problems through the creation of a Learning Health System.

Augmented intelligence through tools such a clinical decision support system has the potential to address these challenges whilst providing bespoke personalised care and avoiding clinician burnout.

### What we will do

We will create a cultural change which understands the power of data to drive a virtuous cycle of quality improvement. This will not be done in isolation but as part of the wider system and links in with the One Devon Data Set. All PCNs will receive data to inform decision-making and meet the needs of the population they cover. PCNs will develop population-specific services in response to this.

## Risk Stratification

Population health management provides the ability to understand variation through benchmarking and comparisons to improve clinical outcomes. It will help identify people who are currently well, but at risk of developing long-term conditions. This targeted approach will work at two levels: individual (known individual risk factors) and population (known risks in certain populations and communities).

This approach will help to prevent or delay the onset of long-term conditions, their functional consequences and the progression of frailty. Population health management will therefore enable more people to benefit from early identification and treatment, personalised care planning, self-management support, medicine management and secondary prevention services. The care model that PHM enables will support improvements in patient activation (people's knowledge, skills and confidence to self-manage) and better self-management will stop, or delay, progression of frailty and functional impairment or disability.

## Multi-Disciplinary Team Approach

Multi-disciplinary teams are already working effectively in many parts of general practice. This will be scaled up across all networks and include a greater number of professionals e.g. allied health professionals, social workers and other people e.g. voluntary sector within these teams to ensure that the right person can support the patient in the right way at the right time.

We will work with GPs to build multi-disciplinary teams around their leadership, with teams which will support delivery.

## Quality Outcomes Framework (QOF)

We will to empower and support professionals working in primary care to focus on quality improvement, we have agreed to introduce provision in the QOF to support professionally led quality improvement cycles, within and between practices. Our purpose is to support activities that are highly valued by patients and professionals, do not easily lend themselves to traditional QOF metrics, and which are expected to improve significantly the quality of care.

As at September 2019 in Devon our practices achieved on average 97.6% QOF achievement with a range of achievement of 77% – 100%. We aim to work with practices to ensure all practices are within the top decile.

### What we will do

In Devon, we will work in partnership with the practices and PCNs to ensure that the opportunities of the revised Quality and Outcomes Framework are fully realised and that practices reach the maximum points attainment which will ensure the quality of care is improved.

# Prevention

The Devon health and care system has had prevention at the heart of its priorities for several years. The Devon STP has invested £2million recurrently in 2019/20, alongside local authorities' public health funding, in a prioritised prevention programme to increase pace and scale of delivery. General Practice is often the best placed service to support this work.

The results of local engagement show that people want to take responsibility for staying well and independent for as long as possible in their own communities. The prevention programme will work towards this by enabling people to better manage their risk factors or conditions.

The priorities for prevention which we will work with General Practice to embed are:

- Making Every Contact count (MECC) - an approach to behaviour change that utilises the millions of day-to-day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations.
- Healthy lifestyles - Focus on reducing smoking, alcohol, obesity and increasing physical activity
- Falls and frailty - Using frailty indexes and falls assessments to reduce incidence of falls
- Social prescribing development support
- Children and young people's emotional health and wellbeing - Range of elements including community-based support, online help, training, bereavement support and support for families
- Adult Mental Health - Focus on suicide prevention and preventing poor mental health
- Multiple complex needs - Transformation of the system response to people with complex needs.
- Focus on identification and response to sexual violence and domestic violence and abuse.
- Long Term conditions - Focus on reducing diabetes, CVD and respiratory conditions.
- Personalisation - Supporting empowerment and the better integration of services across health, social care and the voluntary and community sector.
- Improved use of IT in population health management – To enable PCNs to look at the population health metrics for their communities.

## Self-care

Developing truly effective preventative approaches means helping people take more control of their own health, improving their life experience and reducing the need for reactive intervention by healthcare professionals in future periods.

We want to enable self-care so that patients take greater control over their health and wellbeing, while being able to readily access the right services conveniently located when they need them, and this will be a cornerstone of developing a healthcare system that is sustainable as a result of using our available resources in an optimal way that adequately and appropriately supports a population in which a growing number of people have complex healthcare needs.

## What we will do

We will empower patients who are willing and able to self-care with support and information through the new social prescribing workforce. We will also strive to reach those most vulnerable in our population and work with them to improve their health.

There will be a wider range of affiliated community-based professionals providing care and support as part of an enhanced patient offer. This will be both at practice and network level. Where appropriate patients will be directed to voluntary sector personnel both to deliver care and facilitate self-care using available technological solutions where appropriate. Clinical record keeping will wherever possible be on a shared clinical system.

Delivery will, naturally, though not exclusively, be most effectively delivered where multi-agency teams are co-located or otherwise in close proximity.

## Social Prescribing

There has been a drift towards medicalisation of some of the impacts of the wider determinants of health, such that the GP surgery is seen as a focal point for the community. As a result, this leads to many patient contacts with GPs that do not necessarily result in a resolution for the patient.

We are developing programmes to help local people struggling with long-term health conditions; build confidence and learn how to manage their condition(s), including mental health issues such as anxiety, stress and depression, better. The HOPE Programme (Help Overcoming Problems Effectively) is based on a course developed by the University of Coventry to help people cope better with long-term medical conditions.

The programme helps people to focus on themselves as a person, not as a long-term condition. It helps them to discover new strengths and rediscover old ones to keep yourself well. It also aims to boost self-confidence and resilience, to help people cope better emotionally, psychologically and practically with your condition.

## What we currently do

**Wellbeing Exeter**

Wellbeing Exeter is a partnership of public, voluntary and community sector organisations working together to explore better ways of supporting the 40% of patients who visit their GP with social problems rather than medical problems.

The approach offers social prescribing, in combination with asset-based community development to enable individuals and communities to improve and promote their own health and wellbeing. Central to the Wellbeing Exeter model is the development of community resilience within the city, alongside the social prescribing work.

Wellbeing Exeter is successfully delivering the type of support that is needed, for patients within primary care. Through signposting and one-on-work, Wellbeing Exeter is helping people to improve their mental wellbeing, reduce loneliness, re-engage with their community and manage their own health.

## Impact measures of population health management

We will agree with the PCNs a range of measures to monitor the impact of the population health initiatives. These measures will cover areas such as:

- Improved long-term conditions management (proxy prevalence)
- How all PCNs will use risk stratification to identify patients at most risk of hospitalisation
- How all PCNs will use a multi-disciplinary team approach to manage high risk patients
- Social prescribing will be offered to all patients where appropriate
- Increased use of social prescribing through programmes such as HOPE
- Increased achievement of the Quality Outcomes Framework
- Reduction in inappropriate ED attendances
- Reduction in emergency admissions from exacerbations of long-term conditions

Targets will be set in each annual business plan.

# 4 Primary Care Networks

Primary Care Networks are a pillar of the future of general practice. We know that there is considerable appetite in our local system for increased collaboration – between practices, as well as with associated health and social care providers, the voluntary and third sectors, and patients.

With all practices in Devon working as part of a Primary Care Network (PCN) this will support the personal and local nature of general practice and continuity of care that is at the heart of person-centred care close to home. PCNs will preserve local practices as the first point of contact for patients and enhance their resilience for the future. PCNs will enable:

- an extended range of services with access to specialist advice;
- a focus on population health management for physical and mental health;
- the development of tailored care for people with multi-morbidity and frailty
- peer review and clinical governance;
- investment in IT and other technologies;
- increased resilience, better able to respond to fluctuations in demand and capacity;
- better representation of general practice as a provider in system-level conversations
- career development and support for professional and other staff, including portfolio careers
- strong engagement with local communities

PCNs will be supported to provide fully integrated community-based health and care working seamlessly with their community and social care colleagues. Services will be introduced in line with the Devon Long Term Plan primary care goals, designed to improve quality and phased in over the coming years:

**During 2020**

- Structured medication review
- Enhanced health in care homes
- Anticipatory care (with community services)
- Personalised care
- Supporting early cancer diagnosis

**During 2021**

- Cardiovascular disease prevention and diagnosis, through case finding
- Locally agreed actions to tackle inequalities

**By 2023/24, Primary Care Networks will have:**

- Stabilised general practice locally
- Helped solve the capacity gap and improved skill-mix by growing the wider workforce with additional staff as well as increasing GP and nurse numbers
- Seen further local investment
- Dissolved the divide between primary and community care, with PCNs looking out to community partners not just into fellow practices
- Systematically delivered new services to support implementation of the Devon Long Term Plan and achieved clear, positive and quantified impacts for people, patients and the wider NHS.

## Primary Care Network Development

Implementing this strategy and the Devon Long Term Plan requires the development of effective PCNs. To help all PCNs mature and thrive, we need to put in place high quality support.

National funding has been made available to support: (a) PCN development and (b) a specific Clinical Director development programme. The funds are intended to help PCNs make early progress against their objectives as determined following a joint review of the maturity matrix – for example supporting much closer practical collaboration between PCNs and their community partners, including preparatory activity for the forthcoming national service specifications.

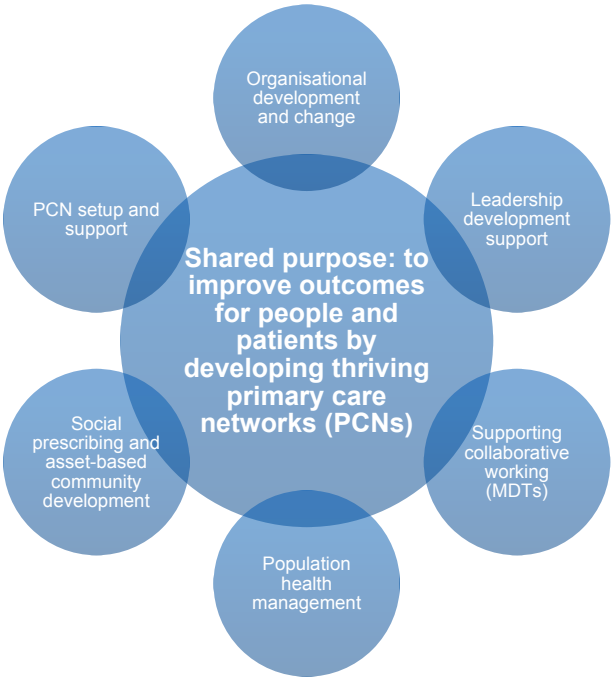
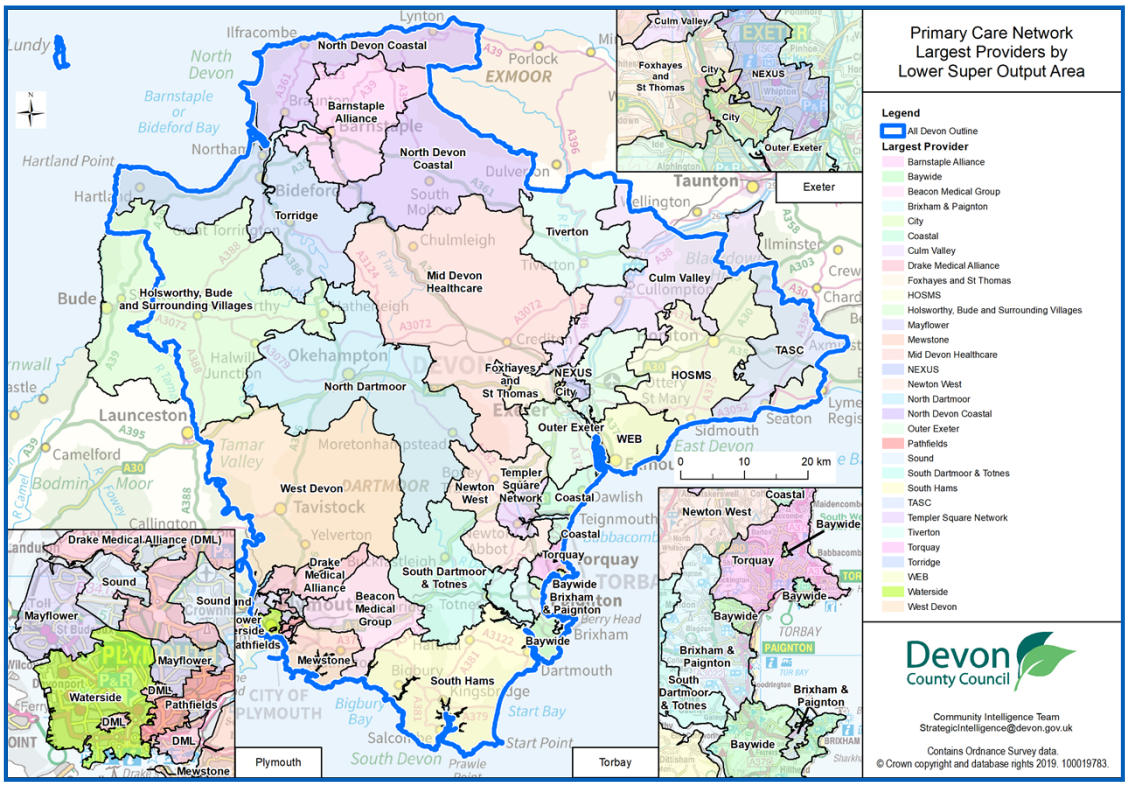



**Diagram: Development support domains**

We have developed our approach to PCN development in partnership with the PCN clinical directors and LMC. We are working with clinical directors and their PCN colleagues to put in place development plans that are relevant and tailored to their PCN and will subsequently support the implementation of these plans. Where appropriate we will ensure that these plans are not only relevant to the needs of the PCN, but that they also align.

The current PCN coverage is shown in the map below, the boundaries of the PCNs are not exact. A description of the configuration of each PCN is available here:

**Map of Primary Care Networks in Devon**



## Impact Measures for Primary Care Networks

We will identify a range of measures to monitor the impact of PCNs. These measures will cover:

- Improvement in relevant patient satisfaction results, measured in GP Patient Survey
- Improved long term conditions management, measured in Quality and Outcomes Framework (QOF)
- Reduced morbidity
- Reduced vacancy numbers for staff working in general practice
- Increased number of new recruits and retention in general practice
- Improved staff survey results for general practice, with improved reported outcomes for staff engagement, morale and wellbeing.
- Proactive involvement in population health management
- Increased ability for PCNs to work as key members of multi-disciplinary teams

Targets will be set in each annual business plan.

# 5 Modern Infrastructure

## Estates

A primary care estate investment plan has been prepared to ensure we have an estate that is fit for purpose. The plan identifies an estimated future capital requirement of £80m for this five-year planning period and also where specific primary care community plans need to be developed.

The plan, developed over a series of workshops with stakeholder engagement, has considered future housing development, current property condition, future service changes, Primary Care Network provision and local factors. For those practices identified as priorities, Project Initiation Documents will be produced in readiness for applications for capital funding. The work in developing the General Practice Estate Investment Plan has considered the impacts of digital transformation together with the new models of care which will see a focus on multi-disciplinary teams and new roles supporting primary care.

These factors will impact on the estate requirement for delivering the primary care for the future. A strengthened primary care service will support out of hospital care and reduce the pressure on emergency hospital services. The development of the investment plan is also considering the accommodation requirements of the integrated care model.

As the models of delivery are developed and implemented, we will continue to take advantage of the opportunities created by co-location of services, the sharing of estates, and joint development projects with co-location being our preferred estates solution.

An example of system working is the capital investment of £1.6m in Dartmouth for a new health and well-being centre incorporating a GP practice which is expected to be completed in June 2021. This work is supported by Torbay Hospital and South Hams District Council.

Through the STP Estates Group and the Primary Care Estates Group, all key parties, including Local Authorities are fully engaged in delivering the estates agenda and supporting the delivery of the Long Term Plan objectives. The Local Planning Authorities have also been committed to supporting the development of the Primary Care Estates Investment Plan by actively participating and providing local housing development information to the series of workshops dedicated to identifying future primary care estate requirements.

Work is in progress to expand the good relationships with the local planning authorities into a collaborative approach for optimising the opportunities associated with the local councils planning processes.

## Feels like One System

Electronic health records (EHRs) are the foundation upon which we build a modern, safe, efficient and responsive health service and general practice has long led the way in the move from paper to digital record keeping,

The GP record forms a core component of our emerging Local Integrated Health and Care Record Exemplar work (LHCRE-One South West) to create a comprehensive patient record that is accessible across all health and social care organisations.

The Devon STP Digital Strategy describes how we will roll-out eHRs across health and care organisations.

### What we will do

We will improve system-wide access to general practice patient information using existing systems including Summary Care Record Additional Information (SCR-AI), Medical Interoperability Gateway (MIG) and GP IT System Viewers.

We will support the national GP Connect interoperability programme to improve flow of information between practices and organisations, while encouraging a consolidation of eHRs between practices making it feel like one system.

## Shared Digital Infrastructure

As general practice forms networks and closer links with multi-disciplinary teams across multiple organisations as well as developing new ways of working, common platforms will be required to create efficient, standardised, safe and effective communication and management.

A shared cloud-based information management system will be deployed across practices to enable closer working with functionality such as back office processes, policies and procedures document management, clinical and referral guidelines, rota planning, communications/notices, eLearning and appraisal management.

### What we currently do

**East Devon Health shared intranet**

East Devon Health (EDH) have implemented GP TeamNet across 13 practices to work together more effectively and efficiently through the use of technology. As a cloud-based information management system, GP TeamNet allows teams to work across multiple locations, standardising processes and procedures by providing a common platform for communication, administration support, mandatory training, risk management and monitoring.

Practices have found an improvement in patient safety/quality, significant reduction in emails, printing and storage and more effective document control.

Popular functions include a CQC tracker, Significant Event Audit (SEA) tool, Continuous Professional Development (CPD) monitoring and reminders, annual leave requests/rota planning.

## Shared back office

Opportunities will be identified for the provision back office services across multiple practices and PCNs for example payroll, mandatory training, HR services. These services could be provided at scale by existing system partners e.g. acute trusts. These services are likely to be provided at a cheaper cost and consistently across multiple partners which will support sharing and rotating staff.

IT support services for general practice are an existing example of providing shared services across practices, PCNs and other health and care partners.

## Impact measures for modern infrastructure

We will use the following measures to show the impact of the initiatives included in this section:

- Improved patient satisfaction, particularly in the areas of access and online services
- Number of building projects completed from the estates investment plan
- Increase in buildings with co-located services
- Each PCN to have shared intranet and same clinical system

To set measures for all of these we need a clear base line. Targets will be set in each annual business plan.

# Finance

Funding for general practice comes from a range of sources and these are specifically earmarked for parts of the primary care system. The CCG will ensure each funding source is used appropriately in line with this strategy for general practice.

Primary Care Network funding is set over the five-year period of the NHS Long Term Plan.

By 2023/24, the national PCN contract is expected to create national entitlements worth £1.8 billion. This would equate to approximately £1.47 million for an average network of 50,000 patients, in return for the commitments and priorities specified in the NHS Long Term Plan.

Of this funding, £1.235 billion is new investment, with the balance of £564 million currently investment in enhanced access, extended hours, and the £1.50 per patient CCG investment for core PCN funding as per the DES specification.

The NHS Long Term Plan further identifies the need for the balancing of investment towards community and primary care services, as well as mental health. This is also factored in to the Devon Long Term Plan, although the plans are currently at strategic level and specific investment plans are to be developed.

# Workforce and estates

## Workforce and Primary Care Networks

One of the key parts of the new GP contract investment plan is the Primary Care Network Directed Enhanced Service (DES).

Of the £1.8 billion investment for Primary Care Networks, £891 million will be invested in workforce initiatives through the PCN DES.

**Intended Funding for Additional Role Reimbursement**

| | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|---|
| **National** | £110m | £257m | £415m | £634m | £891m |
| **Average PCN (50,000 population)** | £92k | £213k | £342k | £519k | £726k |

The CCG will continue to support the development of Primary Care Networks, investing funding as pass-through payments to general practice. During 2019/20 and 2020/21 the CCG will invest £920k in the development of PCNs and clinical directors.

Funding has already been invested during 2019/20 in the development of fellowships and workforce initiatives. This includes funding for GP retention, resilience, online consultation, and training.

As well as this central funding, the CCG has supported the engagement in international GP recruitment drives and initiatives and will continue to do so as part of this strategy.

## Estates and infrastructure

The CCG will maximise the opportunities available from the use of the Estates and Technology Transformation Fund (ETTF) in investments in estates and infrastructure in Devon.

Priorities for primary care estates have been reviewed and set out in the local estates strategy and these are considered as part of any opportunities for national capital.

The CCG will continue to track opportunities to attract capital resources in order to deliver the priorities set out in this strategy. A continuous focus on delivering efficiencies will also enable the support of capital developments with the associated revenue consequences.

# Funding

## Primary care allocations

NHS England have published five year allocations for CCGs. This means an uplift over the five year period of 33.48%. The 2019/20 uplift was the greatest at 9.28%, and further uplifts vary at between 4-6%. Further analysis is required to link the uplifts to the new GP contract investments.

**Devon CCG delegated primary medical care allocations**

| Year | 2019/18 | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|---|---|
| **Allocation** | £151 million | £165 million | £173 million | £184 million | £193 million | £202 million |
| **Uplift** | | 9.28% | 5.22% | 6.05% | 4.67% | 4.59% |

## PMS Premium

The CCG is committed to reinvesting the Primary Medical Services (PMS) Premium in primary medical care services.

