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

County Hall
Topsham Road
Exeter
Devon
EX2 4QD

Date: 4 November 2020

Contact: Gerry Rufolo 01392 382299
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HEALTH AND ADULT CARE SCRUTINY COMMITTEE

Thursday, 12th November, 2020

A meeting of the Health and Adult Care Scrutiny Committee is to be held on the above date at 10.30 am to consider the following matters. This will be a Virtual Meeting. For the joining instructions please contact the Clerk for further details on attendance and/or public participation.

Phil Norrey
Chief Executive

A G E N D A

PART 1 - OPEN COMMITTEE

1 Apologies

2 Minutes

Minutes of the Meeting held on 10 September 2020, 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 Finance and Performance Mid-Year Update: (a) Public Health; and (b) Health and Adult Care

(a) Service Delivery for Public Health Devon (Pages 1 – 4)

Report of the Chief Officer for Communities, Public Health, Environment and Prosperity (PH/20/02), attached

(b) Health and Adult Care (Pages 5 – 9)

Report of the Associate Director (Care and Health) Devon County Council and NHS Devon CCG (ACH/20/129), attached

6 Update on the Phase 3 Elective Care Restoration Programme in Devon (Pages 11 - 16)

Report of the Deputy Director, In Hospital Commissioning, NHS Devon Clinical Commissioning Group, attached

7 Devon Partnership Trust CQC Inspection - Improvement Plan (Pages 17 - 22)

Report of the Director of Corporate Affairs, Devon Partnership Trust, attached

8 Modernising Health and Care Services in the Teignmouth and Dawlish area (Pages 23 - 30)

Report of the Devon Clinical Commissioning Group, attached

9 Devon Doctors Care Quality Commission: Improvement Plan (Pages 31 - 74)

Report of the Chief Executive, Devon Doctors, attached

10 Standing Overview Group: Devon System Winter Plan / Devon Safeguarding Adults Partnership (Pages 75 - 80)

Report of the Health and Adult Care Scrutiny Committee Members (CSO/20/20), attached

11 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

12 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) Torbay and South Devon NHS Foundation Trust Updates: 30 October, 16 October, 2 October, and 18 September 2020.

(b) Think 111 First - a briefing on a new way to manage access to Emergency Departments.

(c) Update on MY CARE from Royal Devon and Exeter NHS Foundation Trust.

(d) Briefing from Devon Doctors Group relating to the CQC inspection report.

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 exempt information and should therefore be treated accordingly. They should not be disclosed or passed on to any other person(s). They need to be disposed of carefully and should be returned to the Democratic Services Officer at the conclusion of the meeting for disposal.

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Induction Loop available

PH/20/02
Health and Adult Care Scrutiny Committee
12th November 2020

Service Delivery for Public Health Devon: In-Year Briefing

Report of the Chief Officer for Communities, Public Health, Environment and Prosperity

Please note that the following recommendations are subject to consideration and determination by the Cabinet (and confirmation under the provisions of the Council's Constitution) before taking effect.

Recommendation: Health and Adult Care Scrutiny is asked to note the update on the delivery of public health services in 2020.

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1. Background

1.1. This report summarises the position on the delivery of public health service during 2020-21. It should be noted that this year, due to the impact of the coronavirus pandemic, the local authority public health function has been at the centre of the response, especially since the publication of the national Contain Framework which required upper-tier and unitary local authorities, from 1st July 2020, to establish COVID-19 Health Protection Boards and Local Outbreak Engagement Boards and a Local Outbreak Management Plan.

2. The delivery of the Council's strategic objectives: public health and health protection

2.1 Public Health Devon has been at the forefront of the local and regional response to the challenges presented by the coronavirus pandemic.

2.2 Specifically, Public Health Devon brought together the decision-making structures to deal with this international public health incident, under a Pandemic Incident Management Team (PIMT), which was chaired by the Director of Public Health. This enabled Devon County Council to:

- mobilise a rapid response across all key Council services;
- co-ordinate effort across the Local Authority;
- lead work with District Council partners, with the NHS, the police and other partners
- use the learning from the 'Doing What Matters' programme to support and develop high-quality decision-making and organisational response.

2.3 The Pandemic Incident Management Team was able to take swift decisions, with appropriate governance, about the deployment of additional resources to meet needs that were known to be escalating as a direct result of the pandemic, such as making
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additional money available to support services responding to increasing incidents of domestic violence, or increasing payments to support infection control in care settings.

2.4 Public Health Devon has since established and provided leadership for:

- The Devon Local Outbreak Management Plan
- The Devon and Torbay COVID-19 Health Protection Board
- and a Tactical Management Group.

2.5 As part of this, Public Health Devon has developed with partners a series of protocols (standard operating procedures) to guide services in responding in a wide range of settings in the event of local outbreaks. It is noteworthy that the arrangements with the University of Exeter have been tested extensively in recent weeks and have worked well.

2.6 Public Health Devon has drawn extensively on its expertise in intelligence and health protection and the capability of the Emergency Planning team to respond to the unprecedented challenges posed by the pandemic.

3. The delivery of the Council's strategic objectives: public health and health improvement

3.1 Public Health Devon's commissioned services have also responded quickly and innovatively. Commissioners and providers have worked together to vary contracts (where appropriate) to allow services to:

- focus on digital and telephone services where it has been deemed safe to stand-down the need for face-to-face delivery;
- develop innovative approaches to meet the needs of the most vulnerable.

3.2 Examples of this include:

- the sexual health service provided by Northern Devon Healthcare Trust was able to move at speed to initiate telephone triage of everyone who would have otherwise attended one of their walk-in centres;
- the substance misuse service provided by EDP/Together rapidly organised virtual contact with clients for support and welfare checks as well as continuing to deliver face-to-face interventions for the most complex clients; was able to modify prescriptions at short notice to provide opiate substitute therapy to individuals without the need for them to attend community pharmacies; in addition,
- the healthy lifestyles services provided by 'Everyone Health' mobilised a vaping pilot offer to rough sleepers who were smokers wanting and needed to quit to facilitate the accommodation they were provided as part of the 'Everyone In' programme;
- the health visiting service provided by Children's Services created a digital/phone model of delivery for health visiting and school nursing which was largely received very positively by families and complemented this with a comprehensive catch-up process based on targeting of higher need families for the 1575 babies born during lockdown who had only had a digital contact

3.3 Alongside responding to the Pandemic, Public Health Devon continues to support the local health and care system, including working with selected primary care networks to test new approaches to population health management, and by providing public health advice to NHS Devon CCG. The Director of Public Health also contributes to NHS senior system meetings on behalf of the Directors of Public Health for Torbay and Plymouth.

4. Delivery of the budget in line with the previously agreed budget

4.1 The work of Public Health Devon - and all of its commissioned services - are funded from within a ring-fenced grant that is paid directly to Devon County Council from the Department of Health and Social Care (DHSC). There are no actual or projected overspends to report against budget projections at the mid-year point.

4.2 Where contracts are paid on the basis of activity, there are underspends at the mid-year point, as fewer people have accessed services in both General Practice and in community pharmacies. Any underspends, though, are a delayed cost (as an example: there have been fewer health checks in the first half of the year than had been budgeted for but the expectation is that those health checks will still happen, just at a later date) rather than an actual saving. In terms of any significant variations from budget, Pubic Health Nursing recruitment vacancies currently account for approximately £300k underspend on the budget.

4.3 Money that hasn't been spent at year end remains within the statutory Public Health ring-fenced reserve, as required by the conditions of the Grant, and it may only be spent on the Grant's defined public health services.

5. Recommendations

5.1 Health and Adult Care Scrutiny is asked to note the update on the delivery of public health services so far in 2020.

6. Financial considerations

6.1 Contained within the report, particularly pertaining to the conditions of the ring-fenced Public Health grant.

7. Legal considerations

7.1 The deployment of the Public Health Grant for specified services is a statutory responsibility under the Health and Social Care Act 2012.

8. Environmental impact considerations

8.1 Contained within the report.

9. Equality considerations

9.1 Contained within the report.

10. Risk assessment considerations

10.1 Contained within the report.

Dr Virginia Pearson

CHIEF OFFICER FOR COMMUNITIES, PUBLIC HEALTH, ENVIRONMENT AND PROSPERITY AND DIRECTOR OF PUBLIC HEALTH

DEVON COUNTY COUNCIL

Electoral Divisions: All

Cabinet Member for Community, Public Health and Transportation and Environmental Services: Councillor Roger Croad

Chief Officer for Communities, Public Health, Environment, and Prosperity: Dr Virginia Pearson

Background publications

More information on health outcomes in Devon can be found in the Public Health Annual Report for 2019-20:

www.devonhealthandwellbeing.org.uk/aphr

FINANCE AND PERFORMANCE MID YEAR UPDATE

Report of the Associate Director (Care and Health), Devon County Council and NHS Devon CCG

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

Recommendations:

1. That the Health and Adult Care Scrutiny Committee receives this report to support its scrutiny of adult social care performance in Devon County Council and to understand progress towards delivering performance targets within the budget allocated to it.

2. The committee is also asked to note the ongoing national challenges set out in the report.

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1. Summary

1.1 To provide a mid-year update on the finance and performance of Adult Health and Care

2. Introduction

2.2 This year has been like no other; COVID-19 has been the focus of the health and care system and impacted the lives of so many. Partnership working across the system has been about maintaining continuity of care and care services and supporting and responding the needs of the most vulnerable people across Devon. The voluntary and community sector has played a significant and vital role.

2.3 Much of the work across the system has been about the here and now; it has needed to have been that way to respond to unprecedented circumstances. We have had to reprioritise our work and think differently about the services in the short term alongside national guidance and restrictions.

2.4 We have also seen a change in behaviours with some of those shielding reluctant to receive care services at home, in many cases family carers providing the necessary care but, in some instances, going without leading to a raise in safeguarding concerns relating to self-neglect and domestic abuse.
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2.5 This dramatic and sudden change to services and service user interaction throughout 2020 makes performance comparisons aiming to chart progress with previous years difficult.

2.6 In addition, the usual and established national reporting patterns and routines have been disrupted meaning we are unable make comparisons with other local authority areas nationally, regionally or locally. This benchmarking data will be available later in the year meaning that ASC Annual Report for 2020 will be presented to Health and Adult Care Scrutiny Committee in March rather than January.

2.7 Key messages from the ADASS budget survey 2020:

2.7.1 Without significant financial intervention from the Government, the lives of people who use social care and their family carers will be seriously impacted in terms of their lives and wellbeing.

2.7.2 The actual costs to local authorities and adult social care providers of the pandemic will far outstrip the Emergency Funding made available by the Government to-date.

2.7.3 The risk of already fragile care markets failing has significantly heightened as a result of the impacts of Covid-19.

2.7.4 Only 4% of respondents are fully confident that their budget will be sufficient to meet their statutory duties this year, down from 35% in 2019/20.

2.7.5 As a nation we want our social care workforce to be rewarded for their compassionate, committed, highly skilled and essential work. A fundamental shift in resources is therefore required from Government as part of a long-term funding settlement for adult social care.

3. Adult Care and Health mid-year finance and performance update

3.1 Adult Care & Health at month 6 is showing an overspend of £2.276m before management action and strategic savings. Management action plans still considered deliverable total £18k have been included which results in a year end forecast overspend of £2.258m which is £37k worse than reported at month 5.

3.2 At month 6 we are overall, currently serving 60 less clients than budgeted for.

Adults Month 6 Position Statement		Month 6					Diff
	Budget	Projected Outturn	Over / Under	Mngmt Action	**Over / Under**	Month 5 Variance	Over / Under
	£000	£000	£000	£000	**£000**	£000	£000
Older People	95,154	94,399	(755)		**(755)**	(997)	242
Physical Disability	22,642	22,179	(463)		**(463)**	(573)	110
Learning Disability (incl Autistic Spectrum Conditions)	84,457	86,472	2,015		**2,015**	2,003	12
Central & Care Management and Support (Localities)	25,538	25,703	165		**165**	227	(62)
Other (incl Rapid Response / SCR / Safeguarding and WD)	(1,353)	(1,285)	68		**68**	219	(151)
In House (Older People & Learning Disability)	8,252	8,186	(66)		**(66)**	57	(123)
Total For Adult Care Operations and Health	234,690	235,654	964	0	**964**	936	28
Adult Commissioning & Health	11,391	11,299	(92)	0	**(92)**	(116)	24
Mental Health	16,417	17,821	1,404	(18)	**1,386**	1,401	(15)
	262,498	**264,774**	**2,276**	**(18)**	**2,258**	**2,221**	**37**

3.3 Adult Care Operations

3.3.1 The forecast over spend is primary due to increased volumes of people served with Learning Disability and Autism or Mental Health

3.3.2 Despite an overall reduction of in the number of people served, down 60 from month 5. We continue to see a rise in the numbers of people served to meet their Learning Disability needs (up 19 from month 5).

3.4 Adult Commissioning

3.4.1 A forecast outturn of £92k underspend which is primarily attributable to capital projects funding transformation staff and staffing vacancies. This month's position is a £24k reduction in underspend forecast due to new apprentices.

3.4.2 For mental health, overspend continues but there is an £15k improvement on month 5 despite an increase of 92 additional people served primarily with individual support and enabling or direct payments.

3.5 Central Government Funding during the pandemic

3.5.1 Central government funding during the COVID-19 pandemic has equated to c£40m, this has been a combination of two rounds of the Infection Control Fund and the Local Government COVID-19 Fund.

3.6 DCC Adult Health and Care comparative performance

3.6.1 The information below provides a snapshot comparison of activity levels as at the end of July 2019 and 2020:

3.6.2 For older people, there has been an increase of 178 people (7.2%) in receipt of personal care packages but the overall hours of care has decreased. This could be related to the Discharge to Assess pathway supporting people's

discharge to home with a time limited package of support to maximise independence.

3.6.3 For working aged adults there are no substantial differences in the total number of people served or in the type of support received.

3.6.4 People being supported in short term residential and nursing care placements was significantly higher in 31 July 2020, due to new hospital discharge pathways resulting from the requirement for Acute Hospital Trusts to reduce occupancy levels to 50% from mid-March.

3.6.5 There has been reduction in the number of older people permanently placed in residential or nursing care, down from 584 per 100,000 in 2019/20 to 515.7 in August 2020. Changing preferences during the pandemic the likely reason.

3.6.6 There has been a significant reduction in the numbers of people supported by other community-based services (655 people or 28.9%) due to impact on these services during the COVID-19 period e.g. day care centres, Reaching for Independence.

3.6.7 Over the last 12 months there has been a 25% increase in the number of safeguarding concerns raised however the number of concerns proceeding to enquiries has decreased to 20.4%. There is clear evidence of the impact of the pandemic in the number of concerns raised during April and May, which is likely to reflect the fact that care homes in Devon locked down early as this is a major source of concerns raised.

3.6.8 The proportion of people with a learning disability in employment has fallen by to 7.3% down from 8%. This is disappointing given the proactive work put in place during the year to promote employment opportunities for people with disabilities.

3.6.9 The corresponding employment indicator for people with mental health needs has increased from 4.1% at year end to 8.2% in August 2020.

3.6.10 The proportion of people with a learning disability living in their own home or with their family continues to decline, to 72.1% in August from 75.6% at year end.

3.6.11 The corresponding accommodation indicator for people with mental health needs has increased to 66.1% in August 2020 from 52.7% at year-end. Work continues to address data quality issues relating to mental health and learning disability employment and accommodation data.

3.6.12 There is a rise in the number of children with Education Health and Care Plans particularly those with higher needs, it is this group that transition into adult services with the greatest likelihood of on-going need.

3.6.13 Through the work of Transforming Care Partnerships, national and local work continues to bring back to local areas their residents with complex Learning

Disability needs currently living out-of-area. This comes at significant costs to local authorities which was previously with the NHS.

3.6.14 As of the 27 October 2020 there have been 131 outbreaks across social care providers in Devon and as of 16 October there have been 95 fatalities.

Tim Golby, Associate Director (Care and Health), Devon County Council and NHS Devon CC

Electoral Divisions: All

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

Jennie Stephens
Chief Officer for Adult Care and Health

Contact for Enquiries: James Martin
Tel No: 01392 383000

Background Paper
Nil

02/11/20
Health & Adult Care Scrutiny Committee
12th November 2020

UPDATE ON THE PHASE 3 ELECTIVE CARE RESTORATION PROGRAMME IN DEVON

Recommendation: That the Health & Adult Care Scrutiny Committee note the update.
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1. Introduction

1.1. This paper will provide an update on the NHS Devon CCG programme for Elective Care Restoration, as part of the Devon Phase 3 Restoration Plans.

2. Phase 3 Restoration of elective

2.1. The national Phase 3 guidance (*Third Phase of NHS Response to COVID19*, dated 31 July 2020) set out an expectation that systems would restore elective activity to:

- 90% of 19/20 levels by October for elective inpatient, day case and outpatient procedures
- 100% of 19/20 levels of Magnetic resonance imaging (MRI), computerised tomography (CT) scans and endoscopy procedures (by October)
- 100% of last year's levels for new and follow-up outpatients

2.2. The final Phase 3 plan for the Devon System was submitted to NHS England on 5 October 2020, setting out activity plans (the amount of elective operations, procedures and outpatients activity to be undertaken) for the period from September 2020 to March 2021 and showing these as a percentage of 2019/20 levels, including outpatients, elective inpatients, day cases and diagnostics.

