Phil Norrey
Chief Executive

To: The Chair and Members of the Health and Adult Care Scrutiny Committee

County Hall
Topsham Road
Exeter
Devon
EX2 4QD

(See below)

Your ref :
Our ref :

Date : 17 January 2018

Email: gerry.rufolo@devon.gov.uk
Please ask for : Gerry Rufolo 01392 382299

HEALTH AND ADULT CARE SCRUTINY COMMITTEE

Thursday, 25th January, 2018

A meeting of the Health and Adult Care Scrutiny Committee is to be held on the above date at 2.15 pm at Committee Suite - County Hall to consider the following matters.

P NORREY
Chief Executive

A G E N D A

PART 1 - OPEN COMMITTEE

1 Apologies

2 Items Requiring Urgent Attention

Items which in the opinion of the Chair should be considered at the meeting as matters of urgency.

3 Public Participation

Members of the public may make representations/presentations on any substantive matter listed in the published agenda, as set out hereunder, relating to a specific matter or an examination of services or facilities provided or to be provided.

MATTERS FOR CONSIDERATION OR REVIEW

4 Annual Report: Devon Safeguarding Adults Board (Pages 1 - 4)

Penny Rogers, Vice Chair of DSAB presenting the DSAB Annual Report, attached

5 South Western Ambulance Service NHS Foundation Trust: Performance (Pages 5 - 16)

Report of the SWAST, attached

6 Adult Social Care Annual Report (Pages 17 - 20)

Report of the Head of Adult Commissioning and Health (ACH/18/78), attached

7 Whole System Performance Report (Pages 21 - 36)

Joint Report of the Head of Adult Commissioning and Health (DCC) and Director Strategy (South Devon and Torbay CCG and NEW Devon CCG), (ACH/18/79), attached

8 The future of services and buildings in Community Hospitals - implementation update & NHS Property Services (Pages 37 - 50)

Joint Report of NHS Property Services and NEW Devon CCG, atached

9 Spotlight Review Report - NHS in Devon (Pages 51 - 68)

Report of the Spotlight Review held on 27 October 2017, attached

10 Accountable Care System (Pages 69 - 76)

In accordance with Standing Order 23(2) Councillor M Shaw has requested that the Committee consider this matter

11 GP Waiting Times for Appointments

In accordance with Standing Order 23(2) Councillor G Hook has requested that the Committee consider this matter

12 Work Programme (Pages 77 - 80)

(a) Progress of the Standing Overview Group (STP)

Notes of the Standing Overview Group (STP) held on 12 December 2017, attached

(b) Forward Programme

In accordance with the Constitution, Scrutiny Committees are requested to review the forthcoming business (previously circulated) and determine which items are to be included in the Work Programme. The Work Programme is also available on the Council's website at http://democracy.devon.gov.uk/mgPlansHome.aspx?bcr=1 to see if there are any specific items therein it might wish to explore further.

MATTERS FOR INFORMATION

13 Information Previously Circulated

Below is a list of information previously circulated for Members, since the last meeting, relating to topical developments including those which have been or are currently being considered by this Scrutiny Committee.

(a) Care Quality Commission report on Northern Devon Healthcare Trust and response from the Chairman on behalf of the Committee.

(b) Update from NHS England on orthodontic procurement.

(c) Press release by the Royal Devon & Exeter NHS Foundation Trust RD&E on winter pressures.

(d) Health and Care Insights - Issue 6: December 2017 - published by the Torbay and

South Devon NHS Foundation Trust.

(e) NHS England South (South West): procurement of orthodontic services across the South West.

(f) Letter from the Committee of Crediton Hospital League of Friends on the future of the Community Hospital and response by the Chairman on behalf of the Committee.

(g) Information on the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 and The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 on the role and duties of Health Scrutiny.

PART II - ITEMS WHICH MAY BE TAKEN IN THE ABSENCE OF PRESS AND PUBLIC ON THE GROUNDS THAT EXEMPT INFORMATION MAY BE DISCLOSED

Nil

Members are reminded that Part II Reports contain confidential information and should therefore be treated accordingly. They should not be disclosed or passed on to any other person(s).
Members are also reminded of the need to dispose of such reports carefully and are therefore invited to return them to the Democratic Services Officer at the conclusion of the meeting for disposal.

Membership
Councillors S Randall-Johnson (Chair), N Way (Vice-Chair), H Ackland, J Berry, P Crabb, R Gilbert, B Greenslade, R Peart, S Russell, P Sanders, R Scott, J Trail, P Twiss, C Whitton, C Wright and J Yabsley Devon Councils Councillor P Diviani
Declaration of Interests
Members are reminded that they must declare any interest they may have in any item to be considered at this meeting, prior to any discussion taking place on that item.
Access to Information
Any person wishing to inspect any minutes, reports or lists of background papers relating to any item on this agenda should contact Gerry Rufolo 01392 382299. Agenda and minutes of the Committee are published on the Council's Website and can also be accessed via the Modern.Gov app, available from the usual stores. .
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Scrutiny Committees set aside 15 minutes at the beginning of each meeting to allow anyone who has registered to speak on any such item. Speakers are normally allowed 3 minutes each.

Anyone wishing to speak is requested to register in writing to the Clerk of the Committee (details above) by the deadline, outlined in the Council's Public Participation Scheme https://new.devon.gov.uk/democracy/committee-meetings/scrutiny-committees/, indicating which item they wish to speak on and giving a brief outline of the issues/ points they wish to make.

Alternatively, any Member of the public may at any time submit their views on any matter to be considered by a Scrutiny Committee at a meeting or included in its work Programme direct to the Chair or Members of that Committee or via the Democratic Services & Scrutiny Secretariat (committee@devon.gov.uk). Members of the public may also suggest topics (see: https://new.devon.gov.uk/democracy/committee-meetings/scrutiny-committees/scrutiny-work-programme/

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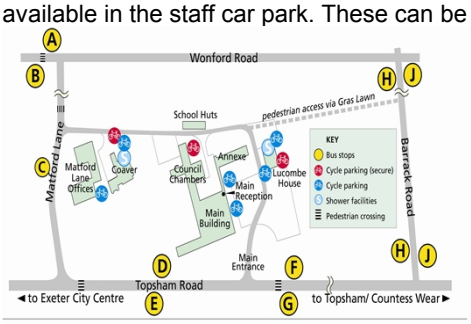

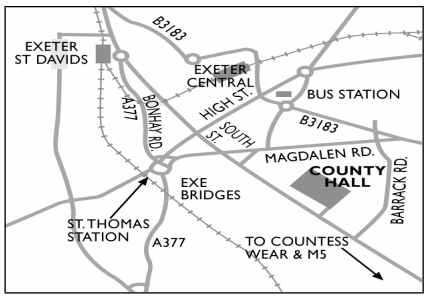

NB A J **Denotes bus stops**

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Contact Main Reception (extension 2504) for a trained first aider.

Health and Adult Care Scrutiny Committee
25 January 2018

Devon Safeguarding Adults Board Annual Report 2016/17- Covering Report
Health and Adult Care Scrutiny Committee

Please note that the following recommendations are subject to consideration and determination by the Health and Adult Care Scrutiny Committee before taking effect.

Recommendation:
Adult Care & Health Care Scrutiny Committee is requested to note the Annual Report 2016/ 2017 of the Devon Safeguarding Adults Board which summarises some of the work that has taken place in 2016/17. More detailed information about the work of the Board is available on the DSAB website: https://new.devon.gov.uk/devonsafeguardingadultsboard/

1. Introduction

1.1 This attached report provides Scrutiny Committee Members with an overview of the Devon Safeguarding Adults Board (DSAB) Annual Report for 2016/17

1.2 The annual report summarises safeguarding activity undertaken throughout 2016/2017 by the Board and its key partners and sets out the progress made against priorities. There is a statutory requirement to present the Annual Report of the Safeguarding Adults Board to the local Health & Wellbeing Board. In Devon the report is also presented to Cabinet and to Health & Adult Care Scrutiny Committee.

1.3 This Annual Report is concise, and has been well received by all partners. It ensures that key messages are portrayed and the report can be delivered and, importantly, understood widely. There is a national trend towards ensuring that such annual reports are reduced in size. Importantly more detailed information is published on the Board's website, including the full Safeguarding Adult Review (SAR) Report and the accompanying Action Plan for SAR T which was completed in 2016/17.

1.4 It is intended that the DSAB Independent Chair will lead a masterclass on safeguarding adults and the work of the Board, prior to the Adult Care & Health Scrutiny Committee on 22 March 2018 (details to follow). At this masterclass there will be a presentation on national trends in safeguarding vulnerable adults, a brief

overview on the legislation which applies to safeguarding and which is monitored by the Board, and an update on delivery of the current DSAB Strategic Plan.

2. Background

2.1.1 DSAB is the strategic lead body for safeguarding for the county of Devon, with an overriding objective to prevent and reduce the risk of significant harm to adults with care and support needs from abuse or other types of exploitation

- Key statutory partners are - DCC, NHS commissioners (CCGs) and the Police with wider representation from other agencies (NHS Providers, Healthwatch, Exeter Prison, Probation and the Community Rehabilitation Company)
- There are 2 key statutory requirements for the Board – to deliver an Annual Report and to ensure that the Board appropriately conducts Safeguarding Adult Reviews

2.1.2 For the purposes of this work, vulnerable adults with care and support needs are defined as:

  - people with learning disabilities
  - people with physical disabilities
  - people with sensory impairment
  - people with mental health needs, including dementia
  - people who misuse substances or alcohol
  - people who are physically or mentally frail

2.2 Legislative Context

2.2.1 The Care Act 2014 requires that local authorities hold the lead responsibilities for safeguarding adults and work in partnership with other agencies as described above. The Local Authority shall appoint an Independent Chair whose role it is to ensure that the Board holds all partners to account for delivering services which safeguard and protect vulnerable adults. The Board acts as the strategic mechanism for ensuring that all partners work together successfully.

2.2.2 As mentioned in 2.1.1 above, there are 2 key statutory requirements for the Safeguarding Adults Board – to deliver an Annual Report and to ensure that the Board appropriately conducts Safeguarding Adult Reviews (SARs).

2.2.3 SARs – there are 4 underway at present and when these are completed they will be presented to the DSAB. Reports and action plans will be uploaded on the DSAB Website. Learning from SARs is tracked by the Board and reviewed to ensure that actions have been undertaken

2.3. A Summary of completed DSAB Work in 2016/17

- Appointment of a new Independent Chair, new DCC Lead Officer for the Board (Principal Social Worker Commissioning), and a Board Business Manager

- Reviewed and implemented a revised board structure and membership and launched a number of new work streams which will be reflected in the report for 2017/18
- Re-focused Board sub groups by working with Chairs to identify and implement key work streams. There is an improved Safeguarding Adult Review process (with a new SAR Core Group Chair) and SAR T was completed and published on the DSAB website
- Reviewed and updated content across DSAB Website
- Refreshed the Operational Delivery Group which acts as the key delivery arm of the Board
- Developed close working links with Torbay SAB to support partners who work across both Boards
- The Chair has relaunched the Peninsula (Devon, Torbay, Plymouth and Cornwall & the Isles of Scilly Chairs' Network and in 2017 has been key in the development of the South-West Chairs' Network to develop best practice across the region
- New Chairs of Mental Capacity Act sub-group have been appointed and its work plan refreshed to reflect DSAB priorities

Siân Walker
Independent Chair
Devon Safeguarding Adults Board

LOCAL GOVERNMENT ACT 1972: LIST OF BACKGROUND PAPERS

Contact for Enquiries: Ben Smith, Business Manager, Devon Safeguarding Adults Board
Tel No: 01392 383000, County Hall, The Annexe, First Floor

South Western Ambulance Service NHS Foundation Trust

Devon Health and Adult Care Scrutiny Committee

30 October 2017

Title:	Ambulance briefing
Main aim:	To provide an update on projects, performance and activity
Recommendations:	To note the contents of the report

1.0 National Ambulance Response Programme (ARP)

1.1 South Western Ambulance Service NHS Foundation Trust (SWASFT) welcomed the announcement by the Secretary of State and NHS England in July 2017 about a new set of ambulance service standards as part of the Ambulance Response Programme (ARP). This new set of standards mean that every incident will count towards the average performance, as opposed to previous time targets for an incident which did not take account of the 'tail' of calls that were out of performance.

1.2 SWASFT has been a pilot trust for ARP since October 2014 with the Dispatch on Disposition pilot which started in February 2015. Since then there have been more iterations with the last trial period, in October 2016, introducing the new call categories and definitions.

1.3 SWASFT has seen improvements in productivity and efficiency from the initial pilot with, on average, less vehicles being sent to each incident, freeing up resources to attend more patients.

1.4 SWASFT is now in the process of updating its Control and Dispatch system in line with the national adoption of the new standards which was due to begin in October 2017.

1.5 The new system will update a decades old system and will provide a strong foundation for the future. The changes focus on making sure the best, high quality, most appropriate response is provided for each patient first time. The new proposed ambulance standards are shown in Figure 1.

Figure 1: Proposed standards

Category	Percentage of calls in this category	National Standard	How long does the ambulance service have to make a decision?	What stops the clock?
Category 1	8%	7 minutes mean response time 15 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •30 seconds from the call being connected	The first ambulance service-dispatched emergency responder arriving at the scene of the incident (There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation)
Category 2	48%	18 minutes mean response time 40 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first ambulance service-dispatched emergency responder arriving at the scene of the incident stops the clock.
Category 3	34%	120 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport the first ambulance, service-dispatched emergency responder arriving at the scene of the incident stops the clock.
Category 4	10%	180 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •240 seconds from the call being connected	Category 4T: If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock.

South Western Ambulance Service NHS Foundation Trust

1.1. Under the new system early recognition of life-threatening conditions, particularly cardiac arrest, will increase. A new set of pre-triage questions identifies those patients in need of the fastest response. The new targets will also free up more vehicles and staff to respond to emergencies.

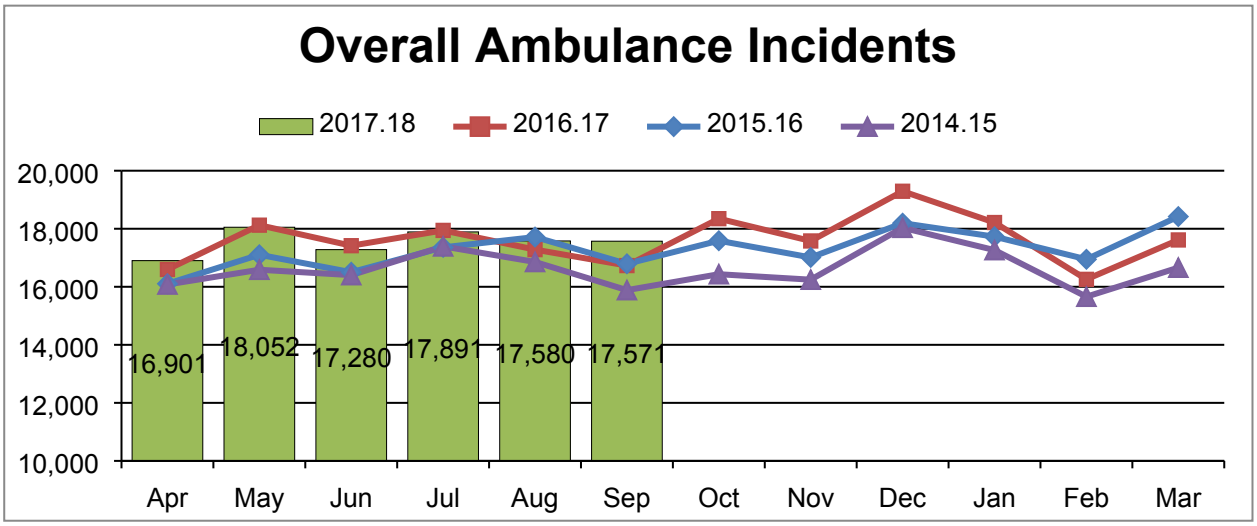
1.2. More information about the categories of calls is available from NHS England at: https://www.england.nhs.uk/urgent-emergency-care/arp/

2. Performance figures

2.1. For the period April 2017 to September 2017 overall activity in Devon shows SWASFT responding to 105,275 incidents. This equates to an increase of just over 1% compared to the same period last year.

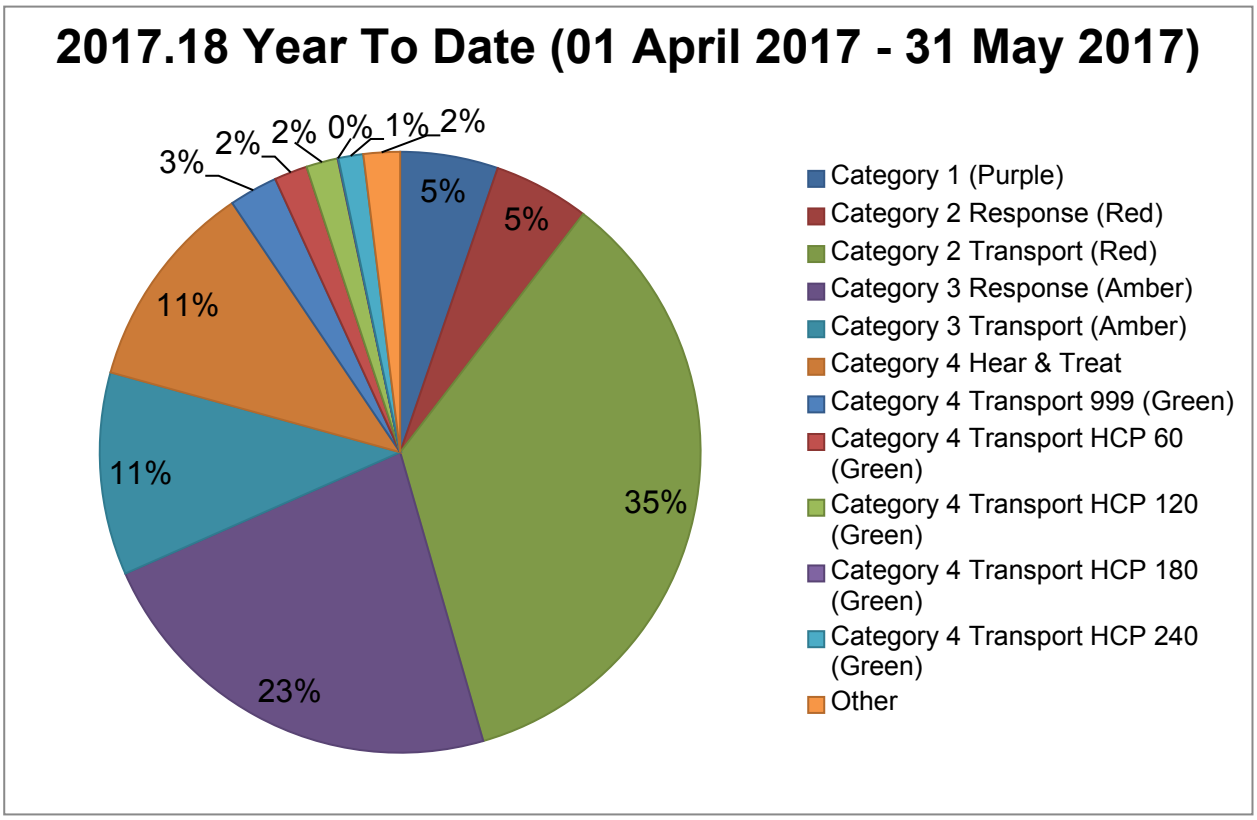
2.2. Broken down to daily figures this shows the Trust is responding to, on average, 575, incidents per day. This compares to an average of 569 incidents per day for the previous year.

Figure 2



The Trust has responded to 5,542 category one calls from April 2017 to September 2017. The number of category one incidents across Devon is low compared to other calls received, representing 5.26% of overall activity. See Figure 3

Figure 3



In Devon the year to date figures show the Trust has not met its 75% performance target of responding to category one incidents within eight minutes. Current figures show the Trust is meeting this time frame for 61.72% of category one incidents. However, 96.1% of category one patients receive a response time in under 19 minutes. See Figure 4.

