Care Quality Commission

Plymouth

Local system review report
Health and Wellbeing Board

Date of review:
4-8 December 2017

Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and for Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives the Care Quality Commission (CQC) the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

The review team

Our review team was led by:
- Delivery lead: Ann Ford, CQC
- Lead reviewer: Rebecca Gale, CQC

The team included:
- Two CQC reviewers,
- One CQC strategy lead,
- One CQC deputy chief inspector (adult social care)

- One CQC head of legal services
- Two CQC analysts,
- One CQC manager for integrated care
- One CQC inspection manager (adult social care)
- One CQC inspector (pharmacist)
- One CQC Expert by Experience and;
- Five specialist advisors (two current directors of adult social services, one former director of social services, one clinical commissioning group board member and one GP).

How we carried out the review

The local system review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on **older people aged over 65**.

We also focussed on the interfaces between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system was functioning within and across three key areas:
1. Maintaining the wellbeing of a person in their usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/ or admission to a new place of residence

Across these three areas, detailed in the report, we have asked the questions:
- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?

We have then looked across the system to ask:
- Is it well led?

Prior to visiting Plymouth we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We asked the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (SOIR) and asked a range of other local stakeholder organisations for information.

We also developed two online feedback tools; a relational audit to gather views on how

relationships across the system were working, and an information flow tool to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care.

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as people who use services, their families and carers. The people we spoke with included:

- System leaders from Plymouth City Council (the local authority), the NEW Devon Clinical Commissioning Group (the CCG), Plymouth Hospitals NHS Foundation Trust, Livewell Southwest Community Interest Company (a social enterprise), the Health and Wellbeing Board (the HWB), the Overview and Scrutiny Committee and elected leaders.
- Health and social care professionals including social workers, GPs, discharge teams, therapists, nurses and commissioners
- Healthwatch Plymouth and voluntary, community and social enterprise sector (VCSE) services
- Independent care providers
- People using services, their families and carers at Improving Lives and the Elder Tree befriending service. We also spoke with people in A&E, hospital wards and at residential and intermediate care facilitates.

We reviewed 19 care and treatment records and visited 11 services in the local area including acute hospitals, community hospitals, intermediate care facilities, care homes, GP practices and domiciliary care providers.

The Plymouth Context

Demographics

- 16% of the population is aged 65 and over
- 96% of the population identifies as white
- Plymouth is in the top 20-40% most deprived local authorities in England

Adult social care

- 78 active residential care homes:
  - Two rated outstanding
  - 62 rated good
  - 9 rated requires improvement
  - Two rated inadequate
  - Three currently unrated
- 22 active nursing care homes:
  - One rated outstanding
  - 11 rated good
  - Seven rated requires improvement
  - 2 rated inadequate
  - 1 currently unrated
- 18 active domiciliary care agencies:
  - 2 rated outstanding
  - 7 rated good
  - 3 rated requires improvement
  - 6 currently unrated

All location ratings as at 01/12/2017. Admissions percentages from 2016/17 Hospital Episode Statistics.

Acute and community Healthcare

Hospital admissions (elective and non-elective) of people of all ages living in Plymouth were almost entirely to Plymouth Hospitals NHS Trust

- Received 97% of non-specialist admissions of people living in Plymouth
- Admissions from Plymouth made up 53% of the trust's total admission activity
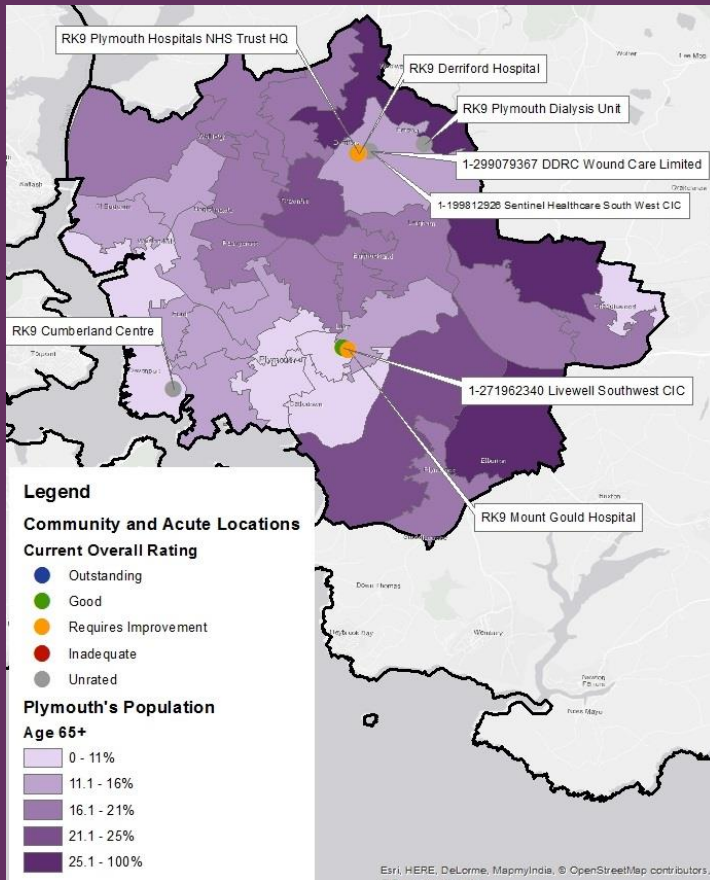- Rated requires improvement overall

Community services are provided by Livewell Southwest
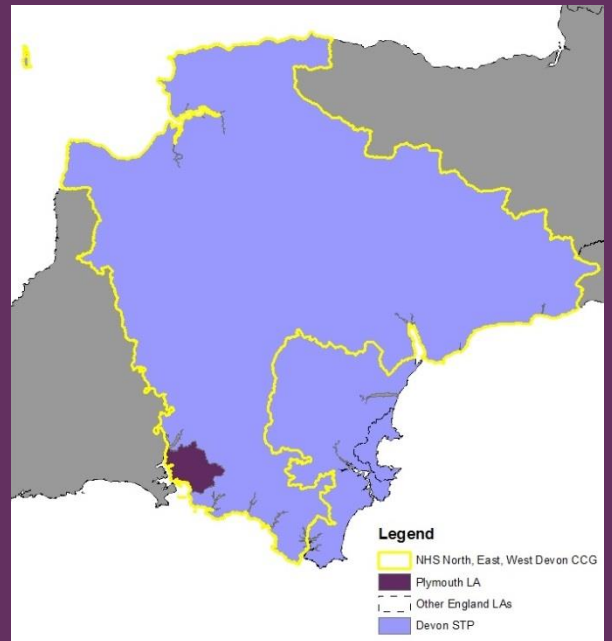
- Rated good overall

GP Practices

- 32 active locations
  - 30 rated good
  - 2 unrated

Map 1: Population of Plymouth shaded by proportion aged 65+.

Also, location and current rating of acute and community NHS healthcare organisations serving Plymouth.

Map 2: Location of Plymouth LA within Devon STP.

NHS North, East .West Devon CCG is also highlighted.

Summary of findings

Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- Plymouth is on a journey to integration. There was a compelling vision for integration within Plymouth, developed in collaboration with system partners and local people and linked to the Devon-wide Sustainability and Transformation Plan (STP). The strength and commitment of Plymouth's leadership meant this strategic vision had the potential to be realised, but only if it was translated at ground level and if the wider current challenges facing the system are addressed.

- Plymouth was part of the north, east and west NEW Devon Success Regime, one of three in the country, owing to the area's significant financial pressures. These pressures continued to be felt at the time of our review. It was reported that Plymouth Hospitals NHS Trust (PHNT) had one of the largest Cost Improvement Plans in the country at £40 million for 2017/18. There were significant capacity issues within primary care and continuing healthcare performance was poor. People's experiences of the care system were variable and these challenges meant there was a risk improvements could not be sustained.

- The ambitions of the Devon-wide STP had been translated into the local *Plymouth Plan* and there were clear lines of communication and accountability between the two. Both officers and political leaders within the system had strived hard to ensure the voice of Plymouth was heard within the STP structures. Plymouth had been recognised by the STP for their approach to integrated commissioning, the way they had involved the public in developing their strategic vision and commissioning plans and the effectiveness of their Health and Wellbeing Board (HWB). This meant there was a clear framework to secure improvements for people who use services.

- There was a shared ambition among system leaders to progress with vertical integration of service delivery to include primary care, community, acute and social care. The challenges will be to ensure staff are engaged in the process and can articulate the strategic vision, and to ensure that positive approaches and ways of working that have been established within the current system are not lost in the change process.

Is there a clear framework for interagency collaboration?

- There was a clear framework for interagency collaboration. Relationships amongst system leaders were positive and there were examples of effective partnership working. However, it was widely recognised that some cultural and organisational barriers remained and that

significant organisational development work was required to overcome these if full integration of service provision was to become a reality.

- Since 2015, the local authority and the Western Locality of Northern Eastern and Western (NEW) Devon CCG had a pooled budget of £462 million to deliver integrated health and wellbeing services. There were four corresponding integrated commissioning strategies, which system partners were all signed up to. While they were reviewed every six months, they had remained consistent to provide clarity and stability.

- There was evidence of risk sharing at an STP and a local level. The Devon-wide STP was working to a system-wide control total which meant if PHNT's Cost Improvement Programme was not addressed, the entire STP was at risk. The risk share arrangement outlined in the Section 75 agreement between the local authority and NEW Devon CCG had been nationally recognised as innovative.

- System leaders were aware of the shared challenge to reduce the causes of delayed transfers of care. They had committed to resolving these issues through the establishment of the System Improvement Board (SIB) in October 2017, which provided a system-level view of performance. This fed into the Devon-wide System Performance and Delivery Group (SPDG) had been established to provide a shared view of performance and high-level scrutiny to drive improvement.

How are interagency processes delivered?
- There were strong governance arrangements in place with clear lines of accountability and communication between system partners within Plymouth and with the Devon-wide STP. However, some governance arrangements had been recently implemented and their impact had not yet been realised in terms of improvements in performance.

- In 2015 the local authority had transferred their adult social care staff to Livewell Southwest (LWSW), a social enterprise, to create an integrated health and social care community provider with the aim of providing a whole-person response to community support. Multidisciplinary teams were now based in four localities across Plymouth working in an integrated way to deliver positive outcomes for people.

- Plymouth's journey to integration had been underpinned by extensive public engagement and co-production. Health and social care providers and voluntary sector organisations described their relationships with commissioners as positive and collaborative.