2.3. The Devon system recovery plans make progress to achieving the national ambition, but do not fully meet the requirements, due to a number of factors, including physical space, such as clinic room and theatre loss, and additional pathway measures to ensure a COVID safe environment. STAFF

2.4. An Elective Care Cell has been established to manage the implementation of the Phase 3 elective restoration priorities and the delivery of the local Adapt & Adopt programme, which is a national
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programme established as part of the National Incident Response Board strategy to accelerate recovery.

2.5. The Elective Care Cell has been broken into four workstreams to support the delivery of the Phase 3 and Adapt & Adopt:

1. Management of GP referral processes
2. Pathway development and GP and patient communication (Devon Formulary Guidance / My Health Devon
3. Outpatients
4. Surgical Restoration

2.6. Each of these workstreams has representation from all acute providers, primary care and the CCG.

3. The key priorities for Elective Care restoration in Phase 3

Priority 1: Increase activity for outpatient appointments and inpatient/day case procedures

3.1. All Trusts are restoring their elective services as rapidly as possible and there are only a small number of services which have not been stood up again. Many services are now being delivered in a different way, to ensure that the services are delivered in a COVID-secure environment. e.g. Virtual outpatient appointments where appropriate.

3.2. Surgical restoration is being taken forward as part of the surgical restoration workstream and outpatient restoration is being taken forward as part of the outpatient workstream.

3.3. Position at end of September:

Devon sustainability and transformation partnership (STP)	
Elective Care Delivered	**% of 19/20**
Elective Inpatients	70%
Daycase	75%
1st Outpatients	71%
Follow Up Outpatients	83%

Priority 2: Elective waiting lists and performance should be managed at system as well as trust level

3.4. There will be a centrally collated STP waiting list to support provider trusts, all of whom are clinically prioritising their waiting lists to ensure that the patients with the greatest clinically are treated first. This is part of the surgical restoration workstream implementation plan.

			20/09/2020	27/09/2020	Wkly Movement	June	July	Mthly Movement
RTT	England	Waiting List	3,682,691	4,017,469	334,778	3,859,962	4,046,707	186,745
		52+ wk	121,188	138,317	17,129			
		18wk performance	56.90%	57.78%	0.90%	52.00%	46.80%	-5.10%
	STP	Waiting List	104,358	102,230	-2,128	90,090	94,617	4,527
		52+ wk	4,007	4,489	482	1,800	1,920	120
		18wk performance	55.60%	57.75%	2.10%	52.40%	49.50%	-2.90%
Diagnostics	England	Waiting List		1,159,431		3,183,228	1,236,628	-1,946,600
		Activity						
		Performance		62%		96.20%	60.40%	-35.80%
	STP	Waiting List	19,848	19,075	-773	20,007	20,257	250
		Activity	6,601	6,914	313	29,415	34,695	5,280
		% of prev year activity				77%	82%	5%
		Performance	61.90%	63.60%	1.70%	52.70%	61.60%	8.90%

Priority 3: Communication to patients waiting for planned care about how they will be looked after and who to contact in the event that their clinical circumstances change

3.5. A Devon-wide approach has been agreed and communication to all patients without an admission date and who have been waiting over 18 weeks has commenced and will completed by the end of November. This is being delivered as part of the surgical restoration workstream.

Priority 4: Ensure the CCG e-Referral Service is fully open to referrals from primary care

3.6. The CCG e-Referral Service has remained open to referrals from primary care throughout the pandemic and remains so.

Priority 5: 25% of first outpatients and 60% of follow up outpatients to be conducted virtually

3.7. All hospitals have increased the number of virtual appointments they are conducting, where this is appropriate, and this is being delivered as part of the outpatient workstream.

Priority 6: Increased use of advice and guidance/patient initiated follow ups

3.8. There is increased use of advice and guidance/patient initiated follow ups in all hospitals and plans to develop this further and this is being delivered as part of the outpatient workstream.

Priority 7: Implementation of National institute for Clinical Excellence (NICE) self-isolation and testing guidance

3.9. All Trusts are implementing the COVID-19 rapid NICE guideline for arranging planned care in hospitals and diagnostic service

3.10. In addition, there are 8 urgent actions in the Phase 3 plan which focus on reducing health inequalities, which have been heightened by the pandemic, and the Elective Care cell are responsible for two of these urgent actions in relation to elective care:

- Restore NHS services inclusively, so that they are used by those in greatest need;
- Develop digitally enabled care pathways in ways which increase inclusion.

3.11. Each workstream has ensured that these urgent actions are incorporated into all the implementation plans.

4. Measures to increase capacity and performance

4.1. The national Adapt & Adopt Programme provided the following structured methodology, which was required to be implemented locally:

- Quantify and define the objective to be met. In each case, this will be a “gap” between current activity levels and those pre-COVID-19 by region.

- Run rapid problem-solving workshops with subject matter experts; regional and national stakeholders; clinicians to brainstorm “big ticket” solutions that can be implemented rapidly.

- Complete further immediate follow up at Integrated Care System (ICS) level with stakeholders and front-line teams to refine ideas further, develop system level plans and establish a programme approach to implement at pace.

- Share a “blueprint” solution to closing the gap with all regions to “adapt and adopt”, issues that are best resolved once escalated to national team.

- With support and co-ordination from national team, regions rapidly adapt the blueprint to fit with local conditions and move to implementation.

4.2. This programme focusses on the following priorities and this is incorporated into the Elective Care Cell's workstreams for delivery:

- **Theatres** - Prepare regional core principles based on national Infection Prevention Control (IPC) guidelines to support systems with practical implementation of relevant measures, including lessening PPE & Cleaning requirements and enabling local decision making to downgrade PPE according to risk.

- **CT MRI** - Prepare regional core principles based on national IPC guidelines to support systems with practical implementation of relevant measures.

- **Endoscopy** - Prepare regional core principles based on national IPC guidelines to support systems with practical implementation of relevant measures, including settling time on COVID negative Aerosol Generating Procedures (AGP).

- **Outpatient** - Prepare regional core principles based on national IPC guidelines to support systems with practical implementation of relevant measures. For outpatient transformation, adapt and adopt work complements and helps with rapid implementation of the existing National Outpatient Transformation Programme

4.3. There are targets to be delivered against each of these priorities and the CCG is required to report weekly to NHSEI against all of these targets.

5. Financial Considerations

5.1. Devon system reached half way point of this year with all its costs covered via the emergency financial framework which included retrospective reimbursement for covid related costs.

5.2. We have been set a fixed financial envelope for the second half of the year, which is representative of spending in the first half of the year, but there is no ongoing retrospective top up payment available. We have submitted a plan to NHS England and Improvement which reflects all the service priorities included in the phase 3 restoration plans and delivers financial balance in the CCG sector and a small (7.8m) deficit in the Provider Sector.

5.3. The significant recurrent deficit in the Devon system pre-covid has effectively been covered for one year by the system receiving more national money. We do not yet know how the funding might change in 2021/22, but it is unlikely that the deficit will be recovered again and we must address it via implementing the changes identified in the Long Term Plan, taking account of how covid will have impacted both positively and negatively on costs of service Provision.

Name: John Finn
NHS Devon CCG
Deputy Director In Hospital Commissioning

Devon Partnership NHS Trust

Devon County Council Health and Adult Care Scrutiny Committee

12 November 2020

Devon Partnership Trust CQC Inspection – Improvement Plan

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1. Background

1.1 During 2019 the Care Quality Commission (CQC) undertook a planned, routine inspection of four of the Trust's 'core services' alongside the annual Well-Led inspection.

1.2 In June 2020, in response to three inpatient deaths reported within a 12 month period, the CQC undertook a focused, unannounced inspection of Delderfield Ward (Exeter) and Moorland View Ward (North Devon).

1.3 In August 2020, following a death at the Langdon Hospital Forensic Mental Health site, the CQC undertook a focused, unannounced inspection of Holcombe and Ashcombe Wards.

2. CQC 2019 Core Service and Well Led Inspection 2019 – Key Themes and Trust responsive Improvement Action Plan

2.1 The CQC's published report in relation to the 2019 core service with well-led inspection, highlighted the following key themes for improvement:

- Trust clear oversight and safe monitoring and management of people who are on waiting lists for adult community mental health services, to include robust and routine review of any change to people's level of risk while waiting
- Improvements to staffing levels on inpatient wards and in adult community teams, ensuring holistic, person-centred, collaborative care and treatment
- Robust risk assessments of ward environments to ensure mitigating risks and plans are shared with and understood by all staff
- Provision of mental health beds for the population of Devon to avoid people having to travel out of Devon to receive inpatient mental health services
- Improvement to the physical health monitoring in compliance with NICE guidelines
- Continued partnership working with local commissioners to ensure resources are secured to meet the needs of people waiting for the Autistic Spectrum Conditions and Attention Deficit Hyperactivity Disorder service.

2.2 Devon Partnership NHS Trust Improvement Action Plan in response to CQC's 2019 inspection is split into five sections, aligned to the structure of the CQC core services that were inspected.

- Provider level action plan
- Adult Community Services action plan
- Adult Inpatient Services action plan
- Older Person's Inpatient Services action plan
- Community services for people with a learning disability or autism action plan

2.3 Positive progress has been made against the plan from the 2019 inspection, which is routinely reported through to the Trust Board of Directors.

Specifically, the following progress has been made:

- The Centralised Waiting List Management Team established following the findings of the inspection, remains in place, overseeing the waiting lists for all 17 adult community mental health teams; to maintain accurate records, manage correspondence with clients and plan regular clinician calls according to each individual's priority status. This centralised team carries out welfare calls, assesses the current situation for each client and any change to priority status or risk rating which is reflected on their clinical record and on the waiting list. They liaise with the appropriate community team where there are queries or concerns. Any identified risks or changes to risk are recorded in the progress notes and updated on the risk assessment within the client's clinical record and escalated to the team manager for allocation where required.

- Recruitment has been undertaken in both the inpatient wards and the adult community teams to increase the numbers of qualified, substantive staff to improve team capacity and stability and reduce the need for bank and agency cover. However, staffing remains one of the Trust's biggest challenges as is the case nationally and we continue to focus on recruitment, retention and staff wellbeing as one of our key priorities.

- Across the three localities, all ward environmental risk assessments are in place and all staff have easy access to these. To ensure staff are up to date, the content is raised through supervisions, team meetings and high risk areas are raised at routine handover. Ward environmental risk assessments are complete and in date. Daily ligature checks take place and identify works that need to be undertaken, which are reported to Estates and commence as soon as practicably possible.

  Environmental risk assessment is a topic on business meeting agendas, and also covered in supervision. Each supervision has a prompt in relation to ligature and management. Routine handovers include high risk areas. The Health and Safety Team and Estates Team do routine health and safety assessments on the wards in partnership with the ward management teams.

- The Trust continues to work in partnership with the local Clinical Commissioning Group and Local Authority colleagues and with NHS England to develop the bed stock for Devon as well as to improve flow through the inpatient mental health services, preventing the need for people to be placed out of Devon for acute adult or older adult inpatient mental health care. Building works have commenced for a new 16 bed ward in Torbay. In addition to this, as part of our plans to cope with the potential surge in demand for mental health services as a result of COVID-19, we have identified some additional inpatient capacity through leasing a brand new facility called Pinhoe View, in Exeter. The unit is owned by Elysium Healthcare, has been registered with the CQC and comprises two 16-bed wards and eight flats on one site. Our Russell Clinic rehabilitation service has recently moved into the Pinhoe View facility.

- All community bases have physical health monitoring equipment in place required to fulfil monitoring requirements of the Lester Tool; a national tool implemented by NHS England to '*support frontline staff in making assessments of cardiac and metabolic health, helping to cut mortality for people with mental illnesses.'* Staff

training in physical health monitoring has been refreshed and rolled out to support staff in delivering monitoring requirements and recording the interventions. COVID-19 restrictions to face to face contact have limited the ability to deliver this monitoring, but it remains a key Trust priority to progress as part of the wider Community Mental Health Framework implementation.

- We continue our partnership working with local commissioning groups and Local Authority partners in relation to the Autistic Spectrum Conditions and Attention Deficit Hyperactivity Disorder service pathways and this work, while delayed due to COVID-19, is now progressing again.

3. CQC June 2020 Unannounced Inspection to Delderfield and Moorland View Wards - Key Themes and Trust responsive Improvement Action Plan

3.1 Immediately following inspection, inspectors identified some serious concerns about patient safety on Delderfield Ward that needed immediate action. The CQC wrote to our organisation shortly after the visits were completed, requesting that we take urgent action to address the concerns that were raised. The CQC was assured by the action that we took, and are continuing to take, to ensure patients are safe.

3.2 The published June 2020 focused, unannounced inspection report that followed highlighted the reported key themes for improvement, which were:

- Robust, routine environmental risk assessments to be updated, including following every serious incident, to ensure robust mitigation is in place. This is to include environmental risks being reduced in a timely manner.
- Robust, comprehensive patient observations and intentional rounding to take place, completed in line with Trust policy.
- Staff must be appropriately trained, competent and confident in intentional rounding, observation and the assessment and management of patient risk.
- All staff, including temporary staff must have a thorough induction to the ward to ensure they are familiar with the ward and the tasks required.
- Quality and oversight of the ward to be ensured to ensure staff are completing their duties to a high standard.
- Learning from audits and serious incidents must be responded to and learned from in a robust and timely manner, ensuring that learning is shared with staff without delay.

3.3 Significant progress has been made against the plan from the 2020 Delderfield and Moorland View inspection, with the action plan nearing completion.

Progress made has been:

- The Trust has completed the Serious Untoward Incident Investigations into all three deaths that occurred on Delderfield and Moorland View Wards. The Trust has engaged with families during these investigations. In addition, the Trust has undertaken a thematic review of all three inpatient deaths, involving our Safer from Suicide team. This review will be completed by the end of this year.
- Significant strengthening of engagement and observation practices, to include a review and enhancement of the Trust's Engagement and Observation policy, particularly in relation to Level 2 observations and direct supervisory support to staff to enhance practice in relation to this.
- Robust auditing in place of engagement and observation processes, to highlight daily where staff require support to improve practice. This has had a positive impact on consistency and confidence across the staff team.

- Suicide prevention and ligature management programme led by the Safer from Suicide Team, which has resulted in the implementation of virtual simulation training; the training includes scenarios that staff have contributed to.
- Approval and progression of the Trust anti-ligature door sensor programme, which is currently in the procurement phase.
- Completion of ligature works in the bathrooms and toilets on Delderfield Ward following suspension of works during COVID-19 first lockdown.
- All incidents are reviewed daily on the ward for immediate action and weekly for themes and shared learning discussed by the Ward Managers and Senior Nurse Managers, to ensure shared action across all adult inpatient wards. Safety briefings are also shared to cascade learning from incidents organisation wide.
- The wards currently operate local induction programmes for new staff. However, in response to the inspection findings, all agency staff receive a local induction at the start of every shift, to ensure that all staff are aware of the most current protocols, policies, procedures and practices.
- Appointment of a substantive Consultant Psychiatrist to Delderfield Ward who commenced in post in September 2020.
- A new Ward Manager has been appointed, and has strengthened the ward management, governance and staff support arrangements, to include robust supervision and team meetings which have safety, quality and learning as the highest priorities.

4. Unannounced Inspection to Secure Services – August 2020 - Key Themes and Trust responsive Improvement Action Plan

4.1 On 18 and 19 August, CQC undertook an unannounced inspection to Langdon Hospital, in response to a death that occurred on 31 July 2020.

4.2 The published August 2020 focused, unannounced inspection report that followed highlighted the reported key themes for improvement, which were:

- Sufficient numbers of suitably qualified, skilled experienced staff to meet the patients care and treatment needs are required on Holcombe and Ashcombe Wards
- Learning from serious incidents and mitigating risks must be shared across all the trust's relevant ward and services and that the learning is used to inform practice.
- There must be safe observation practice on all wards and that staff always account for items that pose a risk
- Themes from conversations with the well-being leads must be escalated so these can be used to inform methods to support staff

4.3 The Secure Services Directorate has developed a responsive action plan to address these issues, which has been included as part of the wider Secure Services Quality Improvement Plan. The Directorate also enacted several interventions to mitigate the identified risks immediately following the serious incident that triggered the CQC's inspection.

Specific progress already made:

- To improve the potential for recruitment of staff, the Secure Services Directorate has invested in a Service specific recruitment team who are proactively seeking staff to recruit and improve the recruitment process. Additionally, the Service has invested in expansion of the Practice Education team who support staff progressing through the career pathway through to Senior Qualified Clinical posts. Further work is progressing in relation to inpatient staffing levels as part of the Trust's annual Safer Staffing review.

- There are forums in place within the directorate to routinely review learning from incidents and from experience and to disseminate this across the wards within the service.
- The Service has employed a Health and Wellbeing (HWB) Lead to develop systems and processes to ensure all staff are supported. As this is a new role they are developing a work plan to ensure their focus on a quality improvement approach to issues and themes identified.
- The lead will ensure a robust post incident management system, a Wellbeing group made up of staff from all professions and grades and to ensure staff views are heard at all levels of the directorate via monthly meetings with the Service Directorate Manager to ensure key themes are shared and issues at all levels are addressed. In addition staff have a confidential escalation route to the Trust Guardian who provides 'Speak Up' Supervision to the HWB Lead.

5. On 28 August 2020, a Quality Surveillance Group was convened led by NHS England / NHS Improvement, at the request of the NHS Devon Clinical Commissioning Group, attended by Care Quality Commission, NHS England Specialist Commissioning and Devon Partnership NHS Trust. The purpose of the QSG was to consider whether the Trust had robust systems and process in place to manage quality and safety of care.