Figure 4

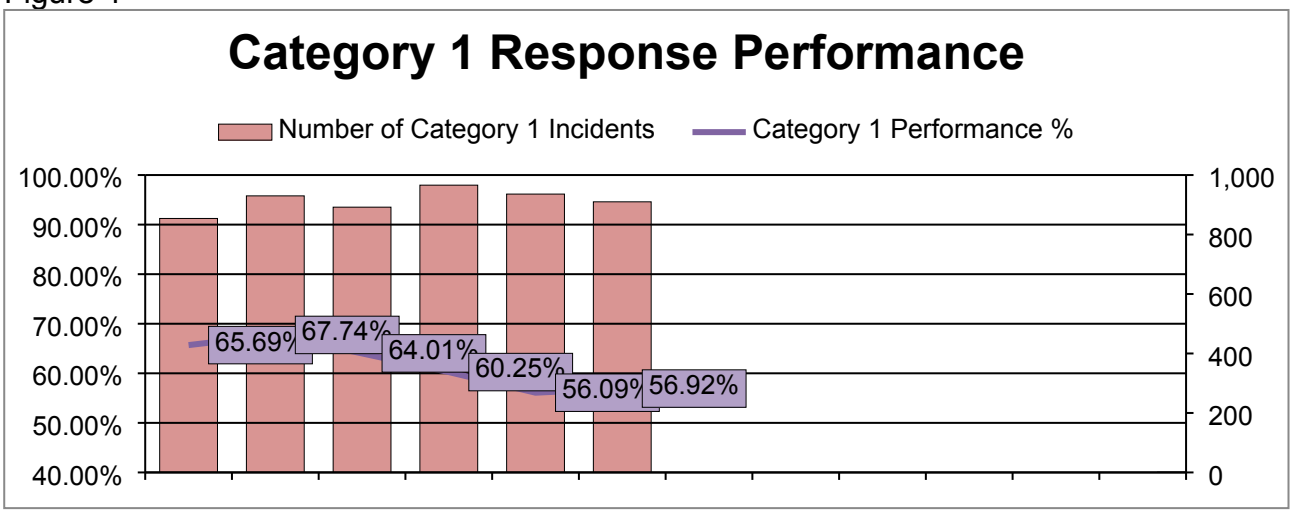


Figure 5 (overleaf) shows where the category one incidents have occurred in Devon and if this target performance time has been met.

South Western Ambulance Service NHS Foundation Trust

Figure 5

Category 1 Incident Map - July 2017

Responded within 8 Minutes

Responded over 8 minutes

3. Patient Experience

For the six month period from March 2017 to August 2017 the Trust received 1217 compliments from patients compared to 664 comments, concerns and complaints.

For the same period in Devon 211 compliments from members of the public were received compared to 140 comments, concerns and complaints.

Figure 6

Month received in 2017	Comments, concerns & complaints	Compliments
March	30	45
April	24	43
May	25	34
June	21	30
July	26	27
August	14	32

Examples of the type of compliments received for Devon:

September 2017
I dislocated my 'new' hip at home yesterday, and my husband called 999. The crew who attended were absolutely brilliant! They were all so good at calming me whilst I was in extreme pain. They worked well as a team and listened to what I had to say, having been in this situation before. I really appreciate all the efforts they went to, to ensure my comfort whilst getting me out of the house .I was reassured all the way to the hospital telling me what he was doing and why. They didn't leave me until the hospital team had taken over. I was also so appreciative of the first crew coming to find me later in hospital to see how I was- it was so kind of them going the extra mile. I can't thank these people more- they are a credit to the ambulance service!

August 2017
I had a need to telephone 999 for the ambulance service as in my opinion I had a suffered a heart attack. The ambulance with two paramedics arrived at my home. They were very efficient in the manner in which they dealt with me and made a decision to convey me to hospital. I was admitted to A&E. I have now made a full recovery from my problem. In this day and age there are many reports about the time it takes an ambulance to attend an incident, in my case they should be commended for their actions. Thanking both of them.

March 2017
My six year old daughter was hit by a car. A paramedic team were there within minutes and they were brilliant. Super child-centred and un-scary, polite, gentle, relaxed and professional. The police officer who attended was the same. Luckily my daughter escaped the incident unhurt but I appreciated so much the time they took to check that everything was ok with both of us before sending us home. Thank you all of you.

May 2017
After having a fall in my bathroom and trying to get you myself my wife decided to phone for an ambulance. Within three minutes of the call they were on the door step. Two lovely chaps from South Western Ambulance Service. After carrying out all their test they decided to take me into hospital to get checked over. I would just like to say from all my family thank you so much for all your help and what an amazing job you do.

4. Rota review

4.1. In recent years the Trust has seen the 999 service come under increasing pressure from the rise in demand. The Trust has explored ways to mitigate this impact with a number of initiatives to protect staff welfare, the patient experience and Trust performance.

4.2. The Trust recognised the need to align rotas and fleet ratios to better meet the current demand and needs of our patients which resulted in the decision to undertake a full rota review.

4.3. The review began in the North division when the rota changes were implemented in April 2017. It was then rolled out to the East and West divisions in July 2017.

4.4. The changes to the rotas now ensure the right number of staff are on duty at the right time, in the right place. This will enable the service to manage peaks in demand, giving an improved response to patients as well as staff welfare and wellbeing.

4.5. The Trust has also increased the number of double-crewed ambulances (DCAs) and reduced the number of rapid-response vehicles (RRVs). Investment earmarked to replace RRVs was instead used to fund additional DCAs.

4.6. The rota review now ensures SWASFT has an operating model which can respond to our current demand and future challenges.

South Western Ambulance Service NHS Foundation Trust

5. Single triage

5.1. After careful consideration South Western Ambulance Service NHS Foundation Trust (SWASFT) has decided to change to a single triage system – MPDS (Medical Priority Dispatch System) for all 999 calls with clinicians moving to LowCode.

5.2. Previously different systems were used in the North Clinical Hub (MPDS and PSIAM) and South Clinical Hub (NHS Pathways) which handle all 999 calls for the SWASFT region.

5.3. The benefits of this decision, which were ratified by the Trust board of directors on 31 March 2017, are:

- A better and more consistent service to patients
- Patients are triaged more quickly using MPDS and LowCode
- The clinical hubs will be more effective
- 999 call advisors can be recruited and trained more quickly
- This option is the most cost effective for the Trust
- A virtual clinical hub, with virtual telephony can be realised

5.4. The Trust also considered the future impact of, and to support the objectives of STPs including requirements for improved patient information sharing, the national NHS Ambulance Response Programme including improvements to hear and treat, see and treat plus future ambulance quality indicators and Clinical Commissioning Groups' CQUINs

5.5. A full and robust review of both the existing systems was undertaken including looking at the clinical impact, patient safety, and the efficacy of each solution as well as the financial impact of implementing each system across the Trust.

5.6. The full implementation is on schedule to be completed in March 2018 when NHS Pathways will be fully phased out of the 999 clinical hubs. NHS Pathways remains the triage system of choice for NHS 111 services.

6.0 Responder updates

We currently have 168 Community First Responders (CFRs) and off-duty staff responders providing a voluntary response ahead of an ambulance, in more than 65 locations throughout Devon including:

Ashburton	Dolton	Northlew
Bampton	East Prawle	Noss Mayo
Barnstaple	Exeter	Paignton
Bideford	Exmouth	Plympton Chaddlewood
Bishopsteignton	Great Torrington	Plymstock
Bovey Tracey	Hartland	Salcombe
Bradninch	Hatherleigh	Salcombe Peninsula
Braunton	Holsworthy	South Brent
Brixham	Honiton	South Molton
Buckfastleigh	Horrabridge	South Pool
Cheriton Fitzpaine	Ilfracombe	Tavistock
Christow	Ivybridge	Tedburn St Mary
Chudleigh	Kenn	Teignmouth
Crediton	Kingsbridge	Tiverton
Croyde	Lustleigh	Torcross
Cullompton	Lynmouth	Torquay A
Culmstock	Modbury	Uffculme
Dartmouth	Moretonhampstead	Winkleigh
Dawlish	Northam	

The number of volunteers attached to each group/location varies from one to ten, with some responders providing cover both from their home address and their workplace. Between them, we achieve in excess of 6000 hours of voluntary responder cover for Devon every month.

With reporting tools on activity profiles, the Trust is able to review each group and work towards matching availability to activity levels.

Each group of volunteers is supported locally by an operational paramedic known as a Responder Liaison Officer (RLO), and Devon's Responder Department staff consisting of a county officer and two assistant county officers.

Since January 2017 we have recruited 43 new volunteers into existing CFR groups across the county. A recent recruitment drive has seen another 15 members of the public be selected and trained for the role.

Devon also has 15 co-responding fire stations (Axminster, Chagford, Chulmleigh, Combe Martin, Crediton, Dawlish, Hartland, Hatherleigh, Holsworthy, Ivybridge, Lynton, Moretonhampstead, Princetown, Seaton and Woolacombe) with 110 qualified staff responding to local life-or-death emergencies in their communities. There are 3 further members of Devon and Somerset Fire and Rescue Service staff currently undergoing training to improve availability at Chagford, Axminster and Dawlish.

We also work closely with the Devon based BASICS scheme, which is comprised of doctors who respond to critical calls for the Trust and provide expert intervention and support as volunteers. We currently have 11 BASICS doctors in Devon.

Defibrillators

There are 658 defibrillators registered with us across Devon either as Community Public Access Defibrillators (CPADs) or Static Site Establishments, as below:

Static Site Establishments	118
CPADs	202
Accredited Sites	338

7.0 Recommendation

The committee is asked to note the contents of this report.

ACH/18/78
Health and Adult Care Scrutiny
25th January 2018

Head of Adult Commissioning and Health

1. Recommendation

1.1 Members of the Health and Adult Care Scrutiny are invited to ask questions regarding the content of the draft annual report and are asked to note its contents.

1.2 The Chair of Health and Adult Care Scrutiny is invited to briefly summarise its activity over the year as it concerns adult social care for inclusion in the final version of the annual report before its wider communication.

2. Purpose

2.1 To present to Health and Adult Care Scrutiny the annual report (or 'local account') of the adult social care function of Devon County Council which includes:

- A self-assessment;
- A range of evidence supporting the self-assessment;
- Links to further sources of external information.

2.2 Members should note that the annual report is designed to be read standalone and online as it contains internal and external links and is over 100 pages long. It can be found here: devon.cc/asc-annualreport-2017

3. Background

3.1 The adult social care functions of local authorities are not subject to routine inspection.

3.2 Instead, we participate in a national and regional approach to sector-led improvement which includes:

- The publication of an annual report;
- An annual self-assessment, in a given format and subject to external moderation and challenge;
- The undertaking of mandatory returns covering a wide range of data and using insights gained from comparative analysis to inform improvement planning;
- Periodic peer review.

3.3 This process is facilitated nationally and regionally by the Local Government Association working with the Association of Directors of Adult Social Services and is the context in which this annual report (or 'local account') is written.

3.4 The Department of Health are now introducing national dashboards and local area reviews to encourage the organisations across health and care systems to work more effectively together and future improvement activity is likely to have an increasingly whole system focus, as is our own performance reporting.

3.5 Councils make a range of statutory returns to allow comparisons to be made between local authority areas covering:

- The views of service users and carers;
- The outcomes they achieve;
- Cost and spend;
- Activity;
- Safeguarding;
- Workforce;
- Service quality.

3.6 We signpost to the published data and tools at the end of the annual report, highlight insights gained in the evidence section, and use them in our self-assessment.

4. Annual Report Contents

4.1 Writing an annual report on adult social care in Devon gives us the opportunity to reflect on how well we are achieving our vision for helping adults in Devon find the support they need to stay healthy, happy and living safely and independently at home, surrounded by their community and friends, where they can retain their independence for as long as possible.

4.2 The annual report process encourages us to identify areas for improvement, and actions to deliver that improvement, which include:

- Using recently convened focus groups of service users and carers to better understand the general decline in the results of surveys of service users and carers and respond accordingly;
- Taking stock of our approach to personalisation, including the use of direct payments, to maximise their impact on outcomes and the independence of those who use them;
- Working harder with district councils and independent and voluntary sector providers to develop a better range of accommodation with care options to maintain our progress in reducing the reliance on residential and nursing care and better supporting people in their own homes;
- Improving further our approaches to modelling, forecasting and managing flow across the health and care system, including to prevent unnecessary admissions into and delayed discharges from hospital;
- Extending our successful approach to quality assurance and improvement into the unregulated care market;
- Integrating further our short-term service offer across health and care to extend its reach and maintain its effectiveness in promoting the independence of its recipients;
- Considering within the Devon Safeguarding Adults Board why concern and enquiry rates are below comparators, especially in some settings.

4.3 The annual report also enables us to celebrate some of the successes of the last year which include:

- Our Proud to Care campaign to promote careers in the health and care sector has been adopted regionally and identified as good practice nationally;
- We enjoyed further success in the Social Worker of the Year Awards, building on our recent record;
- The quality of care people receive in Devon as rated by the Care Quality Commission continues to be better than what is typical regionally and nationally;

- In the six months between June and November, by working together across the health and care system, we more than halved the number of people in Devon delayed in their transfer of care from hospital;
- We have moved up the national rankings in how the government rate local health and care systems and the outcomes they achieve for the people they serve;
- We have continued our journey towards the ever greater integration of health and care in Devon in how we commission and deliver services through new models of care;
- We have demonstrated we can support older people to live as independently as possible in their own home in their community rather than spending unnecessary time in hospital or moving into residential care prematurely.

4.4 Over the next year, we anticipate:

- The publication of a Green Paper on the future of adult social care and its funding;
- The introduction of a new approach to how we arrange and pay for residential and nursing care in Devon;
- Greater clarity on Brexit arrangements and how that might impact on our workforce;
- A local focus on how we are going to take our 'Promoting Independence' approach to working with people with disabilities on whom we now spend the larger part of our budget.

4.5 The independent facilitator of our self-assessment concluded:

- Senior managers provide strong leadership and have a good self-awareness of the how the council is performing;
- Staff are well informed and are a great asset;
- Established and effective working takes place across the system and there is an understanding that this must and will continue;
- Budget challenges persist with next year being very challenging, although the council and its adult social care function can look back to a track record of making significant budget savings while maintaining levels of service;
- Reducing delayed transfers of care in Devon is a challenge but the situation is improving; it will be vital that momentum is maintained over the winter period and beyond;
- The council needs to explore the work with district councils around accommodation with care and develop better partnerships with their planning and housing functions.

5. Adult Care and Health Priorities

Through the self-assessment process we agreed with the independent facilitator a number of priorities for 2018:

5.1 Learning Disabilities.

Explore the opportunities to input into national and regional support programmes to understand approaches to market shaping, commissioning and delivery of service that will promote independence.

5.2 Accommodation with care

Explore how collaborative working with district council partners and others could support the development of an accommodation with care strategy.

5.3 Direct Payments

Review the effectiveness of the council's Direct Payments offer and its alignment to 'Promoting Independence.'

5.4 Community Development

Seek to better understand how other areas are utilising the voluntary and community sector to support the delivery of non-commissioned services and adult social care processes e.g. prevention, care management.

Tim Golby
Head of Adult Care Commissioning and Health

[**Electoral Divisions**: All]

Cabinet Member for Adult Care and Health Services: Councillor Andrew Leadbetter

Chief Officer for Adult Care and Health: Jennie Stephens

LOCAL GOVERNMENT ACT 1972: LIST OF BACKGROUND PAPERS

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BACKGROUND PAPER DATE FILE REFERENCE

Nil

ACH/18/79
Health and Adult Care Scrutiny
25 January 2018

Performance report using data for the year ending November 2017

Joint Report of the Head of Adult Commissioning and Health (DCC) and Director Strategy (South Devon and Torbay CCG and NEW Devon CCG)

Recommendation:

1) Scrutiny note current performance issues and winter planning across the health and care system;
2) Scrutiny advise on Member input to the development of a whole system performance framework.

1. Performance commentary reflects the reported position as at November 2017 (Month 8) and focusses on a range of metrics covering acute and community hospital settings, primary care and social care selected by system leaders to give an overview of health and care in Devon. A whole system scorecard has been developed with each indicator explained in more detail within the report. Work is underway both nationally and locally to further develop performance frameworks for the whole health and care system. We invite interested Members on the Health and Adult Care Scrutiny to volunteer to participate in this.

2. Over the last 12 months closer partnership working through the Sustainability and Transformation Partnership (STP), which brings together partners from across the wider Devon health and care system has led to a number of improvements in finance and performance. This is an improving picture but with key challenges that still need addressing.

3. Progress of NHS strategic planning is monitored by the Department of Health (DoH) against a national baseline view with the rating driven by indicators in three broad areas: hospital performance (emergency, elective and safety), patient focussed change (general practice, mental health and cancer) and transformation (prevention, leadership and finance). As at July 2017, baseline performance has been ranked against 4 categories (1-4: Outstanding to Needs improvement) with Devon being among the 14 of 44 areas assessed as being in category 3 'making progress'. This is an improvement on the previous year, when part of the Devon system (NEW Devon CCG area) were one of the three success regimes, requiring additional support to make rapid improvements in financial sustainability.

4. The DoH continues to develop an Integration Dashboard, which is being used by the Care Quality Commission (CQC) to target inspections. Focus is on three main priority areas: emergency admissions, delayed transfers of care and reablement. As at December, overall Devon County Council ranks 92nd out of 150 Authorities nationally and 7th out of 16 near neighbours, which is an improvement from the July baseline when comparative rankings were 116th and 11th. This performance improvement, together with halving the number of delayed transfers of care in the period June to November 2017, now means that Devon will not be a Local Authority to receive a local system review nor is it under threat of having Better Care Fund monies withdrawn or directed.

5. Changes have been made to the way services are arranged to support our population and this demonstrates in key areas that more people are now being cared for out of hospital, fewer are admitted to hospital and when do, they stay for shorter periods of time. When they are ready to leave hospital, they do so sooner in a more timely fashion due to improved out of hospital care and rehabilitation: delayed transfer rates have halved recently in the DCC area.

6. Devon acute hospital performance in relation to urgent care is generally better than average with no providers in special measures although Plymouth Hospitals NHS Trust has remained at escalation status 3 or above in recent months due to significant operational pressures in the western system. All four Acute Trusts have seen increases in acuity compared to the same period last year, which has meant that flow across the health and care system has been more difficult. STP performance relating to urgent care 4 hour attendances (including Minor Injury Units) has declined to 86.1% (provisional December 2017) from 90.7% (November 2017). While the recent pressures on A&E departments has been experienced nationally, the Devon system continues to benchmark favourably (15th out of 44).

7. In relation to winter, early indications are that we are experiencing similar winter pressures as nationally in terms of people needing our care and how unwell they are; and services have been pressured over the new year period, but are being managed by adopting both national guidance (e.g. deprioritising elective admission and using mixed sex accommodation) and enacting winter plans. Early indication is that where enhanced out of hospital care has been implemented this has supported acute hospitals well in this period.

8. Devon's rehabilitation and reablement services remain effective at keeping people from being readmitted to hospital with Devon's performance benchmarking ahead of regional and national averages (51th/150). Although effective, the service reach (116th/150) needs to be extended and work continues with NHS providers to develop a more integrated offer for rehabilitation, reablement and recovery services with improved triage aimed at getting people out of hospital and enabling them to live independently at home.

9. The overall rating remains weighted towards Delayed Transfers of Care (DToC) given the national focus on reducing the number of patients delayed in hospital having been identified medically fit for discharge. Additional resources have been prioritised through the Better Care Fund (iBCF) with a specific focus on reducing delays within the system with a national monitoring process in place. In November (latest published data) Devon has met the NHSE target reduction for patient delays but there will be difficulties maintaining progress during the winter period.

10. On 5 December 2017, DCC received a letter jointly from the Secretaries of State for Health and Communities and Local Government, which confirmed that due to progress made in reducing delays there would be no impact on Devon's additional iBCF allocation in 2018-19.

11. National datasets from the 2016-17 annual statutory returns were published during Quarter 3. Devon's performance has been benchmarked against England, Statistical Neighbours and Regional comparators to determine our standing in the Adult Social Care Outcomes Framework including the annual statutory survey of service users and the biennial statutory survey of carers. Outcomes are reported to Health and Adult Care Scrutiny elsewhere on the agenda.