- The challenge for this system was to continue to drive forward the strategic ambition while remaining focused on delivering improvements against current performance pressures. The

prevention and early intervention commissioning intentions for hospital admission avoidance remained underdeveloped due to a reactive response to external reviews and sub-optimal performance in parts of the system

- There were some missed opportunities to learn and improve as a system. For example, Plymouth was consistently in a state of escalation and this had become normalised. There was a lack of evaluation at a system level to identify what actions by services or individual staff led to the level of escalation being reduced.

What are the experiences of frontline staff?
- System leaders and senior managerial staff were visible and engaged. Staff were aware of how to escalate concerns within their organisations and across organisations.

- Frontline staff were committed to providing high-quality and person-centred care. There were some particularly innovative and energised staff working within the system who were leading and contributing to system improvements. However, there was a dependence on specific, critical individuals. Leaders should ensure plans are in place for succession and to mitigate any risk of these individuals leaving and that changes and improvements are embedded and sustained.

- While we found examples of staff working in an integrated way to deliver positive outcomes for people, the system remained fragmented in parts and organisational structures were a barrier. Staff did not always know which services were available and there was a lack of trust or understanding in the capability of those services newly established or those outside of their respective organisations. This was supported by the findings of our relational audit.

- While frontline staff were aware of the system's performance in relation to delayed transfers of care, there was not a shared level of responsibility to reduce them, but an acceptance they were the symptom of a pressurised system. This was particularly apparent in the acute hospital. The system needs to ensure that staff are not normalising sub-optimal performance.

- Most frontline staff across the health and social care sector we spoke with were positive about their relationships with commissioners. They described them as collaborative and supportive.

What are the experiences of people receiving services?
- The experience of people receiving health and social care services in Plymouth was varied. We received mixed feedback from people using services and from carers we spoke with. They were complimentary about individual staff, but told us they had had negative

experiences of discharge from hospital.

- If people received reablement services they were more likely to remain independent and remain at home, additionally if they were under the care of a LWSW locality-based team they were likely to only have to tell their story once.

- There were significant pressures within primary care, and GP provision in terms of numbers was poor in parts of the city. This meant people could not always access a GP when they needed one which placed an additional burden on other services within the system.

- There were services commissioned to prevent unnecessary admissions to hospital, however, some were working below capacity and could be better utilised. This meant some people were admitted to hospital unnecessarily.

- There were also missed opportunities to better utilise the services and contribution of the voluntary and community sector in terms of maintaining people at home and avoiding hospital admission.

- If a person went into crisis, they were more likely to be admitted to hospital and experience longer lengths of stay due to delays in the assessment processes for both health and social care.

- People were receiving direct payments and personal health budgets, but we were told it was difficult for people to access information about services available, particularly if funding their own care.

- Performance in relation to continuing healthcare (CHC) was poor. Large numbers of people were waiting for assessments for considerably longer than the expected 28 days. Furthermore, the conversion rate was low, meaning a large number of people referred for an assessment did not receive funding because they did not meet the eligibility criteria. System leaders told us that a high number of inappropriate referrals impacted on the CHC team's ability to respond to the backlog.

Are services in Plymouth well led?

Is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high quality care and support?

As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, interagency and multidisciplinary working and the involvement of people who use services, their families and carers.

Plymouth was well on its journey to integration and some positive progress had been made to date.

We found there was strong system leadership with a clear strategic vision for the future, which was aligned to the wider Devon STP. There was a real commitment among both officers and political leaders to deliver together, and the challenges and pressures faced by the system were well understood by all. Relationships at a system level were positive and there was evidence of effective partnership working. However, some cultural and organisational barriers existed and were impacting on service delivery in parts of the system. It was widely recognised that some organisational development work was required to engage staff at all levels and ensure they were able to articulate the strategic vision and work together to achieve it. Should the wider system challenges be addressed with a clear focus on the here and now as well as transformational change, there was the potential for the strategic vision to be realised.

There had been extensive public engagement in the development of the city's strategic vision and service design. Wider system partners, including health and social care providers as well as voluntary sector organisations felt they had collaborative relationships with commissioners and there was a commitment for the system to learn and improve together.

Strategy, vision and partnership working
- There was strength in the leadership and a shared, system-wide commitment to serve the people of Plymouth well. While there was recognition that some relationships had been challenging and organisational structures had created barriers to integrated working, there was a commitment to overcome these. Findings from 160 respondents to our relational audit showed some issues still existed around organisational cultural issues, trust, and understanding about what services could offer. System leaders need to ensure staff at all levels across health and social care are included in the vision and understand their role in delivering it.

- The system was on its journey to integration. In 2013 the HWB set the ambition to develop

an integrated system of population-based health and wellbeing to tackle inequalities and improve outcomes for residents across the city. The HWB continued to take a leadership role, setting ambitions and agreeing strategic approaches. This strategic vision for an integrated health and social care system within Plymouth pre-dated the development of the STP and system leaders had worked hard to ensure local priorities and challenges were well understood at an STP level from a political, commissioner and provider perspective. There was representation from Plymouth across the STP structures.

- Leadership was strong among officers and political leaders; positive relationships were leading to effective partnership working. Political leaders and shadow leaders were united in their support of the strategic vision and priorities for the city and the NEW Devon footprint, despite political and financial pressures, which was encouraging to see. This meant there was a shared commitment to ensuring people received better quality care.

- The Devon STP, encompassing the local authority areas of Plymouth, Torbay and the rest of Devon, set out ambitious plans to improve health and care services to ensure they are clinically and financially sustainable in the future. It also provided the framework for an Accountable Care System with a single strategic commissioner and four Local Care Partnerships (LCPs) based on a place-based model of care and a network of acute hospitals by 2020/21. One of these LCPs would cover the Western Locality of NEW Devon CCG, including Plymouth.

- The strategic vision and priorities of the Devon STP had been translated into a local strategic framework. The '*Healthy City'* chapter within, '*The Plymouth Plan'* set out the objectives for health and social care, focusing on prevention and early intervention as well as considering the wider determinants of health such as, housing, transport and the environment. This strategic framework was underpinned by four integrated commissioning strategies. The focus was very much on prevention and living well. There had been significant investment across the city to develop 309 extra care housing units for older people, with a further 80 due to complete by February 2019. However, there was an absence of end of life care within the strategic plans at both an STP and local level. This was highlighted by some voluntary sector organisations we spoke with during our review.

- Although system leaders embraced the STP and were committed to delivering the strategic objectives of the STP and *Plymouth Plan,* some system partners felt the STP had hindered progress in some areas. The STP had been slow to develop a primary care strategy and this had impacted on Plymouth's ability to respond to what was an immediate risk within the system due to commissioning arrangements being the responsibility of NHS England.

- Partners had not only succeeded in having a joint plan for the Better Care Fund (BCF)

signed off and approved by NHS England without any conditions, they had also submitted a bid to be part of round one BCF graduation. Plymouth was not one of the seven areas selected for the first tranche, but intended to apply again should the opportunity arise. The Improved Better Care Fund (iBCF) submission for Plymouth outlined a long list of schemes, which all met with the three national conditions imposed on related monies.

- System leaders were aware of the shared challenge to reduce the causes of delayed transfers of care. They had committed to resolving these issues through the establishment of the SIB and the joint appointment of an 'Interim Director of Integrated Urgent Care' by LWSW and Plymouth Hospitals NHS Trust (PHNT). Unverified data showed recent improvements had been made, but delays remained higher than average and wider system pressures, including primary care capacity and workforce put the sustainability of these recent improvements at risk.

- A system level plan for winter had been produced and staff and providers throughout the system were able to articulate how they had been asked to contribute. For example, care providers and voluntary, community and social enterprise sector (VCSE) organisations had been asked to provide information on their capacity.

- The system worked collaboratively with providers, housing partners and VCSE organisations. The feedback we received from these organisations supported this view. They were positive about how commissioners engaged them in developing the vision and strategy and they felt like system partners. There were a variety of fora they could attend, including system design groups at both a local and STP level. However, some VCSE organisations also reported they felt underutilised and that commissioners could be more proactive in their approach. System leaders should ensure VCSE organisations are included in strategic plans to increase future capacity.

Involvement of people who use services, families and carers in the development of strategy and services

- Plymouth's journey to integration had been underpinned by extensive public engagement and co-production. Providers had systems in place within their individual organisations to engage with people and obtain feedback, including a partnership committee at LWSW and a patient council at PHNT. The system's approach to involving people in service design and delivery was positively commented on by many people who use services and staff we spoke with during our review and it had also been recognised at the STP level. For example, the 'Plymouth Sofa' visited different parts of the city to facilitate conversations about what was important to people and a series of 'I' statements were also developed.

- For each of the four integrated commissioning strategies, a system design group (SDG)

had been established. These created opportunities for all stakeholders (including providers, people who use services and carers) to collaborate, review, design and implement structures and pathways. Annual surveys and quality reviews across service provision were undertaken as part of the contract management process, which involved site visits and speaking with people who used services. The feedback from these surveys and reviews helped inform future commissioning plans and identify areas for improvement.

- Healthwatch Plymouth had been commissioned by the local authority to lead a public consultation for the development of ten health and wellbeing hubs across the city where people could access information, signposting and self-management advice and activities. These hubs were at the planning rather than delivery stage and people were being consulted in their design from the outset. The consultation had concluded and Healthwatch had produced a comprehensive outcome report for commissioners prior to our review (published November 2017).

- We received positive feedback from VCSE organisations about their relationship with commissioners and involvement in strategic development to support local people. Not all were represented on Plymouth's HWB, but they described their involvement in SDGs at a local and STP level. However, some felt underutilised in the delivery of services. The system had commissioned a number of VCSE organisations to deliver services on their behalf. For example, Improving Lives ran the city's carers' hub and were commissioned to carry out carers assessments in collaboration with LWSW.

- Work was also being undertaken to develop and build upon community assets. The Plymouth Octopus Project (POP) had received investment from the local authority to go out into communities and help connect like-minded people, projects and organisations to create networks and increase social capital in local areas.

Promoting a culture of inter-agency and multidisciplinary working
- There was a shared ambition and commitment to move to a model of vertical integration which would see integration of statutory community and acute healthcare service provision as well as commissioning. The system had begun to lay the foundations for this and the integrated commissioning arrangements which saw a pooled budget of £462 million since 2015 between the local authority and Western Locality of NEW Devon CCG, meant they were further ahead than other areas of the country (and the Devon STP) in terms of the transformation agenda. This pooled budget extended beyond health and social care to include the wider determinants of health and wellbeing, such as public health, housing, leisure and community safety budgets.

