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| **Report from:** | Craig McArdle, Director of Integrated Commissioning |
| **Report to:** | Health and Wellbeing Board |
| **Re:** | System Improvement Board- Highlight Report January 2018 |

## 1. Introduction

In order to provide System Leadership, Oversight and Assurance and to relentlessly drive system improvement, NEW Devon CCG has established a System Improvement Board made up of Commissioners, Providers and Regulators. The central focus of the Board is to:

1. To reduce patient safety and quality risks across the system predominantly related to Patient Flow
2. To improve performance around key constitutional targets
3. To deliver the required financial improvement.

The Board also oversees and drives transformation programmes with three initial immediate priority areas being identified as-

1. Transforming intermediate care activity to prioritise home based non-bedded care including improving Out of Hospital responsiveness to prevent admissions and avoid delays in discharge home.
2. To deliver the Primary Care Improvement Plan
3. To deliver the revised Ambulatory/Frailty and GP Streaming function at PHNT

This report provides the Health and Wellbeing Board with an update on the System Improvement Board activity during January and an overview of System Performance through visibility of the System Flow Scorecard.

## 2. Transforming System Flow

The ability to manage patients safely, evidence outcomes and report activities is a key system focus following the recent reviews of the Discharge to Assess pathways 1 & 2 which included LCC length of stay and utilisation of spot purchase beds.

To achieve this, we need to effect cultural change across the system; ensure clinical staff have the knowledge and skills to undertake their roles; articulate clear pathways and embed consistent systems and process supported by integrated business intelligence.

Creating a culture in which acute and community staff have the confidence to lead and deliver safe pathways home for patients requires consistency of approach across acute and community clinical teams. To achieve this the community 'offer' needs to be clear with robust processes, documentation and evaluated patient outcomes. The ability to report and use accurate and consistent integrated data will be essential to supporting the governance process.

The key objectives of the programme are to:

- **Discharge to Assess Pathway 1:**

  Implement Discharge to Assess Pathway 1/HSG provision to deliver 'assessment' and 'rehab/reablement care plan' at home within 2 hours of discharge with same day access to reablement or domiciliary care 7 days per week and meet any other national and locally commissioned requirements. Implement a professional review process to as business as usual to optimise rehab/reablement and resource utilisation.

  Consider merging this pathway into an expanded CCRT front door offer and decommission the current DTA 1 set up.

- **Discharge to Assess Pathway 2 including residential spot:**

  Implement Discharge to Assess Pathway 2 provision to deliver 'assessment' and 'rehab/reablement care plan' within 48 hours of admission to care home. Undertake professional reviews of goal achievement and optimise step down and length of stay for patients. Must meet national and locally commissioned outcomes. Demonstrate robust system and process in place to manage backlog reduction. Decommission 50% DTA 2 care home beds;

  Convert LCC beds to DTA 2 pathway beds. Reduce discharged average length of stay to 14 days.

  Urgently develop a clear pathway for nursing spot purchase with tight operational control and clear standards for assessment, review and managing backlog.

  Develop a robust spot purchase process, including reducing the number of stranded patients to zero.

- **Workforce:** Review LCC and DTA therapy establishment and skill mix and wider DTA establishment and provide a gap analysis and option appraisal for optimal utilisation of clinical resource including a numerated capacity plan.

- **Integrated Hospital Discharge Team/Tactical Control Centre:** Establish full Integration of Hospital Discharge Team including the Tactical Control Centre

- **Business Intelligence:** Implement performance and reporting capability such that integrated performance metrics can be used for governance, contractual and statutory compliance evidence. Fully exploit the functionality of PCC bespoke data system to provide Service Managers with access to performance data and improve operational efficiency through decommissioning of legacy reporting processes

The programme will be delivered through a number of linked, yet dependent projects:

- DTA Pathway 1: Clarity of 'offer' and internal professional standards, standardised referral, assessment and documentation linked to clear outcome measures

- DTA Pathway 2 in care homes: Clarity of 'offer' and internal professional standards, standardised referral, assessment and documentation linked to clear outcome measures. Reduction in the stranded patients to zero

- DTA Pathway 2 in MGH: Refocus of resources to ensure unit is operating as a rehab facility with patients having optimal LoS (target 14 days avg LoS in December 17 reducing to 10 thereafter)

- Long Term Care Pathway – new pathway to replace DTA 3: Redesign of pathway for patients who will are identified as needing long term care at the outset. The key aims of this pathway will be to ensure the appropriate eligibility criteria is applied for health/CHC and social care.