The principles that govern this reinvestment have been agreed locally to ensure there is no inequity of the reinvestment in general practice between the two former CCGs in Devon.

## Locally enhanced services

The Devon Long Term Plan recognises that population growth will have a significant impact on general practice. We will make additional funding and investment for primary care available through locally enhanced services through reinvestment of the PMS Premium. This will increase the overall locally enhanced services commissioned by the CCG for Devon GP practices.

The NHS Long Term Plan identifies the need for the balancing of investment towards community and primary care services, as well as mental health. This is described in the NHS Long Term Plan at strategic level, and as the detail is developed would expect investment in enhanced services to include the expansion of shared care services in particular.

The CCG continues with the strategy for the harmonisation and equalisation of enhanced service payments across both former CCG areas.

## How activity in the strategy will be funded

As targets for activity are set in each annual business plan, planned activity will be costed and matched in line with either allocated funding streams or through seeking alternative funding options from the full range of resources available to the CCG.

# Timeline

| | 2019-20 | 2020-21 | 2021-22 | 2022-23 | 2023-24 |
|---|---|---|---|---|---|
| Quality | | New quality indicators, with benchmarked outcomes and learning from best practice. | | | |
| | | Implementation of a system of practice and PCN reviews, including site visits. This will include support for practices who struggle to meet indicator. Support for practices from specialist or professional representatives where it is agreed or felt by either party to be required. | | | |
| | | Sustainability review of single-handed practices in Devon to understand the issues and challenges they face and ensure plans in place to address any identified risks. | | | |
| Better Access | Urgent and routine appointments in general practice are available in the evenings and at weekends, where there is demand or a need. | | ‘Digital first’ approach adopted. | | |
| | | | Primary Care Network-level delivery of combined extended access offer. | | |
| | | | Medical records are available wherever patients interact with health and care services. | | |
| | | The Digital Accelerator project will be expanded to the whole of Devon. This will enable quicker access to general practice by delivering online consultations and better utilisation of resources. | | | |
| | General practice embeds functionality of the NHS App, enabling patients to access self-care and clinical advice, book appointments, order repeat prescriptions, access their medical records, choose preferences for data sharing and organ donation. | | | | |
| | | Promoting digital access amongst all groups of patients, including a digital guidebook developed by Healthwatch | | | |

| | 2019-20 | 2020-21 | 2021-22 | 2022-23 | 2023-24 |
|---|---|---|---|---|---|
| Workforce | Establish Primary Care Network teams to include community pharmacists and social prescribing link workers. | Work closely with system partners on action plans to improving understanding of anticipated workforce needs. | | | |
| | | Capacity and capability analysis completed. | | | |
| | | Primary Care Network multi-disciplinary teams expanded to include physiotherapist, physician associates and community paramedics. | | | |
| | | Primary Care Network and Clinical Commissioning Group work together to:<br>• Attend local, regional and national job fayres promoting Devon as a place to work<br>• Continue to build on the success of the GP retainer scheme<br>• Make the GP fellowship scheme available across Devon<br>• Expand the portfolio and rotational working opportunities to staff working in general practice<br>• Develop a range of flexible working approaches<br>• Participate in the international recruitment of GPs initiative<br>• Implement the 10-point general practice nurse plan<br>• Expand the GP post-training fellow pilot to cover the whole of Devon | | | |
| Population Health Management | | Implement quality improvement. All Primary Care Networks will receive data to help inform decision-making. PCNs implementing population-specific services. | Patients empowered to self-care with support and information through the new social prescribing workforce. PCNs and CCG working with the most vulnerable people to improve health. | | |
| | | Quality and Outcomes Framework maximum points attainment achieved. | | | |
| | | | Wide range of affiliated community-based professionals providing care and support as part of an enhanced patient offer. Patients will be supported to access voluntary sector services for both delivery of care and access to digital services. | | |

| | 2019-20 | 2020-21 | 2021-22 | 2022-23 | 2023-24 |
|---|---|---|---|---|---|
| Primary Care Networks | Implementation of Primary Care Network development plan. | | | | |
| | | Primary Care Networks will implement:<br>• Structured medication reviews<br>• Enhanced health in care homes<br>• Anticipatory care (with community services)<br>• Personalised care<br>• Supporting early cancer diagnosis. | Primary Care Networks will implement:<br>• Cardiovascular disease prevention and diagnosis, through case finding<br>• Locally agreed actions to tackle inequalities. | Primary Care Networks will:<br>• Stabilise general practice locally<br>• Help solve the capacity and skills gap through a wider workforce, with increased GPs and nurses<br>• See further local investment<br>• Integrate primary and community care<br>• Systematically deliver new services to support implementation of the Devon Long Term Plan. | |
| Infrastructure | | System-wide access to general practice patient information. | | | |
| | Develop and agree prioritised estate investment plan. | Implementation of estates investment plan. | | | |
| | | Implementation of national GP Connect interoperability programme. | | | |

# Glossary

| | |
|---|---|
| **AHP** | Allied Health Professional |
| **CCG** | Clinical Commissioning Group |
| **CCT** | Certificate of Completion of Training |
| **CPD** | Continuous Professional Development |
| **CQC** | Care Quality Commission |
| **DES** | Directed enhanced service |
| **ED** | Emergency Department |
| **EHR** | Electronic health record |
| **ETTF** | Estates and Technology Transformation Fund |
| **FTE** | Full-time equivalent |
| **GP** | General practitioner |
| **HEE** | Health Education England |
| **HOPE** | Helping individuals overcome problems effectively |
| **LES** | Locally enhanced service |
| **LHCRE** | Local Integrated Health and Care Record |
| **LDC** | Local Dental Committee |
| **LMC** | Local Medical Committee |
| **LOC** | Local Optical Committee |
| **LPC** | Local Pharmaceutical Committee |
| **LTC** | Long term condition |
| **LTP** | Long term plan |
| **MECC** | Making Every Contact Count |
| **MIG** | Medical Interoperability Gateway |
| **PCN** | Primary Care Network |
| **PHM** | Population health management |
| **PMS** | Primary medical services |
| **POD** | Prescription Ordering Direct |
| **PPG** | Patient Participation Group |
| **QEIA** | Quality and Equality Impact Assessment |
| **QOF** | Quality and Outcomes Framework |
| **SCR** | Summary Care Record |
| **SCR-AI** | Summary Care Record – Additional Information |
| **SEA** | Significant Event Audit |
| **STOMP** | Stopping over medication of people |
| **STP** | Sustainability and Transformation Partnership |
| **VTS** | Vocational training scheme |

## Digital access and sharing solution

### Our offer to you

We are rolling out new technology (GP Connect) in December 2019 to allow practices to view patient records between different clinical systems. This will also allow sharing of appointment systems between groups of practices to make offering shared services easier.

Providing shared services will be easier and safer as practices will be able to securely access patient information and share appointments even if they are on different clinical systems.

### What we ask from you

We ask that you engage with the project, sign data sharing agreements and work with your patients on information-sharing agreements.

## Digital First

### Our offer to you

We are making eConsult and other digital pilots available to all Plymouth practices.

We are offering local 'champions' and best-practice events to support practice-level adoption of eConsult, for online consultations.

These new projects will be subject to testing, so we can demonstrate the benefits before they are rolled out to all practices. Some pilots are already under way. We will look for opportunities to expand some of the existing pilots more widely when we determine it is appropriate to do so.

Patients interacting digitally will save time for GPs and reduce the number of appointments required by diverting patients that do not need to see their GP.

### What we ask from you

We need the continued support and enthusiasm of practices in the pilot groups, and those taking part in future pilots, to develop these new ways of working.

## DELT solutions

DELT Shared Services Ltd. (the CCG's and Plymouth City Council's IT provider) offers professional services for IT, cyber security, information governance, training, telephony, payroll, finance, print and mail, as well as consultancy around HR, organisation development, procurement, digital solutions and business change.

DELT can help practices deliver these services to help maximise investments, as well as reducing risks and cost.

As a public company owned by the CCG and PCC, you may wish to consider DELT Shared Services Ltd. for your solutions and back-office functions.

## Following PCN feedback, we will also be exploring the following:

- Supporting PCNs to work towards delivering Extended Access
- A Devon-wide premises strategy will be published in September and we will work with practices to establish viable solutions
- Following a review of the current planned pilots, we will work with PCNs to roll out system integration of pharmacies and practices in Plymouth, including broader sharing solutions for nursing homes
- Embedding videos into patient pathways to encourage patients to self-educate and release clinical time
- Exploring the potential benefit of a PCN co-ordinator for the city of Plymouth
- Continued initiatives to support workforce development via portfolio working expanded beyond clinical roles and initiatives to attract clinicians back in to primary care
- Establishing an overview of vacancies across clinical roles to identify gaps in the system and support practices to manage the full recruitment cycle



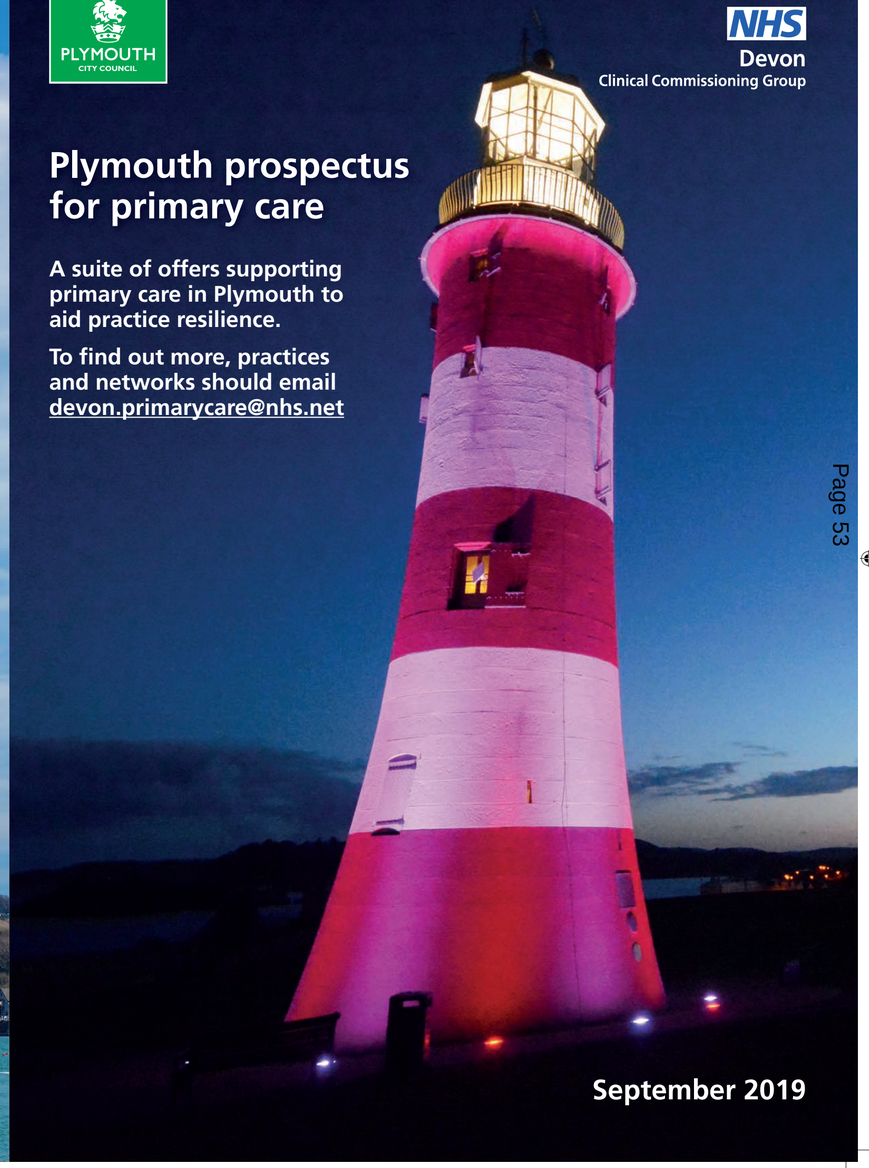
PLYMOUTH CITY COUNCIL

NHS Devon Clinical Commissioning Group

# Plymouth prospectus for primary care

**A suite of offers supporting primary care in Plymouth to aid practice resilience.**

**To find out more, practices and networks should email devon.primarycare@nhs.net**



**September 2019**

## NHS Prescription Ordering Direct

### Our offer to you

We are offering the opportunity to join the Prescription Ordering Direct service to all Plymouth practices (on a phased basis). Promotional materials will be provided for each participating practice to raise awareness of the service.

We are increasing clinical pharmacy input to the service to extend the offer to include medicines reconciliation post-discharge and medication reviews.

Visits can be arranged for practices that want more information.

Increased usage of the Prescription Ordering Direct service will result in a reduction of processing repeat prescriptions in the practice, a reduction in GP time managing prescription queries, and a reduction in queries from community pharmacies.

There are high levels of patient satisfaction in those using the service.

### What we ask from you

If you sign up to the Prescription Ordering Direct service, we ask that you work with the CCG to set up the relevant agreements, actively promote it to your patients, work with us on evaluating the service and expanding the service, should demand require it.

## Support with recruitment

### Our offer to you

We will identify and co-ordinate opportunities for local and system-wide recruitment campaigns to attract clinicians to the area. The CCG is attending a South West event at China Fleet and the *BMJ* event in London (both in October) and will co-ordinate attendance at national and international recruitment events, on behalf of the wider system.

Practices will benefit from a consistent and cost-effective service approach to recruitment and promoting Plymouth as a place to work.

### What we ask from you

We ask that practices promote Plymouth as a place to live and work, and that PCNs work with the CCG to ensure there is a clinical presence at planned recruitment events.

## Increasing fellowships

### Our offer to you

We will fund an additional five placements for GP Fellows who will be in place by the end of October.

This will support attraction and retention of the GP workforce.

### What we ask from you

We ask that practices provide support to enable successful completion of fellowships.

## Providing HCAs with career development

### Our offer to you

We guarantee to subsidise training costs and provide additional staffing resource for ten HCAs interested in nurse associate positions over the next year.

This will enable practices to support staff with career aspirations and improve retention.

### What we ask from you

We ask that practices consider opportunities for HCA development.

## Supporting GPs to return to primary care

### Our offer to you

We are introducing a return-to-work scheme for those who have been out of general practice for less than two years. This is a short programme (two weeks, full time) to reintroduce GPs back into practice. Funding will be provided to both the practice and the GP to ensure a high-quality experience for both parties.

### What we ask from you

We ask that practices and PCNs offer flexible and bespoke placements to returning GPs.

## Introducing rotational nurse preceptorships

### Our offer to you

We are funding training for additional nurse preceptorships. We are co-ordinating their development programme and mentoring across the health and care services, with a focus on the specific needs of the area. We plan to have six nurses in place by spring 2020, with an intake of a further six next summer.

By introducing preceptorships, practices will benefit from specialist skills increasingly required within primary care.

### What we ask from you

We ask that PCNs support with salary costs and rotational roles.

## Providing a greater focus for student nurses in primary care

### Our offer to you

We are supporting and developing the future nursing workforce for general practice through two initiatives:

We are working with the University of Plymouth to develop a nursing degree programme that is specific to primary care and are funding 20 places on this programme to financially support students who would otherwise not be able to complete this course of study.

We are also offering practices a top-up payment to increase the number of experiential placements available for student nurses within general practice. This funding will support an additional 20 placements for this academic year. We will provide a central co-ordinator/supervisor to support their learning and enable practices to better support this increase in placements.

### What we ask from you

We ask that PCNs work with us to ensure the additional placements required for both of these initiatives can be accommodated.

## Providing opportunities for flexible portfolio careers

### Our offer to you

We will provide opportunities and work-based placements to develop portfolio roles for clinicians including six nurses and six GPs. This will appeal to new graduates and those looking for more flexible work options, and will encourage more clinicians to return to general practice.

This will support practices with attraction and retention of all clinical roles.

### What we ask from you

We ask that PCNs provide roles and support with salary costs.

## Shared online platform

### Our offer to you

We are providing a digital platform (like an intranet system) to all Plymouth practices that can be used to collaborate, share information and work jointly on documents and policies within practices, PCNs and other organisations.

Practices will be able to store and share information securely within their own practice and across networks. This will lead to efficiencies in processes such as HR (rotas, appraisals), inspection/audit (CQC), etc.

### What we ask from you

If you sign up to the new digital platform, we ask that you actively engage with it and utilise it when it is in place.

# CORPORATE REPORT SUMMARY

| | | | |
|---|---|---|---|
| **Name of meeting:** | Plymouth Health Overview and Scrutiny Committee | | |
| **Date of meeting:** | Wednesday 29th January 2020 | | |
| **Name of report:** | CQC Inspection report published 3rd January 2020 | | |
| **Authors:** | Trish Cooper | | |
| **Approved by:** | | **Presented by:** | |
| **Report previously presented to: -** | | | |
| **PURPOSE OF REPORT: In just a few words please tell us why you are presenting this paper today and what you hope to achieve** | | | |
| To inform the committee of the findings of the recent CQC inspection of services provided by Livewell Southwest. | | | |
| **RECOMMENDATION(S): In just a few words tell us what you, as the expert, are recommending** | | | |
| That the committee note the report. | | | |
| **Everything we do needs to align with one or more of the LIVEWELL STRATEGIC AIMS so in just a few words tell us how your proposal helps us make progress:** | | | |
| **We put people at the centre of everything we do** | The action taken by Livewell Southwest to ensure Quality and Safety is at the heart of what we do, provides assurance that people are at the centre of what we do. | | |
| **We value, support and empower each other** | | | |
| **We are an organisation with a strong social conscience** | | | |
| **We transform services to make them sustainable** | | | |
| *Please tick as appropriate:* | | | |
| X | This paper provides **assurance** for the above objectives | | |
| X | This paper presents **a risk** to achieving the above objective | | |

**Care Quality Commission (CQC)**

**1.0 Overview and service ratings**

1.1 On 3rd January 2020, the CQC inspection report for Livewell Southwest was published. In summary, the report showed:

| Ratings | |
|---|---|
| Overall rating for this organisation | Good |
| Are services safe? | Good |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive? | Good |
| Are services well-led? | Good |

1.2 The overall organisational rating **Good** remained the same as 2018. Five core services were reviewed at this inspection:

1.3 All Livewell Services are now rated as good or outstanding, due to the improvement in End of Life Care and Child and Adolescent mental health wards.

1.4 The overall organisational rating for Caring reduced in 2019 from Outstanding to Good. This was due to a reduction from outstanding to good for Wards for older people with mental health problems.

1.5 CQC Inspectors had a great deal of positive feedback, including:

*Staff in the organisation had worked hard to address concerns we had raised in the last inspection. Two services that were previously rated as requires improvement at the last inspection were now rated as good. Community end of life care and child and adolescent mental health wards had both improved.*

*Livewell Southwest had strong leadership who had the appropriate range of skills, knowledge and experience to deliver community health and mental health services. Staff felt they were visible and approachable. There was a rolling programme of visits scheduled to services by the executives. Executives used these visits to engage with staff and also listen to their views on the services.*

*There was a positive, open and honest culture throughout the organisation. Staff at all levels of the organisation were proud to work at the organisation and morale among staff was very good. both leaders and staff across the organisation put patients at the centre of everything they did.*

*Staff treated all patients with compassion, respect and kindness. The privacy and dignity of patients was maintained at all times. Patients were supported by staff to understand and manage their care and treatment. Staff actively involved families and carers of patients in their care appropriately.*

*Across the organisation clinical areas and premises where patients received care were clean, well equipped and maintained.*

*The organisation managed incidents well and staff understood how to report them appropriately. Incidents were investigated, and lessons learned were shared with staff.*

*The organisation treated concerns and complaints seriously. The organisation investigated concerns and complaints and shared lessons learned with staff. Patients were included in the investigation of their complaint.*

**Ratings for mental health services**

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Acute wards for adults of working age and psychiatric intensive care units | Good Oct 2016 | Good Oct 2016 | Outstanding Oct 2016 | Good Oct 2016 | Outstanding Oct 2016 | Outstanding Oct 2016 |
| Long-stay or rehabilitation mental health wards for working age adults | Good Apr 2018 | Good Apr 2018 | Good Apr 2018 | Good Apr 2018 | Good Apr 2018 | Good Apr 2018 |
| Forensic inpatient or secure wards | Good Oct 2016 | Good Oct 2016 | Good Oct 2016 | Good Oct 2016 | Good Oct 2016 | Good Oct 2016 |
| Child and adolescent mental health wards | Good ↑ Nov 2019 | Good →← Nov 2019 | Good →← Nov 2019 | Good →← Nov 2019 | Good ↑ Nov 2019 | Good ↑ Nov 2019 |
| Wards for older people with mental health problems | Good →← Nov 2019 | Good →← Nov 2019 | Good ↓ Nov 2019 | Requires improvement ↓ Nov 2019 | Good →← Nov 2019 | Good →← Nov 2019 |
| Community-based mental health services for adults of working age | Requires improvement ↓ Nov 2019 | Good →← Nov 2019 | Good →← Nov 2019 | Good →← Nov 2019 | Good →← Nov 2019 | Good →← Nov 2019 |
| Mental health crisis services and health-based places of safety | Good Apr 2018 | Good Apr 2018 | Good Apr 2018 | Good Apr 2018 | Good Apr 2018 | Good Apr 2018 |
| Specialist community mental health services for children and young people | Good Apr 2018 | Good Apr 2018 | Good Apr 2018 | Good Apr 2018 | Good Apr 2018 | Good Apr 2018 |
| Community-based mental health services for older people | Good Oct 2016 | Good Oct 2016 | Good Oct 2016 | Good Oct 2016 | Good Oct 2016 | Good Oct 2016 |
| Community mental health services for people with a learning disability or autism | Good Oct 2016 | Good Oct 2016 | Outstanding Oct 2016 | Outstanding Oct 2016 | Good Oct 2016 | Outstanding Oct 2016 |
| **Overall** | Good →← Nov 2019 | Good →← Nov 2019 | Good ↓ Nov 2019 | Good →← Nov 2019 | Good →← Nov 2019 | Good →← Nov 2019 |

**Ratings for community health services**

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Community health services for adults | Good Oct 2016 | Good Oct 2016 | Good Oct 2016 | Good Oct 2016 | Good Oct 2016 | Good Oct 2016 |
| Community health services for children and young people | Good Oct 2016 | Good Oct 2016 | Good Oct 2016 | Good → ← Oct 2016 | Good → ← Oct 2016 | Good → ← Oct 2016 |
| Community health inpatient services | Requires improvement ↓ Nov 2019 | Good → ← Nov 2019 | Good → ← Nov 2019 | Good → ← Nov 2019 | Good → ← Nov 2019 | Good → ← Nov 2019 |
| Community end of life care | Good ↑ Nov 2019 | Good ↑ Nov 2019 | Good Nov 2019 | Good → ← Nov 2019 | Good ↑ Nov 2019 | Good ↑ Nov 2019 |
| Sexual Health Services | Good Oct 2016 | Good Oct 2016 | Good Oct 2016 | Good Oct 2016 | Good Oct 2016 | Good Oct 2016 |
| **Overall*** | Good → ← Nov 2019 | Good → ← Nov 2019 | Good → ← Nov 2019 | Good → ← Nov 2019 | Good → ← Nov 2019 | Good → ← Nov 2019 |

## 2.0 Well-Led Rating

A summary of the CQC's findings were:

The leadership team of the organisation had the appropriate range of skills, knowledge and experience to deliver community health and mental health services. The organisation had a strong and experienced group of Non-Executive Directors (NEDs) from a range of professional backgrounds. NEDs chaired committees and were confident to raise any concerns or challenge to the executive team.