- In 2015 the local authority transferred their adult social care staff to LWSW to create an

integrated health and social care community provider with the aim of providing a whole-person response to community support. Multidisciplinary teams were now based in four localities across Plymouth working in an integrated way.

- While there had been some ambitious steps made to encourage a culture of inter-agency and multidisciplinary working, some of these were relatively new and needed to be further embedded as relationships were fragmented in parts. This was supported by the findings of our relational audit where two of the lowest scores were on the statements: "Poor communication creates misunderstanding and ill-formed decisions" and "Opportunities are missed and problems caused as a result of limited knowledge about other organisations".

- The Acute Assessment Unit at Derriford Hospital had been opened the week before our review. This saw LWSW and PHNT staff co-located and working together to prevent unnecessary admissions to hospital through primary care streaming, the Acute GP service and the frailty unit. The Acute GP service had been in operation for some time, but was generally working at 60% capacity despite attempts to engage staff in the Emergency Department at Derriford Hospital to encourage referrals directly from A&E. Some organisational development work needs to be undertaken to break down organisational barriers, strengthen relationships and ensure there is a shared understanding about staff roles and responsibilities and how they fit into the wider system. Should work progress to form a fully integrated service delivery model, the system needs to ensure staff are fully engaged, from the outset and led by a collaborative leadership.

- There was a shared commitment among system leaders to tackle the challenges faced jointly. PHNT and LWSW had recently made a joint appointment of an 'Interim Director of Integrated Urgent Care' to objectively review the system's capacity and to remove barriers to facilitate more effective working.

- More work was required to ensure all providers felt like system partners. While care providers were positive about their relationships with commissioners, they were less so in relation to secondary care providers, who they felt did not understand the limitations of what their services were able to provide.

Learning and improvement across the system
- Although there was evidence of learning and improvement within individual parts of system, there was not a single, co-ordinated approach to ensure that lessons and key messages were shared widely across among system partners, but rather a fragmented approach. This meant there were some missed opportunities to evaluate and learn as a system to prevent incidents from reoccurring.

- The system had been the subject of several external reviews in the past year, including the Emergency Care Improvement Programme. This is a clinically led programme provided by NHS Improvement to provide practical advice and support to improve patient care and flow. Plymouth had produced comprehensive action plans in response to these reviews, which were ratified and monitored by the SIB. However, system leaders acknowledged these had often looked at pressure points within the system in isolation, which had led to a fragmented, reactive response.

- Due to the pressures in relation to flow, the system was regularly in escalation and this had become normalised among staff at all levels. System leaders recognised there was good communication in relation to escalation, but less so about when they were de-escalating. There should be more evaluation of the contributing factors that lead to de-escalation, whether that the actions of particular teams or wider system partners. This should be communicated widely to encourage learning and improvement. In addition, the system should proactively look to other areas within the STP where performance is better to understand this.

- At the time of our review, a "yellow card" system had recently been implemented within primary care. It enabled GPs to easily flag an issue of concern, such as outpatient departments asking GPs to do unnecessary investigations in the community. These were then escalated to the CCG who monitored for themes and action as necessary. Staff who had used the system reported they had received limited feedback to issues they had reported, but commissioners told us plans were being developed for cascading information. The yellow card system was not routinely being used to flag near misses, such as medication errors on discharge, nor was it accessible to social care providers. Therefore, opportunities were missed to identify common themes across the health and social care interface.

What impact is governance of the health and social care interface having on quality of care across the system?

We looked at the governance arrangements within the system, focusing on collaborative governance, information governance and effective risk sharing.

There were robust governance arrangements across the health and social care interface to assess, monitor and mitigate risks. There were clear vertical and horizontal lines of reporting between organisations and up to system level arrangements and the STP. The SIB had been established shortly before our review, but was effective at providing a shared view of performance across the system and driving improvement. However, data used to monitor flow was based on traditional performance indicators rather than universal outcome measures.

Risk sharing agreements and information governance agreements were in place. However, a lack of integrated records systems was a barrier to providing fully integrated care across the system

Overarching governance arrangements

- There were robust governance arrangements in place to support the planning and delivery of integrated care, particularly since the establishment of the SIB. The STP set out the strategic vision, delivery plans and provided an oversight of performance via the Devon-wide A&E Delivery Board, the STP's System Performance and Delivery Group (SPDG) and the Western SIB in Plymouth. There were clear lines of accountability and communication from the local level through to the STP board with horizontal and vertical reporting structures to ensure the correct groups were sighted on performance and quality issues.

- While each organisation within Plymouth had its own reporting structures and boards, two partnership groups had been established to encourage inter-agency working; the SIB to focus on the "here and now" in relation to system flow performance, national targets and financial improvements and the Taking Change Forward group to deliver on the transformation agenda.

- The SIB was established in October 2017 and had taken on the responsibilities of the Local A&E Delivery Board. The SIB included commissioners, providers and regulators, who met fortnightly to direct activity and seek assurance activities were having an impact and leading to improvements. A snapshot view of performance was provided by the System Flow Performance Framework, which included system flow indicators from the community and acute providers, NHS constitution targets and the escalation status of the system. The SIB provided performance updates to the Health and Wellbeing Board.

- Plymouth's HWB had been nationally recognised in a study commissioned by the Local Government Association in 2016 as a good example for being effective, having clarity of purpose and committed leaders. It was the driving force behind the vision and strategy and saw itself as the lead in terms of governance. While the HWB and system leaders recognised it had become "distracted" by the STP, work was ongoing to refocus its role. Both the HWB and the Overview and Scrutiny Committee provided a high level of challenge around specific pressures within the system, such as the system response to the fragility of primary care. They were reassured recent changes within the system would lead to performance improvements, but they did not have evidence of impact yet.

- There was a transparent approach to sharing of management information across the health and social care interface, facilitated by the SIB where some agreed performance metrics

were presented. However, some services were unable to evaluate their activity performance and how it impacted on the wider system. For example, intermediate care and reablement teams told us they did not know how many people currently in hospital were waiting for an intermediate care bed, only those who were referred to them so they could not predict demand. This meant some people in hospital may have been waiting longer than necessary if there were delays in their referral being submitted.

Risk sharing across partners

- There was a shared view of operational and financial risks across the system. However, while there was a shared strategic risk register, operational risks were often contained within organisational-level risk registers. We were advised plans were in place to develop a risk register between LWSW, PHNT and the CCG. However, the system needs to go further to include care providers for it to be truly system-wide.

- The Devon-wide STP was working to a system-wide control total which meant if PHNT's Cost Improvement Programme was not achieved it would impact on the STP income, which in turn would impact on the overall STP system control total.

- Locally, there was a risk-share arrangement outlined in the Section 75 agreement between the local authority and NEW Devon CCG. This had received national recognition as being an innovative approach. Commissioners and financial officers felt this had had a positive impact on relationships and their ability to respond to system pressures collectively. We observed a high level of trust between the two organisations.

- Feedback from external reviews carried out in early 2017 identified that a lack of risk-sharing between the acute and community sectors was affecting Plymouth's ability to respond to a consistently escalated system. System leaders were open and transparent about these findings during our review and were taking strategic steps to resolve them. A joint bid between LWSW and PHNT resulted in a £1 million grant to support the development of the Acute Assessment Unit (AAU) at Derriford Hospital, which opened the week before our review. It had also recently been agreed for the management of the Minor Injury Units to be transferred from LWSW to PHNT to provide greater connectivity and improve performance against the four-hour A&E target. It was hoped these changes would lead to demonstrable improvements in coming months.

- The recent establishment of the SIB provided a single point of escalation for system risks. It was responsible for resolving any issues in the best interests of the people of Plymouth, not individual organisations. All risks were considered shared risks and while leaders were able to articulate how the system had responded to specific issues or pressure points, this approach was reactive.

Information governance arrangements across the system

- There was a joint information sharing agreement in place between all partners in the STP (including Plymouth City Council, NEW Devon CCG, LWSW and PHNT) to support people who moved through the health and social care system. Plymouth was meeting the national conditions around better data sharing between health and social care and had NHS numbers recorded against more than 95% of adult social care records.

- Staff throughout the system reported information sharing across the health and social care interface needed to improve and it was regularly described as a barrier to integrated working and ensuring people experienced seamless care. Integrated multidisciplinary teams working within Plymouth's four localities could all access the same system, as could other LWSW services, such as the Community Crisis Response Team (CCRT). However, GPs and secondary care could not access these community health and social care records and vice versa. We were told this could lead to risk-averse decision making and unnecessary hospital admissions.

- While there was positive intent amongst system partners to share information, current operating systems differed between organisations and prevented frontline staff from sharing accurate, up to date information in a timely way. This meant people often had to tell their story more than once and experienced unnecessary delays.

To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?

We looked at how the system is working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource.

We found there were strategic plans at organisational levels and STP level which aligned the workforce to future demand. It was clear what needed to be done and by whom, with a focus on developing teams rather than just individual professional groups. However, there was not a single, coherent workforce plan for Plymouth. Workforce was one of the most significant risks faced by the system with recruitment and retention challenges across every sector. The situation within primary care was felt most acutely and due to commissioning arrangements, this was being progressed at the STP level, which created its own challenges.

There were some examples of innovative approaches to responding to workforce capacity, looking at new roles and models of care. The system needs to ensure it works together as one, sharing good practice while preventing the burden from being felt elsewhere.

System level workforce planning

- Workforce capacity was a significant challenge for the system. There were a range of workforce strategies across the system at organisational level (Plymouth City Council, PHNT, LWSW) which outlined what needed to be done and by whom. However, there was no overall, coherent strategy for Plymouth. System leaders should work with partners to pull together existing plans, making sure priorities are aligned to address system-wide challenges and that strategic plans are supported by data and timescales for delivery.

- Although the system faced significant workforce challenges across every sector, the situation within primary care was at a tipping point. There was a shortage of 25 whole time equivalent GPs across 32 practices, equating to a 15.3% vacancy rate, and several practices had handed back their contracts or were at risk of doing so (some owing to difficulties with recruitment). Furthermore, it had been estimated that between 25% and 35% of GPs and practice nurses would be retiring within the next five years. The majority of the practices across NEW Devon CCG deemed vulnerable were in Plymouth (11 in total). Some workforce planning and action was taking place at an STP level due to national funding flows and recruitment initiatives to attract staff to the western peninsula. NHS England (NHSE) was the commissioner for primary care across the whole of NEW Devon CCG. NHSE had and is continuing to develop a range of initiatives to improve recruitment to Devon and Cornwall and recognised that there were particular pressures in some locations including Plymouth.