- Full integration of hospital discharge teams and Tactical Control Centre.

- Workforce Capacity and Capability: to match pathways and increase activity

- Performance Information and Management. Triangulated business intelligence.

With the exception of the cultural element of this work, this program is intended to be completed within 3 months. The SRO for this programme is Jo Beer.

## 3. Primary Care Improvement Plan

| **Programme Overview: Aims and Objectives** |
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| **Aim:** To develop and redesign primary care as part of the system of health and wellbeing<br>**Objectives**:<br>• To achieve sustainability in primary care with respect to workforce, funding, IM&T and premises to ensure patients' access to high quality primary care provision and self-care – and at the interface of community and acute care<br>• To support, influence and enable design and implementation of new models of primary care built around a community with integration between primary care, secondary care, the voluntary sector and the community and provided efficiently and effectively 'at scale' where appropriate while maintaining access and continuity where important.<br>• To maximise and influence investment and resource opportunities, prioritising according to the needs of the population and the needs of the health and wellbeing system, whilst supporting innovation |

| Key Issues, Risks and Actions for Escalation |
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| **Risks** (as reported through Western Locality Risk Register)**:**<br>• Current and forecast significant challenges to sustainability of general practices including workforce, demand and capacity<br>• Variable and limited capacity in general practice and practice groups to transform to improve sustainability and enable system wide developments without support<br>• As with general practice there are now challenges to the sustainability of the community pharmacy network that need to be reflected<br>• Lack of evidenced change to new models<br>• Insufficient change capacity at all required levels<br>• Lack of proven ability to plan and mitigate for high risk failure in primary care |

| Workstream | Activity (Projects) | Progress Updates and Key Milestones |
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| **Leadership and governance for transformation** | (a) Improving practices' capacity to transform at scale with investment of £120k funding for a year and aligning commissioner and provider staff to each group for collaborative working to deliver change more rapidly<br>(b) Aligning and strengthening delivery of primary care transformation by forming a Partnership, bringing together the Primary Care Programme Group and Western GP Collaborative Board) to hold and drive the primary care programme, reporting to the System Improvement Board | For (a) and (b):<br>Progress updates:<br>• Proposal developed (Sep 17)<br>• Proposal shared with each practice group and LMC for feedback – positive reception (Sep/Oct 17)<br>• Supported and iterated at Primary Care Programme Group (3/10/17)<br>• Circulated to GP Collaborative Board members for views (10/10/17)<br>• Finalised with Primary Care Programme Group<br>• Launched at GP Forum 17/10/17<br>• Letter to practices and other invitees for Partnership meeting (21/11/17)<br>• First meeting of Western Primary Care Partnership (12/12/17)<br><br>Key milestones:<br>• Agree use of £30k funding with each group and fully implement. Practice Group Start Up Meeting to take place Jan 18.<br>• Second practice group GP Forum to review actions from first GP Forums and refresh action plans (by Mar 18) |
| **Model of Care:**<br>• **At Scale Model (eg Primary Care Home)**<br>• **Pathways of Care (eg Care Homes)** | (a) Implement a model for provision of primary care to people living in care homes. Implementing this will maximise the easing of workload and workforce pressures and reduction in impact to urgent care system (by Dec 17).<br>(b) Develop a model for provision of home visits. Implementing this will maximise the easing of workload and workforce pressures and reduction in impact to urgent care system (by Dec 17).<br>(c) Develop a system of integrated telephone triage for practices. Implementing this will maximise the easing of workload and workforce pressures (by Dec 17) and reduction in impact to urgent care system (by Dec 17).<br>(d) Review benefits of Primary Care Home initiatives at Beacon Medical Group and | (a), (b) and (c):<br>Progress updates:<br>• Scoping and action planning (CCG and NHSE) (Sep 17) with order of priority agreed as care homes, then home visiting and integrated telephone triage<br>• Installation from Aug 17 of telephone triage capacity (Devon Doctors) at Ocean Health Group (use for learning)<br>• Scoping with Devon Doctors for potential options complete. Planned for 5 days over Christmas / New Year for Devon Doctors to provide. Not implemented due to governance concerns. Other remote support offered instead Next, review to either close or explore in other ways. |