The leadership team were considered visible and approachable by staff of the organisation. There was a rolling programme of visits scheduled to services by the executives. Executives used these visits to engage with staff and also listen to their views on the services.

Staff at all levels of the organisation were proud to work there and morale among staff was good. Staff were patient centred.

The leadership team and staff at all levels of the organisation were open and transparent. The vision and values of the organisation were clear and understandable and were integrated into services across the organisation.

The organisation had recently refreshed and published their new strategy. The strategy was developed in line with the NHS long term plan, STP plans and local authority plans. The strategy was co-produced with staff and stakeholders

The organisation was financially stable and there was relevant financial expertise among the executives and NEDs.

The organisation had a Freedom to Speak Up Guardians. There was no requirement on the organisation to have a Freedom to Speak Up Guardian as they are not an NHS organisation. However, the organisation had lobbied to get access to training for the roles. We were provided with examples of support and guidance that had been offered to staff by the Freedom to Speak Up Guardians.

The organisation was engaged in local strategy and had strong working and strategic alliances with partners. The executive team had worked hard to ensure Livewell was an equal partner within the local health economy and supported partner organisations. The organisation was valued in the STP as a non-NHS partner.

The organisation had effective systems and processes in place to support delivery of care. There was an appropriate sub board committee structure and escalation to board through the structure. The organisation had recently had a governance review and had convened a working group to take forward the actions identified to further strengthen and develop their governance arrangements.

There were a range of mechanisms that provided assurance from service level to board level. Directorate governance meetings were held monthly and considered service line performance by operational activity, quality governance metrics (including incidents, complaints and compliments), workforce and financial KPIs and risks faced by each individual directorate.

There was a strong emphasis on Quality Improvement throughout the organisation.

**3.0 Actions/Improvements**

**3.1** There are 4 regulatory actions ('must do'), which require us to submit an action plan to the CQC by 4th February 2010. The Heads of Service have been requested to co-ordinate the actions. This year, the focus will not only be on the required actions, but also how these can be monitored on going. The actions are:

**Wards for older people with mental health problems**

• The organisation must take action to ensure patients can access their bedrooms during the day and the communal ward areas at night time, if they wish, unless there is a clinical reason to prevent this from happening (Regulation 9).

**Community-based mental health services for adults of working age**

• The organisation must ensure that patients are adequately assessed once their referral has been received by the services and ensure that patients waiting for assessments are monitored to detect and respond to any deterioration in their mental health (Regulation 12).

**Community health service inpatients**

• The organisation must ensure staff complete robust pressure ulcer risk assessments (Regulation 12).
• The organisation must ensure that safeguarding referrals are made appropriately to the local authority safeguarding team (Regulation 13).

**4.0 Conclusion**

The outcome of the Livewell CQC annual inspection as:

- 'Good' overall
- 'Good' for each of the domains overall
- 'Good' for 13 core service areas
- 'Outstanding' for 2 core service areas

This is a very strong position going forward. The action plan addressing areas for improvement will be monitored through the Performance committee and plans are being developed for 2020/2021 to demonstrate 'Outstanding' core services within our next inspection.

This external validation of Livewell services provides a high level of assurance to the staff, people who use the services, partner agencies and the wider local community of the quality of Livewell Services.

Plymouth City Council

# Plymouth City Council Independence@Home Reablement service

## Inspection report

Lower Basement, Windsor House
Tavistock Road, Derriford
Plymouth
PL6 5UF

Tel: 01752305253

Date of inspection visit:
12 November 2019
14 November 2019
15 November 2019
18 November 2019
19 November 2019

Date of publication:
06 December 2019

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

| | |
|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

About the service
Plymouth City Council Independence@Home Reablement Service provides support with personal care to people living in their own homes. The service supports people for a period of reablement after being discharged from hospital following illness or injury. The service supports people to regain their independence with activities of daily living such as washing, dressing, meal preparation and other domestic tasks.

At the time of the inspection the service was supporting 105 people. This included a small number of people who had been assessed as requiring longer-term care and for whom alternative care provision was not yet available. The service was also supporting some people who were receiving care at the end of their life.

Not everyone who used the service received personal care throughout the period of time they were receiving support. Once people became independence with their personal care, the service supported people with domestic tasks until they are assessed as safe with these tasks, or if alternative support was required in the long-term. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People, staff and healthcare professionals told us the service was well managed. People received personalised care that promoted their independence and well-being. People told us the service focused on meeting their needs, protecting their safety and promoting their independence. People felt safe and well cared for. People's preferences were respected, and staff were sensitive and attentive to people's needs.

Staff were described as kind, caring and compassionate, and people said staff were well trained. Staff told us how much they enjoyed working for the service. They said they were proud of the support they provided to people and had a great sense of achievement when people regained their independence.

Risks to people's health, safety and well-being were assessed and management plans were in place to ensure risks were mitigated as much as possible. Staff were aware of their responsibilities to safeguard people.

There were sufficient numbers of staff employed to ensure people's needs were met. People were not provided with specific visit times but a time period, such as morning, lunchtime or evening. Staff were not restricted to a length of time they were required to be with people. As the service was a reablement service, staff spent as much time with people as needed to undertake the task people were being supported with. People and relatives told us they were happy with this arrangement. If they did require a visit at a certain time, for example, with time specific medicines or to be ready for an appointment, the service accommodated this. If staff were going to be very late, people said staff would contact them.

The service's aim was to "enable not disable" and people were fully involved in their assessments and the development of their care plans. People discussed their progress with staff which included looking at different ways to undertake tasks or to become familiar with using equipment to make tasks safer and easier. However, not all care plans held detailed information about what people were able to do for themselves, or specific guidance for staff about how to meet people's care needs. We discussed this with the registered manager and deputy manager who took immediate action to review and update people's care plans, and records where necessary.

Where people were supported with their medicines, this was done safely, and people received their medicines as prescribed.

Quality assurance and governance systems were in place to assess, monitor and improve the quality and safety of the service. The registered manager maintained a service improvement plan and carried out regular audits and reviews of the service.

People were supported to have maximum choice and control of their lives and staff supported support them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection This service was registered with us on 01/12/2018 and this is the first inspection.

Why we inspected This was a planned inspection based on the date the service registered with us.

Follow up We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

### Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

### Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

### Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

### Is the service well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

# Plymouth City Council Independence@Home Reablement service

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
One inspector and an assistant inspector carried out this inspection.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 72 hours' notice of the inspection visit because we needed to make sure the registered manager would be available.

Inspection site visit activity started on 12 November 2019 and finished on 14 November 2019. We met with the registered manager, the deputy manager, administrative staff, care staff, and an occupational therapist. We also reviewed care records and those related to the running of the service. We carried out phone calls to people, staff and health and social care professionals involved with the service on 15, 18 and 19 November

2019.

What we did before the inspection
We reviewed information we had received about the service since its registration and we used this information to plan our inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with 13 people who used the service and eight relatives about their experience of the care provided. We spoke with 15 members of staff including the registered manager, deputy manager, an occupational therapist, care workers and administrative staff responsible for co-ordinating care visits. Our contact details were made available by the service to each person receiving support and to staff to allow them to share their views about the service should they wish to do so.

We reviewed a range of records. This included six people's care records and a sample of medicine administration records. We looked at six staff files in relation to staff recruitment and supervision. A variety of records relating to the management of the service, including staff training, meetings and safety and quality audits were reviewed.

Good

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated good.
This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse
• People and relatives told us they received safe care and support. Their comments included, "Definitely", "Goodness me, yes" and "Mum likes the staff and feels safe with them."
• People were protected from the risk of abuse as staff had received training in safeguarding adults. They were aware of their responsibilities and knew who to report concerns to about people's safety and well-being.
• The information given to people when they started to receive a service, provided them with guidance about what abuse is and how and to whom to make any concerns known.
• Healthcare professionals told us they felt the service was safe, not only in relation to providing safe care to people but also in ensuring the safety of staff.

Assessing risk, safety monitoring and management
● The service worked in partnership with Livewell Southwest, (a service which provides and supports integrated health and social care services) and their Home First initiative which is designed to help people return home from hospital as quickly as possible.
• Detailed assessments were undertaken by Livewell Southwest prior to people's discharge from hospital. These identified people's personal care needs, and any risks associated with their health conditions, such as falls or the management of diabetes. This enabled the service to plan their support appropriately and to ensure the person would benefit from reablement support. An additional assessment, by the Home First team and the service, was undertaken within two hours of the person returning home from hospital. This identified if people required any additional equipment to support their reablement, such as shower seats, perching stools and trolleys. If required, these were delivered on the same day.
• Records gave staff guidance on how to reduce risks while promoting people's independence. One person told us how staff make sure they are safe, they said, "The girls make sure I'm safe when I'm cooking, and also when I'm taking my tablets."
• The service employed an occupational therapist. They were involved in people's assessments and guided staff about how to meet people's needs in ways that promoted their independence and protected their safety and that of the staff.
• Risk assessments of people's homes ensured the environment was safe.
• There was an on-call system for people and staff to ring in the event of an emergency outside of office hours.
• The service had contingency plans in place, so people's care would continue in the event of an emergency.

Staffing and recruitment
• All the staff employed at the time of the inspection had transferred from another care agency when

Plymouth City Council took over the management of the reablement service. The service had not recruited any new staff since registration. However, there were robust recruitment processes in place to ensure staff would be recruited safely. These included pre-employment checks, including police checks, and obtaining references to ensure staff were suitable to work with people who might be vulnerable due to their circumstances.

• There were sufficient staff employed to meet people's needs and to be flexible and responsive to people's changing needs and to supporting people new to the service.

• People were not provided with specific visit times but a time period, such as morning, lunchtime or evening. Staff were not restricted to a length of time they were required to be with people. As the service was a reablement service, staff sent as much time with people as needed to undertake the task people were being supported with. People and relatives told us they were happy with this arrangement. If they did require a visit at a certain time, for example, with time specific medicines or to be ready for an appointment, the service supported this. If staff were going to be very late, people said staff would contact them.

• Staff used their phones to scan when they arrived and left people's homes to allow the care co-ordinators to monitor how long staff were needing to spend with people and adjust their visit times accordingly. This system also alerted the service if a member of staff was running late.

• People and relatives said they received support from a consistent group of staff enabling them to get to know the staff well. One relative said this was "a great comfort" for her loved one and they had developed a bond with the staff.

Using medicines safely

• Most people managed their own medicines. Where the service supported people with medicines, this was managed safely, and people received their medicines as prescribed.

• Only staff trained in the safe administration of medicines and who had been assessed as competent, administered medicines to people.

• Where people took medicines 'as and when required' or required topical medicines such as creams for skin protection, staff were provided with guidance about when they should be administered.

• Audit checks and observations ensured records were fully completed and staff's practice was safe.

Preventing and controlling infection

• Systems were in place to prevent and control the risk of infection. Staff had access to protective clothing such as aprons and gloves to reduce the risk of the spread of infection.

• People and relatives told us staff supported them to keep their home clean.

• Staff had attended infection control training.

Learning lessons when things go wrong

• The registered manager told us they were keen to learn from people's and staff's experiences of receiving and providing support.

• Evidence was available to show when something had gone wrong the registered manager responded appropriately and used it as a learning opportunity.

Good

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Assessments prior to and at the time of returning home identified people's needs and provided staff with information about how best to meet these needs in line with best practice guidance and people's preferences.
• The service's care co-ordinators and occupational therapist, as well as community health care professionals such as nurses, provided supervision and oversight of people's clinical and care support needs.
• Staff completed notes at each visit describing the support they provided and what the person had been able to do for themselves. This helped the service monitor and review each person's progress.
• Should people require longer term care, the service undertook additional assessments to determine people's needs in readiness to receive support from alternative care providers.

Staff support: induction, training, skills and experience
• Staff told us they received the training and support they required to meet people's needs effectively. One said, "The training is just great." Staff completed training in areas relating to personal care and health and safety. Learning was provided through face to face training and online training. Staff also had ongoing access to online training videos which covered a large number of topics related to people's care needs. Although the service had not recruited any new staff at the time of the inspection, processes were in place to support staff new to care to undertake the Care Certificate. This is a national induction for staff working within the health and social care sector.
• People and relatives said staff were well trained and knew how to meet their needs.
• Staff confirmed they received regular supervisions and appraisals, as well as undergoing direct observation of their practice and competency assessments of care tasks. This ensured staff could meet people's care needs, remained safe in their practice and reflected the service's standards.
• Staff said the management team were always there to give help and support if needed.
Supporting people to eat and drink enough to maintain a balanced diet
• People's ability to prepare meals was assessed, and care plans were created if staff were required to provide support with this.
• Staff knew to contact the office if they had concerns over whether people were eating and drinking enough. If necessary, an assessment, advice and guidance would be requested from appropriate health professionals.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

• People were supported to maintain good health and had access to external healthcare support as necessary.
• Staff worked with other healthcare professionals such as physiotherapists, occupational therapists, community nurses and GPs to ensure people received appropriate care. If staff had concerns over people's health, they made referrals directly to the appropriate healthcare professional. One relative told us they were very grateful staff had recognised their loved one was not well and had contacted the GP on their behalf.
• When staff had notified the service that people were feeling unwell, the care co-ordinators contacted people later in the day to check how they were and to arrange follow up GP appointments if necessary.
• Staff completed records at care visits to ensure care remained consistent and staff knew how people's independence was progressing.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• Each person who used the service had their capacity to consent to receive support assessed prior to receiving a service. Where people, particularly those requiring longer-term support, were unable to consent, healthcare professionals and relatives had made best interest decisions on their behalf.
• Staff had received training and were aware of the MCA principles. They knew to always ask for people's consent.

Good

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People and relatives told us they were supported by kind, caring and compassionate staff. Their comments included, "It's been wonderful. They're nice people and very helpful", "I'm very impressed with them all" and "The staff couldn't be nicer. They're very friendly and share my sense of humour."
• People's cultural and spiritual needs were respected. Staff had received equality and diversity training and understood how to deliver care in a non-discriminatory way, ensuring the rights of people with a protected characteristic were respected.
• Staff told us how much they enjoyed working for the service. They said they were proud of the support they provided to people and had a great sense of achievement when people regained their independence. One member of staff said, "I love to know when I've closed their front door that I have given them the best possible care" and another said they were "thrilled" that someone who had been told they would not be able to walk again, was able to do so.

Supporting people to express their views and be involved in making decisions about their care
• People were encouraged to express their views about what they wanted to achieve through their reablement support. They identified the goals, contributed to their care plan and reviewed their progress with the staff and care co-ordinators.
• Each person received an information pack containing information about what to expect from the service as well as how to feedback compliments, concerns and complaints.

Respecting and promoting people's privacy, dignity and independence
• People told us they were treated with dignity and respect. One person said the staff were "Really lovely people, excellent. They can't do enough for you."
• Staff were aware of each person's ability to carry out daily living activities and encouraged people to do as much as they could for themselves. One person said, "They are called enablers and live up to their name too. They have supported me every step of the way and gave me back my confidence. I can't praise them enough." One member of staff told us, "It's about supporting people to do things for themselves, not doing things for them" and another said, "We're here to promote their independence, protect their dignity and give them choices."
• Staff were proud to tell us of the success and progress people had achieved with their support. One said, "It is a sense of achievement for me and when you have been going to see someone for a while and then they start to do things for themselves."

Good

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• The registered manager told us the service's aim was to "enable not disable", and a member of staff confirmed this and said, "The ethos of promoting independence is something I strongly believe in."

• People had been fully involved in their assessments and the development of their care plans to ensure support was provided for their specific goals in line with their preferences. People discussed their progress with staff which included looking at different ways to undertake tasks or to become familiar with using equipment to make tasks safer and easier.

• However, not all care plans held detailed information about what people were able to do for themselves, or specific guidance for staff about how to meet people's care needs. For example, one person's care plan did not describe how staff should care for their catheter. In another, for a person who was only able to stand for a short period of time, there was no guidance about how staff should support them with washing and dressing.

• The registered manager told us all staff had been provided with an 'Independence at Home Goals Plan' reference document which described good practice principles when providing support with a number of daily living tasks. These included washing and dressing, medicine management, mobility and meal preparation. Although these provided staff with step by step guidance, this was not personalised, nor did it guide staff about what to be observant for to indicate a person might be becoming unwell, such as from a urinary tract infection. We discussed this with the registered manager and deputy manager who took immediate action to review and update people's care plans, as well as the reference document where necessary.

• Daily care records completed by staff described what people had been able to do for themselves and where they still required staff support. Regular updates were provided to the care co-ordinators who maintained regular contact with people to review their progress.

• Where people were unable to regain their independence, the service referred people to healthcare professionals to arrange support for ongoing care.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• People's communication needs were identified through the initial assessment and staff were guided to ensure people had their hearing aids and glasses to support their communication. The service was able to

provide information in different formats, such as large print, and were aware of their responsibility to meet the Accessible Information Standard.

Improving care quality in response to complaints or concerns

• People and relatives had no complaints but felt confident they would be listened to if they did.
They confirmed that had been provided with written information about how to make a complaint, and what action to take should they be dissatisfied with how the service had responded.

• Records of complaints were maintained, and actions identified to resolve issues. The registered manager reviewed all complaints and told us they used these as an opportunity to learn and make improvements.

End of life care and support

• The service was supporting a small number of people to receive end of life care at home. The service was working in partnership with relatives and community healthcare professionals to ensure people received a dignified and pain-free death.

Good

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

• People received personalised care that promoted their well-being. People told us the service focused on meeting their needs, protecting their safety and promoting their independence. One person said, "They can't do enough for you. They always ask if there is anything else you need before they go. They have a smile on their face when they come and have smile on their face when they go. I'd give them 20 out of 20." Staff told us they listened to people to understand their needs and placed them at the forefront of everything they do.

• People, staff and healthcare professionals told us the service was well managed. One person said they were "very impressed" with the professionalism of the service and other people referred to the service as "excellent" and "tremendous". Healthcare professionals said the service was responsive, flexible and approachable. One said the service "never said no" but looked at ways it could support people.

• The registered manager was aware of their responsibilities under the duty of candour. That is, their duty to be open and honest about any accident or incident that placed a person at risk of harm.

• The registered manager had provided the CQC with important information as required and had done so in a timely way.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

• The registered manager was supported by a deputy manager, a team of care co-ordinators and an occupational therapist. Each understood their responsibilities and there were clear lines of accountability.

• The registered manager kept up to date with best practice by attending care forums and subscribing to newsletters, such as that from the National Institute for health and Care Excellence (NICE). They shared this information with the staff team through regular meetings. These also provided opportunities to reflect on how to improve the service and reviewed staff's knowledge.

• Quality assurance and governance systems were in place to assess, monitor and improve the quality and safety of the service. The registered manager maintained a service improvement plan and carried out a regular audits and reviews of the service. They confirmed they would strengthen the framework for records in relation to care planning content.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

• People and their relatives were asked about their progress and for their views about the service via phone calls and home visits. Records showed people were happy with the service they were receiving. Comments included, "The staff are a real credit to your company and make mum feel like a person, not a task" and "Staff went above and beyond their roles as carers."