- System leaders within Plymouth acknowledged that the STP had been slow to develop a primary care strategy. The system needs to work closely with NHS England as the commissioner of primary care to take this forward at a pace, considering the fragile situation in the city.

- Plymouth had recently been successful in securing approximately £120k in funding from Health Education England, specifically for training and education in relation to new models and roles within primary care. However, it had taken some time for these monies to be released to the system, which was a source of frustration for commissioners and providers in primary care. This delay had impacted on the system's ability to plan and respond to what was a critical situation.

Developing a skilled and sustainable workforce

- Health Education England South West had provided the Devon STP with £861k to spend on workforce transformational activities, which had been prioritised by the STP as essential to the health and social care system. System leaders were working to develop and future

proof the workforce through initiatives at a local and regional level as well as with education institutions. We found examples of innovative approaches to growing a workforce and developing new roles and new models of care. For example, healthcare providers, including LWSW and PHNT, worked closely with a local medical and healthcare college recently set up for pre-GCSE students keen to a pursue a career in healthcare.

- Plymouth was facing significant recruitment and retention pressures in relation to staff across health and social care. However, while vacancy rates of adult social care staff across Plymouth stood at 8.7%, LWSW currently had a vacancy rate of less than one per cent. LWSW had developed a variety of programmes to help grow, support and retain their workforce. For example, scholarships to support staff to obtain degrees, the development of the nursing associate role and protected time for training additional to regulated training. System partners should work together to share initiatives and good practice to support wider improvements.

- Plymouth's substantive GPs cared for 2,364 patients per whole time equivalent GP on average compared with 1,950 on average for the whole of NEW Devon CCG. To reduce workloads and increase capacity, the CCG and GP federations were exploring non-GP scenarios, such as the roles of allied health professionals (pharmacists, advanced practitioners, nurse practitioners and medical associate professionals). In some parts of the city primary medical and community pharmacy models and workforce had been brought together, but recruitment and retention pressures also existed with pharmacists. Plans were in place to ensure every practice had some social prescribing support by early 2018. We saw an example of one GP federation that had employed a multidisciplinary team, including advanced paramedic practitioners to respond to demand for urgent appointments. Although innovative, this had wider implications for the system. South West Ambulance Service NHS Trust (SWAST) reported it had lost 14% of its advanced paramedic practitioners to primary care, but it should be noted this figure covers a much larger area than just Plymouth.

- Skills for Care workforce estimates for 2016/17 showed that the staff turnover rate for social care in Plymouth was 35%, which was higher than the comparator and England averages (24% and 28% respectively). Seventy two per cent of new appointments were made to people who were already working in the social care sector in Plymouth, which meant the system was retaining skills and experience, however a high turnover meant people did not receive continuity of care.

- Vacancy rates in social care were higher than average at 8.7%, compared to a regional average of 6.9% and an England average of 6.6%. Plymouth was part of the 'Proud to Care South West' campaign consisting of 16 local authorities promoting a career in the care sector. The local authority also supported providers with recruitment, for example by

hosting recruitment fairs and providing links with City College Plymouth's social care faculty.

- The local authority supported care providers to develop their workforce. Examples of training provided by or commissioned by the local authority included, leadership training, medicines management workshops, safeguarding and the development of health and wellbeing champions. Providers we spoke with were positive about these initiatives.

Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?

We looked at the strategic approach to commissioning and how commissioners are providing a diverse and sustainable market in commissioning of health and social care services.

Commissioning strategies, underpinned by needs assessments, focused on prevention and were aligned to the wider Devon STP. The system had developed an integrated commissioning function with a pooled budget. Services were commissioned across the health and social care interface, but commissioning practices remained predominantly reactive to pressure points within the system. There was awareness among commissioners at all levels where improvements were required and work was in train to make these. Plymouth did not face the same social care market issues felt elsewhere in the country or compared to the rest of the Devon STP area, but the system needs to ensure there is sufficient capacity and resilience to cope with an increase in demand.

Strategic approach to commissioning
- The HWB set the strategic ambition of system integration, including integrated commissioning. New Devon CCG and the local authority formed this integrated commissioning function as part of the pooling of budgets in April 2015. The local authority and the CCG commissioners were co-located to commission jointly across health and social care and this was well-regarded by local system partners, as well as those at STP level. Commissioning teams themselves described how it was much easier to "get things done" working in an integrated way.

- Commissioning plans were focused on prevention, place-based models of care designed to keep people well at home working to the principle of "the best bed is your own bed". There were four integrated health and social care commissioning strategies, underpinned by Joint Strategic Needs Assessments as well as advice from clinicians and public health specialists. These aimed to reduce inequalities, improve people's outcomes and experience of care and ensure the sustainability of the health and wellbeing system. However, due to current pressures within the system commissioning activity in relation to

hospital admission prevention had been reactive.

- SDGs, involving commissioners, providers and the public, had been established to convert the four commissioning strategies into project plans and deliverable outcomes. Some staff and stakeholders (providers and VCSE organisations) commented that the absence of a specific focus for older people and end of life care within the strategies made it difficult to articulate joint goals.

- The Devon-wide STP outlined ambitious proposals to form one strategic commissioner with four Local Care Partnerships. While system leaders within Plymouth were supportive of this direction of travel, the system was further ahead than its counterparts in relation to integrated commissioning and it was not clear what a strategic commissioner would mean in practice.

Market shaping
- The response to the System Overview and Information Request (SOIR) stated the commissioning strategies set the direction of travel so providers could use them to plan and deliver the services required. However, there was no externally-facing Market Position Statement which signalled to current and future providers what future requirements would be and to encourage innovative approaches. This should be developed as a matter of priority to ensure there is capacity in the market otherwise improvements made to increase flow elsewhere in the system will not be sustained.

- Plymouth did not have social care market capacity challenges seen elsewhere in the country, but there were some quality issues in nursing care and capacity issues with some specialist care. Sixty-eight per cent of care home beds and 67% of domiciliary care packages were partially or fully funded by the local authority or NHS. As of December 2017, 79% of residential homes in Plymouth were rated as good and 12% were rated as requires improvement which was better than comparator areas and the England average (18% and 15%, respectively). However, 9% of Plymouth's nursing homes were rated as inadequate, which was higher than an average of 2% in comparator areas and the England average of 3%. The percentage of domiciliary care providers rated as good or outstanding was higher than average and none were rated as inadequate.

- The system needed to assure itself there was capacity and resilience in the market should performance improvements lead to an increase in demand. Traditional contractual arrangements meant domiciliary care providers were not paid a retainer to keep packages of care open should a person be admitted to hospital. This arrangement may impact on continuity of care for the person and the capacity of providers to recruit and retain staff. Furthermore, should flow improve elsewhere in the system, this may lead to further delayed

transfers of care if packages were not available.

- Plymouth's iBCF submission statement had identified stabilising the social care market as a priority and as a result reported it had increased the rate of pay for domiciliary care. The current hourly framework rate for home care was £14.87, an increase from £14.76 the previous year. According to the response to the SOIR, a Care Home Business Improvement Partner, employed by the Integrated Commissioning team, offered support and a collaborative approach to the care sector regarding fees in a bid to secure a sustainable and viable market. Although care providers we spoke with understood the financial constraints of the local authority, they did not feel the current rate of pay was sufficient to attract and retain the right quality of staff and ensure business viability. The Association of Directors of Adult Social Services (ADASS) 2016/17 budget survey report highlighted there was national variation in the price paid for care and that councils overall had been unable to meet the desired 2016/17 UK Homecare Association (UKHA) benchmark of £16.70.

Commissioning the right support services to improve the interface between health and social care

- The integrated commissioning team commissioned a variety of support services to improve the interface between health and social care. There was a joined-up approach to commissioning preventative initiatives, bringing together public health and iBCF budgets to expand social prescribing and establishing health and wellbeing hubs to reshape existing services rather than procuring new ones. The public health prevention budget was small, but low-level services, such as befriending, had been retained.

- However, there remained a targeted, reactive approach to wider system pressures, which meant hospital admission prevention commissioning was underdeveloped. There was good uptake of personal budgets for health and social care, but there needed to be better use of voluntary sector organisations. The British Red Cross were in discussion with commissioners to increase their offer to support people with the discharge process.

- There were a variety of services commissioned from health and social care providers to prevent admissions to hospital and to facilitate timely discharges, but their effectiveness was hindered by workforce challenges, complex pathways and assessment delays. Emergency admissions for over 65s in Plymouth had been persistently higher than national averages since 2014, and there were a high number of delayed transfers of care. However, the system was aware of where the challenges were and the improvements required, including how it commissioned services.

- There was wide recognition that the discharge to assess pathway had not achieved the expected outcomes for people. Commissioners were working with providers to remodel the

service and ensure the right wrap around support from therapists and GPs was commissioned. Contracts had also been drawn up to commission the out of hours GP service to provide an enhanced visiting service to care homes by Christmas 2017.

- Published data in relation to continuing healthcare (CHC) showed that NEW Devon CCG's performance in quarter one for 2017/18 was poor. High numbers of people were waiting in a community setting for longer than 28 days for an assessment and conversion rates were low. System leaders reported that a lack of understanding amongst staff about the appropriate use CHC funding, the framework and eligibility criteria led to a high number of inappropriate referrals; 91.2% did not meet the criteria and this impacted on the CHC team's ability to respond to the backlog. There needs to be a system wide response to ensure there is a shared understanding and agreement of how the CHC framework should be applied so only appropriate referrals are made, people are not left waiting too long for an assessment and the backlog is resolved.

Contract oversight
- There were comprehensive systems in place to monitor the performance of commissioned services, but there was sometimes a varied response to quality issues. Commissioners were able to provide examples of how they evaluated the quality of service provision and performance dashboards were in use across the health and social care sector. These were being used to improve activity and hold providers to account, for example ensuring timely reviews of people receiving reablement services.

- The Quality Assurance and Improvement Team (QAIT), supported care homes to improve quality and practice, arranging training where required. Although the system was able to demonstrate some positive outcomes, 20% of adult social care services in Plymouth were found to have deteriorated following a CQC re-inspection compared to 15% in similar areas and 12% nationally. Furthermore, only 19% were found to have improved, which was lower than a comparator and England average of 37%.

