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 : 30 May 2018
Please ask for : Gerry Rufolo 01392 382299

Email: gerry.rufolo@devon.gov.uk

HEALTH AND ADULT CARE SCRUTINY COMMITTEE

Thursday, 7th June, 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 Minutes

Minutes of the meeting held on 22 March 2018 (previously circulated)

3 Items Requiring Urgent Attention

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

4 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

5 Winter Pressures 2017/18 (Pages 1 - 16)

Joint Report of the Head of Adult Commissioning and Health; and Director of Strategy (South and Torbay CCG and NEW Devon CCG) (ACH/18/87) attached

6 STP Financial Position (Pages 17 - 24)

Report of the STP Lead Director (NHS South Devon and Torbay and NEW Devon CCGs) attached

7 Delays in GP Appointments (Pages 25 - 30)

Report of the Director of Primary Care (NHS South Devon and Torbay and NEW Devon CCGs), attached

8 Better Care Fund: Task Group (Pages 31 - 54)

Report of the Task Group, attached

9 Adult Social Care Survey and Focus Groups (Pages 55 - 60)

Report of the Head of Adult Commissioning and Health (ACH/18/86) attached

10 Future of Community Hospitals

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

11 Appointment of Commissioning Liaison Member

The Committee is asked to select a Commissioning Liaison Member, whose role will be to work closely with the relevant Cabinet Members and Chief Officers/Heads of Service, developing a fuller understanding of commissioning processes, and provide a link between Cabinet and Scrutiny on commissioning and commissioned services.

12 Work Programme

In accordance with previous practice, 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 Standing Overview Group and Quality Accounts (Pages 61 - 70)

Reponses made on behalf of the Committee, attached

14 Information Previously Circulated

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

(a) Statement by the Royal Devon & Exeter NHS Foundation Trust and Northern Devon Healthcare NHS Trust regarding their future collaboration;

(b) Briefing Note describing the roll out of Universal Credit and the possible impacts on families in Devon and changes to welfare reform since the 2013 report of the 'Unintended Consequences of the Welfare Reform Act Scrutiny Task Group';

(c) May issue of the Torbay and South Devon NHS Foundation Trust newsletter: Health

and Care Insights;

(d) Healthcare Spending and Availability in the UK Compared to Other Countries – report by the King's Fund;

(e) RD&E Trust Briefing on Maternity Services at Okehampton and Honiton community hospitals;

(f) Guide on information about health-related services available in your local area to help people choose the quickest and safest service;

(g) Statement from South Western Ambulance Service and NEW Devon CCG to announce that an agreement has been reached to continue the GP led service at the Tiverton Urgent Care Centre;

(h) A briefing note issued from South Devon and Torbay Clinical Commissioning Group relating to the future proofing of services in Teignmouth.

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), M Asvachin, J Berry, P Crabb, B Greenslade, R Peart, S Russell, P Sanders, A Saywell, R Scott, J Trail, P Twiss, N Way C Whitton, C Wright and J Yabsley

Local Councils
Vacancy

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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Webcasting, Recording or Reporting of Meetings and Proceedings

The proceedings of this meeting may be recorded for broadcasting live on the internet via the 'Democracy Centre' on the County Council's website. The whole of the meeting may be broadcast apart from any confidential items which may need to be considered in the absence of the press and public. For more information go to: http://www.devoncc.public-i.tv/core/

In addition, anyone wishing to film part or all of the proceedings may do so unless the press and public are excluded for that part of the meeting or there is good reason not to do so, as directed by the Chair. Any filming must be done as unobtrusively as possible from a single fixed position without the use of any additional lighting; focusing only on those actively participating in the meeting and having regard also to the wishes of any member of the public present who may not wish to be filmed. As a matter of courtesy, anyone wishing to film proceedings is asked to advise the Chair or the Democratic Services Officer in attendance so that all those present may be made aware that is happening.

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Public Participation

Devon's residents may attend and speak at any meeting of a County Council Scrutiny Committee when it is reviewing any specific matter or examining the provision of services or facilities as listed on the agenda for that meeting.

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/

All Scrutiny Committee agenda are published at least seven days before the meeting on the Council's website.

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Induction loop system available

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The nearest mainline railway stations are Exeter Central (5 minutes from the High Street) and St David's and St Thomas's both of which have regular bus services to the High Street. Bus Service H (which runs from St David's Station to the High Street) continues and stops in Wonford Road (at the top of Matford Lane shown on the map) a 2/3 minute walk from County Hall, en route to the RD&E Hospital (approximately a 10 minutes walk from County Hall, through Gras Lawn on Barrack Road).

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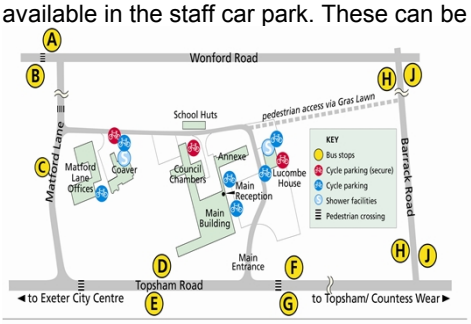
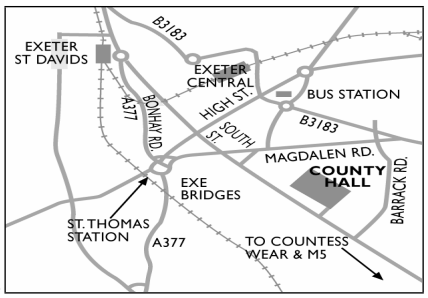
As indicated above, parking cannot be guaranteed and visitors should allow themselves enough time to find alternative parking if necessary. Public car parking can be found at the Cathedral Quay or Magdalen Road Car Parks (approx. 20 minutes walk). There are two disabled parking bays within the visitor car park. Additional disabled parking bays are available in the staff car park. These can be accessed via the intercom at the entrance barrier to the staff car park.





NB A J **Denotes bus stops**

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First Aid

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

ACH/18/87
Health and Adult Care Scrutiny
7 June 2018

WINTER PRESSURES 2017/18

Joint Report Head of Adult Commissioning (Devon County Council) and Director of Strategy (South Devon and Torbay CCG and NEW Devon CCG)

1. Recommendation

1.1 Scrutiny to note content of the Report.

2. Purpose

2.1 This report provides an update to report ACH/18/83, presented to the committee on 22nd March 2018.

2.2 The first section reviews activity and performance over winter, bringing in additional and updated information to cover the whole winter period of October 2017 to March 2018 and provides a comparison to the previous year, where available..

2.3 The second section provides a summary of the winter review held by the mult-agencyDevon Accident and Emergency (A&E) Delivery Board in March. This summarises what went well and what could be improved which informs the priorities for winter planning in 2018-19.

3. Executive Summary

3.1 For Devon wide services, 111 and out of hours primary care activity increased this winter. More modest increases in 999 incidents were seen, and increases in those treated on scene and conveyed to Emergency Departments noted. Call answering performance for 111 and hours lost to ambulance handover continued be issues however.

3.2 Taking a view of winter by locality, the following can be noted when comparing key metrics with last winter. Across providers, Accident and Emergency (A&E), Referral to Treatment (RTT) and diagnostics performance were issues as were cancelled operations.

	East	*North*	*South*	*West*
Accident and Emergency (A&E) activity	↔	↓	↔	↑
Minor Injuries Unit (MIU) or equivalent activity	↑	↔	↔	↑
A&E performance	↓	↓	↓	↓
Emergency admissions	↑	↑	↓	↑
Length of stay	↑	↑	↑	↔
Delayed Transfers of Care	↓	↓	↑	↔
Cancelled operations	↑	↑	↑	↑

3.3 Flu was a key issue impacting on winter performance, with a high number of confirmed cases in Plymouth, Torbay and Exeter. This is likely to account for the rise in emergency admissions across most sites. The severe weather in March, with two episodes of snow within 2-3 weeks, impacted on services: 111 and 999 call volumes increased and hospital attendance decreased during the bad weather, however in demand was experienced afterwards.

3.4 Although delayed transfers of care remained an issue through the year, the rate of delays in providers finished the winter impacting 3-5% of beds. Numbers of delays impacting people living in the in Devon County Council area increased during the late winter period but have significantly improved since 2016-17. The purchase of extra capacity over the winter had a positive effect on individuals awaiting person care packages, which dropped from 88 in October to 38 in March.

3.5 The Devon A&E delivery board partners reviewed their experiences over the winter, including what went well, what did not and priorities for 2018-19. Organisational arrangements, proactive workforce planning and some additional financial resources which supported extra capacity were highlighted as positives. Communications, capacity and demand planning, workforce planning to increase supply during escalation and business continuity plans were noted as issues which needed further attention for 2018-19. Other priorities included 7-day services, flu planning, enhanced integrated urgent care and improved pathways.

4. Urgent and emergency care over winter

4.1 Nationally, the NHS experienced a difficult winter – this is summarised in facts and figures below from NHS Providers, the body with represents NHS Trusts.

Their commentary suggests:

- The NHS was well prepared for winter, with plans and preparation starting much earlier than usual.
- Early indications were that capacity would be an issue, and that flu would be an additional pressure.
- Winter itself was characterised by erratic bad weather and from December demand for services increased significantly.
- Demand remained high and spiked in January, when admissions due to flu increased further.
- In response, the National Emergency Pressures Panel (NEPP) advised NHS Trusts to cancel all non-urgent elective operations and they relaxed mixed sex guidance.
- In February, Simon Stevens confirmed the NHS had experienced its most pressurised month in history, but the pressures continued right up to Easter at the end of March.

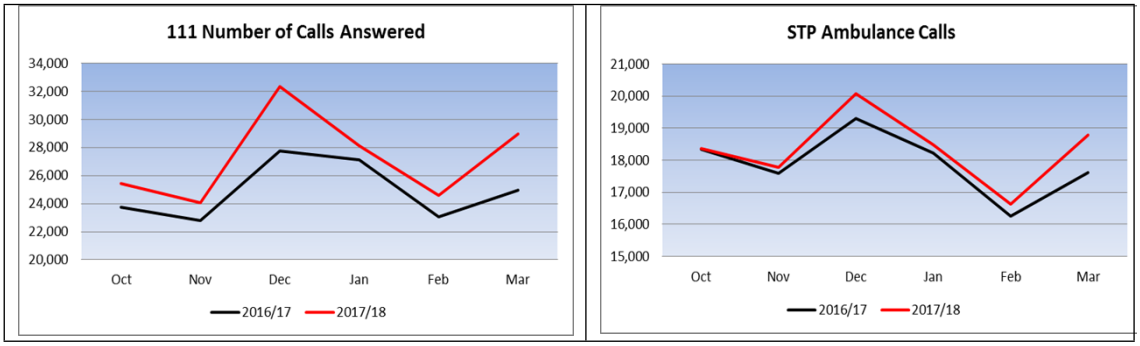
4.2 This section presents local information for the period October 2017 to March 2018 and covers:

- Calls to NHS 111 and 999
- A&E attendance and performance
- Out of hours primary care activity
- Emergency Admissions
- Length of stay in hospital
- Delayed transfers of care
- Cancellations of elective operations
- Referrals to treatment within 18 weeks
- Flu cases
- Impact of ‘snow days’
- Adult social care assessments
- Residential adult social care
- Community based adult social care

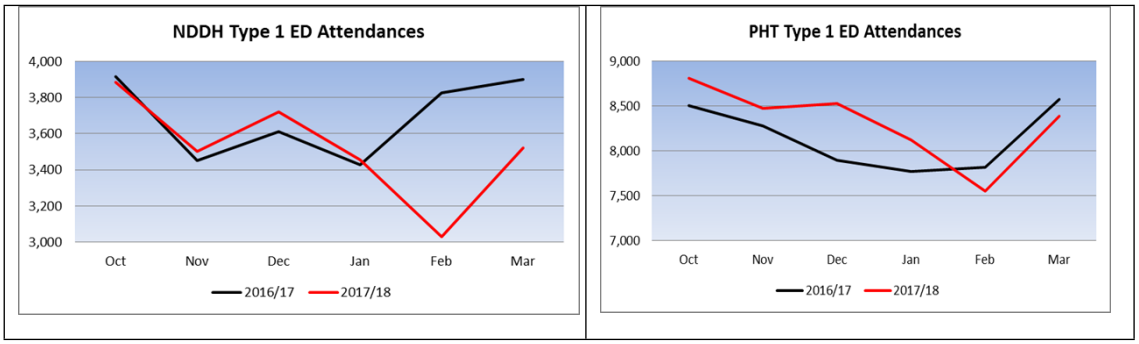
Unless otherwise stated, the NHS information relates to NHS providers and therefore covers the population they serve wherever they live:

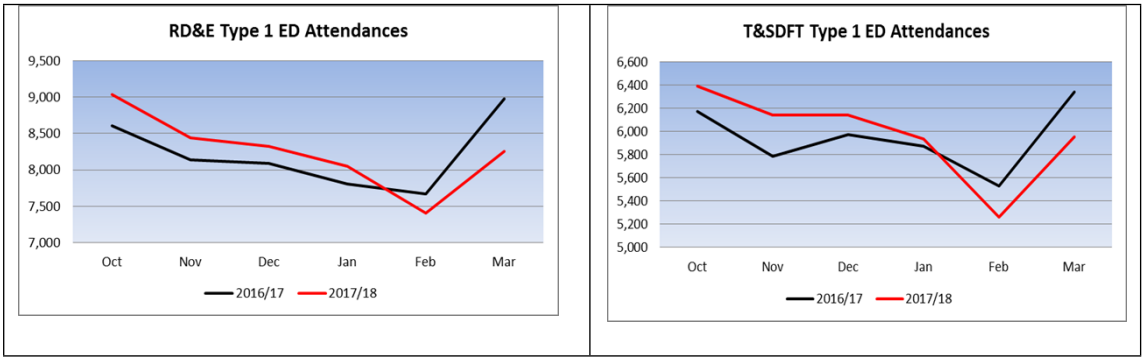
- University Hospitals Plymouth NHS Trust (UHP/PHT)
- Royal Devon and Exeter NHS Foundation Trust (RD&E)
- Northern Devon Healthcare NHS Trust (NDDH)
- Torbay and South Devon NHS Foundation Trust (T&SDFT)
- South West Ambulance NHS Foundation Trust (SWAFT)
- Devon Partnership Trust (DPT)
- Livewell Community Interest Company (Livewell)

4.3 **NHS 111 and 999** are, for many, entry points to the urgent and emergency care system. This winter saw a rise in calls to 111 of around 9%, and across the winter between 25k and 32k calls per month were answered. The rise in calls to 999 was a more modest 2.6%, with monthly call volumes ranging from 17k to 20k. More people with non-emergency conditions are calling 111, with those calling 999 generally doing so for more serious conditions. The Devon 111 service continued to experience difficulties with call answering performance, which worsened over the winter. This pattern has been seen across a number of other providers nationally although the rate of decline in Devon has been greater due to the scale of the rise in demand and difficulties recruiting and retaining call centre staff.

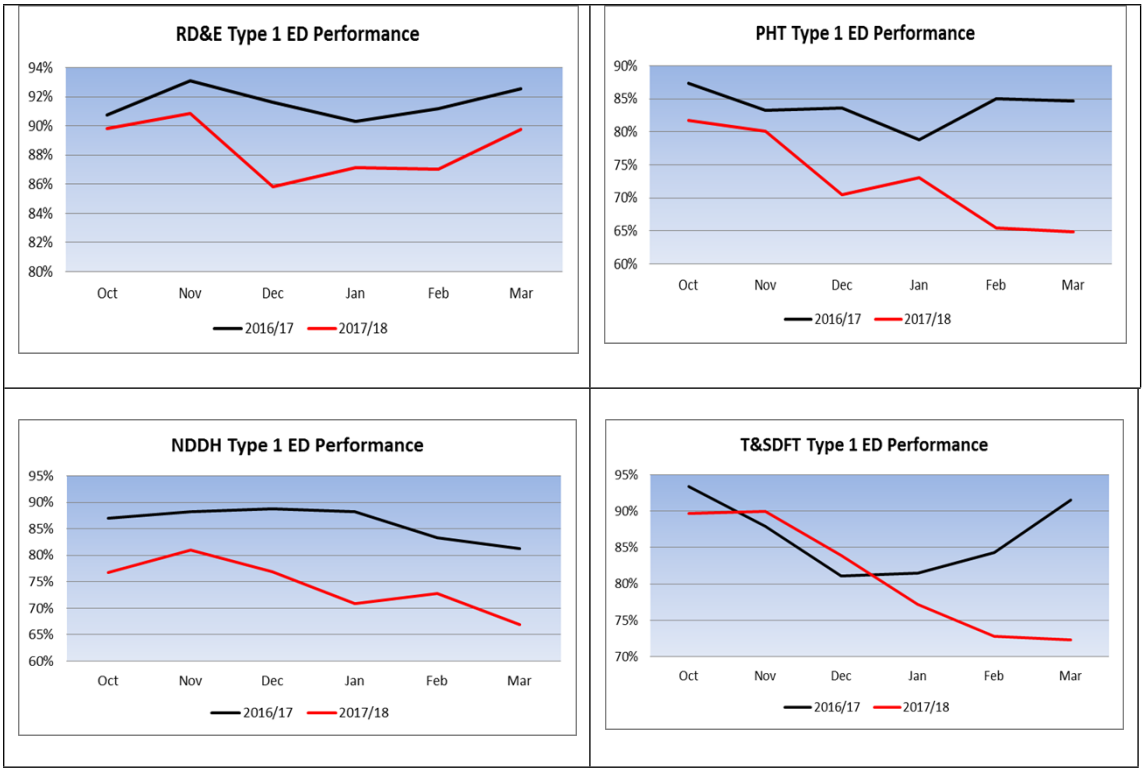


4.4 **A&E attendances** across the four acute providers showed a variable picture over winter in comparison to last year: there was a decrease in activity in North Devon of -4.6%, an increase of 2.1% in Plymouth and modest increases of around 0.5% at the RD&E and Torbay Hospital. Minor Injuries Units experienced increased attendances in Exeter and Plymouth and little change in North Devon and Torbay and South Devon.