• Staff told us they felt listened to by the registered manager and enjoyed working for the service. One member of staff said, "This is the best company I have ever worked for." The service recognised staff's good practice and notified them through a 'thank you' email when they had received praise from people.

• People and staff's protected characteristics were considered and respected.

• The registered manager had developed effective working relationships with other professionals and agencies involved in people's care and support.

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# SUMMARY REPORT

NHS University Hospitals Plymouth NHS Trust

## Plymouth Health and Adult Social Care Overview and Scrutiny Committee

**29 January 2020**

| | |
|---|---|
| **Subject** | **University Hospitals Plymouth NHS Trust CQC Action Plan: Emergency Department Inspection** |
| **Prepared by** | Amanda Nash, Head of Communications |
| **Approved by** | Kevin Baber, Chief Operating Officer |
| **Presented by** | Amanda Nash and Jacqui Beer, Head of Performance Information |

### Purpose

To provide assurance to the Committee around outpatient appointments provided by University Hospitals Plymouth NHS Trust and in particular DNAs (Did Not Attends).

| | |
|---|---|
| **Decision** | |
| **Approval** | |
| **Information** | |
| **Assurance** | ● |

### Corporate Objectives

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

### Executive Summary

The Trust is one of the best performing in the country for DNA (Did Not Attends) rates, ranking 14 best out of 127 Trusts across the country. The report gives an update on work done to reduce DNAs and survey work to understand what matters to patients about their outpatient appointments.

### Quality Impact Assessment

Maximising attendances at outpatient appointments contributes to better quality care for our local population..

### Financial Impact Assessment

There is a cost both to the provider and to the individual patient of missing their outpatient appointment.

### Regulatory Impact Assessment

Not applicable.

### Equality and Diversity Impact Assessment

No equality and diversity issues are identified in this report.

### Main points

**Introduction**

1.1 The Committee has requested an update regarding the number of missed hospital appointments at University Hospitals Plymouth NHS Trust, these are commonly referred to as DNAs – Did Not Attends.

1.2 Please note the scope of this report. This covers missed outpatient appointments in clinics run by University Hospitals Plymouth NHS Trust. It does not cover community outpatient appointments in clinics run by Livewell Southwest or missed appointments with GPs. An update on these will need to be sources from those providers.

**Encouraging patients to attend – a reminder**

2.1 UHP has used a text reminder service since May 2014.

Seven days beforehand, adults or parents/carers of children are contacted by an automated call and offered the opportunity to either confirm attendance at their appointment or reschedule. Adults or parents/carers are authenticated prior to appointment confirmation request.

If this automated call is not responded to, the process is repeated on day six and day five and two days before the appointment, provided we have a mobile number, everyone receives a reminder text.

2.2 Validating contact details

When patients check-in for appointments, we ensure we validate their contact to confirm we have the most up-to-date on record.

**Performance and Benchmarking**

3.1 University Hospital Plymouth's DNA`s rate for Quarter 2 (July to Sept 2019) was well below average at 5.17% (national median is 7.13%, peer median 6.88%), as shown in Figure 1 below.

The Trust ranks 14th lowest (best) out of 127 Trusts.

The Trust has been on an improving (reduced %) trajectory consistently over the last three years (UHP are the blue line in Figure 2 below).

This data is taken from Model Hospital, a digital information service designed to help NHS providers improve their productivity and efficiency. Hospitals can drill down into data to see where they are performing well and where there are opportunities to improve.

Figure 1

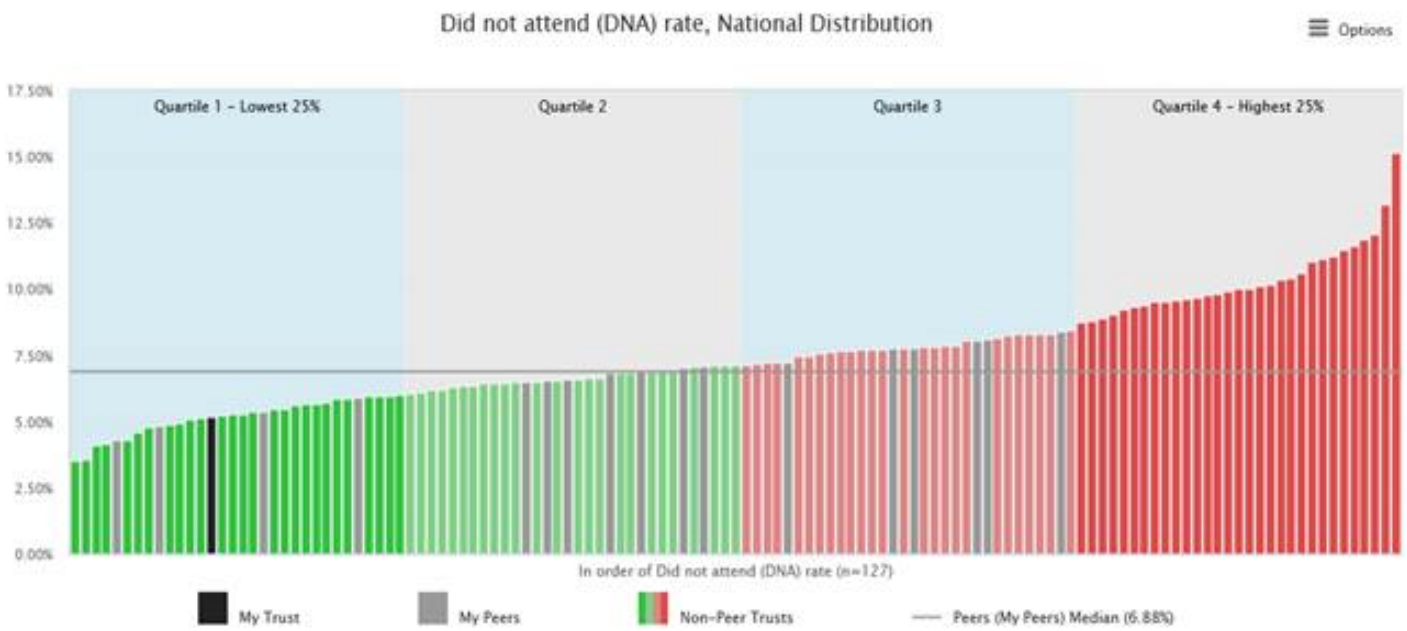
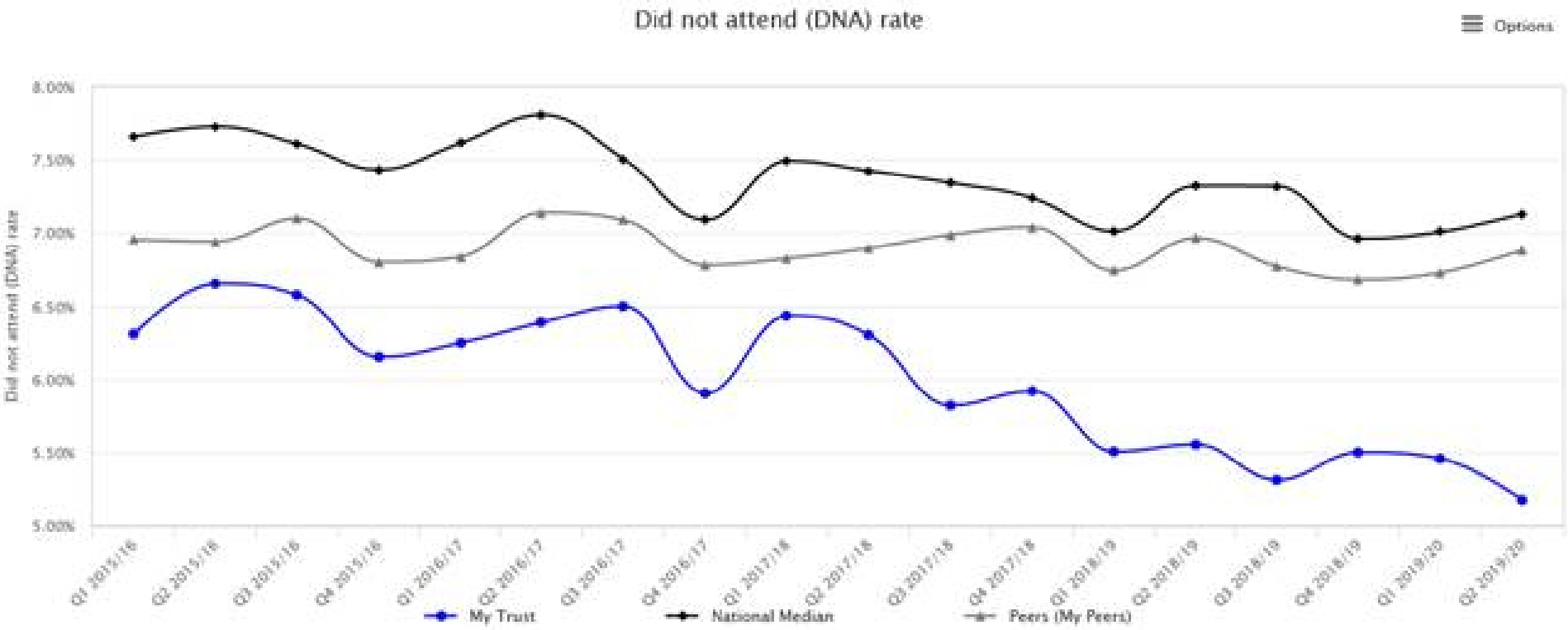

Did not attend (DNA) rate, National Distribution
Options
17.50%
15.00%
12.50%
10.00%
7.50%
5.00%
2.50%
0.00%
Quartile 1 - Lowest 25%
Quartile 2
Quartile 3
Quartile 4 - Highest 25%
In order of Did not attend (DNA) rate (n=127)
My Trust
My Peers
Non-Peer Trusts
Peers (My Peers) Median (6.88%)

Figure 2


Did not attend (DNA) rate
Options
8.00%
7.50%
7.00%
6.50%
6.00%
5.50%
5.00%
Did not attend (DNA) rate
Q1 2015/16
Q2 2015/16
Q3 2015/16
Q4 2015/16
Q1 2016/17
Q2 2016/17
Q3 2016/17
Q4 2016/17
Q1 2017/18
Q2 2017/18
Q3 2017/18
Q4 2017/18
Q1 2018/19
Q2 2018/19
Q3 2018/19
Q4 2018/19
Q1 2019/20
Q2 2019/20
My Trust
National Median
Peers (My Peers)

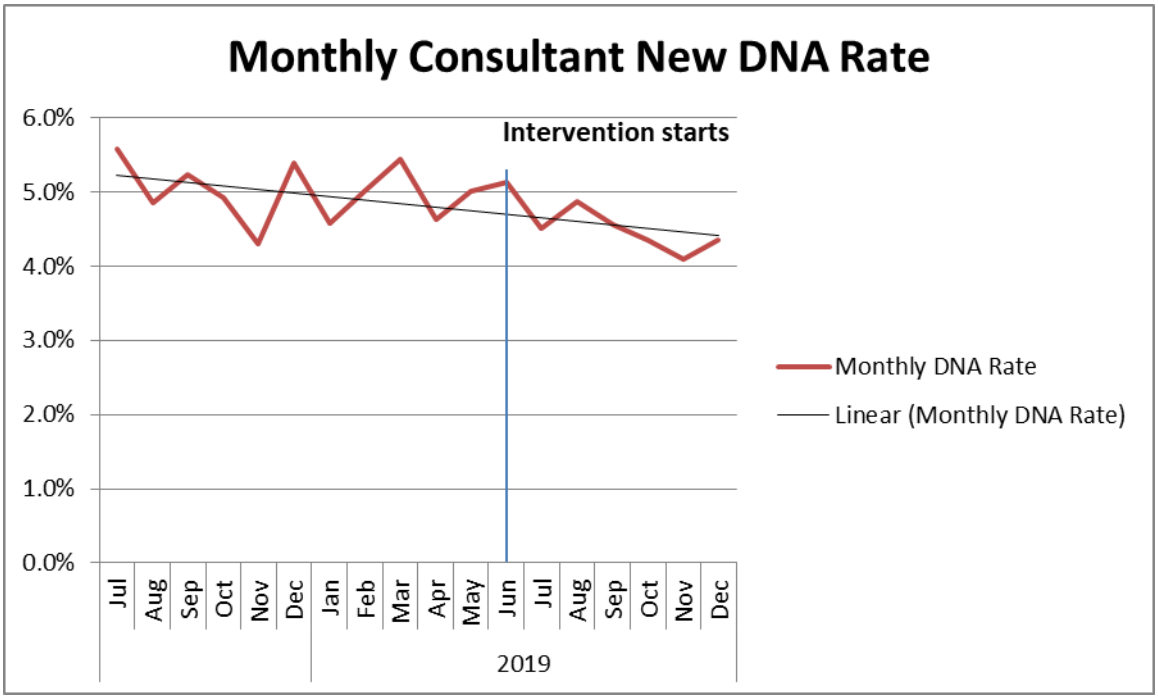
**Further Improvements**

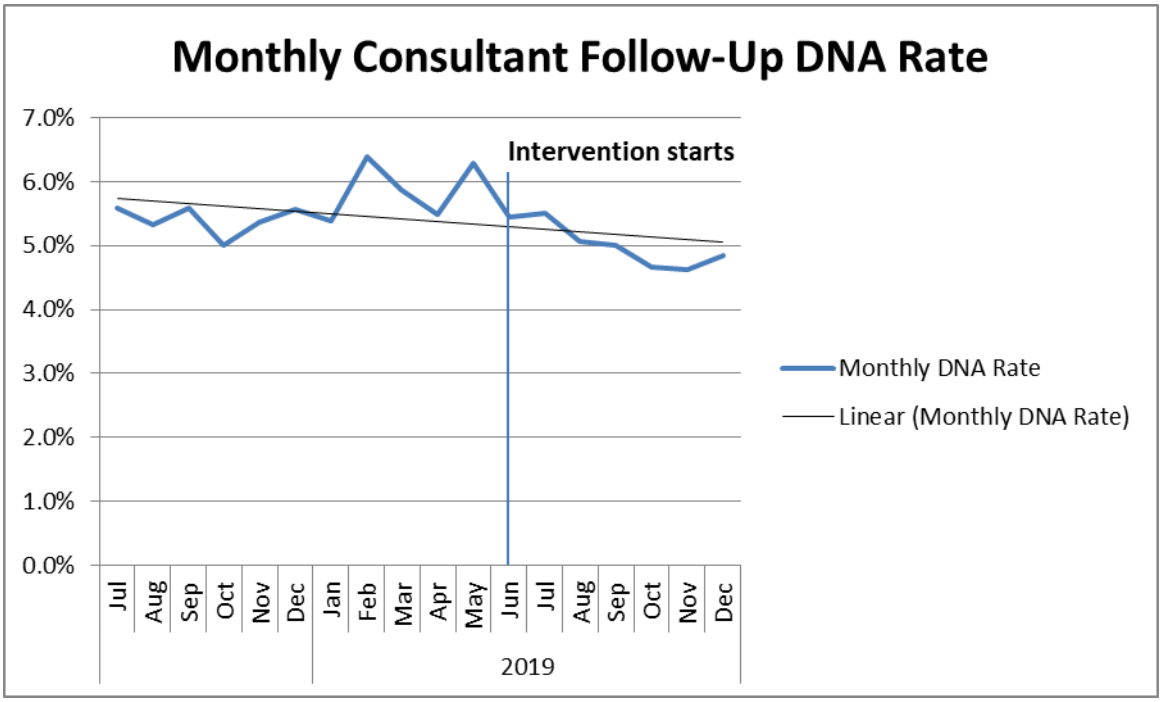
4.1 In line with evidence, the Trust introduced new wording into text reminders and patient appointment letters in June 2019. The next text stated that an appointment costs an average of £100 and was based on evidence from a 2015 trial in Barts which showed that a change in wording can reduce DNAs. In the first trial, a change in message including the cost of a missed appointment to the health system produced a DNA rate of 8.4%, compared to the control group of 11.1% The study is available at: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0137306

The precise wording used in the trial builds on a number of psychological principles that are known to influence behaviour, namely the consistency principle, salient cost linked to individual action and the ease with which people can rearrange if needed.

4.1 These changes have correlated with further falls in DNAs, with November 2019 seeing our lowest rates ever for both new and follow-up appointments.

Figure 3






**Work with patients**

5.1 With the continued reductions in DNA and the excellent national benchmarking, the need to undertake survey work to understand why patients miss appointments was replaced with work supporting a move to provide alternatives to face-to-face follow-up appointments.

5.2 UHP offers more than half a million outpatient appointments every year but still has 40,000+patients waiting for a follow-up appointment beyond their required date to be seen. UHP is keen to change the way some of its services run in order to reduce the number of patients waiting beyond their required date to be seen and to reduce the burden on patients and their families of having to come to the hospital or clinic setting.

5.3 As part of the Devon NHS Long Term Plan engagement work, as the Committee was made aware, in July and August 23019 UHP staff, support by our Patient Council, undertook survey work with patients to understand more about what matters to them in an outpatient appointment and their appetite for possible alternatives. We would like to formally thank our Patient Council for their support with this work and Healthwatch Plymouth for their advice and guidance in advance of undertaking it.

5.4 Face-to-face surveys were undertaken with 163 patients or guardians of patients in 17 clinics. The total number of patients booked for these clinics was 434, representing 38% of all patients in the clinics selected. Key findings included:

**The majority of patients did not undergo a test/examination at their outpatient appointments**
The majority of patients interviewed (67%) did not have a physical examination or undergo a diagnostic test on the day of their appointment. The majority of patients had a discussion with a healthcare professional about their health or were given updates or information about their condition.

**Information-sharing and reassurance matters most to patients; but being seen in a timely way is also a concern for 10% of patients**
In terms of what matters to people about their outpatient appointments, the most important

factor was ongoing monitoring, information and reassurance (n = 56 respondents). The next most often-cited factor was obtaining results, a diagnosis and/or prognosis.
Being seen in a timely way or getting an appointment at all was third place in terms of mentions (n=16). Two patients had waited more than a year for their appointment.

**There is a cost to patients in attending outpatient appointments. 20% of those interviewed had to take time off work and a further 19% have a caring responsibility**
Healthcare costs are most often talked about in relation to provider expenses. When we examine the costs to patients of attending appointments, the majority do experience a cost – financial or otherwise.

- More than half had to pay for parking (n =65) or bus/taxi fare (20).
- 20% (32) had to take time off work.
- 19% of respondents (31) were carers and had to make alternative arrangements for someone they care for to be looked after.

**Three-quarters of patients would prefer to return for a face-to-face appointment**
Out of the 134 respondents for whom this question was applicable, 101 said they preferred to return for a face-to-face appointment with their specialist. 33 (25%) would be happy with an alternative method.

**Scheduled phone calls are the most popular alternative**
The most popular choice amongst respondents for an alternative to face-to-face appointments was a scheduled phone call (78), followed by patient-initiated contact via phone or email (55) - as already used in other services, such as Rheumatology.

These findings have been fed into the work of UHP's Outpatient Steering Group.

## Conclusion and Recommendations

It is recommended the Committee takes assurance from the benchmarking data and work undertaken.

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# Health and Adult Social Care Overview and Scrutiny Committee

| | |
|---|---|
| Date of meeting: | 29 January 2020 |
| Title of Report: | **Financial Inequities (Fair Shares)** |
| Lead Member: | N/A |
| Lead Strategic Director: | Simon Tapley, Interim Accountable Officer – NHS Devon CCG |
| Author: | Warwick Heale, STP Programme Director<br>John Dowell, Director of Finance<br>Ben Chilcott, Deputy Director of Finance |
| Contact Email: | D-CCG.CorporateServices@nhs.net |
| Your Reference: | N/A |
| Key Decision: | No |
| Confidentiality: | Part I - Official |

**Purpose of Report**

The attached report has been provided in response to the Committee's request to consider "Fair Shares". The paper was recently considered the NHS Devon CCG Governing Body in October 2019.

The distribution of resources invested in services across the County is a key responsibility of the CCG as commissioner of services for the population of Devon. The current distribution of, and pattern of access to those services by the populations of each of the four localities (North, South, East and West) of Devon is an artefact of many years, and reflects many complex interactions of patients and services.

In line with the ambition of the NHS Long Term Plan, The Devon STP is committed to reducing health inequalities. In pursuit of this aim, the CCG is, in turn, committed to achieving a more equitable distribution of financial investment in the pattern of services available across the County, by mirroring the approach to Resource Allocation used nationally to determine Allocations at CCG level. This process requires considerable technical expertise, and the STP has established an Advisory Group to assist the CCG in forming its Resource Allocation Policy.

This paper includes the recommendations of the STP Financial Inequities and Health Inequalities Advisory Group for the Governing Body to consider in agreeing its financial inequities policy.

**Recommendations and Reasons**

The committee is recommended to note the report.

**Alternative options considered and rejected**

NHS Devon CCG has provided the report at the committee's request, in compliance with regulation.

**Relevance to the Corporate Plan and/or the Plymouth Plan**

Content of this report is relevant to Plymouth Plan strategic objective one, Delivering a Healthy City.

Consideration of this report aligns with NHS Devon values of One Team and the City Council's Corporate Plan Co-operative and Democratic values.

**Implications for the Medium Term Financial Plan and Resource Implications:**
No implications for the City Council's financial planning are identified in this report.

