Feedback

Plymouth
Local System Review

The focus

- How well do people move through the health and social care system, with a particular focus on the interface?
- What improvements could be made?

The questions

- What is currently happening and what are the outcomes for people?
- What is the maturity of the local area to manage the interface between health and social care moving forward?
- What else needs to happen?

The approach

- Local ***system*** and people's ***experiences***
- 3 key points
  - Maintaining wellbeing
  - Crisis management
  - Discharge, step-down, re-ablement
- Preparation, engagement, site visit, communication

The progress that the Plymouth System has made towards system integration was acknowledged by **Professor Steve Field, Chief Inspector of Primary Care Services who said:**

“The review of Plymouth's services - and how the system works together – has found some shining examples of shared approaches. The system leaders had a clearly articulated, long-established vision of integration which translated well into local commissioning strategies. Leaders were consistent in their commitment to the vision with whole system buy-in.

“I would encourage system leaders in Plymouth to drive this forward to ensure there is a more community, home-based focus. System leaders also need to ensure that as the system moves towards further integration, work is undertaken to ensure that staff are fully engaged, from the outset and led by a collaborative leadership.”

Key Findings – People's experiences

- **Local People were not always seen in the right place, at the right time, by the right person.**
- Peoples' experiences of health and social care in Plymouth were variable.
- People couldn't always get a GP an appointment when they needed one.
- Once ready for discharge, older people were often subject to unnecessary delays.
- Some people told us about their experiences of unsafe and poorly planned discharges.
- The quality of residential nursing care was worse than average and a higher than average number of services had deteriorated on re-inspection.

Key Findings in Plymouth- People's experiences

- If people received reablement services they achieved good outcomes. Readmission rates were lower than average.
- There was evidence of considerable public engagement in development of strategic vision and service design.
- System Design Groups facilitated the involvement of voluntary sector organisations, providers and the public in strategic planning and service design.
- People were positive about the support they received from third sector organisations and it was encouraging to see the commissioning of the befriending service was continuing.
- There were some innovative examples staff and organisations working together to help people stay well in the community, but these weren't widespread.
- There was a high uptake of Personal Budgets for Health and Social Care, but some people reported difficulties in accessing information and support.

Key Findings – Staff Experiences

- System leaders and senior staff were visible and were clear about the direction of travel.
- Care providers were very positive about their relationship with commissioners.
- The workforce across the system were committed to doing the right thing for people, but the degree to how supported they felt varied between and within sectors.
- Staff felt there had been improvements to ways of working, but described a lack of shared IT systems as a barrier to integration. Recruitment and retention of staff were system-wide challenges.
- We found some positive examples of teams working in an integrated way, but other parts of the system were fragmented.
- There was not a shared understanding of the services available and their capabilities and capacity.
- Some of the voluntary sector felt underutilised and could do more to support the prevention agenda.

Key Findings – System Flow

- A 15% GP vacancy rate in Plymouth which saw substantive GPs carrying patient list sizes of 2,364 patients on average compared with 1,950 on average for the whole of NEW Devon CCG meant people could not always see a GP when they needed to.

- A&E attendances were rising (but remained below average), the four hour target was not being met and the ED felt highly pressurised.

- The MIU and Acute GP service were helping to divert people away from A&E, but they could do more. There needs to be a cultural shift; staff within the ED need to more proactively refer people to those services designed to help prevent admissions.
- Bed occupancy rates were high and people were staying longer than they needed to.

- Discharges were not being discussed early enough and whilst there had been some improvements in performance and a reduction in assessment delays, the number of DTOCs remained higher than average.

Key Findings – Winter Planning

- There was a Winter Plan for Plymouth and staff across the system reported they had been asked for their input. However, it felt like two distinct plans between acute and community services.
- System Improvement Board (SIB) was providing a good level of performance monitoring over the Winter period.
- Providers felt part of the system response. The locally developed 'Shackleton Plan' was an area of good practice.
- Some plans were in place to enhance services provided by voluntary sector organisations to increase capacity, but these needed to happen at pace.
- Some new initiatives, including the AAU, the integrated discharge team and review of Discharge to Assess, hoped to reduce system pressures, but too early to demonstrate their impact.

Key Findings – Relationships

- There were clear lines of communication and accountability between Devon wide STP and Plymouth.
- Relationships amongst System Leaders were strong, collaborative and there was real evidence of effective partnership working, particularly amongst commissioners.
- Cross-party support of political leaders was encouraging to see and shared the commitment to both the vision and strategy between leaders and officers provided stability.
- There was an openness and transparency amongst system leaders, facilitated by a considerable pooled budget and innovative risk share agreements.
- Organisational development is required on the front line to ensure staff understand each others roles and responsibilities to deliver the vision for Plymouth.