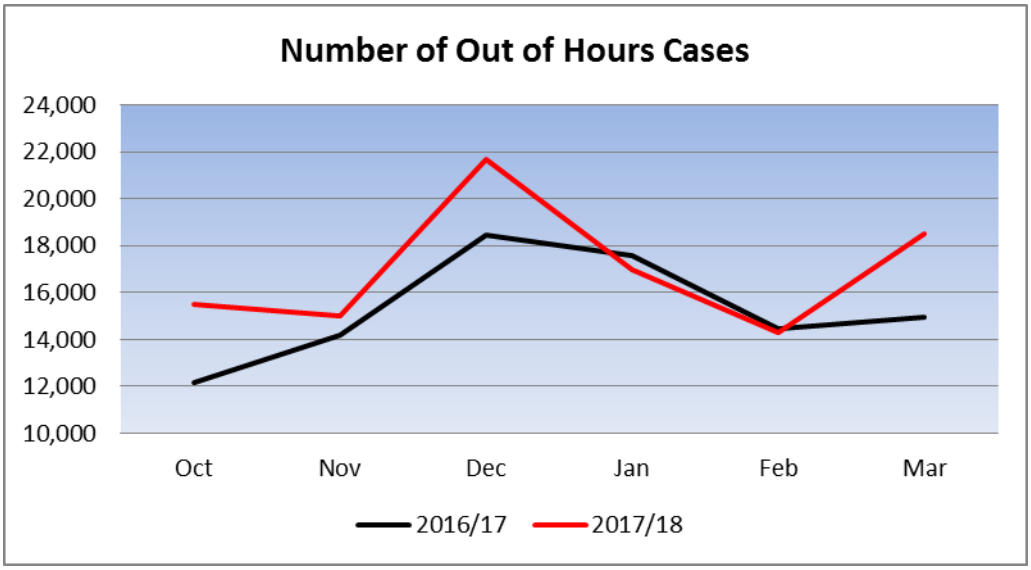


4.5 **A&E performance** across the same four providers also showed a variable picture, and with worse performance against the 4-hour wait standard than the previous winter. The RD&E maintained the best performance (range 86-91%), followed by Torbay (range 72%-90%), North Devon (range 67-80%) and Plymouth (range 65%-82%).



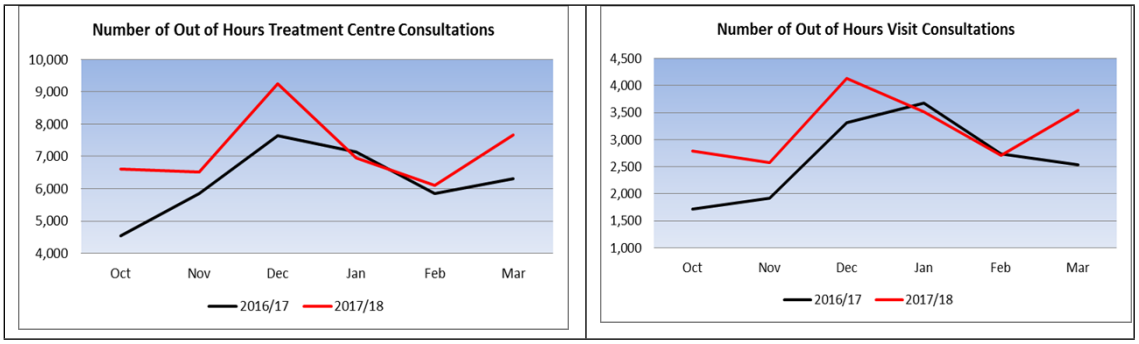
4.6 **Out-of-hours primary care activity**

Devon Doctors saw an increase of 10,186 cases (11%) across Devon during the winter period with significant increases in October of 3,337 (27%) when compared to the previous year.

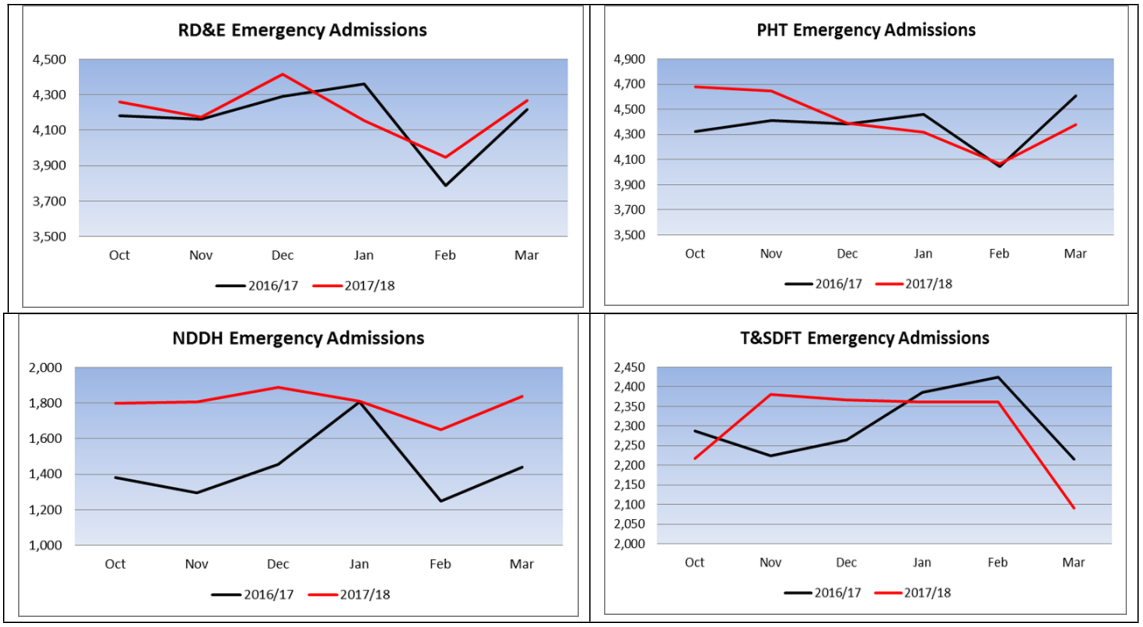


The number of patients seen by the Out of Hours Service at a treatment centre increased by 5,766 (15%) in comparison with last winter, again with a particular increase of 2,068 consultations in October which is a 45% increase on the previous October. The number of visits carried out by the Out of Hours

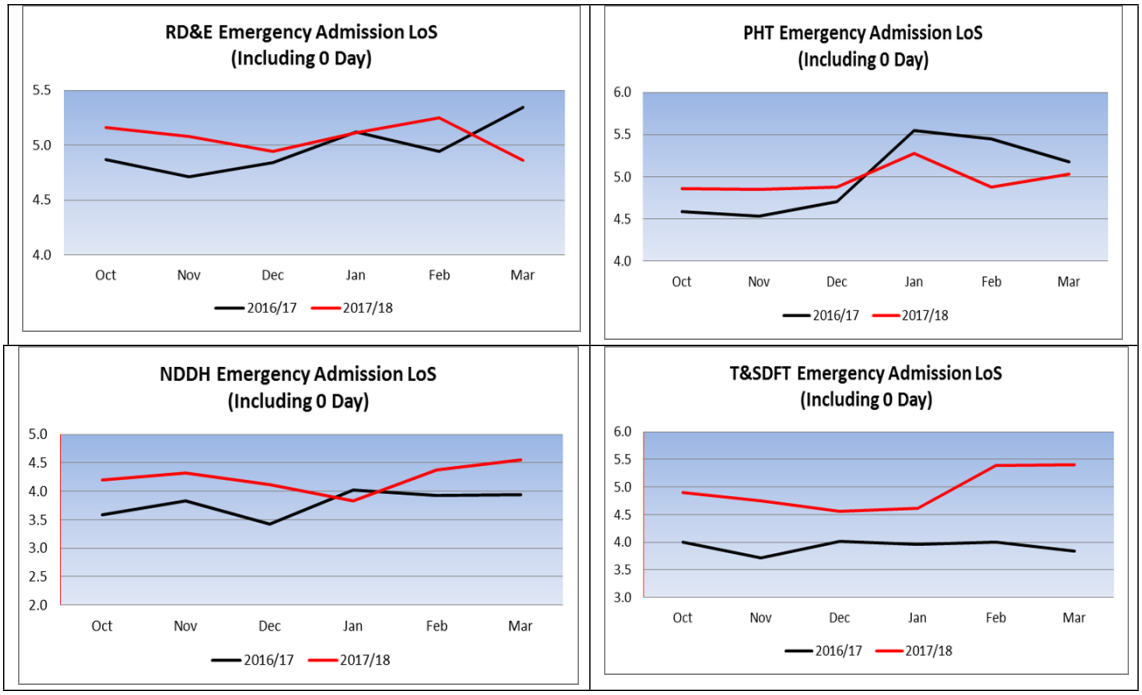
Service increased over the winter period by 3,375 visits (21%) with October seeing the most significant increase of 63%.



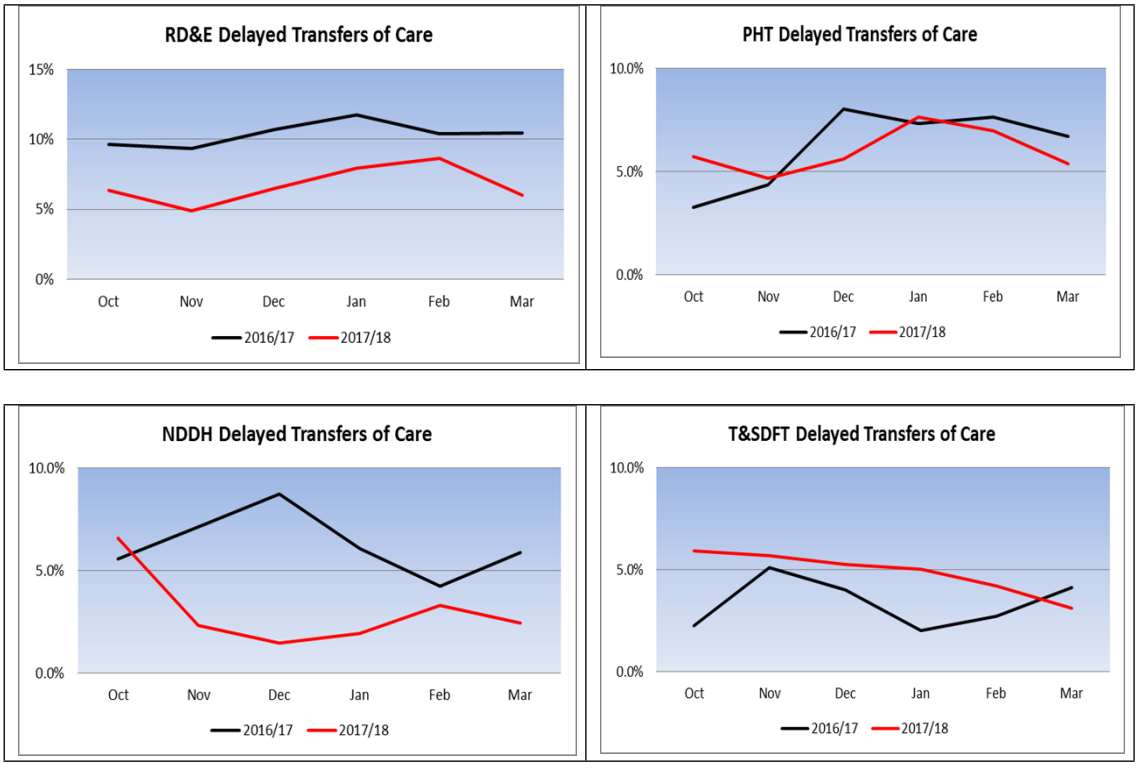
4.7 **Emergency admissions** to hospital rose across Devon by just over 2,500, a rise of 4% in comparison to the previous winter. The position varied by location: Torbay hospital was the only hospital which saw a decrease, North Devon reported a significant increase and there were more modest increases in the RD&E and Plymouth. Nationally and locally, the outbreaks of flu and complications in vulnerable patients, norovirus and cold weather all contributed to rises in admissions.



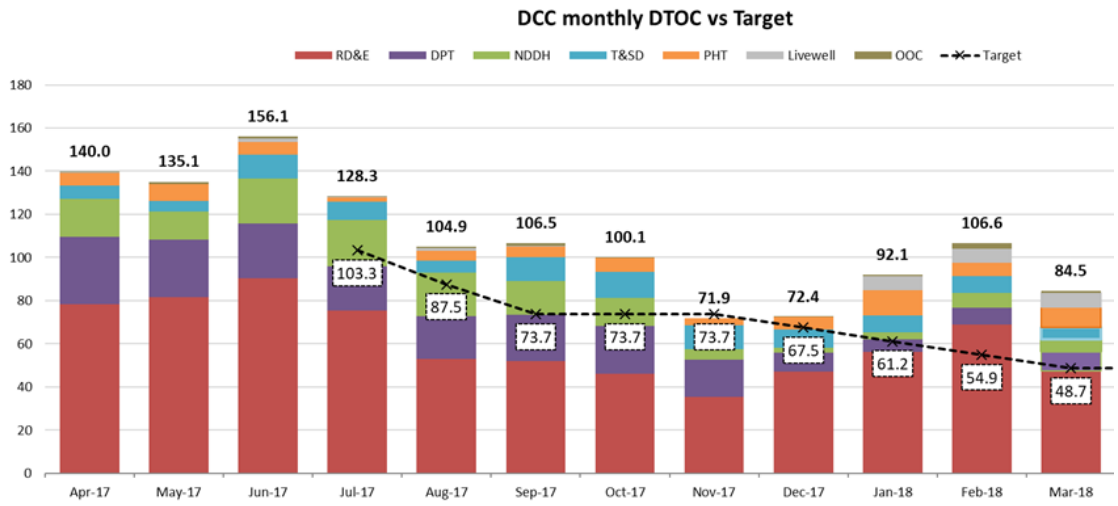
4.8 **Length of stay in hospital** following an emergency admission also showed an increase from the previous year across all providers. The increase in length of stay was particularly marked in Torbay. The rise in complexity and organising discharge for these patients contributed to this. The length of stay changed in Plymouth and in Exeter during the winter, reducing in December and February respectively. In North Devon however, it started to increase from January.



4.9 **Delayed transfers of care (DTOCs) -** measured by the number of delayed bed days as a proportion of all available bed days in acute and community hospitals - shows a general improvement over this winter. Both Plymouth and the RD&E ended the winter with rates of just over 5%, with both providers indicating rates which peaked at around 8% in January and February respectively. The position in North Devon improved dramatically from last year, ending the winter with a rate of around 3%, although it dropped even lower than this in December. The position in Torbay was worse than last year, although they did end the winter with a rate of approximately 4%.



Delayed transfers of care pertaining to residents of the Devon County Council area reduced over the course of 2017, dropping below the target set by NHS England in November, before rising again in the second half of the winter, with signs of improvement emerging after Easter. The integrated approach to person centred care encouraged by the use of Better Care Fund monies contributed to our performance being a significant improvement on the winter of 2016-17.



4.10 The number of last minute **cancellations of elective operations** for non-clinical reasons increased across Devon by 334 or 24% during the winter period. Until quarter 3, the position across Devon showed a slight improvement on the previous year, however the position deteriorated dramatically in quarter 4 due to the recommendation from the National Emergency Pressures Panel to cancel all except cancer and urgent elective operations in January and into the early part of February.

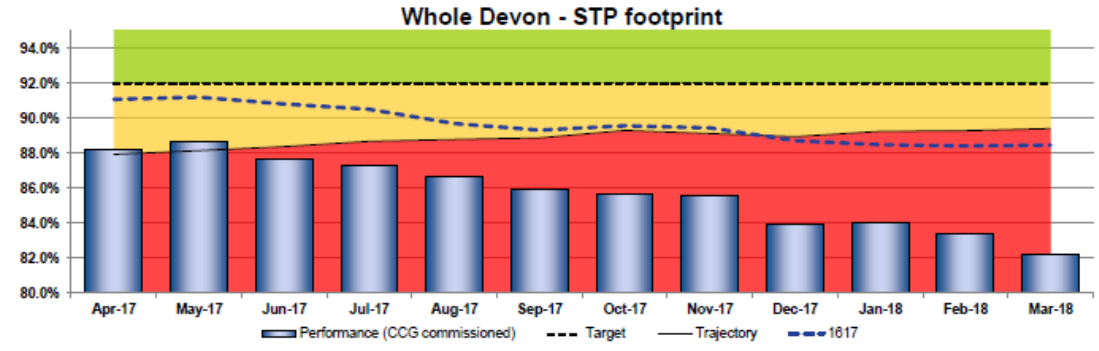
Org Name	Year	Values	DEC	MAR	TOTAL
RD&E	2016-17	Number of last minute elective operations cancelled for non clinical reasons	114	93	207
	2017-18	Number of last minute elective operations cancelled for non clinical reasons	114	194	308
NDDH	2016-17	Number of last minute elective operations cancelled for non clinical reasons	35		35
	2017-18	Number of last minute elective operations cancelled for non clinical reasons	41	34	75
PHT	2016-17	Number of last minute elective operations cancelled for non clinical reasons	457	517	974
	2017-18	Number of last minute elective operations cancelled for non clinical reasons	443	620	1,063
T&SDFT	2016-17	Number of last minute elective operations cancelled for non clinical reasons	110	79	189
	2017-18	Number of last minute elective operations cancelled for non clinical reasons	104	189	293
TOTAL	2016-17	Number of last minute elective operations cancelled for non clinical reasons	716	689	1,405
	2017-18	Number of last minute elective operations cancelled for non clinical reasons	702	1,037	1,739

4.11 Across Devon, the proportion of people being **referred to treatment** within 18 weeks dropped from 86% in October to 82% in March.

18-week RTT (incomplete pathway)

STP footprint

STP footprint	National target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Performance (CCG commissioned)	>92%	88.2%	88.7%	87.7%	87.3%	86.6%	85.9%	85.7%	85.5%	84.0%	84.0%	83.4%	82.2%
RTT total waiting list	63,732	65,771	66,819	58,876	59,473	61,487	63,553	64,862	63,796	63,599	63,636	64,360	66,234
Trajectory		87.9%	88.2%	88.4%	88.7%	88.8%	88.9%	89.3%	89.1%	88.9%	89.2%	89.3%	89.4%
NHS England		89.9%	90.4%	90.3%	89.9%	89.4%	89.1%	89.3%	89.5%	88.2%	88.2%	87.9%	



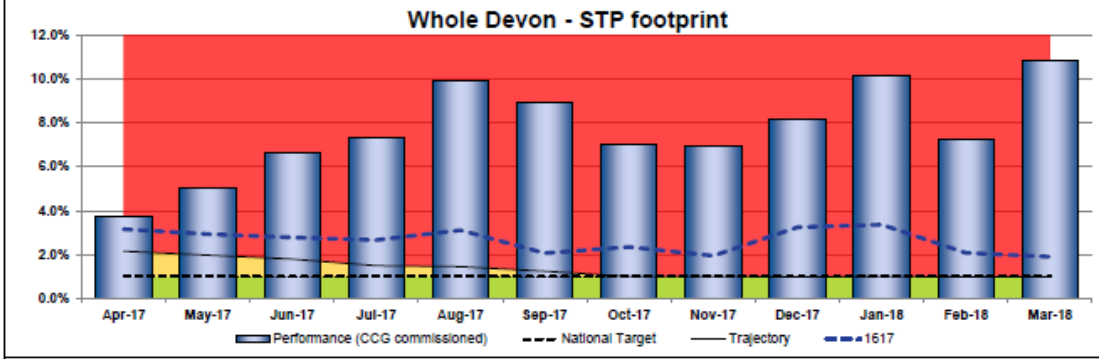
Comment: The STP level RTT position fell again in March from 83.4% to 82.2% as performance deteriorated at all providers. This is expected due to the impact of cancellations related to the periods of snow. NDHT saw the greatest fall in performance, from 79.7% to 76.9% although validation of RTT data continues prior to national reporting recommencing in June. UHP performance fell from 81.0% to 79.7% whilst the RD&E position reduced from 85.1% to 83.3%. TSDFT saw performance fall from 82.4% to 81.6%.
Over 52 week waits increased as expected in March with rises at all providers. UHP saw the highest level of breaches, rising from 85 to 108, whilst NDHT saw 48 breaches and TSDFT 33. RD&E breaches rose from 9 to 30.