**Carbon Footprint (Environmental) Implications:**
N/A

**Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:**
** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*
N/A

**Appendices**
**Add rows as required to box below*

| **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 title | | | | | | | |
| B | Equalities Impact Assessment (if applicable) | | | | | | | |

**Background papers:**
*N/A*

**Sign off:**

| Fin | **N/A** | Leg | **N/A** | Mon Off | **N/A** | HR | **N/A** | Asset s | **N/A** | Strat Proc | **N/A** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Originating Senior Leadership Team member: John Dowell CCG Director of Finance | | | | | | | | | | | |
| Please confirm the Strategic Director(s) has agreed the report? n/a | | | | | | | | | | | |
| Cabinet Member approval: *n/a* | | | | | | | | | | | |

NHS
Devon
Clinical Commissioning Group

# Financial Inequities

## 1. Introduction

1.1 Within Devon there has been a debate over several years about the observed inequitable distribution of CCG funding between localities (North, South, East and West Devon). Analyses of that distribution have consistently shown the allocation to the Western Locality being below its 'fair share' as determined by application of the National CCG Resource Allocation formula. It has been the long-standing intention to address this geographical financial inequity, however, because the system in aggregate is spending more than the resources allocated to it for the population across the whole of Devon, the first priority has been financial recovery – returning total spending to within the allocation. Addressing financial inequity in this context would have meant an even higher savings target for the CCG in order to generate additional money for investment in under-equity areas.

1.2 With the creation of the Devon Sustainability and Transformation Partnership (STP) for Devon, the senior leaders of all partner organisations who form the Collaborative Board have affirmed the importance of addressing financial inequity, and have stated an ambition that this should be achieved over 3 years, beginning in 2019/20.

1.3 The investment of the resources allocated to the CCG for the population Plymouth, Devon and Torbay is the responsibility of the CCG Governing Body. The Governing Body has made a decision on the policy it will adopt with regard to allocation of resources, having taken due consideration of this recommendation from the STP Collaborative Board.

1.4 The STP established an expert advisory group to consider financial inequities and health inequalities. That group completed its work on financial inequities and provided recommendations to the Devon CCG Governing Body to support it in developing its financial equity policy. Recommendations cover all the key questions about financial inequities that have been raised by partner organisations across Plymouth, Devon and Torbay.

1.5 One of the key findings of the group was that an analysis of resource distribution since 2015/16 reveals that without a policy to address financial inequities, there is a risk that some Localities may move in the wrong direction, with the above-equity localities moving further above and the below-equity localities moving further below. Even when a policy is put in place to address financial inequities, we are likely to find that there is an underlying current that, to some extent, works against

this. Therefore, the CCG should guard against constructing a policy that is too conservative or it is unlikely to achieve its objective.

1.6 In this report, the following terms are used:

**National equity formula**: a group of formulae for different service categories (e.g. mental health, general and acute hospital services, maternity, primary care prescribing), based on the size and characteristics of the population that is designed to measure the relative cost of providing services to meet the health demands and needs of a population (although the formulae are based primarily on demand data there is an adjustment for unmet need).

**National allocations model**: a comparison of the current distribution of the national NHS budget by CCG with the 'fair' distribution as determined by the national equity formula, with rules for how additional funds should be allocated to move CCG shares of the national general allocation towards the fair distribution. It should be noted that overspends in providers or commissioners are not taken into account in this model, it is based on the allocation of funds to CCGs.

**Additional allocations**: monies allocated to CCGs in addition to the general allocation which have a specific focus that is not based on general population demand or need.

## 2. Advisory group

2.1 The STP Financial Inequities and Health Inequalities Advisory Group membership was selected to include specific expertise on financial inequities and health inequalities, with coverage across sectors and across the geographies of Torbay, Plymouth and Devon as well as members independent of any geographical allegiance.

2.2 The group members are:

| Member | Role and Organisation |
|---|---|
| Richard Crompton | Chair, UHP (Chair) |
| Simon Tapley | AO, CCG |
| John Dowell | CCG DoF and STP Lead DoF |
| Warwick Heale | STP Programme Director |
| Ben Chilcott | Deputy DoF, CCG |
| Simon Chant | Public Health consultant, DCC |
| Ruth Harrell | Director of Public Health, Plymouth CC |
| Richard Blackwell | Associate Director of Insight, AHSN |
| Rich Smith | Deputy Pro-Vice Chancellor and Professor of Health Economics, University of Exeter Medical School |
| Peter Aitken | Consultant Psychiatrist and Director of R&D, DPT |
| David Greenwell | Joint Clinical Lead GP, Southern Locality, CCG |
| Tobin Savage | Operations & Delivery, NHSE/I South West |

## 3. Financial inequities and health inequalities

3.1 As well as financial inequity, the Western Locality, within which Plymouth is situated, has higher levels of deprivation and poorer health outcomes than the other three localities and this adds to the pressure to provide additional investment in that locality to help to address those issues. It should be noted that there are populations in all localities with high levels of deprivation and poor outcomes and these are equally deserving of attention, but the higher concentrations in Plymouth in particular, increase the pressure to address the geographical financial inequity. However, we should not regard the addressing of financial inequities as if it is an end in itself and there should be much greater emphasis on addressing health inequalities across all our system work.

3.2 It is recognised that the contribution that the NHS can make to reduce health inequalities is relatively small and that other determinants of health, such as education, housing, employment, lifestyle and other socio-economic factors have greater significance. The advisory group is also reviewing indicators of health inequality and the interventions that the NHS and other agencies could make to address health inequalities.

3.3 Another important perspective is the inequity in resource allocation between services (e.g. mental health, acute, community, primary care). This is discussed later in this report, but the majority of this report focuses on geographical financial inequity because that is the primary issue that the CCG has committed to address.

## 4. Scope

4.1 The scope of costs to be considered could include:

- General community, secondary and mental health services commissioned by the CCG
- Primary care services, delegated from NHSE to CCG
- Specialised services, commissioned by NHSE
- Prison health services, commissioned by NHSE
- Health services for the armed forces, commissioned by NHSE
- Public health
- Social care (adults and children)
- Voluntary and community sector

4.2 The primary question for the system has been how we should distribute the CCG allocation most fairly. Therefore, everything covered by the CCG allocation must be included. Primary care and specialised NHS services (commissioned by

NHSE) should also be included in this work in order to give a more complete picture of local NHS provision. Funding for prison and armed forces health services are not distributed according to the general population allocation because prisons and armed forces bases are not equally distributed across CCGs. Therefore, spend on these services should be excluded.

4.3 The national equity formula only relates to NHS expenditure, therefore adding other costs (such as social care or public health) would mean that we would be comparing actual expenditure with an unrelated NHS measure of 'fair shares'. To address this we would have to attempt to develop our own combined model of health and local authority services' financial equity which would be a significant undertaking. There is an added difficulty with social care costs because these are means tested and therefore local authorities might spend proportionately more money in areas where people are less wealthy – potentially an inverse relationship with need.

4.4 However, wider expenditure on support for communities, such as social care and housing, will affect population need and demand for health services and therefore the costs of provision. This could form a second phase of analysis if there was agreement in the system that this was worthwhile.

4.5 **Recommendation 1: That the scope of the analysis is limited to the CCG allocation, primary care and NHSE-commissioned specialised services.**

## 5. Measurement of fair shares

5.1 The national equity formula has been developed over many years. It explains c.70% of the variation in health spend. The 'model' is built upon separate formulae for different services (e.g. hospital and community services, mental health, maternity).

5.2 The individual formulae include their own weightings for age, sex and deprivation. The data to which the formulae are applied are GP registered populations. These populations are mapped to the Devon localities.

5.3 It is accepted that any formula will be imperfect, but there is no better, validated alternative to the national equity formula. Any decision to amend the national equity formula would expose us to the risk of cherry-picking or special pleading by localities and would undermine the validity of the formula.

**5.4 Recommendation 2: That the national equity formula is used for assessing financial inequities within Devon.**

## 6. Recent changes to the national equity formula

6.1 There were significant changes to the national equity formula between the 2018/19 and 2019/20 allocations. The change with the greatest impact between localities in Devon was a change to the mental health formula. This gives a greater weight to Southern and Eastern Devon in particular and a lower weight to Western. We are still awaiting a response to requests to the national allocations team for more information in order to help us understand what has produced that change.

6.2 It is uncomfortable for everyone involved, and particularly for the Western locality, that the national measure of 'fairness' can change and have a material impact on localities' positions relative to equity. However, this discomfort should not lead us to revert to the 2018/19 formula just because it paints a picture that is more familiar. If we accept that we will use the national equity formula we should use the most up-to-date version. However, until we understand the changes to the mental health formula and the reliability of the data sources, we cannot confidently rely on its outputs.

**6.3 Recommendation 3: That the latest national equity formula is used for assessing financial inequities within Devon, but that this is regarded as draft until the changes to the mental health formula are understood. This does not prevent the CCG from developing its financial inequities policy, but the locality values to which this policy are applied should be regarded as subject to change.**

**6.4 Recommendation 4: That an explanation for the changes in the national equity formula from 2018/19 to 2019/20 is obtained and is reported to a future Governing Body meeting, along with an assessment of any risks to reliability of the formula.**

## 7. Disinvestment or differential investment

7.1 The national allocations model does not reduce the allocation to above-equity CCGs. Instead, lower levels of growth are given to above-equity CCGs and higher levels of growth to below-equity CCGs. In this way, CCGs are moved closer to a fair share of national funding without the destabilising effect of withdrawal of funding that could lead to severe service instability or service closures.

7.2 The Devon system is running a substantial deficit and performance against many statutory indicators is below target in all localities. Over-equity localities are suffering from the effects of financial insufficiency even if this is less than the insufficiency in under-equity localities. All localities will have to make significant savings to meet their financial targets. In this context, a policy of disinvestment to address financial inequity would be even more risky than in a financially-balanced system.

7.3 As context, the Devon NHS system will receive c.£60m of growth funding per annum so it is unlikely that we would ever find ourselves in the situation where the financial inequities were so extreme that we would have to adopt a disinvestment policy.

**7.4 Recommendation 5: That movement towards financial equity is made by differential investment rather than a reduction in funding for any locality.**

## 8. Adjustments for additional allocations

8.1 The CCG receives additional funding for the following items and these relate to particular localities rather than being incorporated in the CCG's general allocation:

- Local Improvement Finance Trust LIFT
- Small hospitals/unavoidable remoteness

8.2 These items recognise unavoidable differences in cost that do not relate to the size or characteristics of the population and which should therefore be treated separately from the calculation of fair shares. The cost associated with these items is within the total current spend of each locality so in the comparison between fair shares and current spend an adjustment for these items is required.

**8.3 Recommendation 6: The additional allocations for LIFT and small hospitals/remoteness are not related to population need and should be treated separately in the comparison of fair shares and current spend.**

8.4 While accepting that these items represent unavoidable costs unrelated to population need, we may nevertheless separately consider whether the value attributed to these items is correct. This is a particular question in relation to the size and remoteness allocation for NDHT. The allocation is £3.9m, but the CCG and NDHT are currently assessing whether the unavoidable excess cost of services in NDHT is greater than this. If the conclusion is that the national value is too low, the CCG will have to agree whether to recognise the national value or the locally-agreed value in the local comparison of current spend with fair shares.

8.5 The advisory group considered the argument that we are accepting national formulae and values in our equity calculations in all other cases and if we recognise a higher value we will be depriving other localities of their share of the additional funding that we attribute to Northern. On the other hand, if we know the national value to be too low but use it anyway, the Northern locality will be unable to afford services to meet the needs of the population in an equivalent way to other localities.

8.6 The group noted that the financial inequities discussion should not be extended to attempt to resolve all financial issues within Devon. It was agreed that the unavoidable cost of small scale, remote services in NDHT should be agreed between the CCG and NDHT and that, irrespective of the conclusion that is reached on that point, the national valuation should be used in the inequities model in order to maintain the integrity of that model.

**Recommendation 7: The value of the NDHT size/remoteness adjustment in the local fair shares calculation should be set at the national value**.

## 9. Other potential adjustments

9.1 There may be local factors that drive unavoidable cost that is unrelated to population need and which are not included in the national set of additional allocations. We could agree to take these into account or limit our adjustments to the nationally-recognised additional allocations. To justify taking account of additional factors, they would have to conform to the principle that they represent material, unavoidable differences in cost that are unrelated to population need. They would also need to be unrelated to unavoidable differences in cost that relate to previous years' investment decisions (e.g. failure to invest in infrastructure that now leads to greater cost could have been avoided in previous years).

9.2 An example that meets these requirements is the potential diseconomies of small-scale tertiary services at UHP as a parallel case to the NDHT remoteness/size adjustment. A report commissioned by UHP from Carnall Farrar in 2017 identified some internal productivity opportunities in tertiary services, but a £2m shortfall related to sub-scale services which would require a system solution.

9.3 The case for taking account of the NDHT adjustment is more straightforward because there is a separate source of funding that does not reduce the funding for the other localities in Devon. Recognising the diseconomies of scale of UHP tertiary services would mean a top-slice from the CCG allocation in the equity calculation, leaving a lower sum on which to calculate fair shares for all localities.

9.4 However, if we do not take these unavoidable excess costs into account the Western locality (via UHP) will bear these costs and potentially be unable to afford services to meet the needs of the population in an equivalent way to other localities. The tertiary services at UHP are provided to patients in all localities so arguably all localities should accept a top-slice for the unavoidable excess costs of maintaining local provision.

9.5 As within *Section 8*, the group noted that the financial inequities discussion should not be extended to resolve all financial issues within Devon. It was also noted that extending the list of 'special cases' beyond the additional national allocations could

form the thin end of a large wedge which would invite adjustments for each locality that would soon undermine the integrity of the national model.

9.6 Furthermore, if there is a sound case for recognising the unavoidable costs of small scale tertiary services at UHP this should be a contractual negotiation between UHP and NHSE commissioners who have responsibility for ensuring access for the population of the Peninsula to specialised services. At some point the specialised services budget is likely to be devolved to CCGs and any additional funding for sub-scale services would then become a local decision.

**9.7 Recommendation 8: That no adjustments to the model should be made beyond the additional national allocations.**

## 10. Distance from target

10.1 It is accepted that the national equity formula is imperfect and therefore it should not be used as if it explains 100% of the variation in demand for healthcare resources and is not intended to be used to determine a level of relative investment with absolute precision. Therefore, there is a tolerance around the calculated fair share within which there is no attempt to move a CCG's allocation any closer to equity. The population of Devon CCG's smallest locality is similar to that of the smallest CCG nationally so the national tolerance should be appropriate to use within Devon.

10.2 For 2019/20 the national tolerance is 2.5% below and 5% above fair shares. If this was solely a statistical exercise one would expect the tolerance to be equal above and below, but these tolerances may have a pragmatic or political dimension rather than being purely statistical. We do not understand the reasons for these tolerances nor the statistical modelling that may support them. If we are to be consistent with the national model (as we have recommended in preceding sections) we should maintain that consistency in terms of distance from target.

10.3 However, the locality that has poorest outcomes is most below equity and to bring it just to 2.5% below the modelled equity position while those outcomes remain poor may be regarded as unacceptable.

10.4 We should also bear in mind that the underlying drivers of spend have led to increasing inequity (as noted in *Paragraph 1.4*) so if the CCG policy is intended to deliver no worse than 2.5% below equity and those other drivers continue to push localities away from equity the CCG will probably fall short of achieving its policy intention. The CCG will therefore need to aim higher to achieve what it intends and will probably have to continue to invest differentially in the longer term to offset the effect of those underlying drivers against equity.

**10.5 Recommendation 9: When considering financial equity, the CCG should adopt the national tolerances of -2.5% and +5% around each locality's fair**

**share of the CCG's allocation. This means that if outcome measures were similar, the CCG would be satisfied with this level of funding variation between localities.**

**10.6 Recommendation 10: Where there are poor outcomes, additional investment is needed and therefore we should not be content with areas with the poorest outcomes being funded at the lower end of tolerance. The CCG should aim to bring the locality with the poorest outcomes from -2.5% to 0% below target, specifically to address those unequal outcomes.**

**10.7 Recommendation 11: The position of each locality compared to financial equity should be reviewed each year alongside outcomes and further differential investments made to offset any drift away from equity that may occur for other reasons.**

## 11. Financial inequity between services

11.1 The question about fair shares of health spend is generally focused on distribution between localities and this has been the primary focus of the work of the advisory group. However, the group also considered how fairly money is distributed across services (for example, primary care, mental health, acute physical health). This is included in the accompanying presentation.

11.2 Using the national equity formula to make decisions about relative investment in services goes beyond how it is used nationally. There will be relationships between services that may lead to the national model working better if used as an integrated whole rather being divided into separate service-specific formulae. The service-specific formulae could be used as one indication of service inequity if they were used with sufficient caution. There will be other sources of information that indicate whether the relative investment between services should be addressed.

**11.3 Recommendation 12: The analysis of service inequity requires additional data sources and further work.**

## 12. Should conditions be attached to the additional investment in under-equity localities?

12.1 Differential growth in funding between localities brings with it the risk that the adverse impact on populations in localities with lower growth will not be offset by the benefits derived from the additional investments in localities with higher growth. One potential mitigation would be to set conditions on the use of the additional growth.

12.2 Given the system commitment to address health inequalities as well as financial inequities, the CCG could make the additional growth for under-equity localities

conditional on it being directed to those interventions that will have greatest impact on improving outcomes for disadvantaged populations (as long as these are not outside the scope of the CCG allocation). This could include investment in improving access to services in order to improve outcomes.

12.3 Furthermore, given that there are populations in all localities with high levels of deprivation and poor outcomes, the CCG could set similar conditions for all localities.

12.4 The analysis of inequity in demand by service (see *Section 12*) could be used along with other data to direct the additional growth towards those services that the national equity formula indicates are particularly under-resourced in the under-equity localities. We should also bear in mind that achieving reductions in health inequalities is dependent upon services commissioned by agencies beyond the NHS.

12.5 However, the system also has an intention to devolve responsibility to localities and this would suggest that additional investment should be without conditions as long as it is directed by the Local Care Partnership Board (or equivalent). Localities will be in a better position to understand where there is greatest local need. Where some of the required interventions are outside the scope of the NHS budget, other agencies within the locality should be encouraged to invest to deliver those interventions.

**12.6 Recommendation 13: The CCG should provide advice to localities about how any differential growth should be invested and should include an expectation that attention is given to interventions that will reduce health inequalities, but this should not be a requirement.**

**12.7 Recommendation 14: Any locality benefitting from differential growth should report to the CCG on how that additional money has been invested.**

**12.8 Recommendation 15: The CCG should communicate an expectation to all localities that they should focus on addressing unequal outcomes within their locality.**

## 13. Impact of historic underinvestment in under-equity localities

13.1 If there has been historic underinvestment in some localities it is possible that the population will currently suffer from poorer health as a result and therefore such localities will need a greater share of resources now and in future in order to provide additional services to mitigate that effect.

13.2 However, given the financial deficit in all localities, allocating even more growth to under-equity localities for these theoretical reasons would leave over-equity localities with even lower growth which might not be manageable.

13.3 Where outcomes are poorest and there has been historic underinvestment, that would be addressed via *Recommendation 10*.

**13.4 Recommendation 16: There should be no additional allocation to compensate for historic under-equity investment. However, where there are poor outcomes, *Recommendation 10* addresses this.**

## 14. Should the CCG invest to address inequity solely in the distribution of its allocation or inequity in the distribution of wider NHS allocations?

14.1 The national pace of change policy is applied to the whole place-based budget, including the CCG allocation and NHSE's allocations for specialised services and primary care medical services. This is based on the theory that a CCG area may be able to better cope with being below target if some of the other services are funded above target.

14.2 However, while it may be important for the CCG to understand any inequity in the distribution of NHSE's allocations as this is part of the picture of total locality NHS resource consumption, it could be argued that any inequities in NHSE resource distribution should be addressed by NHSE as they are responsible for ensuring access to specialised services for the whole population. There is a risk that if the CCG uses its allocation to address any inequity in specialised service resource use it will distort the CCG's equitable commissioning of non-specialised services.

14.3 In addition, there are some outstanding questions about the analysis of NHSE Specialised Commissioning expenditure by locality that should be addressed.

**14.4 Recommendation 17: The CCG should understand total NHS resource inequity, but should only differentially invest its allocation to address inequities in the distribution of its own allocation.**

**14.5 Recommendation 18: There should be further analysis of the distribution of NHSE specialised commissioning expenditure compared to equity, but because of *Recommendation 17* that should not delay the CCG in developing its financial inequity policy.**

## 15. Pace of change Policy

15.1 The STP Collaborative Board has recommended that Year 1 of the movement to equity is 2019/20 and that there should be a 3-year pace of change. This is

consistent with the national pace of change. This is a policy decision that depends upon the CCG's financial and non-financial objectives and the Advisory Group therefore had no direct recommendation to make on this matter.

15.2 Pace of change policy seeks to strike a balance between achieving the objective of improving the equity in distribution of resources, without creating undue instability or uncertainty. It is also important to recognise that the formula driven target is an indication of the expected consumption of resources by a population, and not an absolute "right" answer. In this context, a margin of error is appropriate.

15.3 Taken together, Recommendations 9, 10 and 11 from the Advisory group would support a pace of change policy that protects £5m of growth investment to be differentially invested in the Western Locality in 2020/21, with further differential growth investment in 2021/22 and 2022/23, subject to further analysis and understanding of impact on health inequalities and overall movement towards financial equity.