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| | determine whether Primary Care Home is a good model for wider Western (scale to be determined)<br>(e) Review financial risk management barriers and opportunities for GP practices to enable system integration through development of an ACO.<br>(f) Review the boundaries for GP practice federations to ensure they enable integrated primary care and development of health and wellbeing hubs.<br>(g) Develop a single team approach for mental health.<br>(h) Finalise and implement Livewell's offer of resource<br>(i) Develop triage to community pharmacy by 111 using DDocs<br>(j) Implement e-consult | Key milestones:<br>• Following feedback received at a meeting with GP Practices, medical cover for patients in intermediate Care Home beds will be provided by Devon Doctors from 19/12/17<br>(d)<br>Key milestones:<br>• Evaluation of Beacon Medical Group Primary Care Home<br>(e)<br>Progress updates:<br>• Beacon ACO working group meets monthly<br>Key milestones:<br>• To be determined through Beacon ACO group (ongoing)<br>(f)<br>Key milestones:<br>• For discussion and agreement of milestones at Primary Care Partnership (Dec 17) (NB interdependencies with Health and Wellbeing Hubs, development of integrated primary care)<br>(g)<br>Key milestones:<br>• Being progressed by the Mental Health Commissioning Team<br>(h)<br>Key milestones:<br>• Discussed at Primary Care Programme Group (Oct 17)<br>Progress updates:<br>• Implementation in line with relevant priorities (as plan)<br>(i)<br>Progress updates:<br>• Submitted application to Integrated Pharmacy Fund<br>(j)<br>Progress updates:<br>• Project Plan in place<br>Key milestones:<br>• Review interest from Practices<br>• Support Practices with roll-out |
| **Access and Workload** | (a) Reduce patient demand on general practice where a better alternative is available<br>(b) Reduce patients' demand on secondary care urgent care (ED in particular)<br>(c) Ensure plans and funding for extended access (w.e.f. Apr 18) align with national specification and funding criteria/dates and the aims and objectives of this programme<br>(d) Review DRSS to address practice concerns that DRSS creates a barrier between primary and secondary care rather than an aid to efficient referral | (a)<br>Progress updates:<br>• Additional Social Prescribing will be available in all Plymouth and some South Hams and West Devon Practices from early 2018<br>• Training of Care Navigators<br>Key milestones:<br>• Develop scope, priorities and trajectory for reduction in workload over the next 2 years (March 18)<br>• Prepare project plan (Jan 18) |

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| | management and relationships<br>(e) Eradicate duplication in patient experience for QOF (across GP, pharmacy, PHNT, Livewell, Devon Doctors etc)<br>(f) Expand the Single Trusted Assessment used by PHNT and Livewell to general practice to avoid delays in discharge from hospital<br>(g) Facilitate practices sub-contracting with each other for the full range of enhanced services (all commissioners) | • Deliver project (timescales TBC but should have some measurable positive impact by Jan 18)<br>b)<br>Progress updates:<br>• CCG, NHSE, PHNT and Livewell regular liaison with actions<br>Key milestones:<br>• Further analysis at practice level to ensure mitigations are effective (monthly monitoring)<br>(c)<br>Progress updates:<br>• Initial scoping of extended access take-up (current DES), mapping with potential hubs and development of primary care at scale<br>Key milestones:<br>• STP-wide preparation of opportunities to meet national requirements (Jan 18)<br>• Plans developed through Primary Care Partnership (by Jan 18) in liaison with other programmes, particularly urgent care and mental health<br>(d)<br>Key milestones:<br>• Determine project lead (Jan 18)<br>• In liaison with planned care, prepare project plan (Jan 18)<br>• Deliver project (timescale TBC in project plan)<br>(e)<br>Key milestones:<br>• Scope opportunity and prepare project plan (Jan 18)<br>• Deliver project (timescale TBC in project plan)<br>(f)<br>Key milestones:<br>• Determine project lead (Jan 18)<br>• In liaison with urgent care, prepare project plan (Jan 18)<br>• Deliver project (timescale TBC in project plan)<br>(g)<br>Key milestones:<br>• Summary proposal to Primary Care Partnership meeting (Dec 17)<br>• Identify opportunities (websites) for practices to inform others of asks and offers (Dec 17)<br>• Identify administrator and protocols (Jan 18)<br>• Implement (Apr 18) |