Tim Golby
Head of Adult Commissioning and Health (DCC)

Dr Sonja Manton
Director of Strategy (South Devon and Torbay CCG and NEW Devon CCG)

Electoral Divisions: ALL

Local Government Act 1972: List of Background Papers
None

Who to contact for enquiries:
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Contact: 07905 710487

Cabinet Member: Councillor Andrew Leadbetter

Whole System Scorecard - November 2017

			2016/17 Benchmarking			2017/18 Targets	2017/18 November Performance	Direction of Travel from previous report (September)				
Page	Code	Code Description	Devon Average	Comparator (CIPFA) Average	England (National) Average	2017/18 Target	November 2017 Performance	Direction of Travel from previous report (September)	East*	North*	South*	West*
1	Market Quality	Percentage of commissioned services in Devon graded by CQC as Compliant (assumes outstanding/good): NEW inspection regime	**	**	**	**85.0%**	**86.0%**	⇔	**	**	**	**
2	Assessment/ Review	Timeliness of social care assessment - new clients assessed within 28 days	**	**	**	**80.0%**	**65.6%**	⇧	69.3%	65.3%	65.6%	**
2	Assessment/ Review	Annual review - reviewable services	**	**	**	**75.0%**	**62.7%**	⇧	63.3%	50.5%	57.4%	**
3	Short-term services	Older people (65+) still at home 91 days after hospital discharge into reablement/rehab services (effectiveness of the service)	**86.8%**	**82.7%**	**82.5%**	**84.1%**	**86.8%**	⇩	81.5%	85.1%	92.5%	**
3	Short-term services	Older people (65+) still at home 91 days after hospital discharge into reablement/rehab services (offered the service)	**1.8%**	**2.1%**	**2.7%**	**2.7%**	**1.7%**	⇩	**	**	**	**
3	Short-term services	Received a short term service during the year where the sequel to the service was either no ongoing support or support of a lower level	**94.2%**	**81.8%**	**77.8%**	**88.4%**	**95.4%**	⇩	95.8%	97.1%	93.1%	**
5	Placement Rates	Long-term support needs of younger adults (18-64) met by admission to residential and nursing care homes, per 100,000 population **(Low is good)**	**11.5**	**11.7**	**12.8**	**13.2**	**14.5**	⇔	27	14	16	**
5	Placement Rates	Long-term support needs of older adults (65+) met by admission to residential and nursing care homes, per 100,000 population **(Low is good)**	**547.2**	**555.2**	**610.7**	**514.6**	**509.5**	⇩	462	213	269	**
6	Urgent Care	Urgent Care All	**	**	**	**	**90.7%**	⇧	91.7%	91.0%	92.8%	86.6%
8	Admissions	Admissions - Elective	**	**	**	**	**N/A**		7075	1922	3238	5090
8	Admissions	Admissions Non-Elective	**	**	**	**	**N/A**		3478	1837	3173	4646
9	Escalation Status	Escalation Status	**	**	**	**	**N/A**		2.05	1.76	1.68	3.15
10	Delayed Transfers of Care	DTOC (Delayed transfers of care) from hospital per 100,000 population **(Low is good)**	**23.0**	**18.1**	**14.9**	**12.5**	**20.7**	⇧	**	**	**	**
10	Delayed Transfers of Care	DTOC attributable to social care **(Low is good)**	**7.3**	**8.0**	**6.3**	**4.2**	**5.6**	⇧	**	**	**	**

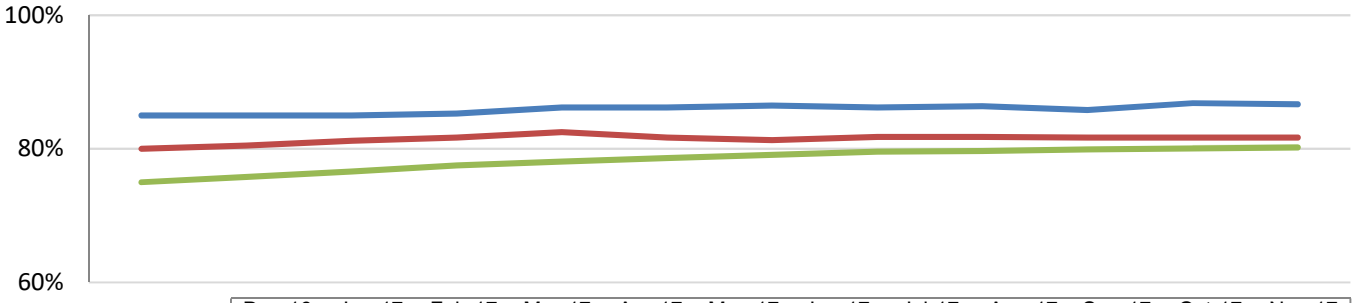
* For NHS Measures:
West = Plymouth Hospitals
East = RD&E
South = Southern Devon and Torbay
North = Northern Devon

Market Quality

Description

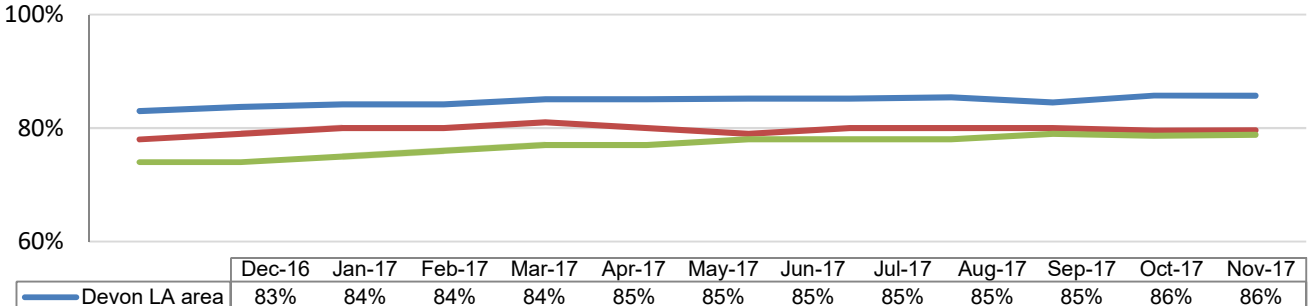
Market quality is assessed by the percentage of social care providers rated as either 'Outstanding' or 'Good' by the Care Quality Commission. Data shown is for active organisations only, not those inactive or de-registered.

Overall Outstanding or Good rating



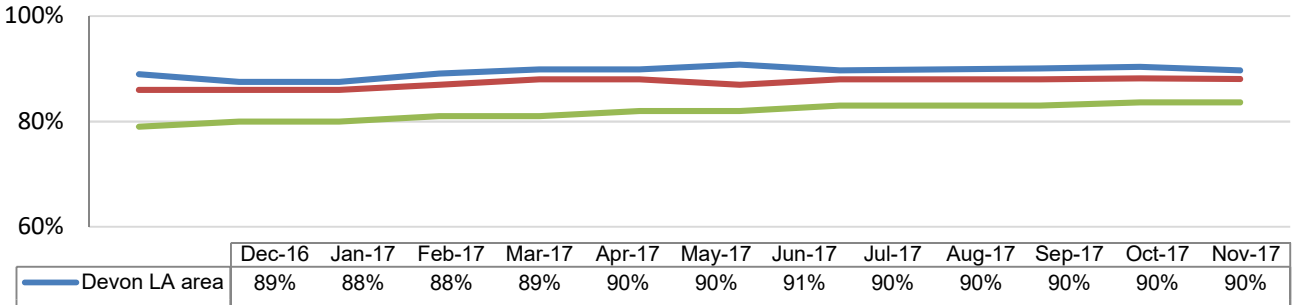
	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Devon LA area	85%	85%	85%	85%	86%	86%	87%	86%	86%	86%	87%	87%
South West	80%	81%	81%	82%	83%	82%	81%	82%	82%	82%	82%	82%
England	75%	76%	77%	78%	78%	79%	79%	80%	80%	80%	80%	80%

Residential Social Care Outstanding or Good rating



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Devon LA area	83%	84%	84%	84%	85%	85%	85%	85%	85%	85%	86%	86%
South West	78%	79%	80%	80%	81%	80%	79%	80%	80%	80%	80%	80%
England	74%	74%	75%	76%	77%	77%	78%	78%	78%	79%	79%	79%

Community Based Social Care Outstanding or Good rating



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Devon LA area	89%	88%	88%	89%	90%	90%	91%	90%	90%	90%	90%	90%
South West	86%	86%	86%	87%	88%	88%	87%	88%	88%	88%	88%	88%
England	79%	80%	80%	81%	81%	82%	82%	83%	83%	83%	84%	84%

Commentary

87% of Devon providers are rated Good or Outstanding by CQC compared with 82% regionally and 80% nationally. 90% of community based providers and 86% of residential providers are rated Good or Outstanding with the gap between these steadily closing.

Action

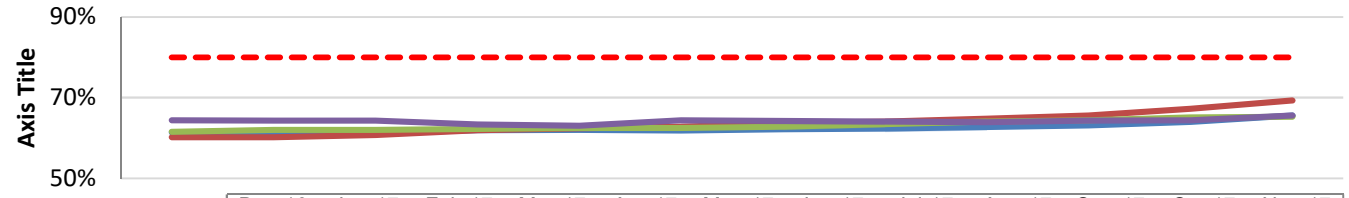
The successful approach of the Quality Assurance and Improvement Team has been extended to personal care, working with the Lead Providers under the Living Well at Home contract. The approach is intelligence-led, increasingly coordinated across the health and care system in wider Devon, and results in both positive interventions and sanctions balancing the imperatives of quality improvement and ensuring sufficiency and choice

Assessment/Review

Description

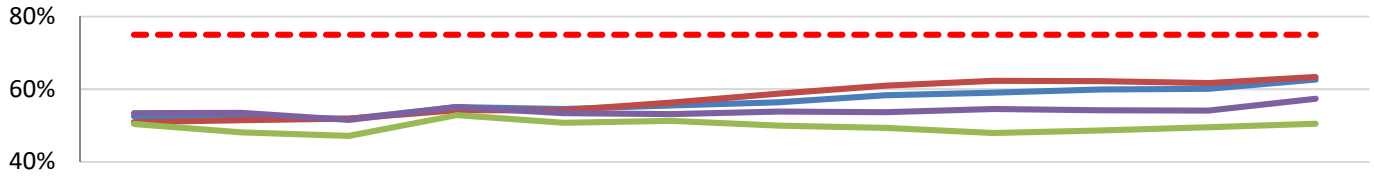
NI132 Timeliness of social care assessment (For new clients (aged 18+), the percentage from where the time from first contact to completion of assessment is less than or equal to four weeks.
L37 Annual social care review – reviewable services (The number of clients receiving reviewable services at the end of the period and who received reviewable services for over 365 days in the period. Numerator - Clients in the denominator who received a review in the 12 month period.

NI132 Assessments completed within 28 days (new clients)



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Devon	61.4%	61.2%	61.3%	61.9%	62.0%	61.9%	62.2%	62.3%	62.7%	63.1%	64.0%	65.6%
East	60.2%	60.2%	60.8%	62.0%	62.4%	62.9%	63.7%	64.1%	64.8%	65.6%	67.3%	69.3%
North	61.6%	62.1%	62.1%	62.2%	62.5%	62.5%	62.8%	63.4%	64.1%	64.4%	65.1%	65.3%
South	64.4%	64.3%	64.3%	63.4%	63.0%	64.4%	64.3%	64.1%	63.9%	64.3%	64.4%	65.6%
Devon Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%

L37 Annual review - reviewable services only



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Devon	52.6%	52.5%	51.9%	55.1%	54.6%	55.5%	56.4%	58.4%	59.1%	59.9%	60.11%	62.66%
East	51.0%	51.5%	51.9%	54.3%	54.2%	56.4%	58.8%	61.0%	62.3%	62.2%	61.7%	63.3%
North	50.4%	48.2%	47.2%	52.9%	50.8%	51.3%	50.0%	49.4%	48.0%	48.7%	49.5%	50.5%
South	53.5%	53.5%	51.6%	55.1%	53.4%	53.1%	53.9%	53.7%	54.6%	54.2%	54.1%	57.4%
Devon Target	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%

Commentary

NI132 The timeliness of assessments has been consistently below the target of 80% in Devon over the year. However, we have been successful in reducing waiting lists to their lowest level in the year, mainly through changes made in Care Direct Plus. The proportion of clients for whom all aspects of their care package were in place within 28 days consistently runs above 90%.
L37 The proportion of people receiving a review within 12 months of their last assessment or review has been consistently below 60% over the year, well below the target of 75%, but is now showing minor improvement. Productivity is broadly consistent between localities but there are variations between teams and individuals. Local managers receive monthly reports to facilitate their team and line management. There has been a 10% improvement in review performance since December 2016, which now stands at 63%.

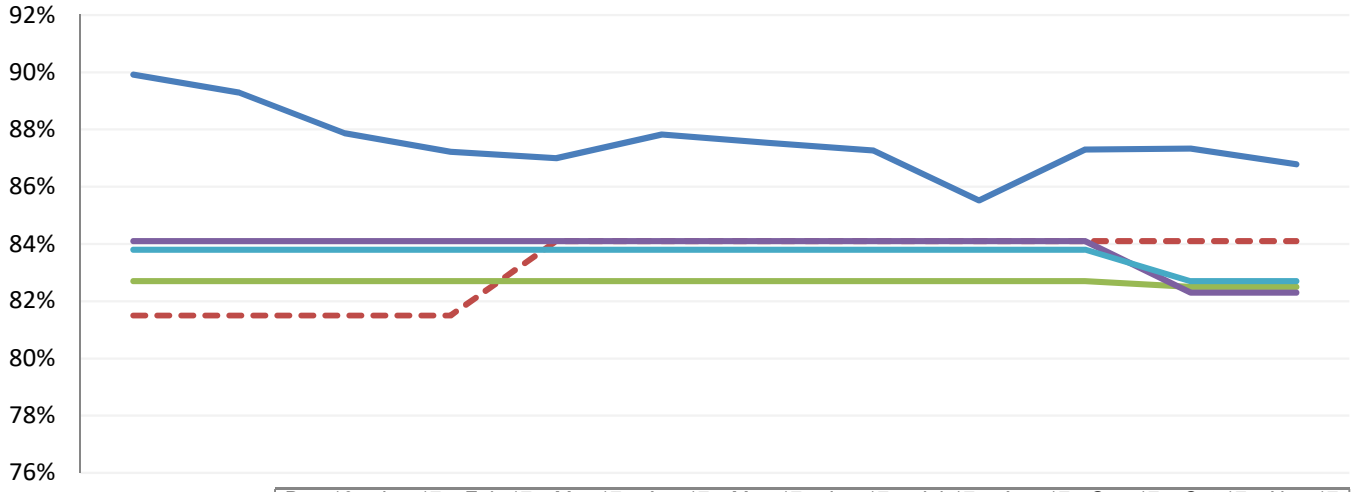
Action

NI132 Changes to our operating model have been piloted in North Devon. We are now preparing to roll out the new approach countywide. Though reduced in scale, waiting lists are managed to ensure those with most pressing needs are prioritised for assessment and service provision.
L37 We have recently bought in additional review capacity focussed on those with the potential to achieve greater levels of independence and 186 reviews were completed by this team (in July, August, September, October and November) and will feed into performance numbers over the coming months.

Description

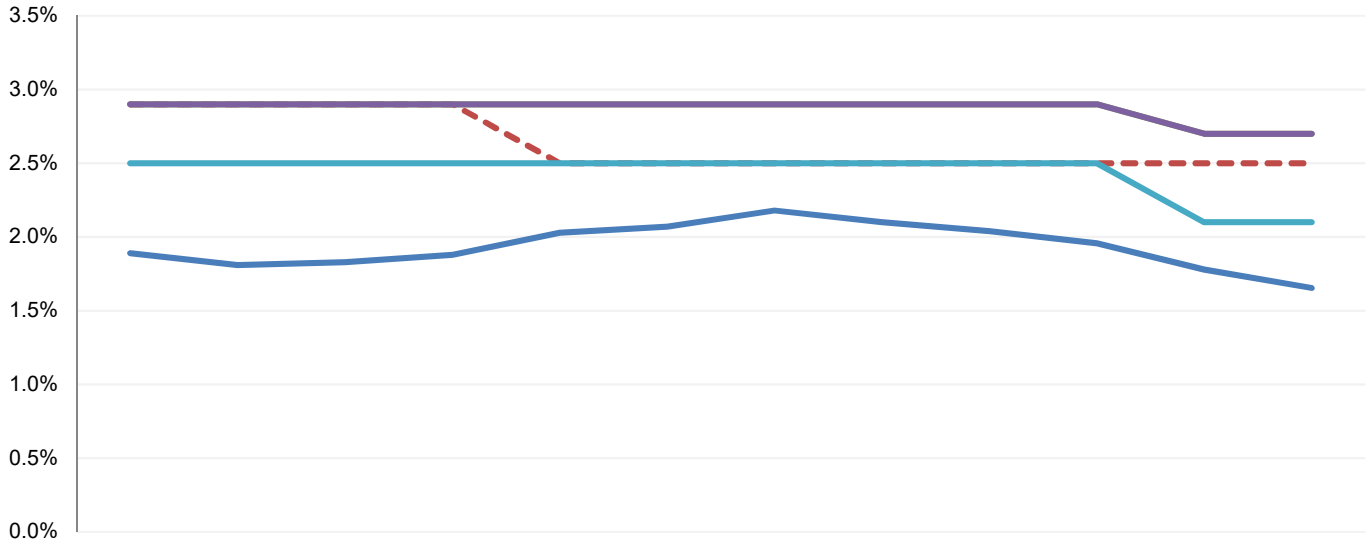
ASCOF 2B Older people (65+) still at home 91 days after hospital discharge into reablement/rehabilitation services (2B1 effectiveness of the service and 2B2 offered the service). Reablement seeks to support people and maximise their level of independence, in order to minimise their need for ongoing support and dependence on public services. Remaining living at home 91 days following discharge is the key outcome for many people using reablement services.

Effectiveness - Proportion 65+ still at home 91 days after hospital discharge into reablement/rehab



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Devon	89.9%	89.3%	87.9%	87.2%	87.0%	87.8%	87.5%	87.3%	85.5%	87.3%	87.3%	86.8%
Devon Target	81.5%	81.5%	81.5%	81.5%	84.1%	84.1%	84.1%	84.1%	84.1%	84.1%	84.1%	84.1%
England Avg	82.7%	82.7%	82.7%	82.7%	82.7%	82.7%	82.7%	82.7%	82.7%	82.7%	82.5%	82.5%
SW Avg	84.1%	84.1%	84.1%	84.1%	84.1%	84.1%	84.1%	84.1%	84.1%	84.1%	82.3%	82.3%
Comparator Avg	83.8%	83.8%	83.8%	83.8%	83.8%	83.8%	83.8%	83.8%	83.8%	83.8%	82.7%	82.7%

Coverage - Proportion 65+ offered reablement services upon discharge from hospital



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Devon	1.9%	1.8%	1.8%	1.9%	2.0%	2.1%	2.2%	2.1%	2.0%	2.0%	1.8%	1.7%
Devon Target	2.9%	2.9%	2.9%	2.9%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
England Avg	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.7%	2.7%
SW Avg	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.7%	2.7%
Comparator Avg	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.1%	2.1%

Commentary

Effectiveness – Reablement services are effective at keeping those we support from being readmitted to hospital with performance in excess of regional and national averages. We are also more effective at promoting the independence of those we support with reablement services after discharge (measured by the proportion who do not need ongoing services) than comparators.

Coverage - Our performance is on a slight upward trend but remains below comparators and target. Our current short-term service pathway means that we do not count e.g. rapid response service users in our return. We are also deploying reablement (and rapid response) capacity to ensure that those with personal care needs are met, some of whom won't be leaving hospital.

Action

Effectiveness - We currently screen in rather than screen out, with some people with more complex needs including those with dementia not being offered a reablement service even though with the right support they might benefit most. Our future arrangements will seek to support those with most potential to recover independence, not just those who need temporary support while they make a natural recovery.