The position for performance in respect of **diagnostics within 6 weeks** also deteriorated through the year, with 7% waiting more than 6 weeks in October and nearly 11% by March.

6 Week Diagnostics

STP footprint

STP footprint	National target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Performance (CCG commissioned)	>1%	3.8%	5.0%	6.6%	7.3%	9.9%	8.9%	7.0%	6.9%	8.1%	10.2%	7.3%	10.9%
Trajectory		2.2%	2.0%	1.8%	1.5%	1.5%	1.2%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
NHS England		1.8%	1.9%	1.9%	1.8%	2.2%	2.0%	1.7%	1.7%	2.2%	2.3%	1.6%	

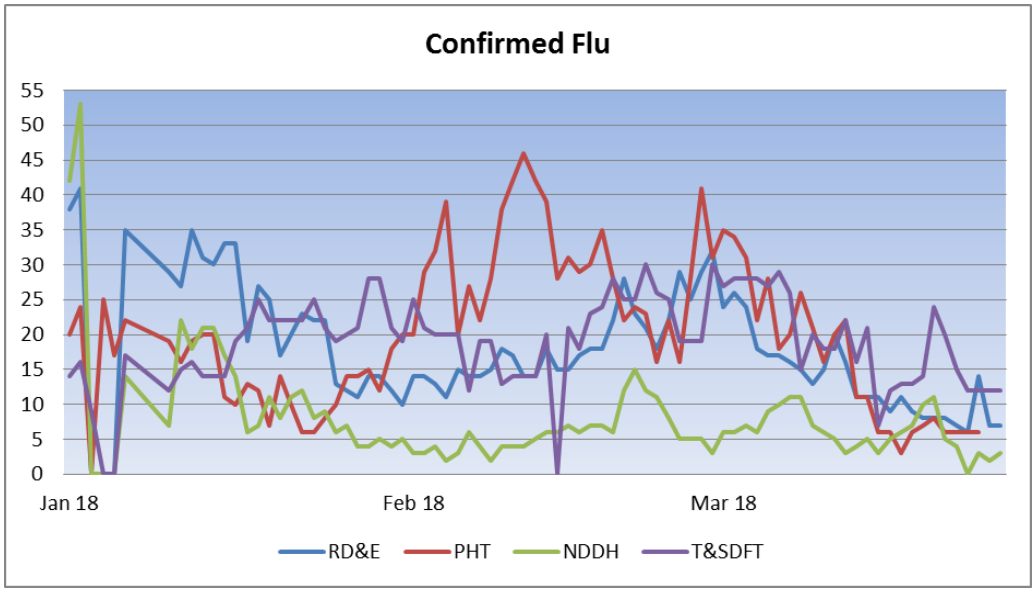


Comment: STP level performance worsened in March, with the percentage of breaches moving from 7.3% to 10.9%, the highest level seen in 2017/18. All providers saw an increased level of breaches
Following improvement in February the NDHT position deteriorated sharply in March from 16.3% to 23.3% due to high levels of breaches in MRI, endoscopy and CT. UHP also see a rise in breaches, increasing from 8.5% to 12.3% with MRI, endoscopy and ultrasound the main problem areas. The TSD breach rate increased from 3.1% to 8.9% with CT, MRI and endoscopy seeing the highest numbers of breaches. RD&E performance remained relatively static at 5.7%, although endoscopies continue to be a pressure area but with sustained improvement against MRI and sleep study breaches

4.12 Confirmed **flu cases** across Devon were one of the key issues for additional workload in urgent and emergency care over winter. This pattern was reported nationally and was worse than in 2016-17 when the outbreak was only classified as “moderate”. Most cases were reported in Plymouth, closely

followed by Torbay and then Exeter. However, when considering the size of the hospital and the bed base, the impact at Torbay would have been significantly greater. The uptake of flu vaccinations across Devon was like the national picture with relatively good uptake amongst those aged 65 and over, but it was below 50% for all other groups at risk, including pregnant women and children. Efforts will need to continue to improve this, a priority in the 2018-19 winter planning work plan.

RD&E	PHT	NDDH	T&SDFT
1,464	1,605	656	1,548

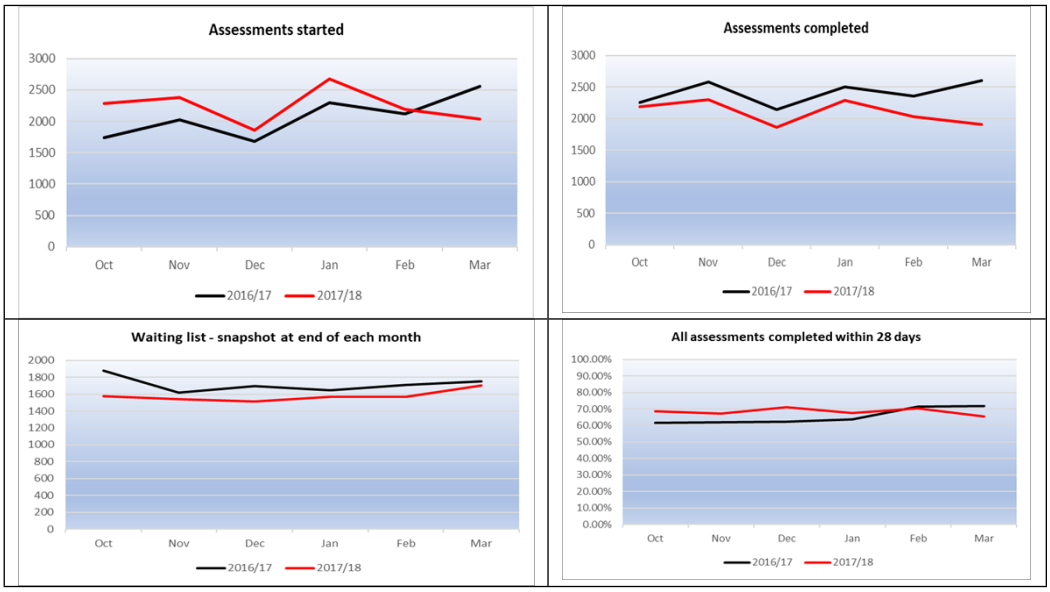


4.13 At the end of February and into March, Devon experienced two episodes of **severe weather "snow days**". The effect generally showed a marginal drop in the number of A&E attendances when the weather was worst, and an increase in activity following the bad weather. Calls to 111 and 999 increased as patients could not access normal health services and were often in receipt of health advice over the phone. Maintaining sufficient staff to handle calls proved a challenge for both providers. There were many examples across all sectors of staff making exceptional efforts to maintain care during difficult times, with many staff walking to or staying overnight at work.

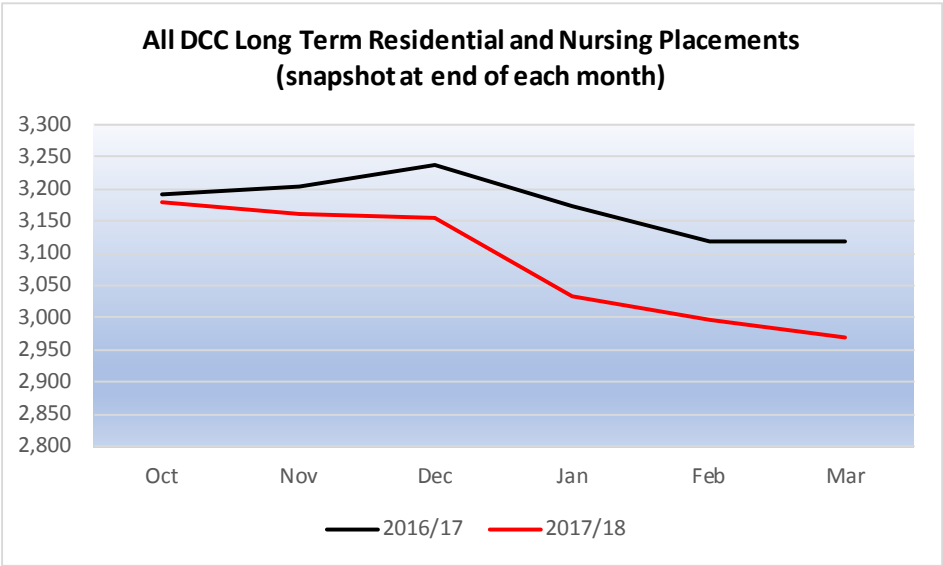
	Wednesday 28/02/2018	**Thursday 01/03/2018**	**Friday 02/03/2018**	Saturday 03/03/2018	Sunday 04/03/2018	Monday 05/03/2018	Tuesday 06/03/2018
ED Attendances	761	**524**	**600**	832	965	1,035	887
Emergency Admissions	458	**351**	**282**	334	349	491	524
111 Calls	621	**680**	**919**	2,132	2,004	840	751
999 Calls	586	**579**	**604**	683	696	744	606

	Saturday 17/03/2018	**Sunday 18/03/2018**	Monday 19/03/2018	Tuesday 20/03/2018	Wednesday 21/03/2018	Thurday 22/03/2018	Friday 23/03/2018
ED Attendances	**806**	**706**	801	938	936	847	888
Emergency Admissions	**345**	**298**	406	453	461	475	500
111 Calls	**1,589**	**1,369**	725	662	641	648	646
999 Calls	**590**	**580**	560	588	595	583	596

4.14 Similar volumes of **adult social care assessments** have been started and completed in the winter of 2017-18 when compared with 2016-17 with waiting lists marginally lower and timeliness slightly worse this than the previous winter. However, assessments are prioritised according to acuity of need and circumstances of the person involved, and those relating to people in hospital fit for discharge are prioritised.

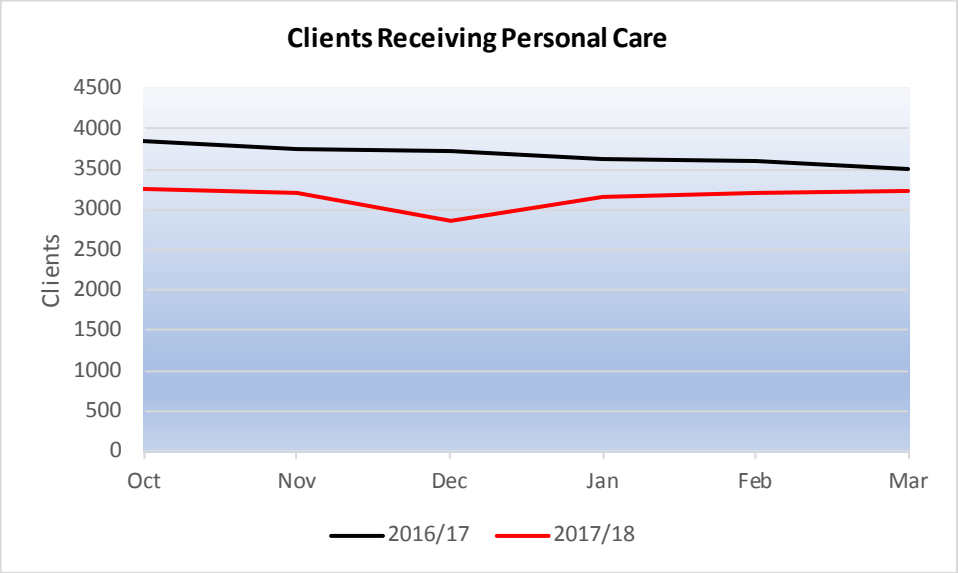


4.15 The severity of the winter and higher prevalence of related infectious diseases such as influenza is illustrated by the increased mortality of the frail elderly, in particular those living in **residential and nursing care**, with overall numbers supported by the local authority reducing far more significantly in the winter of 2017-18 than in 2016-17.

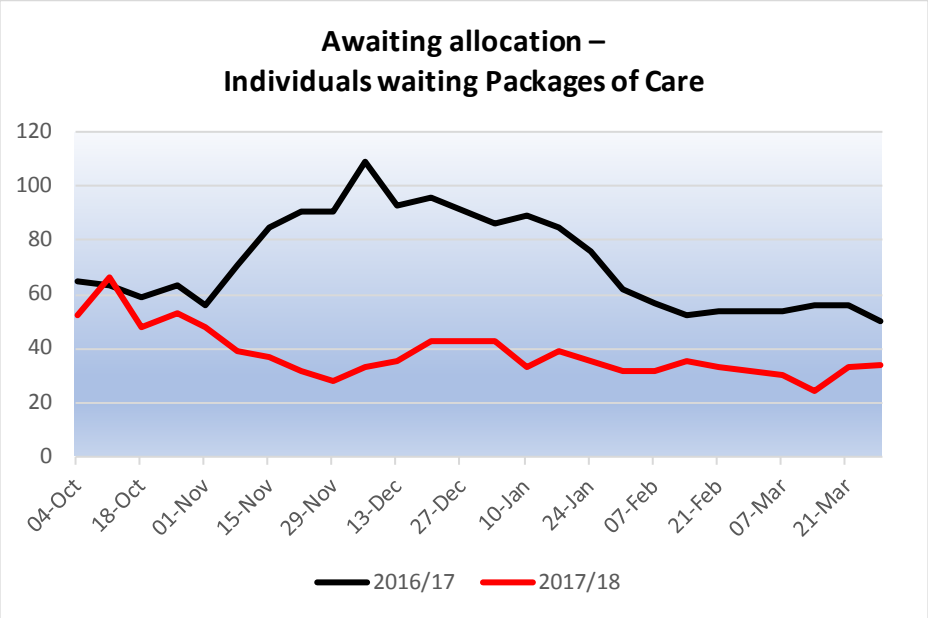


4.16 Although the number of clients receiving **personal care** and the number of hours of personal care being arranged by Devon County Council has been reducing over the last 24 months due to more emphasis being put on reablement services, technology enabled care and other approaches that

promote people's ability to live independently, the number of recipients over the 2017-18 winter has remained more-or-less static. The winter challenge is not one of increased volume but increased change with more people ending packages, starting packages and having changes to packages than at other times of the year.



Importantly, the number of individuals awaiting allocation of personal care is significantly less this winter than in the previous year. Contingency arrangements keep people safe where individuals are awaiting care to be agreed.



This has contributed to the proportion of delayed transfers of care attributable to social care being well below average in Devon with all agencies continuing to work together to ensure access to health and care services is timely and sufficient however they are funded.

5. Review of winter plans and preparation for next year

5.1 The Devon A&E delivery board undertook a “deep dive” at their April meeting. Each provider in Devon was asked to summarise what went well, what could have been improved and key learning for next winter.

5.2 Those represented included:

- Devon County Council Adult Social Care
- Devon Doctors Ltd.
- Devon GP practices
- Devon Partnership NHS Trust
- Livewell South West
- North Devon Healthcare NHS Trust
- University Hospitals Plymouth NHS Trust
- Royal Devon and Exeter NHS Trust
- South Western Ambulance Services NHS Trust
- Torbay and South Devon NHS Trust

The narrative below provides a high-level summary of key points from Devon provider plans and the summary&E Board Chair.

6. Summary of what went well over winter

6.1 Most providers noted that organisational arrangements worked well, including on-call systems and specific bed/winter management teams were established across Devon. Control meetings were held 7 days a week, with good engagement from a range of sectors and providers.

6.2 Workforce planning successes included:

- Annual leave planning to ensure workforce supply was in evidence. Some organisations, for example the ambulance service, already have leave embargos and plan to widen these next year.
- Additional staff were planned to support urgent and emergency care flow in acute hospitals and in particular Emergency Departments. Medical and nursing teams were supported by additional therapy and pharmacy staff.
- Incentives were used by most organisations to improve staffing levels.
- The flexibility and willingness of staff was noted repeatedly. Some providers, for example Devon Doctors and South West Ambulance, offered flexible working options including remote call answering and triage to provide additional capacity.
- Devon Partnership Trust ran a particularly successful flu campaign for front line health care workers, achieving 65% uptake overall, and 75% in in-patient facilities.

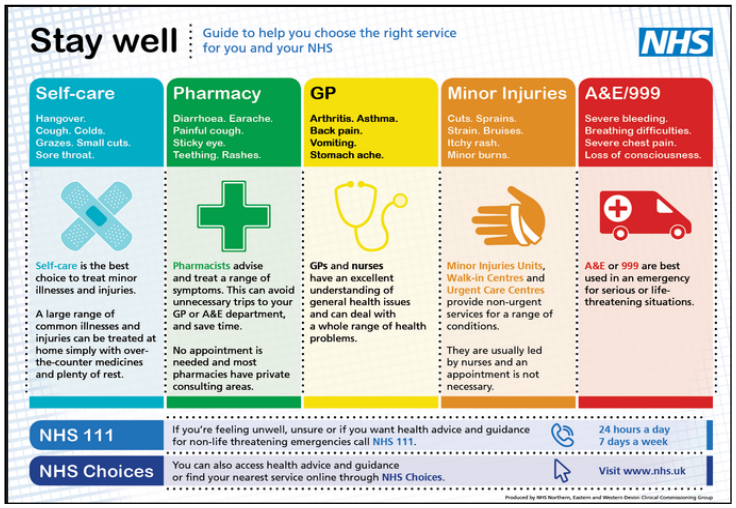
6.3 Some additional financial resources were made available from NHS England, albeit relatively late into the winter period. The funding was used to support a range of initiatives including additional beds, a GP frailty visiting service, liaison psychiatric support and, primary care acute visiting services, with a particular focus on care homes.

6.4 Extra capacity in personal care was made available across DCC, with an extra 820 hours (approx. 2%) of personal care purchased from November 2017 to February 2018. The outcome of this was a substantial reduction in individuals awaiting allocation of packages of care over the winter. It was

noted that market resilience during the severe weather incidents was excellent.