## 16. Consideration at Governing Body

16.1 This report was considered by the CCG Governing Body in October 2019. All but one of the recommendations were approved.

16.2 The GB response to recommendations 10, 13, 14 and 15 was as follows it was agreed that the CCG will consider a further move to the calculated equity figure (rather than just to 2.5% below) where an under-equity locality has particular poor outcomes. The list of outcomes, the timescale for a further move to equity and the question of conditions being set on that additional investment would be discussed at a future Governing Body meeting when the equity model has been updated for the 2020/21 plan. At that point, recommendations 10, 13, 14 and 15 will be reconsidered.

# DEVON INTEGRATED CARE SYSTEM PERFORMANCE

## QUARTER TWO 2019/20

## 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. This reports also takes into account some performance specific to Plymouth that might not form part of the outcomes framework, these areas of performance will be reported within the 'Performance by Exception' section.

## 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.

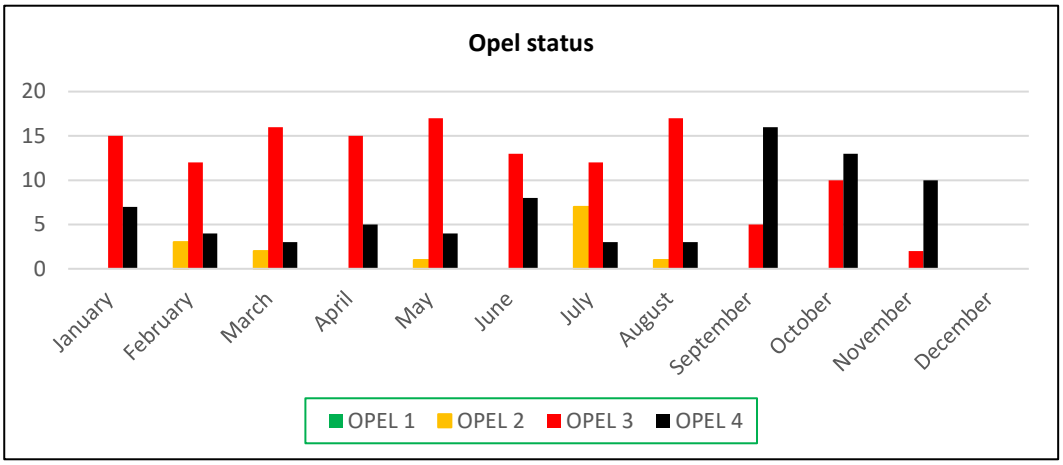
## 4. PLYMOUTH PERFORMANCE BY EXCEPTION

Specific performance issues to draw attention to this quarter are:

## Accident and Emergency

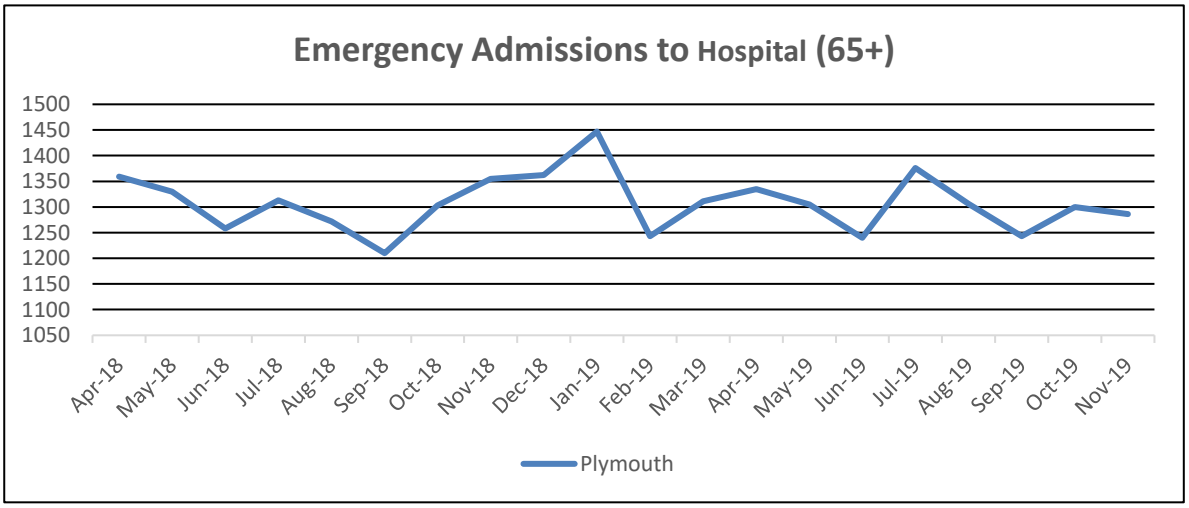
Currently there is no reporting against the 4 hour target for Accident & Emergency however Operational Pressures Escalation Level Status (OPEL) suggests that there are significant challenges as illustrated in the graph below. (Note November is part month only). This mirrors the national position, which demonstrates the significant pressures across all acute hospitals. The prevalence of OPEL 4 in the Western system is higher than the rest of the Devon CCG area.

Since the beginning of 2019/20 the Western system has been on OPEL 4 on 86 of 208 days (excluding weekends), this equates to 41.4% of days. This compares to 16.8% in the Southern System and <1% in the Northern and Eastern systems.




## Emergency Admissions Aged 65+

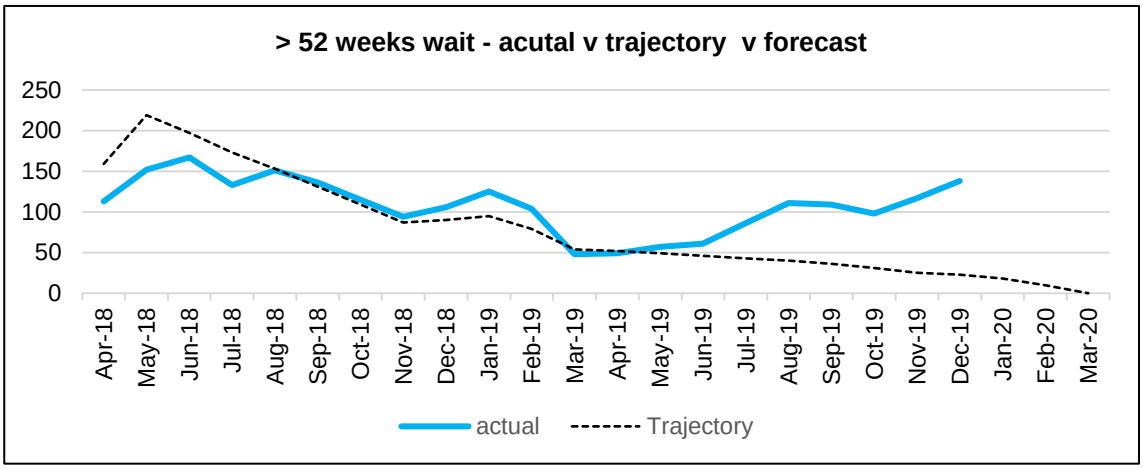
| | Qtr.2 2018/19 | Qtr.3 2018/19 | Qtr.4 2018/19 | Qtr.1 2019/20 | Qtr.2 2019/20 |
|---|---|---|---|---|---|
| Emergency Admissions Aged 65+ | 3795 | 4020 | 4001 | 3880 | 3925 |




Over the long term emergency admissions aged 65+ continue to be high but have remained relatively static over the year. Levels of admissions peak in the winter due to the level of respiratory admissions linked to the flu and the cold weather. This year we have seen higher numbers in the summer months than previous years, particular July and August which has correlated with the hot weather.

## Planned Care: 52 week waits

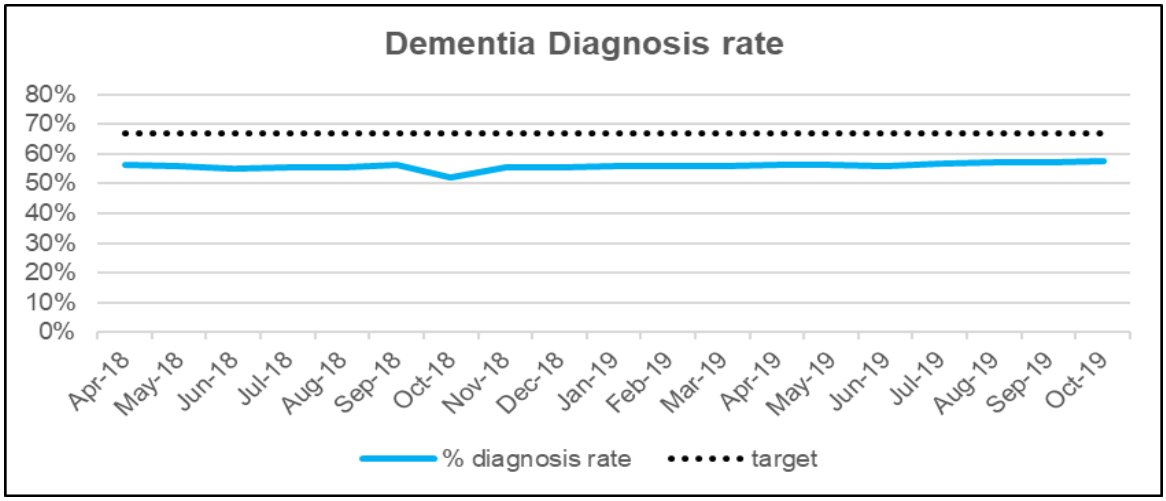
| | Jul 2019 | Aug 2019 | Sep 2019 | Oct 2019 | Nov 2019 | Dec 2019 |
|---|---|---|---|---|---|---|
| Over 52 week waits | 86 | 111 | 109 | 98 | 117 | 138 |




The revised forecast trajectory indicates that there will be 66 patients waiting more than 52 weeks at the end of March 2020 compared with a trajectory target of 20. All 66 patients forecast to breach will be in neurosurgery this is due to the ongoing imbalance between demand and capacity which has resulted in long waiting times for routine spinal surgery.

## Mental Health: Dementia Diagnosis

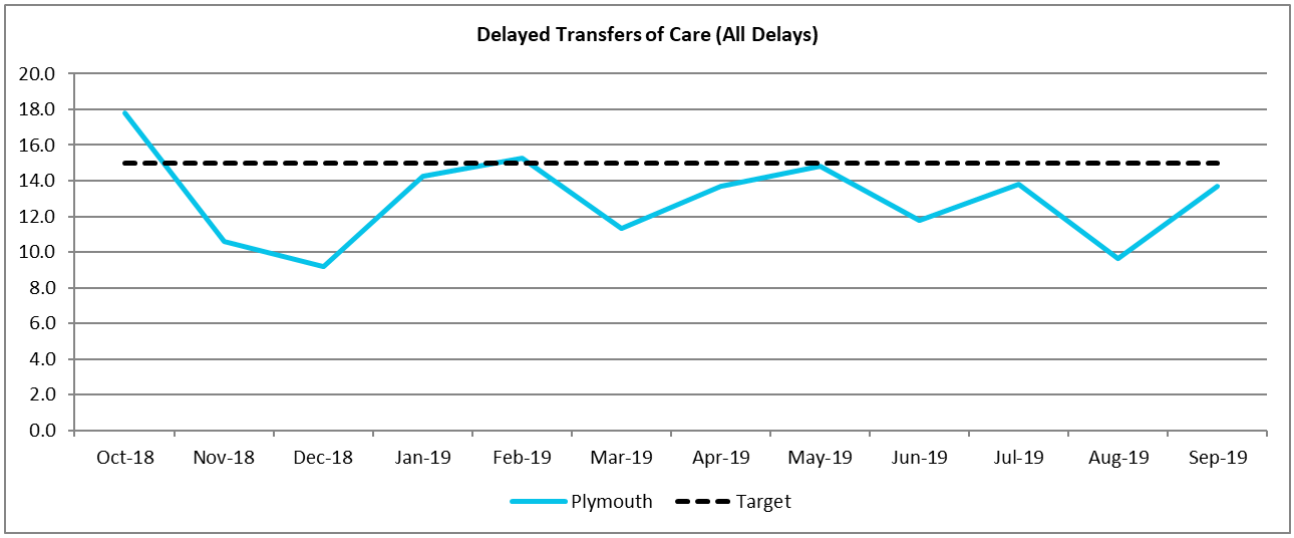
| | Target | Jun 2019 | Jul 2019 | Aug 2019 | Sep 2019 | Oct 2019 |
|---|---|---|---|---|---|---|
| Dementia Diagnosis rate | 67% | 56.0% | 56.9% | 57.0% | 57.0% | 57.4% |




The dementia diagnosis rate continues to be fairly static, remaining just below the 60% mark. Providers continue to work towards to a target of 59 positive dementia diagnoses per month. In 2019/20 the service received an average of 71.35 referrals per month, for dementia diagnosis.

## Urgent Care/ Patient Flow: Delayed Transfers of Care (All Delays)

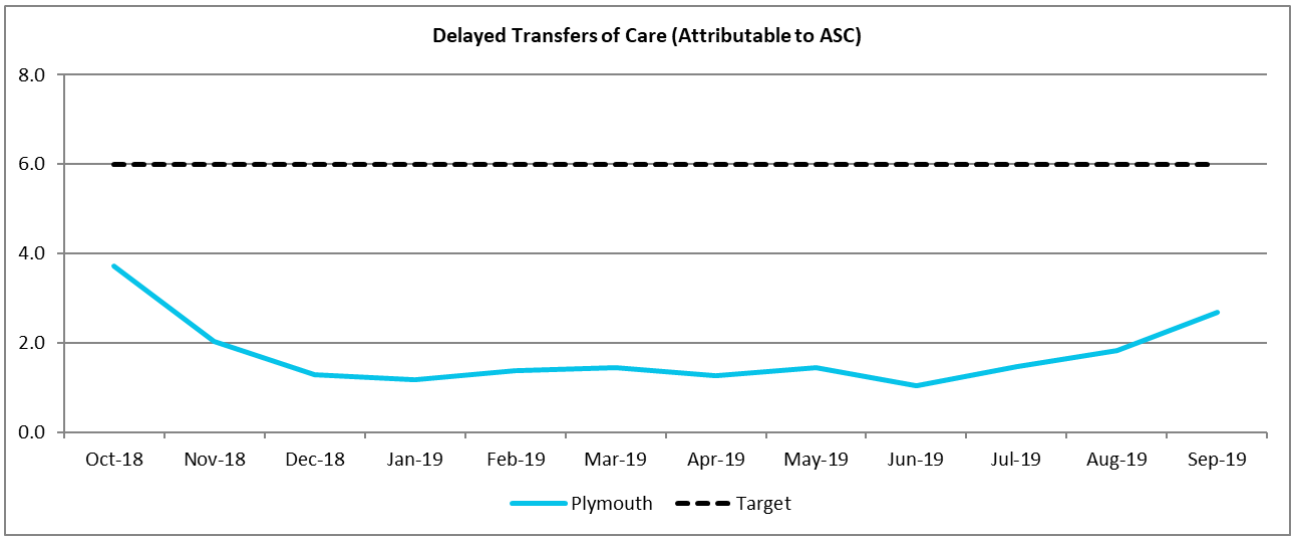
| | Target | Qtr.2 2018/19 | Qtr.3 2018/19 | Qtr.4 2018/19 | Qtr.1 2019/20 | Qtr.2 2019/20 |
|---|---|---|---|---|---|---|
| Delayed Transfers of Care | 15 | 16.7 | 12.6 | 13.6 | 13.4 | 12.4 |




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. In quarter two there was 2,409 delayed days across the system, this is lower than the 3,259 in quarter two 2018/19 and continues to be significantly lower than performance in 2017/18 and early part of 2018/19.

## Urgent Care/ Patient Flow: Delayed Transfers of Care (Attributable to Adult Social Care)

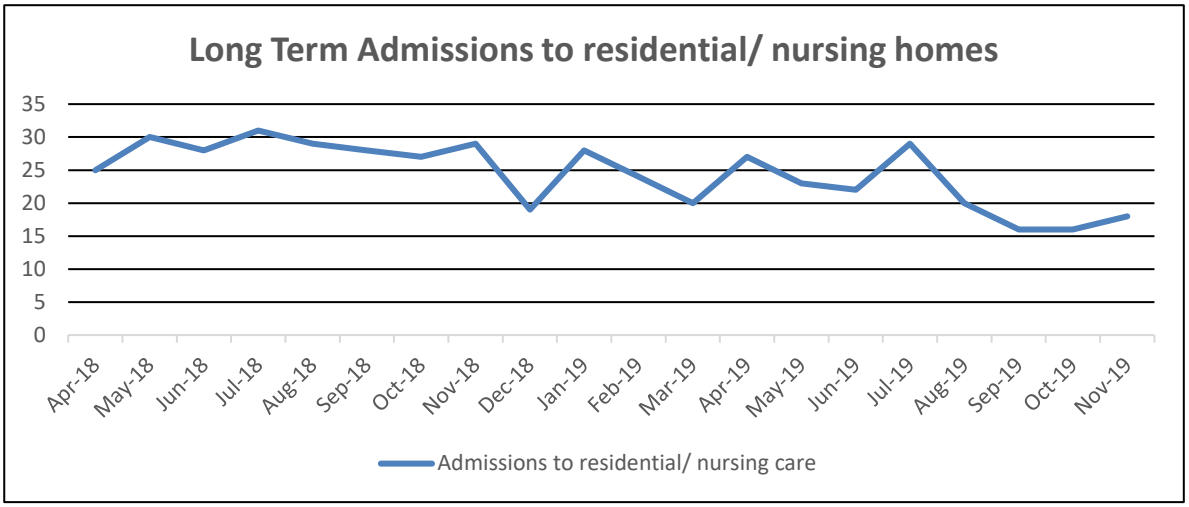
| | Target | Qtr.2 2018/19 | Qtr. 3 2018/19 | Qtr. 4 2018/19 | Qtr. 1 2019/20 | Qtr. 2 2019/20 |
|---|---|---|---|---|---|---|
| Delayed Transfers of Care | 6 | 2.3 | 2.3 | 1.3 | 1.3 | 2.0 |




In quarter two there was 387 delayed days that are attributable to Adult Social Care, this is lower than the 484 recorded in quarter two of 2018/19 and is significantly lower than performance in 2017/18 and early part of 2018/19. The number is higher than last reported in quarter one (242), this can be attributed to an increase in delays in September and October. Performance against this indicator improved again in November.

**Community: Long Term support needs of people aged 65+ met by admissions to Residential or Nursing Care**

| | Qtr.2 2018/19 | Qtr. 3 2018/19 | Qtr. 4 2018/19 | Qtr. 1 2019/20 | Qtr. 2 2019/20 |
|---|---|---|---|---|---|
| Long Term Admissions to Residential/ Nursing Care | 88 | 75 | 72 | 72 | 65 |




The number of long term admissions to residential and nursing care continues on a long term downward trend, the number of admissions in quarter two being seven fewer that quarter one 2019/20 and 23 fewer than quarter two in 2018/19. Increased availability of community based support and the Discharge to assess process have helped contribute to this improved performance.

**Safeguarding: % of completed safeguarding enquiries where risk has been identified and reduced or removed**

| | Qtr.2 2018/19 | Qtr. 3 2018/19 | Qtr. 4 2018/19 | Qtr. 1 2019/20 | Qtr. 2 2019/20 |
|---|---|---|---|---|---|
| % of completed safeguarding enquiries where risk has been identified and reduced or removed | 93.3% | 89.2% | 93.5% | 91.0% | 91.0% |

In quarter two there were 161 safeguarding enquiries completed, and in 118 of cases a specific risk had been identified. In 107 of these 118 cases the identified risk has been reported as having either been removed (32%), or the level of risk has been reduced (64%). The percentage of enquiries closed with a risk removed was an increase on performance in quarter one (32%, up from 28%).