The Trust presented the improvement action already undertaken and the progress that has been made in respond to these concerns. The Quality Surveillance Group resolved that robust assurance had been received and that no further formal action was required of the Trust. Enhanced partnership working was agreed as an outcome of the meeting, to ensure that the Trust is supported and enabled to enact some of the changes required that are not fully in its control to deliver.

6. Conclusion

The safety of the people we look after and the quality of services we deliver to them remain of paramount importance to the organisation. No death of a person in our care is acceptable. We extend our deepest sympathies to the families of the four patients who have died. We have already addressed many of these concerns and we will be working closely with the CQC and our Clinical Commissioners to continue to monitor progress and provide overall assurance that our services are safe.

Compiled by: Laura Hobbs, Director of Corporate Affairs

Presented by: Melanie Walker, Chief Executive

Date: 3 November 2020

NHS
Devon
Clinical Commissioning Group

Report to Devon County Council Health and Adult Care Scrutiny Committee

Modernising Health and Care Services in the Teignmouth and Dawlish area

3 November 2020

1. Introduction

The paper is to update the committee on the progress of the consultation. It follows previous presentations and updates, most recently at the meeting of 10 September 2020.

The formal public consultation on the future delivery of services in the Teignmouth and Dawlish areas ended at midnight on 26 October 2020, with more than 1,000 people having taken part.

Starting on 1 September 2020, the consultation invited views and comments on a proposal by Devon Clinical Commissioning Group (CCG) that arose from plans by Torbay and South Devon NHS Foundation Trust (TSDFT) to build a new £8million Health and Wellbeing Centre in the heart of Teignmouth. This will house Channel View Medical Group, the local health and wellbeing team, Volunteering in Health and possibly one of the existing Teignmouth pharmacies.

The proposal for consultation consisted of four elements:

a) Move the most frequently used community clinics from Teignmouth Community Hospital to the new Health and Wellbeing Centre

- This includes podiatry, physiotherapy and audiology. Because they are closely related to audiology, specialist ear nose and throat services would also move to the new centre

b) Move specialist outpatient clinics, except ear nose and throat clinics, from Teignmouth Community Hospital to Dawlish Community Hospital, four miles away

- These are the specialist clinics, 23 in number, that are less frequently used at Teignmouth Community Hospital, making up only 27% of total appointments there

- They are currently used by people from all over South Devon and Torbay as well as those from Teignmouth and Dawlish. 70% of people using them come from outside the Dawlish and Teignmouth area

c) Move day case procedures from Teignmouth Community Hospital to Dawlish Community Hospital

- This service includes minor procedures that require a specific treatment room
- 86% of those using them come from outside the Dawlish and Teignmouth area, with more than half from Torbay

d) Continue with a model of community-based intermediate care, reversing the decision to establish 12 rehabilitation beds at Teignmouth Community Hospital

- After investment in community teams, we can now treat four times as many patients in their own homes as we could on a ward at Teignmouth Community Hospital
- With the Nightingale Hospital established in Exeter, current analysis shows Teignmouth Community Hospital would not be needed for patients with COVID-19.

The consultation document stated clearly that if the proposal were approved, Teignmouth Community Hospital would no longer be needed for NHS services, and it would be likely to be sold by Torbay and South Devon NHS Trust, with the proceeds reinvested in the local NHS.

2. The consultation process

Because COVID-19 was, and continues to be, present in the community, the CCG made the decision to conduct the consultation remotely, enabling people to take part safely without needing to travel or come unnecessarily into contact with others.

To this end, and to ensure the widest possible awareness of the consultation, the CCG:

- Sent out 16,000 consultation documents and survey forms, to reach all households in the Teignmouth and Dawlish area
- Had 133,000 leaflets delivered to postcodes in South Devon and Torbay
- Publicised the consultation on Twitter, with 19,999 views and 174 engagements
- Arranged paid-for Facebook posts, which were viewed 47,153 times
- Ensured weekly news coverage in local media, enhanced with in-print and online advertising
- Created a dedicated consultation section on the CCG website which included links to the consultation document, supporting documentation (including regularly updated Frequently Asked Questions), videos and the Pre-consultation Business Case on the CCG website. People could also use the website to register as an interested stakeholder and receive regular updates, express an interest in attending an online meeting or to invite the CCG to meet remotely with a community group to discuss the proposal at a community or consultation meeting.
- Developed an easy read and audio version of the consultation document. The CCG website also featured a support software tool called Browsealoud, which helps improve accessibility by adding speech, reading and translation helping to reach a much wider audience.
- Contacted all the schools in Teignmouth and Dawlish to request they raise awareness of the consultation via their communications within the school community.

There were a number of ways people could take part in the consultation, namely:

- Respond to the hard copy survey included in the consultation document
- Complete the survey online
- Attend one of the 6 online consultation meetings that were held
- Watch the online consultation meeting back after the live event
- Invite the CCG to a community meeting to discuss the proposals
- Request a telephone appointment to have 1-1 discussions about the proposals
- Contact Healthwatch with queries or to request further information on a freephone telephone number, Monday to Friday
- Write (Freepost) or email with queries and/or feedback

In addition to more than 1,000 survey responses, recorded activity and contact also includes:

- 56 phone calls from local people calling with a range of queries.
- 6 online public meetings on different days of the week and at different times of the day:

Public meeting	Total audience	Households attending live event	Views of meeting recording
Fri 11/9, 2.30-4pm	**77**	12	65
Thurs 17/9, 10.30am-12pm	**54**	19	35
Wed 23/9, 6-7.30pm	**62**	17	45
Tues 29/9, 3-4.30pm	**51**	12	39
Mon 5/10, 11.30am-1pm	**46**	24	22
Sat 17/10, 11am-12.30pm	**38**	14	24

  - Feedback was received that some people attended on behalf of a number of others, asking questions on their behalf etc. More than one person can be watching per household.
  - Extensive social, digital and print media promotion
- 6 community group online meetings attended
- 2 meetings with members of staff and 2 with trust governors at TSDFT
- CCG website – 4,000+ views of Teignmouth and Dawlish consultation pages and 410 document downloads
- 34 letters and emails received by Healthwatch

3. Role of Healthwatch in Devon, Plymouth and Torbay

Healthwatch have supported the CCG with the consultation by:

- Collating all responses and analysing all responses to the survey
- Proactively contacting community groups to encourage participation and raising awareness for members
- Using social media to publicise the consultation
- Running a freephone telephone line Monday to Friday 10am-4pm for people to contact with queries and requests for information along with a contact email address.
- Attending all meetings to take notes to form part of the feedback

- Chairing the online public meetings
- Compiling a final report of all the feedback received
- Receiving correspondence and managing replies

4. Responses and key themes

Healthwatch in Devon, Plymouth and Torbay received 1,013 completed surveys, of which nearly half, 464, were paper copies.

This compares with 1,400 responses in a 2016 consultation on community services over a much bigger geography (four localities), indicating a high level of interest and a strong response to engagement in the process. Analysis of these responses is currently being carried out by Healthwatch who have provided the CCG with some initial high-level statistics about the consultation process from the survey as follows:

- 96.64% of respondents understood the proposal being made
- 83.1% of respondents said that the reasons why changed is needed was clearly explained
- 77.44% of respondents said they had 'completely' or 'mostly' been able to been able to get the information they needed and been able to contribute their feedback, 17.97% said they had been able to do so to 'some extent' and 5.13% answered 'no'

The following initial themes have emerged from the online public meetings:

- **Integration of services:** There is significant support for the idea of services being joined up so that care can be well coordinated around the needs of individuals. We heard appreciation of the work of GPs and community teams in the area.
- **Health and Wellbeing Centre:** This is viewed as a positive addition to healthcare facilities in Teignmouth, although there is concern about parking (see below) and some people did not want it to be built at the expense of beds in Teignmouth Community Hospital.
- **Parking:** There is significant concern that parking would be difficult at the new Health and Wellbeing Centre and that traffic congestion in the centre of Teignmouth would make travel by car more difficult. There is also some concern that parking at Dawlish Community Hospital is not free, whereas there is no charge at Teignmouth Community Hospital.
- **Transport:** Concerns have been voiced by Teignmouth residents about the need to take public transport to Dawlish Community Hospital, with the associated cost involved. Some individuals have also noted that there is no bus stop outside the new Health and Wellbeing Centre site, so a short walk is required.
- **COVID-19:** There has been some concern that having no beds available at Teignmouth Community Hospital could be a risk to the local NHS if the pandemic situation worsens.
- **Teignmouth Community Hospital:** It is clear from views expressed that the hospital is greatly valued, and for some individuals it is irreplaceable.
- **Workforce:** People have expressed concern about lack of nurses and care workers and ability to provide enough capacity to look after people in their own homes.
- **Space:** People have queried if there is enough space in the new Health and Wellbeing Centre and in Dawlish Community Hospital to accommodate the proposed clinics.

Healthwatch will be submitting a full report including analysis of all responses to the CCG by the end of November 2020. The outcomes of the report will be used to inform the final recommendations resulting from the consultation.

5. Evaluation of alternative options

During the consultation we invited alternative proposals to be put forward. A number of people have suggested alternatives and these are being compiled by Healthwatch in Devon, Plymouth and Torbay. Alternative options put forward will be evaluated by a panel of stakeholders at the end of November. It is intended that the panel will be made up of representatives from:

- Teignmouth Hospital League of Friends
- Dawlish Hospital League of Friends
- Coastal Engagement Group
- Teignmouth Patient Participation Group, Channel View
- Voluntary and community sector
- Teignmouth Town Council
- Dawlish Town Council
- Channel View Medical Group
- CCG commissioning
- CCG Governing Body GP

Advisers to the panel, providing factual information only, will include:

- Torbay and South Devon NHS Foundation Trust, estates department
- Teignbridge District Council
- Devon County Council highways department
- CCG finance department

To ensure a sound process, the criteria used to evaluate these options will be the same criteria as used to assess the options considered for public consultation.

Criterion	Factors to consider	Weighting
Space/capacity	• Is the location/site large enough to accommodate the all currently provided services? • Does the location support the commitment to provide services within the Teignmouth and Dawlish locality?	Yes/No
Finance	• Is it affordable? • Capital cost required – are there any abnormal costs? • Has funding been identified to deliver?	High
Does it support delivery of the vision for the Coastal area:	• To build on the success so far of integrating services by bringing a range of local services together under one roof in a new Health and Wellbeing Centre in Teignmouth	High

'Excellent Integrated Services' ?	• To ensure the sustainability of primary care in Teignmouth • To help people stay well and support them when they need help • To enable people to stay at home for as long as possible • To optimise use of the purpose-built Dawlish Community Hospital	
Sustainability of service ➢ Service ➢ Population ➢ Building ➢ Staff	• Can the option respond to future changes to service models and population growth? • Is the option in a building that has long term viability? • Is it an attractive proposition for staff?	High
Clinical Evidence – best place to care for people	• NHSE South West Clinical Senate	High
Public transport	• Is public transport available nearby to and from the site?	Medium
Car parking	• Number of disabled spaces (and proximity) • Nearby parking • Cost of parking	Medium
Travel impact	• What is the impact on distance travelled by people using the service?	Medium
Pedestrian access	• Is there easy pedestrian access?	Medium
Impact on local vicinity	• What will be the impact of any additional traffic on the local area? • Will access to the site be unduly affected by seasonal traffic? • What impact will this have on the local economy? • How convenient will it be to access other local services?	Medium
Environmental impact	• What is the environmental impact on the difference in travel arrangements? • Are the buildings environmentally friendly and sustainable?	Low

6. Next steps

Once the evaluation panel has completed its work, its conclusions, together with the full report from Healthwatch in Devon, Plymouth and Torbay, will be considered by the CCG Governing Body at its meeting on 17 December 2020.

7. Recommendation

This report forms part of the continuous engagement and consultation with Devon County Council's Health and Adult Care Scrutiny Committee on the modernisation of health and care services in Teignmouth and Dawlish.

The committee is asked to note:

- the contents of the report
- that committee members have had the opportunity to respond to the consultation
- next steps

ENDS

Devon Scrutiny Committee: Devon Doctors CQC Improvement Plan

12 November 2020

Introduction

On 14-16 July 2020 the Care Quality Commission (CQC) visited Devon Doctors (the Organisation). Following the visit, six conditions and five requirements were placed upon the Organisation's registration.

This paper sets out the improvements made to date against the Conditions set out by the CQC. This paper should be read alongside the Presentation from Devon Doctors to the Scrutiny Committee.

Condition One: Generating the plan

The Board approved the CQC Improvement Plan ahead of the submission date of 11 August 2020. Updates have been provided to the Devon Doctors Board on a weekly basis as well as through the monthly Board meetings. Assurance on progress has also been provided to Devon CCG and the CQC on a weekly basis through a series of touchpoint meetings.

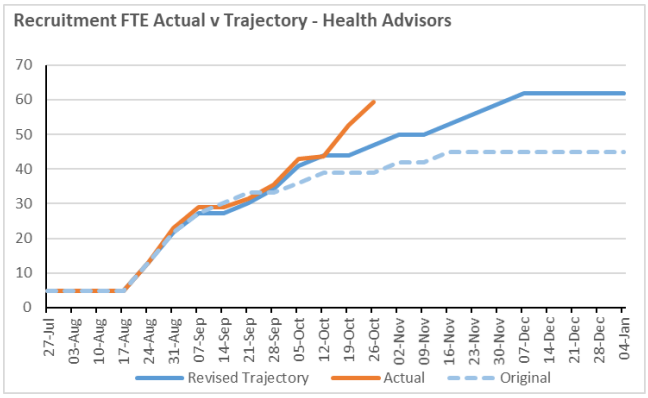
While the Organisation has not had confirmation that this Condition will be removed, there has been no challenge as to the scope or depth of the plan from either Devon CCG or the CQC.

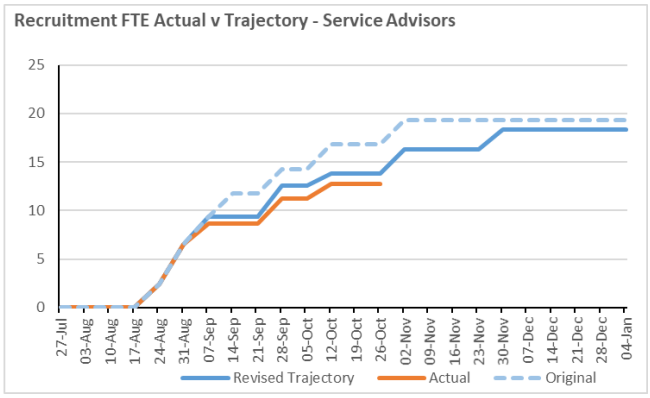
The CQC Improvement PMO meeting holds the senior responsible officers to account for delivery of the plan on a weekly basis, and reports to the Devon Doctors CQC Executive on areas of improvement and challenge before these points are escalated to the Board.

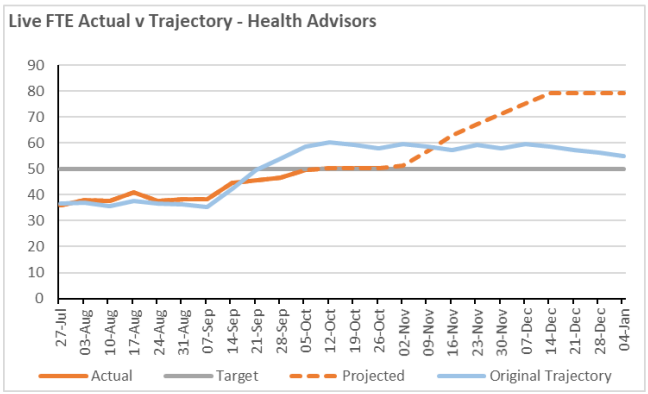
Condition Two: Improving the Devon NHS111 service

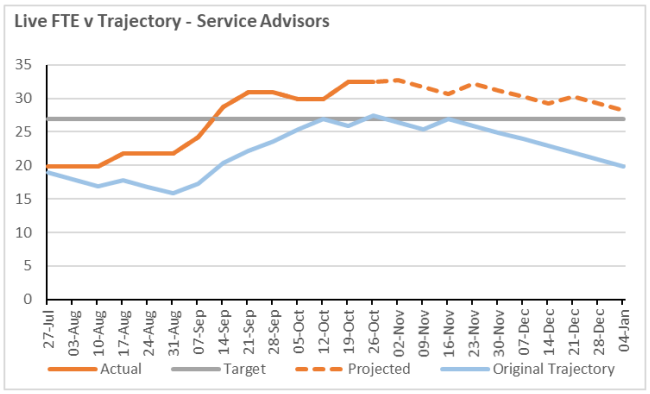
The delivery of the Organisation's NHS111 service requires sufficient well-trained health and service advisors and clinical advisors to answer the calls being made by members of the public. As such, it is essential that work is undertaken to monitor the design of the rota compared to the presentation of calls within the service, while recruiting sufficient call operatives to meet the demand.

The following graphs set out the position in relation to Recruitment and Performance. This is based on information to the end of the week commencing 19 October 2020. It should be noted that the charts below show the recruitment trajectory for both the Core 111 service and the Think111First service in Devon.









Resources – Service Advisors

Since July 2020, the organisation has recruited 12.7FTE of Service Advisors in to the CAS, with 2.2FTE leaving the business in the same period. This has been attributed to the improved training programme and an increase in the level of support within the CAS for the Service Advisors working on shift leading to improved morale.