6.5 Additional beds could be made available across the system, including mental health beds (Psychiatric Intensive Care Unit and acute) and medical escalation beds. Admission assessment facilities were in place across all acute hospitals, which had an important impact on reducing numbers and crowding in Emergency Departments and supporting same day emergency care where suitable and appropriate.

6.6 A co-ordinated winter communications campaign worked well and included themed activities by week/month as well as the general promotion of initiatives including “Choose Well” and the NHS Quicker app, which shows real time activity and waiting times in EDs and community urgent care facilities.

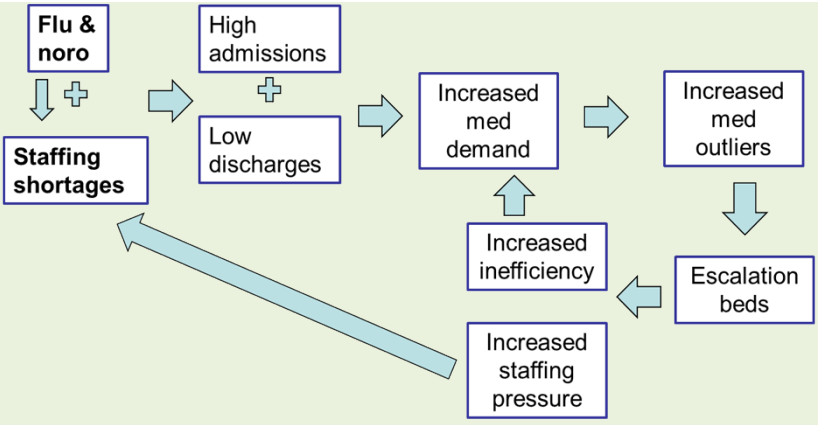


7. Summary of issues/areas for improvement

7.1 Communication across partners could be further improved, as could joint capacity and demand planning.

7.2 The nursing home sector continues to challenge with de-registration an issue, and workforce challenges for nursing staff a key factor. The Proud to Care campaign has gained national prominence in its efforts to promote careers in health and care and Devon County Council is working on a capital programme to attract investment in new nursing homes where capacity is, or is projected to be, needed. There are also questions on whether the “promoting independence” message is universally understood and working fully although it is acknowledged this involves a long-term cultural shift.

7.3 Increases in demand were noted across the system, as described in more detail in the activity/performance sections of this report. High attendances at hospital and admissions, alongside lower discharges and staffing shortages, combined to make for a difficult situation on many days. This diagram from the Royal Devon and Exeter Trust describes the situation well:



7.4 Workforce challenges persisted over the winter, with most providers struggling to ensure sufficient numbers of staff were available to meet predicted or actual demand. Higher levels of sickness were reported, including those with flu like symptoms. Agencies were used to fill shifts in many cases, a costly method of ensuring availability. Shift fill in the 111 service – call advisors and clinicians – persisted as an issue over winter.

7.5 Acute providers noted a range of issues of concern including the need to cancel elective surgery, medical outliers, Emergency Department crowding, 12-hour trolley breaches and long length of stay. The ambulance service saw a steep rise in the number of hours lost to hospital handover.

7.6 The severe weather in March tested most organisations emergency plans to breaking point. Most of them worked well, although a need for improved co-ordination was noted by most through Incident Control Centres (ICCs) and a focus on the timelier availability of 4x4 vehicles, if required.

8. Priorities for 2018-19

8.1 A recurring theme from the winter review was the need to start planning much earlier. As an example, adult social care leads are planning to hold a primary provider workshop with statutory agencies in May. The co-ordination and connection of plans across agencies needs to improve further.

8.2 There is a need to consider how to manage fluctuations in demand and determine which services may be able to be stood down, to deploy staff elsewhere to meet surge demand. Adult social care are actively pursuing this and the concept of a “winter hospital” has been proposed in South Devon and Torbay, which will include planning a more timely elective pause.

8.3 Seven-day services has been highlighted locally, and elsewhere, as having a significant impact on avoiding prolonged periods of escalation and surge following weekends/bank holidays. 7-day services, particularly in the community, were identified as one of the key reasons for success in the Cornwall “GOLD” command system reset. The Devon board has received a presentation from Cornwall and are currently working through the opportunities which can apply to Devon.

8.4 The A&E delivery board has agreed a set of priorities which will inform a work plan for winter 2018-19.

8.5 A number of providers identified a number of schemes they would enact for winter, or which had been so successful they will continue as business as usual. They include:

- Admission assessment units;
- Single point of contacts/discharge;
- Emergency Department streaming to primary care;
- Additional GPs during peak times;
- Clinical validation of Emergency Department and low-acuity ambulance outcomes from 111;
- Planning how and when escalation beds would be used;
- Near patient testing.

2018-19 Devon Winter Plan Priorities

- *Demand and capacity profiling;*
- *A shared approach to risk assessment and prioritisation;*
- *Workforce planning strategies to ensure the workforce is available across known busy periods;*
- *A consistent approach to escalation declarations and actions taken as a result;*
- *Pro-active management of flu including learning from DPT frontline health care workers campaign;*
- *Enhancing the role of the Integrated Urgent Care Service (including 111) to support demand across the emergency care system in particular;*
- *Repatriation of people from specialist services;*
- *Improved pathways into specialist mental health services.*

Tim Golby
Head of Adult Care Commissioning and Health
Devon County Council

Sonja Manton
Director of Strategy
South Deon and Torbay CCG and
NEW Devon CCG

Electoral Divisions: All

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

Chief Officer for Adult Care and Health: Jennie Stephens

[

LOCAL GOVERNMENT ACT 1972: LIST OF BACKGROUND PAPERS

Contact for Enquiries: Damian Furniss
Tel No: 01392 382300 Room: First Floor Annexe

BACKGROUND PAPER DATE FILE REFERENCE

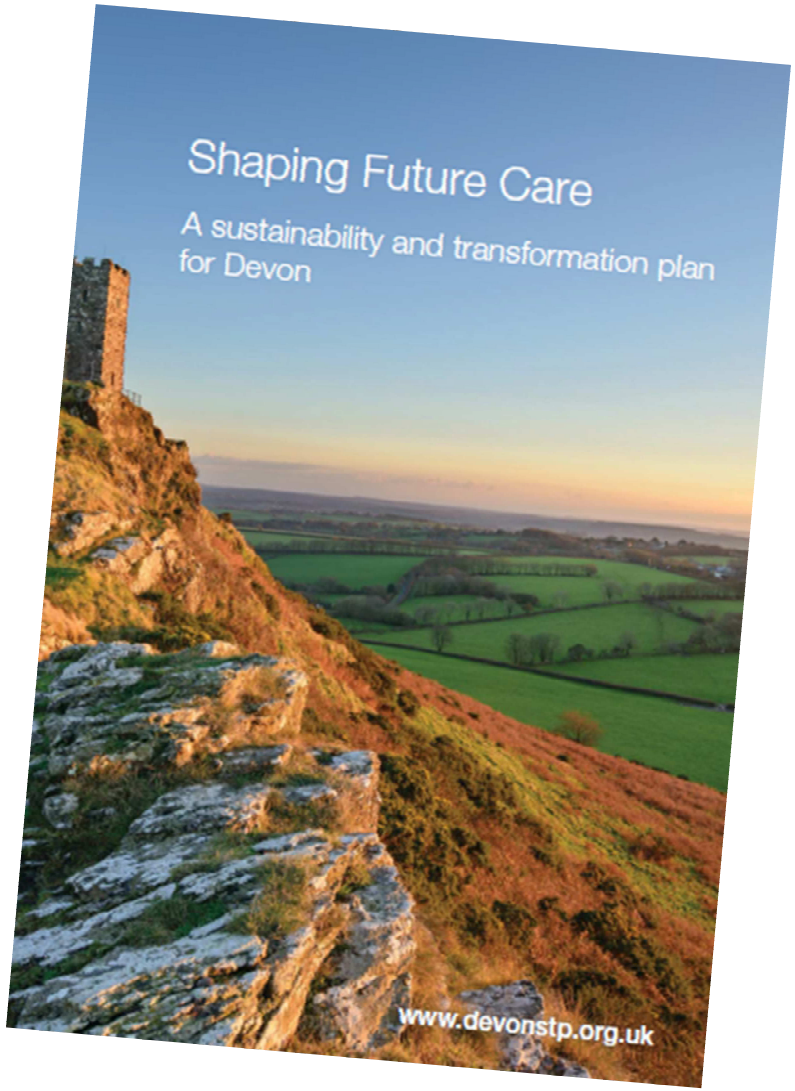
Nil

Health Overview and Scrutiny Committee
Devon STP Financial Overview

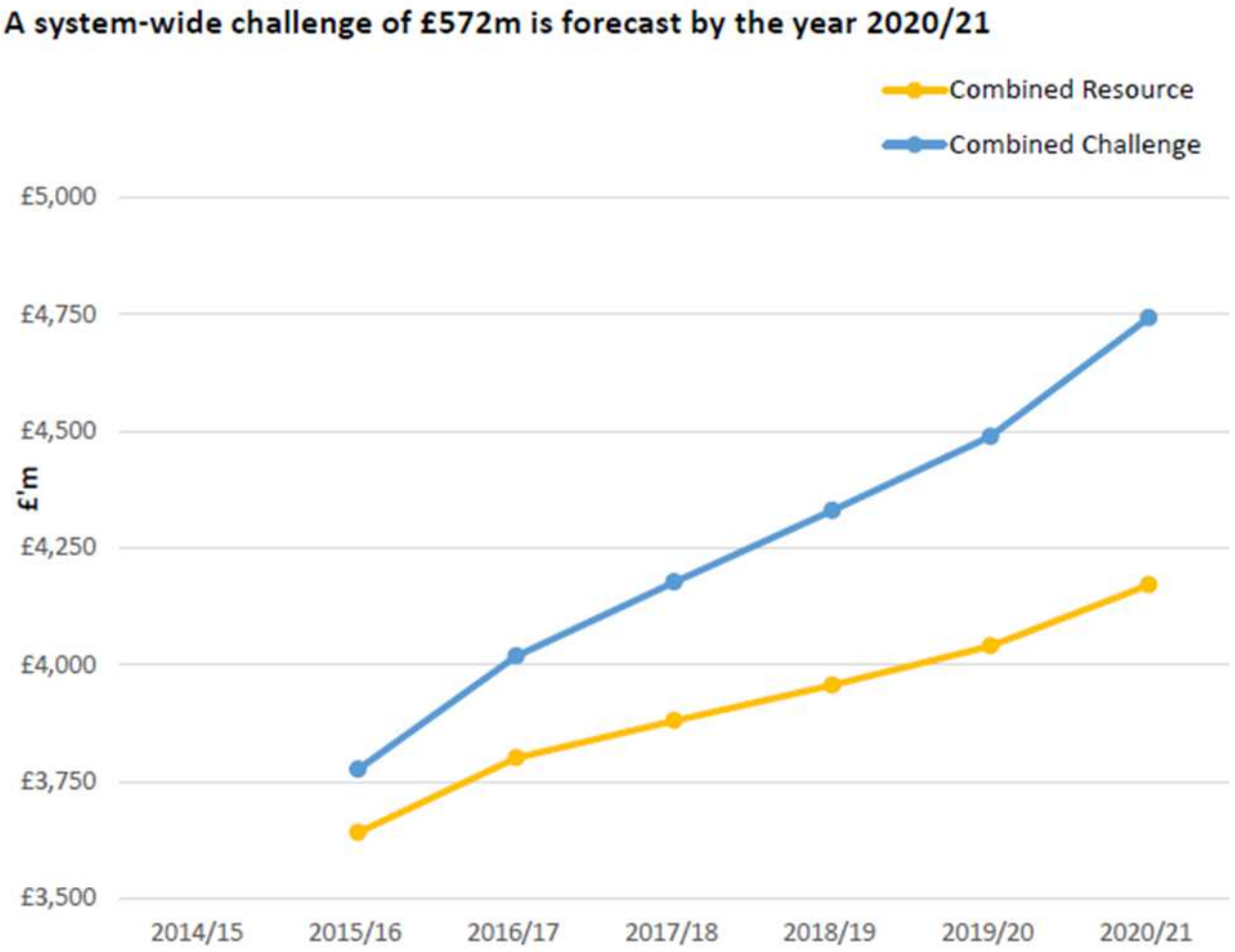
John Dowell
Devon STP Lead Director of Finance
7th June 2018

How STP has helped us transform together

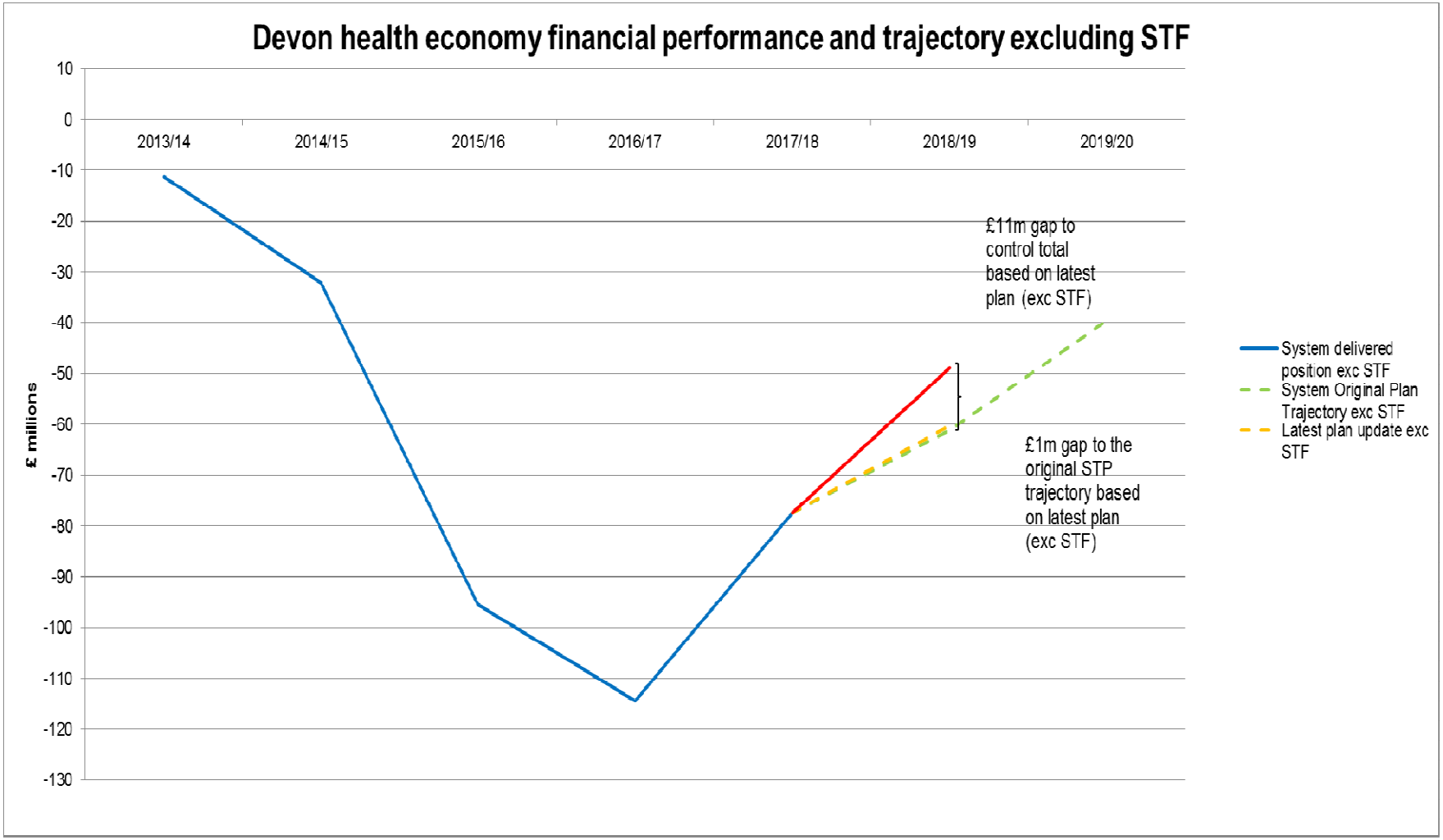
- Taking a pan-Devon approach to our challenges has reaped rewards:
  - On track to financial balance in 2019/20
  - Saved £103 million in 2016/17; and £157 million in 2017/18
  - Shared commitment to improving performance: Devon in top 30% nationally for cancer treatment, emergency care and mental health
  - New model of care approach has reduced reliance on hospital beds
  - New networks and workforce solutions across four acute hospitals



A reminder of the original STP forecast challenge - £572m by 2020/21



Devon Health Economy – Where are we now?



2017/18 Outturn – Better than plan

In 2017/18, the Devon STP delivered a deficit of £22.7m against a planned deficit of £61.9m (£39.3m better than plan).

This improvement in financial position was achieved by a combination of local improvement and additional national funding earned.

Organisation	2017/18 Plan Surplus/ (Deficit)	2017/18 Outturn Surplus/ (Deficit)	Variance	Variance Consists of: Local Performance Improvement	Tranche 1 Winter Funding	STF Bonus	National CCG Headroom Release	National CCG Cat M Drugs Release	Total Improvement
	£m	£m	£m	£m	£m	£m	£m	£m	£m
DPT	2.6	3.8	1.2	0.0	0.0	1.2			1.2
Livewell	1.1	1.1	0.0	0.0	0.0	0.0			0.0
NDHT	3.9	6.5	2.6	(0.3)	0.4	2.5			2.6
PHNT	(3.4)	3.1	6.5	(1.8)	1.2	7.1			6.5
RD&E	(0.5)	12.5	13.1	4.1	0.9	8.1			13.1
NEW Devon CCG	(57.1)	(49.9)	7.2				5.8	1.4	7.2
Subtotal NEW Devon Footprint	(53.4)	(22.8)	30.6	2.0	2.5	18.9	5.8	1.4	30.6
TSDFT	4.5	10.7	6.2	0.0	0.6	5.6			6.2
SD&T CCG	(13.0)	(10.5)	2.5				2.0	0.5	2.5
Subtotal South Devon Footprint	(8.5)	0.2	8.7	0.0	0.6	5.6	2.0	0.5	8.7
TOTAL DEVON SYSTEM	(61.9)	(22.7)	39.3	2.0	3.1	24.5	7.8	1.9	39.3

To deliver financial improvement significant savings have been delivered

£m	Savings Delivered/Planned In Year £m			FYE
Year	Recurrent	Non-Recurrent	Total	Full year effect of recurrent savings
2016/17	83	20	103	90
2017/18	114	43	157	131
2018/19	141	10	151	148

- The Devon health economy have evidence of significant savings delivery over the last two financial years since operating in a collaborative environment.