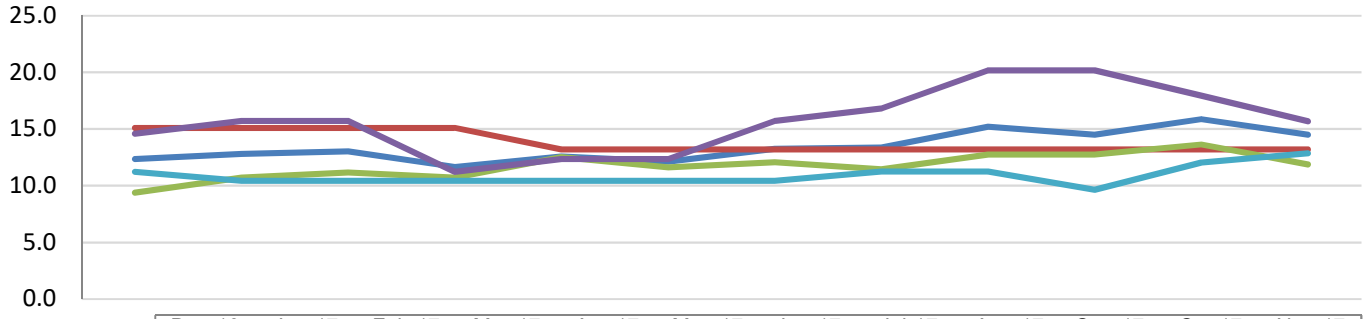
Coverage - We are reviewing our Short-Term Service (STS) offer across health and care to better integrate social care reablement with rapid response and NHS rehabilitation services to work better as a system to avoid unnecessary hospital admissions and prevent delayed transfers of care by improved discharge to assess arrangements. This should allow us to include STS not currently captured in the data as we believe we are currently under-reporting reach and over-reporting effectiveness.

Placement Rates

Description

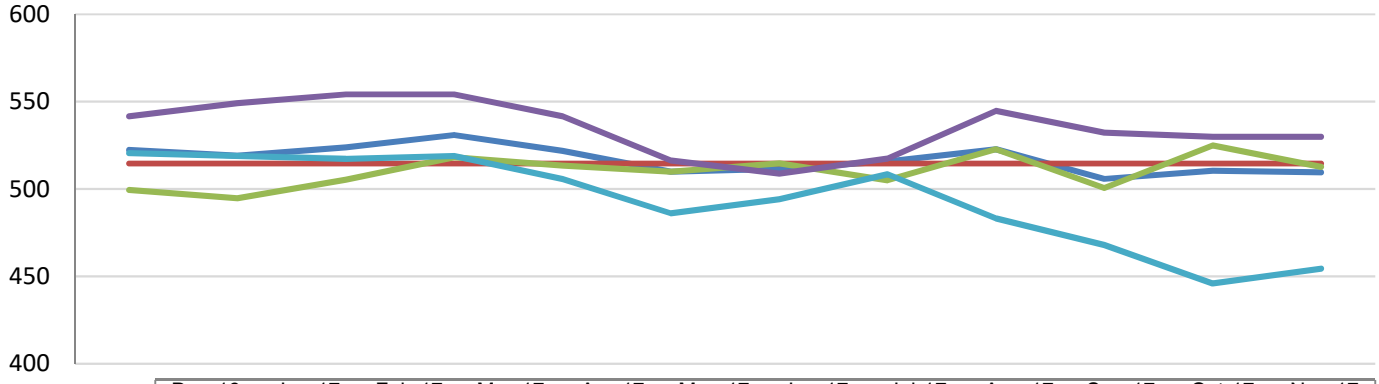
ASCOF 2A Long-term support needs of younger adults aged 18-64 (part 1) or older adults 65+ (part 2) met by local authority funded admission to residential and nursing care homes, per 100,000 population. (Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some individuals that admission to residential or nursing care homes can represent an improvement in their situation. Good performance is low.

2A(1) Residential Nursing admissions 18-64 per 100k pop.



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Devon	12.4	12.8	13.0	11.7	12.6	12.1	13.3	13.4	15.2	14.5	15.9	14.5
Target	15.1	15.1	15.1	15.1	13.2	13.2	13.2	13.2	13.2	13.2	13.2	13.2
East	9.4	10.7	11.2	10.7	12.5	11.6	12.1	11.4	12.8	12.8	13.6	11.9
North	14.6	15.7	15.7	11.2	12.4	12.4	15.7	16.8	20.2	20.2	17.9	15.7
South	11.2	10.4	10.4	10.4	10.4	10.4	10.4	11.3	11.3	9.6	12.1	12.9

2A(2) 65+ admissions to long term care per 100k pop.



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Devon	522	519	524	531	522	510	512	516	523	506	511	509
Target	515	515	515	515	515	515	515	515	515	515	515	515
East	499	495	505	518	513	510	515	505	523	501	525	513
North	542	549	554	554	542	516	509	517	545	532	530	530
South	521	519	517	519	506	486	494	508	483	468	446	454

Commentary

In Devon we have successfully reduced the proportion of older and younger adults relative to population being accommodated in residential or nursing care homes from above to below the regional and national averages by better supporting people in their own homes and also perform at or below our target level.

Action

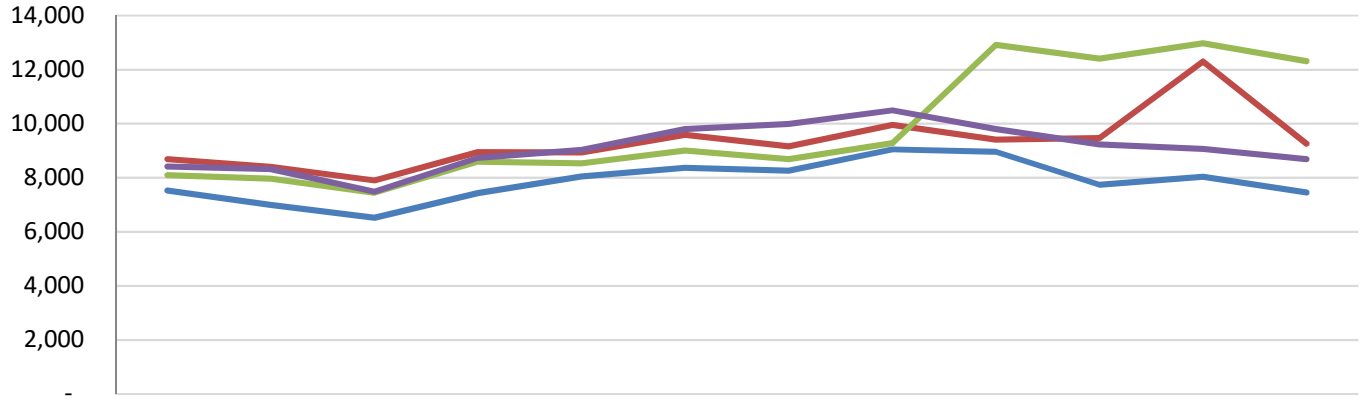
We are now focussed on developing our community based offer for those groups where we benchmark above comparators: younger adults with mental health needs, or where length of stay is longer than average e.g. older people with dementia.

Urgent Care 4 Hour Target Performance

Description

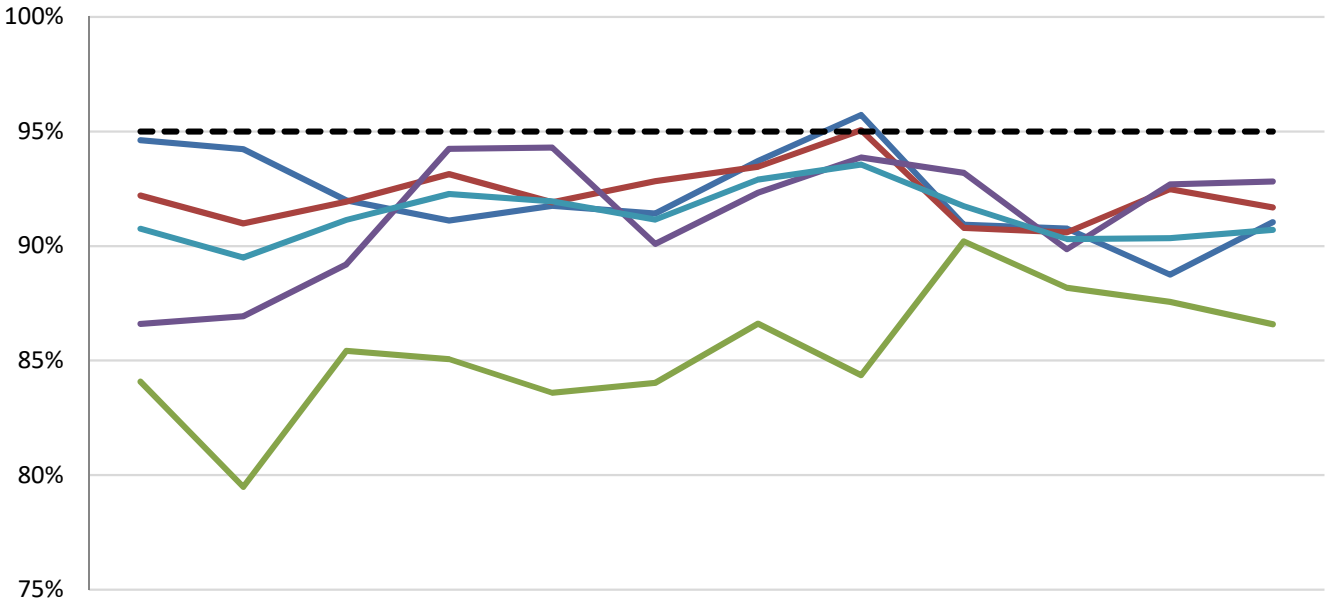
All Type performance – this is the total number of patients that are treated and discharged or have a decision to admit within 4 hours at an Emergency Department, Minor Injuries Unit, Walk in Centre, or Minor Injuries Service.

Urgent care 4 hour attendances (All)



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Northern Devon	7,524	6,990	6,520	7,432	8,049	8,370	8,265	9,050	8,962	7,741	8,035	7,462
Royal Devon and Exeter	8,689	8,400	7,902	8,952	8,940	9,589	9,165	9,953	9,411	9,468	12,304	9,255
Plymouth Hospitals	8,102	7,964	7,446	8,595	8,537	9,007	8,693	9,286	12,921	12,415	12,977	12,317
Southern Devon and Torbay	8,419	8,323	7,487	8,737	9,030	9,799	9,989	10,494	9,806	9,230	9,073	8,694

Urgent Care - Performance



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Northern	95%	94%	92%	91%	92%	91%	94%	96%	91%	91%	89%	91%
Eastern	92%	91%	92%	93%	92%	93%	93%	95%	91%	91%	92%	92%
Western	84%	79%	85%	85%	84%	84%	87%	84%	90%	88%	88%	87%
Southern	87%	87%	89%	94%	94%	90%	92%	94%	93%	90%	93%	93%
STP Overall	91%	89%	91%	92%	92%	91%	93%	94%	92%	90%	90%	91%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Commentary

The information above shows performance against the four hour target A&E target in each of the 4 acute hospitals within Devon. The target performance level is 95%, although each of the Trusts has their own trajectory to hit this target by the end of March 2018. In addition to performance in acute hospitals, where a provider also delivers minor injuries services in a community setting they are able to count this activity within the overall performance metric.

The latest (November) overall position for the four systems is:

Northern = 91% Eastern = 92% Western = 87% Southern = 93%

Performance in Devon has fallen slightly in 2017/18 compared with the previous year but remains above the national average (90%). Whilst performance in Eastern and Southern Devon has remained relatively good when compared to improvement trajectories and the national position, Northern Devon has seen a sustained reduction in performance and the Western system continues to see urgent care pressure affecting the 4-hour target.

All four Trusts have seen an increase in A&E attendances and emergency admissions compared to the same period last year, and also an increase in acuity. This increase in volume and acuity has meant that flow across the health and social care system has been more difficult resulting in lower performance within A&E departments.

Action

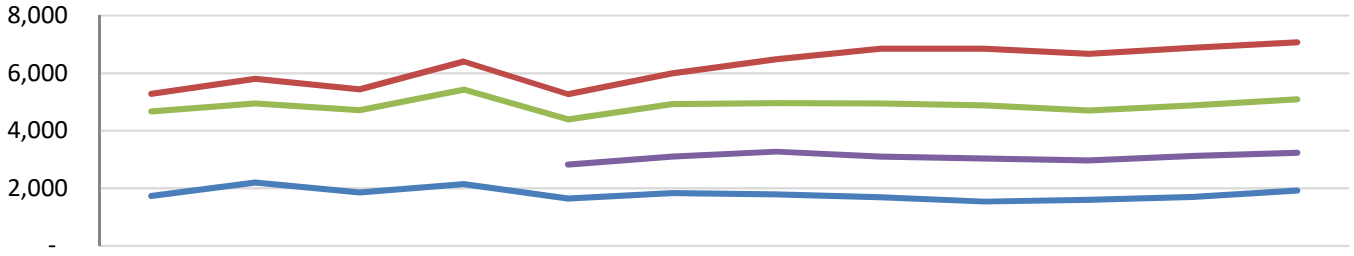
A&E performance is a measure of how the whole system is operating due to its reliance on flow throughout the hospital to admit patients which is then reliant on the effectiveness of community services to receive patients from the acute hospital. Each of the four health and social care systems has a detailed plan in place to address acute and community pressures which will lead to an overall increase in performance. Each A&E team also has a specific action plan to ensure that processes are improved and monitored within the Department.

Admissions - Elective and Non-elective

Description

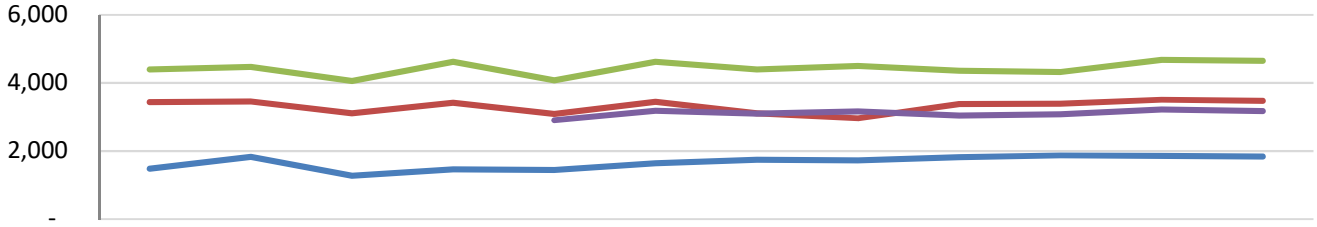
Elective Admissions – this is the number of patients who are attending hospital for a planned episode of care (i.e. a known operation)
Non-Elective Admissions – this is the number of patients who attend hospital in an unplanned manner. This is usually via the Emergency Department or Medical Assessment Unit (MAU)

Elective admissions



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
NDHT	1,738	2,203	1,857	2,147	1,647	1,834	1,789	1,692	1,541	1,606	1,700	1,922
RD&E	5,284	5,811	5,444	6,411	5,272	5,990	6,480	6,848	6,846	6,673	6,885	7,075
PHT	4,666	4,954	4,720	5,429	4,394	4,929	4,964	4,951	4,883	4,704	4,886	5,090
SD&T					2,828	3,099	3,275	3,101	3,040	2,975	3,131	3,238

Emergency non elective admissions



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
NDHT	1,478	1,825	1,274	1,461	1,447	1,638	1,743	1,722	1,823	1,871	1,854	1,837
RD&E	3,436	3,454	3,106	3,418	3,093	3,442	3,109	2,961	3,383	3,390	3,507	3,478
PHT	4,400	4,475	4,056	4,626	4,078	4,622	4,392	4,501	4,360	4,321	4,678	4,646
SD&T					2,907	3,179	3,100	3,167	3,043	3,081	3,224	3,173

Commentary

The average daily level of non-elective admissions has increased during 2017/18. This is reflective of the higher level of activity and acuity that the system has experienced, which has increased during quarter three.

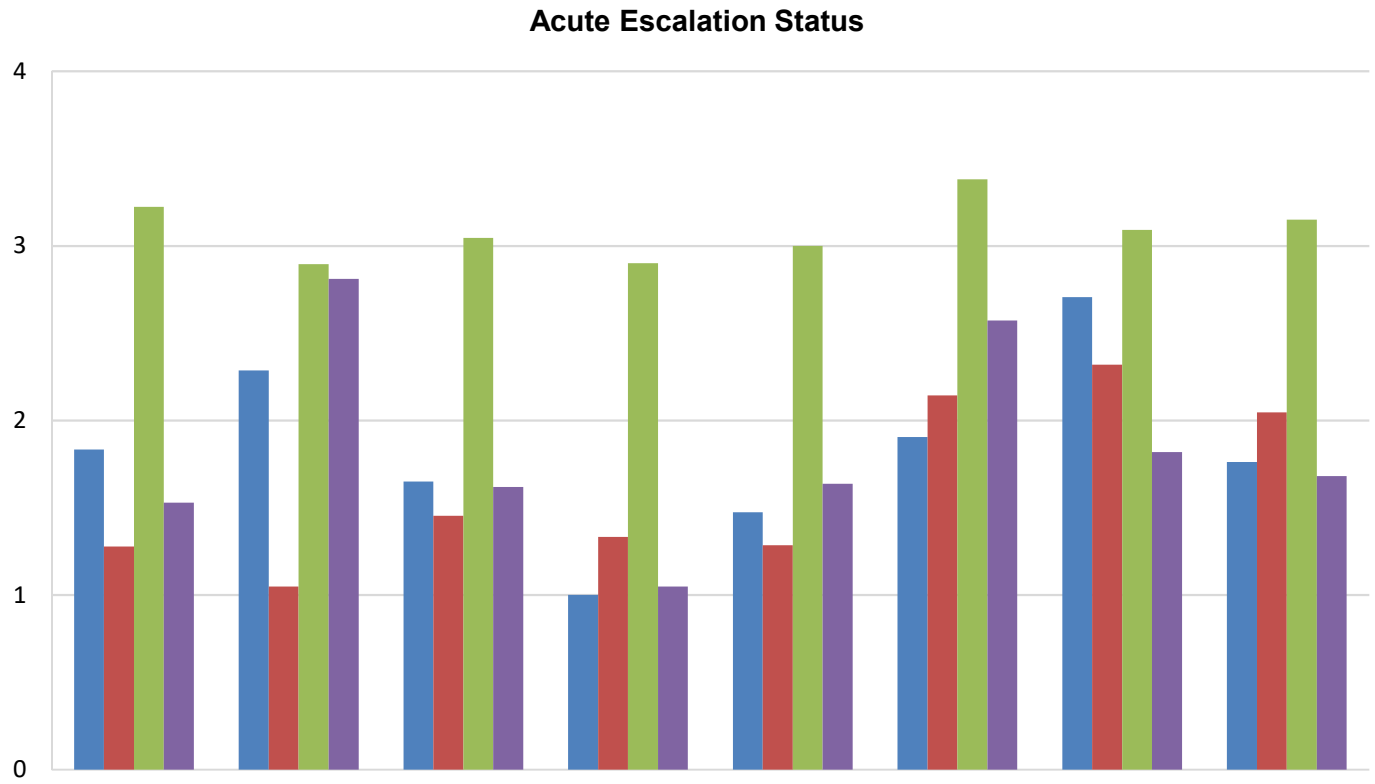
Elective admissions are lower than planned partly due to the focus on supporting urgent care pressures. This is likely to continue during quarter four as elective operations are reduced to ensure capacity is available for emergency admissions and to ensure flow is maintained through hospitals.

Action

Management of non-elective admissions is covered within the A&E Delivery Plan referenced above and includes actions to avoid admission to hospital and enable patients to better manage their conditions in the community, preferably in their own home. The STP has robust referral management processes to ensure that patients receive only the care that they require.

Description

The Operational Performance and Escalation Level (OPEL) is set by each provider on a daily basis between 1 (no escalation) and 4 (full escalation).