The Service Advisor training programme was completely redesigned following concerns raised by staff that the previous approach was not sufficient for them to do their role. As well as training all of the new recruits, all members of the Service Advisor team have been retrained to enable them to confidently and safely deliver all parts of the Service Advisor role.

The result of this is that Service Advisor levels of recruitment remain above those set out as necessary within the CAS staffing model. The current level is being maintained while consideration is given to the long term operational model, and how Service Advisors can be used during peak times to support the wider 111 service.

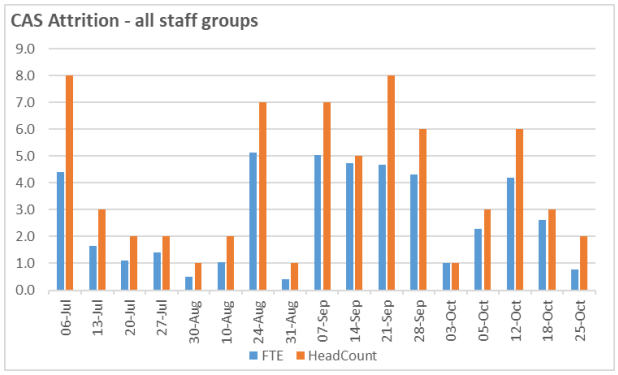
Resources – Health Advisors

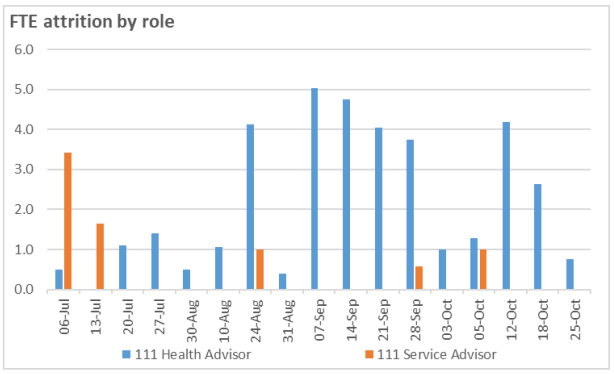
The initial analysis identified that there were significant gaps within the Health Advisor roles. Furthermore, analysis undertaken the NHS England national team has identified that the original funding envelope is insufficient in this area and that rather than aiming for a total of 68 FTE (Health Advisors and Service Advisors) we should in fact have recruited to 88FTE. We have worked collaboratively with the CCG to increase the level of funding for an initial 20 FTE during the summer of 2020. The national analysis has determined that Devon Doctors actually require 96FTE to deliver the core service based on current activity levels. As part of the mobilisation of the Think111 service we are discussing the long term funding model for the service with Devon CCG (please see below).

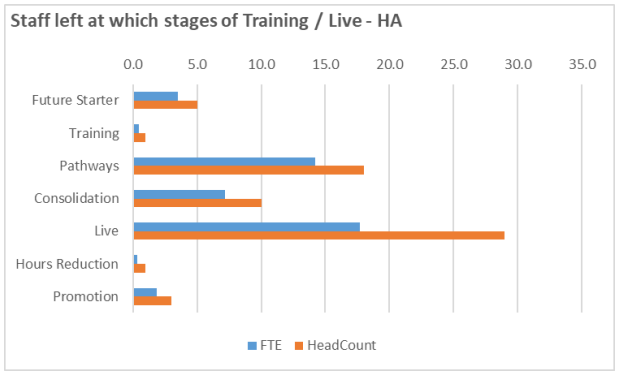
Since July 2020, the Organisation has recruited 44.0FTE (excluding the latest recruitment for Think111First in Devon) of Health Advisors in to the Devon 111 service, including 6.3FTE who were already trained. This is in line with the revised trajectory for recruitment as shown in the chart above.

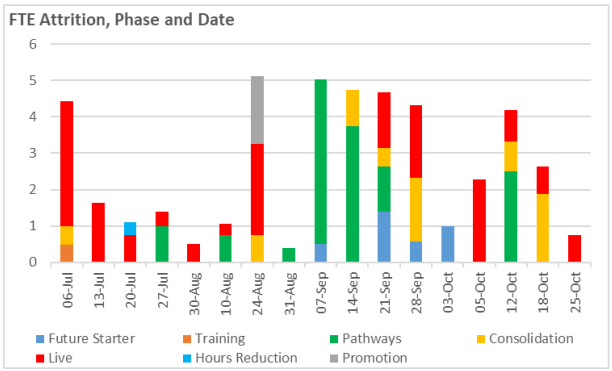
Due to the significant levels of attrition in this cohort of staff during both training, consolidation, and from the “Live” staff, the level of Health Advisors (net of those on long term sick) within the service has only increased by 14.1FTE during the same period. Overall, there are 9.0FTE fewer Health Advisors within the service at the time of writing than was projected at the start of the recruitment phase. This equates to approximately 18 members of staff as many of the rotas are less than 0.5 FTE.

The graphs below show the level of attrition within the service since July 2020. The graphs include both Service Advisor and Health Advisor attrition, but the greatest majority (80%) of the attrition below relates to Health Advisors (92% if the data from July is excluded).









Since September attrition has been greatest within the Training and Consolidation phases. Those that have recently left the service from the “Live” cohort have been relatively new recruits who had passed consolidation but had decided that the role was not suited to them after a few weeks in the service.

The high levels of attrition for Health Advisors is very concerning. A detailed review of attrition within the training cohort has been completed, in conjunction with the CCG and the Turnaround Director and as a result of this a number of key actions has been undertaken, including:

- Recruitment via REED using pre-determined rota patterns so staff are aware of the working expectation.
- Increased selection criteria before candidates are offered an interview.

- 1:1 interviews of all candidates before they are offered a placement on the 111 Pathways course.
- Corporate induction day prior to the start of the course to explain the role and to play examples of calls that could be taken to provide the breadth of experience of some of the more complex and challenging cases that could be presented.
- 15-minute introductory session with the Chief Executive Officer during the first day of the course to welcome the candidates to the role and introduce them to Devon Doctors.
- Daily touch point calls between the 111-leadership team and the trainers to identify candidates who may be struggling and agree further tuition and support.
- Increased numbers of trainers and coaches to support during the consolidation process and while the new trainees are on shift.
- Detailed exit interviews to understand why people are leaving so that further improvements can be made.

Following the introduction of the measures above, there has been a reduction in the number of trainees leaving the organisation during the training phase. The level of trainees and attrition is reviewed on a weekly basis through the PMO and Executive process so that immediate corrective actions can be put in place as required and additional courses mobilised to deal with attrition. We continue to evaluate this process to seek continual improvement. Examples of the future measures being introduced include:

- Internal end to end review of the training programme to determine whether the delivery of the mandatory training programme and consolidation process could be improved (02.11.2020).
- NHS Pathways national team to be requested to undertake a review of the quality of the training provided.
- Face to face training course to be implemented to compare quality of training to the current virtual process.
- Adastra focused sessions now implemented to ensure that recruits are able to easily navigate the system during their consolidation period.

Further training courses are being put on to address the current level of attrition and ensure that the necessary resources are in place to deliver the required service level. This is in addition to the recruitment required for Think111 (see below).

Work is also ongoing to ensure that Health Advisors are aligned to the core periods of activity (weekend mornings) to ensure that peaks in demand can be serviced without adversely impacting on either patient safety or performance.

The ongoing recruitment and retention of Health Advisors remains one of the largest challenges within the CQC Improvement Plan. In addition to the actions taken above the opening of our new contact centre in Plymouth should improve attrition further are we have the ability to recruit from a different geographical area.

Resources – Clinical Advisors

The level of Clinical Advisors within the rota remains significantly higher than required as determined by the local modelling of 111 demand. This has been funded by Devon CCG as part of the ongoing Covid-19 funding. This funding ceased on 30 September 2020 and the Organisation is in discussion with the CCG about the ongoing support of this funding to enable clinical advisors to

“front end” the 111 service in the short-term due to our health advisors being below the required FTE.

While further Clinical Advisors will be needed as part of the Think111 work, the current level of Clinical Advisors within the rota exceed the adjusted number. As such, changes to the service delivery model will need to be made if the CCG are unable to continue funding the current position. Negotiations continue.

Think111

In addition to the recruitment being undertaken for the core 111 service, the service is required to increase the number of Health/Service Advisors from 88 to 104 (approximately 50 new members of staff) by 01 December 2020 in order to deliver the anticipated increase following the first phase launch of Devon’s Think111. It is anticipated that this will then need to be increased further to 116 by 01 April 2020.

Work is already in place to deliver the required level of recruitment in line with the timescales above subject to managing the level of attrition. This is however, a monumental challenge given the short timescales for mobilisation and training of a new service.

In order to recruit the additional number of staff, focus has been switched to Plymouth, with the CCG and Local Authority providing an office space to host the service. This provides an increased pool of resources both for Think111, but also to manage future attrition within the Core service. This will also enable the Think111 service to be delivered while maintaining social distancing in the current call centres based in Exeter and Taunton.

Dental Calls

One of the biggest pressures within the CAS is created by the management of dental calls; this has been further exacerbated since the Covid-19 pandemic with fewer face to face appointments being available.

Once all urgent appointment slots have been filled, the role of the Service Advisor historically was simply to advise patients via the telephone that there are no more appointments left. This invariably led to very unhappy callers speaking to call handlers for extended periods of time. In order to remove this pressure point once the appointments are full, the service now implements an automated message providing the caller with the information provided by dental commissioners about alternative services that patients can access depending on the severity of their pain. Patients are advised that if they have red flag symptoms to attend ED, this is exactly the advice that would be given by a Dental Service Advisor. This decision has the support of the dental commissioners.

We continue to work with the local dental commissioners to stress the importance of more face to face clinical appointments. Without these being offered this chronic short fall in appointments will not be addressed.

Mental Health Calls

Devon Doctors have agreed that all crisis mental health calls (without physical complications) for patients within the Plymouth area can be passed through to the Livewell Southwest crisis management line 24 hours a day. This has reduced the impact on the 111 service of having to take

complex calls, and ensures that the patient is able to speak to a clinician specifically trained in the management of complex mental illness.

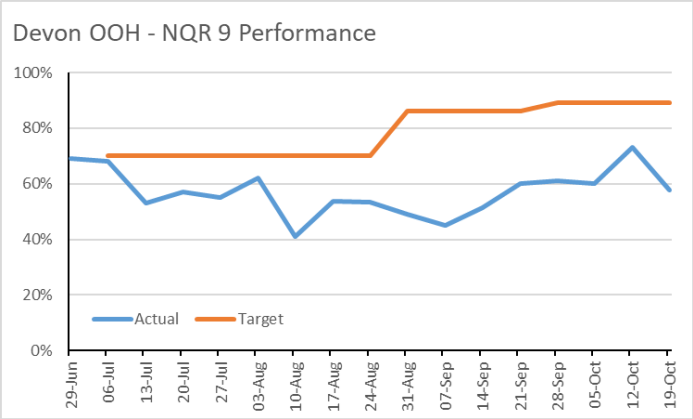
Conversations are ongoing with Devon Partnership Trust to get a similar arrangement in place for the Devon County Council footprint.

Condition Three: Improving Out of Hours Triage

Unlike the 111 service, the Out of Hours (OOH) triage model is multi-factorial and as such requires a more complex improvement plan to address the concerns identified by the Care Quality Commission.

Performance

The graphs below set out the Organisation's weekly NQR9 performance since July 2020 compared to trajectory.



During this period, activity increased during the summer months and has now returned to levels seen during June. Rota fill is also challenged during the summer months. This year was no exception despite the travel restrictions caused by Covid-19, with clinicians still taking their annual break from clinical work. The combination of increased activity and reduced rota fill has meant that performance has remained challenged. In recent weeks, the new Clinical Model combined with improving rota fill has seen an improvement in the level of performance in Devon.

Since September 2020, the Organisation has put a new operating model in place to increase the level of triage resource within the IUCS. This has resulted in a general improvement against the NQR9 target. The latest week's performance showed a reduction compared to other weeks due to reduced clinical rota fill.

In addition to core activity, the Devon service is now undertaking additional revalidation work as part of the Think111 mobilisation. While additional shifts have been put on to provide this work, it has not always been possible to fill them given the limited pool of clinicians that the service can call upon. This makes the recent upturn in performance more remarkable as the service has not only managed its own demand, but also revalidated and redirected a high proportion of ED and 999 dispositions from 111 which then can often require further work from a clinician within the IUCS.

In response to the concerns raised by the CQC, the organisation has re-evaluated its triage model and implemented two key changes:

Lead IUCS Clinician

The Lead IUCS Clinician is a new role and is operational at times of peak service pressure, (Saturday/Sunday/public holidays 08:00 – 23:00). The role is held by a number of highly experienced out of hours clinicians, who work five-hour sessions across these time periods. The Lead IUCS Clinician is supported by the on call Medical Director as required.

The Lead IUCS Clinician plays a critical role in monitoring the Devon clinical queue, ensuring that cases are correctly prioritised and that response times are appropriate and based on clinical acuity. Key areas of responsibility include:

- Monitoring of the clinical queues to ensure that patients receive a clinical response appropriate for the acuity of their presenting condition.
- Reviewing cases where worsening of the patient's condition subsequent to the original call is identified, (eg by way of patient callback or during a comfort calling'), and escalating appropriately to ensure timely clinical assessment.
- Supporting fellow clinicians on shift where clinical advice from an experienced colleague is required, (including the service's own Home Visiting Paramedics). As well as being on a dedicated telephone extension and also contactable via Adastra's internal messaging service, the Lead IUCS Clinician carries a dedicated mobile telephone to facilitate communication with clinicians in the field.
- Supporting operational colleagues where decisions around appropriate deployment of clinical resources are being made.
- Undertaking telephone consultations where there is the capacity to do so, with a focus on high priority/high acuity cases e.g. ED/999 validation, HCPs on scene, palliative cases.

The presence of a dedicated resource with oversight of the clinical queues ensures that cases requiring rapid assessment are swiftly identified and appropriate action taken to maintain the safety of individual patients. Furthermore, the support provided by the Lead IUCS Clinician to colleagues, (both clinical and operational), on shift engenders an environment that feels supportive and facilitates smooth running of the wider service.

Direct booking of telephone cases into vacant treatment centre appointments

Detailed evaluation of our service has identified that approximately 30% of clinical time during weekends is unused, primarily as a result of empty appointment slots in our treatment centres. It was also apparent that clinicians working in our treatment centres did not always pick up telephone cases in between face to face appointments despite having capacity to do so.

It was clear, therefore, that if this resource could be utilised in a more efficient manner, service performance and, consequently, the level of patient safety would increase accordingly.

As such, a decision was made to book triage "appointments" for treatment centre clinicians. Current timescales allow a clinician 20 minutes to see a patient in the treatment centre to take account of the additional time to don and doff the necessary PPE. It was, therefore, agreed that no more than three appointments would be booked for each clinician per hour, irrespective of whether this was

made up of triage, face to face, or a combination of the two. Importantly, only 'routine' telephone cases are booked into vacant treatment centre appointments as part of this process.

This process was initially implemented on the 3rd of October and has been running since then. Whilst the full impact of this change needs to be evaluated, there has been a clear change in the length of the clinical queue at peak times. Analysis will be produced at the end of October.

While the new triage model has not resulted in a step change in NQR9 performance and detailed analysis of performance data is pending, early evidence suggests that the clinical queues have become shorter and response times have improved as a result of booking routine telephone cases into treatment centre slots. The productivity of our treatment centre clinicians has increased accordingly; this has also allowed our CAS and remote clinicians to focus on higher acuity cases within the clinical queues. Feedback from clinicians also suggests that the shorter clinical queues that have resulted from this new process have made the service feel significantly safer and workload feel less overwhelming. Furthermore, implementation of the Lead IUCS Clinician role has provided an additional layer of assurance regarding patient safety and has also been well received by clinical and operational colleagues for the additional benefits it brings in terms of support of colleagues on shift.

Clinician Efficiency

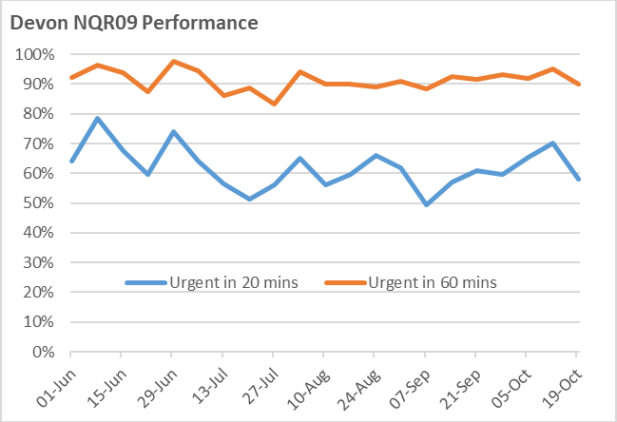
The Medical Director, supported by the Senior Clinical Management Team, have developed reporting statistics that measure the number of consultations completed on shift, the utilisation percentage, and the log on and log off times. Clinicians are then RAG rated to identify those that are consistently falling below the required standard. Individual action is taken, and a summary of this action will be presented to QAC for assurance back to the PMO / CQC Executive and the wider Board.

Disposition (DX) Based Operating Model

The current performance requirements for Devon Doctors are based on historic National Quality Requirements (NQR). These measures are now out of date and do not reflect the timescales provided by 111 through Pathways. When a patient calls 111, they are taken through a Pathways assessment that will give them one of a range of disposition codes (DX Codes). Some of these DX codes then mean that the patient is passed to the OOH service. The DX code has a target time associated to it by which time the patient should receive the necessary clinical care. The timescales range between 1 and 24 hours and have been assessed nationally as being clinically safe.