Key Findings – The Health and Wellbeing Board and Scrutiny Board

- The Health and Wellbeing Board (HWB) had been nationally recognised as effective and well performing. It was the driving force behind setting the strategic vision for Plymouth back in 2013.
- There had been consistency in the HWB leadership and the cross-party support had helped maintain its purpose.
- System Leaders acknowledged the HWB had become 'distracted,' by the STP, but it was refocusing its role.
- Both the HWB and the Overview and Scrutiny Committee provided a high level of challenge around specific pressures within the system.
- The Boards were assured recent system improvements would lead to positive change, but they did not have evidence of impact yet.

Key Findings – System Working

- The system's journey to integration had begun and was on a positive trajectory.
- The was a system wide commitment to achieving positive outcomes for the people of Plymouth and leaders were aware and transparent about the challenges faced.
- There was a compelling strategic vision, but its success was at risk due to:
  - Capacity of services, workforce challenges and organisational development.
  - Current performance in relation to flow and Continuing healthcare (CHC).
  - Plymouth's significant financial pressures which also placed the STP at risk.

Key Findings – System Working

Service capacity

- Future commissioning plans were focused on prevention and the person rather than services. However, due to system pressures commissioning in relation to hospital admission prevention were had been reactive.

- Plymouth did not have the same social care capacity issues seen elsewhere in the country, but there was no Market Position Statement to signal to existing and new service providers what future requirements would be.

- There were workforce strategies for individual sectors or organisations, but not a single, co-ordinated strategy for Plymouth.

- Capacity issues within primary care were placing an additional burden on the wider system.

- Due to workforce challenges the AAU and not been able to recruit the full compliment of Nurse Practitioners and was not working at full capacity.

Key Findings – System Findings

Performance

- There was transparent approach to sharing performance information amongst system partners and some individual staff were having a significant impact.
- The system was consistently in escalation and there had been some missed opportunities to learn as a system.
- The High Impact Change Model had begun to be implemented in parts of the system, but remained fragmented.
- Hospital admission avoidance services were not available 7 days and the Trusted Assessor role needed to be expanded.
- There was an over-reliance on bed-based care (both in hospital and the community), but the discharge to assess model was being evaluated.
- CHC performance needed addressing. Large numbers of people were waiting a long time for an assessment and the conversion rate was low due to a high number of inappropriate referrals.

Key Findings – System Findings

Financial risks

- Plymouth was further ahead then some of its counterparts in the STP in relation to integrated commissioning arrangements. The pooled budget, associated risk share arrangements and the four integrated commissioning strategies provided the framework for interagency working.

- There were robust governance arrangements in place and the newly established System Improvement Board provided a high-level of scrutiny.

- PHNT's Cost Improvement Programme posed a risk to the future income of both Plymouth and the wider STP.

- Plymouth faced a significant funding gap per head of the population, but were realistic about how this would be addressed. Whilst the public health budget was small, it was ring-fenced.

- No retainers were paid to domiciliary care providers if a person was admitted to hospital.

Emerging Messages

- There was a compelling vision, strength in leadership and strong relationships amongst leaders. However, this had not been translated to the front line and people's experiences were variable.

- The system needs to continue with transformation whilst addressing current performance issues.

- There needs to be a shift away from an over-reliance on bed-based care to keeping people well in their own homes.

- The system needs to future proof the workforce and capacity of primary care and social care to cope with an increase in demand.

- There needs to be system-level evaluation and learning to lead to improvements.

- Organisational development work is needed to improve communication and integrated working between front-line staff.

Reflections

- System leaders have developed strong and mature relationships. Stability in the leadership has meant Plymouth has started its journey to integration.

- The strategic vision is a compelling one and one that system partners have consistently been signed up to. However, it has not been translated to the frontline and the reality for people in Plymouth is varied. The system needs to ensure staff are part of the journey.

- Current pressures within parts of the system, place the success of Plymouth's vision and the wider the STP at risk. These need to be addressed whilst pushing ahead with transforming service delivery.

Development of action plan

- Summit held 2nd Feb with System Leaders
- Existing plans reviewed against findings and gaps identified
    - Local Workforce Plan
    - Commissioning Intentions
    - Performance Improvement Plan
- Action plan developed for approval by NHS Improvement Partner/CQC

Recommendations

- Health and Wellbeing Board to delegate oversight and monitoring of system delivery against the action plan to Overview and Scrutiny.