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
NDHT	1.83	2.29	1.65	1.00	1.47	1.90	2.71	1.76
RD&E	1.28	1.05	1.45	1.33	1.29	2.14	2.32	2.05
PHT	3.22	2.89	3.05	2.90	3.00	3.38	3.09	3.15
SD&T	1.53	2.81	1.62	1.05	1.64	2.57	1.82	1.68

Commentary

The level of pressure within the healthcare system is measured using OPEL: Operational Performance and Escalation Level. This grades organisations from Level 1 (not escalated) to Level 4 (fully escalated) according to a set of criteria. These include the level of bed occupancy and operational performance. The table and chart above show the average daily OPEL score for each of the four acute Trusts within Devon.

The average OPEL level typically increases for providers as we progress through the year, with highest levels experienced during winter months. This pattern is evident this year, with all four acute providers seeing periods of Opel 3 in December and, in some cases, escalation to Opel 4.

Increases in the OPEL level have been caused by pressure on hospital beds and increased volumes of patients within hospitals. Flow has been made difficult by the acuity of patients and pressure on community services to take patients. Derriford Hospital continues to be escalated to OPEL3 or OPEL 4 every day due to significant operational pressures in the Western Devon system.

Action

The overall management of escalation is driven by the delivery of the wider system plan.

The CCG has agreed a consistent set of escalation metrics across the four acute providers which will be used to manage escalation processes this year and ensure that the declarations made are consistent.

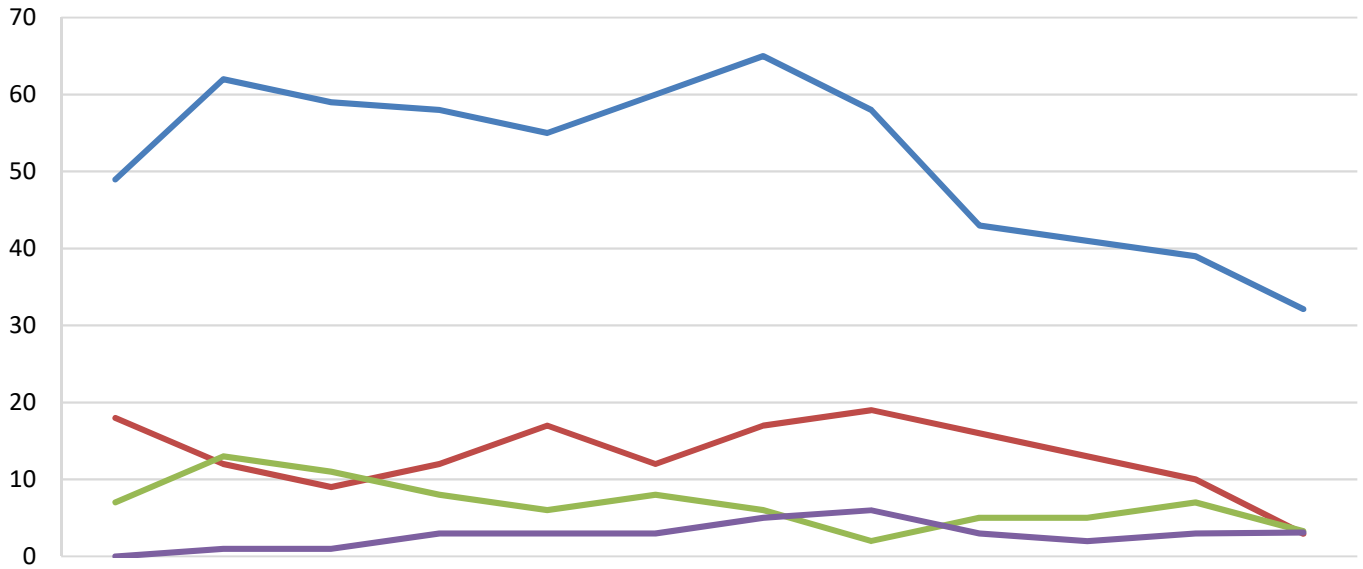
A&E Delivery Boards review progress against plans to improve system flow, whilst in Western Devon a System Improvement Board (SIB) is focused on the specific issues that are affecting that community, including gaps in primary care capacity.

Delayed Transfers of Care

Description

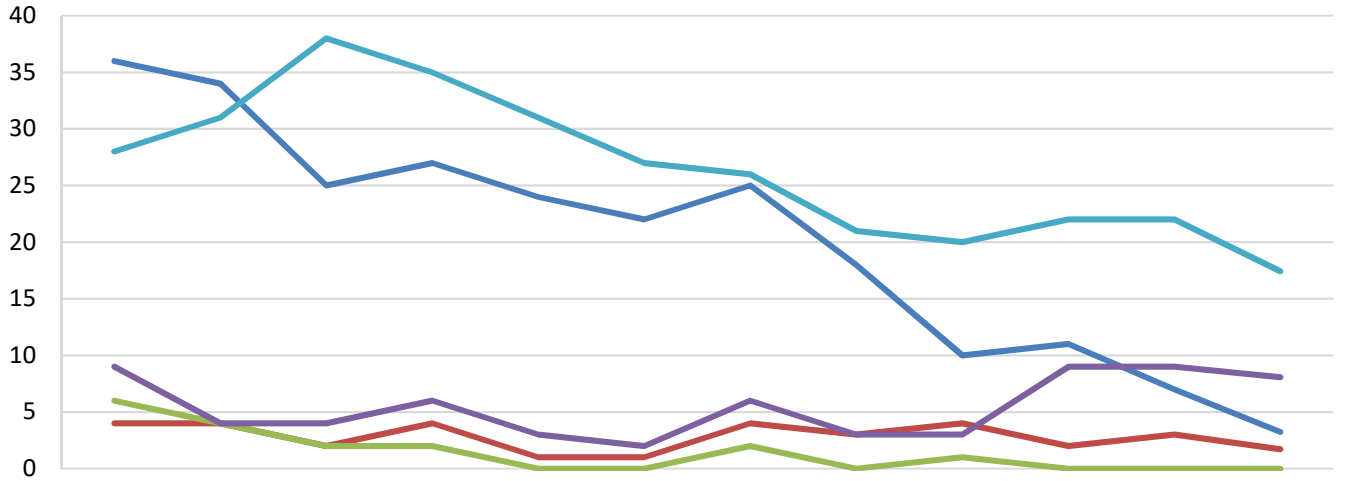
A delayed transfer of care occurs when a patient is medically fit for discharge from acute or non-acute care and is still occupying a bed.
This indicates the ability of the whole system to ensure appropriate transfer from hospital for all adults. Minimising delayed transfers of care and enabling people to live independently at home is one of the key objectives of the health and care system with national monitoring.

Average daily number of bed days lost to delayed transfers by acute provider



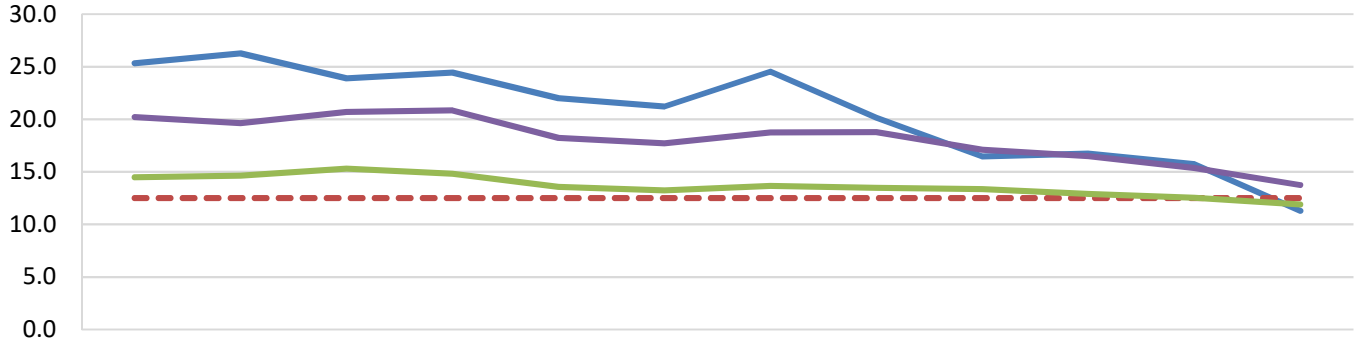
	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
RD&E	49	62	59	58	55	60	65	58	43	41	39	32
NDHT	18	12	9	12	17	12	17	19	16	13	10	3
PHT	7	13	11	8	6	8	6	2	5	5	7	3
T&SD	0	1	1	3	3	3	5	6	3	2	3	3

Average daily number of bed days lost to delayed transfers by non acute provider



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
RD&E	36	34	25	27	24	22	25	18	10	11	7	3
NDHT	4	4	2	4	1	1	4	3	4	2	3	2
PHT	6	4	2	2	0	0	2	0	1	0	0	0
T&SD	9	4	4	6	3	2	6	3	3	9	9	8
DPT	28	31	38	35	31	27	26	21	20	22	22	17

Monthly rate of bed day delays per 100k of population



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Devon	25.3	26.3	23.9	24.4	22.0	21.2	24.5	20.2	16.5	16.7	15.7	11.3
Devon Target	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5
England Avg	14.5	14.7	15.3	14.8	13.6	13.2	13.6	13.5	13.4	12.9	12.5	11.9
SW Avg	20.2	19.6	20.7	20.8	18.2	17.7	18.8	18.8	17.1	16.5	15.4	13.7

Commentary

The top 3 reasons for delay (all sources): Awaiting further non-acute NHS care (22%), Completion of assessment (19%), Care package in own home (17%)

In November 2017, 72% delays are attributable to NHS, 17% to Social Care and 11% to Both. Nationally, the split is 58%, 34% and 8%

Devon County Council ranks 93 out of 151 for the monthly rate of all delays. DCC rank 61 when only considering delays attributable to Social Care.

In the 12 months to November 2017 RD&E accounted for 69% of acute delays (55% of all delays). DPT accounted for 46% of non-acute delays (20% of all delays).

Action

We have agreed a system wide action plan to reduce DToC, developed with providers and commissioners from both health and social care, including mental health. This includes the following underlying principles:

1. Embed a cultural approach to delayed transfers which addresses two key issues:
   - o. home should be the discharge location of choice, and
   - o. that there should be a zero tolerance to delay.
2. Ensure that the best practice High Impact Changes are achieved in each community.

We have gathered learning from elsewhere, including visiting areas with good DToC performance, as well as taking the learning from a DToC peer review in the Eastern locality. The peer review team came from NHSE, NHSI and the LGA and observations included:

- Since the integration of community and acute services the system wide level of DToC has fallen
- Early stages of integration are promising
- Robust plans for the future about doing the right thing by people which will also drive out improvements in performance
- System commitment to not compromising the long term outcome by rushing to make short term changes

We have also conducted self-assessments against the High Impact Changes in each locality, and will use this to help measure the success of our BCF DToC plans.

Projects to help reduce DToC include:

- Development of an enhanced community response
- Increased capacity within social care reablement
- Development of a Trusted Assessor model
- Review and improve the CHC assessment pathway in the community
- Care Home education
- Increased market sufficiency

The future of services and buildings in community Hospitals – implementation update and NHS Property Services

Overview

This is to provide an update on the future of services and the 12 community hospital buildings involved in the 2016 transfer of ownership from Northern Devon Healthcare Trust to NHS Property Services.

This report is provided jointly by NHS Northern, Eastern and Western Devon CCG (NEW Devon CCG) and NHS Property Services.

Update on the transfer of ownership

Background information on the transfer of the hospitals can be found in Appendices 1-4, which contain the written information previously submitted to the committee, correct at the time of writing.

In 2016, NEW Devon CCG awarded its contract to provide clinical community services in the eastern locality of Devon to the Royal Devon and Exeter NHS Foundation Trust (RDEFT).

As part of this process, the Department of Health decided that ownership of the 12 hospitals where the majority of these services are provided would be transferred to NHS Property Services from the previous healthcare provider, Northern Devon Healthcare Trust (NDHT).

The properties involved in the transfer were: Axminster Community Hospital, Honiton Hospital, Tiverton Hospital, Seaton Community Hospital, Budleigh Salterton Community Hospital, Exmouth Community Hospital, Sidmouth Hospital, Ottery St Mary Community Hospital, Crediton Hospital, Moretonhampstead Hospital, Okehampton Hospital and Whipton Hospital.

The transfer of the 11 hospitals owned on a freehold basis – all the above except Tiverton – completed on 1 December 2016. The transfer of the Private Finance Initiative (PFI) leasehold interest for Tiverton Hospital is expected to complete imminently.

This process means NHS Property Services has become the landlord of the properties and therefore ownership remains in the NHS.

NHS Property Services is wholly owned by the Secretary of State for Health and any funds generated are reinvested back into our National Health Service to help improve the estate and support frontline patient care.

Facilities management (FM) services

Services known as ‘soft FM’ (eg cleaning, portering) are provided by RDEFT while ‘hard FM’ (buildings maintenance) is provided by NHS Property Services using a number of contracted suppliers.

Future service provision and use of the buildings

The NHS in Devon is moving towards a model of care that focuses on community and home-based services – similar to that offered by Devon County Council.

In 2017, NEW Devon CCG made a decision to reduce inpatient beds in Community Hospitals in Eastern Devon by 71, from 143 to 72. By directing this 'bed-based' investment towards home-based and community care when individuals are well enough to be out of hospital, the support and workforce would be better placed to help people remain at home or return to their homes, and the right care, to be as independent as possible.

Those remaining beds in community hospitals were to be used for intensive rehabilitation, shortening length of stay and ensuring people are able to regain their independence as quickly as possible.

The community hospital sites affected by these changes were Honiton, Seaton, Exeter and Okehampton. and there are 72 beds remaining in Tiverton, Sidmouth, and Exmouth. The RD&E and the CCG have been closely monitoring the impact and outcomes of these changes and that peoples' needs are being met in a safe and timely way.

As part of the NHS family, the role of NHS Property Services is to work with commissioners to meet their healthcare estates requirements.

The type of healthcare estate needed depends on the type of services that are being provided and the way in which they are delivered.

Deciding what type of services to provide and how to provide them is the responsibility of healthcare commissioners – CCGs and NHS England. Healthcare providers, the organisations chosen by commissioners to deliver that healthcare, can also play a role in the process.

In addition to owning the properties, NHS Property Services provides professional estates services and information to colleagues at local CCGs and providers to help them develop their plans.

The CCG is working with partners in health and care to assess how new and emerging models of care can continue to meet the needs of the population and the implications that this has for the way in which services are configured and delivered. The implications for all resources and current service provision can then be assessed, including the need for space in buildings and facilities. This will allow the CCG to take a view on what space is required in the future and how this can be best accommodated in local communities.

In terms of future plans for the buildings, NHS Property Services will continue to hold them as facilities for local healthcare as long the CCG says they are needed. NHS Property Services only disposes of properties that have been declared surplus to NHS requirements by commissioners and none of these buildings has been declared surplus.

Market Rent

In April 2016, NHS Property Services moved to market rent charging, which was introduced to help improve understanding of the true cost of occupation. It is only by knowing these costs that they can be addressed.

The move to market rents is consistent with initiatives being introduced more widely across central government to improve utilisation and value for money in property occupancy.

The market rent model offers benefits for our customers and the NHS – including:

1. It helps the NHS understand the true cost of occupation and reflect these transparently.
2. It informs decisions about the best location for services and investment.
3. It drives better and more efficient use of space.

CCGs receive a corresponding uplift in their funding from NHS England to cover any increase in rental levels arising from the introduction of market rent.

Community contributions

Funding for projects from community groups or Leagues of Friends has always been voluntary and remains so, regardless of who owns the building. Projects funded by Leagues of Friends are generally to provide enhancements above and beyond the basic building requirements that NHS Property Services provides as landlord.

Items of equipment funded by community donations are generally owned by NHS healthcare providers, as opposed to NHS Property Services.

Community donations towards buildings or equipment are always hugely appreciated by the NHS, but the buildings or equipment remain in the ownership of the NHS (whether this is an NHS Trust, NHS Foundation Trust or NHS Property Services).

It is important to remember that over time, patients and the community release value from donations by benefiting from the use of the building or equipment supported by the donation, but the donation does not in itself provide rights of ownership. It is also important to remember that the NHS generally meets the on-going costs – including insurance, cleaning and maintenance – associated with a building or piece of equipment and that buildings and equipment have a limited lifespan.

NHS Property Services is always happy to work with local communities to consider local circumstances in specific cases.

Investment

NHS Property Services has begun a programme of investment in the properties that transferred and continues work on its wider Devon estate. NHSPS will continue to work with the CCGs and provider organisations to prioritise work to ensure investment supports commissioning plans and taxpayers' money is spent wisely.

Work carried out so far includes a £123,000 project to address external backlog maintenance issues at Budleigh Salterton Community Hospital, which contributed towards the opening of the Budleigh Health Hub in autumn last year.

List of Appendices

- **Appendix 1** – Report to the committee prior to NEW Devon CCG and NHSPS attendance at the meeting of 19 September 2016.
- **Appendix 2** – Information submitted to the committee in response to questions arising further to NHSPS and CCG attendance at the meeting of 19 September 2016.
- **Appendix 3** – Responses to questions submitted to the committee meeting of 19 January 2017.
- **Appendix 4** – Responses to questions arising further to New Devon CCG and NHSPS attendance at a briefing session for members held on 20 June 2016.

Note: Appendices are correct at the time of writing.

Appendix 1 – Report to the committee prior to NEW Devon CCG and NHSPS attendance at the meeting of 19 September 2016:

Overview

This paper is to provide general information about NHS Property Services.

It also includes details regarding the transfer of 12 community hospitals to NHS Property Services as part of NHS Northern, Eastern and Western Devon Clinical Commissioning Group's plans to award its contract for community services to the Royal Devon and Exeter NHS Foundation Trust (RDEFT) for the Eastern locality of Devon.

This information is provided further to a briefing given to members of the committee at County Hall in Exeter on 20 June, 2016.

About NHS Property Services

NHS Property Services manages, maintains and improves NHS properties and facilities, working in partnership with NHS organisations to create safe, efficient, sustainable and modern healthcare and working environments.

NHS Property Services is a limited company created as part of the 2013 health reforms and wholly owned by the Secretary of State for Health. It is responsible for managing 3,500 NHS properties, worth an estimated £3 billion. The portfolio covers around 10 per cent of the NHS estate in England and was inherited from the 161 Primary Care Trusts and Strategic Health Authorities which were abolished as part of the 2013 health reforms. It comprises mostly clinical premises such as health centres, GP practices and community hospitals but also includes office buildings.

The company aims to drive efficiency in order to offer occupiers, tenants and customers reduced costs in running properties and related services.

In 2015/16, core operating costs were reduced by more than £30 million and over the last two years, operating costs have been reduced by £84.6 million.

Every pound saved by the company is returned to the NHS.

NHS Property Services has two main roles:

- Strategic estates management – acting as a landlord, modernising facilities, buying new facilities and selling facilities the NHS no longer needs.
- Dedicated provider of support services such as cleaning and catering.

Transfer of 12 Community Hospitals in Eastern Devon

NHS Northern, Eastern and Western Devon Clinical Commissioning Group (NEW Devon CCG) has set out plans to award its contract for community services to the Royal Devon and Exeter NHS Foundation Trust (RDEFT) for the Eastern locality of Devon.

As part of this process, the Department of Health decided that 12 properties will be transferred to NHS Property Services from the ownership of the existing healthcare provider, Northern Devon Healthcare Trust (NDHT).

The properties transferring are: Axminster Community Hospital, Honiton Hospital, Tiverton Hospital, Seaton Community Hospital, Budleigh Salterton Community Hospital, Exmouth Community Hospital, Sidmouth Hospital, Ottery St Mary Community Hospital, Crediton Hospital, Moretonhampstead Hospital, Okehampton Hospital and Whipton Hospital.

As part of the NHS family, the role of NHS Property Services is to work with commissioners to meet their healthcare estates requirements.

NHS Property Services will therefore provide professional estates services to colleagues at NEW Devon CCG to help them develop their commissioning plans for the hospitals involved in the transfer, but it is important to be clear that decisions about service provision in these buildings, and their futures, rest with the CCG.

NHS Property Services can only act on the wishes of commissioners (i.e. CCGs and NHS England) if they declare a site surplus to NHS requirements.

The transfer of community services is due to take place on 1 October 2016

The transfer of the ownership of community hospitals is due to take place on 1 December 2016.

Property managers are currently finalising a due diligence exercise as part of the transfer process and are working closely with NHS partners to agree leases with occupiers.

This process will see NHS Property Services become the landlord of the properties and therefore ownership remains in the NHS.