How has this been facilitated

- We have reduced the rate of growth in inappropriate referrals for acute services
- Working with GP Practices, We have controlled growth in Primary Care Prescribing Costs effectively
- We have improved processes for access to continuing care, ensuring those entitled to care have their needs met in the most effective way.
- We have significantly reduced our reliance on Agency staff, reducing the pay bill and improving the consistency of workforce in the process
- We have also made great gains in efficiencies in corporate services, procurement and moving to national best practice (Model Hospital)
- We have worked collaboratively with Local Authorities to ensure maximum benefit is derived from the Better Care Fund
- We have reduced administrative costs by aligning the two CCGs in Devon
- We have implemented new Care Models in Torbay and Southern Devon, Eastern Devon, North Devon and Plymouth. This has allowed the total number of beds in our system to be safely reduced by more than 200

Priorities going forward for continued financial improvement

- Continuation of our major STP programmes, building on success so far
- Working with partners, deliver a Financial framework that allows for comparatively greater investment in Mental Health services and Prevention than has been achieved in the recent past
- Ensure Devon is receiving appropriate resources for its population, particularly in respect of Remoteness of some communities

Access to General Practice - 7 June 2018 Health & Adult Care Scrutiny

Introduction and Response to Committee Comments

The Devon Health & Adult Care Scrutiny Committee has enquired about the accessibility of GP appointments in the county, following specific concerns within the Newton Abbot area.

As Devon GP Practices serve very different populations with varying circumstances (e.g., age, deprivation, rurality) across the county, the practices' appointment systems have been developed to be sensitive to this. They review the way they work with their peers across federations and local groups to learn from each other to be best placed to manage heightening demand and expectations.

Following comments put forward regarding access to GP appointments in and around Teignbridge, a snapshot audit was undertaken (from the Newton Abbot area) with the outcomes outlined below:

Survey undertaken on 29th May 2018

Practice	Next Urgent GP appointment	Next Non Urgent Appointment with a GP
Practice 1	Telephone and face to face appointment 29th May	12th June 2018
Practice 2	Face to face appointment 29th May	15th June 2018
Practice 3	Face to face appointment available 29th May	31st May 2018
Practice 4	Face to face appointment available 29th May	19th June 2018
Practice 5	Face to face appointment available 29th May	31st May 2018
Practice 6	Emergency sit and wait clinic on 29th May	8th June 2018
Practice 7	Appointments available 29th May for triage and subsequent appointments (29th) if necessary	1st June 2018

Our survey of practices highlighted that if patients needed an urgent appointment they could acquire that on the same day. The availability of non-urgent appointments varied between being available within 24 hours and an appointment within three weeks.

Most practices have systems that allow booking appointments in advance as well as on the day, and it is important that some appointments are held as on the day appointments to ensure those with acute unplanned need can have their needs met promptly. This is important in avoiding those in greatest need having to travel to less convenient and sometimes less appropriate places.

Within the national General Practice survey, Devon has received above average performance in the indicators regarding access, though like most of the country there have been slight declines in performance in recent periods owing to demand.

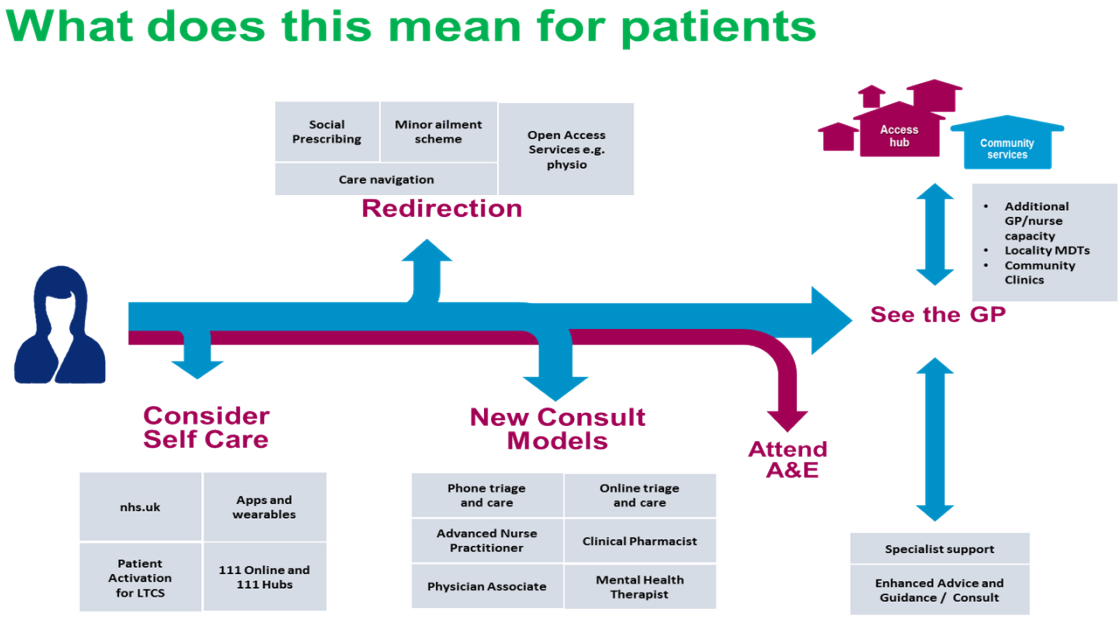
Clearly though, and as the audit above illustrates, we need to work with our GP colleagues to improve responsiveness to non-urgent care requirements.

It should be noted that Primary Care accounts for approximately 90% of all patient contacts.

Future Planned Improvements to GP Access

Public satisfaction with General Practice remains high, but in recent years patients have increasingly reported, through the GP Patient Survey, more difficulty in accessing services including a decline in good overall experience of making an appointment in General Practice.

The General Practice Forward View (GPFV) published in April 2016 sets out ambitious plans for Clinical Commissioning Groups (CCGs) to fund additional GP capacity to ensure that, by 2020, everyone has improved access to GP services including sufficient routine appointments at evenings and weekends. This sitting alongside and complementing effective access to out of hours and urgent care services.



The NHS Operational Planning and Contracting Guidance 2017–2019 sets out the funding trajectory for this work as well as a number of core requirements which commissioners of General Practice will be required to demonstrate they are meeting.

Refreshed planning guidance published in February 2018 now requires CCGs to provide extended access to GP services, including at evenings and weekends, for 100% of their population by 1 October 2018. This must include ensuring access is available during peak times of demand including bank holidays and across the Easter, Christmas and New Year periods.

Access to General Practice

However, good access is not just about getting an appointment when patients need it. It is also about access to the right person, providing the right care, in the right place at the right time.

In Devon we are identifying and developing solutions that allow patients to access care through alternative means where clinically appropriate, including via community pharmacists, the voluntary sector and by using technological solutions. This also includes patients seeing members of the General Practice team in settings other than their registered practice, or by seeing other healthcare professionals involved in their care within GP premises. During 18/19 we will also be introducing in some areas additional in-hours capacity such as early in the day visiting and proactive visiting to the most vulnerable patients such as those in care homes.

In addition we are working as a healthcare system to better our ways of working such that as patient care transfers from one setting to another, the needs of the patient are established in conjunction with the patient and shared promptly so that they can then be met. When a patient is discharged from hospital they and we need to be clear on how soon they will need to be seen by a GP or other healthcare professional, and know that an appointment will be available at that point in time. Patients being seen either too soon or not soon enough are both undesirable.

Provision of Online Offers

We are currently rolling out eConsult across Devon. This enables the patient to interact with their GP practice online in a way that provides a response to their initial contact within 24 hours, and which is convenient to them. The response can take many forms, including where appropriate a face to face appointment, though many queries can be managed remotely, making better use of both GP and patient time. This often allows patient and GP to work effectively to manage conditions in circumstances where doing so had previously been difficult, for example when working away from home, or being on holiday.

Self-care

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

We are empowering patients who are willing and able to self-care with support and information. We will also strive to reach those most vulnerable in our population and work with them to improve their health.

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

To achieve this we will make available to GPs a wider range of easily accessed and readily available alternatives to GP provided care. This will have GPs at the heart of the care model, but they will not be responsible for the delivery of each patient interaction. These alternatives for delivering each patient interaction will include other healthcare professionals, whose voluntary provision will be supported by onsite and remotely available information systems. Delivery will, naturally, though not exclusively, be most effectively delivered where multi-agency teams are co-located or otherwise in close proximity.

Social Prescribing

In recognising the need to support both GPs and patients, it is important to acknowledge that there has been a drift towards medicalisation of some of the impacts of the wider determinants of health, such that the GP surgery is seen as a focal point for the community. This is ever more important as we have seen a departure from the traditional family unit and reduced attendance in churches and religious services, both of which have been traditional sources of social and emotional support. As a result, this leads to many patient contacts with GPs which do not result in a resolution for the patient, triggering a cycle of repeated consultations which are seen as fruitless and frustrating to patients and burdensome to GP services.

We are seeking to empower patients to improve their own health and wellbeing by enabling them to connect with social, environmental and physical activities that will improve the quality of their lives. We are exploring and identifying models of social prescribing for patients who require support and facilitation in order to connect with the appropriate community service or voluntary sector provider which best meets their needs. Examples include art therapy, cooking, gardening, befriending and dog-walking. We will seek to personalise this service in order to maximise the benefits to individuals and to fully exploit the potential of social prescribing to reduce demand on GP services and on our acute hospitals.

With our local authority colleagues, we will work proactively with the voluntary sector to map provision in our communities and identify, where possible, areas of unmet need where voluntary organisations such as communities and charities could work co-operatively with commissioners and Primary Care to support patients to improve their well-being.

Voluntary and Third Sector

Much work has been undertaken locally in recent years to bring together statutory and voluntary entities, and to better align effort such that we complement rather than duplicate, all in pursuit of optimising our combined efforts to assist and support members of our communities.

We will continue the development of these working relationships between primary care (and also the wider health and social care system), and the third sector as we recognise still more can be achieved as a result. This will include exploring how we could better work with our third sector partners to support delivery of primary care provision, particularly where patient expectation extends beyond that which we are able to meet through traditional means. This will be grounded in learning from past experience and pilots.

It will remain important to understand the difference between entirely voluntary provision and that which is provided by voluntary sector providers as a result of commissioned and contracted activity. As a commissioner we recognise the opportunities and values that both offer to patients as well as the wider health and social care system. We acknowledge though that our planning, reliance and expectations must be different for wholly voluntary provision as opposed to that for which we formally contract.

We will actively engage in forums that bring together members of the third sector, as well as Patient Participation Groups and Healthwatch. We will also seek to further strengthen their input within our commissioning bodies where the value of doing so is identified.

In particular we hope to learn from the voluntary and third sector as regards their successes in working with identified communities and groups which for statutory health and social care have been identified as being ‘hard to reach’.

Health and Adult Care Scrutiny Committee

Better Care Through Integration?

An Investigation into the Working of The Better Care Fund in Devon

Final Report

7 June 2018

Contents

This report can be downloaded from:

http://democracy.devon.gov.uk/ieListDocuments.aspx?CId=428&MId=2855&Ver=4

Preface

In 2016 NHS organisations and local councils came together to form 44 Sustainability and Transformation Partnerships (STPs) covering the whole of England, and set out proposals to improve health and care for patients. Integrated care, close collaboration of health and social care, is firmly on the agenda and gathering pace.

In June 2013, the Government announced the Better Care Fund (BCF). Its purpose was to ensure a transformation in integrated health and social care. What made it different was that it created a single pooled budget to incentivise the NHS and local government to work more closely together.

The role of Health and Adult Social Care Scrutiny is to ask challenging questions about the way the system is structured and how it functions. As an important forerunner to an integrated care system, the Task Group was set up to come to a deeper understanding about the BCF and how it can help to inform quality working practices in this move to full integration.

I would like to thank the members of the Task Group for sharing their experiences and ideas, their insightful comments and consistent support that has helped me shape up this piece of work and write the final report. I would also like to thank the many witnesses who gave up their time graciously and talked to us openly and honesty which has enabled us to reach a better understanding of how the system works. Finally thank you Camilla de Bernhardt Lane for setting us on our way and inducting me as a new councillor into the ways of 'The Task Group' and thank you to Dan Looker for picking up the reins and helping me to finish the job.

Councillor Hilary Ackland,
Chair, Better Care Fund Task Group,
Health and Adult Care Scrutiny Committee

1. Introduction

1.1 The Task Group — Councillors Hilary Ackland (Chair), Sara Randall Johnson, Sylvia Russell and Carol Whitton — would like to place on record its gratitude to the witnesses who contributed to the review. In submitting its recommendations, the Group has sought to ensure that its findings are supported with evidence and information to substantiate its proposals.

1.2 On 19 June 2017 the Health and Adult Care Scrutiny resolved to set up the Better Care Fund Task Group. The terms of reference for the review were:

1. To appreciate the historical aims and applications of the Better Care Fund.

2. To understand the purpose and accountability of partners in integration.

3. To contribute to the future direction and monitoring of success of the outcomes of the Better Care Fund.

4. To report back to the Health and Adult Care Scrutiny Committee on the findings of the Task Group.

1.3 Time and resources necessitate that this report provides a snapshot approach to highlight significant issues. The list of witnesses to the review does not pretend to be exhaustive but it does provide insight into some of the central themes.

1.4 Therefore, the Task Group asks the Health and Adult Care Scrutiny Committee, Cabinet and Northern, Eastern and Western (NEW) Devon CCG and South Devon and Torbay CCG to endorse this report and seriously consider the recommendations tabled below.

2. Recommendations

Financial

Recommendation 1

That Devon County Council (DCC), Northern, Eastern and Western (NEW) Devon Clinical Commissioning Group (CCG) and South Devon and Torbay CCG should request that Government generate financial models that encourage full integration of health and social care budgets.

Measurement and Evaluation

Recommendation 2

That the Executive Team of the STP should consider the following:

i. That beyond monitoring of targets and outcomes, ongoing evaluation of impact is built into the system and this robust evidence accrued is used to review, change and develop the system for the benefit of the service users.
ii. That the evaluation framework should include significant public engagement and involvement.
iii. That serious consideration should be given to fund external evaluation of the BCF using iBCF monies to inform the development work of creating the Integrated Care System.

Acute / Community Services

Recommendation 3

i. That acute and community service providers should, together recognise that risk management is shared and should result in the establishment of a common risk assessment tool.
ii. That Health and Adult Care Scrutiny Committee should add the Carers' Contract into its work programme at least every two years.
iii. That GPs and community services should explore together innovative ways of working.

Workforce

Recommendation 4

That DCC should use its expertise to generate a mixed economy of care businesses to help alleviate the shortage of workers by setting up feasibility studies of new business models of care delivery that would lead to the possibility of investing in innovative practices.

Technology

Recommendation 5

i. That DCC should consider using iBCF money to develop quality Big Data and Big Data Analytics to support strategic decision making by commissioners.
ii. That both Social Care and the CCGs should ensure that there is full access for professionals and patients across both health and adult care to patient records and explorations around common assessment tools should be encouraged.

Mental Health

Recommendation 6

That, moving in the direction of the NHS England national target, equal priority is given to mental health as to physical health. There is a greater recognition that healing the whole person often means professionals across mental and physical health working closer together alongside Social Care, Public Health and Housing.

Governance

Recommendation 7

i. That CCGs with encouragement from DCC should put into place a governance structure where they join with Social Care and Public Health under the umbrella of local democratic accountability in both policy formulation and commissioning activities.
ii. That given the BCF governance is accountable to the Health and Wellbeing Board, recommendations 2, 4 and 5 would be monitored by the Board at regular intervals.

3. Background / Context

3.1 The Better Care Fund (BCF) was instigated by Norman Lamb, the Minister for Care Services when he initiated the Integration Transformation Fund that became the BCF. The underlying philosophy and purpose of the Fund has not changed since its inception. He gave a speech to the King' s Fund on 23 January 2014 where he outlined his vision. He called for 4 shifts in the Health and Care systems:

- Shift One was to move from repair to prevention. 'Payments by Results incentivises activity in acute hospitals. There has not been sufficient emphasis on preventing ill health and preventing the deterioration of health to prevent crisis from occurring in the first place.'

- Shift Two was to integrate a fragmented service and to have joined up thinking shaped around the needs of the individual. 'There has been years of institutional separation mental health from physical health, primary care from secondary care, and health care from social care.'

- Shift Three was to change from a culture of paternalism. 'The systems are very paternalistic and that needs to change to something that absolutely focuses on the individual, gives them power to determine what happens to them'.

- Shift Four was to move from what he describes as a very exclusive system to one where 'there has a much richer collaboration between the statutory services and the wider community. The voluntary sector and volunteers, people in the communities doing things to support others.'

3.2 Norman Lamb had high hopes for the BCF. He told his audience, 'the BCF, it seems to me, provides an extraordinary catalyst for accelerated change and it's the biggest promotion in my view of this shift from repair to prevent and the shift from fragmented care to joined up care that we have ever seen.'

3.3 The BCF comprised of existing budgets to create a pooled budget of £3.8 billion

- £1.1 billion transfer from health to social care
- £130 million Carer's Break funding
- £300 million CCG re-ablement funding
- £350 million capital grant that included £220 million Disabled Facilities Grant
- £1.9 billion from NHS allocations

3.4 Although not new money, Brandon Lewis Under Secretary of State in the Department of Communities and Local Government, at the same conference stated the following:

'What I would say, across the sectors, is to be absolutely clear about one thing in particular. Doing the same thing in the same way but with just a new co-signed signature on the plans will not cut it. We will pick that up. It is about working together in a new way, and working together from start to finish with local authorities and clinical commissioning groups coming together as equal partners.'