- The local authority was described by CQC inspectors as more reactive than proactive in managing struggling services; only focusing on those rated as inadequate by CQC rather than those rated requires improvement. Feedback from the relational audit also included comments about commissioners not responding quickly enough to those providers who were financially challenged to prevent them from failing financially.

How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting people's independence?

We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high quality care and promote people's independence.

We found there were robust controls and governance arrangements in place to provide assurance that available resources were being used in the most effective manner. Plymouth's financial situation was challenging with both the acute trust and CCG running large deficits, coupled with a funding gap of approximately 10% compared to the rest of Devon. The pooled budget arrangements facilitated open and transparent lines of communication between organisations and clear reporting structures meant system leaders were able to provide assurance they were aware of how resources were being used.

- There were robust governance arrangements in place to provide assurance around how resources were being used across the system. The system faced some significant financial challenges; it was reported that PHNT had one of the largest Cost Improvement Programmes nationally at £40 million and the CCG was running a planned deficit of £57.2m for 2017/18. Plymouth also faced an inequity challenge whereby funding per head of population was approximately 10% less in western Devon compared to eastern and northern Devon. There was also inequity in the public health budget compared to similar areas. System leaders were realistic about how and when this may be resolved and, in the meantime, ensured there were sufficient controls to effectively manage the current resource.

- Governance structures were designed to provide assurance. Since the pooling of budgets between the local authority and the CCG in 2015, the fund has been hosted by the CCG, with the fund manager being employed by the CCG and the deputy employed by the local authority. The pooled budget of £462 million was managed through an Integrated Commissioning Board. Financial officers worked closely with commissioners to measure the effectiveness of investments. There were a series of dashboards that tracked both budget and activity on a daily basis providing real time financial information.

- There were clear lines of reporting between the two organisations and up to their respective boards as well as the SIB. The Overview and Scrutiny Committee also fulfilled its function to provide challenge around the system's financial status.

- The iBCF funding was included within the pooled budget in its entirety and was being used to drive forward next phase of the 'One System, One Aim' programme of activity. The system was meeting requirements of the iBCF funding by providing quarterly update reports to the Department for Communities and Local Government.

- Our analysis showed that there were more residential beds per population aged 65+ in Plymouth compared to comparator areas and the England average with a 2% increase in the number between April 2015 and April 2017. There were a similar number of nursing beds per population aged 65+ in Plymouth compared to comparator areas and the England average. The number of nursing beds had reduced by 8% between April 2015 and April 2017. Rates of admission to residential and nursing care homes to provide long term support for older people had declined in 2016/17 to 461 per 100,000 from 513 per 100,000 the previous year and were below the England average and that of similar areas. Avoiding permanent admissions is a good measure of delaying dependencies.

Do services work together to keep people well and maintain them in their usual place of residence?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in usual place of residence

Are services in Plymouth safe?

There was a demonstrated commitment at all levels across the system to proactively maintain people in their usual place of residence; prevention and early intervention were the focus of the strategic vision. However, it was widely acknowledged by system leaders, frontline staff and stakeholders that the focus had been on acute, bed-based care due to pressures within the system and the prevention agenda relating to hospital admission prevention was underdeveloped. Current systems and practices were working well for the majority of people, but more needed to be done to ensure there was a shared view of who in Plymouth was at risk of hospital admission and that recently implemented initiatives were embedded. This will help mitigate the risk posed by the current capacity issues within primary care.

- There were a variety of systems and practices in place to support people to stay safe at home, but some were in their infancy and needed embedding. An Admission Avoidance Project Board had been established and was responsible for monitoring the progress of project delivery plans. It was widely recognised Plymouth's hospital admission prevention agenda was underdeveloped, but work was in progress to shift the focus from acute, bed-based care to the community.

- The Adult Safeguarding Health Needs Assessment provided an in-depth analysis in relation to the people in Plymouth who were in need of care and support and may be unable to protect themselves from harm. There was a multi-agency response to people deemed to be vulnerable through risk management meetings which included partners from health to housing. Frontline staff across the system were able to describe the process for reporting safeguarding concerns and other incidents. We were told the recent introduction of a

webform to report safeguarding concerns provided greater assurance, but both staff and stakeholders commented they often had to follow-up on referrals. They felt that there was limited feedback on any themes or lessons learned which could be cascaded widely across health and social care for future improvement.

- There was not a system wide risk stratification tool to provide a single view of those who were at most risk of a hospital admission. Individual teams or professionals had separate tools. A risk stratification tool had been agreed at STP level, but was yet to be rolled out in Plymouth at the time of our review. Five weeks before our review, LWSW had established locality multidisciplinary team (MDT) meetings attended by GPs, social workers and the LWSW MDT team for the area to discuss those people deemed to be at risk. The GPs we spoke with during our review were positive about these meetings and commented how LTC Matrons were effective at identifying and responding to deterioration in a person's condition.

- Most older people living in care homes in Plymouth were supported to remain safe and well in their usual place of residence and were less likely to attend A&E or be admitted to hospital with conditions which could be treated in the community. Our analysis of Hospital Episode Statistics (HES) data showed that between October 2015 and September 2016, admissions from care homes in Plymouth as a result of decubitus ulcers was higher than similar areas at 220 per 100,000 aged 65+, compared to 165 per 100,000 aged 65+ across comparators, and the England average of 161 per 100,000 aged 65+. However, the system has conducted its own analysis using information from Dr Foster and the NHS safety thermometer which showed Plymouth's observed rate of admission due to ulcers compared to the expected rate was below the national average. In the 12 months preceding our review, performance had improved and the data showed Plymouth's rate of admissions due to ulcers was in the lowest quintile nationally. A wellbeing clinic for leg ulcers had been piloted by LWSW and a bid had been submitted to commissioners. The pilot had demonstrated some positive outcomes. For example, one person had suffered from an ulcer for over two years and healed within eight weeks following input from the LWSW team. The bid outlined proposals to work with and provide training to practice nurses and care homes to support them in leg ulcer management.

- Our analysis of HES data in the first quarter of 2017 showed the rate of A&E attendances for people aged 65+ was 9,129 per 100,000; lower compared to similar areas with a rate of 12, 532 per 100,000 and the England average of 10,534 per 100,000. Data collected by the system showed the number attending A&E daily had remained fairly consistent between April 2017 and October 2017, with an average rate of between 271 and 292 people daily. However, these figures had increased since the previous year where the average daily attendance figures ranged from 256 to 276 during the same period.

- There were concerns throughout the system that capacity issues within primary care would see this number rise further. For example, performance figures for a GP practice with a patient list size of 21,000 people and a critical shortage of GPs had led to 14.8% increase in A&E attendances between April and August 2017 compared with the same period the previous year for those patients. This meant more people were accessing acute care, placing an increased burden on PHNT.

- The Minor Injuries Unit (MIU) at The Cumberland Centre was well utilised, seeing approximately 120 people a day. Staff reported they had seen an increase in attendees as a result of the lack of primary care capacity. There was an expectation for the MIU to continue to reduce the burden on Derriford Hospital's A&E department. Therefore, the system should assure itself it has the resource and capability to respond to deteriorating individuals appropriately. During our visit, staff told us they did not have the necessary medications to respond to a cardiac event and, as they were deemed a 'safe space' by the ambulance service, calls to 999 were not categorised as high priority. This placed people at risk of harm if the service was unable to respond appropriately to medical emergencies.

Are services in Plymouth effective?
There was a system wide commitment from staff at all levels to proactively maintain people in their usual place of residence. There had been some innovative work undertaken to design a service model which aimed to improve flow and prevent unnecessary hospital attendances or admissions. We found some positive examples of staff working in an integrated way to achieve good outcomes for people. However, parts of the system remained fragmented and work was required to bring staff from different organisations together to share information, increase their understanding of services available and ensure they were accessible to all. While staff were well supported and had the right skills. a lack of shared IT systems across organisations was a barrier to providing truly integrated, seamless care.

- We received positive feedback from people who use services and their carers about the support they received from VCSE organisations, including the Elder Tree befriending service and Improving Lives. However, if multiple organisations were providing support, it was not clear who was co-ordinating it. We also heard it was not always easy to access information and advice about services available. The Plymouth Online Directory (POD) provided a comprehensive list, but this was only accessible via the internet. Arrangements were in place to provide information to people in the format they required, including printing documents for people in libraries. The Plymouth Contact Centre provided information over the telephone and staff signposted people. Adult Social Care Outcomes Framework (ASCOF) data for 2016/17 showed 77% people over 65 in Plymouth found it easy to find information about support, which was in line with the average for similar areas and England at 75%.

- VCSE organisations felt they could be better utilised to support people to stay at home, especially if like-minded organisations worked together to come up with a combined offer. We were given powerful examples of where organisations had come together to respond to specific cases, such as supporting a homeless person at end of life to die in their preferred place of care. The System Design Groups (SDGs) provided a forum to collaboratively plan future service delivery, but it was felt there needed to be a more structured approach to responding collaboratively to individual cases.

- Although frontline staff in health and social care services had the right skills and were provided with regular training and development, they described a lack of understanding of services available as a barrier to support the effective transition of people. We found knowledge amongst staff varied and with the recent implementation of new initiatives, there needed to be some proactive and joined-up communication from system leaders.

- There had been a considerable about of work undertaken in recent years to remodel the system, reduce duplication and encourage holistic assessments of individuals. In 2015 local authority adult social care staff were transferred to LWSW, which led to integrated, multidisciplinary teams working together within four localities across the city. People who were under the care of these teams had a crisis prevention plan in place which could be accessed by all LWSW staff. However, when a person moved between organisations this information did not go with them.

- Services designed to improve flow through the system and to keep people at home were evidence based. There was a single telephone number for all community health and social care professionals, as well as paramedics, which they could access for advice and a response to a person at risk of going into crisis. All frontline staff we spoke with were aware of this single contact point and we were given multiple examples of how it had successfully prevented hospital attendances and admissions. Teams accessible via this number were provided by LWSW and included:
    - Community Crisis Response Team (CCRT) - a MDT which responded within two hours and could provide packages of care up to six weeks.
    - Acute GP Service (based at Derriford Hospital providing advice to GPs on clinical options)
    - Acute Care at Home Team (a nurse-led service which could provide intravenous antibiotics in the community)

- Data collected by the system showed the Acute GP Service received 766 referrals in October 2017 and 47% resulted in an admission avoidance. This was a similar figure to the previous year's performance. However, the service was currently working at 60% capacity, which meant it was not being fully utilised.

- There was no single point of access for care providers. If they identified a person may need additional support to stay safe and well at home, they had to go via a health professional or the local authority's contact centre for low-level equipment. This was a missed opportunity which may also be placing an additional burden on some parts of the system and should be reviewed as a priority.

