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Portsmouth CITY COUNCIL

NOTICE OF MEETING

HEALTH OVERVIEW & SCRUTINY PANEL

THURSDAY, 17 OCTOBER 2013 AT 9.30 AM

THE EXECUTIVE MEETING ROOM - THIRD FLOOR, THE GUILDHALL

Telephone enquiries to Jane Di Dino 023 9283 4060
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Portsmouth Members

Councillor:
Peter Eddis (Chair)
David Horne (Vice-Chair)
Margaret Adair
Margaret Foster
Jacqui Hancock
Mike Park

Co-opted Members

Councillor:
Gwen Blackett, Havant Borough Council
Dorothy Denston, East Hampshire District Council
Peter Edgar, Gosport Borough Council
Keith Evans, Fareham Borough Council
Mike Read, Winchester Borough Council
David Keast, Hampshire County Council

Portsmouth Standing Deputies

Councillor:
Michael Andrewes
Lee Mason
Jim Patey
Caroline Scott
Phil Smith
Neill Young

(NB This agenda should be retained for future reference with the minutes of this meeting.)

Please note that the agenda, minutes and non-exempt reports are available to view online on the Portsmouth City Council website: www.portsmouth.gov.uk

A G E N D A

1 **Apologies for Absence**

2 **Declarations of Members' Interests**

3 **Minutes of the Previous Meeting** (Pages 1 - 10)
RECOMMENDED that the minutes of the Health Overview & Scrutiny Panel meeting held on 13 June 2013 be confirmed as a correct record and signed by the Chair.

4 **Update on Public Health Progress Following the Transfer of Responsibility and Health Information.** (Pages 11 - 28)
Matt Smith, Associate Director of Public Health & Primary Care will answer questions on the attached report.

5 **Portsmouth Hospitals NHS Trust Update** (Pages 29 - 32)
Allison Stratford, Associate Director of Communications and Engagement will answer questions on the attached update.

6 **The Right Place, Right Time Community Lounge** (Pages 33 - 44)
Representatives from Southern Health, Solent NHS Foundation Trust and Portsmouth Hospitals NHS Trust will answer questions on the attached report.

7 **Solent Health NHS Foundation Trust's Update** (Pages 45 - 48)
Andrea Hewitt, Head of Marketing Communications will answer questions on the attached report. The integrated business plan and operating plan can be read here: http://www.portsmouth.gov.uk/yourcouncil/8312.html

8 **Guildhall Walk Health care Centre**
Julia Bagshaw, Head of Primary Care, NHS England (Wessex) will answer questions on the report that is to follow.

9 **Portsmouth Clinical Commissioning Group's Update**
Dr Jim Hogan, Portsmouth Clinical Commissioning Group will answer questions on the report that is to follow.

10 **NHS England (Wessex)'s Update**
Julia Bagshaw, Head of Primary Care will answer questions on the report that is to follow.

11 **Healthwatch Portsmouth** (Pages 49 - 50)
Steve Taylor, Manager, Healthwatch Portsmouth will answer questions on the attached report.

12 **Continuing Healthcare - Section 75 Agreements** (Pages 51 - 52)
Claire Budden, Senior Programme Manager will answer questions on the attached report.

13 **Report on 2011-12 Five-Year Olds Dental Epidemiology Survey in Portsmouth.** (Pages 53 - 60)

Dr Jeyanthi John, Consultant in Dental Public Health (Wessex) and Lee Loveless, Advance Health Improvement Practitioner will answer questions on the attached report.

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HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held in Conference Room A, the Civic Offices on Thursday 13 June 2013 at 9:30am.

Present

Portsmouth members

Councillors Peter Eddis (chair)
Margaret Adair
Margaret Foster
Jacqui Hancock
David Horne (vice chair)
Mike Park

Co-opted members

Councillors Gwen Blackett
Keith Evans

Also in attendance

Portsmouth Hospitals' NHS Trust.
Gill Walton, Director of Midwifery
Allison Stratford, Associate Director of Communications and Engagement

South Central Ambulance Service.
Neil Cook, Area Manager Portsmouth and South East Hampshire.

Solent NHS Trust
Judy Hillier, Director of Nursing and Quality
Denise Matten, Clinical Director of Specialist Dental Services.

Portsmouth Clinical Commissioning Group.
Dr Jim Hogan, Clinical Lead and Chief Clinical Officer
Innes Richens, Chief Operating Officer.

Care Quality Commission
Catherine Campbell, Compliance Manager (Portsmouth)

Portsmouth City Council
Jackie Charlesworth, Senior Programme Manager
Justin Wallace-Cook, Assistant Head of Adult Social Care

25. Welcome and Apologies for Absence (AI 1)

Councillors Peter Edgar and Dorothy Denston sent their apologies.

26. Members' Interests (AI 2)

No interests were declared.

27. Minutes from the Meeting held on 14 March 2013 (AI 3)
RESOLVED that the minutes of the meeting held on 14 March 2013 be confirmed as a correct record and be signed by the chair.

28. Maternity Update (AI 4).
Gill Walton, Director of Midwifery, Portsmouth Hospitals NHS Trust presented her report that had been circulated with the agenda and in response to questions from the panel, the following points were clarified:

- Three midwifery PHD students have recently been appointed.
- Although efficiency savings are sought, staffing levels have not been reduced. There has been more joint working with partners.
- Income for the maternity service has increased.
- Outcomes have improved.
- National research has shown that home births are cheaper and carry more likelihood of a normal delivery than at the hospital.
- Will continue to deliver more services at the Portsmouth Maternity Centre at St Mary's Hospital.
- Mothers-to-bes' future needs are identified at ante-natal appointments and individual care packages are designed with the involvement of GPs and social services as required.
- Health visitors and midwives provide more support to vulnerable women including home visits.
- Joint clinics are run in children's centres.

The panel commented that it had recently visited the service and had been very impressed.

REVOLVED that the update on Portsmouth Hospitals NHST Trust maternity service be noted.

Actions
Health Visitors and GPs be invited to a future meeting to discuss the arrangements in place to ensure that vulnerable mothers who miss appointments are followed up.

29. South Central Ambulance Service NHS Foundation Trust Update (AI 5).
Neil Cook, Area Manager Portsmouth and South East Hampshire presented his report that had been circulated with the agenda and in response to questions from the panel, the following points were clarified:

111 Service.

- South Central Ambulance Service (SCAS) provides the training for the call centre staff.
- Care UK is responsible for the out of hours element of the service.
- GP appointments are not booked for out of hours or daytime callers in Hampshire but this is being considered from the out of hours service and maybe other surgeries in the future.
- The service is working very well in Hampshire and SCAS is advising other areas on how to improve.

- Following a big recruitment drive in October last year, current staffing levels are good.
- Calls peak in the mornings and at weekends.
- The increase in demand for the service co-incided with winter when would normally see an increase.
- The campaign to reduce the number of inappropriate calls to the 999 service has led to an increase in demand for the 111 service. This should read; SCAS has experienced an uplift in 999 calls which have been associated the introduction of the 111 service however our misuse campaign led to an initial increase and is possibly the reaction of the public to a new service.

Standby Points.

- Ambulances are based in standby points to cover Hayling Island.
- The service is currently seeking 10-12 standby points in Hampshire.
- The Ambulance Service has yet to speak to the Seafront Manager regarding the standby point by the lifeguard station at the seafront. The life guards' contract is now managed by the RNLI.

Ambulance Stations.

- The South East Hampshire Resource Centre in North Harbour on Western Road is due to be completed in the Autumn. The panel was invited to visit.
- The Portsea station was sold approximately six months ago; performance in this area still as high as ever.

Community Responders

- A Community First Responder is a trained volunteer available to be dispatched by an ambulance control centre to attend medical emergencies in their local area to support patients until the ambulance arrives.
- The training (provided by the ambulance service) covers the use of defibrillator, oxygen therapy, full resuscitation and first aid.
- Two or three kits are shared between each area's group.
- Community responders are especially important in rural areas where ambulance response times tend to be longer than in urban areas.
- Community responders are not sent to road traffic accidents or alcohol-related incidents.
- The ambulance service manages the groups and has 4-5 trainers.
- There are 600 volunteers in Hampshire. Recruitment is steady.
- Training is updated annually.

The ambulance service also works with nursing homes and shopping centres to ensure that staff have defibrillators on site and are fully trained.

RESOLVED that South Central Ambulance Service NHS Foundation Trust's update be noted.

Actions

- Mr. Cook to check whether 111 day staff can book GP appointments for callers.
- Visit to the ambulance station in North Harbour to be arranged when completed.

30. Solent NHS Trust Update (AI 6).

Judy Hillier, Director of Nursing and Quality and Denise Matten, Clinical Director of Specialist Dental Services presented their report that had been circulated with the agenda and in response to questions from the panel, the following points were clarified:

- Solent NHS Trust provides community and mental health services in Portsmouth Southampton and parts of Hampshire regarding substance misuse, specialised dentistry and sexual health.
- Governors are sought to join the board which meets at various locations in Portsmouth and Southampton.
- The Community Assessment Lounge deals with patients who do not require admission but who need more attention to ensure that they are sent home with the appropriate support e.g. a care package or equipment.
- Generally people are more aware of the risks of substance misuse. The service carries out a lot of work in schools with the police on this issue and teenage pregnancy.
- The cost improvement programme will continue over the next five years. A lot of work is being carried out to encourage mobile working and releasing time to care. Currently have a small surplus and plan to have next year, as is required of a Foundation Trust. Assessments of all proposed efficiency measures are carried in terms of potential risk, quality and impact on staff, patients and relatives. The strategic overview is essential.
- The Grove Unit is at full capacity and is working well to its specifications. Ms. Hillier receives a weekly update on the unit.
- The podiatry service pilot in Southampton will be extended out to Portsmouth. The Single Point of Access is working well and will be phased in gradually for all services. It is hoped that this will be available 24/7 in time. The concerns raised by the panel with regard to how elderly and vulnerable service users will access will be fed back to the appropriate team.
- The specialised dental service caters for people who may be vulnerable because they have learning difficulties or are immune-compromised patients. The dentists can offer sedation or anesthesia via IV or inhalation.
- Solent works closely with stakeholders including school nurses, GPs, medical visitors and learning disability services.
- After an initial assessment, patients will be treated or referred to a community dentist.
- The dental helpline facilitates access to dental care.
- There is an adequate supply of NHS dentists in the city.
- The commissioners decided to close the dental practice in Lake

Road.

- The Grove Unit fulfills a slightly different need than the Spinnaker Ward.
- Community equipment with a value of less than £30 cannot be returned to the provider because the costs of collection, cleaning and carrying out safety checks would not be covered by reselling it.

The panel suggested that it might be possible for the providers to receive the equipment and then sell it for scrap.

RESOLVED that Solent NHS Trust's update be noted.

Actions.

- The panel's concerns regarding the return of community equipment will be fed back to the providers.
- A response to members' concerns regarding elderly and vulnerable service users having to book future appointments themselves will be given to the panel.
- The results of a review into the effect of community places including the Grove Unit on admissions to the Emergency Department will be brought to a future meeting.

31. Portsmouth Clinical Commissioning Group Update (AI 7).

Dr Jim Hogan, Clinical Lead and Chief Clinical Officer presented his report that had been circulated with the agenda and in response to questions from the panel, the following points were clarified:

- Responsibility for public health (the prevention agenda) has been transferred to the local authority. GPs, pharmacies, dentistry, ophthalmology have moved to the Local Area Team.
- The two main areas of focus for the CCG are: medicine for elderly people and redesigning the emergency department.
- The Emergency Department (ED) was designed to cater for 270 attendances a day. It now regularly sees over 300 people per day.
- There has been a national increase in ED attendances of between 7and10%, locally it has been around 7% - and this increase started several months before the introduction of the 111 service.
- During the day (08:30-18:30) an advice only service is provided. GP appointments cannot be made directly for callers.
- At night, callers can be transferred to the GP out-of-hours service or can be made an immediate appointment.
- The 111 service is working better in Portsmouth than elsewhere in the country.
- The 999 and 111 service work on different systems in the same building. The management of the two systems is being reviewed.
- Callers to the GP out of hours service are advised to call 111.
- Ambulances are dispatched before 999 calls are completed because the service is driven by response times.
- There are high numbers of ED attendances; however the fact that there has not been a subsequent increase in ED admissions, suggest that these

are inappropriate attendances.

- Analysis shows that younger people are more likely to attend the ED.
- The Guildhall Walk GP surgery has dealt with a previously unmet need.
- The ED is not very good at managing primary care and children. The staff feel responsible for the patients and reluctant to send them away to a more appropriate treatment centre. In the past, patients have declined offers of taxis to treatment centres. Under the new plans, GP appointments will be made for patients with minor ailments so that they can be sent away.
- The community assessment lounge will still be required.
- The CCG has recently funded an extension to a telehealth care pilot so that a further 400 patients can benefit. The results will be reviewed.
- The cost per person seen at the St Mary's Treatment Unit was requested and are shown in appendix one.
- The out of hours service will be reviewed shortly.
- Havant is part of the SE Hants CCG's area.
- The CCG offered to be involved in the maternity service update that will be given to the panel.

RESOLVED that Portsmouth Clinical Commissioning Group's update be noted.

Actions.

- The cost of treatment at St Mary's Minor Injuries Treatment Centre per person will be provided to the panel (
- The results of the out of hours service will be brought to a future meeting.
- The CCG will be invited to participate in the maternity services update that will be brought to a future meeting.