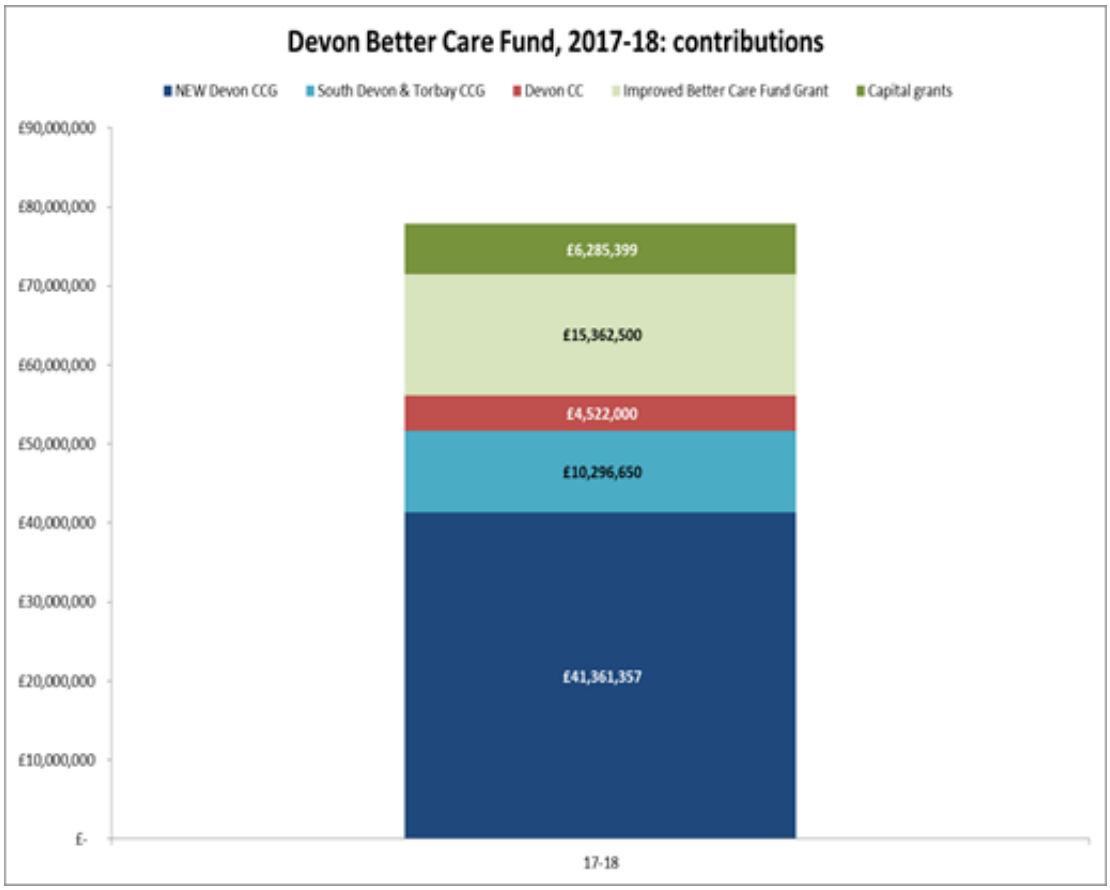
3.5 Fast forward to the present Better Care Fund 2017-2019, that is the subject of this report, we can see from its key purposes that it has remained integral to the project. In a very recent event 20/3/2018 the Deputy Programme Director of the BCF Support Team stated in her opening remarks. 'The BCF remains the main way in which government is supporting the creation of a better joined up model of integration that

aims to improve the way in which services are co-ordinated and delivered to individuals.'

3.6 Norman Lamb's shifts are reflected in the present-day policy goals of the BCF given at the event.

- Help individuals to manage their own health and wellbeing and live independently in their communities as long as possible
- Support and encourage more investment in out of hospital, preventative and personalised approaches to manage health and wellbeing
- Bring together health, social care and housing to produce joint integration plans (with a statutory underpinning)
- Create pooled budgets in every area to fund these plans
- Support an aligned cross-partner perspective on integration in all areas
- Support successful delivery of schemes towards integration and learn what works.

3.7 The size of the BCF has grown to over £7 billion each two years: 2017-2019. This includes the improved BCF Grant (over £2 billion) that is a revenue grant to give additional support to social care. This iBCF can only be used for meeting adult social care needs, reducing pressures on the NHS which includes supporting people to be discharged from hospital when they are ready and ensuring the social care provider market is supported.



3.8 The BCF is part of the bigger picture in Health and Social Care developments, the STP (Sustainability and Transformation Partnerships) and the impending Integrated Care Systems, all intent on ensuring local integration plans support and enable personalised, preventative approaches to care. The Government perceive the BCF as accelerating and making happen conversations about joint working across

agencies and therefore ‘oiling the wheels’ for whole system integration. There is an expectation that there will be full integration by 2020.

3.9 The individual is at the heart of the BCF ideology. It is, on the one hand, giving citizens joined up health and social care and on the other the Government is looking to find ways to have a healthier (therefore cheaper to look after) population. If a citizen becomes less healthy they will be living in a culture that expects them to stay as independent as possible, for as long as possible and to access help to stay at home surrounded by a resilient community. By rolling back the paternalistic culture-the state knows best attitude-the health system will only be there for specific and acute needs.

3.10 This Task Group was set up to investigate how the BCF plans in Devon are working and what impact it is having in integration in Devon. Therefore, it was considered important to understand how the commissioners and managers were engaging in the implementation of the BCF and how they have included the improved Better Care Fund grant.

3.11 It was felt that given the time limitation the emphasis should remain on the perspectives of the commissioners and managers. There is clearly a possible follow up report that would concentrate on the outcomes for providers and the public who use the services.

3.12 The report that follows highlights issues that have emerged through the witness interviews. It also suggests further considerations leading to recommendations. These could, potentially, improve the progress and pace of change towards a fully integrated system that appears to be the aim of the Health and Social Care leadership in Devon.

4. Better Care Fund in Devon

4.1 It is worth remembering that the Devon County Council area covers 2,543 square miles and has a population of over 750,000 residents.. It is largely rural with a number of small towns, scattered villages, hamlets and Exeter city, moderate as cities go with a population of around 128,000.

4.2 Devon's approach to the Better Care Fund (BCF) chimes with the underlying philosophy of the fund:

'The plan sets out our commitment to transforming care to deliver the best possible outcomes for our population; shifting our model of care so that more people are cared for in out of hospital settings-through prevention, more proactive care, and new models of care delivery-and reducing reliance on secondary care. We will take a place—based approach to wellbeing for our communities through joint working of statutory partners and the voluntary and charitable sectors.' (BCF Narrative Plan 2017/2019).

4.3 The Devon BCF is developed and agreed by the commissioning partners and signed off by the Devon Health and Wellbeing Board. The partners are Devon County Council New Devon Clinical Commissioning Group (CCG) and South Devon and Torbay CCG. During the year 2017 the two CCGs have come together to form a single strategic executive team to deal with a common set of financial and service challenges. They remain, however with two Boards. The Devon Model of Care has 3 principle elements that has been set up to put into practice the 3 priorities of the Devon Plan, targeted prevention and maintenance, support when crisis comes, and enhanced recovery and independence:

1. Comprehensive Assessment: putting a care plan in place that is designed to capture the potential need for further care in the future.
2. A single point of access to make it easier for GPs and others to get additional support when needed. It is connected to a Rapid Response service.
3. Comprehensive Rapid Response (care at home) so people can stay at home if possible and not be taken automatically to A&E should they, for example, have a fall at home. Support will be put in place for the immediate future to avoid hospital admission and support will be there for people leaving hospital if they need it for safety reasons. Reablement support will also be available alongside traditional care.

4.4 Building community resilience is also an important feature of the plan:

'Our voluntary and community partners will be at the heart of our new care model. It is vital that statutory public services and the voluntary and community groups work together if we want to improve people's health and wellbeing and reduce demand on health and care services.'

4.5 The Devon Model of Care is structured around Community Teams. Devon is divided into 4 localities (see Appendix 1) each with its own director of operations mandated to fulfil the strategic aims of the BCF. It was strongly felt that different solutions are required for different parts of Devon. Outcomes are set centrally but local solutions are sought that best fit local need.

5. Issues / Further Considerations

5.1 The issues arising from the witness interviews are presented here. The Better Care Fund exists within a fast-changing landscape of Health and Social Care. The interview methodology was open ended and conversations ranged over many topics. Interviewees were able to talk about the areas of work in which they were closely engaged and where the BCF fitted into their brief. Hence many of these issues were covered from different perspectives and so each issue written up here reflects the interests of more than one interviewee. Hence no attributions are given. Following issues raised by the interviews are further considerations that in our view emerge from the issues and lead to our recommendations.

Issue 1: Financial

5.2 The BCF is divided into three separate pools, reflecting differences in the external constraints and reporting requirements of the fund; capital, the improved BCF grant and revenue. Allocations of the three pools fall into the scheme type taxonomy required by NHS England although these categories are not used locally.

5.3 The BCF pooled budget sits alongside fragmented budgets of the NHS and Social Care. It is worth mentioning here that a Scrutiny Task Group undertook a spotlight review of Fair Funding in the NHS in Devon published in January 2017 and provides information on the funding formula and situation in Devon where reference is also made to how Social Care funding is allocated.

5.4 Working under specific budget headings causes issues for managers who are spending too much of their time discussing, debating and challenging each other about who pays for what when instead they want to be dealing with the person holistically. The BCF has given a flavour of what it is like to be able to look at the person's need as a whole and therefore managing to respond proportionally to that rather than identifying specific needs that match a particular budget. Total financial integration would potentially alleviate this.

5.5 However total financial integration would require trust, openness and transparency. It would require financial responsibility and a professional, positive approach to risk management. Local Government have years of experience of working within budgets whereas the CCGs have been able to go into debt. It would involve a change of approach working with individuals as a person in a context as opposed to only working with the conditions they have and dealing with individual conditions on a piecemeal basis. This is crucial as the NHS and Social Care is dealing with more and more people with increasingly complex needs and multiple conditions: one in three people in Devon live with one or more long term conditions.

Further Considerations

5.6 Financial integration is a means of enabling integrated care. Integrated financial approaches could possibly address and correct perverse incentives. Given the close working relationships across different organisations, legal frameworks set out centrally by government would specify the management of pooled budgets with equity and justice. A harmonisation of reporting requirements between NHS England and Department of Communities and Local Government would support the process.

5.7 However it is important to recognise that with integration, the social care budget could potentially move across into the Health budget and the local authority will become one of the funders instead of an equal partner. This is a concern within Local Government and impacts on local democratic accountability. This is discussed later in this report.

Recommendation 1

That Devon County Council (DCC), Northern, Eastern and Western (NEW) Devon Clinical Commissioning Group (CCG) and South Devon and Torbay CCG should request that Government generate financial models that encourage full integration of health and social care budgets.

Issue 2: Measurement and Evaluation

5.8 Delayed Transfer of Care (DTOC) occurs when a person is ready for discharge acute, non-acute or mental health care, but is still occupying a bed designated for such care. A person is ready for transfer when the following three criteria are met:

1. a clinical decision has been made that the person is ready for transfer
2. a multidisciplinary team decision has been made that a person is ready for transfer
3. the person is safe to discharge.

5.9 When the three criteria are met the clock starts ticking and there are 72 hours to sort it out. The clock pauses if one of the criteria is lost. Daily data is gathered at midnight each day. Best practice is 24/48 hour planned discharge.

5.10 The issue arising from this national measurement of DTOC is that it is skewing the work of the main principles of the BCF. The emphasis on hospital flow is causing problems. It was explained that there is an implicit misunderstanding about local context. There is a problem about what is being measured with the demanding DTOC targets difficult to meet. Government tries to simplify success as a specific target not being concerned by the complexities behind the statistic. DTOC is the first priority of the senior commissioner as there was a fear that funding would be cut if the November target has not been met. There is the receiving of daily DTOC data and the November target was met. In 2016/17 DCC rated below most comparators and regional neighbours and did worse than the national and regional averages. However, it halved between June and November 2017 and in November DCC was 93rd out 150 and was sufficient not to have funding put in jeopardy. Progress was made in all trusts, in particular the RD&E where 50% of Devon DTOC takes place. Progress has not been maintained over winter but it is worth noting that on other measures for example, length of hospital stay and re-admissions, the figures are better.

5.11 DTOC is attributed less to social care than NHS. In fact, the proportion of DTOC attributed to social care in Devon in November was half the national average. The three top reasons for DTOC in Devon are:

1. Awaiting NHS care
2. Awaiting a care package for own home
3. Awaiting a place in a residential or nursing home.

5.12 There is no robust evidence for this though it could be surmised that access to a bed in a home is not available at the right time and there are insufficient staff to process the care package in the time allowed. This highlights the need for processes and practices to be investigated. It is also interesting to note that the RD&E was praised for its exemplary plans to manage DTOC but this did not follow though in sufficiently reduced DTOC.

Further Considerations

5.13 Further consideration should be given to setting up an evaluation model that enables operational processes to be systematically observed and recorded for discussion and forward planning. Overarching the monitoring and the reporting of the national metrics could be an evaluation framework that has the brief to explore the impact the changes put in place have had on patients' experiences of care. The possible question to ask is: Has the way the resources have been spent, and the changes implemented, improved care outcomes in terms of the overall health and well-being of the population of Devon?

5.14 As part of the evaluation process, consideration should be given to how success or otherwise of the new model of care is to be judged. Does success mean having driven DTOC down? Does success mean better services for the public? Does success mean people are more aware of health issues and are looking after themselves better? An evaluation framework that explores these questions reliably would enable judgements to be made with a feedback process built in so continuous maintenance and improvement is possible. NEW Devon CCG have had issues with respect to patient and public participation. Including significant public involvement as part of the evaluation framework, would provide evidence of a meaningful engagement with patients, carers and communities. Perhaps there is a place here for using some of the monies unallocated from iBCF to fund an independent evaluation agency.

Recommendation 2

That the Executive Team of the STP should consider the following:

i. That beyond monitoring of targets and outcomes, ongoing evaluation of impact is built into the system and this robust evidence accrued is used to review, change and develop the system for the benefit of the service users.
ii. That the evaluation framework should include significant public engagement and involvement.
iii. That serious consideration should be given to fund external evaluation of the BCF using iBCF monies to inform the development work of creating the Integrated Care System.

Issue 3: Acute/Community Services: changing ideology through the commissioning process

5.15 The model of care is very much about promoting independence and supporting people to avoid crisis. Measuring pressure on the urgent care system and A&E works as a barometer to ascertain whether community services are working well or not. Community teams work to keep people well, out of hospital and in their own homes. Key members of the community are the unpaid carers who support the cared for and mitigate the need for the statutory services to step in to keep people safe. There has been over the life time of the BCF, a recognition that looking after carers' health and emotional wellbeing is crucial to de-escalation in the use of the acute services. Community service action plans seem to be working as non-elective activity is down. There is a direct correlation between increasing the treatment and support into the community and reduction of the number of people going to A&E.

5.16 There is an issue about acute/community service relationships. It is recognised that there needs to be a discussion between acute hospital staff to communicate better with community services-linking up with the patients then offering to let patients go

to community support. Consultants want to be sure that the patient can leave hospital safely but they need to let go the paternalistic stance and be confident that the community is supported, family members who see themselves as the primary carer, community and care teams alongside GPs offering a real patient centred approach.

5.17 The cultural shift to home based care from hospital based care carries risk. Risk is an issue and needs to be managed effectively. The community services need to be able, with evidence, to assess the risk to the satisfaction of the clinicians in the hospital services.

Further Considerations

5.18 The BCF was the first national driver to move money from health care to social care. This has put the emphasis on community services and has been a catalyst to start conversations about community health and wellbeing integration on the ground seeing the hospital as the last resort for people.

5.19 As mentioned above, the key cohort of people that are crucial to the success of care at home, are the army of unpaid carers supported by community volunteers who look after family members and friends in the community day by day. The new carers contract went live on 1 May 2018 and is funded out of the BCF at £2.2 million. It is a 5-year contract to which the CCGs are also absolutely committed. Carers were closely involved in the design of the contract and so key features they asked for are included: peer support and information, advice and guidance. Helplines are also available on managing conditions and carers' training is being offered so carers can take an active role and be recognised for maintaining their cared for at home in a stable state. As it is a 5-year contract it needs to be able to be reviewed over its life span. As well as careful monitoring, qualitative evaluation of this contract to give quality support to this group of people is crucial.

5.20 A further consideration is the improvement of communication and working relationships between community services and GPs. This relationship is central to making the system work. Innovative working models between GPs and community services should be explored. One new way of working is taking place in Devon where a team of GPs have given up their independence and are working under contract to the RD&E community services.

Recommendation 3

i. That acute and community service providers should, together recognise that risk management is shared and should result in the establishment of a common risk assessment tool.
ii. That Health and Adult Care Scrutiny Committee should add the Carers' Contract into its work programme at least every two years.
iii. That GPs and community services should explore together innovative ways of working.

Issue 4: Workforce

5.21 It is the role of community teams to keep people safe and to help them with their health issues outside the hospital. The teams are multi-disciplinary and have people in them who span health and social care; nurses, occupational therapists, care workers, all of whom offer services to help and support. The system moves people into it after they leave hospital for short term support-up to 7 days on average to help them get in their feet and be independent.

5.22 Teams also go into homes when health problems erupt. This is a rapid response team who can assess the situation and signpost to the appropriate service which may or may not mean hospital admission.

5.23 There is the issue within the teams of people working across the two different salary schemes of Health and Social Care with different terms and conditions, even in areas where they are doing the same job. In recent years to alleviate this situation, Rapid Response staff have been employed through Health rather than DCC, in some of the localities. These staff groups are often unqualified but with core competencies to support people with care needs at home. They are always overseen by clinicians such as community nurses and therapists.

5.24 One of the problems when people come out of hospital and received support, it is difficult to move them on if it is not possible to source help. As it is not right to leave people not safe they are continued to be supported for up to 6 weeks or more until social care can take over. This is known as 'back filling' and ties up staff who should be engaging in short term rapid response work. Hence, the issue here is the difficulty in having sufficient care staff in the system.

Further Considerations

5.25 The new ways of working in the community that is supporting integration is creating new roles for the staff as Health and Care workers are working across boundaries.

5.26 Reaching across organisational structures to build relationships, interconnections and interdependencies is defined as boundary spanning[1]. This can be done at an individual level to develop and manage interactions and at an organisational level by setting up policies and structures that facilitate and define the relationships between individuals and their respective organisations.

5.27 A notable new role that is emerging is that of the Care Navigator. This is now established in a range of health and community settings. Their main role is to support individuals to plan, organise and access support although their remit and extent of practice varies from giving advice and signposting to a more active role in supporting people to engage in activities. Exeter, for example, has developed community facilitators: connectors and builders and introduced social prescribing. The role of the Care Navigator could compliment this work.

5.28 Turning to the issue of sufficiency, DCC is very open about the shortage of care workers across the County and particularly in Exeter. This resonates with the situation nationwide. A recent survey of half of all local authorities in England responsible for social care commissioning found that 77% had experienced provider failure in the year 2015/16 and 74% thought another failure likely in the coming year[2].

5.29 One analysis warns of the loss of 37,000 beds in the care sector by 2020/21, whilst the chairman of one of the largest providers (which rescued almost 250 care homes from Southern Cross) has recently claimed that 50% of care homes are 'non-viable[3].'

5.30 In the case of home care, three of the top five providers, (Care UK / Saga / Mitie), recently decided to pull out of the market, after struggling to make a profit following the introduction of the living wage, and tougher immigration rules making recruitment more difficult. Mitie cites 'sustained downward pressure on homecare charge rates and reductions in the volumes of care commissioned' as reasons for the sale of its healthcare business for £2[4].