Devon CCG has agreed that Devon Doctors should transition to a DX operating model. Both organisations are currently working on a Contract Variation Order (CVO) to enable performance reporting to be formally switched over from NQR9 to an aggregate DX reporting model.

The graph below shows the level of triage performance in Devon against the current NQR9 (blue) and DX (orange) measures for urgent cases. Performance within 60 minutes remains above 90%.



Performance for routine cases within 240 minutes (a proxy for other timeframe DX codes) is 91% in Devon this week. Performance under the DX model will be reported as an amalgamation of all DX codes, although it will be possible to disaggregate them for performance management purposes.

It is anticipated that the CVO will be signed in the next couple of weeks to enable the new model to be operational during November 2020. A mobilisation plan is currently being developed to ensure that all necessary communications and system/process upgrade are made in a controlled and clear manner to minimise any adverse impact on service delivery.

Direct Booking

Due to the Covid-19 risk there is currently no direct booking of Treatment Centre appointments from 111. This means that all cases that end up in a Treatment Centre are receiving two touchpoints from within the service. This is inefficient as it creates potentially unnecessary patient contacts. When the proportion of “Contact” dispositions (those requiring face to face clinical input) being closed at triage was reviewed it was found to be between 55% and 75%. Based on this, it is more efficient for the service not to direct book patients in to Treatment Centres.

This will continue to be reviewed to determine when it is appropriate for Direct Booking to be turned back on. In the meantime, the Lead IUCS Clinician will stream patients to Treatment Centres from the Triage queue where it is clear that they will need a face to face appointment. For those that have potentially Covid symptoms they will be directed to a HOT site once operational.

HOT Sites

During the first wave of Covid-19 HOT patients were treated in four HOT sites within Devon.

The Organisation has secured HOT site funding for Devon until 01 April 2021 and is in the process of mobilising the sites in Plymouth, Torquay, Exmouth and Barnstaple ahead of the winter period and forecasted second wave. Devon CCG are requesting that weekday evening HOT site provision is mobilised. This is currently in the planning stage.

The consistent delivery of HOT provision will enable more effective streaming of Treatment Centre appointments from the triage queue as it will be possible to stream both HOT and warm patients to an appropriate location.

Clinical Recruitment

The level of clinicians working within the Devon OOH service remains a significant challenge. A recruitment paper has been produced and is being mobilised to improve the current recruitment numbers. The Organisation is working closely with Devon CCG and Devon LMC to increase the level of clinical recruitment in to the service.

Home Visiting Strategy

Patients awaiting a home visit from the OOH service are some of the most at risk within the Organisation's portfolio. Current performance against the NQR12 target for home visits raises concerns about the safety of patients, especially those waiting for an Urgent Home Visit.

The Organisation has had conversations with SWASFT about the management of mobile resources and how learning can be taken to improve performance in this area. This includes:

- Mobilising the cars as soon as the shift starts irrespective of the triage position. This will reduce the pressure on visits later in the day.
- Provide dedicated set up / down time for drivers ahead of the start of the shift so that resources are ready to go.
- All visits to be managed from the CAS via a Visit Coordinator supported by the Lead IUCS clinician, with the driver / mobile clinician not having sight of further calls. This ensures that cases are delivered based on clinical importance not geographic proximity.
- Change mobile resources to a blend of paramedics and GPs so that cases can be prioritised based on clinical need.
- Utilise mobile resources to cover calls based on clinical need not based on geography.

No further work is being undertaken in this area while the focus remains on improving patient safety and performance in relation to the triage queue. The changes set out above, with the exception of the clinical resourcing model, will be monitored using a combination of patient safety and performance metrics. The blend of resources utilised for Home Visiting will be picked up as part of the wider review of the operating model.

Condition Four/Five: Improving Governance and Quality Processes

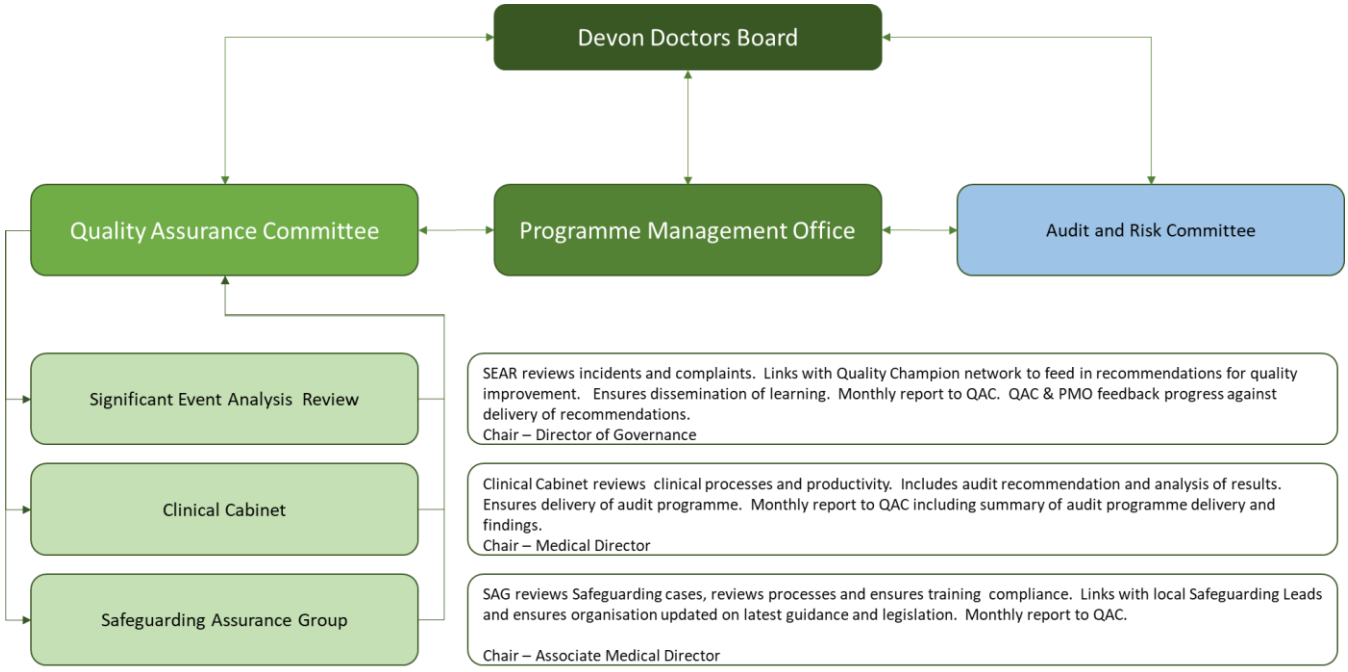
Concerns were raised by the Care Quality Commission about the efficacy of the Governance processes within Devon Doctors and the ability to implement change as a result of complaints, incidents, and serious incidents. In order to address these concerns, a full review of the Governance Framework has been undertaken and a new model of Quality and Patient Safety meetings has been implemented. These meetings are attended by a Non-Executive Director from the Board to provide independent review and challenge, as well as a direct line of reporting from/to the Board on areas of concern.

Quality Framework

The diagram below sets out the revised Governance Framework. This has been further reviewed since the previous Board meeting to take account of the additional meetings that are needed to ensure that all appropriate aspects of patient safety and quality are captured, reported, escalated, and actions taken to address areas of concern at the appropriate level within the Organisation.

The Quality Assurance Committee (QAC) receives assurance and areas for escalation from the three subgroups, each of which has a specific focus as set out in the diagram below. The QAC escalates areas for improvement to the Programme Management Office (PMO) and provides assurance to the Board. These then complete the feedback cycle through the QAC to the subgroups. This ensures that a cycle of continuous improvement is embedded throughout the organisation.

The QAC is chaired by the Medical Director and is attended by a Non-Executive member of the Board.



In addition, a review of the Governance arrangements identified that it was necessary to further embed governance processes within the wider organisation. In order to address this a network of Quality Champions was created from staff members (clinical and non-clinical) across the Organisation. The Quality Champions have two roles; firstly to share information about areas of concern from within the Organisation, and secondly to cascade learning back in to the Organisation when improvements are made.

The Audit and Risk Committee is included in the diagram above for completeness. It sits outside of the Governance Framework and focusses specifically on corporate risk. Patient Safety and Quality risk is managed by the QAC, with the Board retaining responsibility for oversight and scrutiny of the whole Risk Register.

The initial rounds of meetings for the QAC and its subgroups have been held. The design of these groups, if they function as intended, will provide appropriate scrutiny and challenge over all aspects of patient safety and quality within the IUCS. Initial meetings have been focussed on setting up scope and purpose, and are as a result in their early c phase of delivering service change based on the outcome of complaints, incidents, Serious/Moderate incidents, and clinical audit. However, it is important to note that the level of engagement in this new Framework, alongside its design, is more robust than any previous Governance structure within the Organisation.

Call Audits

As part of the Organisation's Pathways license, Devon Doctors is required to undertake a specific call audit programme for each of the Health and Clinical Advisors within the 111 service. This has been expanded to cover all of the Service Advisors.

Audits are being completed within the required timescales with a pass rate exceeding 85%. The pass criteria are exacting and require all aspects, from empathy, documentation, condition probing and accuracy of pathway selection to be correct. A failure in one particular area will fail the whole audit irrespective of the severity.

Appropriate training and disciplinary actions if required are being taken against those that are failing audits. Assurance on the audit process is provided to the CQC Executive through the PMO.

Safeguarding and Mandatory Training

The CQC report identified that Safeguarding and Mandatory training was below the expected level for clinical and non-clinical staff. Work has been done in this area, including removing clinicians from shift, to improve the level of training within the Organisation.

At the end of September, the training figures were as follows:

Safeguarding Level 2 (non-clinical)	95% (June: 88%)
Safeguarding Level 3 (clinical)	94% (June: 72%)
Overall Mandatory Training Compliance	90% (average across all modules) – (June: 85%)

This is a marked improvement on the level of compliance when the CQC visited in July 2020 (when they would have seen the June numbers presented above).

Further work is being done to ensure that staff remain compliant with their mandatory training on a rolling basis and not just at the end of the year. This will not only improve the safety of the service provided but will also reduce the burden on staff of having to complete all of their training in one month.

Assurance Map

In order to enable the CQC Executive, Board, CCGs, and CQC to have full and transparent visibility of performance and quality during the period of improvement, the Organisation has developed an 81 metric Assurance Map. This Map is reviewed on a weekly basis at the CQC Executive and is shared with the Board, CCG and CQC on a weekly basis.

The metrics cover all aspects of the 111 and OOH service and cover all areas of performance, patient safety, and workforce.

A one-page dashboard has been produced that shows, at a glance, performance against the key headline metrics so that a balanced view of the services can be gleaned from one page. This has been shared with the Board with a request that it is reviewed and feedback provided regarding the format and content of the information provided in understanding the impact of the delivery of the CQC Improvement Plan.

Clinical Audit

At the August Board meeting, approval was given to further resource the clinical audit programme within the Organisation. Resources are now in place, with the Medical Director taking overall responsibility for the delivery of the Clinical Audit Programme, supported by the Associate Director of Quality and Governance. The outcomes and learning from clinical audit will be taken through the Clinical Cabinet and reported to the QAC, before being presented to the Board.

The regular clinical audit work (including long waits, 111 call handling, burns and bruises, controlled drug prescribing, clinician performance) are all ongoing. The additional resource identified are allowing targeted specific pieces of work to be completed.

Condition Six: Improving Patient Safety

The Care Quality Commission identified that while patients are within the OOH Triage queue, sometimes for long periods of time, appropriate measures were not in place to ensure the safety of patients while they were waiting for their clinical contact.

The measures below have been implemented solely to improve patient safety, although some will also have an impact on performance.

Lead IUCS Clinician

The Lead IUCS Clinician role set above has a significant role in improving patient safety as well as driving performance. By overseeing the clinical queue, the Lead IUCS Clinician is able to identify patients that need to be prioritised and, where there are delays, review the patients who have breached their target time and upgrade those where there are clinical concerns based on the information from 111 or the Comfort Calling process (see below).

Comfort Calling: Triage

Dedicated call handlers have been put in the rota to make calls to patients who have been waiting for a clinical call for more than two hours. This call provides assurance to the patient that they are still in the queue to be called back, checks that there has been no deterioration in the patient's condition, and provides worsening advice. In some cases, patients will advise that their condition has improved and that they no longer need a call back. In this instance a clinician within the CAS will review the case and close it if it is clinically appropriate to do so.

Currently 95% of those patients that need a comfort call are getting one within 30 minutes of it becoming due. The Patient Safety and Governance Team are also reviewing all cases that have not had a comfort call to gain assurance that no one has come to harm.

Comfort Calling: Home Visit

The mobile clinician is responsible for comfort calling patients who have breached their home visit target time. This ensures that vulnerable patients have appropriate clinical oversight from the clinician that will be visiting them, and that any worsening symptoms can be escalated as appropriate.

Long Wait Audits

The medical director undertakes a monthly audit of 25 cases that have exceeded their triage deadline to identify whether there are any instances of harm that have been caused by the delay in providing treatment. The latest audits, completed for July and August, identified 1 case where there was potential for harm to have been caused as a result of the delay in the clinical call back. On further investigation, no harm had actually been caused.

These reviews will be completed on a monthly basis as part of the patient safety processes, with the results being provided to the SEAR/QAC.

CAScade

A detailed review of CAScade is underway to determine whether the outcomes that it generates are safe, and that the pathways within the system are up to date and reflect the latest operational practices. Consideration is also being given as to the use of CAScade on an ongoing basis, or whether a full Pathways model should be used for the 111 service. A full discussion paper will be produced during the Autumn and will be presented to the Board and CCG prior to any decision being made. This is a key area of focus for the Organisation over the coming month.

Improving Culture

The CQC inspection identified a number of cultural concerns, and received feedback about aspects of the Organisation's approach to service delivery which were raised as part of the feedback process. These concerns matched feedback that had been received by the Organisation's SMT and focused on a range of cultural issues, specifically:

- Low levels of staff satisfaction, high levels of stress and work overload
- Policies and procedures do not support staff in raising concerns
- Limited approach to sharing information or seeking the views of staff
- Low staff morale due to a lack of continuity
- Lack of management team knowledge regarding IT systems
- Poor communications systems in place
- Contradictory information from different managers and across the IUCS/111 service lines
- Significant attrition
- Reports of staff feeling stressed, not valued and not listened to by management
- The ethos of 'Putting Patients First' had been lost
- Lack of consistency regarding mandatory training compliance

The list above clearly points to a service under significant pressure resulting in issues with staff engagement within the Organisation; however, our awareness is currently limited to the comments contained within the CQC report and anecdotal feedback escalated through levels of management. That said, it is accepted and understood that morale is low in a number of areas within DDG for varying reasons; not least the impact COVID-19 and numerous (but ultimately necessary) change projects immediately preceding the pandemic.

In order to address these concerns, a paper has been produced that sets out the work that will be undertaken to improve the culture within the Organisation. This work has already started with the following steps being put in place:

- An Organisation wide staff survey is currently being conducted by an independent consultancy firm (Picker) who are used to run the NHS staff survey. The results of this survey will be used to inform the wider plan.
- Increased visibility of senior leaders within the CAS and Treatment Centres
- Scheduled meetings between the Director of Operations and the Treatment Centres and CAS staff to provide an opportunity for two-way information sharing.
- On site visits by the Director of Operations and Engagement Lead to the Treatment Centres and CASs across Devon to increase visibility of the Executive and HR Team.
- Promotion of the Speak Up Guardian role to enable staff to raise concerns on a confidential basis within the Organisation.
- Training of Mental Health First Aiders to support staff within the Organisation.
- Closer engagement with UNISON and other unions to promote staff engagement and partnership working.

Further work will be undertaken during the 2020/21 winter period to develop a full cultural improvement plan on the basis of the staff survey results. The Board will be fully engaged in the development and delivery of this plan for the Organisation.

Care Quality Commission Feedback

The Care Quality Commission provided feedback to Devon Doctors on 07 October 2020 as to the level of assurance regarding the current level of improvement. This feedback identified that while improvement was being made, the CQC are expecting to see long periods of sustained and continued improvement to give them the assurance that the Organisation has delivered against the Conditions and Requirements. They noted the challenges set out above in relation to staff attrition for the delivery of the 111 service improvements and the challenges of changing behaviours and practice in relation to delivering a safer and more efficient and effective triage service.

Conclusion

Since the Care Quality Commission visited the service, the Organisation has delivered fundamental change to governance, recruitment, patient safety, and operational processes within Devon Doctors. The list of bullet points below sets out the significant amount of work that has been undertaken by the Organisation in the past three months:

- Developed a detailed and comprehensive plan and response to the CQC initial report and Conditions on Registration in compliance with the requirements of Condition One.
- Undertaken a significant level of recruitment in to 111 Health Advisors and Service Advisors roles, redesigning the recruitment and training delivery model to improve quality of call handlers within the service and reduce the attrition rate in these staff groups.
- Revised the operational triage model to improve clinical efficiency of the Out of Hours service
- Introduced monitoring of individual clinician efficiency (covering both performance and quality) within the Out of Hours service
- Reduced sickness and improved culture within the Organisation
- Developed a cultural improvement plan with an Organisation-wide staff survey currently being conducted which will then be used to inform the detailed and longer-term cultural improvement plan.