- Our review of case files showed some positive examples of integrated working by staff delivering community services. However, the lack of digital interoperability impacted on the ability of staff to share information effectively, especially between organisations. This often led to duplicated assessments and could contribute to delays.

Are services in Plymouth caring?

Staff at all levels demonstrated a clear will and commitment to provide person-centred care and there were some innovative initiatives in place. Personalisation was high on the agenda and articulated within strategic plans and delivery plans. It was hoped that the development of 10 health and wellbeing hubs in early 2018 would improve the accessibility of information to people including professionals, as well as encouraging a more co-ordinated response to people's needs. Carers assessments had increased, but we received some mixed feedback about the support available, particularly in relation to respite care.

- ASCOF outcome data for 2016/17 showed the average quality of life score for people receiving social care in Plymouth (68) was higher than the national average, and the fourth highest when compared to its 15 comparator local authority areas where scores ranged from 54 to 71. Our review of case files showed some positive examples of person-centred care, supporting people to achieve their goal to remain independent at home.

- Plymouth's voluntary sector was dynamic, providing a range of services designed to maintain and improve people's health, wellbeing and independence. While organisations felt they could be better utilised in relation to the prevention agenda, they reported positive engagement with commissioners and the development of the 10 health and wellbeing hubs across the city in 2018 was hoped to lead increased activity.

- There were some examples of innovative practice, demonstrating a commitment to people being at the centre of service delivery. Plymouth was awarded the Dementia Friendly City of the Year in 2017, encouraging businesses and staff from across the city to receive dementia training and increase awareness. Community Connectors had been in operation for a year, connecting housing services to community teams to take a holistic approach to problem solving. These initiatives were linked to 'creative solution forums' where people who were vulnerable and resisted support from services were considered in terms of

alternative approaches. However, services were not imposed on people and our review of case notes showed examples of where a person's decision to no longer receive community care was respected.

- The local authority continued to commission low-level services, such as a befriending service, recognising the role this played in preventing social isolation and loneliness. Some people we spoke with during our review had been using this service for over 15 years and stressed the important role it played in maintaining their health and wellbeing. Plans were in place to extend the provision of social prescribing such that all GP practices would have this support from early 2018. Some VCSE organisations felt they were almost acting as social workers for some people, so the system needs to ensure these hubs do not blur the lines of accountability.

- As part of our review, we spoke with a carers group, supported by Improving Lives. They described challenges in accessing respite care, particularly in an emergency due to a lack of available placements in the community. Commissioners acknowledged it could be challenging if a person had complex needs. Our review of case files showed mixed experiences for carers. In one there was evidence of respite care being arranged, but in another there was no evidence of a carers assessment being completed despite it being identified that they felt in need of support. The response to the System Overview and Information Request (SOIR) reported that a collaborative approach between LWSW and Improving Lives to improve services for carers had seen the number of carers assessments increase from 549 in 2015/16 to 909 the following year and, correspondingly, the number of personal budgets for carers increase from 210 in 2015/16 to 704 in 2016/17.

- Data provided by the system showed the proportion of people in receipt of funded care in the form of a direct payment in Plymouth was slightly lower than the national average at 23% (575 people) compared to 28%. NEW Devon CCG was on track to achieve a target to have 1,740 personal health budgets (PHB) in place by March 2018. At the time of our review, 7.13 people per 50,000 were in receipt of a PHB compared to an England average of 5.82 per 50,000. However, it should be noted these figures apply to the whole of the CCG area, not just Plymouth.

Are services in Plymouth responsive?
We found some positive examples of staff working in an integrated way to achieve good outcomes for people. However, the capacity issues within primary care were placing an additional burden on the wider system. There was a risk of people not being seen at the right time, in the right place and by the right person.

- GP Patient Survey data for 2016/17 showed 64% people in Plymouth felt supported to

manage their long-term condition. This had improved from 62% the previous year, but was still below comparator and England averages. Our review of case files showed evidence of responsive, coordinated assessments. In one case file, the CCRT had been carrying out regular reviews on a person and appropriately escalated a skin integrity concern to their GP and the district nurses.

- The system faced significant capacity issues within primary care, which meant people could not always access a GP when they needed one; GPs we spoke with told us it was not uncommon for the waiting time for a routine appointment to be four weeks. There had been several closures and practices handing back their contracts to NHS England over recent months, affecting approximately 32,000 patients. While we were provided with assurance these practices were being staffed by regular locums, some people with long-term conditions were changing practices for consistency of care. The impact of these closures was felt by other practices stretched beyond their limits.

- A March 2017 national data set on provision of extended access to GPs outside of core contractual hours showed that none of the 29 GP practices in Plymouth surveyed (there are 32 in total) offered full provision of extended access over the weekends and on weekday mornings or evenings compared to the England average of 22.5% and the average across Plymouth's comparators of 23.2%. However, NHS England, the commissioner for primary care told us no funding was available for full provision until April 2018, so this was the reason for the low score. Our data showed 76% of GP practices provided partial extended hours provision outside of core hours and 24.1% provided no extended provision at all. NHS England told us 10 practices had opted out providing any extended provision outside of core hours, a total of 31%. This was considerably higher than comparator averages and the England average at 11.5% and 12.3%, respectively. NHS England, the commissioner for primary care, confirmed out of hours provision was available and this was provided by Devon Doctors.

- GPs' reported workloads had increased dramatically in recent years as had the complexity of the people's conditions. There were high levels of deprivation in parts of the city and a high number of refugees and asylum seekers saw some GPs using translation services every session, which was time consuming and resource intensive. We were provided with a copy of a letter written by a group of GP appraisers to the Lead Appraisal Team outlining their concerns about GPs' increasing workloads and the risks this posed.

- There were some systems in place to support people to remain at home following a change in circumstance. Domiciliary care providers were able to increase packages of care for a limited time without having to obtain approval from the brokerage team and the CCRT could also arrange emergency packages of care from the reablement service to prevent a

hospital admission. However, while these teams could provide a rapid response to prevent a crisis, staff reported discharging them could be problematic due to long waits for routine community therapy input. There was a falls team, but people could only be referred by a GP or consultant for an undiagnosed medical reason. For slips, trips and falls people were referred to the community therapy team after a second incident and could experience waits of several weeks. A review was underway, driven by staff, to respond to some of these issues and how community and acute teams worked together.

- However, the system's ability to respond out of hours was impacted by the availability of some services. The system's BCF submission demonstrated a commitment to implementing the high impact change model, including the provision of seven day services. Whilst the CCRT operated seven days a week, it was not open 24 hours a day and referrals were not accepted after 3pm at weekends. There were plans for the recently opened Acute Assessment Unit to be open at weekends, but recruitment challenges meant it was uncertain when this would be achieved. Therefore, at the time of our review, people were not always being seen in the right place at the right time.

Do services work together to manage people effectively at a time of crisis?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management

Are services in Plymouth safe?

There was a shared view of risks to service delivery which may impact on the system's ability to respond to people in crisis and keep them safe. While A&E attendances were lower than in similar areas, emergency admissions were higher than national averages and on an upward trajectory. Some people experienced delays if they were transferred by ambulance and people over 65 experienced longer lengths of stay, both of which put them at greater risk of harm.

- Once a person was in crisis and transferred to hospital, systems, processes and practices did not always safeguard people from unnecessary admissions and long lengths of stay which put them at risk of avoidable harm. In one case file we reviewed a person was admitted in July 2017 due to a series of falls (this was their fourth admission). They were transferred to Mount Gould for rehabilitation, but a further fall resulted in a fractured hip and head injury. The person was readmitted back to Derriford Hospital. From a review of this person's records we found that there had been missed opportunities to maintain them at home and delays in their transfer of care had placed them at risk of deterioration.

- The number of ambulance handovers at Derriford Hospital's A&E taking more than 30 minutes had steadily increased since April 2015, peaking at 406 (11%) in November 2017. A total of 334 hours, approximately 10 hours per day, were lost by South Western Ambulance Service NHS Trust (SWAST) to Derriford delays lasting more than 15 minutes in November 2017. This was considerably higher than other hospitals accessed by SWAST. This put the people waiting to be admitted to A&E and also those who may need assistance in the community at risk of harm should they be waiting for long periods.

- Fewer people attended A&E in Plymouth compared to other areas, and while they were less likely to be admitted compared to similar areas, admission rates were higher than national averages and had increased. Our analysis of HES data in the first quarter of 2017 showed the rate of A&E attendances for people aged 65+ was 9,129 per 100,000 compared to similar areas with a rate of 12,532 per 100,000 and the England average of 10,534 per 100,000. The emergency admission rate for people aged 65+ in Plymouth was 6,434 per 100,000 compared to a rate in similar areas of 7,343 per 100,000 and the England average of 6,391 per 100,000. Unverified data provided by the system showed there had been a 10.8% increase in the number emergency admissions for people aged 65+ across the western locality in 2017/18 due to an increase in acuity and pressures in primary care.

- Our analysis of HES data showed that in the first quarter of 2017, 37% of people aged over 65 had a hospital stay lasting longer than seven days, which was higher than similar areas with an average 33% and the England average of 32%. The length of stay had remained consistently higher than average since 2014. If people were admitted to hospital from a care home, they were likely to have significantly longer lengths of stays at 49% staying longer than seven days compared to the England average of 36%. Longer lengths of stay put people at avoidable risk of harm.

- There was a system-level escalation procedure to manage risks to service delivery; the Operational Pressure Escalation Levels (OPEL) framework. Between April 2017 and October 2017 PHNT was consistently at OPEL 3 or 4 status (the highest of escalation) and this had become normalised amongst staff. We were told it was not uncommon for there to be several escalation calls a day involving system partners.

- The locally developed, 'Shackleton Plan' was an innovative approach adopted by domiciliary care providers to support people to stay safe at home during times of increased demand or staff shortages. This had been triggered five times within two years and saw providers working together, with the support of commissioners, to deliver packages of care during challenging periods, including winter.

- There was a shared view of risks to delivery of services to people in crisis and these were monitored closely. Dashboards regarding flow, safeguarding and incidents were provided daily to system leaders. Derriford Hospital historically had a higher than expected number of falls with harm and work had been ongoing to investigate this. Data provided by the system following our review showed the number of falls with harm at Derriford Hospital was in the lowest 25% nationally; in November 2017, it was 0.9%.

Are services in Plymouth effective?