32. Care Quality Commission (AI 8).

Catherine Campbell, Compliance Manager (Portsmouth) presented her report that had been circulated with the agenda and in response to questions from the panel, the following points were clarified:

- The CQC is funded by the Department of Health but is an arms-length body.
- Additional funds were made available to the Commission this year.
- A large recruitment drive for inspectors was carried out over the last 18 months.
- Most inspections are unannounced. Inspectors decide on 5-6 regulations that they will focus on; however on the day they can gather information on others if required.
- The gravity of any non-compliance of a standard is determined by how many people are affected, the level of risk and the outcome area.
- Judgments on compliance are made by evidence collected through observations of care, review of documentation and talking to service users and their families. People may speak to inspectors after the visit if they prefer.
- Hospitals (NHS and independent), domiciliary care agencies, GPs, dentists, ambulance service (NHS and independent), nursing and care

homes (private and local authority run nursing/ care homes) are inspected.
- The CQC welcomes information and concerns about premises which inform its work. There are several ways in which people can get in contact: by calling 03000 61 61 61; emailing Enquiries@cqc.org.uk; or completing a form online at http://www.cqc.org.uk/contact-us;
- The CQC has good links with adult social care.

Councillor Jacqui Hancock expressed concern regarding the risk of patients deconditioning during hospital stays and the support given at mealtimes at Queen Alexandra Hospital, Cosham.

Actions.
Links to the following information will be sent to the panel:
1. The CQC's response to the Francis Inquiry.
2. The Business Plan.
3. The Voices into Action section of the CQC website.

- Concerns raised by the panel regarding assistance given to patients during meal times will be fed back to the inspections team to see if future inspections could include this area.
- Any further questions that the panel may have can be sent to the CQC.

RESOLVED that the Care Quality Commission's update be noted.

(Councillor Evans left the meeting).

33. Project Closure Report: Reprovision of Exbury Ward, St James' Hospital (AI 9).

Councillor Eddis presented the report that had been circulated with the agenda. Mr. Richens explained that the process had been exceptionally well carried out with minimal impact on the patients. The good practice will be used to inform the planning of future projects.

In response to a question from the panel, Mr. Richens explained that there would have been places at Harry Sotnick House for all the residents if that had been a suitable location.

RESOLVED that the update on the re-provision of Exbury Ward be noted.

34. Adult Social Care Update (AI 10).

Justin Wallace-Cook, Assistant Head of Adult Social Care presented his report that had been circulated with the agenda and in response to questions from the panel, the following points were clarified:
- The number of posts has been reduced by 50- only 6 were compulsory redundancy. Out of 600-700 staff.
- Increased number of older people requiring assistance. National trend. More dementia. One of the biggest pressures.
- If the pilot identifies a requirement for more premises of that type, will look into where that could be accommodated.
- More pressure for early discharge from hospital, where appropriate.

- Caroline Lodge changed name to Caroline Square by the landlord Housing 21 used to be court.
- Organising visits of the show flat for ward councillors.
- Personal Health Budgets - update in your regular update.
- Concern regarding potential abuse. More choice and control for the individual.
  ASC to CHC. Now under ASC makes transition easier.
- Safeguards in place against fraud.

RESOLVED that Adult Social Care's update be noted.

35. Possible Repatriation of Plastics from St Richard's Hospital, Chichester (AI 11).

Allison Stratford, Associate Director of Communications and Engagement presented her report that had been circulated in advance of the meeting and informed the panel that a similar report will be considered by West Sussex County Council's Health and Adult Social Care Select Committee on 26 June.

RESOLVED that the update be noted.

36. New Ways of Working (AI 12).

The panel felt that most organisations did not need to report updates more than twice a year; however service changes would still need to be reported within adequate time for the panel to consider them.

RESOLVED that:

1. **The proposed work programme be adopted.**
2. **The overview meetings be held on 17 October 2013 and 16 January 2014.**
3. **The dates of the review meetings will be set as part of the scoping documents.**

Action.

The work programme will be updated regarding the frequency of reports.

37. Framework for Assessing Change (AI 13).

RESOLVED that the framework for assessing significant developments or substantial variations be noted.

The meeting concluded at 13:05.

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Councillor Peter Eddis
Chair, Health Overview & Scrutiny Panel

Appendix One.

The cost per patient at St Mary's Minor Injuries Treatment Unit.

Type of attendance.	Cost.
Minor Injuries	£58.16
Walk Ins	£36.74

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THIS ITEM IS FOR INFORMATION ONLY

Portsmouth CITY COUNCIL

Agenda item:

Title of meeting:	Health Overview and Scrutiny Panel
Subject:	Update on Public Health progress following transfer of responsibility and health information
Date of meeting:	17 September 2013
Report by:	Dr Andrew Mortimore, Director of Public Health
Wards affected:	All

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1. Requested by Health Overview and Scrutiny Panel

2. Purpose: To provide the Panel with:

a. an update on progress following transfer of responsibility to Portsmouth City Council, and

b. the latest Public Health information developments

PROGRESS FOLLOWING TRANSFER

3. Local leadership

3.1 The new health system for England has put local leadership for public health in the hands of local authorities, supported by a new national agency – Public Health England (PHE). People and resources transferred from the NHS to the council to complement the programmes and services that it had previously provided. The council now has a leadership role in:

- tackling the causes of ill-health, and reducing health inequalities
- promoting and protecting health
- promoting social justice and safer communities

3.2 As previously reported, the council has responsibility for five mandated and 16 other public services linked to the Department of Health Public Health Outcomes Framework. Spending on Public Health outcomes will be funded by a ring-fenced grant which, for 2013/14 and 2014/15 has been set at £15.7M and £16.1M respectively; the grant for 2015/16 has yet to be announced. The financial conditions applicable to the grant were also set out in the previous report.

3.3 Use of the grant

The public health grant is provided to give local authorities the funding needed to discharge their public heath responsibilities and that these funds are used to:

- improve significantly the health and wellbeing of local populations
- carry out health protection functions delegated from the Secretary of State
- reduce health inequalities across the life course, including within hard to each groups
- ensure the provision of population healthcare advice.

4. Vision for Public Health in Portsmouth

4.1 The vision is that:

'Public Health will be at the heart of everything that the city council does in working to shape our Great Waterfront City and will provide leadership and influence across all council services and activities to improve the overall health and well-being of the people of Portsmouth, concentrating on improving the health of the poorest, fastest.'

4.2 Strategic principles which underpin the vision:

- Build on the successful citywide collaborative and cooperative model of working across agencies to prioritise Public Health in Portsmouth
- Develop a remodelled, enhanced and locally led Public Health approach
- Focus firmly on the needs of the residents of Portsmouth, working together to shape the environment in which local people live, work and play, as well as challenging and tackling inequality and deprivation to improve health outcomes and reduce health inequalities in the City
- Lead and influence across the full range of services, functions and activities to improve health and reduce inequality

5. Roadmap for delivering the Public Health vision in Portsmouth

5.1 **Where are we now?** In undertaking its public health functions the performance of the city council will be monitored against the Public Health Outcomes Framework (PHOF). A variety of indicators for the responsibilities are grouped in four domains:

- the wider determinants of health
- health improvement
- population healthcare
- health protection

5.2 The national Public Health Observatories have recently released data for the city's performance against some of these indicators where data is available (http://www.phoutcomes.info/). Listed below are key indicators, which are consistent with the findings of the Joint Strategic Needs Assessment, where we are performing significantly worse than the national average or where we need to maintain performance:

Improving wider determinants

- Pupil absence
- 16-18 not in education, employment or training
- Killed and seriously injured on the roads

- Violent crime
- Re-offending
- Statutory homelessness

Health improvement

- Mothers smoking at time of delivery
- Physically inactive adults
- Cervical cancer screening
- Take-up of NHS Health Checks
- Self-reported wellbeing - feeling worthwhile

Health protection

- MMR for 5 year olds

Healthcare public health and preventing premature mortality

- Overall mortality rate from causes considered to be preventable
- Premature mortality rate from cardiovascular diseases
- Premature mortality rate from cancer
- Premature mortality rate from respiratory disease considered preventable
- Preventable sight loss - age related macular degeneration
- Preventable sight loss - diabetic eye disease
- Excess winter deaths

A more detailed overview and explanation of the latest Public Health information, health needs and development of the Joint Strategic Needs Assessment is at Appendix 1.

5.3 **Where would we like to be?** In summary the main aims include:

- Population health gain
- Reducing the inequalities gap
- Achieving value for money across services
- Understanding impact on overall costs to the council and others

5.4 **How do we get there?** Key actions to help move us to where we want to be include:

- Establish a process for review of contractual arrangements to improve value for money and reflect changes in priorities for investment
- Engagement with other PCC services, residents and external stakeholders in line with priorities
- Redesign services and implement improvement initiatives

5.5 There is a unique opportunity in Portsmouth to develop a public health service that builds on a strong track record of delivery. Combining a specialist public health team which transferred from the NHS with the children and young people health improvement team in the council (Health Improvement and Development Service) to become Public Health Portsmouth will provide the capacity and expertise to help

shape how the council undertakes its new responsibilities. Underpinning all areas of work is the public health intelligence team which is an integral and essential part of the core team. Furthermore, following the merger of public health with community safety and licencing, in May 2013 to form the Health, Safety and Licencing Service, additional opportunities for integrated services have been created.

5.6 To ensure that the council's public health responsibilities are delivered, Public Health Portsmouth will continue to work in new and innovative ways; an operating model has been developed and will continue to be refined to support new ways of working. Eight programmes of work have been defined, each comprising of a range of projects that will work collectively to tackle key threats to health and open up opportunities for people to make healthy choices (Appendix 2).

5.7 Recognising the mix of generic and specialist skills available and required, and the need for flexibility and future-proofing, the operating model proposes matrix working, with a mixture of short-life project teams and longer term initiatives. These will address the following five strategic objectives in the Public Health Strategy:

- Get the best possible start in life - by concentrating on pre-birth to 5 year olds, we will ensure that every child has the best possible start in life through access to universal and targeted services supported by positive parenting.

- Help young people to be ready, willing and able to work - by providing services that our residents need and want and to support them staying fit and healthy.

- Create a better environment for people to live, work and play - by working across the city council to fully integrate planning, transport, housing, environmental and health. The aim is to address the social determinants of health and support locally developed and evidence based community regeneration programmes that remove barriers to community participation and action, and reduce social isolation.

- Encourage healthy lifestyles, for example, by helping people to stop smoking, lose weight and not misuse alcohol - by commissioning innovative, evidence-based prevention services and programmes that are effective, targeted and readily accessible to those in greatest need. The aim is to enable communities and individuals to shape their own futures and make informed and appropriate choices about their collective and individual lifestyles.

- Maintain maximum independence and dignity in old age - by working in partnership with all adult and community services to improve physical and mental fitness. The aim is to maximise the potential to be independent, overcome barriers to active life, e.g. improve access to health care and health promotion services for those who are socially isolated, living in poverty, have mental health problems, those from black and minority ethnic groups and protecting vulnerable older people from cold and heat-related illness.

These strategic objectives mirror the health determinant themes and improvement recommendations set out in the Marmot Review.[1]

5.8 The existing and future workforce will be developed to ensure that there is the capacity and the skills to deliver the public health functions. This provides the core of expertise. However, the wider council workforce, as potential public health champions, has a key role in supporting the council's responsibility. Broadening the understanding of public health across the wider workforce to build a network of champions is therefore a key developmental work strand. Underpinning the professional development and training of specialists, attached staff and other practitioners will be in conjunction with the Wessex School of Public Health, and in line with national accreditation standards.

5.9 The ambition during 2013/14 and 2014/15 is to review and redesign public health services to achieve more with the resources available, add value to the council's overall offer and that of partner organisations to ensure more services are provided in a "joined-up" way (e.g. pathways of care). This is a significant change programme which will require focus and leadership. As such we have brought together a small team of senior managers from within Public Health Portsmouth to concentrate on this work. It is envisaged that this review and re-design work will release a proportion of the grant over the next three years (approximately 25%) which will then be redistributed to support other council services activity that meets public health outcomes.

5.10 The following summary table shows a high level breakdown of current service provision, the 2013/14 spend and contract end dates;

Sexual Health	3,758,760	31/03/15
Smoking	1,342,698	31/03/15
Children 5-19 Programme	710,191	31/03/15
Health Checks	191,698	31/03/14
Obesity	747,354	31/03/14
Substance Misuse	4,232,166	30/06/17
Alcohol	1,332,552	30/06/17
General Prevention	507,535	31/10/15
Public Health Advice	192,604	
Dental Health	263,254	31/03/16
Operating Costs	780,681	
Contribution to other services delivering positive public health outcomes	317,000	
Public Health Change Programme - capacity building and system redesign	1,360,907	
Total	**15,737,400**	

5.11 To tackle deep-seated health inequalities and raise the health and well-being of Portsmouth people, the aim is to work collaboratively across the council to identify activities, which have the greatest impact on those public health outcomes identified

[1] Fair Society Healthy Lives' (The Marmot Review) Strategic Review of Health Inequalities in England post 2010.

as priorities in the business planning process. Once identified, the public health team can then work with the relevant city council services to "tailor" activities towards achieving improved public health outcomes.

5.12 Activity which has been identified by Public Health Portsmouth which could potentially contribute to public health outcomes is tabled below. These activities, along with proposals from services, will be evaluated and compared to current public health service provision to assess their respective value and quality toward achieving reduction in inequalities and meeting those outcomes defined in the Public Health Outcomes Framework.