Community involvement

Many communities and Friends groups have raised vital funds for their local hospital and this is always hugely appreciated by the NHS and patients.

However, the buildings themselves are owned by the NHS (whether this is an NHS Trust, NHS Foundation Trust or NHS Property Services) and charitable donations raised by leagues of friends and other groups are gifted to the NHS for a specific purpose. Patients and the community benefit from this specific purpose but the donation does not in itself provide rights of ownership.

NHS Property Services has about 270 hospital related properties nationwide and property and facilities teams work with NHS partners, local people, councils, charities and friends groups – and the organisation will work to achieve the same in eastern Devon.

Health hubs

When the NHS requirements for each of the buildings involved in the transfer are confirmed, NHS Property Services will be able to consider the options available for working with other prospective tenants locally.

Market-based charging

At the start of the current financial year, NHS Property Services moved to market-based rental charging on all freehold properties, which has been agreed with the Department of Health and NHS England.

The market rent model applies the property sector's standard method of charging and is a long-planned part of a move across the public sector to improve utilisation and value for money in property occupancy by putting publicly owned property on a level with privately owned alternatives.

The change has benefits for the NHS:

- It helps the NHS understand the true cost of occupation and reflect these transparently.
- It informs decisions about the best location for services and investment.
- It drives better and more efficient use of space.

The Department of Health has committed to meeting any increased property costs in the 2016/17 financial year arising from the introduction of market rent. Arrangements in relation to funding adjustments for 2017/18 and beyond will be considered by the Department of Health in conjunction with NHS England and NHS Improvement.

Charging market rents will provide the money needed for the ongoing renewal of the estate to the high standards that people rightly expect and NHS Property Services does not make a profit from its involvement. Any surplus funds are reinvested into NHS services.

The estimated annual rental value for all 12 hospitals is approximately £3.1million. This is based on 100% occupation at market rent.

Investment in the health estate

Projects to keep our buildings statutorily and lease compliant and in a good state of repair, are carried out by NHS Property Services in line with our obligations as a landlord.

Larger schemes, typically major multi-million pound projects, such as new buildings, extensions and major refurbishments, are requested by our customers. Up-front funding is normally provided by NHS Property Services, but in some cases we work with third-party development partners. These capital projects are led by commissioners and, if approved, delivered by NHS Property Services.

By way of local example, NHS Property Services has recently completed a £4.2 million refurbishment of two wards at the Glenbourne Unit in Plymouth.

Nationally, NHS Property Services invested £55.4 million through the capital programme in 2015/16 to improve the property portfolio. Of this, £21.1 million related to new or refurbished buildings requested by customers within the NHS, and £34.3 million related to ensuring the estate managed by NHS Property Services is safe, warm, secure, and operates efficiently.

Further information

More details about NHS Property Services are available on the organisation's website, www.property.nhs.uk

Appendix 2 – Information submitted to the committee in response to questions arising further to NHSPS and CCG attendance at the meeting of 19 September 2016:

1. Properties in the Devon area where NHS Property Services has a freehold or leasehold interest.

The freehold ownership of the following hospitals is transferring to NHS Property Services (NHSPS) from Northern Devon Healthcare Trust (NDHT) on 1 December 2016: Axminster Community Hospital, Honiton Hospital, Seaton Community Hospital, Budleigh Salterton Community Hospital, Exmouth Community Hospital, Sidmouth Hospital, Ottery St Mary Community Hospital, Crediton Hospital, Moretonhampstead Hospital, Okehampton Hospital and Whipton Hospital. The leasehold of Tiverton Hospital (PFI), is also transferring to NHSPS from NDHT on the same date.

The transfer occurs because NEW Devon CCG has awarded the service provision contract in the hospitals to a new provider, changing from NDHT to Royal Devon and Exeter Foundation Trust (RDE). The decision to transfer the hospitals to NHSPS was made by the Department of Health.

Other properties in Devon (not including Plymouth City Council area) where NHS Property Services has a freehold or leasehold interest:

Property	NHS PS Tenure	Street	Town
Tavyside Health Centre (part)	Leasehold	The Quay Centre, Abbey Rise	Tavistock
St Leonards Practice (part)	Leasehold	Athelstan Road	Exeter

Westexe Children's Centre (part)	Leasehold	Cowick Street	Exeter
Withycombe Centre	Freehold	Withycombe Centre	Exmouth
Stowford Rise Community Centre (part)	Leasehold		Sidmouth
Blackmore Health Centre	Freehold	Blackmore Drive	Sidmouth
Blackmore Health Centre (Car park adjacent)	Leasehold	Blackmore Drive	Sidmouth
Raleigh Building, Express Diagnostics	Leasehold	Research Way	Derriford, Plymouth
Pomona House	Leasehold	Oak View Close	Torquay
9 New North Road (The Clocktower Surgery)	Leasehold	New North Road	Exeter
Lescaze Offices (part)	Leasehold	Shinners Bridge	Dartington, Totnes
Larkby Evergreen Matford Lodge & Coach House	Leasehold	Victoria Road Park	Exeter
Ilfracombe Police Station (part)	Leasehold	Princess Avenue	Ilfracombe
Unit 1 Exeter International Office Park	Leasehold	Exeter International Office Park, Exeter Airport	Clyst Honiton, Exeter
Crown Yealm House (part)	Leasehold	Pathfields Business Park	South Molton
County Hall (part)	Leasehold	Topsham Road	Exeter
Chestnut Avenue Family Centre (part)	Leasehold	Magnolia Avenue	Exeter
Buckfastleigh Health Centre (part)	Leasehold	Bossell Road	Buckfastleigh
Brunel Dental Centre	Leasehold	Brunel Road	Newton Abbot
12 Boutport Street (part)	Leasehold	Boutport Street	Barnstaple

Bluecoats Children's Centre (part)	Leasehold	Borough Road, Burwood	Torrington
Bideford Hospital (part)	Leasehold	Abbotsham Road	Bideford
Unit 2, Bay House	Leasehold	Riviera Park, Nicholson Road	Torquay
Barnstaple Health Centre (part)	Leasehold		Barnstaple
Trelawney Clinic	Freehold	Ham Drive	Plymouth
The Quay	Leasehold	Plymouth Road	Tavistock
Unit 3, The Hayloft	Leasehold	Puslinch, Yealmpton	Plymouth
The Byre	Leasehold	Puslinch, Yealmpton	Plymouth
Syrena House	Freehold	284 Dean Cross Road, Plymstock	Plymouth
St Olafs Chapel (Car Park)	Leasehold	Puslinch, Yealmpton	Plymouth
Plymstock Clinic	Freehold	Plymstock Clinic	Plymouth
Plympton Clinic	Freehold	Plympton Clinic	Plymouth
Pinewood Ward - Plympton Hospital	Freehold	Pinewood Ward - Plympton Hospital	Plymouth
Meadowpark Health Centre	Freehold	Meadowpark	Exeter
Lee Mill	Freehold	Lee Mill Unit	Ivybridge
Hillcrest	Freehold	Hillcrest	Honiton
Foxhayes Practice	Freehold	Civil Service Car Park	Exeter
Culm Valley Integrated Centre For Health	Leasehold	Willand Road	Cullompton
Colyton Health Centre	Freehold	Colyton Health Centre	Colyton
Bull Meadow Clinic	Freehold	Bull Meadow Clinic	Exeter
Barnes Greenways Bungalow Belmont Hospital	Freehold	Barnes/Greenway Bungalow	Tiverton

The properties in the table are not involved in the above transfer. Most will have been previously owned by the former Primary Care Trusts and Strategic Health Authority and transferred to NHSPS ownership as part of the health reforms of 2013.

It is important to be clear that NHS Property Services is simply the landlord or leaseholder of these properties and does not determine what services are commissioned or provided in them or whether they are to be retained or released. These decisions are taken by healthcare commissioners, ie clinical commissioning groups or NHS England.

2. What happens to disposal receipts?

Proceeds from the sale of properties are reinvested in the NHS. These are not ring-fenced for local use but commissioners in Devon can submit a business case for funding new facilities.

3. Donations/equipment given by the community or leagues of friends.

Many communities and Friends groups have raised vital funds for their local hospital and this is always hugely appreciated by the NHS and patients.

However, the buildings themselves are owned by the NHS (whether this is an NHS Trust, NHS Foundation Trust or NHS Property Services) and charitable donations raised by leagues of friends and other groups are gifted to the NHS for a specific purpose. Patients and the community benefit from this specific purpose but the donation does not in itself provide rights of ownership.

Donated items of equipment are generally owned by the NHS trusts or organisations providing healthcare.

4. Blackmore Health Centre, Sidmouth

NHS Property Services is working closely with the practice on a number of business issues. Agreement with the practice has been reached on the main issues of rent and service costs that were raised at the committee meeting. The rent charged has not changed and members will be aware that GP practices are reimbursed for the costs of their rent, rates, water charges and clinical waste by NHS England.

Regarding the ownership of the practice, doctors from the surgery approached NHS Property Services in 2014 with a request to acquire the premises.

This was declined as it is in the interests of the NHS that NHS Property Services retains ownership of the property to ensure it can be used for NHS healthcare for as long as commissioners need it, and allows a strategic approach to be taken when managing the local NHS estate.

NHS Property Services is focussed on delivering premises improvements and a number of options are being considered. These include redeveloping the site to provide a purpose-built surgery with flats above it. This would ensure patients can receive treatment in a modern building and would offset some of the development costs. Parking issues and the potential

need for expansion space will also be taken into consideration as part of ongoing discussions with the practice.

NHS England has indicated that in principle it would continue to reimburse the practice for these costs if a new development were approved.

Appendix 3 – Responses to questions submitted to the committee meeting of 19 January 2017:

1. How much is each individual community hospital being charged for rent by NHSPS?

Further to the information provided in July, market rent values for the individual hospitals remain commercial in confidence while lease negotiations are being concluded.

2. How much is the rental income for NHSPS nationally compared with the amount spent on maintenance?

In 2016/17 our budgeted rental income is £408 million. This includes freehold and leasehold income.

For leasehold properties, we normally hold a head lease on behalf of the NHS. The level of rent we have to pay our superior landlord is set out in the terms of this lease. We recover this cost by invoicing our customers for the same amount (plus a 5% management charge to cover our costs). Our customers' rents will be subject to the same review patterns as our head lease.

In 2016/17, our budgeted spend on 'Hard Facilities Management' (normally referred to as 'Hard FM'), which is mainly for routine, small-scale maintenance, is £98 million. These are direct costs and do not include overheads such as the salaries of our FM teams. It is also important to note that the £98 million does not include the money spent on larger maintenance projects that become part of our Construction Project Management (sometimes known as 'Capital') programme. The forecast CPM spend for 2016/17 is £60 million and typically funds a range of projects from new roofs and boilers to refurbishments and new-builds.

Appendix 4 – Responses to questions arising further to New Devon CCG and NHSPS attendance at a briefing session for members held on 20 June 2016

1. Please explain the role of NHS Improvement or send an explanation of the NHS landscape.

The creation of NHS Improvement was announced in July 2015 by the Secretary of State for Health. Further information can be found here: https://improvement.nhs.uk/

A useful guide to the NHS landscape was produced by the King's Fund in 2013. It can be viewed, along with supplementary notes regarding changes since the animation was published on this page: http://www.kingsfund.org.uk/projects/nhs-65/alternative-guide-new-nhs-england

2. Request that the NHS looks at possibility of providing accommodation for nursing/medical students.

NEW Devon CCG and NHS Property Services will consider any options available for providing this type of accommodation as part of the CCG's evolving Strategic Estates Plan.

3. What will the market rents be for the hospitals?

As stated at the briefing, the estimated rental value for all 12 hospitals is approximately £3.1million. This is based on 100% occupation at market rent.

4. What is the market rent for each hospital?

Market rent values for the individual hospitals are commercial in confidence while lease negotiations are ongoing.

5. Re: Supplementary information in response to a general discussion and concerns about distribution of nationally pooled funds for improvement projects by NHS PS.

Certain works, typically small-scale projects to keep our buildings statutorily and lease compliant and in a good state of repair, are carried out by NHS Property Services in line with our obligations as a landlord. Larger schemes, typically major multi-million pound projects, such as new buildings, extensions and major refurbishments, are requested by our customers. Up-front funding is normally provided by NHS Property Services, but in some cases we work with third-party development partners. These capital projects are led by commissioners and, if approved, delivered by NHS Property Services.

6. Can you provide case studies of the spending of the proceeds of market rent?

Market rent was only introduced in the 2016/17 financial year and as such we would be happy to provide examples of where it has provided funds for the renewal of the estate when they become available. In the interim, members may be interested to know that NHS Property Services has recently completed a £4.2million refurbishment of two wards at the Glenbourne Unit in Plymouth.

7. Do you have a national figure for how much money you have spent/are spending to maintain your hospitals nationally/how much are you spending on maintenance?

In 2015/16 NHS Property Services spent approximately £25million on repairs and maintenance across its portfolio. NHS Property Services also invested £55.4 million through its capital programme in 2015/16 to improve the property portfolio. Of this, £21.1 million related to new or refurbished buildings requested by customers within the NHS, and £34.3 million related to ensuring the estate managed by NHS Property Services is safe, warm, secure, and operates efficiently.

Health and Adult Care Scrutiny Committee

NHS Inquiry Spotlight Review

January 2018

CS/18/05
25th January 2018
Health and Adult Care Scrutiny Committee

1. Recommendations

The Health and Adult Care Scrutiny Committee does not, at this time, call for a public inquiry but will continue to monitor the impact of the STP and the move to an Accountable Care System.

The Task Group ask the Health and Adult Care Scrutiny Committee, Cabinet and the NHS in Devon to endorse the report and recommendations below; with a report on progress against the spotlight review recommendations in six months' time. The spotlight review also calls for this report to be sent to all Devon MPs.

	Ambition	Specific recommendations	Agency
1	Increase and maintain the Health and Care workforce through effective recruitment and training opportunities and retention of quality staff.	1.1 Ask Sarah Wollaston, as Chair of the Health Select Committee and a Devon MP, to establish a Select Committee inquiry into system wide approaches to recruitment and retention in the NHS and Adult Social Care. 1.2 All Councillors in their community leadership role to promote the value of health and social care as fantastic, rewarding careers.	DCC
		1.3 Work through the NHS and Local Authority to take a system wide collaborative approach to promoting innovative recruitment and retention ideas. For example, looking at the lessons from East Kent as well as opportunities for apprentices right through to incentives to retain or reintroduce retirees.	All
		1.4 Further work to take place on dual contracts where two providers employ the same member of staff part time each, reducing competition for the same staff pool and offering the most flexibility to staff members. 1.5 Identify GP practices in Devon that may be vulnerable if staff were to retire or leave. Work with practices to help improve resilience.	NHS
2	Reduce unnecessary pressure on the system	2.1 Clear communication of where to go in an Emergency. Investigate the opportunities for greater sign posting e.g. through technology such as NHSQuicker app. 2.2 Better promotion of pharmacies as places to go for advice and treatment.	CCGs
3	Recognise, Value and Support the role of social prescribing, social enterprise and community groups in enabling preventative measures, coping strategies and treatment options.	3.1 Investigate the mechanisms by which GPs could promote alternative treatments to prescription drugs such as physical activity and/or activities for mental wellbeing. 3.2 Review the effectiveness of the Integrated Care Exeter project and Community Connectors and embed lessons where appropriate to increase people's access to support. 3.3 Write to DFT to ask that the age limit on volunteer drivers for community transport is reviewed and possibly increased to reflect changing demographics.	DCC/ NHS

2. Introduction

2.1 This Spotlight review was conducted to explore some key themes that members of the Health and Adult Care Scrutiny Committee were particularly concerned about. This item began with a Notice of Motion submitted to Cabinet:

NOTICE OF MOTION to Cabinet, full reference here:
http://democracy.devon.gov.uk/ieListDocuments.aspx?CId=133&MId=2126&Ver=4

'While applauding the care provided by all our NHS medical staff the County Council is concerned at the current state of the NHS in Devon, the impact the NHS "Success Regime" is having and studies suggesting many GP's will be retiring, being examples of areas for concern.

Accordingly the County Council agrees to establish a local public inquiry to consider the state of the NHS in Devon'.

RESOLVED that the Notice of Motion be noted and the Health and Adult Care Scrutiny Committee be invited to consider with the Cabinet Member for Adult Social Care and Health Services how best to ensure the Council's views on the issues raised by the Notice of Motion and reflected upon in Report CS0/17/19 are represented to Government, acknowledging not only the ability of the Scrutiny Committee to require NHS bodies to attend upon it but also to determine decide how best to take this forward.

2.2 The Health and Adult Care Scrutiny Committee subsequently determined to establish a task group to:

- gather evidence on challenges in Devon against the National picture with particular focus on staffing, and access to care
- consider whether a Public Inquiry is the best way of addressing the concerns of the committee

2.3 The Spotlight review group wanted to understand some of the pressures upon the health and care system to be able to make a judgement about whether an independent inquiry would add value. The first part of the work was to narrow the focus of the review in order to meaningfully engage with the issues. The spotlight review team met twice to discuss the issues that were pertinent and then sense checked their approach with input from the Director of Public Health and the Director of Adult Care and Health for Devon County Council.

2.4 The spotlight review challenged each issue against whether it was a concern that all areas nationally were facing or whether some issues are experienced to be more of a concern in Devon or the South West.

2.5 This work was very clear in recognising and valuing the excellent work that is undertaken by staff across the health and social care landscape in Devon. The issue for the spotlight review group was the pace of change in the NHS and local authorities coupled with significant pressure on the whole system largely driven by changing demographics.

3. Pressures on the Health and Care System

3.1 The number of people aged 65 and over is projected to increase in all regions of England with corresponding growth in the number of people with chronic conditions such as cancer and heart disease.[1] As is well documented, Devon has an older population profile than nationally. This is particularly seen in those aged 50 to 70 years of age, reflecting significant in-migration in this age group, and those aged 85 years and over, reflecting the ageing population and longer life expectancy. The proportions of those aged under 40 years are below the national average, particularly in those aged 25 to 39, reflecting significant out-migration from Devon.[2] This means more people needing to use the health and care system, and potentially fewer people to recruit to provide these roles.

3.2 The Sustainability and Transformation Partnership in Devon is clear that the system of health and social care needs to evolve to provide a different model of care, and some of the way that care has been provided need to change: '*The services we have inherited were not designed to deliver care for the 21st Century.'*[3]

3.3 The spotlight review worked to ascertain whether these pressures were typical of the national issues with health and social care or whether there were challenges that were felt more in Devon. The table below summarises these findings:

Theme	How does Devon compare to other authorities nationally?
Staff Recruitment, retention and retirement	Staff recruitment is a national problem however there are higher proportions of older people in Devon which in turn increases the need for health and care staff. In addition, there is a net outward migration from Devon of people in their 20s and 30s. Higher housing costs and a higher general cost of living in Devon, given uniform national pay scales for NHS staff can make other areas more appealing for NHS staff. Devon has an older population structure and tends to be a net importer of people aged between about 50 and 75. Coupled with the out-migration pattern, this results in an older NHS workforce and higher levels of staff nearing retirement.
Access to Services	The geographic, demographic and financial pressures in Devon make access to services more of a challenge in a large rural county than in other areas of the Country. A dispersed rural population also creates greater challenges for the delivery of emergency care than an urban population, with distance and accessibility major factors.

[4]

3.4 Devon has a significantly older population when compared with the rest of the Country. A population of around 770,000 that has been described as 'ageing' but

[1] *The state of care in general practice 2014 to 2017; Findings from CQC's programme of comprehensive inspections of GP practices*, Care Quality Commission, September 2017, p. 6.
[2] JSNA pg25 http://www.devonhealthandwellbeing.org.uk/jsna/
[3] STP: Shaping future care in Devon http://www.devonstp.org.uk/case-for-change/
[4] Based on Information provided by the Public Health Team

'reasonably healthy'.[5] This ageing population is likely to increase demand for health and care services.[6]

3.5 The spotlight review felt that it was important to stress that whilst there are significant pressures on the system, there is a comprehensive network of services that operate effectively across Devon, this includes:

- **241 pharmacies**
- **137 GP practices**

In any given month:

- **28,000 A&E attendances**
- **26,000 calls to NHS 111**
- **19,000 GP Out of Hours Contacts**
- **18,000 ambulance incidents**
- **13,000 emergency admissions to hospital.** [7]

4. Workforce

4.1 During initial discussions members identified the value of the workforce in providing exceptional services but also the risk inherent in struggling to recruit or retain staff. One of the catalysts for undertaking this work was the report produced by Exeter University which concluded:

'A substantial majority of GPs in South West England report low morale. Many are considering career intentions which, if implemented, would adversely impact GP workforce capacity within a short time period.'[8]

4.2 The spotlight review group was also concerned about staff across the NHS as well as in social care and other areas that are sometimes overlooked such as pharmacists and dentists. Members particularly mentioned newspaper headlines decrying the reduction in recruitment of nurses and other healthcare workers, particularly GPs. The Royal College of General Practitioners' Chair Maureen Baker summarised the challenge as follows:

'General practice is currently facing intense resource and workforce pressures caused by years of underinvestment in and undervalue of our service'.