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| **Workforce**<br>(this section to be aligned with STP Workforce Plan) | (a) Arrange clinical interface opportunities (e.g. evening sessions) for GPs, practice nurses, consultants, specialist nurses and others<br>(b) Enable portfolio careers by finding how the system can allow trainees to work across organisations, eradicating barriers and duplication<br>(c) Simplify career navigation such that the clinical workforce are enabled to make career changes which meet a workforce need in our local system<br>(d) Enable GP career changes for joint primary/secondary care roles required by the system<br>(e) Describe the role of Physician Assistant and determine whether this is useful locally<br>(f) Arrange action learning sets for training grades / all clinicians<br>(g) Implement a health passport across the local system so the workforce can share and not duplicate mandatory training across organisations<br>(h) Enable and increase placements of student nurses in practices<br>(i) Find a way to join up recruitment across organisations<br>(j) Ensure maximum advantage is taken of the GP international recruitment national programme in partnership with PHNT and the Medical School<br>(k) Better understand, optimise and secure the role of clinical pharmacists and pharmacy technicians | Progress updates:<br>• Workforce work stream Lead identified and committed until June 18<br>• Primary Care Conference supported (Nov 17)<br>Key milestones:<br>• Deliver and report on HEE funding and plan (£120k) (quarterly to Mar 18)<br>(a) to (i):<br>Key milestones:<br>• Project plan to Western Primary Care Partnership for implementation (12/9/17)<br>• Deliver projects (timescales in project plans)<br>(j)<br>Progress updates:<br>• Positive discussions with PHNT and Medical School to create best environment<br>Key milestones:<br>• Develop project plan (Jan 18) including prioritisation of practices / areas for increased GP capacity<br>• Delivery project (timescales TBC in project plans)<br>(k)<br>Progress updates:<br>• Variety of pharmacy roles in practice with various funding mechanisms (Practice, CCG, NHSE)<br>• CCG/Livewell/PHNT agreement for system working in Pharmacy to improve recruitment and retention of pharmacists. Inaugural meeting of System MO and Pharmacy Board to oversee (19/10/17)<br>• Good liaison with proactive LPC<br>Key milestones:<br>• Develop project and timescales (Jan 18) |
| **Data, Quality and Safety** | (a) Data exchange between commissioners and providers (CCG, NHSE, PHNT, Devon Doctors, Livewell, pharmacies practices, AHSN) and decisions taken as a result<br>(b) Improve outcomes for patients with chronic pain | (a)<br>Progress updates:<br>• Data being exchanged between organisations ad hoc, with appropriate information governance, through various projects including practice dataset (May 17), Beacon ACO (ongoing)<br>Key milestones:<br>• Finalise information sharing protocols<br>• Implement within projects across organisations<br>(b)<br>Progress updates:<br>• CCG medicines optimisation and |

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| | | NHSE liaising<br>• Action plan developed (11/10/17)<br>• Positive Practice Engagement meeting (14/11/17)<br>• Pilot commenced (23/11/17)<br>Key milestones:<br>• Pilot evaluation |
| **Change Support** | (a) Ensure practices' delivery of At Scale and Resilience plans is embedded in relevant activities in each workstream and that practices are using At Scale and Resilience funding to best effect<br>(b) Recruit Change Manager to support practices and practice groups to make required change more rapidly | (a)<br>Progress updates:<br>• Supportive review taking place with practices (ongoing)<br>Key milestones:<br>• Ensure next tranche of funding implemented to support delivery of this programmes aims and objectives (in progress)<br>• Practice specific priorities agreed for 17/18<br>(b)<br>Progress updates:<br>• CCG/NHSE urgently exploring potential for joint post to better integrate opportunities and levers for change<br>Key milestones:<br>• Recruitment (timescale TBC) |
| **Resource Enablers** | (a) Ensure live ETTF projects will deliver<br>(b) Create a plan for infrastructure (estate and IT) change required with consideration of whole system (urgent care, elective care, mental health etc) | (a)<br>Progress updates:<br>• PCC OPE working with Beacon Medical Group<br>(b)<br>Progress updates:<br>• Primary care estate sub-group of health and wellbeing hubs programme group developed<br>• Crafting initial plan for IT and telephony liaising with other programmes etc Digital Roadmap<br>Key milestones:<br>• Develop project plans ensuring estate and IT are planned together (Feb 18) |
| **Communication and Engagement** | (a) Ensure change is supported by communication and engagement – scope is all stakeholders (public, patients, providers, voluntary sector, national) supporting all workstreams | Progress updates:<br>• Initial scoping of immediate opportunities with CCG complete (Sep 17)<br>• Primary care commissioning input to winter plan communication (Sep/Oct 17)<br>• Winter comms plan shared with practices (13/10/17)<br>• MP briefings (Sep/Oct 17)<br>• Western GP Forum (17/10/17)<br>• Health navigation information now included on Practice phone messages<br>• Teleconference CCG and NHSE with practices re messaging and channels to support practices |

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| | | (19/10/17)<br>• Z Flyer distributed to 70,000 Plymouth homes (Dec 17)<br>Key milestones:<br>• Continue implementation of communications plan and engagement with practices to inform (ongoing) |