Early Years	Family Nurse Partnership
	Children's Centre Offer
	Parenting Support
5-19	Youth Support Services
	Active Travel inc. Cycling
	Healthy Schools (inc Mental Health & Wellbeing)
	Free Swimming
Adults	Community Projects with a health/physical activity impact
	Domestic Violence
	Green Gyms
Environment	Air Quality Improvement
Later Years	Community Projects
	Independence and Wellbeing Services
	Free Swimming

6. Summary

6.1 Considerable progress has been achieved over these past six months in shaping how public health responsibilities are delivered by the council. There is strong recognition that the opportunity and potential to make a difference for the people of Portsmouth now exists. Closer engagement and understanding the needs of residents to improve public health outcomes and provide supporting services is at the heart of the Public Health strategy. Harnessing the collective capability of the council workforce to support the improvement in public health outcomes is a key driver in the strategy. The focus of the core team now is to review and re-design current services, and identify areas in the council which will provide public health outcomes which are equal to or better than those which are currently in place.

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Signed by Director of Public Health

Appendices:

Appendix 1: Report on Public Health Information Developments
Appendix 2: Diagram of Public Health Portsmouth Operating Model

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location

Portsmouth CITY COUNCIL

Appendix 1

PUBLIC HEALTH INFORMATION DEVELOPMENTS

1. The Joint Strategic Needs Assessment and the health needs of Portsmouth

1.1 The production of the Joint Strategic Needs Assessment (JSNA) is a joint statutory responsibility for the city council and NHS Portsmouth Clinical Commissioning Group, overseen by the Health and Wellbeing Board. The JSNA is used to inform the development of the Joint Health and Wellbeing Strategy. A full description of the health needs of Portsmouth can be found in the annual summary of the JSNA), which is produced by the Public Health Intelligence Team.

1.2 The draft JSNA annual summary for 2013 will be issued at the beginning of October and HOSP members advised accordingly. A period of consultation will take place between October and 4 December 2013 where we will be seeking views about whether the range of issues identified in the JSNA reflects people's concerns about current issues in Portsmouth. It is intended to use the outcomes of the consultation to inform, devise and prioritise a research work programme to understand the root causes of these issues and evaluate the evidence for the most effective way to tackle the problems. This programme will also enable more efficient application of the analytical resource available to the Council.

1.3 It is intended that the consultation will also include a JSNA stakeholder event on 3 December and that the draft JSNA summary will also be discussed at the Health and Wellbeing Board meeting in public on 4 December.

2 "The big picture of health and wellbeing"

2.1 The JSNA provides 'the big picture' of health in Portsmouth. It informs and, where necessary, challenges the objectives in the Joint Health and Wellbeing Strategy.

2.2 A wide range of information about health and wellbeing has been obtained during the last year:

2.2.1 **2011 Census**

- results for a wide range of areas - demography, housing, caring, transport, etc.
- National release of more data behind the wide range of outcome measures affecting health and wellbeing in the Public Health, NHS, Adult Social Care Outcome Frameworks and the Clinical Commissioning Indicator Set Group

2.2.2 Local research examining these issues in more detail is listed below and can (mostly) be found on the JSNA website Joint Strategic Needs Assessment:

Socio-environmental factors:
- Annual crime and anti-social behaviour report
- Fire and rescue profile of Portsmouth
- Scrutiny Panel Review of air quality
- Impact of changes to the welfare system

Tackling inequalities affecting vulnerable groups:
- Profile of people from non-EU countries (as part of EU-funded integration project)
- The health of men (Public Health Annual Report, 2012)
- Profile of adults with a learning disability
- Profile of carers

Surveys carried out this year
- Young people's substance misuse

Specific health and wellbeing issues:
- Why people with HIV infection delay going to see their doctor
- Additional analysis of reasons behind Portsmouth comparatively high rate of excess Winter deaths
- Scrutiny Panel Review "Consider advancing the use of technology in Adult Social Care (telehealth and Telecare)"

Services
- Redesign services from the customer's perspective to meet the needs of families with multiple problems ("Positive Family Steps")
- Review of child and adolescent mental health services
- Starting to use geo-segmentation data from Experian's Mosaic database to profile residents and be able to communicate with them more effectively

On-going needs assessments or research

- Supply of affordable housing (PUSH)
- Diversity of Portsmouth – updating overview of aspects of diversity (
- Children and young people's needs assessment
- Health and wellbeing needs of looked after children (also subject of review by Education, Children and Young People's Scrutiny Panel)
- Health and wellbeing needs of young offenders
- Health and wellbeing needs of city council housing tenants (required by Joint Health and Wellbeing Strategy)
- Profile of children with speech, language and communication needs
- Additional analysis of reasons behind Portsmouth's comparatively high rate of older people falling.

3. Summary of key findings

3.1 Population

3.1.1 Between 2001 and 2011 Portsmouth's population grew by 9.8% overall. Between 2013 and 2021 a smaller level of growth is predicted (4.5%) but there are differences across the age range:

- The 0–4 years population is projected to grow by only 1.1% (from 13,300 to 13,500), while the 5–15 years population is projected to grow by 9.1% (from 24,500 to 26,700)
- The working age population (16-64 years) is projected to grow by only 2.7%
- While the 65+ years population is projected to grow by 11.2% overall, it is the 85+ years population that will see the greatest increase (19.5%, from 4,400 to 5,200).

3.1.2 Portsmouth has a lower percentage of residents from Black and minority ethnic (BME) communities (including White Irish and other White non-British communities) compared to in England (16% compared to 20%). However:

- Portsmouth is a diverse multi-ethnic community with some 32,800 people identifying with an ethnicity other than White English/Welsh/Scottish/Northern Irish/British.

- After White British, the six largest ethnic groups in the city are: Other White (3.8%), Bangladeshi (1.8%), African (1.4%), Indian (1.4%), Other Asian (1.3%) and Chinese (1.3%)

- Polish is the largest single ethnicity within the Other White group, with the Polish community making up 0.8% of the city's total population.

- By 2011, 22% of all births were to non-British born mothers (up from 11% in 2011)

- All BME groups (except Mixed) have larger proportion of their group of working age than White British.

3.2 Poverty

3.2.1 About 11,000 children live in poverty and the cost of child poverty to the city is estimated at £121m each year. The consequences of poverty cost society: in the money that government spends in trying to counter the effects of child poverty, and in the economic costs of children failing to reach their potential. People and agencies across the city are seeing the effects of increasing poverty:

- Between 2011 and 2012, the number of people using the Foodbank in Portsmouth doubled. Between 1 January to 31 August 2013 1,939

vouchers were given out (increase of 50% for the same period in 2012). The main reason for referral to a Foodbank is benefit delays or changes

- Spend has been rising sharply within the Local Welfare Assistance Scheme (although some of this is due to seasonal variation)

- Money, debt and benefits advice services are reporting record numbers of people asking for help

- Rent arrears are rising in relation to reforms such as under-occupancy (the bedroom tax)

- About 131 Portsmouth families have been hit by the benefits cap and are each losing an average of £73 a week

- The Centre for Economic and Social Inclusion (2013) estimates that, in Portsmouth in 2015/16, the average loss per claimant household from key housing benefit reforms will be £976 (affecting 12.5% of all households).

3.3 **Community safety**

3.3.1 The Safer Portsmouth Partnership has seen a 16% reduction in reported crime (greater than 7% reported nationally).

3.3.2 Alcohol services are showing positive achievements but we still have a slightly higher proportion of people drinking at levels that may harm their health.

3.3.3 Drug services are going through a period of change and require monitoring to ensure that the hoped for improvements are achieved. There is a link between substance misuse and prolific offending/anti-social behaviour and more work is needed to try and target this (hard to engage) group.

3.3.4 There are concerns regarding our most prolific young and adult offenders and those committing more serious offences

3.3.5 We need to understand why only a small proportion of domestic abuse incidents are recorded as crimes.

3.3.6 Internet crime and cyber-bulling are likely to be increasing, but this is likely to be very under-reported so we cannot get an accurate picture of whether the pattern of crime types is changing.

3.3.7 Although crime is going down, we still need to focus on improving performance by working together. We have the opportunity to identify specific vulnerable groups or locations where the experience of crime remains higher than expected and target our resources

3.4 Give every child the best start in life

3.4.1 The report summarises areas where Portsmouth compares better or worse than England and also identifies key risk factors for poorer developmental outcomes in children:

Key risk factor	Impact in Portsmouth
Parental depression	Applying national prevalence estimates, about 265 women each year could suffer perinatal mental ill-health
Parental illness or disability	Paulsgrove (9%), Wymering (8%) and Buckland (7%) had the highest percentages of households where one person in the household had a long-term health problem or disability **and** had dependent children aged 0-4 years
Smoking in pregnancy	All pregnant women who **smoke** are offered smoking cessation advice and/or referred to smoking cessation services. Last year, 62 pregnant women used NHS Smoking Cessation services to set a quit date and 42 successfully quit. Other women will quit smoking without using NHS services. However, we want to encourage more women to have support from NHS Stop Smoking Services as they are more likely to remain smoke-free for life than when they quit on their own. Last year, 463 women were still smoking at the time their babies were born.
Parent at risk of alcoholism	National prevalence estimates that 11,346 (30%) of children aged under 16 years live with one binge drinking parent. The local substance misuse survey of secondary school pupils found that 79% of pupils were not worried at all about their parents'/guardians' drinking. Three per cent were 'worried a lot' and 4% said parents'/guardians' drinking affected their home life
Domestic violence	Domestic abuse remains the largest driver of violence – accounting for 1,102 assaults (29% of all assaults
Financial stress	About 24% of children live in poverty but much higher rates of childhood poverty are in Landport (67% of children living in poverty) and City Centre North (66% of children living in poverty) areas of Charles Dickens ward
Parental worklessness	12% of households in Buckland, 11% of households in Wymering and 9% of households in City Centre had no adults in **employment** and had dependent children aged 0-4 years
Teenage mother	**Teenage conception** rates are significantly higher than the national level but are improving. In the most recent rolling quarter there were 39.9 conceptions per 1,000 girls aged 15-17 years (about 34 conceptions). More deprived areas have higher teenage conception rates
Parent lack of basic skills which limits their daily activities	No local intelligence about parents in particular but we know that Portsmouth adults have comparatively lower skills in for example numeracy
Household overcrowding	Households in City Centre, Somerstown, Palmerston and Seafront areas were most **overcrowded**
Source: ONS. 2011 Census. CHIIMAT: http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=48&geoTypeId=#iasProfileSection1	

3.5 A better environment to live, work and play

3.5.1 The report incorporates more information from the Portsmouth Plan, the Regeneration Strategy and the Parks and Open Spaces Strategy as we try to make better connections between the information about 'people' and the information about 'place'. We need to make sure that we derive maximum

benefit from the socio-economic environment to impact positively on health and wellbeing eg use of open spaces, the built environment, employment, the economy, housing and winter warmth.

3.5.2 Although Portsmouth is densely populated, it also has a rich natural environment with internationally protected harbours and other nationally and locally protected sites. Most of the city is flat and compact and offers an ideal environment for walking and cycling. Portsmouth is ranked 16th of 348 authorities for percentage of people cycling to work and ranked 22nd for people walking to work.

3.5.3 Between 2001 and 2011, the city accommodated an additional 6,754 households. Owner-occupiers are still the largest tenure category (47,722 households, 56% of households) but the biggest change is the 87% increase in the number of households renting from a private landlord or letting agency (an increase from 10,164 households in 2001 to 19,044 households in 2011).

8.5.4 Compared to England and the South East region, Portsmouth has a significantly higher rate of statutory homelessness (397 homeless households in 2010/11, 4.8 per 1,000 households). Family homelessness was also significantly higher (363 homeless families in 2011/12, 4.9 per 1,000 households).

3.5.5 The key challenge is to provide a good mix and the right level of housing to meet the needs of the whole community - the forthcoming Strategic Housing Market Assessment will provide information about this

3.5.6 The Economic Area Assessment (2012) found:

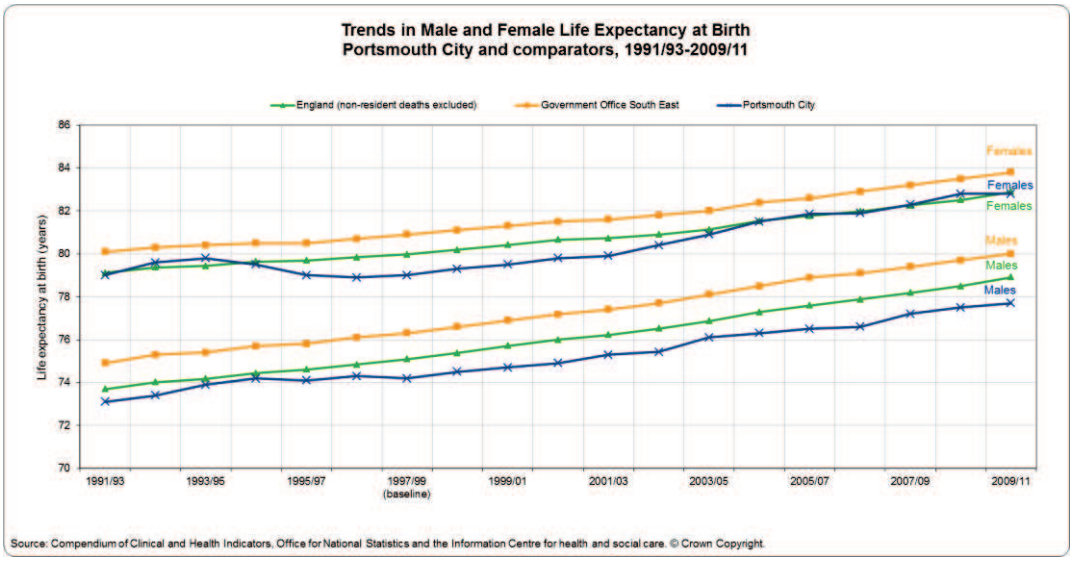
- In-commuters tend to occupy the 'better'/higher level jobs
- Prosperity (Gross Value Added per head) is satisfactory but not as high as similar areas
- Productivity (Gross Value Added per job filled) is improving but remains low
- Possible reasons for Portsmouth's lower prosperity and productivity:
    - **Skills** - Current residents of working age, and those entering workforce, continue to have low skill levels
    - **Innovation** - Portsmouth has potential for "innovativeness" – we can build on what is already here, remove barriers to firms wanting to expand
    - **Competition** - Low business density (implying lack of competitiveness), due in part to a high proportion of large firms (employing over 1,000 people), in Portsmouth
    - **Entrepreneurship** - improving rates of business start-ups and survival.