- Developed a new approach to clinical recruitment across Devon incorporating the LMC and other partner organisations
- Implemented new processes for the oversight of patients while they are experiencing delays (comfort calling and lead IUCS clinician)
- Redesigned Governance and Patient Safety processes
- Mobilised a PMO structure to have oversight of the work plan with scrutiny and challenge in partnership with CCG / CQC colleagues

The implementation of an Associate Director of Contract Assurance and a Head of PMO to oversee this programme of work has greatly helped. There are also improved governance and executive structures in place to ensure that there is appropriate rigour in overseeing performance and delivery of the improvement plan. There is a constant need to remain vigilant and continue to seek the next improvement piece.

The performance information is demonstrating early signs of performance and patient safety improvement throughout the IUCS in Devon. It is, however, important to note that there is still a significant amount of work to be completed across the Organisation to deliver a consistent and sustained level of service improvement over the coming months. We need to deliver this change while also meeting the increasing demands of seasonal illness, Covid-19, and delivering a Think 111 plan in a new location. All of this is going to be a considerable challenge for the organisation. Probably the biggest challenge our organisation has ever faced.

Dr Justin Geddes
Chief Executive Officer
October 2020

Devon Doctors Group

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Putting

ing the Care Quality Commission (CQC) inspection of Devon Doctors (the Organisation) in July 2020, the isation has put significant efforts and resources in to addressing the areas of concern that were highlighted ne. This presentation sets out the progress made to date against the action plan, the governance and assur sses in place to oversee the delivery of the plan, and the impact that these actions have had on patient safe nance and performance.

QC Improvement plan was developed with oversight from Devon Clinical Commissioning Group (the CCG) have also been a key part of the assurance process, holding weekly meetings to obtain assurance on the y of the model, and holding Devon Doctors to account where the necessary progress has not been made. oration has enabled a system approach to resolving the concerns raised by the CQC.

ne forthcoming mobilisation of Think111First in Devon on 30 November 2020, it is essential that the Organis strong place to deliver this system-wide change programme to enable the health and social care system to ective as possible over what is forecast to be the most challenging for many years due to the combination o l winter pressures and Covid-19. It is against this background that this presentation and supporting paper i .

stin Geddes
Executive Officer, Devon Doctors

Darryn Allcorn
Chief Nursing Officer, Devon CCG.

CQC Findings, Conditions, and Requirements

nal Report Findings

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September 2020 the Care Quality Commission published its final report on the areas of improvement iden
the visit. In particular the following points are highlighted (taken from the Executive Summary):

tems to keep patients safe and safeguarded from abuse were not consistently followed or monitored
all staff had received up-to-date safeguarding and health and safety training appropriate to their role.
service could not consistently demonstrate how significant events were identified; used to make improven
nsured relevant learning was embedded in everyday practice.
rmation to enable staff to deliver safe care and treatment to patients was not always up to date.
dback from some staff included that they were not always confident that the training they received adequa
pared them for their role.
a related to key performance indicators for the NHS 111 service showed that the service was consistently
siderably below England averages and did not achieve the required national targets.
service used a recognised forecasting tool to determine staffing levels required; however, there were time
n there were significant shortfalls in the number of staff on duty.
ders were unable to demonstrate that actions to address challenges to quality and sustainability were effe
into place and monitored.
all staff told us they felt supported by leaders to perform their role effectively. Staff were not fully involved i
ning of the service.
tems and processes in place to support good governance were not fully embedded.

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onditions Required

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July 2020, Devon Doctors received notification from the Care Quality Commission of 6 Conditions on the I
ration following the completion of the inspection visit on 14-16 July 2020. These Conditions were:

oduce a plan that addresses conditions 2 to 6 below

sure that the Devon 111 service is appropriately resourced to enable the national 60 second SLA and
andonment %age targets to be delivered on a consistent basis.

sure that the Devon and Somerset OOH services are appropriately resourced to enable the national NQR9
gets to be delivered on a consistent basis.

prove the governance and service improvement processes with regards to the 111 service. This must inclu
ntification, review and learning from significant events and serious incidents.

prove the governance and service improvement processes with regards to the OOH service. This must incl
identification, review and learning from significant events and serious incidents.

plement new processes to oversee patient safety when there are delays in the OOH service.

ll conditions are reproduced at Appendix A to this document.

QC Requirements

Devon Doctors Group

Putting

ition to the Conditions on Registration, the final published CQC report requires Devon Doctors to make cha
following five areas:

lays in identifying and reporting safeguarding concerns

ovision of safeguarding training

oviding Staff with sufficient opportunities to feedback on how the service was provided and developed.

mpletion of mandatory training

view operational training to ensure that it meets the needs of staff to enable to perform their duties.

onse to the Conditions and Requirements on the Organisation's registration, Devon Doctors has created a
d plan. This presentation sets out the high level detail of the areas covered in the plan and the impact that
made on patient safety and performance.

ection Report: https://www.cqc.org.uk/location/1-382762170/reports

mprovement Plan – 111, Out of Hours Governance, and Patient Safety

1 Recruitment

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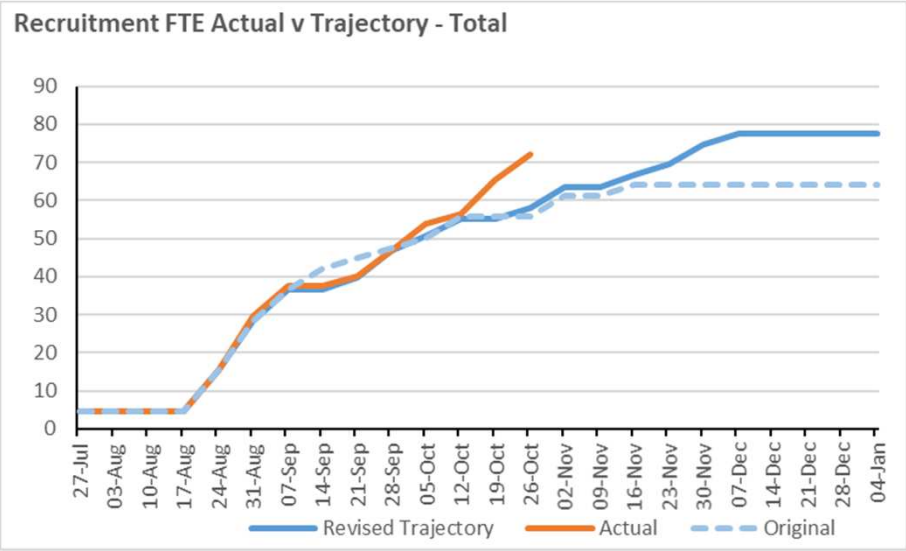
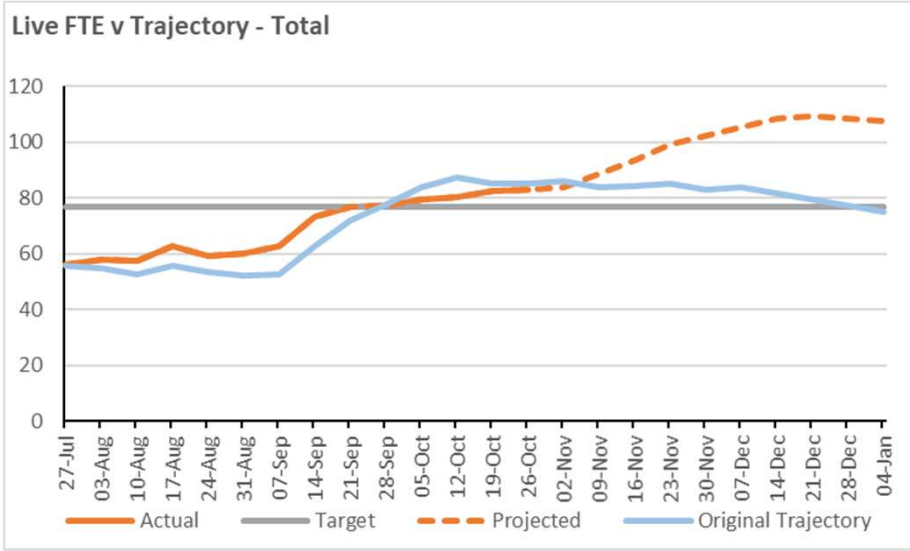
nance within the 111 service is solely dependent upon the number of people available to answer the calls being made by As such performance is sensitive to staff vacancies and sickness, as well as the call volume. The Devon 111 service wa ssioned to be delivered with 68FTE; this was increased to 88FTE during the summer of 2020. The recent NHS England s produced for Think111 shows that the service requires 96FTE to deliver the core service and a further 8FTE to deliver nal activity for Think111. There are ongoing long term funding discussions with Devon CCG to agree the required level o .

1 Improvement plan is mainly focussed on increasing the number and quality of call handlers within the service. The gra show the level of staff recruited in to the service since July and the conversion of those staff in to active call handlers ove me period. The shortfall in recruits transferring in to the Live system is due to the level of attrition within the training pha ment.





1 Recruitment

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er to improve recruitment, and reduce attrition, within the Devon 111 service, the Organisation has taken th
ng steps:

anced selection and onboarding processes to ensure that the correct recruits are put on the 3 week trainin
cess. This includes playing anonymised calls which demonstrate how challenging the role can be.

O and current Health Advisor attend induction to discuss the positives of the role and experiences within D
ctors.

pping of the attrition to determine the pressure point in the recruitment pathway (see next slide)

rnal “independent” end to end review of training by the Company Secretary (an accredited train the trainer

gagement with the national NHS England Pathways Team to review the Organisation’s provision of the nati
alth Advisor training scheme to identify areas for improvement.

: Interviews with all members of staff to identify where improvements can be made within both the training a
environments.

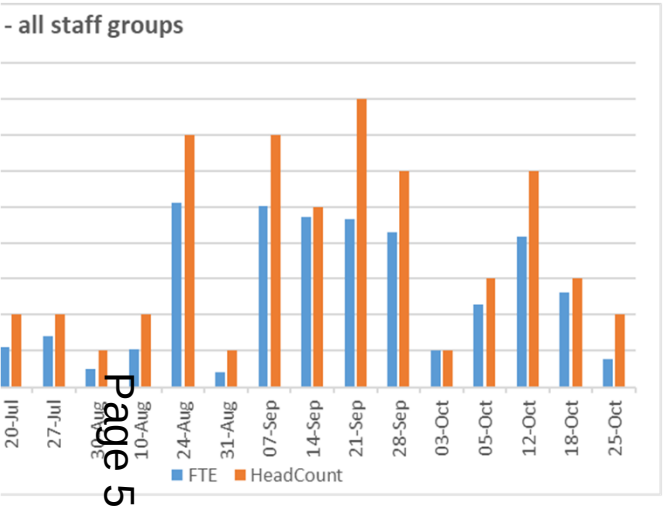
roved corporate induction as part of the training course.

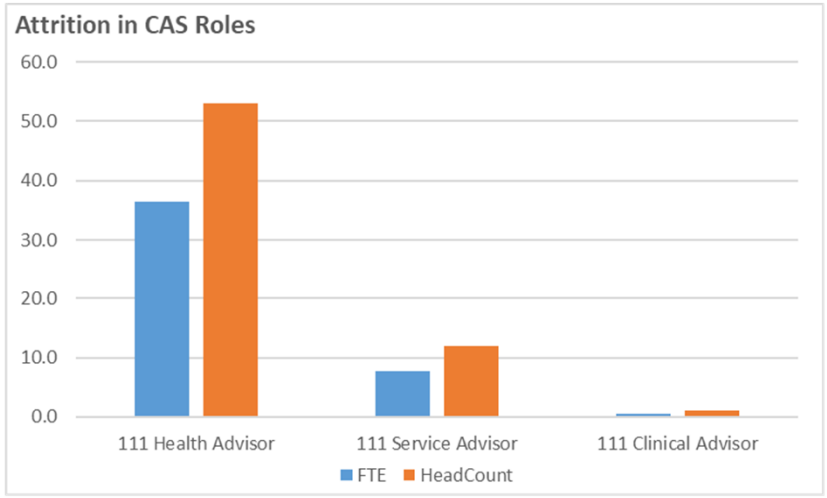
vision of the Service Advisor (in house) training course based on feedback from trainees.

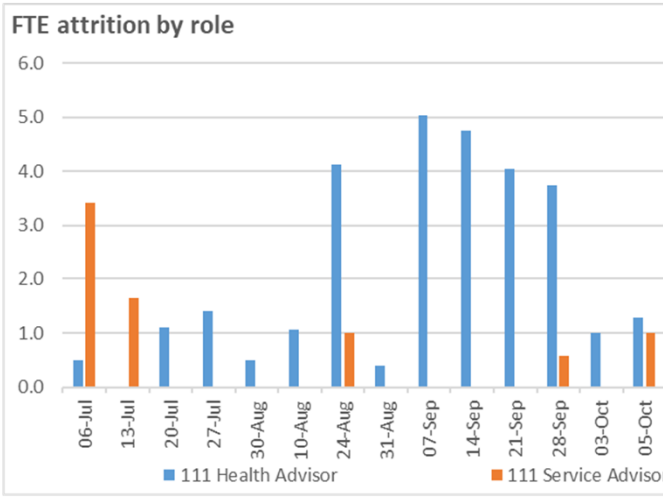
part of Think111First an additional call centre has been set up in Plymouth to target a new recruitment area
er levels of employment compared to Exeter and East Devon.

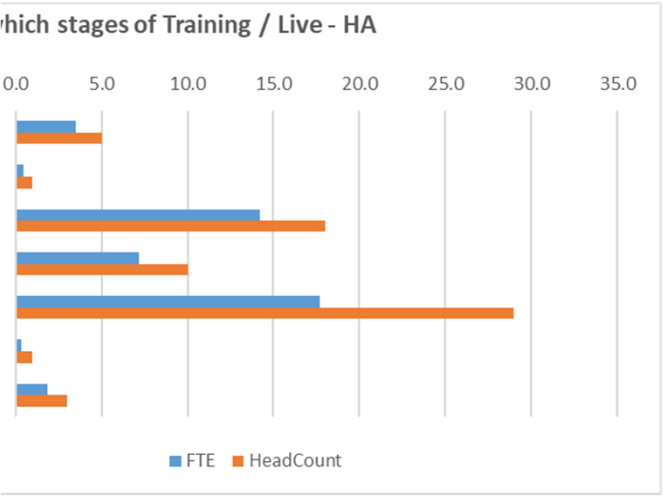
. / CAS Attrition 01 July 2020 onwards

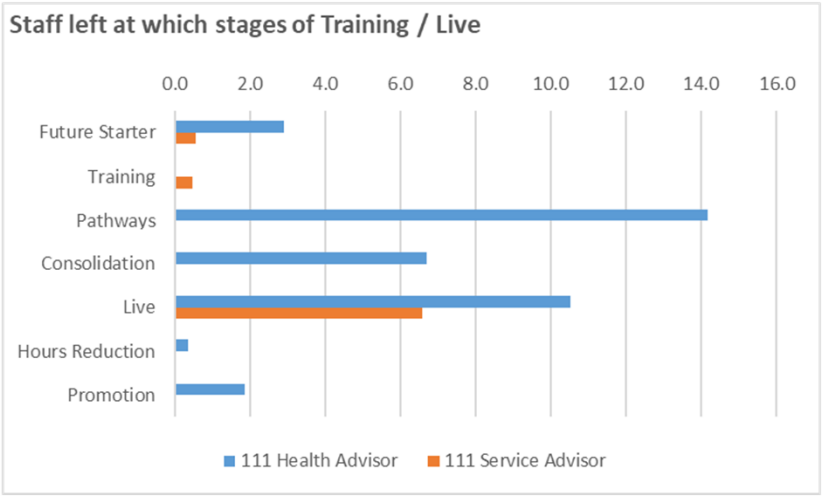
harts below track the attrition by FTE and Headcount since July 2020. This information is used to identify w
tive action is required to address why people are leaving the service and put mitigations in place.

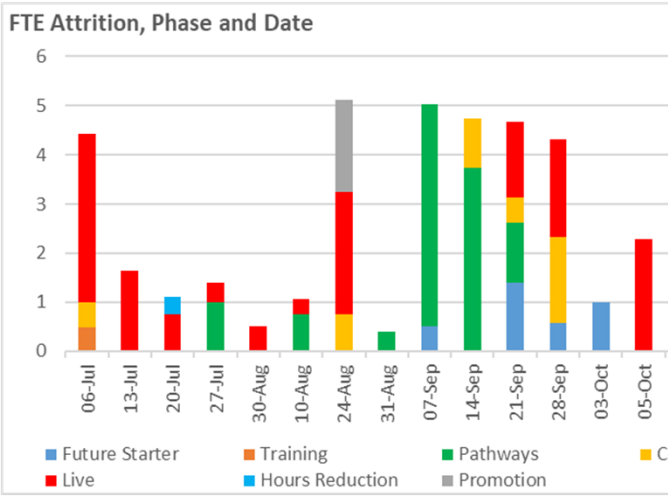












her areas for action - 111

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Putting

erflow Model: A test of change is being proposed to enable calls queuing within the 111 service to be answ
a Service Advisor, assessed for an emergency health care need using CAScade and placed in a queue for
ical call back if required. This is due to be tested during November.

dated Service Advisor Training: All existing Service Advisors have been retrained in all aspects of the rol
spective of the calls types normally taken. This means that they can be more flexible in answering the man
tracted call types within the Call Centre. Current retraining levels show that 91% of all modules are comple
% compliance will be achieved during November 2020.

ntal Health Calls: Livewell Southwest have provided a direct dial number 24/7 to take all Mental Health Cr
s from 111 once they have been through Module 0. This process is not in place for the rest of Devon, altho
versations are ongoing with Devon Partnership Trust in relation to this. Although the volume of Mental Hea
s is low, they take a long time to take through the Pathways process and can often be traumatic for call ha
to the nature of the call. Patients also benefit from the transfer to another service as they will get to speak
ntal health clinician who will be able to provide the support needed.

l Audits: This is an ongoing process – the results for September were positive in terms of the quality of He
visors (pass rate 85% Health Advisor, 94% Clinical Advisor). Additional training has been provided to those
dlers who did not pass their audits, and appropriate action has been taken where practice was found to be
afe.