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[1] Williams P (2011) "The life and times of the boundary spanner", Journal of Integrated Care, Vol. 19 Issue: 3, pp.26-33
[2] Department of Health 2016.
[3] ResPublica (2016) The Care Collapse: The imminent crisis in residential care and its impact on the NHS
[4] Telegraph Business online 10/4/2017

5.31 The improved Better Care Fund (iBCF) can be used to stabilise the market. The Care Act 2014 provides LAs with powers and duties 'to shape' the market locally in order to achieve better outcomes. This remains unachievable because of the heavy reliance of DCC on private providers to deliver services.

5.32 Marc Sandel, public philosopher, argues that markets have become detached from morals and there has been a drift from having a market economy to being a market society. As a result, markets and market values have penetrated into spheres in which they do not belong[5].

5.33 Surely the time has come to have a different approach and a more mixed economy in the care sector with organisations with a social purpose being prioritised. Oxfordshire has earmarked funding from their iBCF to create micro-enterprises and community companies to support individuals in the home care sector.

5.34 In Devon, feasibility studies should be carried out to look at new and innovative care delivery models for the home care market and develop a business model which supports partnership working with the Local Authority.

Recommendation 4

That DCC should use its expertise to generate a mixed economy of care businesses to help alleviate the shortage of workers by setting up feasibility studies of new business models of care delivery that would lead to the possibility of investing in innovative practices.

Issue 5: Technology

Information Technology

5.35 There are information technology issues that are slowing down integration development and work that integration teams are doing. Devon has not created integrated assessment tools nor are there currently integrated electronic records. There could have been more focus on prevention with quality data informing policy decisions from the Joint Strategic Needs Assessment (JSNA) as a baseline. However, in reacting to strategic imperatives the focus of the BCF has been constrained to Health and Social Care in the context of financial pressure

Further Considerations

5.36 The sharing of data and common IT systems would encourage smoother integration. There is a call for easy access across both sectors and for a single assessment tool across both Health and Social Care. It is also felt that it needs to belong to the individual so that service users recognise their plan and know that they are the front and centre of it. The National Audit Office report on Health and Social Integration (February 2017) stated that an April 2016 review by the Local Government Association found there were no policy restraints preventing information sharing. They found from their case study visits that the local bodies were still unsure of the legal requirements for data sharing and felt this was still acting as a barrier. The Department of Health admitted they had not done enough to explain the rules around information governance.

[5] Sandel M (2012). What Money Can't Buy; the Moral Limits of Markets London: Allen Lane

5.37 The Joint Strategic Needs Assessment (JSNA) is central to the integration agenda and funded through the public health grant. The JSNA informs the health and social care system about the needs of the populace. The intention of the BCF is to increase resilience and enable a focus on preventative measures. A clear link should be developed from the JSNA to BCF spend. The Public Health Grant is ring fenced and reducing, however it would be possible through the iBCF for money invested in the development of the quality of Big Data to support strategic decision making by commissioners.

Assistive Technology

5.38 Assistive Technology (AT) is a broad term used to describe any item, object, device or system that enables the person to perform a task that they would be unable to do, or increase the ease and safety by which certain tasks can be performed.

5.39 It is seen as a supportive, complimentary means of enabling frail and vulnerable members of society to live safely and well at home for a longer period of time.

5.40 There is a yearly budget of £0.5 million from the iBCF to innovate the use of assistive technology. AT items can be bought through the community equipment service. The AT allocation is designed to enable delivery of the strategy, to ensure that technology enabled care and support (TECS) are considered at ever point of the assessment and review. The Devon plans for the iBCF allocation cover more than the first year and some of them will take time to fully scope and complete appraisals. The budget funded hosting a 'SmartHouse' event to demonstrate the use of TECS in a home environment.

5.41 Plans for 2019-2021 include option appraisal of the 'First Responder' service to respond to alerts for those using telecare. Also developing a business case for the best use of TECS to maximise independence for adults with disabilities as well as, a second 'SmartHouse' and development of case study videos and website to promote TECS to staff service users and families.

Further Considerations

5.42 According to the Social Care for Excellence AT for Older People research briefing, some of the key benefits of AT include:

- Increased choice, safety, independence and sense of control
- Improved quality of life
- Maintenance of ability to stay at home
- Reduced burden to carers
- Improved support for people with long term health conditions
- Reduced accidents and falls in the home

5.43 Combined with quality and consistent care and support and recognising the proposed technology must suit the individual and their unique situation, it can be a win, win for the individual and the care services.

Recommendation 5

i. That DCC should consider using iBCF money to develop quality Big Data and Big Data Analytics to support strategic decision making by commissioners.
ii. That both Social Care and the CCGs should ensure that there is full access for professionals and patients across both health and adult care to patient records and explorations around common assessment tools should be encouraged.

Issue 6: Mental Health

5.44 Mental illness is a huge agenda. It has been the Cinderella service. The Better Care Fund is as if money has dropped from the sky. BCF has allowed opportunities to focus on the preventative side as well as targeting ill health provision. It is hugely positive that a two year programme has been set which should allow the opportunity to look at the root causes of problems rather than just dealing with the consequences of bed blocking. (It is worth noting that in November 2017 half of the DTOC beds in non-acute settings were mental health beds) iBCF providing £2 million is helping to prevent the spiral.

5.45 Over the two-year programme the aim is to strengthen the provision across the Country and drive out areas of inequality in terms of access and quality. Teignbridge in particular has been identified as requiring more work in adult mental health. There is a crisis house in Torbay which helps to give support before things get to the point of acute. This quality of provision is going to be replicated with crisis drop-in centres in both Exeter and Barnstaple. There are mental health services in the prisons in the County at Exeter, Princetown and Channing's Wood but time did not allow the Task Group to review this.

Further Considerations

5.46 An emphasis needs to be placed on new communities to ensure there is adequate resilience in the system. There is a need to reach out in a more robust way. BCF can certainly 'oil the wheels' as part of the process. BCF is an adult pot but it is possible to bring families into it.

5.47 Between 12 and 18 percent of all NHS expenditure on long term conditions is estimated to be linked to mental health. The Joint Commissioning Panel for Mental Health (2012) suggests that liaison services should be provided in A&E departments for patients who have a mental and physical disorder to ensure their needs are met. Rapid Assessment Interface and Discharge, a model of liaison services which includes health and social care capacity as well as specialist skills to provide a complete mental health service in an acute trust has been shown to reduce hospital bed use, particularly by older people[6].

Recommendation 6

That, moving in the direction of the NHS England national target, equal priority is given to mental health as to physical health. There is a greater recognition that healing the whole person often means professionals across mental and physical health working closer together alongside Social Care, Public Health and Housing.

Issue 7: Governance

5.48 The original roots of the BCF came from existing funding streams, and this fact impacted on the approach to governance of the Fund. As it was now statutory for the budgets to be pooled it was initially seen as an administrative and bureaucratic issue and so a health and social care development group was set up to have oversight of the Fund and was originally chaired by the Cabinet member responsible for Social Care. The focus of discussion was around the deployment of the money and metrics to monitor what was going on. Public Health was involved in the

[6] Naylor C, Parsonage M, McDaid D, Knapp M, Fossey M, Galea A Long Term Conditions and Mental Health (London Kings Fund, 2012)

framework for the indicators that the BCF was hoping to achieve. The BCF reported to the Joint Commissioning Coordinating Group (JCCG) who provided quarterly reports to the Health and Wellbeing Board. This Board has to sign off the plans but it has no jurisdiction or influence on the nature of those plans as there was no direct line of accountability to the Board from the JCCG. The BCF Group is no longer convened and officers simply present the BCF plans to the Chair of the Health and Wellbeing Board who signs them. This situation is no longer considered to be a good one and plans are being put in place to have formal governance for the BCF and the iBCF together. There has been learning from 2017/2018 that indicates that the light touch approach has resulted in a lack of visibility of progress and lack of clarity about how to access funding. This is clearly an issue of accountability. A governance group is going to be set up. The issue now is that this group ultimately needs to be accountable to the Health and Wellbeing Board.

Further Considerations

5.49 The Health and Wellbeing Board is a statutory requirement within the Local Authority and has statutory functions for the oversight of the integration of Health and Social Care. It brings together social care, public health with the local NHS, police, fire and probation services as well as district councillors and patient groups including Healthwatch. It produces the Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Strategy for Devon. There is general agreement that the Better Care Fund has been instrumental in progressing the integration agenda and as mentioned previously, there should be a clear link between the JSNA and BCF. This would provide an evidence based approach that would be a model for STP/Social Care Integration.

5.50 At present, in Devon, the Health and Wellbeing Board has no commissioning responsibilities nor does it engage in policy formulation and is not a decision-making body. With a move towards full integration, a single integrated care system (ICS) is being developed. Within the ICS will sit a strategic commissioner who will involve the CCGs, the LA and NHS England. The lead on this is the CCGs and although they have informed the Health and Wellbeing Board what they are doing, the executive bureaucrats are moving ahead and making decisions including setting up a shadow ICS structure with the intention of then informing partners of their thinking. It would certainly be the case that the Health and Adult Care Scrutiny could challenge what the CCGs are doing but this is rather like closing the stable door after the horse has bolted. The democratically elected members are not involved in the shaping of strategy of this momentous move to full integration. Democratic accountability is missing in this scenario. Current accountability arrangements of local health services are out of date. New accountability frameworks need to be generated and cover health care, social care and public health. The structures in which to develop this exist, culminating in the Health and Wellbeing Board as an umbrella to the different levels of accountability needed for the purposes of monitoring and improving service quality and cost-effectiveness. The health and social care system is funded by public money, some of which goes direct to the local CCGs from NHS England bypassing the local democratic process. Other monies come through the LA where it is answerable to local democratic processes. There needs to be assurance that with the integration of these services public money needs to stay in public hands and not be swallowed up in NHS bureaucracy.

5.51 This situation has been recognised by the LA and plans are afoot to reconfigure the Health and Wellbeing Board to take a positive and influential role in the new health and social care system. Public transparency, public accountability and public engagement should be at the heart of our Health and Social Care system, a National Health and Care Service that is truly accountable to its local residents.

Recommendation 7

i. That CCGs with encouragement from DCC should put into place a governance structure where they join with Social Care and Public Health under the umbrella of local democratic accountability in both policy formulation and commissioning activities.

ii. That given the BCF governance is accountable to the Health and Wellbeing Board, recommendations 2, 4 and 5 would be monitored by the Board at regular intervals.

Councillors Hilary Ackland (Chair)
Sara Randall Johnson
Sylvia Russell
Carol Whitton

Copies of this report may be obtained from the Democratic Services & Scrutiny Secretariat at County Hall, Topsham Road, Exeter, Devon, EX2 4QD or by ringing 01392 382232. It will be available also on the County Council's website at:
http://www.devon.gov.uk/index/councildemocracy/decision_making/scrutiny/taskgroups.htm
If you have any questions or wish to talk to anyone about this report then please contact:

Dan Looker
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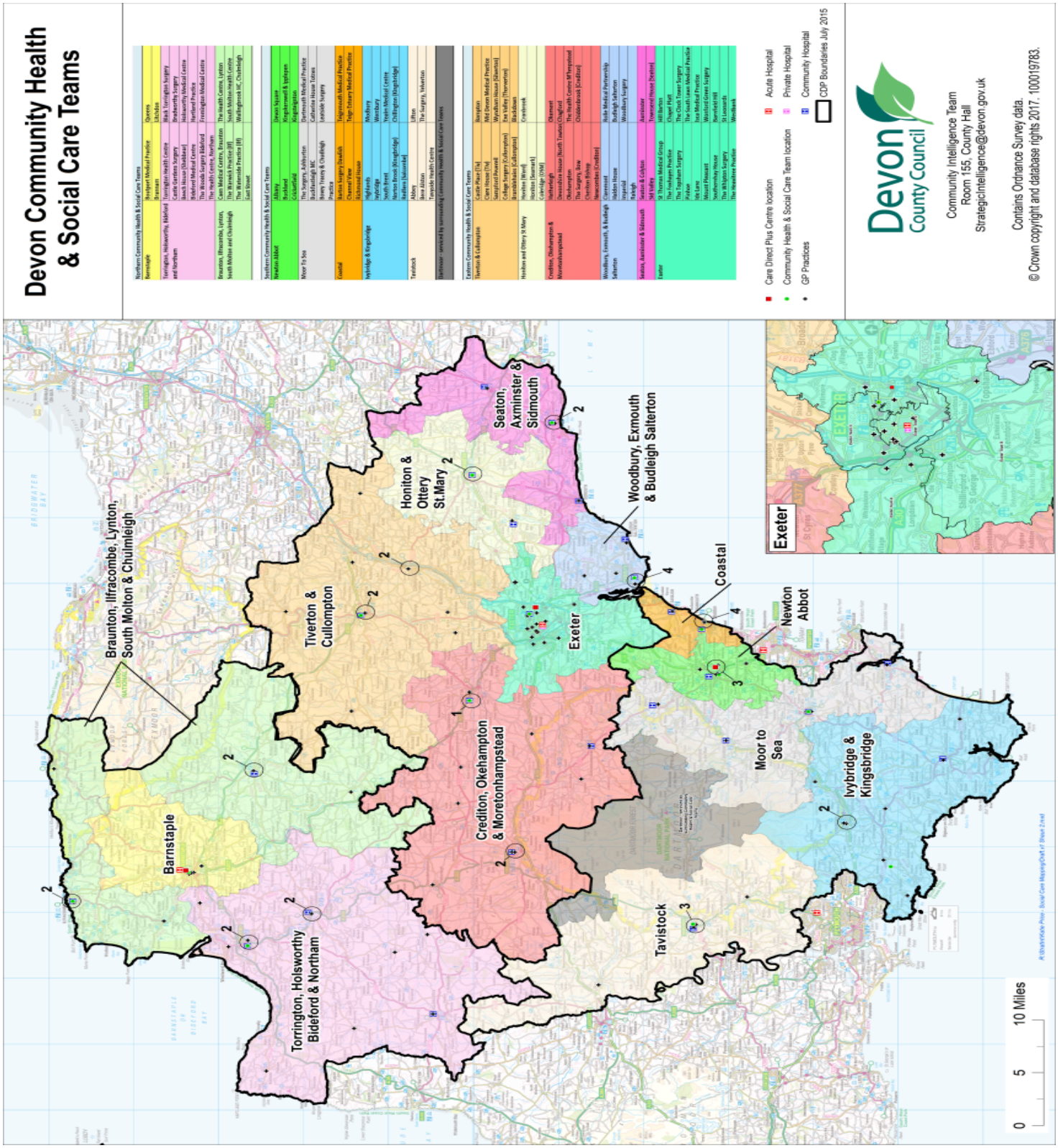
APPENDIX 1

Devon Community Health & Social Care Teams



APPENDIX 2

Task Group Activities

A1.1 The first meeting of the Task Group took place on **13 September 2017 to** discuss the scoping of the review with the Senior Manager (Older People), Adult Commissioning and Health.

A1.2 On **19 October 2017** members received evidence from the Chief Operating Officer NEW Devon Clinical Commissioning Group and Chief Operating Officer/ Deputy Chief Officer South Devon and Torbay Clinical Commissioning Group.

A1.3 On **7 November 2017** the Task Group met with the Head of Adult Commissioning and Health.

A1.4 On **13 November 2017** members met with Senior Project Accountant (Finance).

A1.5 On **5 December 2017** the Task Group received evidence from the Area Director (Eastern Division, Health and Social Care Services.

A1.6 On **22 January 2018** the Task Group met the Chief Officer for Communities, Public Health, Environment and Prosperity.

A1.7 On **7 February 2018** members met with the Integration Director, Royal Devon and Exeter Hospital; Senior Manager for Policy, Performance and Involvement (Adult Care and Health) and the Acting Area Director (Eastern Division) Health and Social Care Services.

A1.8 On **21 March 2018** the Task Group received evidence from the Head of Adult Care Operations and Health and the Assistant Director, Health & Social Care – Southern.

A1.9 On **23 April 2018** members met with the Senior Commissioning Manager - Market Management, Prevention, Carers and Living Well at Home and the STP Mental Health Commissioning Lead (South Devon and Torbay Clinical Commissioning Group.

A1.10 On **10 May 2018** the Task Group met to discuss the draft findings and recommendations.

APPENDIX 3

Contributors / Representations to the Review

Witnesses to the review in the order that they appeared before the Task Group. Members also met with a significant number of children and young people on their school visits.

Witness	Position	Organisation
Solveig Sansom	Senior Manager (Older People), Adult Commissioning and Health	Devon County Council
Rob Sainsbury	Chief Operating Officer	NEW Devon Clinical Commissioning Group
Simon Tapley	Chief Operating Officer/ Deputy Chief Officer	South Devon and Torbay Clinical Commissioning Group
Tim Golby	Head of Adult Commissioning & Health	Devon County Council
Duncan Ford	Senior Project Accountant	Devon County Council
Gary Patch	Area Manager (Eastern Division)	Devon County Council
Dr Virginia Pearson	Chief Officer for Communities, Public Health, Environment and Prosperity	Devon County Council
Gary Patch	Area Director (Eastern Division) Health and Social Care Services	Devon County Council
Adel Jones	Integration Director	Royal Devon and Exeter Hospital
Damian Furness	Senior Manager for Policy, Performance and Involvement (Adult Care and Health)	Devon County Council
Maggie Gordon	Acting Area Director (Eastern Division) Health and Social Care Services	Devon County Council
Keri Storey	Head of Adult Care Operations and Health	Devon County Council
Lee Baxter	Assistant Director, Health & Social Care - Southern	Devon County Council
Ian Hobbs	Senior Commissioning Manager - Market Management, Prevention, Carers and Living Well at Home	Devon County Council
Derek O'Toole	STP Mental Health Commissioning Lead (South Devon and Torbay Clinical Commissioning Group	Devon County Council

APPENDIX 4

Bibliography

- Devon Better Care Plan 2016-17
- Devon Better Care Fund Narrative Plan 2017-19
- Devon Health and Wellbeing Board, 'Better Care Fund: 2016/17 Fourth Quarter Return and Performance Reporting', 8 June 2017
- DoH, DCLG: '2017-19 Integration and Better Care Fund Policy Framework'
- Fair Funding in the NHS in Devon Task Group, Health & Wellbeing Scrutiny, January 2017
- LGA, NHS Confederation, Association of Directors of Adult Social Services, NHS Clinical Commissioners: 'Stepping up to the place The key to successful health and care integration'
- What Money Can't Buy; the Moral Limits of Markets London: Allen Lane, Sandel M, 2012

ACH/18/86
Health and Adult Care Scrutiny
7 June 2018

ADULT SOCIAL CARE SURVEYS AND FOCUS GROUPS

Report Head of Adult Commissioning and Health

1. Recommendation

1.1 That the Scrutiny Committee notes the insight gained from the service user and carers focus groups held to discuss the service user and carer survey results, and the actions being taken as a result of listening to individual experiences.