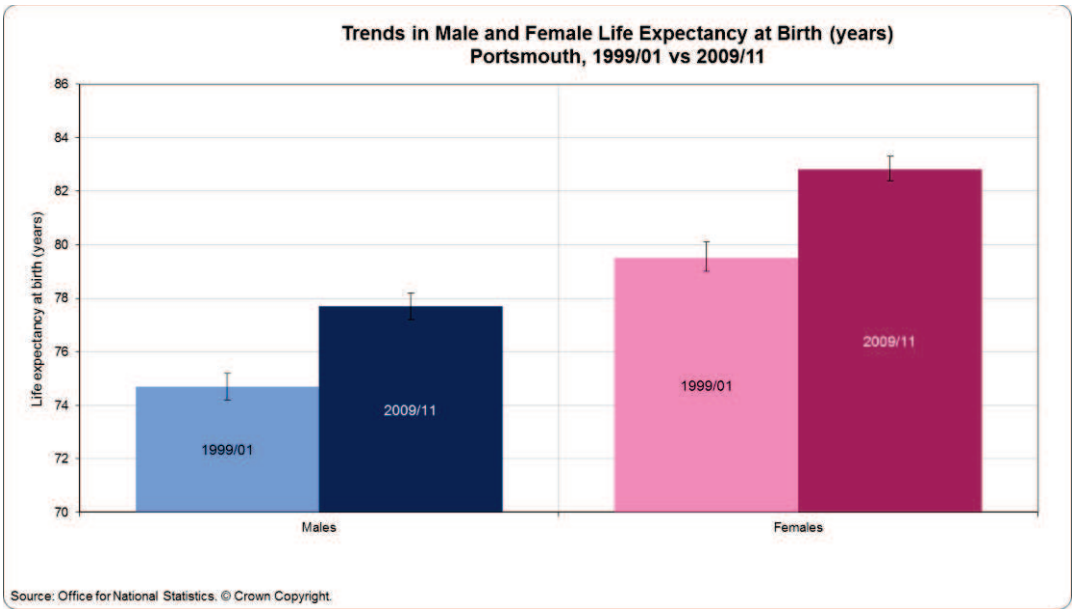
3.5.7 Portsmouth's employment rate is usually slightly higher than the GB rate, but slightly lower than the SE rate. The local rate has not changed significantly over time. However, higher rates of Job Seeker Allowance are claimed in the

more deprived areas. The rate of unemployment amongst BME community is 11% higher than that of whole population.

3.6 Encourage healthy lifestyles by helping people to stop smoking, drink responsibly and be a healthy weight

3.6.1 Life expectancy at birth is a key indicator of the overall health of a population. Male life expectancy at birth remains significantly lower than the England average. Female life expectancy at birth is not significantly different to that of England.





HOSP has previously received reports on life expectancy at birth. The Annual Public Health Report 2012 focussed on male health and wellbeing.

3.6.2 Stopping smoking - Smoking is the main reason for the gap in life expectancy between rich and poor. Compared to England, Portsmouth has significantly higher levels of:

- Mothers continuing to smoke throughout pregnancy
- Lung cancer registrations
- Smoking attributable deaths from heart disease
- Smoking attributable deaths overall
- Deaths from lung cancer, and from chronic obstructive pulmonary disease (COPD).

But, smokers who use Portsmouth's NHS Smoking Cessation Service are significantly more likely successfully to quit smoking than the England average.

3.6.3 Drinking responsibly - Compared to the South East or England, Portsmouth has significantly higher rates of:

- People claiming incapacity benefit or severe disability allowance due to alcoholism
- Alcohol-attributable crime, violent crime and sexual crimes
- Alcohol-attributable hospital admissions – and the male trend is increasing
- Alcohol-specific mortality rate for males (see chart below).

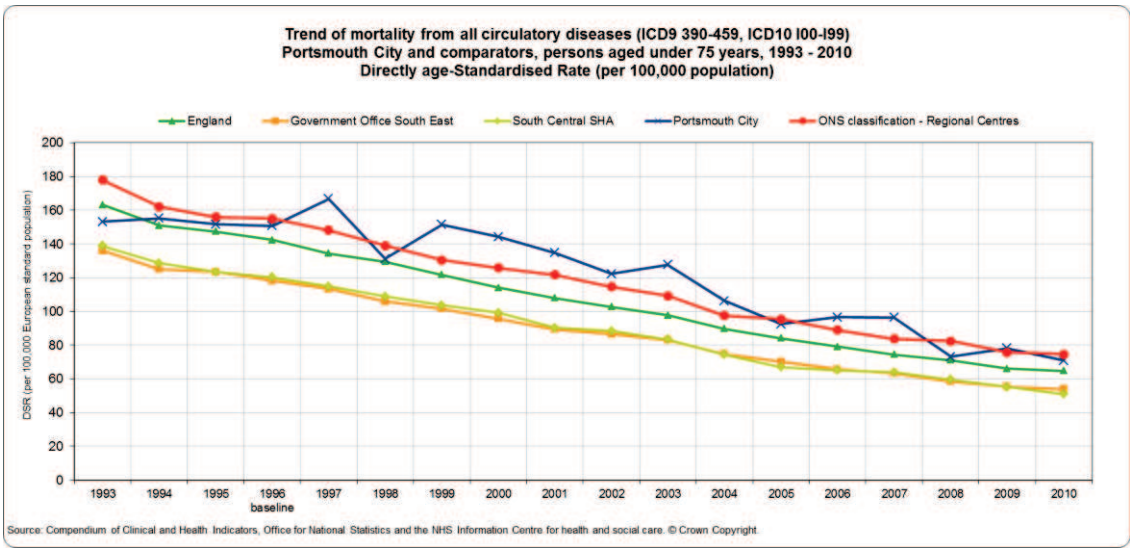
3.6.4 Be a healthy weight - Obesity prevalence is estimated – 23.8% of Portsmouth adults are estimated to be obese (not significantly different to England). However, we do not have enough information about adult obesity in the city – particularly what motivates people to keep to a healthy weight

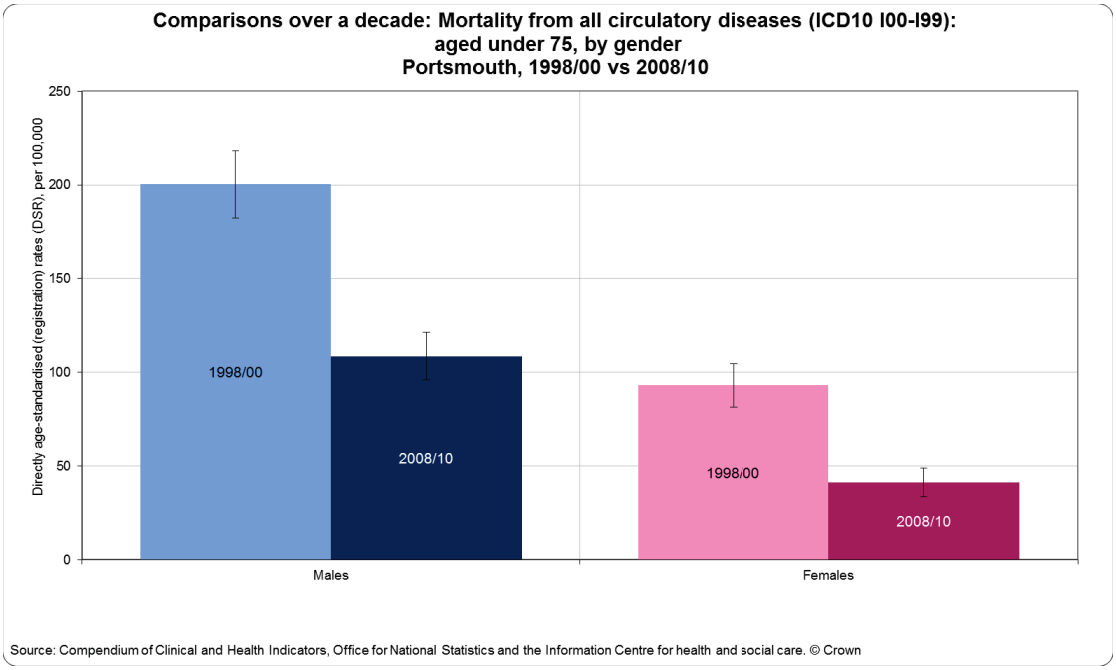
A Healthy weight strategy is currently in development with a main theme of 'making the healthy choice, the easy choice'.

3.7 **Mortality**

8.7.1 Mortality from circulatory disease aged under 75 years.

Premature mortality rates are improving but Portsmouth's rate is again higher than the England average.

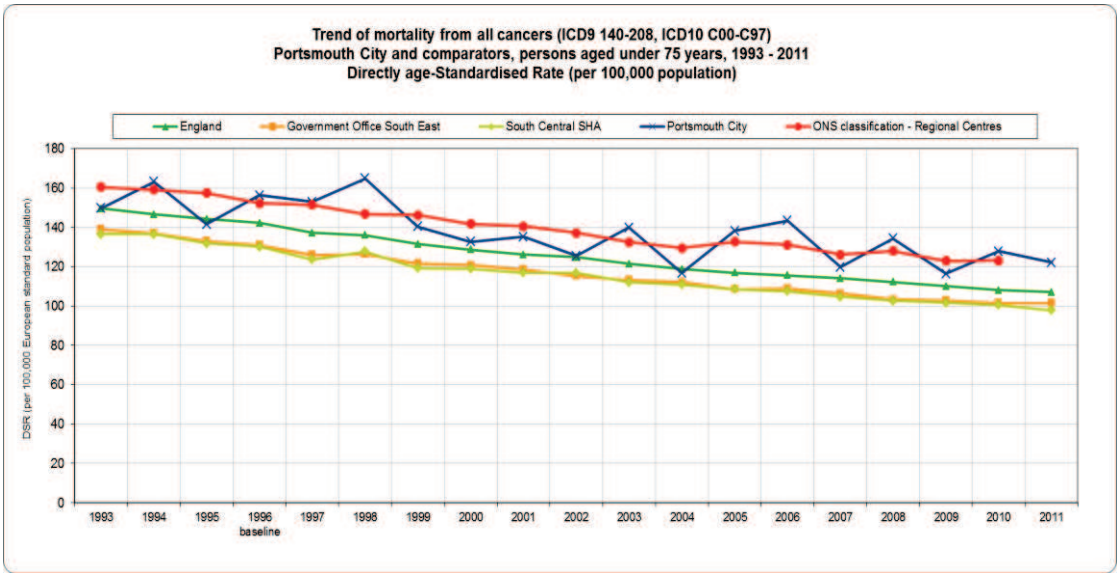


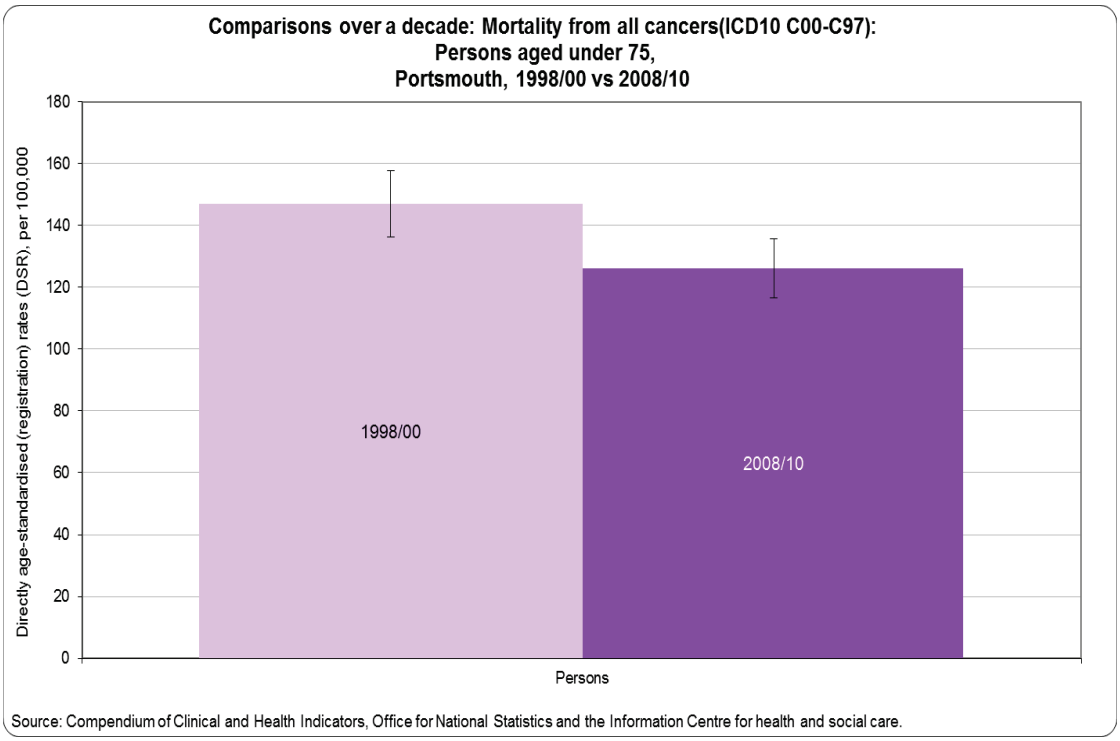


Circulatory disease premature mortality rates have improved for males and females but the male rate has yet to reach the level of the female rate 10 years ago.