# 4. System Flow Scorecard (also sent separately as A3

## Summary of flow

| Type | Indicator | Type | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Key performance targets | 4hr wait in A&E (by A&E type) | Actual | 83.6% | 84.0% | 86.6% | 84.4% | 90.2% | 88.2% | 87.6% | 86.6% | 79.3% | | | | |
| | | *Trajectory* | *86.0%* | *86.3%* | *86.6%* | *87.9%* | *88.5%* | *90.0%* | *90.5%* | *91.9%* | *93.5%* | *91.2%* | *93.3%* | *95.0%* | |
| | DTOC performance (acute) | Actual | 7.7% | 6.3% | 6.3% | 6.7% | 6.5% | 6.9% | 5.6% | 4.6% | 5.6% | | | | |
| | | *Trajectory* | *3.5%* | *3.5%* | *3.5%* | *3.5%* | *3.5%* | *3.5%* | *3.5%* | *3.5%* | *3.5%* | *3.5%* | *3.5%* | *3.5%* | |
| | RTT (PHNT) | Actual | 85.2% | 85.9% | 85.6% | 84.8% | 83.8% | 82.2% | 82.2% | 82.4% | 81.3% | | | | |
| | | *Trajectory* | *85.2%* | *85.5%* | *85.7%* | *85.9%* | *85.7%* | *85.8%* | *86.2%* | *86.5%* | *86.2%* | *86.4%* | *86.7%* | *87.0%* | |
| | RTT long waiters >52 weeks | Actual | 84 | 66 | 59 | 55 | 49 | 50 | 46 | 39 | 45 | | | | |
| | | *Trajectory* | *95* | *86* | *77* | *68* | *51* | *46* | *41* | *36* | *31* | *26* | *19* | *0* | |
| | 62 day Cancer | Actual | 80.1% | 85.4% | 80.5% | 78.9% | 75.3% | 77.0% | 75.9% | 78.2% | 82.3% | | | | |
| | | *Trajectory* | *77.2%* | *77.9%* | *77.9%* | *85.4%* | *85.1%* | *85.3%* | *85.3%* | *85.5%* | *85.3%* | *85.3%* | *85.2%* | *85.4%* | |
| | Cancer 2-week wait | Actual | 89.6% | 94.2% | 92.0% | 91.1% | 91.8% | 93.1% | 93.1% | 92.0% | 92.5% | | | | |
| | | *Trajectory* | *93.0%* | *93.0%* | *93.0%* | *93.0%* | *93.0%* | *93.0%* | *93.0%* | *93.0%* | *93.0%* | *93.0%* | *93.0%* | *93.0%* | |
| | Breast symptomatic | Actual | 19.8% | 8.0% | 7.7% | 6.3% | 12.8% | 3.4% | 22.7% | 56.7% | 21.7% | | | | |
| | | *Trajectory* | *93.0%* | *93.0%* | *93.0%* | *93.0%* | *93.0%* | *93.0%* | *93.0%* | *93.0%* | *93.0%* | *93.0%* | *93.0%* | *93.0%* | |
| | 6-week wait diagnostics | Actual | 7.4% | 10.6% | 10.8% | 11.2% | 12.9% | 14.2% | 10.1% | 9.1% | 9.5% | | | | |
| | | *Trajectory* | *6.1%* | *6.7%* | *6.6%* | *4.6%* | *2.7%* | *1.2%* | *1.0%* | *1.0%* | *1.0%* | *1.0%* | *1.0%* | *1.0%* | |
| | OPEL status Livewell | Actual | 2.7 | 2.5 | 2.4 | 2.7 | 2.9 | 2.7 | 2.8 | 2.6 | 3.3 | | | | |
| | OPEL status PHNT | Actual | 3.2 | 2.9 | 3.0 | 3.0 | 3.0 | 3.4 | 3.1 | 3.1 | 3.7 | | | | |
| Pre-admission/ admission avoidance | Acute GP - Face to Face | Actual | 66 | 84 | 94 | 76 | 80 | 75 | 123 | 76 | | | | | |
| | Acute GP - Telephone | Actual | 615 | 667 | 603 | 587 | 604 | 618 | 652 | 496 | | | | | |
| | NHS 111 - Ambulance dispatches (Devon) | Actual | 3956 | 2426 | 3467 | 3820 | 3588 | 3735 | 4486 | 4414 | 5358 | | | | |
| | NHS 111 - Recommended to attend A&E (Devon) | Actual | 2273 | 1354 | 2315 | 2451 | 2253 | 2128 | 2373 | 2222 | 2397 | | | | |
| | NHS 111 - Recommended to attend primary care (Devon) | Actual | 16090 | 10406 | 12725 | 14432 | 13739 | 12936 | 14124 | 13355 | 18643 | | | | |
| | SWAST call outs (Western Locality) | Actual | 5850 | 5985 | 5786 | 6130 | 5915 | 5955 | 5771 | 5797 | 6292 | | | | |