[5] Devon County Council, 'Public Health Annual Report 2016-17; placed based public health', 2017, p. 16.

[6] Joint Strategic Needs Assessment, 'Devon Overview', http://www.devonhealthandwellbeing.org.uk/jsna/overview/ , (last accessed 17 October 2017).

[7] Data provided by Devon CCGs

[8] Quitting patient care and career break intentions among general practitioners in South West England: findings of a census survey of general practitioners http://bmjopen.bmj.com/content/7/4/e015853

Recruitment Concerns in general

The number of people in the NHS workforce increased by 2% in the year to April 2017. But growth has been uneven. The staff groups with the highest rates of growth were those who provide support to clinical staff (2.5%), medical consultants (3.5%), and managers and senior managers (4.3%).

While there has been continued growth in hospital-based doctors, the number of full-time equivalent (FTE) GPs has fallen. This comes amid increasing demand pressures in primary care and despite the Government's commitment to grow the number of GPs by 5,000.

The number of FTE nurses employed in the NHS in England fell between April 2016 and April 2017. There were 460 fewer nurses and health visitors in April 2017 compared to a year before, despite rising activity pressures.

The number of nurses per 100,000 people in England is not keeping pace with population growth and declined from 604 in 2009 to 576 by 2016. There has also been a reduction in the number of EU nurses joining the NHS since the EU Referendum. In 2016, nurses were placed on the Shortage Occupation List.

There has been more than 14% increase in nationwide emergency admissions measured from 2010, but the nursing workforce of 2017 is only 0.7 per cent higher than it was in 2010.

Box information sources: [9] [10] [11]

GPs

4.3 General practice accounts for around 90 per cent of all patient contacts in the NHS.[12] It is currently facing serious challenges in other parts of the Country[13]. Rural Services Network Chief Executive Graham Biggs: '*some rural patients have to wait the best part of a month to see a doctor*'. The GP shortage means patients in part of rural Lincolnshire must wait four weeks to see a GP.[14] However the Spotlight Review did not uncover evidence of waiting times of this duration in Devon.

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[9] The Health Foundation@ Rising Pressure: the NHS workforce challenge, workforce profile and trends of the NHS in England Oct 2017 http://reader.health.org.uk/rising-pressure-nhs-workforce-challenge?utm_source=The%20King%27s%20Fund%20newsletters&utm_medium=email&utm_campaign=8824742_NEWSL_HMP%202017-10-31&dm_i=21A8,5957Q,OZZ6MJ,K9D8J,1

[10] The Royal College of Nursing, *RCN Labour Market Review. Unheeded warnings: health care in crisis The UK nursing labour market review 2016*, 21 October 2016, pp. 3-4.

[11] The King's Fund, 'Falling number of nurses in the NHS paints a worrying picture', https://www.kingsfund.org.uk/blog/2017/10/falling-number-nurses-nhs-paints-worrying-picture?utm_source=The%20King%27s%20Fund%20newsletters&utm_medium=email&utm_campaign=8773922_NEWSL_HMP%202017-10-17&dm_i=21A8,58202,OZZ6MJ,K3SPT,12 October 2017 (last accessed 17 October 2017).

[12] *South Devon and Torbay Proactive case management using the community virtual ward and the Devon Predictive Model*, The King's Fund, 2013, p. 6.

[13] 'Map: GP shortages across England', http://www.gponline.com/map-gp-shortages-across-england/article/1334024, 17 February 2015 (last accessed 17 October 2017).

[14] 'Shortage of rural doctors puts patients' health at risk', http://www.rsnonline.org.uk/press-releases/shortage-of-rural-doctors-puts-patients-health-at-risk,17 February 2017 (last accessed 17 October 2017).

4.4 The spotlight review heard that in the South West:

- 1 in 3 practices have permanently unfilled posts
- 80% of GPs state that workloads are unmanageable

4.5 The discussion in the review was clear that uniform national pay scales for NHS staff, higher housing costs and a higher general cost of living can make Devon less attractive for NHS staff. Net out-migration of Devonians in their 20s and 30s adds to recruitment pressures in Devon.[15] However, The Royal College of General Practitioners (RCGP) has estimated that Devon needs less than a 10% increase in GP numbers by 2020 in order to meet patient demand.[16] The spotlight review heard that if these vacancies are in rural practices they may have a disproportional impact. The spotlight review also heard from witnesses on this issue that the challenges were not in the future but now:

'Overall, 7 out of every 10 GPs in this region (The South West) reported a career intention which, if implemented, would adversely impact the GP workforce capacity in South West England through GPs leaving direct patient care, reducing hours spent in direct patient care or by taking a career break within the next 5 years'.[17]

4.6 On the whole GP recruitment would seem to be less pressing in Devon than in some other areas as Members were informed that Devon has not been included in a national incentive scheme for GP training because it has not been identified as a particularly severe area for GP shortages. Whilst there is the opportunity to study medicine in the South West, spotlight review participants underlined how there is strong competition from medical schools throughout the country. Young people may be attracted to more urbanised regions of the UK to study. However, the spotlight review heard that 60% of GPs trained in Devon stay locally (typical of other regions in the UK).

Nurses, Paramedics and other staff groups

4.7 Pressure on recruitment and retention of staff is mirrored in other staff areas across the Country as well. Last year The British Medical Association highlighted: *'69% of UK trusts were recruiting abroad for doctors or nurses. Staff numbers have not kept up with number of new posts and increases in population'.*[18]

4.8 The move to degree level training for paramedics means that the talent pool only increases substantially in October.[19] This move happened some time ago for Nursing, but now bursaries are no longer available for Student Nurses to complete training, and Nurses training now are liable for their tuition fees. The spotlight review heard that this has had a significant impact on students starting nursing, particularly mature students. This is likely to be because it is difficult for those people that start a nursing career later in life, to give up paid work to start an unpaid university training course and find the money for tuition fees. The members of the spotlight review felt that the Country should be encouraging nurses to train, not increasing the barriers for them to do so.

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[15] Public Health, Devon County Council, 19 October 2017.

[16] http://www.gponline.com/map-gp-shortages-across-england/article/1334024

[17] 'Quitting patient care and career break intentions among general practitioners in South West England: findings of a census survey of general practitioners' http://bmjopen.bmj.com/content/7/4/e015853

[18] The British Medical Association, 'GP Recruitment Problems Increase', https://www.bma.org.uk/news/2016/june/gp-recruitment-problems-increase, 2 June 2016, (last accessed 17 October 2017); BBC News, 'Thousands of NHS nursing and doctor posts lie vacant', http://www.bbc.co.uk/news/health-35667939, 29 Feb 2016 (last accessed 17 October 2017).

[19] South Western Ambulance Service, 'Integrated Corporate Performance Report, November 2014', 23 December 2014, p. 10.

4.9 The Devon General Practice Nurse Workforce Strategy has recommended that more support opportunities (such as mentoring) should be provided to support General Practice Nurse trainees on placements.[20]

4.10 In 2016, the South Devon Clinical Commissioning Group reported that 90% of the additional staff needed for enhanced intermediate care had been recruited. The only area that has seen difficulty recruiting to was band 6 physiotherapists.21

Dentists

4.11 The British Dental Association (BDA) has reported that recruitment of dentists is a significant problem across all UK countries.[22] A study across 600 UK dental practices in 2016 reported that Devon was one of 14 counties experiencing dentist vacancy gaps of more than three months.[23]

Morale and leaving Concerns

75% of GP partners who responded to a survey by the British Medical Association in 2016 believe that the current responsibilities of being a partner are too heavy. The number of staff leaving the NHS for work-life balance and ill-health issues has risen sharply since 2010.

Almost a quarter of Devon GPs plan to leave the NHS in 5 years. Smaller rural practices with fewer GPs may be hit harder by retirement than larger practices if one of their GPs retires. It is also harder for practices in more remote rural areas to merge together and combine GPs.

Nearly two in five of private/NHS dental practice owners interviewed by the British Dental Association (BDA) in 2016 said they were somewhat, mostly, or completely dissatisfied with their current job.

Nationwide, there are many challenges to the morale of nurses including workload pressures, the public sector pay cap, and public perceptions of nursing. In 2012 there was a public sector pay freeze for those earning above £21,000 per year.

Box information sources: [24] [25] [26] [27] [28] [29]

[20] Devon Community Education Provider Network, 'Devon General Practice Nurse Workforce Strategy', 23 May 2017, pp. 13,19.
[21] South West Clinical Senate, *Stage Two Clinical Review Report: Clinical Review of South Devon and Torbay CCG Community Services Transformation*, 14 October 2016, p. 11.
[22] The British Dental Association, 'Evidence to the Review Body on Doctors' and Dentists' Remuneration for 2017/18', September 2016, p. 23.
[23] The British Dental Association, 'Evidence to the Review Body on Doctors' and Dentists' Remuneration for 2017/18', September 2016, p. 23.
[24] The British Medical Association, 'Health service faces GPs exodus', https://www.bma.org.uk/news/2015/april/health-service-faces-gps-exodus, 30 June 2016 (last accessed 17 October 2017).
[25] 'RCN Labour Market Review 2016', p. 26.
[26] 'House of Lords Select Committee on the Long-term Sustainability of the NHS', p. 175.
[27] NHS NEW Devon CCG, 'Sustainability & Transformation Plan (STP) Wider Devon', 4 November 2016, p. 5.
[28] BBC News, 'Villages face GP shortage', http://news.bbc.co.uk/1/hi/england/2336807.stm, 17 October 2002 (last accessed 17 October 2017).

4.12 The spotlight review considered morale and leaving the health and care profession as separate conversations. However, to recognise their interrelated nature they are put together in this report. There are significant concerns about morale across the system, which of course is conflated if posts are unfilled either through recruitment challenges or retirement. Devon's age demographics give a workforce that has a significant portion of people nearing retirement age.

4.13 The health profession is also seeing many people take early retirement. The spotlight review considered this and discussed reasons for GPs, in particular, to retire:

- heavy workloads and long hours causing pressure and stress;
- fear of risk of complaints and court action;
- poor public perception caused in part by constant criticism by the press;
- pay cap and increase in pension contributions;
- the Government's reduction of the Lifetime Allowance 'pension pot' to £1m;
- a move to Agency work for better pay;
- a move to Locum work where sessions/workloads can be personally controlled; and
- Australia offering golden handshakes to attract UK GPs.

4.14 Devon has a practice nursing workforce comparable to the rest of the UK, with approximately a third eligible to retire by 2022.[30]

Current good practice

4.15 There are initiatives attempting to address the national concern in these areas. For example, from 2018, GP surgeries in hard-to-recruit-to areas will benefit from a new government scheme that will offer a one-off payment to work in areas of the country where training places have been unfilled for many years. Many of these areas are rural or coastal.[31]

4.16 Regarding staffing it is important to balance concern with the challenges with positive steps that are being taken. As outlined in this paper there are significant challenges in Devon over and above those typically faced in other areas. However, the spotlight review also uncovered some excellent and innovative practice (see box below). In 2016, the South Devon Clinical Commissioning Group reported that 90% of the additional staff needed for enhanced intermediate care had been recruited. The only area that has seen difficulty recruiting to was band 6 physiotherapists.[32]

4.17 The spotlight review also heard that staff satisfaction surveys within CCGs in Devon recorded positive results.

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[29] Fletcher E, Abel GA, Anderson R, et al. 'Quitting patient care and career break intentions among general practitioners in South West England: findings of a census survey of general practitioners', *BMJ Open*, p. 9.

[30] 'Devon General Practice Nurse Workforce Strategy', p. 9.

[31] Rural Services Network, '£20,000 'Golden hello" for rural GPs', http://www.rsnonline.org.uk/services/£20000-golden-hello-for-rural-gps , 12 October 2017. (last accessed 17 October 2017).

[32] South West Clinical Senate, *Stage Two Clinical Review Report: Clinical Review of South Devon and Torbay CCG Community Services Transformation*, 14 October 2016, p. 11.

Devon Innovations: staffing

- The Devon Proud to Care Campaign has been recognised by the Guardian Newspaper. The campaign works to attract young people campaign is aiming to attract more people to the care profession by raising its profile and encouraging people to see it as a rewarding and worthwhile career choice. https://www.proudtocaredevon.org.uk/
- In recognition of the work taking place to attract young people into choosing a caring profession, the Devon 'Proud to Care Campaign' has been mentioned as innovative practice in the National News
- South Western Ambulance Service Trust (SWAST) runs national recruitment campaigns aimed at recent graduates to encourage paramedics to move to Devon.
- Health Education England South West provides postgraduate medical education and training, available through Peninsula Postgraduate Medical Education. Post graduate medical training delivered through HEE South West has among the highest satisfaction ratings with junior doctors and trainers and also includes dentists.

Box information sources: [33] [34] [35]

Further work to be done

4.18 The Royal College of Nursing has claimed that the approach to training qualified nurses is uncoordinated, with poor workforce planning structures, reductions in the number of training places, and a move away from nursing bursaries to student loans: *'Insufficient numbers of nurses have been trained to meet demand for nurses in the care and independent sectors, creating an undersupply in these areas'.*[36]

4.19 Clinical pharmacists work as part of the general practice team to resolve day-to-day medicine issues and treat patients directly. Relative to GPs, the UK has an overproduction of pharmacists. Clinical pharmacists can be used to ease pressure on GPs.[37] However this necessitates trust, visibility and confidence about when the best option is speaking to the local pharmacist.

4.20 The spotlight review heard that in Devon there are two pinch points at which personal care workers leave, this is typically at 8 months and 18 months. It is important to need to ensure staff feel valued in the team and society, feel supported in their role and have the opportunity for reflective practice (also reference article from East Kent at http://www.nhsemployers.org/~/media/Employers/Publications/EAST%20KENT%20retention%20case%20study%20FINAL.pdf)

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[33] The Guardian, 'why it's difficult to attract younger people into the social care sector: https://www.theguardian.com/careers/2017/dec/20/why-its-difficult-to-attract-younger-people-into-the-social-care-sector

[34] Health Education England South West, 'High satisfaction levels for medical training in the south west', https://www.hee.nhs.uk/hee-your-area/south-west/news-events/news/high-satisfaction-levels-medical-training-south-west, 7 August 2017 (last accessed 17 October 2017).

[35] Health Education England, 'Education and training: Dentists', https://www.hee.nhs.uk/hee-your-area/south-west/education-training/dentists, 29 October 2015 (last accessed 17 October 2017).

[36] *Ibid*., p. 4.

[37] The British Medical Journal, 'How pharmacists could help save the NHS', http://careers.bmj.com/careers/advice/How_pharmacists_could_help_save_the_NHS , 3 December 2014 (last accessed 17 October 2017).

4.21 East Kent Hospitals University Foundation Trust has worked to improve retention of new starters by understanding why many personal care workers left within a year. 40 % of staff leavers were those who left in their first year. They worked to change the culture and make their staff feel:

- cared for as individuals
- safe, reassured and involved
- teamwork trust and respect at the heart of everything they do
- content that they are making an effort

This included having the right approach to recruitment and induction, good training for recruiting managers and improving organisational culture. In one year the trust went from 40% of leavers being in the first year to 18%[38].

4.22 The spotlight review heard from many providers who have been competing for staff. Where one provider may train a paramedic or a nurse, another may lure them away with less anti-social hours or more pay. What was refreshing to hear in the spotlight review was that some providers were collaborating to retain staff between them. In particular SWAST were developing dual contracts and split shifts to enable talented staff to be employed by two organisations e.g. SWAST and the Fire and Rescue Service. More work clearly needs to be done between agencies to collaborate on shared solutions.

4.23 The spotlight review would like to see a collaborative approach taken to encouraging and supporting staff across the local system. From more apprentices to enable young people to have a realistic view of some of the challenges and rewards right through to incentives to retain or reintroduce retirees.

5. Prevention

5.1 The role of prevention in keeping people well and reducing strain on the system is very important. Much work has been done in Devon by Public Health on preventive initiatives and measures to improve the population's health. However, witnesses at the spotlight review underlined that Devon is the third lowest local authority in terms of public health funding per head or population.

5.2 The spotlight review determined that the factors that promote unhealthy lifestyles need to be confronted at a local level to reduce the number of preventable health problems. Poverty (food poverty, fuel poverty) and poor-quality housing (with mould and inadequate heating) were identified as the main factors contributing to preventable health problems. Food poverty might lead to diets that are unhealthy or nutrient deficient, encouraging problems such as diabetes. Exposure to mould can trigger respiratory illness.

5.3 Smoking was also identified as a cause of preventable health problems. It was suggested that the culture that encourages smoking and unhealthy eating needs to be confronted. Individuals may be more likely to smoke if their parents smoked or if they come from socially deprived backgrounds.

5.4 Although good cycle networks exist in Exeter and parts of Devon, a culture and infrastructure that promotes healthy living (e.g. cycle paths, shops that sell fresh fruit, exercise groups) should continue to be encouraged in Devon.

[38] NHS Employers, East Kent University Hospitals Foundation Trust: Improving new starter turnover August 2017 http://www.nhsemployers.org/~/media/Employers/Publications/EAST%20KENT%20retention%20case%20study%20FINAL.pdf

5.5 The spotlight review would like to see more technology (such as smartphone apps) to enable individuals to monitor their health and take more control for their wellbeing.

5.6 There are also community solutions such as local walking groups, which can encourage individuals to exercise and take control of their own physical and mental health within friendly and motivating environments. However, witnesses to the spotlight review expressed frustration around the fact that there are not currently routes through which GPs can prescribe exercise services or walking groups. There are initiatives promoting access to groups, for example the Active Devon website. [39]

5.7 Health Champions are members of pharmacy teams. They provide individuals with advice on health and wellbeing and direct the public to services that will help them to adopt healthier lifestyles. Staff in some pharmacies have been able to build strong relationships with regular customers. It was suggested that Health Champions could have huge potential in encouraging healthy living within communities.

5.8 Attention was drawn to the very high number of elderly people in parts of Devon such as Sidmouth. It was identified that loneliness and bereavement are serious problems among elderly populations. There was the concern that many elderly people experiencing loneliness request support from social workers to have company. This ties up resources and adds to the pressures that social workers face. The needs of these elderly people should be met through different channels such as support from friends/volunteers and community organisations such as Age UK.

5.9 The spotlight review stressed that loneliness among elderly people is a societal issue. Participants were keen to highlight how it is a misconception that loneliness is a rural problem only. Loneliness is also an urban problem. Changing attitudes towards ageing and raising public awareness of loneliness among the elderly through community organisations is essential. Illfracombe, which includes some of the highest areas of social deprivation in Devon, was praised for having established a supportive community network.

6. Access to Services

6.1 It was clear in the discussions in the spotlight review that there was some confusion around definitions of what constituted an emergency and access to services. The spotlight review found that this is symptomatic of access to healthcare services where there is often confusion over the best place to go when a person has worrying symptoms. The review group heard that there are many instances where people turn up to A&E when they could have gone to their GP or pharmacy. This is of course a draw on valuable resources and could lead to a reduction in service for true emergencies.

6.2 The spotlight review talked about the need for better mental health services before a person was in crisis as well as when they are in crisis. This is particularly an issue for homeless people, who may be homeless because they have a mental health condition. The spotlight review discussed whether there were options for better mental health training for paramedics and other first line responders.

Access to Emergency Services

6.3 Between April and October 2014, the national averages for ambulance trusts in England were all below national target levels.[40]

[39] https://activedevon.org/

[40] 'Integrated Corporate Performance Report, November 2014', p. 5.