During a crisis, frontline staff demonstrated an awareness of assessing a person holistically, but a lack of digital interoperability impacted on how effectively they could share information with colleagues. There were multiple pathways available once a person was in crisis and work was required to increase staff understanding and confidence in the capabilities of different services to ensure the whole system was working effectively considering the pressurised state of the system.

- Our review of case files showed holistic assessments of people's needs and multidisciplinary input. The CCRT staff had been upskilled to enable them to assess the whole person, so that they were able to respond appropriately to any identified issues or risks. The aim of this was to prevent the person from having to tell their story more than once. However, the extent to which people we spoke with felt involved and aware of their plan of care varied.

- Services designed to improve flow through the health and social care system were evidence based. However, there were multiple pathways, provided by different staff groups and a lack of trust or knowledge by staff meant they were not always being used effectively. People in crisis could be routed to the Community Crisis Response Team (CCRT), the Acute Assessment Unit (AAU) where they could be seen by a GP or Advanced Nurse Practitioner, or the frailty service in an attempt to prevent their admission. If admission was deemed necessary, there continued to be multiple pathways; the medical assessment unit (MAU), the clinical decision unit (CDU), the short-stay ward or hospital wards.

- It was widely recognised some organisational development work was required to increase staff's trust in the capability of services available. Staff we spoke with described a "risk averse" culture of decision making and we were given examples of where people who needed best interests decision meetings or Deprivation of Liberty Safeguards assessment had been admitted rather than undertaking these in the community despite the people being medically fit. Findings from our relational audit showed one of the lowest scores was on the statement: "People take organisational risks where it had the potential to serve wider system goals without fear of criticism or failure". Data collected by the system showed

during times of escalation some community services were working under expected capacity. Work needs to happen at pace to improve understanding and communication between staff.

- Due to pressures within the acute care system, Plymouth had a significant number of outpatient appointment cancellations. Data collected by the system showed that in September 2017, 82% of people received treatment within 18 weeks of referral, but there were 163 operations cancelled on the day of admission or after for non-clinical reasons. This meant people experienced delays in treatments, placing them at an increased risk of crisis as a result of missed early interventions.

- There was limited interoperability between records systems to allow staff to share accurate, real time information. While there were plans in place to address this and staff reported it was better than it had been, it remained disjointed. In one case file we reviewed, a person had been referred to A&E by the out of hours GP due to raised potassium levels. As staff were unable to access the person's record at their registered GP to see what was deemed to be a 'normal' range, the person was transferred to the AAU and then admitted for treatment. Staff were not clear if the Acute Care at Home team could provide the necessary treatment and this option, which may have prevented an admission, had not been explored.

Are services in Plymouth caring?
Frontline staff understood the importance of involving people and their families in decisions about their care. Some case files we viewed clearly documented the discussions had with people, but we were told by some people and their carers during our review that they were not always aware of what the plan of care was or that they had been involved in the decision making process.

- Our review of case files showed assessments of care were centred on the needs of the person and took into account social factors, as well as health. Some people we spoke with at Derriford Hospital were complimentary about the care they had received and knew the plan for their care. However, others told us they were not aware what was happening.

- Since February 2017 the Plymouth Carer's Hub run by Improving Lives has had a presence within Derriford Hospital to provide advice, support and signposting to carers of patients in the hospital about local services and help available to them.

- Staff we spoke with demonstrated an awareness of dementia care and it had been recognised some parts of the hospital (A&E and the AAU) were not as dementia friendly as they could be, but there were processes in place to manage this. Providers, VCSE organisations and carers raised some concerns about support for people with dementia

when they went into crisis, including the environment on hospital wards and staff skills.

Are services in Plymouth responsive?

People living in Plymouth did not always receive the services needed at the right time during times of crisis, particularly out of hours. There were some responsive community-based services, but if people arrived at A&E they were increasingly likely to be admitted to hospital and stay in hospital for too long. It was hoped that the newly opened AAU would reduce some of the pressures on the hospital, but it was too soon to measure its impact.

- People were often seen in multiple places and experienced a disjointed pathway. We looked at eight people's records during our visit to Derriford Hospital and all were moved within the hospital several times after admission. All but one person went from A&E to the MAU before going onto a ward; some stayed on three different wards.

- There were some examples of proactive and rapid responses to people in a crisis. Plymouth Community Homes had installed emergency telecare alarms in 1,400 properties; the CCRT provided advice to paramedics attending falls; and people attending majors within A&E received a Front Loaded Initial Care (FLIC) assessment by a clinician in an attempt to identify the most appropriate pathway as quickly as possible. On 5 December 2017 the AAU had seen 28 people and only admitted two.

- In July 2017 South West Ambulance Service (SWAS) treated 49% of 999 calls without transferring the person to hospital and 14% of calls were resolved with telephone advice; both these figures were higher than the England average. However, some care providers we spoke with gave us examples of where they had had to wait for several hours for an ambulance to attend after a fall or other incident.

- Between 2014/15 and 2016/17 PHNT failed to meet the national four hour A&E target of 95%, falling from 91% to 84%. Unverified data, collated by the system showed performance had improved in August 2017 when 90% of people were seen within four hours. However, this was not sustained and in November 2017 in the week commencing 18 November performance decreased to 65% on two days. On the Monday, Tuesday and Wednesday of that week A&E attendances were similar (280, 298 and 307, respectively). However, the number of four hour breaches increased from 49 on the Monday, to 79 on the Tuesday and 106 on the Wednesday. PHNT needs to scrutinise this data to determine what is causing these downturns in activity.

- During the same week in November when A&E performance dipped, corresponding performance data for the hospital avoidance schemes such as Acute Care at Home, the CCRT and Acute GP service showed they did not start meeting their expected activity targets until the Wednesday. This meant seven day services were not fully operational and

those designed to prevent hospital admissions were not being utilised effectively during periods of increased demand.

- Older people in Plymouth were more likely to end up being admitted to hospital than national averages and to stay in hospital longer. Between 2016 and 2017, bed occupancy at PHNT was consistently above the optimal target of 85%, peaking at 89%. Some hospital staff reported they cared for people who should not have been admitted. Examples given included failed packages of care, a fall with no injury and some low-level antibiotic treatment.

Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/or admission to a new place of residence

Are services in Plymouth safe?
The number of people over 65 in Plymouth who were readmitted to hospital following discharge was consistently below average, including those who were discharged to care homes. Providers reported they received comprehensive discharge summaries most of the time and our review of records supported that. However, the level to which providers trusted the information was poor and we were given examples of when people had experienced unsafe discharges.

- VCSE organisations, providers and carers of people who use services told us about their experiences of discharges, some of which they felt were poorly managed and organised with risks not always fully mitigated. For example, a person being discharged and left on their doorstep with no key; another was discharged to a care home at 2am and left in the car park; and others where people with considerable care needs were discharged with no, or insufficient, packages of care.

- Medicines management was not optimised across the system to support timely and safe discharges. While work had been undertaken to facilitate more effective information sharing between hospital and community pharmacists, processes within the acute setting needed improving. Medicines were not being requested early enough in the discharge process and approximately 100 people's medicines per month were being sent to them via courier after discharge; a costly response. There had been no analysis to determine which wards were generating this activity in order to encourage learning and improvement. This put people at risk of avoidable harm due to delays in receiving their medication and medication errors.

- The number of older people in Plymouth requiring emergency readmission once discharged from hospital was consistently below comparator and England averages. Our analysis

showed that throughout 2016/17, Plymouth's emergency readmission rates occurring within 30 days of discharge for people aged 65+ ranged from 15% to 17%, compared to the England average of 19%. This indicated people were only discharged from hospital when they were medically fit and were less likely to be readmitted due to inappropriate discharges.

- The same applied to people from care homes. Our analysis of HES data showed that in the first quarter of 2017 emergency readmission rates occurring within 30 days of discharge for people aged 65+ from care homes in Plymouth was lower (at 15%) than similar areas and the England average (21% and 20% respectively). Performance had fluctuated, but had been consistently better than average since 2014.

- Fourteen out of the 20 Registered Managers of care providers who responded to our survey reported they received discharge summaries at least 75% of the time, mostly in paper format or via secure email. However, six respondents received discharge summaries less than 75% of the time. Fifteen respondents reported receiving discharge summaries within 24 hours, but two responses relating to domiciliary care providers stated they never received summaries within 24 hours. Not receiving timely discharge summaries puts people at risk of unsafe and inappropriate care, which may lead to readmission.

Are services in Plymouth effective?
There had been a considerable amount of effort at a system level to address the issues in performance in relation to delayed transfers of care, both in the acute and community setting. A number of external reviews had made a series of recommendations and these were being acted upon. The appointment of an Interim Director of Integrated Urgent Care and recent changes to the system model were having a positive impact. Reablement services were achieving good outcomes for people, but the number of delayed transfers of care remained high.

- Readmission rates were consistently below average and people in Plymouth were more likely to receive a reablement service than in other areas. Analysis of ASCOF data for 2016/17 showed 4.1% of older people received a reablement service compared to similar areas and the England average (3.6% and 2.7%, respectively). Where people did receive reablement, it had good outcomes; 85% of people over 65 were at home 91 days after discharge from hospital to a reablement service.

- The number of delayed transfers of care was consistently, and significantly, higher than average. There had been a sudden increase in December 2016 and while there had been a decline between April 2017 and September 2017 from 32.1 days to 27 days per 100,000 population (aged 18 and over), this was more than double the comparator average of 11.9 and England average of 13 days. Data collected by the system showed performance had

improved and was on the right trajectory, but it was still off the national target of 3.5% (5.6% in October 2017).

- The high impact change model for managing transfers of care identifies a series of changes that can support the reduction of delays and the system was in the process of implementing some of these. For example, a multidisciplinary, integrated discharge team comprising LWSW and PHNT staff had recently been established at Derriford Hospital and community teams were being encouraged to do more in-reach to facilitate the discharge of people on their caseloads. At the time of our review there was one Trusted Assessor working between Derriford Hospital and providers commissioned to provide discharge to assess beds, but plans were in place to recruit more.

- Facilitating timely discharges and reducing length of stay should be considered a shared responsibility, not a delegated one. The Tactical Control Centre (TCC) at Derriford Hospital provided an oversight of capacity within the community to facilitate complex discharges and there were daily meetings to discuss transfers of care where ongoing support was required. However, staff across all levels of the system felt the absence of some senior clinical and operational staff at these meetings meant they were not as effective as they could be. The integrated discharge team and Discharge Case Managers (DCMs) were seen as a positive, but this had also encouraged a lack of clinical ownership in relation to discharges. Our review of case files showed estimated discharge dates were not being discussed early enough and there was a lack of urgency among clinical staff; delays were an accepted part of the system.