1 Performance

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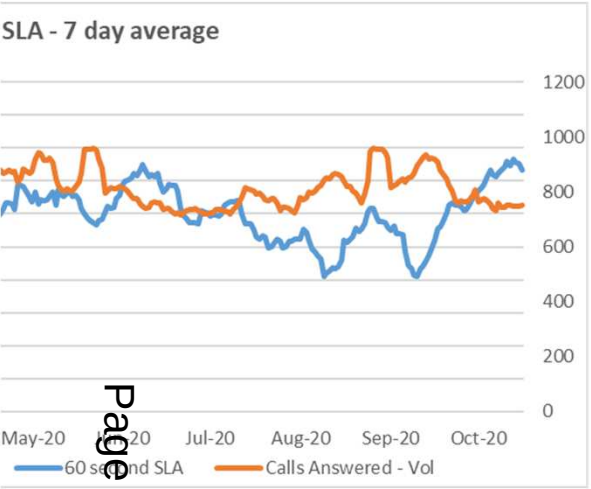

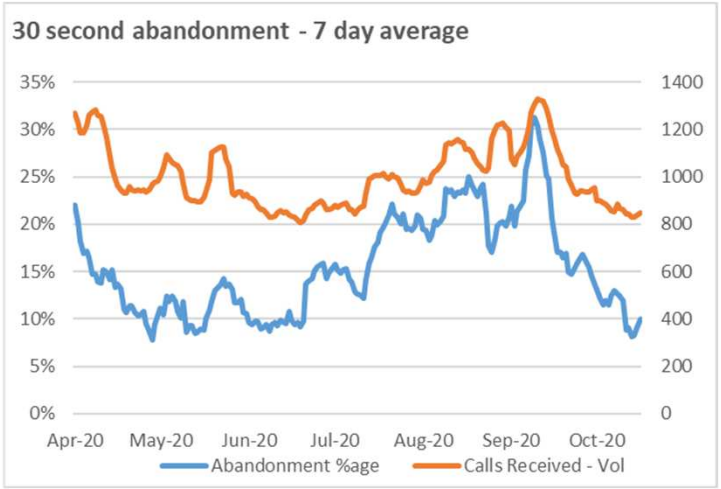

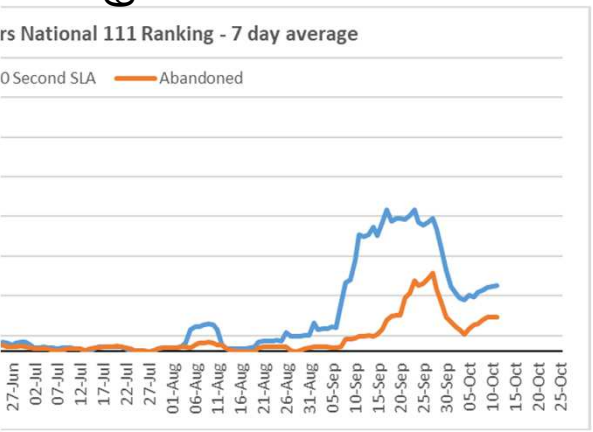

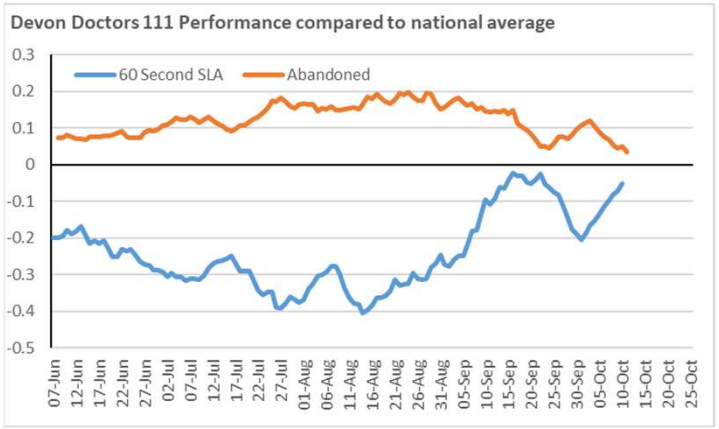

- 111 performance has improved steadily si the inspection in July as there has been ar increase in the level of call handlers within service. Similarly, there has been a reduct the proportion of calls abandoned during period.

- However, the improvement is behind the trajectory for both the 60 second SLA and level of calls abandoned. This is due to a h than anticipated level of failure during the training process.

- Performance compared to the national 11 service has improved, with both the 60 se SLA and level of calls abandoned approach the national average. This data currently l internal performance data by 2 weeks due national reporting delays.

age Improvement Plan

rove performance against the NQR9 performance requirement (the time taken to triage a patient on receipt from 11
has been taken in the following key areas:

esign the Clinical Operating model within the ICUS so that clinicians are focussed on the patients that represent the
test risk
ease the efficiency of clinicians working within the Triage service
ure that patients that have Covid-19 symptoms (HOT patients) are able to be direct booked without double handling
s received from 111.
iew the operating model to ensure that patients are seen within clinically appropriate timescales.
rove efficiency of home visiting resources to minimise down time between patients, but also ensure that patients ar
ed on clinical priority.

Model

lysis has mathematically shown there is sufficient resource in the rota to meet Treatment Centre and Triage demand
he Visiting is excluded from the analysis as managed as a separate resource due to mobile nature of work.
d to increase efficiency of workforce within Treatment Centres to maximise triage performance by direct booking ca
k in to face to face clinicians without appointments.
s of change undertaken during October have demonstrated an improvement in performance
ent / Emergency activity is still managed within the CAS / remote clinical resources to retain central oversight of high
es.

age Improvement Plan

Putting

n Efficiency

ician efficiency is based on the number of patients a clinician can manage without compromising patient safety and
lity. An unnecessary face to face appointment can often be avoided if more time is taken on the triage which is bette
patient and more effective for the service.
a has been produced showing the number of appointments that a clinician spoke to / saw during their shift, the time
y logged on and off of the clinical system, and the proportion of time that they are with a patient.
clinicians are then RAG rated, and those that consistently show as Red are spoken to by the Medical Director. As effic
roves so the tolerance against the RAG scores will be reduced.
clinical efficiency data is reviewed in the Clinical Cabinet and then by the Quality Assurance Committee for oversigh
urance.
ply advising clinicians that this review is in place has seen a group wide improvement in performance (Hawthorne ef

Booking face to face patients in to a Treatment Centre

rder to maximise efficiency, a patient calling 111 who then needs an onward appointment should be booked directly
tment Centre without further triage. At the current time, this is not possible because the service can not be sure th
ent does not have Covid-19. As such all patients are given a triage prior to their face to face appointment to ensure
y do not have Covid-19 symptoms. This is inefficient and poor for patient experience.
are developing HOT sites across Devon to enable patients to be streamed by the Lead IUCS clinician to either a HOT
rm Treatment Centre depending on their need and symptoms.

Operating Model

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Putting

d Operating Model

atient accessing healthcare services will be given a Disposition Code following completion of the assessment in NHS
nways. If onward care is required, these Codes provide a timescale in which the patient should receive their next clin
tact. These codes have been determined nationally as being clinically safe.

on CCG has agreed to change the Out Of Hours service to an operating based on DX codes and not the historic NQR
ets.

means that instead of an arbitrary allocation of a target time of between 20 minutes and 60 minutes, patients will l
cated a timescale of between 1 and 4 hours based on the information provided at the 111 assessment stage.

le some Disposition Codes have a longer timescale than 4 hours, in order to minimise the impact on Emergency
artments it has been agreed that the longer codes will be reduced to 4 hours.

change in model will increase patient safety as it will ensure that patients are seen in a timescale based on their ass
d. It will also lead to a performance level that is comparable with other providers who have already transitioned to t
service model.

on Doctors are currently developing the reporting behind the new Disposition Model. As a proxy, the performance f
are urgent will increase from 70% to ~90%, and for routine call from 74% to ~92%.

her areas for action

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Putting

ical Recruitment: A new Clinical recruitment and “onboarding” process has been designed to improve the first conta
first shift experience for all new clinicians. This process includes a greater use on partner agency contacts and circul
to improve promotion of opportunities.

ical Communications: During the first wave of Covid-19 the Organisation increased the frequency of clinical
mmunications to weekly due to the ever changing nature of the legislation and local infection position. In response to
tive feedback, these weekly communications have been maintained, providing a much needed update to clinicians
st policies, processes, practice, and learning. In addition, the Medical Director is now holding monthly clinical briefin
binars for all sessional and salaried clinicians within the service.

rove Home Visiting Efficiency: Meetings have been held with SWASFT to understand how they manage their mobile
ources. Points of learning will be taken from these meetings and applied to the Devon Doctors mobile resource.

DH Performance

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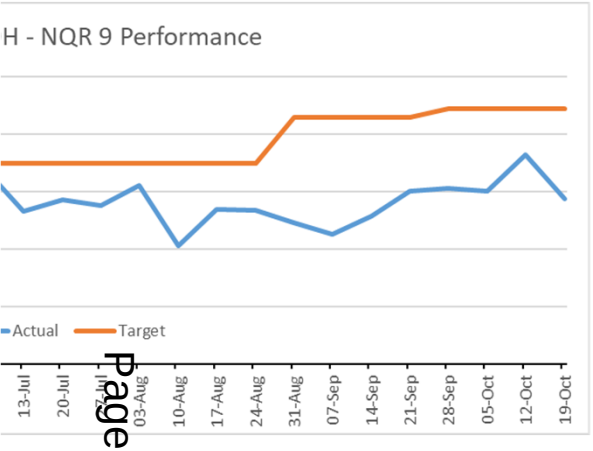
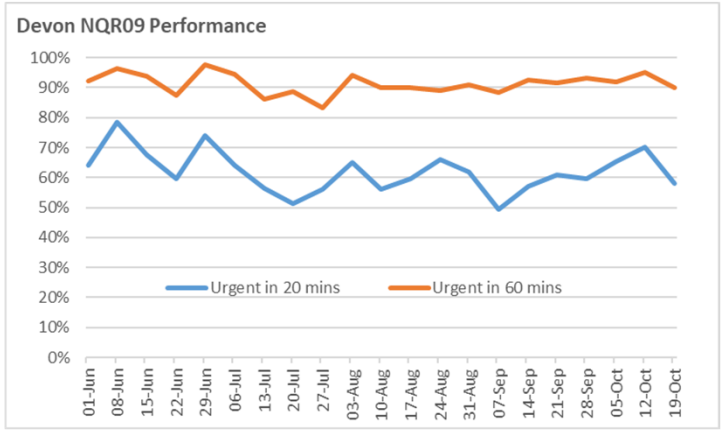
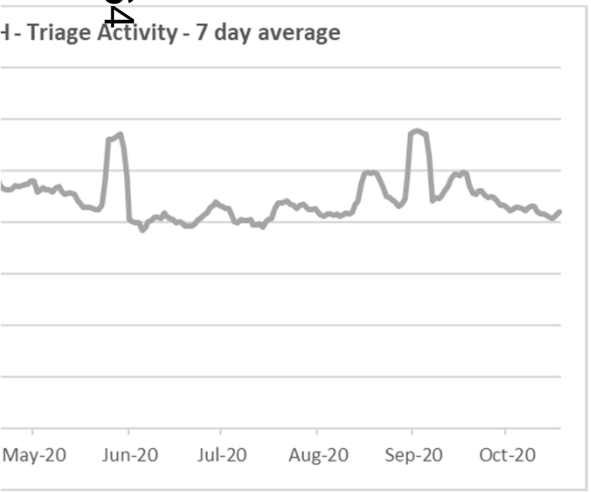
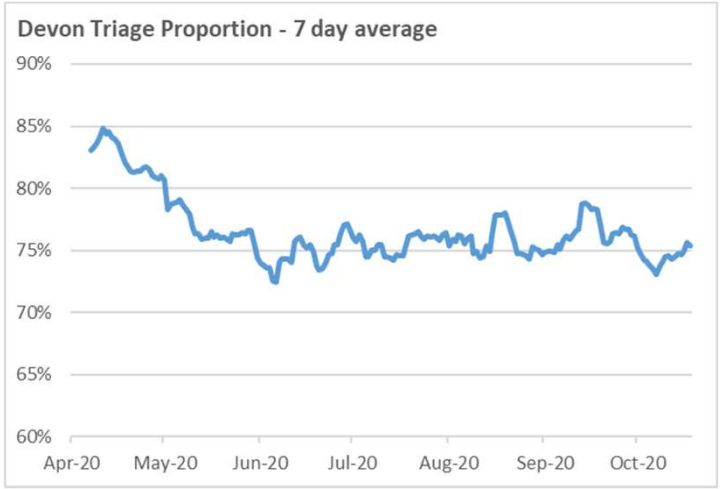








- Devon NQR9 Performance is improving compared to the summer months as the r triage model is introduced. The reduction last week (w/c 19.10) was due to reduced fill in core clinical shifts.
- The proxy for DX reporting (top right char shows that urgent calls are being made w timescales 90% of the time on a consisten basis.
- Discounting the August Bank Holiday, triag levels have been consistent since June 20
- The fall in the proportion of cases being c at triage has fallen as more patients are al be safely seen face to face during the Cov epidemic. This level is still much higher th normal times (~50%)

vernance Improvement Plan

Putting

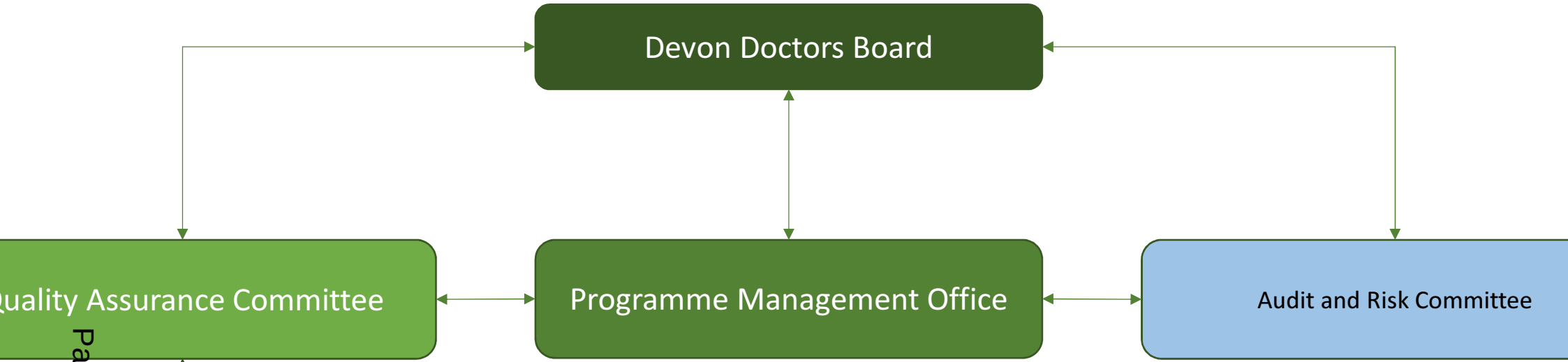
e CQC identified that it was necessary to improve the Governance arrangements to ensure that learning wa
en from Serious Incidents and was implemented across the Organisation to minimise the likelihood of a sim
e happening again.

rder to achieve this, the new Governance Framework (overleaf) was implemented to ensure that informatio
urance from across the Organisation is reviewed on a monthly basis and improvement plans are implemen
actioned to improve patient safety and performance.

e Quality Assurance Committee (QAC) receives assurance and areas for escalation from the four subgroup
h of which has a specific focus as set out on the next slide. The QAC escalates areas for improvement to t
gramme Management Office (PMO) and provides assurance to the Board. These then complete the feedb
le through the QAC to the subgroups. This ensures that a cycle of continuous improvement is embedded
oughout the organisation.

ddition, a review of the Governance arrangements identified that it was necessary to further embed goverr
cesses within the wider organisation. In order to address this a network of Quality Champions was created
f members (clinical and non-clinical) across the Organisation. The Quality Champions have two roles; firstl
re information about areas of concern from within the Organisation, and secondly to cascade learning back
Organisation when improvements are made.

vernance Framework



Significant Event Analysis Review	SEAR reviews incidents and complaints. Links with Quality Champion network to feed in recommendations for quali improvement. Ensures dissemination of learning. Monthly report to QAC. QAC & PMO feedback progress against delivery of recommendations. Chair – Director of Governance
Clinical Cabinet	Clinical Cabinet reviews clinical processes and productivity. Includes audit recommendation and analysis of results. Ensures delivery of audit programme. Monthly report to QAC including summary of audit programme delivery and findings. Chair – Medical Director
Safeguarding Assurance Group	SAG reviews Safeguarding cases, reviews processes and ensures training compliance. Links with local Safeguarding and ensures organisation updated on latest guidance and legislation. Monthly report to QAC. Chair – Associate Medical Director

tient Safety Improvements

Putting

C identified that while the service had delays in providing care to patients, it was necessary to improve the oversigh
within the call queue. All patients are given advice to call 111 back (or 999 in an emergency) if their symptoms wor
er, it was identified that it was necessary to introduce a number of key measures to improve patient safety within th
alongside improvements to performance.