3.7.2 Mortality from all cancers

Premature mortality from cancer has also declined





3.7.3 Respiratory disease

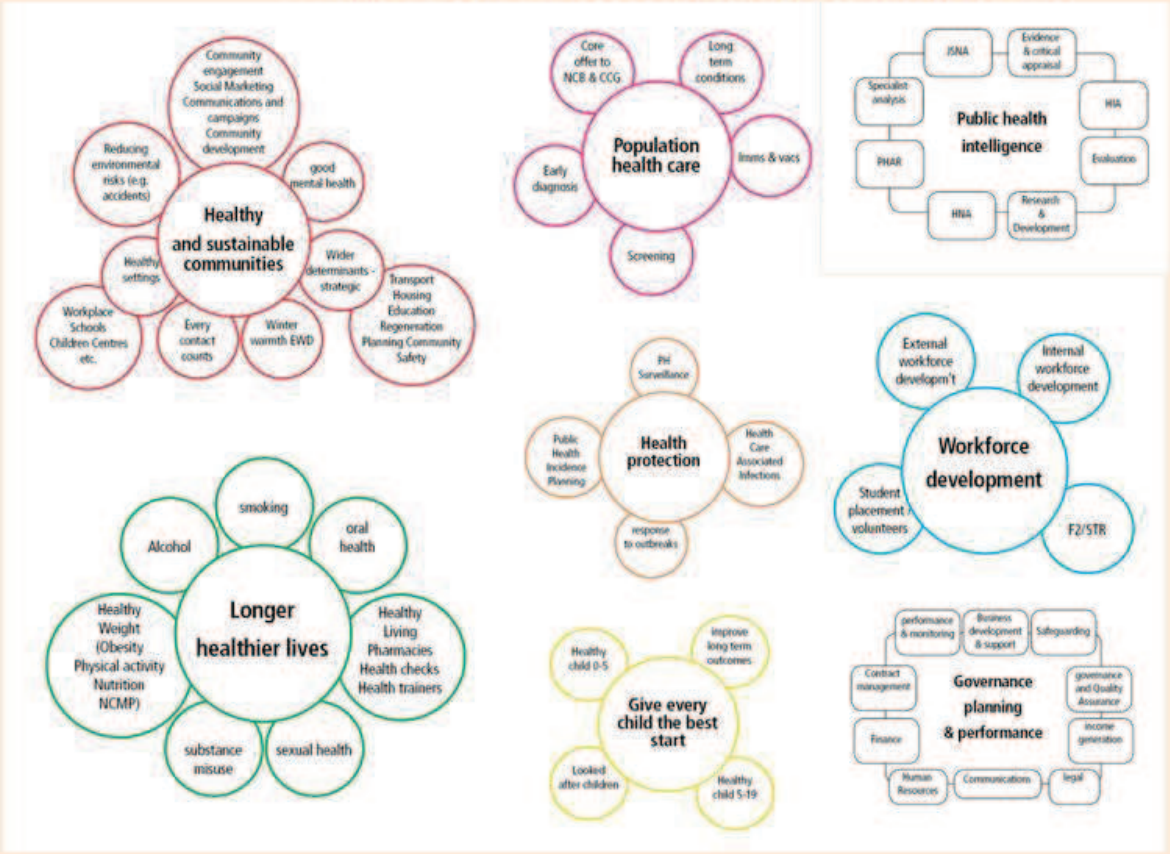
Compared to England, Portsmouth has significantly higher rates of premature mortality due to respiratory disease and of premature mortality from respiratory disease considered preventable. Respiratory diseases contribute 18.1% of the gap in female life expectancy between Portsmouth's least and most deprived quintiles, and 14.8% of the male gap in life expectancy.

3.8 The Summary also looks at good mental health, diabetes, adults with a learning disability, issues affecting older people, carers, excess Winter deaths and dementia.

Portsmouth CITY COUNCIL

Appendix 2

Public Health Portsmouth Operating Model



Transferred Staff

20 posts
17.74 FTE (5 vacant but 3 filled temp)

HIDS
18.74 FTE

Designed to provide a more flexible way of working

www.portsmouth.gov.uk

Portsmouth Hospitals NHS Trust

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Ursula Ward MSc MA
Chief Executive

Chair, Health Overview & Scrutiny Panel
Customer, Community & Democratic Services
Portsmouth City Council
Civic Offices
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PO1 2AL

4 October 2013

Dear Chair

Update letter from Portsmouth Hospitals NHS Trust

I write to provide the Health Overview Scrutiny Panel with an update from Portsmouth Hospitals NHS Trust to reflect some of the important challenges in the year to come and also to share some of our recent achievements.

Since April the local NHS landscape has seen lots of change and we are now commissioned by new GP Clinical Commissioning Groups (CCGs). I am pleased to say that much work was done in the transition stage to position ourselves as a provider of choice. We remain committed to delivering world class services to our local population to best meet their health needs.

We have continued to evolve our services and further improve upon the patient experience. Here is a flavour of some of our work since my last update to the Panel:

- The 2012 inpatient survey published by the Care Quality Commission (CQC) asked the views of adults who had stayed overnight as an inpatient in June 2012. Patients were asked what they thought about aspects of the care and treatment they received at Queen Alexandra Hospital. We are proud to be achieving better than average performances on most of the categories looked at in this survey.
- The trust has won the CHKS Top Hospitals programme patient safety award 2013. The CHKS Top Hospitals awards celebrate the success of healthcare providers across the UK and are given to acute organisations for their achievements in healthcare quality and improvement. The patient safety award recognises outstanding performance in providing a safe hospital environment for patients and is based on a range of indicators, including rates of hospital-acquired infections and mortality.
- We have taken delivery of our da Vinci surgical robot. There are just 14 high-definition da Vinci surgical robots in the country. Queen Alexandra Hospital is unique as it will now perform robotic surgery across a wide range of surgical specialties including colorectal, head and neck, urology and gynaecology patients. Manufacturer da Vinci specifically chose Portsmouth as a European training centre as we have the best quality outcomes and survival rates for laparoscopic surgery on colorectal patients, contributing to 24 per cent of colorectal surgery in the UK and completing over 1,500 operations to date.
- A state-of-the-art Bard Encore Enspire device has recently been purchased as a diagnostic tool for patient breast biopsies. The service offers women in Portsmouth, and the surrounding areas, a much improved breast tissue sampling experience with a far higher likelihood of pre-operative diagnosis in a single procedure. The Portsmouth Breast Unit is the first in the South of England to offer a service of this

nature and now has a platform on which to base further key service developments in the future.

- Clinical research is on the rise in the NHS and the trust is helping to spearhead the trend, ranking highly in a new national league table. Clinical research is a vital part of the work of the NHS and provides evidence about "what works" so that treatments for patients can be improved. In addition, there is some research evidence to show that patients do better in hospitals and surgeries that do research – even if they don't actually take part in a study themselves. We increased our number of studies from 126 in 2011 to 2012 to 137 in 2012 to 2013.
- The Care Quality Commission (CQC) recently published the trust's inspection report which confirmed our full compliance in the standard of care offered, following their unannounced external inspection on the 16 May 2013. Throughout the inspection the CQC looked at the personal care and treatment records of the people that use our services, and spoke to patients and their loved ones to assess how they were cared for. They were accompanied by a pharmacist, a specialist advisor and a person that has experience of caring for someone who uses similar services. The inspection assessed our discharge process and spent time in our discharge lounge, pharmacy and various wards within the Medical Assessment Unit (MAU). The report also states that a patient's dignity, privacy and independence was respected, and the care and treatment offered was planned and delivered in a way that was intended to ensure people's safety and welfare.
- The trust has won a Department of Health fund to improve the hospital's environment for people with dementia. The work will take place in four wards within the Medicine for Older People Clinical Service Centre. Hospitals and care homes across the country submitted dementia improvement initiatives to the Department of Health earlier this year in order to receive a share of a £50 million national fund that was offered to create pioneering care environments for those with dementia across the country. We will receive £466,382.00 for our project. We recognise the magnitude of the challenge that dementia presents and through our dementia strategy, and with the help of the DH funds, we will deliver a high quality, person-centred dementia care package that enhances the quality of life and wellbeing of patients with dementia and their carers.
- The recently published Friends and Family test score for the trust shows that our emergency department scores are significantly better than the national average, which indicates that patients are satisfied with the treatment received in the department. Our inpatient scores sit on or around the national average, so we recognise that we still have some work to do. The national survey, which will grow into the most comprehensive ever undertaken, covers around 4,500 NHS wards and 144 A&E services. It allows hospital trusts to gain real time feedback on their services down to individual ward level and increases the transparency of NHS data to drive up choice and quality.
- Figures published in NHS Blood and Transplant's *Organ Donation and Transplantation Activity Report 2012/13* confirmed that 78 of our patients received a life-saving or enhancing transplant during 2012/13. Queen Alexandra Hospital accounted for 2.6 % of all kidney transplant operations carried out across the UK. The Portsmouth and Wessex renal transplant centre performed 27 living kidney transplants. At the end of March 2013, 235 of Queen Alexandra Hospital patients were still on the waiting list for a kidney transplant.
- We are delighted that we continue to out perform others in the achievement of quality indicators for hip fracture care from the National Hip Fracture Database (NHFD) Report 2013, indeed ranking first in the results. Patients with a hip fracture needs to be seen without delay and carefully organised to get them in a state ready for surgery. By quickly stabilising patients and ensuring that expert clinical teams respond to their frail conditions and complex needs, the most positive outcomes can be achieved. For many patients best practice care from the moment they arrive at hospital, can make the difference between independence and even life and death. The trust treated 736 patients with hip fracture in 2012/13 and in terms of numbers is ranked first against achieving the components of best practice.

- We have also performed highly in the first publication of Patient-Led Assessments of the Care Environment (PLACE) results. All of our scores were significantly higher than the national average for all quality markers, showcasing the hospital's high standards. The PLACE survey looks at a range of non-clinical services which contribute to the environment in which healthcare is delivered in the both the NHS and independent/private healthcare sector in England.

We have recently undertaken in-depth business planning, helping to ensure our long term financial sustainability and looking at a programme of cost efficiencies. As previously detailed we continue to face very challenging times as government policy looks to save £20bn from across the NHS and locally our health economy is facing an increased demand for services without additional resources. These are tough times for all hospitals, and in Portsmouth we are working hard to ensure our long term sustainable financial position, which will help us to achieve foundation trust status.

The difficult decisions we are taking now will put us in a stronger position to enable us to continue to deliver high quality services to our patients going forward. Our funding levels for 2013/14 have required us and other hospitals up and down the country to achieve internal efficiencies of 4%. Taken together our underlying financial position and the requirement for new efficiency savings represent a sizeable financial challenge.

We have therefore embarked on a major transformation programme to respond to this. Whilst it will take some time to fully embed we are making some good progress. We have engaged with our medical workforce to give us sizeable cost efficiencies in rescheduling their work planning. Together we will reduce the amount of paperwork and administration that top clinicians have to do, to better enable them to return to front line patient care. Putting the patient first and using clinician's skills to best effect will ensure our focus is on the patient experience and outcomes.

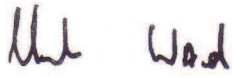
We are similarly enabling more time for our nursing colleagues to get back on to the wards, meaning less time spent in meetings. This re-focus is releasing our valued nursing staff at all levels, giving more time for their care and compassion direct to our patients, which is being warmly welcomed.

An efficiency work stream is looking to avoid waste and duplication within the organisation. One example is running our operating lists in a more business like way, keeping waiting times to a minimum on the day of a patient's operation and making sure clinics are run to full capacity. Another initiative is focused on our bed utilisation, looking at the length of stay of our patients, the best use of this expensive resource and making sure we have beds in the right place at the right time.

All of this work has been endorsed by the Trust Development Authority and we are on course to save £5million through this transformation work, which will help us return to a sustainable surplus in 2014/15.

Finally, we are opening our doors to the public to go behind the scenes and witness for themselves, the fantastic work of the NHS. This year's open day is set to be a great success with many exhibits and tours. A warm invite is extended to the Panel to attend on Saturday 5 October 2013 between 11am and 3pm.

Yours sincerely



Ursula Ward MSc MA
Chief Executive

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Southern Health NHS
NHS Foundation Trust

Solent NHS
NHS Trust

Portsmouth Hospitals NHS
NHS Trust

Community Assessment Lounge

Acknowledgments:

Solent NHS Trust.
Southern Health NHS Foundation Trust.
Portsmouth Hospitals NHS Trust.