- Some care providers told us they had to proactively contact the hospital to find out when an existing client may be ready for discharge. Both families and care providers gave examples of when the first contact they had was to be told the person was being discharged that day. Registered Managers of care providers who responded to our survey commonly felt that the discharge summaries supplied were sufficient for their service to make a decision on whether they could support the placement; however 15 out of 20 respondents were less positive about whether they trusted them. Where the Trusted Assessor had strong links with care providers, we were told they were beginning to trust their assessment for package of care re-starts. However, it was recognised there was more work to be done.

Are services in Plymouth caring?
It was acknowledged by staff across the system that people, their families and carers or advocates were not involved early enough in the discharge process. Our conversations with people, their families and carers supported this view as experiences varied. People, especially those funding their own care, found information difficult to access and while some voluntary sector organisations were effectively supporting people to be discharged home, more could be done.

- Our review of case files showed a person-centred approach was adopted and people's preferences were documented. However, some records showed conversations with people, their families and carers were not being started early enough. People told us it was difficult to access information, particularly if they were arranging the care themselves. There was a choice policy in place, but it had not been ratified and not all staff could refer to it.

- Staff were committed to providing compassionate and high-quality care. However, some carers and providers gave examples of where people had experienced very poor discharges which had been undignified and unsafe.

- The British Red Cross had been commissioned to provide support with the discharge process by ensuring people returned to safe, warm homes with the essentials supplied. The organisation was in talks with commissioners to see how this service could be expanded. There was recognition among voluntary organisations and system leaders, that they could do more.

- According to the response to the SOIR, 52.8% of people died in their usual place of residence in 2015, which was slightly higher than the national average of 46%. Data in relation to standard continuing healthcare (CHC) was poor with a low referral to service provision conversion rate. As at November 2017, the number of outstanding disputes was 152 across NHS NEW Devon CCG. People were not only waiting a long time for an initial assessment, but were also waiting too long for their appeal to be heard. Data provided by the system following our review, showed there had been a considerable improvement. As of 17 January 2018, there were 27 outstanding appeals across NEW Devon CCG, 11 of which related to Plymouth. We were assured all people were receiving care while waiting for the outcome of their appeal.

Are services in Plymouth responsive?
There were multiple pathways to facilitate discharges from the acute setting and support people to remain as independent as possible. However, delays in assessments across the system meant people's support needs were not regularly reviewed, leading to longer lengths of stay in inappropriate settings. Recent performance data collected by the system showed performance had improved, but it was unclear if there was capacity within the market to cope with an increase in demand. People referred for continuing healthcare (CHC) were experiencing significant delays and this needs to be acted on as a matter of urgency.

- The process for reviewing people's support needs was not always timely and was contributing to delays in the acute and community settings. Published data in relation to delayed transfers of care between February and April 2017 showed the majority of delays

were attributable to the NHS with 'awaiting completion of assessment' and 'awaiting further non-acute NHS care' reported as the main reasons for delay in Plymouth. 'Awaiting completion of assessment' accounted for an average daily rate of 13.8 days per 100,000 population, compared to an average of 2.2 days in similar areas and 2.5 days nationally. 'Awaiting further non-acute NHS' accounted for an average daily rate of 8.1 days per 100,000 population, compared to an average of 1.8 days in similar areas and 2.6 nationally.

- Unverified data provided by the system showed there had been an improvement in performance. In November 2017, the total number of delayed days had decreased from 27 per 100,000 in September 2017 to 18.3 per 100,000. Delays in assessment were the biggest contributing factor in an acute setting, and awaiting package of care in a person's own home was the main cause of delay in community settings.

- There were multiple pathways available to support people to return home and remain as independent as possible; reablement, intermediate care, discharge to assess one (home-based), discharge to assess two (bed-based) and discharge to assess three (complex, bed-based care). Reablement services were achieving good outcomes for people, but delays in reviews and assessments across each of these pathways meant some people were not being rehabilitated or discharged within expected timeframes. In one case file we reviewed, the person was receiving a reablement service but it was not clear when it started, when it was due to end or what the person's goals were.

- Consistent themes had been identified by external reviews, one of which was the fact too many people were spending too long in intermediate care. Data collected by the system supported this. As of 13/10/2017 there were 126 people who had been in spot-purchased, discharge to assess beds for more than the target of six weeks; 49 for more than 20 weeks. Those in spot-purchased beds did not have the dedicated MDT input of those in block-purchased beds which led to delays in assessment and rehabilitative input. The system had recognised the current discharge to assess pathways were not working as effectively as they could be. A thorough analysis had been carried out to diagnose the issues and plans were underway to remodel the pathways, shifting the focus to Home First and reducing a cultural reliance on bed-based care.

- The delays in assessments were widely understood by system leaders and recent efforts had shown these had gradually come down. However, the system needs to assure itself that it has the capacity within community based services and the social care market to cope with increased demand and activity should flow continue to improve elsewhere in the system.

- Significant improvements were required in relation to standard continuing healthcare (CHC)

to ensure staff understood the eligibility criteria and made appropriate referrals so there was a timely use of the framework and people's rights to care were being met. While it was positive the system had achieved their commitment not to conduct any CHC assessments in an acute setting, published data showed a high number of people waited a long time for an assessment. It should be noted that this data does not just describe the situation in Plymouth, but relates to the whole NHS NEW Devon CCG area. In quarter one of 2017/18 the number of people waiting longer than 28 days for their assessment was 54.3 per 50,000 compared to the England average of 10.2 per 50, 000. Furthermore, the conversion rate for standard CHC was 13% compared to an England average of 25% meaning fewer people who were referred for CHC funding were deemed to meet the eligibility criteria. We were told the CHC team received a high number of inappropriate referrals and educating staff and improving their understanding was cited as a priority. The system were aware of their performance and data collected as part of the SIB's ongoing monitoring of performance showed in October 2017 there was a backlog of 253 people waiting in Plymouth for an assessment, with an average waiting time of 227 days. A high number of inappropriate referrals was impacting on the CHC team's ability to meet expected assessment targets.

- The Department of Health's analysis of activity showed between October 2015 and September 2016 the proportion of older people discharged over the weekend in Plymouth was similar to comparator areas at 18%. Performance data collected by the system showed this had increased to 20.7% in October 2017. However, social care providers were less likely to accept discharges over the weekend and the lack of seven day services across the system meant this figure was unlikely to increase significantly.

Maturity of the system

What is the maturity of the system to secure improvement for the people of Plymouth?

- Our review showed Plymouth is striving to make improvements in the way that people move through the health and social care interface. The positive intent was clear amongst the system leadership, but in reality people's experiences varied. If the system continues on the current trajectory with the further development of the western locality, the improvements in flow from secondary care to the community and the potential vertical integration of service provision, people should enjoy a responsive, effective, caring and safe journey through the system. However, the lack of primary care provision, poor prevention and inadequate CHC arrangements may compromise these improvements.

- The system had a clearly articulated, long-established vision of integration, translated into local commissioning strategies. Leaders were consistent in their description and commitment to the vision with whole system buy-in. Plymouth needs to drive this forward to ensure there is a community, home-based focus.

- Governance arrangements in Plymouth were strong across health and social care and closely linked to the Devon STP. System leaders were well represented at STP level to ensure the voice of Plymouth was heard. The System Improvement Board (SIB) was effective, and had begun to think about developing a set of integrated performance metrics shared across the system. This work should continue at pace even if the role of the SIB changes in the future.

- Relationships at a system level were positive and there was strong political consensus. However, some cultural challenges existed between organisations and these need to be overcome if the vision for vertical integration in service delivery is achieved. The system had a good track record of public engagement and they need to ensure this continues as they move forward with the integration agenda.

- There was evidence of engagement with the current local provider market, but there is an opportunity to develop a more strategic approach to include the anticipated future need and attract potential providers. This applies to health and social care providers.

- There was a shared understanding of resources. The system had an integrated budget in place, but future funding flows were fragile. The current financial position was vulnerable at both a local and STP level due to shared risk agreements.

- There was an STP level workforce strategy, but not a single, coherent strategy for Plymouth.

- There was a lack of system-wide digital interoperability, but integrated teams within the community had joint records and there was a shared use of NHS numbers.

- There was a shared commitment to the prevention agenda and investments had been protected. However, the implementation and effectiveness of the agenda was underdeveloped and budgets were vulnerable considering the current financial position.

Areas for improvement

We suggest the following areas of focus for the system to secure improvement

- System leaders need to drive forward the strategic ambition while remaining focused on delivering improvements against current performance pressures. Attention should be given to commissioning for prevention and early intervention as performance is sub optimal in these areas.

- As the system moves towards further integration, work needs to be undertaken to ensure that staff are fully engaged, on board from the outset and led by a collaborative leadership.

- Organisational development work needs to be undertaken to break down any organisational barriers, strengthen relationships, improve communication and ensure there is a shared understanding among staff of their role in achieving the strategic vision at an operational level.

- Due to the fragile primary care situation, the system needs to work with NHS England at pace to avoid the sustainability of the wider system improvement being put at risk.

- System leaders should develop a coherent workforce strategy for Plymouth.

- Continuing healthcare (CHC) performance needs to be addressed as a matter of urgency to ensure people are assessed and given an outcome in a timely way.

- The system needs to undertake more evaluation of the actions taken by teams and individuals during times of escalation and this should be shared with system partners to encourage learning and improvement.

- The local authority needs to ensure it continues to fulfil its statutory obligation under the Care Act 2014 and provide assurance there is capacity of good quality services within the domiciliary care market to cope with an increase in demand.

- Commissioners need to consider how the practicalities of not paying a retainer to domiciliary care providers and how the current rate of pay may impact on continuity of care for the person and the capacity of providers to recruit and retain staff.

- The activity data for services designed to prevent admissions should be reviewed to ensure they are being used effectively, particularly during times of escalation.

- The system should assure itself that the Minor Injuries Unit has the resources and capability to respond to deteriorating individuals appropriately.

- The system should consider expanding the single access point currently available to community health and social care staff to independent care providers.

- There should be a review of how the "yellow card" reporting system is used and who it is accessible to, to ensure common themes across the health and social care interface are identified.

- The system should continue to review performance data in relation to pressure ulcers to assure themselves there are no gaps in commissioning.

- The system should progress with the review into the number of falls in hospital with harm to determine the root causes.