| | SWAST conveyed to hospital (Western Locality) | Actual | 2696 | 2761 | 2640 | 2886 | 2792 | 2908 | 2773 | 2820 | 2860 | | | | |
| | SWAST conveyance rate (Western Locality) | Actual | 46.1% | 46.1% | 45.6% | 47.1% | 47.2% | 48.8% | 48.1% | 48.6% | 45.5% | | | | |
| | Ambulance handover delays >30 mins | Actual | 127 | 127 | 94 | 93 | 83 | 167 | 134 | 278 | 260 | | | | |
| | Robin ward attendances | Actual | 121 | 145 | 112 | 113 | 80 | 84 | 73 | 56 | | | | | |
| | Acute care at home referrals | Actual | 27 | 26 | 29 | 27 | 26 | 21 | 16 | 11 | | | | | |
| | Acute care at home caseload | Actual | 8 | 8 | 7 | 6 | 9 | 10 | 8 | 9 | | | | | |
| | Community Crisis Response Team patients caseload | Actual | 100 | 95 | 99 | 84 | 82 | 74 | 73 | 83 | | | | | |
| Emergency department | A&E attendance - type 1 (average daily) (including major / minor) 17/18 | Actual | 276 | 282 | 271 | 292 | 271 | 277 | 281 | 278 | 262 | | | | |
| | | *Expected* | *270* | *281* | *284* | *286* | *267* | *280* | *277* | *274* | *268* | *262* | *270* | *283* | |
| | A&E attendance - type 1 (average daily) (including major / minor) 16/17 | Actual | *256* | *276* | *270* | *276* | *264* | *272* | *273* | *278* | *262* | | | | |
| | % A&E attendances in triage category 1&2 | Actual | | | | | | | | | 22.3% | | | | |
| | 4hr wait in A&E | Actual | 83.6% | 84.0% | 86.6% | 84.4% | 90.2% | 88.2% | 87.6% | 86.6% | 79.3% | | | | |
| | Conversion rate from ED | Actual | 36.7% | 38.1% | 35.4% | 34.5% | 36.7% | 37.3% | 35.9% | 38.0% | 38.3% | | | | |
| | | *Expected* | *37.0%* | *36.3%* | *35.7%* | *35.6%* | *37.2%* | *36.8%* | *37.7%* | *38.3%* | *40.1%* | *40.8%* | *39.1%* | *37.6%* | |
| Assessment Units/ Emergency admissions | Emergency admissions to MAU via A&E | Actual | 1221 | 1353 | 1153 | 1200 | 1115 | 1132 | 1182 | 1218 | 1228 | | | | |
| | Emergency admissions to MAU NOT via A&E | Actual | 225 | 243 | 302 | 341 | 368 | 353 | 327 | 321 | 146 | | | | |
| | % of admitted directly to ASU within 4 hours of arrival at ED | Actual | 58% | 61% | 56% | 64% | 53% | 67% | 61% | 70% | 55% | | | | |
| | % of Stroke Patients receiving brain imaging within 1 Hour | Actual | 64% | 57% | 57% | 63% | 53% | 67% | 67% | 55% | 64% | | | | |
| Acute hospital | Emergency admissions (medical) | Actual | 2062 | 2312 | 2173 | 2227 | 2097 | 2186 | 2464 | 2562 | 2677 | | | | |
| | | *Expected* | *2204* | *2236* | *2166* | *2213* | *2060* | *2177* | *2306* | *2339* | *2517* | *2412* | *2239* | *2476* | |
| | Emergency admissions (surgical) | Actual | 855 | 970 | 982 | 915 | 892 | 901 | 913 | 890 | 858 | | | | |
| | | *Expected* | *873* | *924* | *921* | *961* | *920* | *916* | *925* | *885* | *886* | *854* | *806* | *913* | |
| | Non-elective LoS (medical) | Actual | 5.30 | 4.86 | 4.94 | 4.83 | 5.18 | 5.22 | 4.66 | 4.50 | 4.13 | | | | |
| | | *Expected* | *5.19* | *5.02* | *5.10* | *4.93* | *5.10* | *5.01* | *4.84* | *4.66* | *4.66* | *5.03* | *5.08* | *4.94* | |