# 5. OUTCOMES FRAMEWORK SCORECARD

| Devon ICS Strategic Outcomes Framework | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | STP in Context | | | Local Authorities | | |
| Outcomes | Measures | Source | Latest period | England | Actual | Trend | STP Chart | Devon | Plymouth | Torbay |
| More people will be living independently in resilient communities | ASCOF 1E: Proportion of adults with learning disabilities in paid employment | Social Care | 2019-20 Q2 | 5.9% | 7.1% | ▲ | | 7.2% | 5.6% | 8.5% |
| | ASCOF 1F: Proportion of adults with mental health needs in paid employment | Social Care | 2018-19 | 8.0% | 6.3% | ▲ | | 7.0% | 8.0% | 4.0% |
| | ASCOF 4A: Proportion of people who use services who feel safe | Social Care | 2018-19 | 70.0% | 68.3% | ▲ | | 70.6% | 66.4% | 68.0% |
| | ASCOF 4B: Proportion of people who use services who say that those services have made them feel safe and secure | Social Care | 2018-19 | 86.9% | 85.2% | ▼ | | 82.8% | 89.8% | 83.1% |
| | Children in poverty | Public Health | 2016 | 17.0% | 14.2% | ▼ | | 12.5% | 20.0% | 21.2% |
| | Fuel poverty | Public Health | 2017 | 10.9% | 12.4% | ▼ | | 11.6% | 13.0% | 12.6% |
| | Self-reported wellbeing (low happiness score) | Public Health | 2017-18 | 8.2% | 8.0% | ▼ | | 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 | Social Care | 2018-19 | 45.9% | 47.1% | ▲ | | 44.7% | 44.8% | 51.8% |
| | ASCOF 1Iii - Proportion of carers who reported that they had as much social contact as they would like | Social Care | 2018-19 | 32.5% | 27.4% | ▼ | | 23.2% | 26.6% | 32.4% |
| More people will be choosing to live healthy lifestyles and less people will be becoming unwell | Adult smoking prevalence | Public Health | 2018-19 | 14.4% | 14.4% | ▼ | | 13.4% | 17.0% | 16.0% |
| | Alcohol-related admissions | Public Health | 2017-18 | 2224 | 2039 | ▼ | | 1711 | 2159 | 2248 |
| | Physically active adults | Public Health | 2017-18 | 66.3% | 70.7% | ▲ | | 72.8% | 68.7% | 70.7% |
| | Excess weight in adults | Public Health | 2017-18 | 62.0% | 64.7% | ▲ | | 67.2% | 67.2% | 59.8% |
| | Fruit and vegetable consumption | Public Health | 2017-18 | 54.8% | 60.1% | ▼ | | 62.3% | 57.2% | 60.7% |
| | Life expectancy at birth (males) | Public Health | 2015-17 | 79.6 | 79.4 | ▼ | | 80.4 | 79.0 | 78.7 |
| | Life expectancy at birth (females) | Public Health | 2015-17 | 83.1 | 83.1 | ▼ | | 84.2 | 82.2 | 82.8 |
| | Life expectancy gap (males) | Public Health | 2015-17 | 9.4 | 7.8 | ▲ | | 5.6 | 8.5 | 9.4 |
| | Life expectancy gap (females) | Public Health | 2015-17 | 7.4 | 5.0 | ▲ | | 4.5 | 6.3 | 4.3 |
| | IAF 102a: 10-11 classified overweight /obese | NHS | 15/16 -17/18 | 34.2% | 29.5% | ▼ | | | | |
| | Dementia diagnosis rate | NHS | 2019/20 Q2 | 68.5% | 59.9% | ▼ | | | | |
| People who do have health conditions will have the knowledge, skills and confidence to better manage them | OIS 2.2 Proportion of people who are feeling supported to manage their condition | Public Health | 2017-18 | 60% | 62.8% | ▼ | | | | |
| | Hospital admissions for self-harm (aged 10 - 24) | Public Health | 2017-18 | 421 | 749.7 | ▲ | | 593.7 | 706.1 | 949.2 |
| | IAF 126b: Dementia post diagnostic support | NHS | 2017-18 | 77.5% | 77.1% | ▲ | | | | |
| | Percentage of people that received an NHS Health Check of those offered | NHS | 18-19 Q4 | 49.1% | 51.4% | ▲ | | 45.6% | 53.9% | 54.8% |
| | IAF 127b: Emergency admissions for urgent care sensitive conditions | NHS | 19-20 Q2 | 2484.0 | 2099.8 | ▼ | | | | |

# Devon ICS Strategic Outcomes Framework

| | | | | | STP in Context | | | Local Authorities | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Outcomes** | **Measures** | **Source** | **Latest period** | **England** | **Actual** | **Trend** | **STP Chart** | **Devon** | **Plymouth** | **Torbay** |
| 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 | Public Health | 2017 | 52.2% | 56.3% | ▲ | | 56.1% | 54.2% | 49.9% |
| | Mortality rate from preventable causes | Public Health | 2016-18 | 180.8 | 195.8 | ▲ | | 159.9 | 212.7 | 214.8 |
| | Suicide rate | Public Health | 2016-18 | 9.6 | 13.4 | ▲ | | 11.2 | 9.6 | 19.5 |
| | OIS 1.10: One-year survival from all cancers | NHS | 2016 | 72.3% | 74.0% | ▲ | | | | |
| | OIS 1.4: Myocardial infarction, stroke and stage 5 chronic kidney disease in people with diabetes | NHS | 2017/18 | 100 | 93.3 | ▼ | | | | |
| 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) | Social Care | 2019-20 Q2 | 13.9 | 12.7 | ▼ | | 12.1 | 10.3 | 24.2 |
| | 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) | Social Care | 2019-20 Q2 | 580 | 414.8 | ▼ | | 571.9 | 579.5 | 551.4 |
| | Deaths in usual place of residence | Public Health | 2017 | 46.6% | 53.4% | ▲ | | 53.2% | 54.5% | 53.4% |
| | IAF 127f: Hospital bed use following emergency admission | NHS | 2019-20 Q2 | 979.9 | 838.7 | ▲ | | | | |
| 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 | Social Care | 2018-19 | 19.1 | 19.2 | ◄► | | 19.1 | 19.1 | 19.4 |
| | ASCOF 3A: Overall satisfaction of people who use services with their care and support | Social Care | 2018-19 | 64.3% | 70.3% | ▲ | | 70.7% | 70.6% | 69.7% |
| | ASCOF 3B: Overall satisfaction of carers with social services | Social Care | 2018-19 | 38.6% | 39.1% | ▼ | | 38.1% | 37.9% | 41.2% |
| | ASCOF 1C(2A): proportion of people who use services receiving direct payments | Social Care | 2018-19 | 28.3% | 28.7% | ▼ | | 30.7% | 19.7% | 26.6% |
| | IAF 128b: Patient experience of GP services | NHS | 2019-20 Q2 | 82.9% | 87.6% | ▼ | | | | |
| | OIS 2.1: Health-related quality of life for people with long-term conditions | NHS | 2016/17 | 73.7% | 72.7% | ▼ | | | | |
| | OIS 2.15: Health-related quality of life for carers, aged 18 and above | NHS | 2016/17 | 79.7% | 79.7% | ▼ | | | | |
| | OIS 2.16: Health-related quality of life for people with a long-term mental health condition | NHS | 2016/17 | 51.9% | 52.4% | ▼ | | | | |
| | OIS 2.2: Proportion of people who are feeling supported to manage their condition | NHS | 2017/18 | 59.6 | 65.4 | ▼ | | | | |
| People who need treatment will be treated effectively and quickly in the most appropriate care setting | To be confirmed | To be confirmed | | | | | | | | |
| 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 | Social Care | 2019-20 Q2 | 82.4% | 79.1% | ▼ | | 83.0% | 80.4% | 76.7% |
| | ASCOF 2Bii: the proportion of people 65+ discharged from hospital who are offered reablement services. | Social Care | 2018-19 | 2.8% | 4.2% | ▲ | | 1.8% | 4.7% | 6.2% |
| | ASCOF 2Ci: delayed transfers of care from hospital in year per 100,000 population | Social Care | 2019-20 Q2 | 10.3 | 11.4 | ▼ | | 12.6 | 12.4 | 9.2 |
| | ASCOF 2Cii: delayed transfers of care from hospital in year attributable to social care per 100,000 population | Social Care | 2019-20 Q2 | 3.1 | 3.1 | ▼ | | 3.1 | 2.0 | 4.1 |

# Health and Adult Social Care Overview and Scrutiny Committee

| | |
|---|---|
| Date: | 29 January 2020 |
| Title of Report: | **Corporate Performance Report 2019/20 – Quarter 2** |
| Lead Member: | Councillor Mark Lowry (Cabinet Member for Finance) |
| Lead Strategic Director: | Giles Perritt (Assistant Chief Executive) |
| Author: | Andrew Loton (Senior Performance Advisor) |
| Contact Email: | andrew.loton@plymouth.gov.uk |
| Your Reference: | CPCRM112019 |
| Key Decision: | No |
| Confidentiality: | Part I - Official |

**Purpose of Report**

**This report is the quarter two 2019/20 Corporate Plan Performance Report (Health and Adult Social Care Overview and Scrutiny Committee (ASCOSC) version).**

This is a reduced version of the report includes only the sections of the report relevant to ASCOSC. All indicator updates are submitted as provided to Cabinet including the recommendation below.

In terms of performance against the Corporate Plan, this report provides analysis as at the end of September 2019 of performance against the Council's key performance indicators (KPIs), providing a detailed performance update against the Corporate Plan priorities.

This report forms part of the Council's Performance Framework and is a key part of our aim to achieve a 'golden thread' from the Corporate Plan and its KPIs and delivery plans, through to service and team level business plans, and ultimately to individual objectives.

**Recommendations and Reasons**

That Scrutiny:

1. Notes the Corporate Plan Quarter Two Performance Report and consider the implications for delivery of the Council's priorities;

Click here to enter text.

**Alternative options considered and rejected**

None – our Financial Regulations require us to produce regular monitoring of our finance resources

**Relevance to the Corporate Plan 2016/17-2018/19**

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

**Implications for the Medium Term Financial Plan and Resource Implications:**

Robust and accurate financial monitoring underpins the Council's Medium Term Financial Plan (MTFP). The Council's Medium Term Financial Forecast is updated regulary based on on-going monitoring information, both on a local and national context. Any adverse variations from the annual budget will place pressure on the MTFP going forward and require additional savings to be generated in future years.

**Carbon Footprint (Environmental) Implications:**

No impacts directly arising from this report. Indicators relating to recycling rates and carbon emissions are included within the Corporate Plan Performance Report.

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

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

**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** |
| | **Corporate Performance Report 2019/20 – Quarter 2** | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

**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 | djn.19.20.151 | Leg | lt/33610/2510 | Mon Off | Click here to enter text. | HR | Click here to enter text. | Assets | Click here to enter text. | Strat Proc | Click here to enter text. |
| Originating Senior Leadership Team member: Andrew Hardingham (Service Director for Finance) and Giles Perritt (Assistant Chief Executive) | | | | | | | | | | | |
| Please confirm the Strategic Director(s) has agreed the report? Yes<br>Date agreed: 29 October 2019 | | | | | | | | | | | |
| Cabinet Member signature of approval: Councillor Mark Lowry (verbally)<br>Date: 30 October 2019 | | | | | | | | | | | |

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# CORPORATE PLAN PERFORMANCE REPORT, QUARTER TWO 2019/20

Health and Adults Social Care Scrutiny

# The Corporate Plan

The Plymouth City Council Corporate Plan 2018-2022 sets out our mission of 'making Plymouth a fairer city, where everyone does their bit'. It was approved by Full Council in June 2018.

The Corporate Plan priorities are delivered through specific programmes and projects, which are coordinated and resourced through cross-cutting strategic delivery plans, capital investment and directorate business plans.

The key performance indicators (KPIs) and their associated targets detailed in this report for the first two quarters of 2019/20 (April to September 2019) tell us how we are doing in delivering what we have set out to achieve in the Corporate Plan.

# Structure of this Report

The purpose of this report is to provide a risk-informed analysis of performance against the priorities of the Corporate Plan 2018-2022. The priorities are grouped under 'A Growing City' and 'A Caring Council', and the outcomes for 'How We Will Deliver' – the enablers of the Corporate Plan – are also reported on.

## Trend (RAG) colour scheme

A red-amber-green (RAG) trend rating is provided to give an indication of whether the figure is improving or declining based on the two latest comparable periods for which information is available. For example, number of dwellings inspected is compared to the previous quarter in the same year; household waste sent for reuse, recycling or composting is compared to the same period in the previous year (due to seasonality); and annual measures, such as carbon emissions, are compared to the previous year.

- Indicators highlighted **green:** improved on the previous value or is on an expected trend
- Indicators highlighted **amber:** within 15% of the previous value (slight decline)
- Indicators highlighted **red:** declined by more than 15% on the previous value
- Indicators not highlighted or 'N/A' have stayed the same, have no trend, or the most recent value is not comparable with previous values.

## Target (RAG) colour scheme

A RAG target rating is applied for indicators that have a target. For these indicators, the bar for the latest reporting period is coloured either red, amber or green in the chart to visually display how we are performing compared with the target.

- Indicators highlighted **green** show where Plymouth is better than target
- Indicators highlighted **amber** show where Plymouth is within 15% of target
- Indicators highlighted **red** show where Plymouth is more than 15% worse than target
- Indicators not highlighted or 'N/A' show where no in year data is available to compare against target, or no target has been set.

## Performance summary page

An overall summary page is presented for the KPIs that relate to the Performance, Finance and Customer Focus Scrutiny to visually display how we have performed against our priorities. Our RAG-rating on these pages is used to show whether we have done better, worse or had a slight decline from the previous quarter or year (coloured arrows), and whether we have done better, worse or got close to the target (coloured hexagons). Some indicators do not have a target (for example, due to being a new indicator) and will therefore have no target RAG-rating (blue hexagons). Similarly, some of our indicators are new and we do not have any previous data to compare our performance to; these will have no trend RAG-rating in the summary pages.


For example, the hexagon for excess weight in 10-11 year olds is green because at 33.2% in 2017/18 (latest available data) it is above the target (34.2%), whilst the arrow within the hexagon is amber because there was an increase from 2016/17 (31.7%; a reduction indicates positive performance).

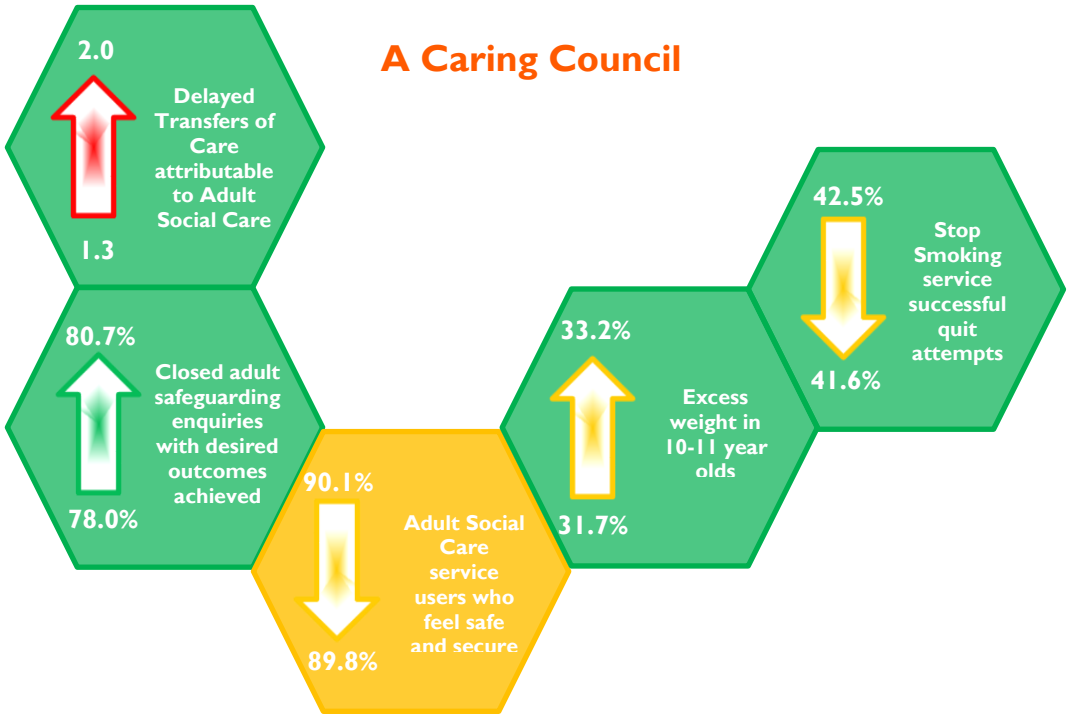
# Health and Adults Social Care Quarter Two Executive Summary

Good performance continues in the areas relating to health and adult social care in quarters one and two. As shown in the performance summary below, four of the six key performance indicators exceeded their targets in the latest reporting period, while the one indicator that was red against target improved by 20 percentage points from the last round. Highlights from the quarter two report include:

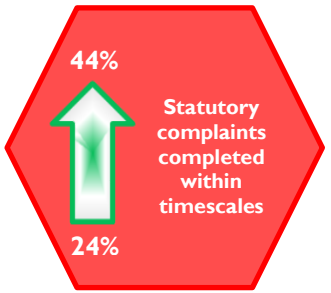
- Despite an increase in numbers and pressure at the acute hospital performance continues to be good in relation to Delayed Transfers of Care. In quarter two the national expectations set of us are being achieved with both the total rate of delays and the rate of delays attributable to ASC exceeding targets.
- The percentage of safeguarding enquiries in which, at the point of completion, the individual affected or individual's representative's desired outcomes had been fully achieved increased to 80.7% in quarter two, which is the highest percentage seen for more than a year. Performance had been declining in quarters two and three of 2018/19, which had been raised as a concern with Livewell Southwest, and subsequent practice guidance has had a positive impact.

The individual pages within this report reflect on what is working well, what we are worried about and what needs to happen for all of the key performance indicators relating to health and adult social care. In particular, we acknowledge areas in which performance is not meeting the targets that we have agreed and set out how we are working to address concerns and improve performance in these areas.

# Health and Adult Social Care Quarter Two Performance Summary




How We Will Deliver



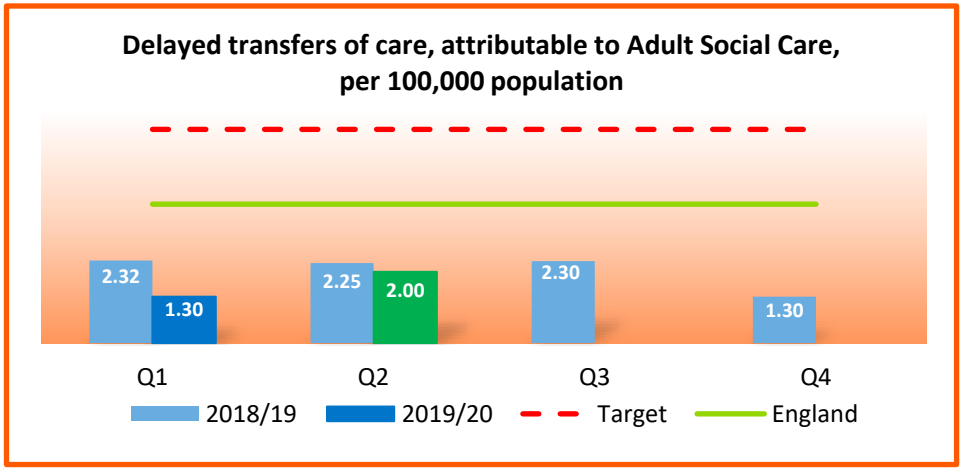
# A Caring Council

# Keep children, young people and adults protected

## Delayed transfers of care (DTOC) attributable to Adult Social Care

**What we measure:** The average daily number of delayed discharges within an acute or community hospital, presented as a rate per 100,000 population. This tells us the number of people who are still in hospital after they have been identified as fit for discharge, with the delay attributable to Adult Social Care (ASC).

**Why we measure it:** It is a marker of the effective joint working of local partners, and a measure of the effectiveness of the interface between health and social care services. Reduced delayed transfers of care (DTOC) and enabling people to live independently at home are desired outcomes of social care.




**How have we done? 2.00 delays** (per 100,000 population)

The average daily number of delays increased by 0.7 from the previous quarter, which is an increase of 53.8%.

Trend rating: **Red**

**Target for 2019/20: 6.0 delays** (per 100,000 population)

The increase in quarter two now puts performance at 4.30 delays per day per 100,000 population (71.7%) below the target.

Target rating: **Green**

**What's working well?** 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.

**What are we worried about?** Good performance continued in quarters one and two. Although the rate of delays increased, performance remains significantly improved on the last two years. Quarter two saw an increase in the rate of delays in the non-acute part of the system, which will be a focus for improvement. There are concerns about performance sustainability as front door pressure continues at the hospital due to high demand and complexity.

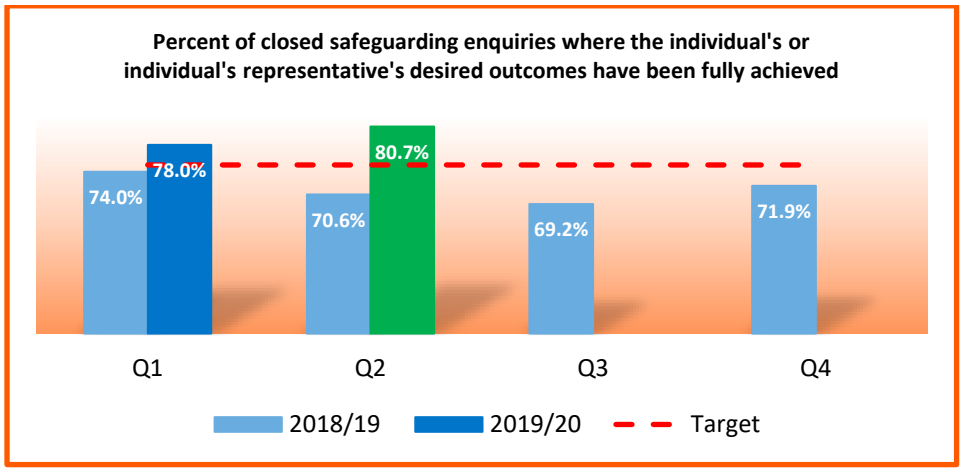
**What needs to happen?** The Western A & E Delivery Board will continue to monitor system performance, including key system indicators on Accident and Emergency, length of stay and DTOC. We will continue to work with the Clinical Commissioning Group, Livewell Southwest and University Hospitals Plymouth on the delivery of five key demand led projects aimed at reducing admission rates, providing better preventative care for people with respiratory disease, supporting primary care capacity, and increasing the ability to provide same day emergency care services.