Contents

Executive Summary

The Community Assessment Lounge (CAxL) is provided as part of a commissioned community pathway developed specifically to target admission avoidance within the Emergency Department (ED) at Queen Alexandra Hospital (QAH) in Portsmouth. The Community Assessment Lounge provides a clinician led specialist community assessment service, to enable the safe, timely transfer of care of patients who do not require hospital admission back to the community with a support plan that addresses their immediate and longer term health and social care needs.

The primary aims of the service are to:

- Provide active comprehensive community assessment to facilitate a timely and safe transfer from the Emergency Department to the patient's usual place of residence or to a rehabilitation or re -enablement environment if appropriate.
- Plan and co-ordinate immediate packages of care to enable a timely and safe discharge to the patient usual of residence to maximise their functional potential and regain/maintain their optimal level of independence.
- To provide timely, comprehensive, person centred assessment and intervention
- Provide a safe, quality service that promotes dignity and supports choice for people
- To minimise the need for acute admission
- Prevent avoidable admissions to acute hospital where a medical assessment has been carried out and a diagnosis has been established.
- Facilitate timely transfer of care following presentation at the Emergency Department

The service is provided as an integrated commissioning approach between Solent NHS Trust, Portsmouth Hospitals NHS Trust and Southern Health NHS Foundation Trust with close interdependencies with ED, MAU, CEDT, Virtual Wards, and the wider health and social care community.

The key focus of activity for the service is that cohort of patients who have received a medical assessment, have a diagnosis, are deemed not to require hospital admission but who require an immediate response from community health and /or social care services to enable them to be discharged from the Emergency Department. The presence of the Community Assessment Lounge enables the immediate transfer of care from the ED Team to a space within ED where needs based assessment can be completed and the appropriate community response activated for those patients. Patients may be referred directly into the Lounge by the ED nursing and medical team, or following assessment by the Community ED Team in ED, the Observation Ward or MAU.

1. 0 Introduction

The purpose of this report is to review the first six months of the CAxL. The Lounge opened on Dec 10th 2012 with full co-operation from all three provider Trusts in Portsmouth & SE Hants in addition to full Commissioner support. This report covers the time period from Dec 10th 2012 to May 31st 2013 inclusively.

This report will cover a variety of metrics broken down to show current performance.

Agreed expected outcomes are as follows:

- To support a reduced admission rate to the ED Observation Ward and Medical Assessment Unit where acute admission was previously unavoidable.
- To enable patients to be assessed in the most appropriate setting and supporting patients in making decisions about their future thus increasing the number of discharges directly from the PHT ED Department.
- A reduction in avoidable emergency admissions and re-admissions.
- To reduce number of 4 hour breaches within the ED.

To date (31st May 2013) ***1004*** have been assessed in the CAxL with ***587*** pure admission avoidances and **417** assisting with flow through the ED/MAU/wards.

The Community Assessment Lounge has received positive feedback from both staff and patients.

2. 0 Service Model

The Community Assessment Lounge is delivered from designated space within the Emergency Department. It is operational between the hours of 09.00 – 21.00 hours over seven days. The service is provided by a Band 6 Nurse and a Band 2 Health Care Support Worker with dedicated admin support. Clinical and operational support is provided by the Community Matrons within the Community ED Team

Solent NHS Trust is currently recruiting to an 8a Clinical Manager role. This individual will oversee the operational management of the CAxL and CEDT.

During the time frame of this report the CAxL was lead by an 8b Senior Physiotherapist who was responsible for leading the mobilisation of the service and providing direct operational support. Management oversight and leadership will transfer with effect

from 01.06.13 to the Solent NHS Trust Locality East Community Healthcare Services Business Unit.

3. 0 Current Annual Financial Costs

Wte	Role	Cost
0.61 wte	Band 8a Clinical Manager	£39,247
3.16 wte	Band 6 Nurses	£136,782
3.16 wte	Band 2 HCA	£71,049
1.21 wte	Band 2 Admin Support	£27,212
	Catering Cost	£6,570
	IM&T	£6,000
	Patient Transport	£24,840
	Property & Estates	£22,843
	Corporate Overheads	£5,756
		TOTAL £340,299

The cost of the CAxL for the 6 months from Dec – 31st May was **£170,150**.

4. 0 Numbers/Metrics & Findings

The Community Assessment Lounge became operational December 10th 2012 to

The metrics agreed upon were as follows, these have been captured since January 2013:

Table 1: CAxL Performance Metrics

Actual Daily Admission Avoidances
Actual CAxL triages in MAU/Obs 10pm-10am - CAxL + CEDT
No. of patients arrived in CAxL before 4 hour breach.
No. of patients arrived in CAxL after 4 hour breach.
Actual No of patients 'PULLED' from MAU/Obs/wards
TOTAL No of patients seen in CAxL

Table 2: Total number of Admission Avoidances

December (from 12th Dec)	52
January	105
February	99
March	116
April	106
May (up to 27th May)	109
TOTAL ADMISSIONS AVOIDED	**587**

Table 3: Time patient arrived in the CAxL (12th Dec – 31st May)

	December	January	February	March	April	May	TOTAL
09.00 - 10.00	16	4	25	26	32	28	**131**
10.00-11.00	10	28	30	16	34	32	**150**
11.00-12.00	10	16	11	21	30	22	**110**
12.00-13.00	8	16	12	19	17	18	**90**
13.00-14.00	8	15	9	17	18	8	**75**
14.00-15.00	9	18	24	16	16	20	**103**
15.00-16.00	10	12	8	11	4	12	**47**
16.00-17.00	11	18	12	12	15	16	**84**
17.00-18.00	6	21	13	20	9	25	**94**
18.00-19.00	5	15	7	14	14	13	**68**
19.00-20.00	0	4	4	7	6	12	**33**

20.00-21.00	0	3	2	4	4	4	**17**
21.00-22.00	0	2	0	0	0	0	**2**
							Total 1,004

Figure 2: Patient Attendance by Time (12th Dec – 31st May)

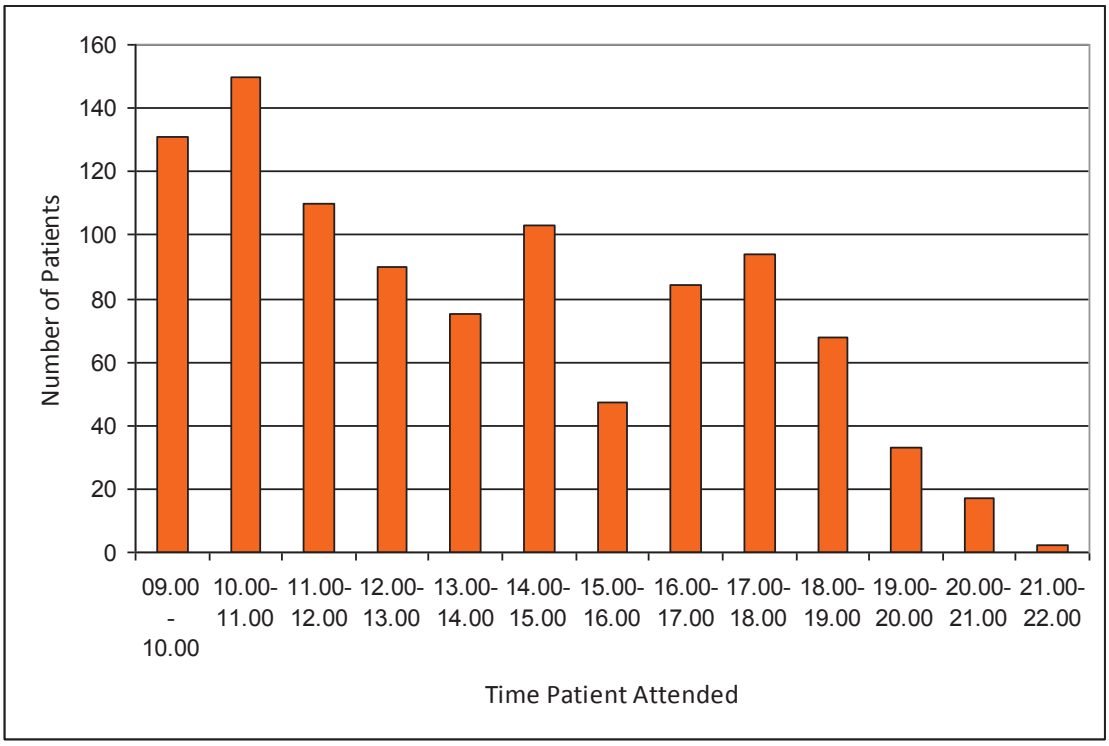

Table 4: CAxL patients by area (12th Dec – 31st May)

	December	**January**	**February**	**March**	**April**	**May**	**TOTAL**
Hampshire	60	100	93	110	131	142	636
Portsmouth	27	61	54	67	81	69	359
Other	2	0	3	2	1	1	9
						TOTAL	**1,004**

Figure 3 : Discharge destinations of patients seen in the CAxL (12th Dec – 31st May)

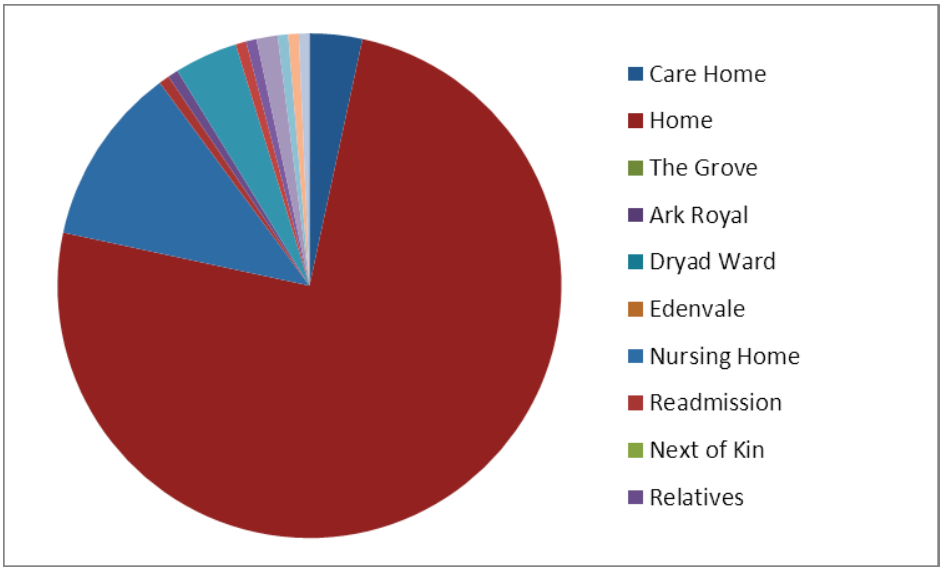

Table 5: KPI update from Dec 2012 – 31st May 2013

4 Hour Breach Target	
Total number of patients who arrived in CAxL before the 4 hour breach *(data was collected from Feb onwards & only applicable to patients who attended the CAxL from Minor/Majors)*	499
Total number of patients who arrived in CAxL after the 4 hour breach *(data was collated from Feb onwards & only applicable to patients who attended the CAxL from Minor/Majors)*	178
Patients 'Pulled' by the CAxL from MAU/Obs	
Total number of patients 'Pulled' from Obs	374
Total number of patients 'Pulled' from 'Other'	13

Total number of patients 'Pulled' from MAU	30
Total number of patients 'Pulled'	**417**

5. 0 Patient & Staff feedback.

Patient surveys have been undertaken since January that have asked questions about the quality of the service, privacy & dignity, advice and information and overall experience of their stay in the CAxL. By far the majority of the responses are positive with many patients commenting positively about the ethos and attitude of the staff, all privacy and dignity, and the information they were provided with. The CAxL has received no complaints to date.

Examples of patient feedback:

"Just to say thank you for the excellent care"

"Many thanks, really excellent care. The dignity of my 95 year old mother was carefully considered"

"We were amazed at the kindness, competence and care received whilst in the Lounge. Many thanks to all concerned"

"Staff were very friendly and supportive although they were busy and made my brother feel that they cared"

"I would like to say every one was so kind and caring to me and my mother"

"Treated with kindness and respect"

"It was a scary situation for me but everyone in A & E and the Assessment Lounge were super and kindness itself"

Examples of staff from ED feedback:

"Very useful, friendly, effective service and have prevented unnecessary admission to hospital multiple times"

"This service makes a huge difference to flow in A/E also enabling quick discharges when appropriate. Definitely a great service which department needs due to its high turnover"

"Very good, stay very professional. Aids inpatient flow and avoiding Obs ward admission"

"CAL has assisted me greatly in the safe management of a number of elderly patients"

"Very helpful service. Would like CAxL to stay"

"Excellent service and much appreciated by patients when they are told they are to have discharge assessment in there. Reduces stress on minors re discharge among practitioners and nursing staff"

6. 0 Next Steps

- Confirm recurrent funding from the commissioning organisation
- Evaluate financial efficiencies of the scheme
- Recruit to substantive posts
- Merge management and performance lines of the Community ED Team and Community Assessment Lounge to improve governance and service provision
- Work with PHT and Southern partners to integrate the Community Assessment Lounge with proposals relating to the expansion of Ambulatory Care and the Urgent Care Centre

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Solent NHS Trust

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23 September 2013

Councillor Peter Eddis, Chair
Portsmouth HOSP
Conference Room A
Civic Offices
Guildhall Square
Portsmouth
PO1 2AL

23 September 2013

Dear Councillor Eddis,

Re: Update letter from Solent NHS Trust

Please find below an update on activities at Solent NHS Trust ahead of the HOSP meeting on 17 October 2013.