| | Non-elective LoS (surgical) | Actual | 4.45 | 4.52 | 4.17 | 3.60 | 4.49 | 4.31 | 4.06 | 4.03 | 3.98 | | | | |
| | | *Expected* | *4.44* | *4.15* | *4.19* | *4.19* | *4.20* | *4.35* | *4.36* | *4.37* | *4.43* | *4.51* | *4.58* | *4.40* | |
| | LoS >6 days (medical) | Actual | 537 | 546 | 525 | 527 | 522 | 550 | 545 | 561 | 534 | | | | |
| | | *Expected* | *561* | *543* | *534* | *533* | *510* | *525* | *537* | *524* | *571* | *597* | *554* | *592* | |
| | LoS >6 days (surgical) | Actual | 165 | 186 | 184 | 143 | 173 | 158 | 160 | 154 | 154 | | | | |
| | | *Expected* | *166* | *166* | *167* | *172* | *167* | *171* | *172* | *165* | *169* | *165* | *157* | *170* | |
| | Medical outlier (Alamac) | Actual | 32.6 | 28.5 | 24.6 | 25.7 | 12.7 | 24.1 | 22.2 | 22.0 | 35.4 | | | | |
| | Escalation beds open (PHNT) | Actual | 36 | 30 | 32 | 29 | 33 | 36 | 31 | 33 | 36 | | | | |
| | Bed occupancy rate (PHNT) | Actual | 98.1% | 97.9% | 97.4% | 96.9% | 97.0% | 97.6% | 97.2% | 98.2% | 94.6% | | | | |
| | Cancelled operations on day of admission or later for non clinical reasons | Actual | 135 | 165 | 128 | 130 | 141 | 163 | 152 | 158 | 133 | | | | |
| | Cancelled operations on day of up to 7 days before for hospital reasons | Actual | 439 | 525 | 483 | 440 | 430 | 412 | 513 | 453 | 397 | | | | |
| | Stroke patients who spend at least 90% of their time on a Stroke Unit | Actual | 68.3% | 71.1% | 73.5% | 65.7% | 74.7% | 77.1% | 70.0% | 74.4% | 78.9% | | | | |
| Acute discharge | DTOC performance | Actual | 7.7% | 6.3% | 6.3% | 6.7% | 6.5% | 6.9% | 5.6% | 4.6% | 5.6% | | | | |
| | Discharges to usual place of residence | Actual | 65.2% | 67.4% | 67.7% | 70.8% | 61.6% | 65.0% | 66.4% | 66.6% | 65.6% | | | | |
| | Discharges to other hospital | Actual | 11.0% | 8.7% | 11.0% | 8.8% | 12.8% | 11.2% | 10.1% | 12.8% | 12.1% | | | | |
| | Discharges to carehome/ temporary place of residence | Actual | 16.5% | 16.9% | 15.6% | 14.5% | 18.9% | 18.3% | 16.3% | 13.1% | 15.8% | | | | |
| | Time of day discharge (% by midday) | Actual | 15.7% | 15.4% | 14.8% | 15.7% | 14.8% | 15.7% | 16.4% | 17.2% | 16.2% | | | | |
| | Weekend discharges | Actual | 18.7% | 19.5% | 18.6% | 17.9% | 19.2% | 18.1% | 18.0% | 18.1% | 19.1% | | | | |
| | Green to go list (ie patients fit to leave hospital - Alamac) | Actual | 69 | 60 | 78 | 99 | 101 | 98 | 76 | 71 | 80 | | | | |
| Community | LCC rehab bed occupancy (Kingfisher / Skylark) | Actual | 96.0% | 96.0% | 96.0% | 97.0% | 95.0% | 93.0% | 98.0% | 92.0% | 95.0% | | | | |
| | Stroke rehabilitation bed occupancy | Actual | 102.0% | 96.0% | 99.0% | 102.0% | 109.0% | 112.0% | 95.0% | 112.0% | 114.0% | | | | |
| | South Hams (Kingsbridge) bed occupancy | Actual | 86.0% | 93.0% | 94.0% | 94.0% | 96.0% | 97.0% | 95.0% | 97.0% | 96.0% | | | | |
| | Tavistock bed occupancy | Actual | 92.0% | 98.0% | 94.0% | 90.0% | 98.0% | 89.0% | 95.0% | 89.0% | 95.0% | | | | |
| | LCC Rehab (Kingfisher / Skylark) - Discharges | Actual | 37 | 47 | 46 | 37 | 38 | 48 | 53 | 50 | 48 | | | | |
| | LCC Rehab (Kingfisher / Skylark) - Discharges Plan | Plan | 90 | 92 | 90 | 92 | 92 | 90 | 92 | 90 | 91 | 91 | 88 | 92 | |