# Keep children, young people and adults protected

## Adult safeguarding enquiries

**What we measure:** The percentage of safeguarding enquiries in which, at the point of completion, the individual affected or individual's representative's desired outcomes have been fully achieved.

**Why we measure it:** Making Safeguarding Personal (MSP) is a sector-led initiative that aims to develop an outcome focus to safeguarding work and a range of responses to support people to improve or resolve their circumstances. This is an indication of how well we are achieving this outcome.




### How have we done? 80.7%

Increase of 2.7 percentage points from the previous quarter, which is an increase of 3.5%.

Trend rating: **Green**

### Target for 2019/20: 75%

The increase in quarter two puts performance at 5.7 percentage points (7.6%) above the target.

Target rating: **Green**

**What's working well?** Over the past six months performance has shown considerable improvement, with improved outcomes for victims of abuse. Between 1 April and 30 September 2019, 391 individuals were the subject of a completed safeguarding enquiry; 279 (71.4%) expressed a desired outcome at the start of the enquiry and in 220 (78.9%) of these cases, the desired outcome was fully achieved. In 45 cases, the outcome was partially achieved (16.1%). Performance had been declining in quarters two and three of 2018/19, which had been raised as a concern with Livewell Southwest, and subsequent practice guidance has had a positive impact.

**What are we worried about?** It is the responsibility of the local authority to make statutory enquires, or cause others to do so, where it has reasonable cause to suspect that an adult with care and support needs is experiencing, or is at risk of, abuse or neglect. Therefore, we will continue to ensure that our improved performance position is maintained.

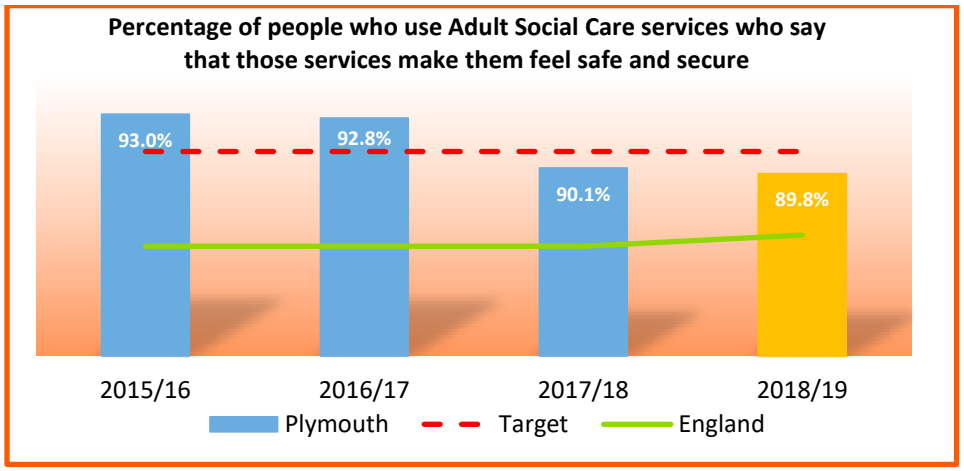
**What needs to happen?** The effectiveness of safeguarding interventions, and related recording, is part of the work for the Plymouth Safeguarding Adults Board Quality and Performance sub group; performance against this indicator though improving will continue to be reviewed and inform specific practice guidance for frontline staff. We will revisit, via contract performance meetings and the strategic leads network, the importance of consistency of interpretation and accurate recording of information.

# People feel safe in Plymouth

## Proportion of Adult Social Care service users who feel safe

**What we measure:** The proportion of people who use Adult Social Care (ASC) services who say that those services make them feel safe and secure, as measured using the annual Statutory ASC Survey.

**Why we measure it:** Safety is fundamental to the wellbeing and independence of people using social care, and the wider population. Feeling safe is a vital part of users' experience of their care and support.




**How have we done? 89.8%**

Decrease of 0.3 of a percentage point from the previous year.

Trend rating: **Amber**

**Target for 2018/19: 91.0%**

The decrease in 2018/19 put performance at 1.2 percentage points below the target.

Target rating: **Amber**

**What's working well?** Between 1 April and 30 September 2019, 3,445 Health and Social Care assessments and plans were completed by either Livewell Southwest (as part of the social care contract) or by the Plymouth Guild (as part of the carers contract). We monitor activity and timeliness of assessments through regular contract performance meetings with our providers. Throughout the past five years, the proportion of Plymouth's ASC service users who feel safe or feel that services they receive help them to feel safe has been consistently higher than the England average (86.5% in 2018/19).

**What are we worried about?** Performance has declined for the past two years. In response to the 2018/19 survey results, we have put in place an ASC performance action plan aimed at improving outcomes, with actions focused on how the Community Safety Partnership, contract management and provider forums can improve performance. We are concerned that the cohort of social care users that feel least safe are those aged 18 to 64 without a learning disability and actions taken will look to improve feelings of safety for this particular cohort, as well as all other users.

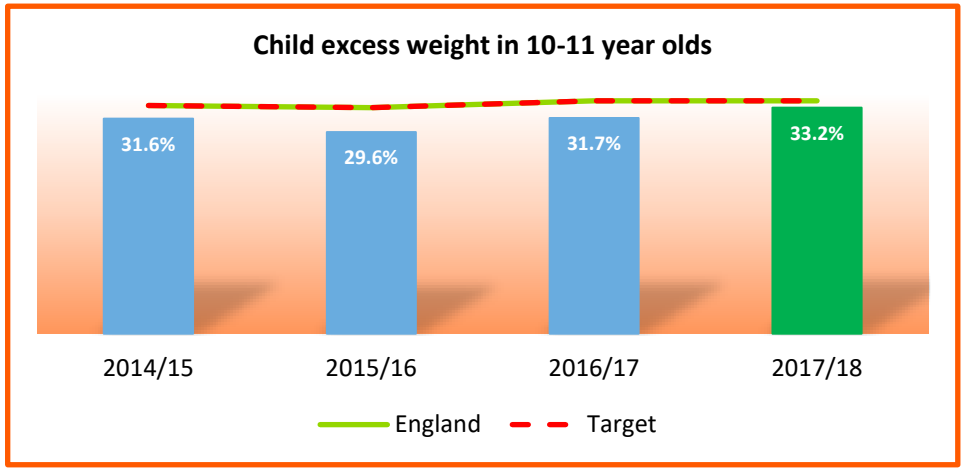
**What needs to happen?** We will continue to monitor social care and safeguarding activity via provider performance and assurance meetings. We will ensure that all actions identified within the ASC performance action plan are delivered against. Actions cover activity to be undertaken by the Community Safety Partnership and commissioners via contract management and provider forums.

# Reduce health inequalities

## Excess weight in 10-11 year olds

**What we measure:** The prevalence of excess weight (including obesity) among children in Year 6 (aged 10 to 11 years old). The latest available data is for 2017/18, with the next national data release due in quarter three.

**Why we measure it:** Excess weight in childhood is a key risk factor for obesity and its associated illnesses in adulthood, as well as potentially having a negative impact on children's physical and mental health.




**How have we done? 33.2%**

Increase of 1.5 percentage points from the previous year, which is an increase of 4.7%.

Trend rating: **Amber**

**Target for 2017/18: 34.2%**

The increase in 2017/18 puts performance at 1 percentage point (2.9%) below the target.

Target rating: **Green**

**What's working well?** 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 complexities associated with individual behaviour change where weight is an issue. 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.

**What are we worried about?** Though levels are lower than England for Year 6, these levels are too high. Childhood obesity is closely linked to deprivation and therefore is a strong indicator of inequality. Being overweight and obese in childhood is a risk factor for overweight and obesity in adulthood and increased risk of diseases, such as Type II Diabetes, cancers, and cardiovascular diseases. Healthy weight can only be addressed through a whole system approach, where everyone works together to have an impact.

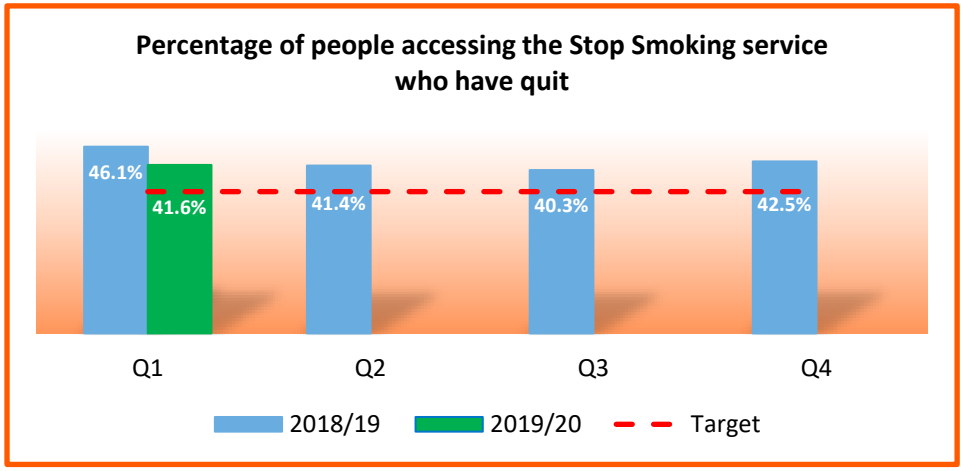
**What needs to happen?** There is a lack of a firm evidence base on the most effective interventions to reduce excess weight in children. We are therefore working on developing the current system offer to improve outcomes for children, young people and their families. We know that provision of prevention and early intervention measures are key in making a difference for families, along with an environment that supports healthy behaviour, and we will continue to work with our partners to create change.

# Reduce health inequalities

## Stop Smoking Service successful quit attempts

**What we measure:** The number of people who engage with the Stop Smoking Service and set a quit date, with successful quit attempts measured at four weeks. This reports on quarter one 2019/20 as the latest available data.

**Why we measure it:** Smoking is the leading cause of preventable ill health and premature mortality in the UK. Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease.




**How have we done? 41.6%**

Decrease of 0.9 of a percentage point from the previous quarter, which is a decrease of 2.1%.

Trend rating: **Amber**

**Target for 2019/20: 35.0%**

The decrease in quarter one puts performance at 6.6 percentage points (18.9%) above the target.

Target rating: **Green**

**What's working well?** Numbers seen by the service each year are dropping. However, we are maintaining a good successful quit rate, which was 42.5% overall in 2018/19. This is particularly pleasing as we continue to work with longer standing smokers and those with complex support needs. In quarter one 2019/20, 375 people accessed services and 156 successfully quit smoking (41.6%). We provide smoking cessation interventions through GPs, pharmacies and specialist services and train staff in 'making every contact count' (MECC), helping them to signpost people into services.

**What are we worried about?** People who smoke tend to be those with complex issues and are 'hard to reach', which presents a challenge and we are working to change our approaches to ensure that we engage with people and work with them in a way that works for them. National Institute for Health and Care Excellence guidance for stop smoking services sets performance guidelines, which states that good services should treat at least 5% of current smokers each year; we are currently not achieving this target.

**What needs to happen?** We will continue to invest in the services and roll out 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 tobacco treatment in all of their pathways and MECC training 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. This approach led to the seizure of £100,000 of illicit tobacco in the city in October 2019.

# How We Will Deliver – Progress against Plans

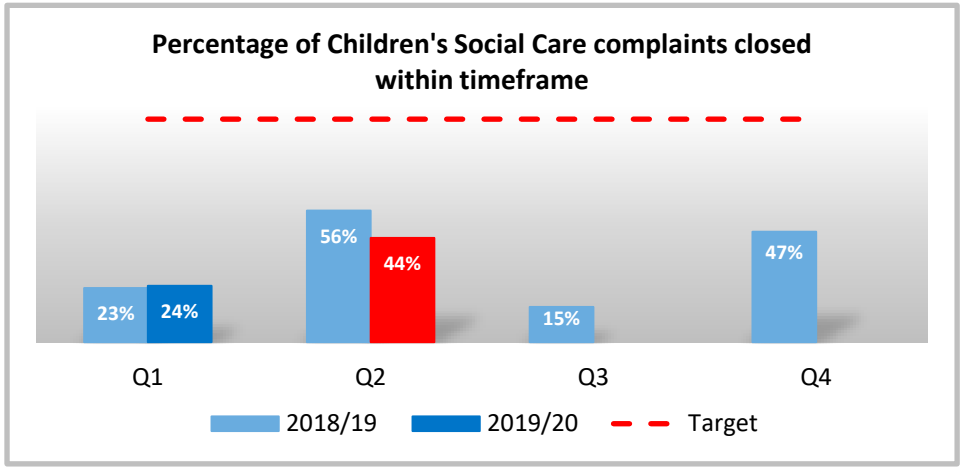
| Corporate Plan priorities | Key performance indicators | Page number |
|---|---|---|
| **Providing quality public services** | Statutory complaints completed within timescales | 13 |

# Providing quality public services

## Statutory complaints completed within timescales

**What we measure:** The percentage of Children's Social Care (CSC) complaints that are responded to within expected timescales (20 working days) and the percentage of Adult Social Care (ASC) complaints responded to within a timescale agreed with the complainant. Responses to CSC complaints are dealt with solely by Plymouth City Council whilst Livewell Southwest (LWSW) respond to ASC complaints.

**Why we measure it:** People accessing CSC and ASC services are some of the most vulnerable people in the city. For this reason it is extremely important that we respond to complaints in a timely manner. This indicator allows us to assess how well we are performing in this area.




**How have we done?** **44%**

Increase of 20 percentage points from quarter one 2019/20, which is an increase of 83.3%.

Trend rating: **Green**

**Target for 2019/20:** **95%**

The increase in quarter two now puts performance at 51 percentage points below the target.

Target rating: **Red**

**What's working well?** Between 1 April and 30 September 2019, 32 CSC complaints were received; this is on track to be considerably less than the 92 complaints that were received for the whole of 2018/19. ASC complaints are administered by LWSW and we now have an established process for receiving the information within the Council. Between 1 April and 30 September, 42 ASC complaints were received and of those resolved during the period, 91.7% were resolved within the timescale agreed with the complainant.

**What are we worried about?** Between 1 April and 30 September 2019, 26 CSC complaints were closed, five (19.2%) of which were fully upheld and 10 (38.5%) were partially upheld; this represents a fault with the service response that we delivered in these cases. In the same period, 21 ASC complaints were closed, two (9.5%) of which were upheld and 10 (47.6%) were partially upheld; 42.9% (9) were unjustified.

**What needs to happen?** In order to address the timeliness performance, weekly complaints clinics are being held. This allows CSC team managers to review open complaints and receive support on tackling the investigation and/or help with drafting responses. With regard to ASC complaints, regular monitoring meetings have been established to ensure that a robust process to deal with statutory complaints is in place and where patterns emerge, LWSW is asked to provide the Council with additional detail. The Customer Liaison Manager will continue to focus on improving the management of the statutory complaints process and will work with both ASC and CSC services to ensure that lessons learned from customer feedback are used to support service improvements.

# Further Information

This report was produced by the Plymouth City Council Performance and Risk Team. For further information, please contact:

**Andrew Loton**
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**Health and Adult Social Care Overview and Scrutiny Committee**

| Minute No. | Resolution | Target Date, Officer Responsible and Progress |
|---|---|---|
| 9 October 2019<br>Winter Planning – Minute 30 | The Committee also agreed to be provided with a briefing report at the end of the winter period. | **Date:** Jan 2020<br>**Officer:** Amelia Boulter<br>**Progress:** Added to the Work Programme |
| 9 October 2019<br>Health and Wellbeing Hubs – Minute 31 | Agreed that:<br>1. A small group of this committee to review the programme with officers and agree a wider communication to elected members and to clarify the situation on external funding opportunities available.<br>2. The Committee notes and supports the delivery of this exciting programme of Wellbeing Hubs.<br>3. The Committee to review the performance of the Health and Wellbeing Hubs at a suitable time. | **Date:** Jan 2020<br>**Officer:** Amelia Boulter<br>**Progress:** To be progressed. |
| 9 October 2019<br>Brexit – Minute 33 | The Committee noted the verbal update on Brexit and requested a summary of the points raised to be circulated to members. | **Date:** Jan 2020<br>**Officer:** Amelia Boulter<br>**Progress:** To be progressed. |
| 9 October 2019<br>Plymouth Integrated Fund Finance Report – Month 5 2019/20 – Minute 34 | The Committee noted the Plymouth Integrated Fund Finance Report – Month 5 2019/10 and to review the Long Term Plan at a future meeting. | **Date:** Jan 2020<br>**Officer:** Amelia Boulter<br>**Progress:** Added to the work programme. |
| 9 October 2019<br>Work Programme – Minute 36 | The Committee noted the work programme and requested that the following items to be scheduled:<br>• Alliance Contract/Action Plan – how this item will be scrutinised;<br>• Marmot principles/review together;<br>• Food Justice – Cllr Mrs Bowyer to email the group to find a member;<br>• Mental health take place towards the end of the year;<br>• Long Term Plan | **Date:** Jan 2020<br>**Officer:** Amelia Boulter<br>**Progress:**<br>Added to March meeting.<br>Health Summit – 12.02.20<br>Completed.<br>Scheduled for June 2020<br>Added to the work programme. |

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# HEALTH AND ADULT SOCIAL CARE OVERVIEW SCRUTINY COMMITTEE

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** | Broadreach/Longreach Update | | | Ruth Harrell/Gary Wallace/Anna Coles |
| | Adult Social Care – Future Direction | | | Craig McArdle |
| | Healthwatch Annual Report | | | Tony Gravett |
| | Devon Long Term Plan Consultation | | | Ross Jago |
| | CQC Emergency Department Action Plan | | | Julie Morgan |
| | Devon Integrated Care System Performance | | | Rob Sowden |
| | | | | |
| **9 Oct 2019** | Winter Planning | **5** | Yearly review | Elaine Fitzsimmons, David Brown and Sarah Mackereth |
| | Health and Wellbeing Hubs | 3 | Update on progress made | Ruth Harrell |
| | Brexit | 5 | Update | Ruth Harrell and Jo Watson (CCG) |
| | Director of Public Health Annual Report | **4** | To note the report and help inform the work programme | Ruth Harrell |
| | Devon Integrated Care System Performance | 5 | Standing Item | Rob Sowden |
| | Integrated Finance Report | 5 | Standing item | David Northey and Ben Chilcott (CCG) |
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| 4 December 2019 – meeting cancelled due to the election. | | | | |
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| **29 Jan 2020** | GP Strategy | 4 | Following on from Select committee | Paul Barker – NHS Devon CCG |
| | CQC Reports –<br>• Livewell Southwest<br>• Independence at Home | 4 | To review the CQC Reports | Dr Adam Morris Craig McArdle/ Gary Walbridge |
| | Possible alternatives to face to face appointments/Update on Did Not Attends | 3 | Following a report received by committee last year | Amanda Nash and Nick Pearson |
| | Fair Shares | 4 | Ensuring Plymouth are receiving fair funding | Simon Tapley – NHS Devon CCG |
| | Devon Integrated Care System Performance/Finance and Corporate Plan | 4 | Standing item | Rob Sowden |
| | | | | |
| **25 March 2020** | Adult Social Care Market | 3 | | Gary Walbridge |
| | NHS Operating Plan 2020 – 21 | 3 | | Paul O'Sullivan |
| | Alliance Contract | 3 | To review the last 12 months | Matt Garrett |
| | University Hospital Plymouth NHS Trust CQC Action Plan Update | 4 | To review the CQC Action Plan | Ann James |
| | Integrated Finance Report | 4 | Standing Item | David Northey |
| | | | | |
| **Items to be scheduled for 2020/21** | | | | |
| | NHS 111 Update | | | |
| | Workforce Development Strategy | 4 | | |
| | Maternity Services (Devon-wide Strategy) | 3 | | |
| **Jul 2020** | Plymouth Safeguarding Adults Board Update | 4 | Review of activity/ performance | Andy Bickley |
| | Adult Social Care Green Paper | | | |
| | Spending Review | | | |
| | NHS Long Term Plan | 3 | | |
| | | | | |
| **Briefing Papers to be circulated to the Committee -** | | | | **When** |
| Alliance Action Plan (Substance Misuse) – Matt Garrett | | | | |
| Loneliness – Ruth Harrell | | | | |
| Parking Derriford Hospital – Site Development Plan – Stuart Windsor | | | | |
| Blood Transfusion Service | | | | |
| Winter Planning – Elaine Fitzsimmons (CCG), David Brown (UHPT) | | | | |
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|---|---|---|
| **Meetings to be arranged –** | | |
| Jan 2020 | Section 106 and Health | Cllrs Mrs Aspinall/ Mrs Bowyer/ Nicholson and Paul Barnard |
| | | |
| **Workshop** | | |
| 12 Feb 2020 | Health Summit - Preventative Measures against the Marmot Principles | |
| | | |
| **Select Committee Reviews** | | |
| 30 Oct 2019 | Food Justice | Report currently being finalised. |
| Feb 2020 | Dental Services | Scoping meeting to be set up. |
| 2020/21 | End of Life Care/ Compassionate City | To take place in 2020/21 following prioritisation of other select committees. |
| 2020/21 | Community Urgent Care Review | To take place in 2020/21 following prioritisation of other select committee. |
| | | |
| **Cross scrutiny items** | | |
| June 2020 | Joint Mental Health Select Committee | Joint Select Committee with Education and Children's Social Care |
| | | |

# Annex 1 – Scrutiny Prioritisation Tool

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

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