2. Purpose

2.1 The January Scrutiny Committee received a report which referred to the results of two national surveys in which Devon County Council participates. It was also reported that focus groups of service users and carers had been convened to discuss those survey results. At the March Committee it was agreed to submit a report describing the focus group findings and the action being taken in response to them, with Councillor Wright taking a lead on behalf of the Committee with the appropriate senior officers.

3. Background: About the Surveys

3.1 DCC participates in two national mandatory surveys:

- Annual Personal Social Services Adult Care Survey (ASCS) – service users
- Biennial Personal Social Services Survey of Carers in England (SACE) - carers

3.2 Both surveys are nationally produced by the Department of Health and are sent to all relevant local authorities in England.

4. The Service User Survey

4.1 The 2016/17 Adult Care Survey took place between 16 January and 10 March 2017.

4.2 1,281 surveys were issued, 561 were completed, a response rate of 44%.

4.3 We have just completed the 2017/18 survey and the results will be announced nationally in October this year.

5. The Carers Survey

5.1 The 2016/17 Carers Survey took place between 1 October 2016 and 30 November 2016.

5.2 992 surveys were issued and 655 were completed, a response rate of 66%.

5.3 The 2018/19 will take place during October and November this year and the results will be announced nationally in August 2019.

6. Survey results in our Annual Report

6.1 The results of both the Service User and Carers surveys were presented to the Scrutiny Committee as part of the 'Supporting evidence' section of the Adult Social Care Annual Report 2017. The report was published on the Devon County Council web site at: Adult Social Care in Devon 2017 Annual Report

7. About the Focus Groups

7.1 The results of both surveys were discussed by a number of focus groups to add qualitative insight from service users and carers to the figures presented in the Annual Report.

7.2 Three focus groups were held in late 2017 to discuss the results on the 2016/17 Service User survey, of which one group was for people with learning disabilities. 14 people participated in those groups. Devon currently provides services to around 17,000 adults.

7.3 Four focus groups were held in the autumn on 2017 to discuss the results of the 2016/17 Carers survey. 25 people participated in those groups. Devon currently provides support to around 3,500 carers.

7.4 Participants for all groups were independently recruited by Living Options Devon and the same simple format was used at each session. Participants were simply asked how they would have responded to the questions which prompted the most negative responses, and to consider the experiences which lay behind the results.

7.5 Given the self-selection of the groups, a motivating factor for participation was the chance to air personal discontent, and how groups focused on the survey questions which had the worst results, our approach was to deliberately provoke criticism and the must be read in that context. Comments made by group members were aggregated and fed back to participants who agreed that our thematic analysis had not distorted their views.

8. Themes which emerged from the focus groups

8.1 Clarity over what social care offers

8.1.1 The Service User focus groups highlighted how confused people can be over what level and type of support they actually receive from social care. Some people mixed up welfare benefits with social care support and most could not easily describe our 'offer'.

8.2 Confusion over what support is for the carer or cared-for person

8.2.1 The Carers focus groups highlighted how people are often unclear about whether they are receiving social care support as a carer or on behalf of their loved one. The group discussions uncovered some disconnection between carers services and adult social care management which was compounding this issue.

8.3 Difficulty in managing Direct Payments

8.3.1 Both carers and services users expressed frustration with the Direct Payments system and their ability to manage them. Some carers questioned why they were receiving Direct Payments rather than commissioned services and concerns were raised about the information provided on Direct Payments.

8.4 Dissatisfaction with Direct Payments monitoring

8.4.1 The way in which the care managers were monitoring what Direct Payments were being spent on and the way in which unspent payments were reclaimed was a concern raised by carers.

8.5 Lack of choice in provision

8.5.1 Some service users told us that providers were not giving them enough choice in the way they received their support.

8.6 Getting 'the basics' right

8.6.1 Service users reminded us how distressing it is when a carer worker fails to turn up on time or changes to arrangements are not communicated.

8.7 What makes people feel safe

8.7.1 When discussing what makes service users feel safe, the issues raised were far wider than social care support: street lighting, the built environment, isolation and fear of crime were cited.

8.8 Our role in making people feel safe

8.8.1 Interestingly, some service users stated that they thought social care had either no role or a very limited role in making them feel safe.

8.9 Reductions in support following reviews

8.9.1 Some carers expressed concern that they been receiving the same support for years which had then been reviewed from a perspective of helping promote their independence. They perceived the level of reduction to be unreasonable and stated that they had not been listened to effectively in the review process.

8.10 Lack of alternatives to day provision

8.10.1 Some carers focus group participants raised the way in which previous day services reductions had taken place without viable alternative sources of support.

8.11 The importance of GPs in supporting carers

8.11.1 Carers were clear about the difference that having a GP who understands carers issues and offers proactive support can make to their wellbeing and ability to cope.

8.12 The importance of informal carers support

8.12.1 Carers emphasised how important carer-to-carer support is in terms of practical advice and the ability to share experiences with people in similar circumstances, and questions were asked about how well DCC supports informal carers' networking.

8.13 Carers felt taken for granted

8.13.1 Some carers were quick to remind us how much the support they provide would cost us if they were not in their caring roles.

8.14. Some improvements too

8.14.1 Although the focus groups homed in on areas of concern, they did highlight some areas in which our performance has improved. The online 'Pinpoint' directory of local support had proved very useful for some people and there was some very positive feedback about the new 'Community Connector' role.

8.15 Action in response to insight

8.15.1 Holding focus groups in which people have a safe environment to comment on our services gives us valuable insight into the impact of our decisions, policies and practice on individuals. While the small size of the groups and the motivation of participants means our response must be proportionate, we are committed to acting on the what we have heard.

8.15.2 The insights gained from the focus groups have been shared with management in both social care commissioning and operations, and have informed a number of actions which have been grouped thematically below. Almost all of the actions listed below build upon work which was already underway before the focus groups, and receiving the feedback from individuals meant resulted it the acceleration of some workstreams, especially those which strengthen the links between the carers' provider and adult social care teams.

9. Public information

9.1 Adult social care public information is being reviewed, with service users and carers participating in that process. Following the focus group feedback, the review of public information has prioritised information for carers and information about Direct Payments. A new Devon Carers web site went live at the start of May.

10. Direct Payments

10.1. The review of the Direct Payments Strategy is looking at the circumstances in which the payments are offered and the way in which the offer is explained and monitored. This will include whether they are the most appropriate means of receiving support and the way in which reductions identified in reviews are managed.

10.2 The documents which accompany the Direct Payments process are being reviewed to ensure they are as user-friendly as possible.

11. Carers and adult care management join-up

11.1 There will be new training in Carer awareness and working with carers for Devon County Council Social Care staff and relevant Devon Partnership Trust staff – targeting staff who undertake assessments of people who may have a Carer.

11.2 Staff who undertake service user assessments are being prompted to undertake Carer assessments where appropriate, with appropriate training and familiarisation.

11.3 The Carer Champion role in DCC operational teams has been enhanced and extended to cover all adult social care teams.

11.4 Arrangements are in place to increase informal contact between the contracted Devon Carers provider staff and DCC and Devon Partnership Trust operational teams.

11.5 A Carers focus is being reinjected into operational staff development activity and project and change management documents and tools are being reviewed to ensure they do not overlook the Carers' perspective.

11.6 The Carer Recognition Tool is being rolled out to all community teams, hospitals and, crucially, GPs.

11.7 The carers contract provider is accelerating training for its staff in adult social care practices and processes.

12. Basic social care provision

12.1 The feedback received about a lack of choice and control being offered to service users by providers and the need to 'get the basics right' will be raised with them via the Provider Engagement Network.

13 Social care and safety

13.1 The wider reasons given for people not feeling safe have been raised with the parts of Devon County Council responsible for broader community matters via the LG14 leadership group.

13.2 People will be asked how safe they feel during reviews and the role social care support plays in making someone feel safer will be explained to them. This is being implemented as part of the ongoing development of professional practice.

13.3 The survey results and focus group comments have been reviewed by the Devon Safeguarding Adults Board and haver informed the Board's business plan for this year.

14 Summary and conclusion

14.1 The focus groups provided individual insight into the experiences which influenced how service users and carers responded to the surveys. That insight has been considered within the context of the small number of participants relative to the number of people receiving social care support, but is still valuable and has influenced our service development including the creating the action plans listed in this report.

Tim Golby
Head of Adult Care Commissioning and Health

Electoral Divisions: All

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

Chief Officer for Adult Care and Health: Jennie Stephens

[

LOCAL GOVERNMENT ACT 1972: LIST OF BACKGROUND PAPERS

Contact for Enquiries: Damian Furniss/Paul Giblin
Tel No: 01392 382300 Room: First Floor Annexe

BACKGROUND PAPER	DATE	FILE REFERENCE

Nil

Health and Adult Care Scrutiny Committee

COMMENTARY ON THE NORTHERN DEVON HEALTHCARE NHS TRUST

Devon County Council's Health and Adult Care Scrutiny Committee has been invited to comment on the Northern Devon Healthcare NHS Trust's Draft Quality Account for the year 2017 to 2018. All references in this commentary relate to the reporting year 1st April 2017 to 31st March 2018 and refer specifically to the Trust's relationship with the Scrutiny Committee and its Members.

The Scrutiny Committee believes that the Quality Account for 2017/18 is a fair reflection and gives comprehensive coverage of the services provided by the Trust, based on the Scrutiny Committee's knowledge.

The Committee appreciates the work undertaken by the Trust in 2017-18 to improve the effectiveness of transfers of care. Although Members understand the challenges the Trust faces, it has been an issue of significant concern to the Committee that an inspection by the Care Quality Commission in October 2017 rated the Trust as 'requires improvement' in several key areas.

Members found it useful that the Trust could attend the Health and Adult Care Scrutiny Committee meeting in March, in which the Trust outlined the Action Plan which was being implemented in response to the findings of the CQC inspection. The Committee is pleased to hear that a Trust-wide improvement programme is in place to address the areas requiring improvement and that these areas have been included in the Trust's priorities for 2018/19. The Trust undertook to keep the Committee informed on the progress of the Action Plan.

Members also found it useful that the Trust could attend the meeting of the Health and Adult Care Scrutiny Committee Standing Overview Group in May 2018 in which the Trust outlined its Quality Account for 2017-18 to Members.

The Committee welcomes the Trust's Quality Priorities for Improvement in 2018-19 and expects that the Trust will continue to work on improving patient flows, reducing waiting lists, and implementing integrated governance. Members also endorse the Trust's aim to strengthen training and appraisal processes for staff.

The Members of the Health and Adult Care Scrutiny Committee look forward to following the Trust's improvements in 2018/19 and hope for a continued positive working relationship to continue to ensure the best possible services for the residents of Devon.

COMMENTARY ON THE ROYAL DEVON AND EXTER NHS FOUNDATION TRUST'S QUALITY ACCOUNT

Devon County Council's Health and Adult Care Scrutiny Committee has been invited to comment on the Royal Devon and Exeter NHS Foundation Trust's Draft Quality Account for the year 2017/18 which includes the priorities for 2018/19. All references in this commentary relate to the reporting period 1st April 2017 to 31st March 2018 and refer specifically to the Trust's relationship with the Scrutiny Committee and its members.

The Scrutiny Committee commends the Trust on a comprehensive Quality Account for 2017-18 and believes that it provides a fair reflection on the services provided by the Trust, based on the Scrutiny Committee's knowledge.

In terms of the priorities for 2017-18, Members appreciated the campaign undertaken by the Trust in May 2017 to support the rehabilitation and reablement of its patients. The Committee also supports the work of the Trust in improving the availability of quality domiciliary care across Eastern Devon.

The Committee notes however that despite the Trust's shift from a bed-based model of care to providing more rehabilitation and reablement support in people's own homes, the Trust has been unable to meet the NHS Acute target for Delayed Transfers of Care. Reducing delayed transfers of care has been an issue of concern to Members.

Overall, the Committee is impressed with RD&E performance. It would like to commend the Trust on reducing the percentage of people readmitted to hospital within 30 days of being discharged with support from the Urgent Community Response service from 25% to 11% between September 2017 and March 2018.

Members are also grateful to the Trust for attending the meeting of the Health and Adult Care Scrutiny Committee Standing Overview Group in May 2018 in which the Trust outlined its Quality Account for 2017-18 to Members.

In the next year the Committee looks forward to receiving information on the Trust's progress in promoting the independence of patients. Members also appreciate the Trust's focus on continuing to improve the health and wellbeing of its staff and on the use of patient feedback to drive improvements in care. However, the Committee feels that there could be more of a focus on prevention surrounding drug abuse.

The Committee welcomes a continued positive working relationship with the RD&E in 2018/19 and beyond to continue to ensure the best possible outcomes for Devon residents.

Health and Adult Care Scrutiny Committee

COMMENTARY ON THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST QUALITY ACCOUNT

Devon County Council's Health and Adult Care Scrutiny Committee has been invited to comment on the Torbay and South Devon NHS Foundation Trust's Quality Account for the year 2017/18. All references in this commentary relate to the reporting period of the 1st of April 2017 to the 31st of March 2018 and refer specifically to the Trust's relationship with the Scrutiny Committee.

The Scrutiny Committee commends the Trust on a comprehensive Quality Account for 2017-18 and believes that it provides a fair reflection of the services offered by the Trust, based on the Scrutiny Committee's knowledge.

In terms of the priorities for 2017-18 Members appreciate the work undertaken by the Trust in the last year to increase the number of patients discharged earlier in the day and to reduce delayed transfers of care and lengths of stays. Reducing delayed transfers of care has been an issue of importance to Members. The Committee notes however that the progress of the Trust in improving outpatient pathways during 2017/18 has been mixed.

The Committee fully supports the Trust's Quality Priorities for Improvement 2018-19, and expects that the Trust will continue to work on improving outpatient pathways. Members also appreciate the willingness of the Trust to learn from and act on the experiences of its local population during the winter period 2017/18.

The Committee also supports improvements to patient experience measures to reflect service users' experience of care in the integrated care organisation. Members applaud the Trust's introduction of the NHS quicker app and the priority to increase the usage across Torbay and South Devon. The Committee also supports the aim of the Trust to encourage people to become more active in managing their own health through the HOPE (help overcoming problems effectively) programme.

Members anticipate that regular information on the progress of the HOPE programme will be shared by the Trust.

The Committee welcomes a continued positive working relationship with the trust in 2018/19 and beyond to continue to ensure the best possible outcomes for Devon residents.

Health and Adult Care Scrutiny Committee

COMMENTARY ON THE SOUTH WESTERN AMBULANCE SERVICE NHS FOUNDATION TRUST'S QUALITY ACCOUNT

Devon County Council's Health and Adult Care Scrutiny Committee has been invited to comment on the South Western Ambulance Service NHS Foundation Trust's (SWAST) Quality Account for 2017-18. All references in this commentary relate to the reporting period 1st April 2017 to 31st March 2018 and refer specifically to the SWAST's relationship with the Scrutiny Committee.

The Scrutiny Committee believes that the Quality Report for 2017-18 is a fair reflection and gives a comprehensive coverage of the services provided by the Trust, based on the Scrutiny Committee's knowledge.

In terms of the priorities for 2017-18, the Members of the Committee recognise the work undertaken by the SWAST in the last year to improve the identification of frailty in older adults. The Committee also acknowledges the Trust's work in improving the timeliness of responses to patient complaints. Members note however that there is still the need for improvement in this area.

Members are grateful to the SWAST for attending the NHS Inquiry Spotlight Review in October and the January Health and Adult Care Scrutiny Committee meeting in January. In January, the Trust provided the Committee with performance figures relating to the new targets for ambulance response times. The Trust representatives undertook to provide further information for members in relation to the Trust's performance. It has been an issue of concern to Members that the Trust has been unable to meet national standards for response times.

Members are also thankful to the Trust for attending the meeting of the Health and Adult Care Scrutiny Committee Standing Overview Group in May 2018 in which the Trust outlined its Quality Account for 2017-18 to Members.

The Committee supports the Trust's Quality Priorities for Improvement in 2018-19 and expect that the Trust will continue to work on improving ambulance response times. The Committee welcomes the initiative planned by the SWAST to improve the patient care experience through the 'Always Events' programme and endorses the Trust's aims to better understand the experience of mental health patients and to use a new response framework to refine the appropriateness of responses that

patients receive. Members also appreciate the Trust's focus on continuing to improve the health and wellbeing of its staff.

The Committee looks forward to a continued positive working relationship with the SWAST in 2018/19 and beyond to continue to ensure the best possible outcomes for Devon residents.

Health and Adult Care Scrutiny Committee

COMMENTARY ON THE DEVON PARTNERSHIP NHS TRUST

Devon County Council's Health and Adult Care Scrutiny Committee has been invited to comment on the Devon Partnership NHS Trust (DPT) Draft Quality Account for the year 2017/18 which includes the priorities for 2018/19. All references in this commentary relate to the reporting period 1st April 2017 to 31st March 2018 and refer specifically to the Trust's relationship with the Scrutiny Committee and its Members.

Members believe that the Quality Report 2017/18 is a fair reflection and gives comprehensive coverage of the services provided by the DPT, based on the Scrutiny Committee's knowledge.

The Committee is pleased to see that Trust has undertaken work in 2017-18 to develop clinical care pathways and to expand the Single Point of Access service. Members commend the Trust for reducing aggression experienced within wards and in developing partnerships with carers. The Committee is also grateful to the DPT for attending a Member development session in November on mental health.

The Committee notes however that the Trust has not achieved targets to improve physical healthcare monitoring and the experience and outcomes for young people as they transition into adult services. Members also acknowledge the challenges that Devon Partnership faces in recruiting to key posts in the medical and nursing professions, but appreciate that the Trust has performed well in relation to agency staff costs.

In terms of the priorities for 2018/19, Members endorse measures to further reduce the severity of harm reported in incidents on the Trust's inpatient wards. The Committee supports the implementation of carer awareness training for clinical staff and looks forward to hearing the Trust's progress in improving the physical health monitoring of people with mental health and learning disability needs and in embedding the integrated governance structure.

Members are grateful to the Trust for attending the meeting of the Health and Adult Care Scrutiny Committee Standing Overview Group in May 2018 in which the Trust outlined its Quality Account for 2017-18 to the Committee.

The Committee welcomes a continued positive working relationship with the DPT in 2018/19 and beyond to continue to ensure the best possible outcomes for the residents of Devon.