| | Stroke Rehabilitation - Discharges | Actual | 12 | 12 | 11 | 11 | 16 | 14 | 17 | 10 | 14 | | | | |
| | Stroke Rehabilitation - Discharges Plan | Plan | 9 | 9 | 9 | 10 | 10 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | |
| | South Hams (Kingsbridge) - Discharges | Actual | 26 | 24 | 27 | 28 | 30 | 28 | 31 | 30 | 31 | | | | |
| | South Hams (Kingsbridge) - Discharges Plan | Plan | 22 | 24 | 22 | 24 | 24 | 22 | 24 | 22 | 23 | 24 | 22 | 24 | |
| | Tavistock Bed - Discharges | Actual | 21 | 17 | 18 | 21 | 19 | 25 | 27 | 30 | 22 | | | | |
| | Tavistock Bed - Discharges Plan | Plan | 13 | 14 | 13 | 14 | 14 | 13 | 14 | 13 | 13 | 14 | 12 | 14 | |
| | Community DTOC (excluding stroke) | Actual | 13.5% | 15.6% | 17.4% | 16.0% | 15.1% | 15.8% | 13.8% | 13.2% | 14.8% | | | | |
| | Mental health DTOC | Actual | 13.7% | 11.8% | 15.9% | 10.8% | 10.7% | 6.9% | 6.0% | 3.0% | 8.6% | | | | |
| Social Care | Long term admissions to residential and nursing care (18-64) | Actual | 2 | 1 | 1 | 2 | 0 | 2 | 1 | 2 | 1 | | | | |
| | Clients receiving long term Residential and Nursing Care (18-64) | Actual | 218 | 213 | 212 | 212 | 212 | 211 | 212 | 213 | 213 | | | | |
| | Number of clients receiving long term Community Based Care (18-64) | Actual | 1294 | 1285 | 1289 | 1288 | 1290 | 1300 | 1304 | 1307 | 1312 | | | | |
| | Long term admissions to residential and nursing care (65+) | Actual | 17 | 17 | 18 | 20 | 22 | 18 | 22 | 10 | 15 | | | | |
| | Clients receiving long term Residential and Nursing Care (65+) | Actual | 786 | 784 | 780 | 782 | 783 | 779 | 788 | 773 | 800 | | | | |
| | Number of clients receiving long term Community Based Care (65+) | Actual | 1300 | 1290 | 1276 | 1273 | 1296 | 1298 | 1276 | 1291 | 1289 | | | | |
| | Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | Actual | | 87.0% | | | 82.0% | | | 85.0% | | | | | |
| CHC | CHC total number of clients (Plymouth) | Actual | 482 | 496 | 502 | 500 | 486 | 479 | 482 | 461 | 459 | | | | |
| | CHC total number of non-fast track clients (Plymouth) | Actual | 361 | 356 | 354 | 348 | 341 | 342 | 338 | 332 | 334 | | | | |
| | CHC total number of fast track clients (Plymouth) | Actual | 121 | 140 | 148 | 152 | 145 | 137 | 144 | 129 | 125 | | | | |
| | CHC Newly funded clients (Plymouth) | Actual | 65 | 81 | 89 | 78 | 66 | 69 | 80 | 79 | 57 | | | | |
| | CHC Newly funded non-fast track clients (Plymouth) | Actual | 2 | 5 | 9 | 3 | 3 | 8 | 8 | 10 | 6 | | | | |
| | CHC Newly funded fast track clients (Plymouth) | Actual | 63 | 76 | 81 | 74 | 63 | 66 | 74 | 69 | 51 | | | | |
| | CHC backlog waiting for assessment | Actual | 250 | 283 | 283 | 305 | 292 | 283 | 253 | 236 | 207 | | | | |
| | CHC backlog waiting for review | Actual | 374 | 365 | 369 | 352 | 343 | 332 | 327 | 305 | 306 | | | | |
| | Waiting time for assessment (days) | Actual | 95 | 116 | 183 | 148 | 120 | 242 | 225 | 244 | 175 | | | | |
| | CHC conversion rate (CCG quarterly only) | Actual | | 13.4% | | | 12.4% | | | 13.0% | | | | | |