Integrated Business Plan and Operating Plan 2013/14
Attached to this update is a copy of our five year Integrated Business Plan and our Operating Plan for 2013/14.

The Integrated Business Plan describes the work we will undertake, over the next five years, to achieve our vision: *To lead the way in local care*. It also includes information regarding our clinical strategies for our Adult Services, Adult Mental Health Services, Child and Family Services, Sexual Health Services, and Health and Wellbeing Services. You will also find attached a copy of our Operating Plan which describes the work we will do in 2013/14 to ensure we provide safe, effective and timely care consistently and reliably.

We hope you find these documents useful and that they provide you with a good overview of our plans for the future.

Foundation Trust status
We are in the final stages of our journey to become a Foundation Trust (FT). We entered the Monitor assessment phase on 24 July 2012. The assessment phase can last 3-5 months and will check our readiness to become a Foundation Trust. Our Board to Board with Monitor is due to take place on 3 December

2013, after which they will decide if we are ready to be licensed. We will continue to update you about the Monitor phase of our Foundation Trust journey.

Membership recruitment and engagement
We are currently ahead of schedule in terms of our overall membership figures. At the time of writing we have recruited over 6,700 public members. We are now focussed on recruiting the final 300 members in order to meet our target of 7,000 public members by the end of December 2013. Our focus remains on young people aged 14-16 and men.

We are very keen to communicate and engage with our membership. We regularly keep them informed through our 'Shine for members' newsletter, as well as via emails. I have attached the latest edition of 'Shine for members' for your information.

A number of our members have engaged with us by taking part in various panels including our virtual patient literature group. This group of people check all new patient leaflets for ease of reading and understanding. In addition, we invited some members to read and comment on the Quality Account. Members were also asked to assist in the annual PLACE inspections, the new system for assessing the quality of the patient environment, replacing the old Patient Environment and Action Team (PEAT) inspections.

We are currently exploring ways in which we can involve our younger members in campaigns within our Sexual Health Service, for example, setting up a new forum to ensure young people's views are known and that messages are targeted correctly to reach this key group of service users.

Council of Governors
The elections for our Council of Governors close on 27 August 2013.

The following public Portsmouth candidates, who will represent our Portsmouth members, were successfully elected:

David Stephen Baker
Narcisse Kamga
Michael North
Paul Rolfe
Sharon Ward

As well as our 14 elected public governors, five staff governors and six appointed governors form the Council, which will play an important role in engaging with our members, and representing their views to help shape the future of services provided by the Trust.

The full election results can be found on our website at www.solent.nhs.uk/membership.

Portsmouth City Integration Pioneer
In June 2013 we worked with Portsmouth City Council, Portsmouth Clinical Commissioning Group and Portsmouth Hospitals NHS Trust (PHT) to write an expression of interest for Portsmouth City to become an 'integration pioneer'.

The expression of interest outlines how we will work closely together in an effort to deliver better outcomes for local people. The bid outlines our vision: 'for everyone in Portsmouth to be supported to live

healthy and independent lives, with care and support that is integrated around the needs of the individual at the right time and in the right setting'.

The organisations already work closely together on a wide variety of joint service ventures including the Portsmouth Rehabilitation and Reablement Service and the Community Assessment Lounge.

We were delighted to have been one of the twenty health economies shortlisted to the next stage of the process and subsequently attended an interview and presentation in early September. We will hear if the city of Portsmouth has been chosen as an Integration Pioneer during October.

Supporting the Emergency Department

As part of the national money available from NHS England to support Emergency Departments across the country, we submitted a number of community orientated service initiatives.

We are pleased to announce that NHS England have supported a number of our initiatives including:

- **Community Assessment Lounge (joint bid with Southern Health):** The monies awarded will continue to fund the CAL until the end of the financial year. The service will continue to help avoid acute admissions of patients with complex co-morbidities.
- **Psychiatric Assessment (joint bid with Southern Health):** This additional resource will enhance the current Older Person's Mental Health and Adult Mental Health Psychiatric Liaison Service.
- **Inreach support (joint bid with Southern Health):** Delivered in partnership with Southern Health, this service will facilitate early supported discharge and ensure that clinically stable patients are transferred back into the community.

Wheelchair Services

We currently provide Wheelchair Services to people living in Portsmouth, Southampton, South East Hampshire and in some parts of West Hampshire. In 2012 we served notice to our commissioners. Our contract is due to end at the end of the financial year.

A number of commissioners have issued a joint tender for the provision of Wheelchair Services in Eastleigh, Chandlers Ford and Winchester, in addition to the areas served by the Trust. We are currently reviewing the opportunity to provide a Wheelchair Service over the wider geographical area and are examining the opportunity of bidding for the service with an additional provider.

Podiatry

The Trust's Podiatry Service is currently experiencing increased demand. To ensure we can continue to provide a timely service to all of our patients, we are currently looking at clinical capacity. We are examining all of our options to ensure the needs of all parties who use clinical podiatry space in Portsmouth are accommodated.

If you have any questions regarding any of the issues mentioned in this correspondence, please contact Kirstie Henry on 023 8060 8889 or email kirstie.henry@solent.nhs.uk or contact me direct as above

Yours sincerely,

Ros Tolcher.

Dr Ros Tolcher
Chief Executive

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Unit 3, St Georges Business Centre
Portsmouth
PO1 3EY
Email: Info@healthwatchportsmouth.co.uk
Tel: 02393977079

Dear members,

Healthwatch Update to the Health Overview and Scrutiny Panel (HOSP) 17th October 2013

Thank you for the invitation to update you on the progress of Healthwatch Portsmouth so far.

Healthwatch Portsmouth is now up and running and we are providing the services required of us in the Health and Social Care Act 2012 which are:

1. Information and signposting services for health and social care services in Portsmouth
2. NHS complaints advocacy services (helping people through the complaints process)
3. Community engagement and recording local people's views on services and also enacting change.

We have been fully established since May 2013 and are beginning to build up our services and the awareness of Healthwatch in the city.

Our work so far:

- 149 people helped to find the correct local service in Portsmouth through our information service.
- The Healthwatch network has grown to 2,132 people and 407 local services have now been mapped on the Healthwatch website.
- We have helped or are currently supporting 15 people through the NHS complaints process.
- We have made 2 official requests for information from service providers and have made 1 visit to a health care provider.
- We have weekly outreach events and visit groups throughout the city to gather views and experiences of health and social care services.

Key outcomes so far:

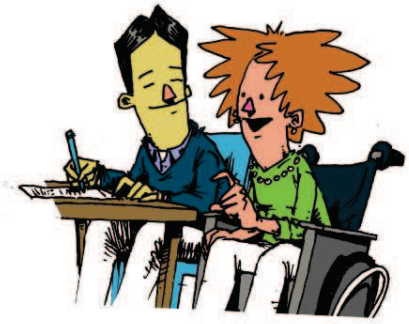
- The Healthwatch interim board have identified key priorities for the year that link with the Clinical Commissioning Group and Health and Wellbeing Board priorities. They are:
    - Principles of good engagement and consultation
    - The Dementia Pathway
    - Integrated Care Pilot Projects
    - Portsmouth response to the Francis Report and other national reports

- Healthwatch Portsmouth has provided service user feedback and consultation around the service user charter being developed by the integrated commissioning unit and clinical commissioning group. This project also included an engagement event on the 16th October and has added a lot of value to the work of our partners.

- We are also playing a role in raising local issues to decision makers; such as the problems being faced by local people being reassessed from ESA benefit funding and the issue around the GP violent patient scheme.

- Healthwatch Portsmouth is also in discussion to work closer with the Portsmouth Independent Living Network and Adult Social Care on their information provision.

- We have also been in close contact with the CQC about local issues and complaints and now feed into their procedures around serious incidents that include patient feedback.



How can Healthwatch assist in HOSP functions?

- Many of the services we offer can be of benefit to members of the public that come to HOSP with individual issues or complaints and we are happy to receive referrals.

- As we progress in our work we will be identifying trends and issues that arise and will feed those into the HOSP group for consideration.

- We are also happy to consider joint work projects around issues identified by either Healthwatch or the HOSP which could include the Healthwatch network and our community research volunteers.

I am happy to answer questions on any of the above issues at the meeting.

Yours sincerely,

Steve Taylor

Steve Taylor
Manager
Healthwatch Portsmouth

Report to: Health Overview & Scrutiny Panel

Date: 02 October 2013

Report by: Claire Budden, Senior Programme Manager

Presented by: Claire Budden, Senior Programme Manager

Subject: **Continuing Health Care – Section 75 Agreements**

1. Purpose of the Report

1.1 To update the Health Overview and Scrutiny Panel on the integration of the local authority and health teams dealing with Continuing Healthcare assessment and commissioning within the City, following the September 2012 report.

2. Recommendations

2.1 That the Health Overview and Scrutiny Panel note the content of this report.

3. Background

3.1 Under the NHS Act 2006 local authorities and Clinical Commissioning Groups (CCG) can enter into partnership arrangements to provide a more streamlined service and to pool resources, if such arrangements are likely to lead to an improvement in the way their functions are exercised. These powers give rise to the three Health Act "flexibilities", namely:

- Pooled budgets.
- Lead commissioning.
- Integrated provision.

3.2 NHS Continuing Healthcare (CHC) and local authority social care are commissioned from largely the same care home and home-based care providers. The development of the Personal Health Budgets programme also means that the CCG and PCC now share the same 'direction of travel' in terms of personalisation.

3.3 There are significant potential benefits in terms of continuity of care for the individual and also improved value for money from the CCG and PCC working together locally to develop integrated arrangements. In relation to the integrated CHC team the key issues are:

i) multi-disciplinary assessment and case/care management,
ii) hospital discharge,
iii) rehabilitation and reablement,
iv) personalisation, including Personal Health Budgets,
v) commissioning of care and support,
vi) end of life care.

4. Scope of Integration

4.1 The S75 agreements for CHC put in place in 2012 establish PCC as the lead commissioner and pooled budget holder for the CHC and funded nursing care

budget, supported through the integration of the CHC clinical assessment and social work teams, as well as the Council acting as the lead commissioner to commission services from third party providers.

5. Progress

5.1 Integrating the two partner organisation's teams and processes into a unified structure is a long term project but considerable progress has been made over the last year since co-location took place. By working in partnership we have harnessed the best of both organisations; the clinical leadership of the CCG and PCC's experience of commissioning and procurement - achieving better patient outcomes and a reduction in management costs and commissioning budgets.

5.2 Joint working has led to a significant decrease in cases being taken to review or appeal, and the combined structure has enabled resources to be used more effectively. The team have been through a period of process mapping their work to maximise efficiencies - this work will be ongoing and is supported by a unified IT system which has gone live for the service.

5.3 Through the use of a pooled fund we have achieved a budget underspend position for reinvestment in pre-agreed schemes such as: facilitating the roll out of a personal budget and brokerage service pilot, an extended telecare service, specialist rehabilitation services, and extended therapy services. These trials are designed to reduce the long term cost of care but more importantly to improve the quality of life for these individuals. It is too early to provide definitive statements as to their successes but we believe that the initial findings will support an extension of this work.

6. Next Steps

6.1 Reports on the activity and financial spend of the integrated team are produced and reviewed internally on a monthly basis, with quarterly benchmarking data providing a comparison between local and national data. The newly unified IT system will support more accurate and efficient data collection.

6.2 The project was recently shortlisted for a national HSJ Efficiency award and the judges commended the "*very impressive approach to joint commissioning and integration*".

6.3 True integration is an ongoing process and changing the way that the team support service users with increased personalisation and improving outcomes against a backdrop of financial challenges will continue to be developed over time. However all of the evidence around service user's feedback, staff feedback and budgetary work indicates that the team are working well.

THIS ITEM IS FOR INFORMATION ONLY

Portsmouth CITY COUNCIL

Agenda item:

Title of meeting:	Health Overview and Scrutiny Panel
Subject:	Report on 2011-12 five-year olds dental epidemiology survey in Portsmouth
Date of meeting:	17 September 2013
Report by:	Dr Jeyanthi John Consultant in dental public health (Wessex)
Wards affected:	All

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1. Requested by Health Overview and Scrutiny Panel

2. Purpose: To provide the Panel with:

An update on the position of the dental health of five-year olds in Portsmouth

3. The report attached has been produced by Public Health England in response to the release of the 2011-12 five-year olds dental epidemiology survey in Portsmouth

Public Health England

Report on 2011-12 five-year olds dental epidemiology survey in Portsmouth -

Executive Summary

This paper reports on the dental epidemiology survey of five-year-olds in Portsmouth. Overall the data indicated that 25% of Portsmouth children had experience of dental decay and 21% had dental decay which had not been treated. The levels of decay in Portsmouth children is not statistically significantly different from the previous survey and tooth decay remains a common disease in young children, with risks for pain, sepsis and having a general anaesthetic to remove teeth. Disappointingly, the proportion of children who participated in the survey has fallen which may affect the accuracy of the figures. There is a process on-going across Portsmouth schools to obtain “blanket consent” at school entry to obtain permission for dental examinations to be carried out throughout school life. It is anticipated that this will improve participation rates for future dental surveys and therefore improve the quality of data available.

Public Health England

1. Background and context

1.1 Dental epidemiology surveys of children are carried out in Portsmouth as part of a national programme of surveys coordinated by Public Health England. Children are examined by dentists from the local Community Dental Services who are calibrated to a common standard and trained to use a standard protocol. This facilitates comparisons of the oral health of Portsmouth children nationally with other areas. Locally, the surveys inform the commissioning of dental services by the Wessex Area Team as well as the Local Authority-commissioned oral health improvement programmes.