Lead IUCS Clinician plays a critical role in monitoring of the clinical queues, both to ensure that cases are correctly
ritised and also that response times are appropriate and based on clinical acuity. Key areas of responsibility for the L
S Clinician include:

Page 97

- Monitoring the clinical queue/s to ensure that patients receive a clinical response appropriate for the acuity of their presenting co
(see below for details pertaining to specific workstreams).
- Supporting direct booking of appropriate cases from 111 to TC by way of reviewing 'contact' dispositions from 111 and streaming
appropriate cases to TC without prior telephone consultation, (thereby avoiding delays and inefficiencies inherent in the double h
of cases in a 'total triage' model).
- Supporting fellow clinicians on shift where clinical advice from an experienced colleague is required (including the service's own H
Visiting Paramedics). As well as being on a dedicated telephone extension and also contactable via Adastra's internal messaging s
the Lead IUCS Clinician carries a dedicated mobile telephone to facilitate communication with clinicians in the field.
- Supporting operational colleagues where decisions around appropriate deployment of finite clinical resources are being made – t
include participation in operational conference calls where appropriate.
- Undertaking telephone consultations where there is the capacity to do so, with a focus on high priority/high acuity cases eg ED/9
revalidation, HCPs on scene, palliative cases.
- A system is in place to enable all Lead IUCS contacts to be audited so that the role can be further developed and improved.

her areas for action

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ge Comfort Calling: Resource (40 hours) has been secured to provide comfort calling for patients in the triage queue ere their call time has breached. These calls determine whether the patient's symptoms have deteriorated (leading t lation of their call priority), improved, or stayed the same, and to advise them that they are still in the call queue ar uld escalated their concerns if their symptoms deteriorate further. All patients in the queue for more than two hours fort call. Approximately 85% of those patients that need a comfort call get one, and of those 98% are called within 3 utes.

ne Visit Comfort Calling: This has been introduced where a Home Visit is due to breach its target time. This is under he mobile clinician and performs the same role as the Triage Comfort Calling.

lation Policy: The escalation triggers (OPEL) have been split out between triage and face to face activity so that esca on can be taken based on the specific pressure within the service.

g Wait Audits: A monthly review of patients who have experienced a delay in treatment is undertaken to determine ether they have come to harm while they have awaited care. The outcome of this monthly review is reported to the inet and QAC, with the necessary recommendations being made to the PMO for implementation.

CQC Improvement Plan Assurance Processes

ssurance Processes

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llowing governance and assurance steps are in place within the CQC Improvement programme of work to
e that delivery of key actions is monitored and assurance is provided to the Executive, Board, CCGs, and C
mely basis.

nthly Devon Doctors Board meetings

eekly Devon Doctors Board Briefing and assurance pack.

eekly joint Devon CCG, Somerset CCG, and Care Quality Commission assurance touchpoint meeting.

ice weekly CQC Improvement Executive chaired by the Chief Executive Officer, and attended by directors
nior managers from across the business as well as the NED Finance Director and NED Turnaround Directo

eekly PMO assurance meeting with each of the Senior Responsible Officers from the workstreams. Opportu
internal check and balance of progress being made with performance and patient safety improvement.

eekly workstream meetings with attendees from across the business to develop and undertake action plans
iver improvements in patient safety and performance.

Appendix A: Conditions of Registratio

onditions of Registration

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Putting

registered provider must provide the Care Quality Commission with written documentation by 11 August 2020 that sets o
ey will implement a safe system to ensure delays to care and treatment are reduced and there is always appropriate (in
tionally determined targets) call answering, triaging, prioritising and call backs to patients across the NHS 111 service in
l backs and comfort calling, across the Out of Hours GP service in Devon and Somerset.

registered provider must provide the Care Quality Commission with written documentation by 11 August 2020 setting ou
vider will ensure adequate numbers of suitably qualified, competent and skilled members of staff for the provision of the
von contract, across all provider sites. This documentation needs to clearly outline how the registered provider will meet
ments of patients accessing the NHS 111 Devon service. This would include how the registered provider intends to asse
t capacity and resources and how it intends to plan and safely deliver this to meet patients' needs, in relation to a reduc
nber/percentage of calls to the NHS 111 service being abandoned and an increase in the number/percentage of calls to
11 service answered within 60 seconds. The report must document the steps to ensure the required improvement is mad
ober 2020.

registered provider must provide the Care Quality Commission with written documentation by 11 August 2020 setting ou
vider will ensure adequate numbers of suitably qualified, competent and skilled members of staff for the provision of the
GP Service for Devon and Somerset. This documentation needs to clearly outline how the registered provider will meet t
ments of patients accessing the Out of Hours GP Service for Devon and Somerset. This would include how the registere
r intends to assess the relevant capacity and resources and how it intends to plan and safely deliver this to meet patient
in relation to patients awaiting a telephone assessment from the Out of Hours GP service. The report must document th
o ensure the required improvement is made by 09 October 2020.

onditions of Registration

Devon Doctors Group

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Putting

registered provider must implement and maintain sufficient oversight of governance processes across the NHS 111 Dev
and provide the Care Quality Commission with written documentation by 11 August 2020 setting out how the service int
ss, monitor and improve the quality and safety of the NHS 111 Devon service. This must include the identification, revie
g shared from significant events and serious incidents. This oversight of improvement must include senior leaders and r
nt scrutiny and challenge at a board level. This would document how the provider will monitor progress against plans to
e the quality and safety of the NHS 111 service and take appropriate action without delay where progress is not achieve
ed. Furthermore, the registered provider must by, 11 August 2020 establish an effective system to ensure the identificati
use analysis of any patterns or trends in low performance within the NHS 111 Devon service in relation to the
r/percentage of calls being abandoned and the number/percentage of calls being answered within 60 seconds. The repo
ocument the steps to ensure the required improvement is made by 28 August 2020.

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registered provider must implement and maintain sufficient oversight of governance processes across the Out of Hours
in Devon and Somerset and provide the Care Quality Commission with written documentation by 11 August 2020 settin
e service intends to assess, monitor and improve the quality and safety of the Out of Hours GP service. This must inclu
cation, review and learning shared from significant events and serious incidents. This oversight of improvement must inc
eaders and receive sufficient scrutiny and challenge at a board level. This would document how the provider will monito
ss against plans to improve the quality and safety of the Out of Hours GP service and take appropriate action without de
progress is not achieved as expected. Furthermore, the registered provider must, by 11 August 2020 establish an effecti
to ensure the identification and root cause analysis of any patterns or trends in low performance within the GP Out of H
in relation to delays in patients receiving safe and timely care.

onditions of Registration

Devon Doctors Group

Putting

registered person must, by 11 August 2020 devise and implement an effective system to ensure that the risk and incider
d assessments and appointments at the GP Out of Hours service in Devon and Somerset are properly identified and ma
gistered provider must also ensure that there are appropriate systems in place to monitor the condition and risk of deteri
atients awaiting assessment and appointments within the GP Out of Hours service. The report must document the steps
the required improvement is made by 28 August 2020.

CS0/20/20
Health & Adult Care Scrutiny Committee
23 October 2020

23 October 2020 Standing Overview Group

Devon System Winter Plan / Devon Safeguarding Adults Partnership

Report of the Health & Adult Care Scrutiny Members

Please note that the following recommendations are subject to confirmation by the Committee before taking effect.

Recommendations:

That the Committee shares the learning from the most recent Standing Overview Group meeting on 23 October 2020 on the Devon System Winter Plan and the Devon Safeguarding Adults Partnership to inform its future work programme.

Background

The Standing Overview Group of the Health and Adult Care Scrutiny Committee meets bi-monthly as an information sharing and member development session where issues are presented to the councillors to raise awareness and increase knowledge. Any action points arising from the sessions are reported back to the formal Committee meeting.

On 23 October 2020 the Standing Overview Group received presentations from officers on work relating to winter planning in the Health and Adult Social Care system and the Devon Safeguarding Adults Partnership.

Members in Attendance

- Cllr Randall Johnson (Chair)
- Cllr Ackland
- Cllr Evans (District Council Representative)
- Cllr Russell
- Cllr Saywell
- Cllr Scott
- Cllr Trail
- Cllr Yabsley

Devon System Winter Plan

During discussions with members the following key areas were raised:

Devon Approach

- The Devon system approach to planning for winter builds upon the learning from the previous winter and learning from the system response to the COVID-19 pandemic. Balance urgent care response (COVID-19 / non COVID-19) and planned care recovery with a proactive locality focus to minimise escalation and ability to de-escalate fast.
- Ensures that the additional pressure on services does not compromise the safe and effective delivery of services for Devon patients.
- Reflects operational actions at both a locality and a system level to ensure effective delivery of the plan.
- Establishes the system escalation arrangements, which build upon the arrangements in individual organisations.
- Identifies the key risks and mitigating actions.

Testing

- Follow all Public Health England/Department of Health and Social Care policies on testing in both acute and community settings.
- Weekly COVID-19 testing for care home staff and 4 weekly testing for residents. Plans for testing of health & care staff visiting care homes.
- Testing capacity is prioritised for pre-discharge testing of all patients transferring to care home settings and this is now well established as routine across the Devon system.
- Developed a joint testing strategy for the Peninsula with partners in Cornwall. A daily report of laboratory capacity and the number of tests undertaken per day is received to ensure real-time information on capacity and utility of testing resource.

Infection Prevention Control

- Infection Prevention Control (IPC) support for community health and care services and primary care medical services is in place through the recently implemented Community Infection Management service integrated within the 4 acute providers specialist teams and with additional microbiology cover available. This ensures responsive specialist advice for all out of hospital services.
- The service will support in the winter months when there are the additional winter pressures of influenza and viral gastroenteritis.
- Plans are in place in local authorities to support particularly ‘at risk’ areas such as supported living and day services where the IPC risk is greater due to the social nature of the service.
- NHS Nightingale Hospital Exeter has been ready to receive patients since July and has been inducting and training staff. It is currently in standby mode ready to take 1 ward of patients within 72 hours. The hospital provides a fully-equipped environment to care for patients with COVID-19, has 116 beds, divided into five wards – all capable of providing mechanical ventilation, with two Wards designated for ICU.

Delivering an Expanded Flu Vaccination Programme

- A multi-agency Devon-wide flu planning and oversight group will enable monitoring of vaccine uptake rates and outbreaks in the system and provide prompt support or resolution to challenges as they may arise throughout the flu programme.
- A flu immunisation plan sets out the specific activities that will ensure there is an offer to 100% of frontline health and care workers, as well as maximise uptake for housebound patients, residents of care homes, shielded patients and their household contacts.
- Devon’s communications and engagement strategy includes action to increase vaccination.

Primary Care

Key aim of winter planning is to secure the resilience of primary care providers, enabling them to maintain a level of access to their patients that can meet urgent primary care need and minimises risk of escalation to other parts of the system. From a system perspective, the main priorities for primary care winter planning are:

- Maximising opportunities through digital acceleration – remote working, eConsults etc.
- Enhanced support to care homes – working with multi-disciplinary teams as part of the Primary Care Network (PCN) requirements.
- Extended Access – maximising uptake of extended access in primary care and embedding 111 direct referral into primary care workflows.
- Supporting primary care delivery of the flu vaccine.
- Enhancing primary care data collection.
- Ensuring primary care engagement in locality forums and winter plans.
- PCN development.
- Estates development prioritisation.
- Strengthening our Primary Care workforce.

Locality Winter Planning

System winter plan underpinned by four locality plans, with demand and capacity modelling and plans for:

- Emergency Department
- Emergency admissions
- Elective activity
- Out of hospital care with focus on demand and capacity required for patient discharges in compliance with the Discharge to Assess model.

The challenge is balancing emergency demand and capacity whilst protecting elective capacity, crucial to address the lengthening waiting lists. Key to this are the initiatives to avoid unnecessary attendance/admission to hospital and effective management of patient flow through the system; funded through winter monies and integrated Better Care Fund (iBCF).

Ensuring Workforce Resilience

Actions to support staff health and wellbeing include:

- Regular promotion of the national health and wellbeing offer.
- Extensive and regular system and organisational communications provided to staff, including those across primary care and social care including regular webinars hosted by the CCG.
- DPT Talkworks service, a priority pathway for those people working in the NHS, Social Care and the Police.
- All staff able to access Occupational Health and Employee Assistance Programmes.
- Free staff parking offered across all NHS sites.
- Rest and recuperation offer to staff in all NHS organisations with clear guidance. Regular communications to staff to encourage taking time off and taking leave in particular before winter pressures.
- Provision of adequate PPE for all services across the health & care system to protect staff and support workforce resilience and capacity throughout winter is critical
- Health inequalities amongst staff, has been brought to the forefront as a result of COVID-19. All BAME staff and staff at higher risk must have a risk assessment in their role to ensure appropriate measures are in place to keep them safe.

Communications / Public Messaging

Key areas of focus for 2020/21 communications campaign include:

- Think 111 First – behaviour change campaign to encourage contacting 111 before attending Emergency Departments.
- Digital offer – eConsult, video consultations, NHS app etc.
- Flu – all groups and added messaging on measures in place to keep people safe, limit exposure, etc.
- Mental health - support available for people, especially on approach to Christmas and New Year, and launch of 24/7 crisis lines, as well as crisis cafes.

Issues Identified by Members

The following issues were identified by members during their discussion with officers:

- The need for people going home with personal care packages to be routinely tested for COVID-19.
- Concern about testing of domiciliary care staff and risk of asymptomatic personal care workers visiting the vulnerable. Officers advised that there is limited capacity to offer testing to all private domiciliary care providers. If anyone has symptoms, they will be prioritised for a test through Pillar 1.
- Concern about risk of contracting COVID-19 for people who are at home and receiving domiciliary care. Officers advised that this would be a very small number from the data they have available on this.
- Personal protective equipment (PPE) has a hugely important role. There have been challenges along the way, but domiciliary care providers have effective PPE.
- Test results for symptomatic individuals takes between 4–12 hours, though have some access in emergency to 15 minute tests. Tests for asymptomatic is 2–5 days but working with national teams to try to get this time down.
- Public Health advice in Devon has been that visiting a care home can be undertaken safely, but that the final decision on this is with the care home. Members highlighted mental health impact where individuals are not being visited.
- All care settings in Devon can access quality assured PPE.
- Need a critical mass of 40% COVID-19 patients at RDE to open the Nightingale.
- Good uptake on flu vaccinations and supply available. Officers advised that the ambition is to reach 100% of all staff and are certainly expecting to exceed 74% from last year. Members hoped to see the figures for flu vaccinations reach at least 90%.
- Only 1 or 2 care homes in Devon are not now linked to a PCN and officers are working on this.
- Members flagged up their role in communicating with their local communities in terms of directing people to use 111 and the digital offer available.
- Sewage testing for COVID-19.

Devon Safeguarding Adults Partnership

Officers presented to members on the legislative requirement of the Devon Safeguarding Adults Partnership (DSAP) and highlighted the following:

- Safeguarding adults' means protecting an adult's right to live in safety, free from abuse and neglect.
- Preventing abuse or neglect from happening in the first place.
- Stopping abuse and neglect where it is taking place.
- Protecting an adult in line with their views, wishes, feelings and beliefs.
- Empowering adults to keep themselves safe in the future.
- Everyone taking responsibility for reporting suspected abuse or neglect.
- COVID-19 has had an impact on DSAP referrals with firstly a reduction and then an increase in numbers but this has been in line with the rest of the Country.
- The biggest increase in concerns has been self-neglect, neglect and acts of omission and domestic abuse.
- The nature of enquiries has changed through the pandemic to those where isolation is a feature - psychological, self-neglect and domestic abuse but the numbers are small.
- DSAP campaign to increase the level of public awareness of adult abuse and how to recognise the signs, encourage individuals affected, friends, family and neighbours to report any concerns by promoting how and where they can seek advice and support.
- Reaching people who have connections to adults who may be, or are, at risk of abuse or neglect including those with physical or learning disabilities, and people with mental health issues.

The Chair of the DSAP then presented the 2019/20 Annual Report, during which the following issues were raised during the discussion with members:

- It was felt last year that the number of safeguarding concerns in Devon was not as high as it should be. Officers undertook a deep dive on this and identified how partners could work better together.
- DSAP at a place where there is good challenge and holding partners to account.
- There is a strong team sitting behind DSAP now and a huge amount of progress has been made in recent years.
- There will be more to learn through the challenges presented by COVID-19.
- Members highlighted the high profile work on mental health led by people such as Prince William but did not feel there was the same focus on learning disability and autism.
- Atlas Care Homes Review published in September 2019 illustrates work undertaken by DSAP where there were serious issues within care homes.
- Members thanked the outgoing Chair of DSAP for her work and rigour over the last 5 years and wished her well for the future.

Conclusion

The Committee thanked the officers for attending this meeting and recognised the invaluable work they are undertaking in unprecedented circumstances responding to the COVID-19 pandemic. Members also thanked officers and their staff for working around the clock to make sure services continue to reach communities, ensuring the most vulnerable people are cared for and that frontline staff are supported.

Councillor Sara Randall Johnson, Chair
Health & Adult Care Scrutiny Committee

Electoral Divisions: All
Local Government Act 1972
List of Background Papers
Contact for Enquiries: Dan Looker / Tel No: (01392) 382232

Background Paper	Date	File Ref
Nil		

There are no equality issues associated with this report