6.4 The King's Fund has argued that national targets and monitoring systems within the NHS remain focused on A&E and the acute sector – greater focus is needed on moving care into the community to reduce pressure on NHS services.[41]

6.5 Demand pressures facing the South Western Ambulance Services Foundation Trust (SWASFT) have been replicated nationally. In 2014, all ambulance services reported increases in incident numbers.[42] Ambulance trusts have limited ability to scale up resource levels quickly due to the longer term nature of training and recruitment of additional qualified clinicians. The performances of SWASFT have compared well nationally against other ambulance services - performance for the period April to October 2014 was above the national average for all three performance metrics.[43]

6.6 The chair of the Fire and Rescue Service attended the spotlight review and spoke about how the Fire and Rescue Service are often the first responders on a scene, and have to treat emergencies.

6.7 In Devon, 80% of the out of hours service is provided by GPs, not blue light services. The use of the 111 service is intended to be a single point of entry to emergency services. However, some people are unaware of the service, or believe that they will go to A&E anyway. This preference is affected by geography, having an easily accessible hospital will promote attendance, where in more rural areas the out of hours GP service may be more likely to be used.

6.8 The spotlight review did raise questions about isolated people's ability to access services if they need to travel in an emergency and are unable to do so due to rurality or personal circumstances.

Non-emergency access to Services

6.9 A lower percentage of children in Devon are receiving dental assessments they are entitled to. In 2014/15, 89% of children nationally aged under five were up-to-date with child health surveillance/health promotion checks compared with 63% in Devon (Public Health Devon, 2017).

6.10 Community Car Schemes in Devon provide over 68% of journeys to and from non-emergency health appointments. This eases pressure on NHS services by reducing the number of missed appointments. The scheme relies on volunteers, but still receives DCC/ NHS funding to cover vehicle expenses and legal/admin costs. Over half of these schemes faced a deficit in 2014-15 as the NHS withdrew much of its funding.

7. Conclusion

This spotlight review has taken a snapshot view of some of the challenges in the health and care system that local politicians are concerned about. These circumstances are not unique to Devon and are experienced across the Country. The spotlight review understands that some of the unique characteristics that Devon enjoys contribute to the pressure that the local system is under. The influx of people retiring to Devon and the comparative high house prices combined with national pay scales for NHS staff and low local wages give a higher than average need for services with a lower than average pool of potential staff to draw upon.

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[41] The King's Fund – Written Evidence, Select Committee on the Long-term Sustainability of the NHS, p. 655.

[42] *Ibid*., p. 9.

[43] SWAST 'Integrated Corporate Performance Report, November 2014', p. 9. http://www.swast.nhs.uk/Downloads/SWASFT%20downloads/SWASFT%20Corporate%20Performance%20Reports/ICPRFebruary2017.pdf

A system-wide focus on early intervention and prevention is present within the Sustainability and Transformation Partnership. Financial pressures coupled with a growing and ageing population creates significant pressure on health and care services. This makes the development of new models of care, integrating and a greater focus on early intervention and prevention to reduce future demands on services an absolute necessity.

The spotlight review understands that the pinch points discussed in this report impact upon the whole system of health and care in complex and multifaceted ways. There are rays of hope however with a great deal of innovation coming from the South West. The spotlight review anticipates that conversations about these prominent challenges will continue through scrutiny as well as through the whole of Devon.

8. Sources of evidence

Witnesses

The Task Group heard testimony from a number of sources and would like to express sincere thanks to the following for their involvement and the information that they have shared as well as to express a desire of continuation of joint work towards the fulfilment of the recommendations in this document.

Organisation	Role	In attendance
DCC	Assistant Director of Public Health	Tracey Polak
DCC	Chief Officer for Adult Care and Health	Jennie Stephens
NEW Devon CCG	Chief Operating Officer	Rob Sainsbury
South Devon and Torbay CCG	Chief Operating Officer	Simon Tapley
South West Ambulance Service NHS Foundation Trust	Head of Resourcing and Organisational Development for Operations Head of Operations (West)	Vicky Evans (am) Steve Boucher (pm)
Devon Local Pharmaceutical Committee	Chair	David Bearman
University of Exeter	Professor of Medical Practice & Primary Care	Professor John Campbell
Livewell South West	Chief Executive	Steve Waite
DCC	Head of the Transport Co-ordination Service	Damien Jones
North Devon Voluntary Services	Devon Access to Services (DASP) Project Manager	Tim Lamerton
Healthwatch	Trustee (Board Member)	John Rom
Sidmouth PPI Group	Chair	Di Fuller
Devon Health and Social Care Forum	Secretary	Elli Pang
Devon & Somerset Fire and	Safeguarding Manager	Mandy Davies

Organisation	Role	In attendance
Rescue Service		
Devon Local Medical Committee	Medical Secretary	Dr Mark Sanford-Wood
Hospiscare	Chief Executive	Glynis Atherton `
Exeter Patient Participation Group / Exeter Primary Care	Chair (Exeter PPG) Chief Executive Officer (Exeter PMC)	Elizabeth Deasy
DCC	Cabinet Member	Cllr Andrew Leadbetter
DCC	Cabinet Member	Cllr Roger Croad

With thanks to Public Health Intelligence team for providing information and insight. Thanks also to Wendy Simpson, Philip Bridge and Stephanie Lewis, from the Democratic Services and Scrutiny Secretariat for research, organisation and facilitation for this spotlight review.

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- JSNA pg25 http://www.devonhealthandwellbeing.org.uk/jsna/
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9. Task Group Membership

The Task Group review was chaired by Councillor Brian Greenslade and membership of the Spotlight Review was as follows:

Councillors Sara Randall-Johnson, Claire Wright, Carol Whitton and Rufus Gilbert

10. Contact

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THE DEVON ACCOUNTABLE CARE SYSTEM:
Questions for the Health & Adult Care Scrutiny Committee

A. WHAT WE KNOW ABOUT THE DEVON ACCOUNTABLE CARE SYSTEM

The Devon Sustainability and Transformation Plan (STP) has announced plans to establish a Devon Accountable Care System (ACS) from 1 April 2018.[1] This will be a more permanent organisation of the NHS in the whole of Devon, including both CCGs, providers and Councils.

Proposals approved by the Collaborative Board and the CCGs' Governing Body meeting in common, both in September 2017, state: 'During 17/18, through the STP Strategic Commissioning/ACS work stream, Council and NHS partners will agree the staging, mechanisms and pace to progress the agreed ambition for a consistent model of integrated health and social care commissioning arrangements and pooled commissioning budgets, including the performance management and accountability arrangements that underpin these…'
'Objective: To implement the first phase of these new arrangements during 2018/19.'[2]

The ACS will include:

1. A single strategic commissioner for Devon
This will be the Joint Chief Executive of the two CCGs, who will also take the STP lead role.

2. An integrated delivery system for Devon, providing affordable health and social care within a fair share of resources for the population served.
'Phase 1: To develop integrated delivery systems that will better achieve the service ambitions set out in 'Shaping Your Future Care'. Phase 1 will focus on addressing the most pressing delivery challenges in the Devon care system, these are:
(i) A single delivery system for Mental Health services in Devon ...
(ii) Place-based integrated delivery systems with agreed delivery networks where more specialist services need to be delivered at greater scale across these 'place based' systems.'

3. Shared Corporate Services Across Devon
'Corporate services (such as Information Technology, Finance, Human Resources, Estate services, legal services and others) will be organised on a Devon-wide basis to improve resilience and productivity and to further reduce cost.
'Objective: To develop a shared services delivery model for Devon by December 2017 with a phased implementation plan that will be delivered from Q1 2018/19.'

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[1] RD&E, 'Devon STP – top 10 developments and successes'. Webpage published 29 November 2017.
[2] NEW Devon and South Devon & Torbay CCGs, Governing Body meetings in common - PUBLIC 28.09.2017 V2.pdf, http://www.southdevonandtorbayccg.nhs.uk/about-us/our-governing-body/meetings/Documents/governing-body-common-2017-09-sep.pdf

Governance
'The developments of the ACS for Devon in relation to both the commissioning and delivery parts of the system, will be overseen by the Organisational Design Programme (Nick Roberts as SRO) and reported on regularly through the STP PMO and PDEG.'

Role of local authorities
'The partner arrangements with the three local authorities within Devon will "lift and shift" to this arrangement. This will replace the current STP leadership and infrastructure. Under this partnership the "Single Strategic Plan for Devon" will be refreshed and implemented, with all NHS and Councils working as a commissioning partnership to deliver this plan through collaborative investment of their respective health, social care and public health funding for the populations they serve.'

B. QUESTIONS FOR THE HEALTH & ADULT CARE SCRUTINY COMMITTEE

Many important questions are raised by the development of the ACS. Below I indicate some provisional answers on the basis of the available information, but these are all issues which this Committee needs to investigate further.

1. **This transformation of the existing 'plan' into an ongoing 'system' appears to be a fundamental change in the organisation of health care. But what precisely does it mean and where is it going?**

The documents quoted above refer to 'Phase 1', developing integrated delivery systems. Clearly there will be a Phase 2 and possibly further phases. The direction of travel is explained in the 'toolkit – a route map for creating an Accountable Care Environment – that considers possible future options and a structured approach to determine the best solution locally', written by Rebecca Harriott, former Chief Officer for NEW Devon CCG, and published in December 2017 by the South West Academic Health Science Network (SW AHSN).[3]

This toolkit, which describes how 'colleagues working as part of the Devon STP started to consider its options for the future, they engaged to look into the different options available for commissioning in the future', comes with a recommendation from Dr Tim Burke, NEW Devon CCG Chair[4], and can be seen as an authoritative explanation of the purpose of the changes.

[3] Rebecca Harriott, *Designing the commissioning system in an accountable care environment: A route map for Sustainability and Transformation Partnerships (STPs)*, South West Academic Health Science Framework,, https://www.swahsn.com/wp-content/uploads/2017/12/Accountable-Care-Environment-Route-Map-2.pdf

[4] *SW AHSN publishes a route map to creating an Accountable Care Environment*, 18 December 2017 https://www.swahsn.com/sw-ahsn-publishes-route-map-creating-accountable-care-environment/

According to this toolkit, **'the move to an accountable care delivery model has at its centrepiece a population health focus and a capitation funding approach'**. The Devon Accountable Care System will involve what is called 'capitated accountable care'. Capitation means that providers are contracted to provide a package of services for a whole population at a fixed price per capita, rather than being paid per treatment. Obviously, this type of payment is good for accounting but could lead to patients' treatments being pared back or even denied if the overall costs threaten to exceed the contracted payments to the provider.

2. **What will the Phase 1 developments, the single delivery system for Mental Health services and the place-based integrated delivery systems, involve?**

What is entailed in 'agreed delivery networks where more specialist services need to be delivered at greater scale across these "place based" systems'? Since these changes are to be rolled out imminently, can we have a full explanation of what they mean for localities?
Does 'a fair share of resources for the population served' mean that areas will have standardised per capita allocations, involving reductions in funding for areas which currently have above-average funding (even though differences may reflect population needs?).

3. **What will Phase 2 and subsequent phases involve?**

This has not yet been formally decided by the STP. However according to the 'toolkit', key elements of the Accountable Care Environment include:

(a) **'The Accountable Care Delivery System (ACDS) will hold the capitated budget for the population covered (that may exclude some specialised services)'.** It is not clear if this delivery system has been established, or what precisely it involves.

(b) **The development of Accountable Care Organisations, which agree contracts to provide services to a population.** The aim is 'through bringing budgets together on a whole population and/or model of care basis, [to] provide signals to providers on how to organise. This will signal the number, shape and scope of accountable care organisations and how they will need to work together to deliver.'

(c) **'Utilising national new models of care contract document and locally developed investment approach.'** I assume this refers to the new standard contract for Accountable Care Organisations developed by NHS England.[5] However the legality of

[5] https://www.england.nhs.uk/publication/accountable-care-organisation-aco-contract-service-conditions-1bii/

this contract has been challenged in the courts by health professionals and others[6] and a judge has now agreed to allow a judicial review of the contract to go forward. This will begin on 22 April 2018.

(d) **'Stimulating the market to ensure there are a number of high-quality options for patients available when commissioning services, and that there are alternative providers available in the event of provider failure.'** This clearly means that Accountable Care Organisation contracts may involve private providers taking over large packages of Devon NHS services, i.e. the large-scale privatisation of NHS provision. The reference to provider failure indicates that NHS contracts will be subject to the vagaries of the market in the same way as Carillion's contracts and the Virgin/Stagecoach contract for the East Coast Main Line. The public have not accepted the legitimacy of this kind of privatisation in the NHS.

(e) **'Ensuring that, where appropriate, patients are offered personal health budgets or integrated personal commissioning. People receiving NHS continuing healthcare (or continuing care in the case of children) have the legal right to a personal health budget.'** Personal budgets sound as though they offer choice but in reality they are a way of capping expenditure on individual patients, especially those with chronic conditions.

4. **In what sense will this system be 'accountable'?**

It appears that the system is 'accountable' in the sense of financial accountability, i.e. accountable to the parameters of the agreed capitated budget.

5. **Will the Accountable Care System remain fully accountable to this Committee?**

It may be that in Phase 1, the integrated delivery systems remain fully within the purview of the Health & Adult Care Scrutiny Committee. However it appears unlikely that private providers with Accountable Care Organisation contracts will remain subject to scrutiny in the same way as at present, if at all. Private providers are also exempt from FoI requirements.

6. **Do 'shared corporate services' include DCC, and what are the implications of the ACS for our adult social care services?**

Both these points are unclear and need to be investigated by the Committee.

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6 http://www.independent.co.uk/news/uk/politics/jeremy-hunt-health-department-nhs-legal-action-americanise-privatisation-customers-id-pay-a8033986.html

7. **How has Devon County Council been involved in the development of the ACS, and on what authority?**

DCC's logo is used on the SPT documents about the ACS, which envisage that 'During 17/18, through the STP Strategic Commissioning/ACS work stream, Council and NHS partners will agree the staging, mechanisms and pace to progress the agreed ambition ... including the performance management and accountability arrangements that underpin these' in order to 'implement the first phase of these new arrangements during 2018/19.'

Have DCC representatives been involved in agreeing these proposals, through the STP's Collaborative Board? We need proper reporting on the Council's involvement.

8. **Why haven't these major changes in the organisation of Devon's health and social care been reported to this Committee, to Cabinet or to Council, or consulted with the public?**

The Accountable Care System is an 'evolution' of the Sustainability and Transformation Plan which launched at the end of 2016, itself a new version of the Success Regime established early in 2016. Council resolved on 8 December 2016 (by 55 votes to 0), that: '*County Council believes that the NHS Success Regime project for Devon is now flawed and accordingly asks the Secretary of State for Health and NHS England to put the process on hold, until issues relating to the "independence" of the Success Regime are investigated and for fair funding to be considered.'*

Just as the Council asked for the Success Regime process to be put on hold, it was being renamed the STP. Eight days later, on 16 December 2016, the 'Devon STP memorandum of understanding for governance' was agreed. This memorandum states that DCC is a party, although the verson available online is not signed of behalf of the Council.[7] It is not clear on what authority the Council has been involved in the STP over the last year. I have been unable to locate a formal decision by the Council to authorise DCC's participation.

Clearly the transformation of the STP into a more permanent Devon Accountable Care System, with the further changes envisaged in the toolkit, is a fundamental organisational change in health and adult care and should have been brought to this Committee and to the Council well before its start date of 1 April 2018.

As the toolkit acknowledges, there is a 'Statutory obligation on clinical commissioning groups (CCGs) and NHS providers to involve the public in the planning, development, consideration and decisions for service change proposals.'

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7 http://www.northdevonhealth.nhs.uk/wp-content/uploads/2017/02/Annex-4.2-Board-07.02.17-Devon-memorandum-of-understanding-for-STP-governance-Part-2.pdf

However it seems that the CCGs don't consider the establishment of an Accountable Care System, and the sweeping further changes envisaged, as in need of consultation. In Cornwall, in contrast, where the establishment of an Accountable Care System is also being considered, Cornwall Council has established an enquiry to consider 3 questions:[8]

1. To understand the rationale behind the establishment of Accountable Care Systems across the NHS in England and specifically for Cornwall and the Isles of Scilly.
2. To consider the option put forward for integrated strategic commissioning as part of a Cornwall and Isles of Scilly Accountable Care System (including the ones discounted and take a view on which is more likely to achieve the desired outcome) and the route map to achieve it.
3. Within the preferred option, ascertain how democratic control and clinically led commissioning can be retained.

Cornwall Council has published information about the ACS for the public[9] and their Cabinet Portfolio Holder says "The inquiry sessions will be open to the public and there is no hidden agenda – this is fully transparent. The inquiry will make a recommendation to Cabinet and then full Council." I gather it will go to Cornwall's Cabinet on February 7.

Why haven't this Committee, Council and the public been similarly informed and consulted, and why has no authority been obtained for the Council's role in the preparation of the ACS?

C. CONCLUSIONS

Members will doubtless agree with the principles of integrating health and social care and bringing the fragmented NHS created by the 2012 Act into a common framework.

However the STP's plans to create an Accountable Care System raise fundamental issues about the direction of the NHS in Devon, in particular whether it is right that NHS care should be provided through capitated contracts and whether large-scale private contracts are the right vehicles to deliver major areas of Devon's NHS services.

At a time when, as this Committee has acknowledged, public confidence in the CCGs is very low, it is truly astonishing that these plans have not been properly presented to this Committee in good time for you to scrutinise them before they are implemented, and that there has been no public consultation and no decision by the Council.

[8] https://democracy.cornwall.gov.uk/mgCommitteeDetails.aspx?ID=1242

[9] https://www.cornwall.gov.uk/council-and-democracy/council-news-room/media-releases/news-from-2017/news-from-december-2017/plans-for-a-shadow-accountable-care-system/

The Committee's only remaining meeting is on 22 March 2018, nine days before the ACS is due to come into being. I ask the Committee to hold a special meeting as soon as possible to consider these developments and to seek answers to the questions outlined above.

Councillor Martin Shaw
14 January 2018

12 December 2017
Standing Overview Group – Health and Adult Care Scrutiny Committee
'Urgent care'

Present

Councillors Sara Randall Johnson (Chair), Hillary Ackland, Rufus Gilbert, Andrew Leadbetter, Sylvia Russell, Phil Twiss, Nick Way, and Carol Whitton

Camilla de Bernhardt Lane, Head of Scrutiny
Philip Bridge, Democratic Services and Scrutiny Support Officer
Tim Golby, Head of Adult Commissioning and Health at Devon County Council
Jo Turl, Deputy Chief Operating Officer at South Devon and Torbay Clinical Commissioning Group

Apologies

Councillors Brian Greenslade, Philip Sanders, Richard Scott, Jeffery Trail, Claire Wright

During discussion, reference was made to the following:

- The difference between urgent and emergency care
- Urgent care services in Devon
- The underlying reasons for repeat visits to urgent care services
- The importance of other services outside the NHS in providing urgent care (e.g. domiciliary care)
- National workforce recruitment problems across all health and care professions, including domiciliary care, and how this affects urgent care provision
- Possible solutions to these recruitment problems, such as using money from the Better Care Fund and promoting caring as an attractive career through the 'Proud to Care' Campaign
- The importance of mental health support in urgent care
- GP streaming in urgent care and how this improves the flow of patients into urgent care
- The importance of urgent care services working together as a system
- The performance of the urgent care system in Devon, including the area of Delayed Transfers of Care
- The importance of standardising services within urgent care

- Primary care as the 'bedrock' of urgent care, and the challenge of GP recruitment problems
- The Opportunities that exist to work with voluntary sector grassroots 'community' organisations in providing urgent care services

Summary of Actions	Who will action
1. Circulate data on repeat visits to ED within Devon	**JT**
2. Consider inviting Providers to future SOG meeting, possibly to coincide with Quality Accounts next spring.	**PB**
3. To ask if the recent letter from The Department of Communities and Local Government/the Department of Health to Devon County Council on the iBCF and progress towards meeting Delayed Transfers of Care targets could be circulated to members of the Committee	**CdBL**
4. Presentation data on urgent care could be revisited by Scrutiny at a later date	**CdBL**
5. The King's Fund video to be circulated to Members to help them better understand how the NHS system works	**PB**

Next Meeting

The next Standing Overview Group meeting will take place at 10AM on 28 February 2018 with the theme of 'Learning Disability'