1.2 Participation in the national surveys has been low since the introduction of positive consent in 2006. Up to 2006, good response rates of 75% and above were achieved nationally. From the 2007-8 survey, children, who do not return a signed consent form, giving permission for them to participate in the survey, cannot be examined. Previous reports (NWPHO, 2009) suggest that parents of children living in areas of higher deprivation are less likely to return consent forms. Additionally, there is more absenteeism in more deprived areas, increasing the likelihood that these children are not at school on the days of the examinations. A combination of these factors affects participation rates across all children, but is particularly poor for children from more deprived backgrounds who are more likely to have experience of dental decay. The quality of data is dependent on the participation rate – if participation is low (less than about 75%), the data is less useful as a reflection of the state of oral health in that area.

1.3 The national data from the 2011-12 survey of five year olds was released by Public Health England on 20 September. Overall the participation rate for the five-year-old surveys across England fell from 75% in 2005-6 to 67% in 2007-8, with a further smaller drop to 65% in 2011-12. In the 2011-12 survey, only a small proportion of parents (5%) actively stated that they did not want their child to participate and absenteeism accounted for a further 5% of non-participation. Non- response to the request (about a quarter of the children approached) was the most common reason for children not participating in the survey.

Public Health England

2. Results for Portsmouth

2.1 The proportion of children in Portsmouth participating in the survey dropped from 70% in 2007-8 (67% for England) to 61% in 2011-12 (65% for England). As a comparison, the proportion of children examined in 2005-6, using negative consent or opt-out process, was 87% (75% for England). The data has to be viewed in the context of the proportion of children included in the survey.

2.2 Participation rates for the survey varied widely across schools ranging from 24% in Cottage Grove Primary School to 89% in Langstone School (Chart 1). Highbury Primary School was not surveyed. The participation rates in some of the schools were still low, even with two visits from the dental team to try and maximise participation (schools shown as red bars). For example only 42% of children in Flying Bull Primary School and 49% in Somers Park Primary School were examined even with two visits. The average consent rates for the five schools in the most deprived neighbourhoods is 42% compared to 70% for the five schools in the least deprived neighbourhoods. There demonstrates the relationship between response rates in relation to deprivation.

Chart 1

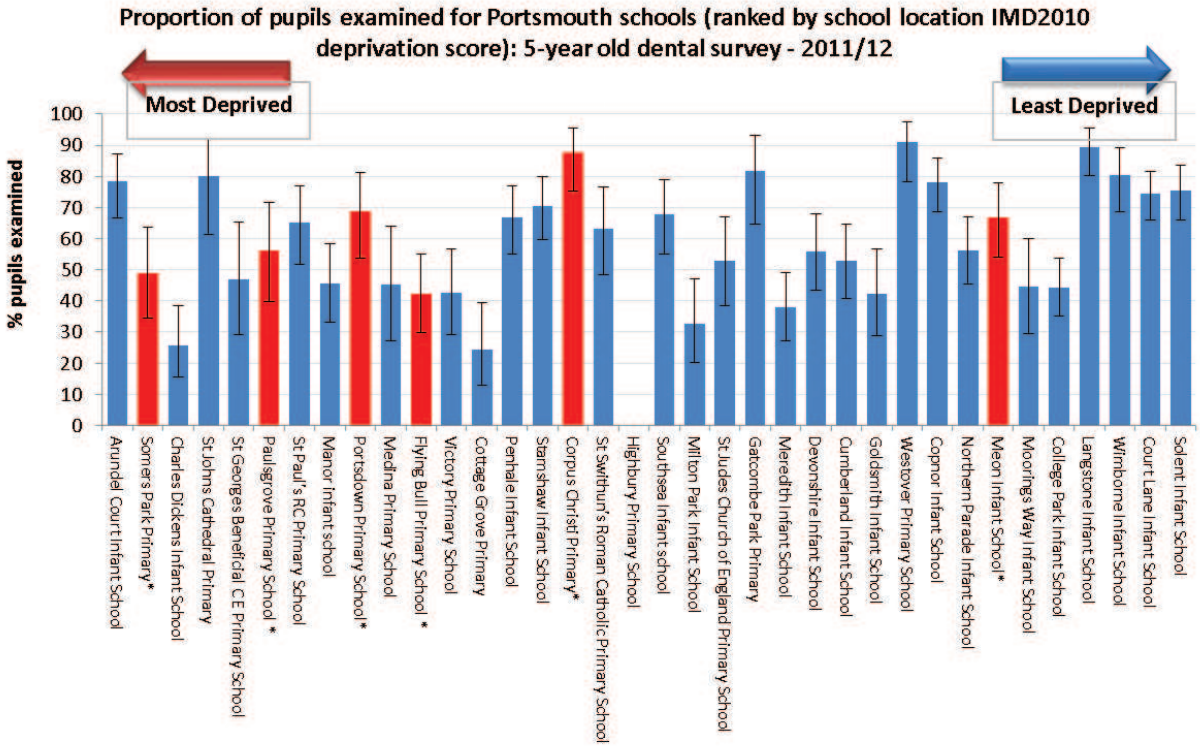
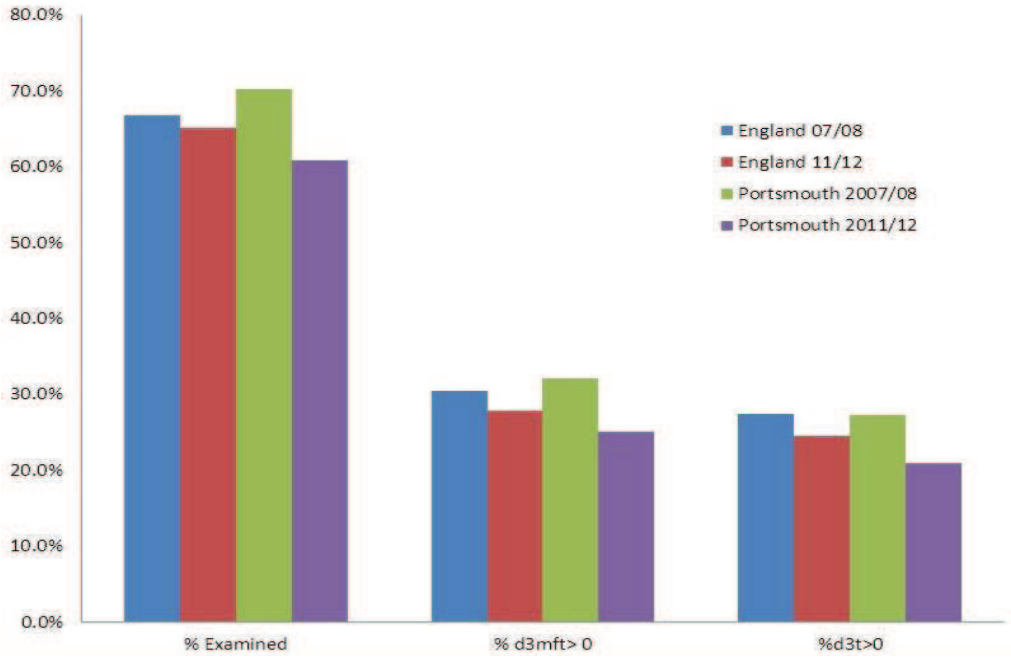


Chart 2 below shows the proportion of children examined in Portsmouth, 70% in 2007-8 to 61% in 2011-12 (67% in 2005-6 and 65% in 2011-12 for England). The chart also shows the proportion of children with experience of dental decay in Portsmouth (i.e. with decayed, filled or missing teeth) in 2011-12 was 25% (32% in 2007-8). The proportion of children with untreated dental decay was 21% in 2011-12 (27% in 2007-8). England data is included as a comparison and also shows a decline, although the difference is smaller than in Portsmouth.

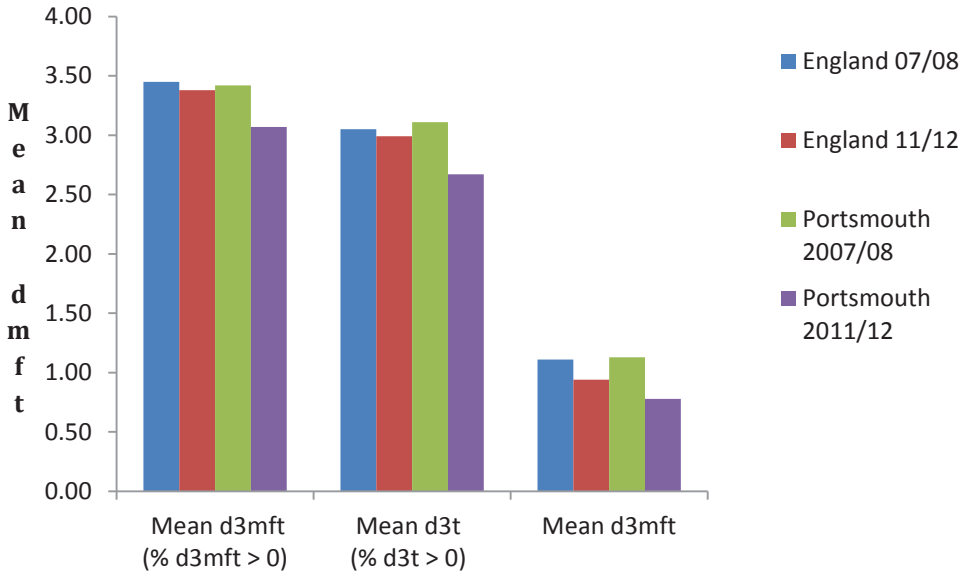
Chart 2: Proportion of children examined, with dental decay experience (%d3mft>0) and with untreated decay (%dt>0)



2.3 Chart 3 below shows the differences of mean number of teeth with experience of dental decay. The data indicates that overall Portsmouth children have an average of 0.78 teeth affected by dental decay (1.13 in 2007-8). If the children without experience of dental decay are excluded, the mean number of teeth affected by dental decay in the affected 25% of children is 3.11 (3.42 in 2007-8). The 21% of children with untreated dental decay have, on average, 2.67 affected teeth (3.11 in 2007-8) which may need treatment. England data indicates that there is a drop in these indicators but the decline is smaller than for Portsmouth.

Public Health England

Chart 3: Mean number of teeth with decay experience



3. Summary of Portsmouth data

3.1 Nationally, data indicated that dental decay rates across England have dropped between 2007-8 and 2011-12. It is postulated that this may indicate a true improvement due to increased use of fluoride toothpaste and fluoride varnish. However there is concern regarding the inequalities still present and the 28% of children nationally who still have dental decay. There were also wide variations in the state of dental health with areas of higher deprivation generally experiencing higher levels of dental decay.

3.2 Dental decay rates in Portsmouth appear to have fallen between 2007-8 and 2011-12. However, as there is a large decline in the proportion of children examined, this may not be an accurate reflection of the state of dental health in Portsmouth children.

3.3 About a quarter of five-year-old children examined had experience of dental decay by the age of five years and these children had, on average, three teeth affected by dental decay. Many of these children had untreated decay. These children are likely to be from more deprived backgrounds indicating the dental inequality which exists at this young age.

3.4 To improve dental health in young children, the focus needs to be on preventing dental decay. Once teeth are decayed, it is likely that other teeth will be involved. In young children, the option is often a general anaesthetic for extraction of the affected teeth. It is also known that once there is dental decay in primary teeth, it is likely that the child will go on to experience dental decay in their permanent teeth. If permanent teeth cannot be repaired (filled), they will have to be extracted resulting in permanent loss of these teeth.

3.5 As shown by the data, dental decay affects a significant proportion of these young children in Portsmouth. Generally, these children come from more deprived backgrounds adding to the health inequality which exists in the City. There is a need to address this inequality if the dental health for Portsmouth's children overall is to be improved.

3.6 Portsmouth has a strong programme to raise awareness and promote better dental health via supervised tooth brushing and individual targeted fluoride varnish schemes. These are continuing to prevent tooth decay and need to be sustained and built upon.

4. Future plans for dental epidemiology programme

4.1 The next national survey of five-year-old children will be in 2014-15. There is currently an on-going process across Portsmouth to get blanket consent at school-entry for permission to examine children throughout their school life. An opt-in approach is being used as required. As the forms requesting permission for dental examinations is going out with other forms required for school-entry, it is anticipated that there will be a good response rate. All head teachers received a letter from Portsmouth's Director of Public Health to advise them of this process. Permission will still be sought at the time of each dental examination, but an opt-out process can be used subsequently, which means that children can still be examined even if a signed consent form is not received at that stage.

4.2 This should improve participation rates across Portsmouth schools for the 2014-15 survey and give a better indication of the state of dental health of the City's children. This data can then be used to make decisions about appropriate interventions to achieve improvements to dental health at population level in Portsmouth.

4.3 There will be data available next year from the national survey of three-year-olds which has just been completed. Data will be available on Portsmouth's children which can be used to supplement the available information.

4.4 A national survey of children in special schools is planned for the 2013-14 academic year. This will be the first time that children in special care schools are being examined nationally and will provide important information regarding their dental health. The survey will help identify any inequalities with regard to the state of dental health and need for dental care in this very vulnerable group of children.

5. Improving dental health in Portsmouth

5.1 The dental health improvement programme in Portsmouth is on-going. The Portsmouth Dental Academy and Solent NHS Trust provide a targeted programme of supervised tooth brushing, topical fluoride varnish applications and healthy eating for young children.

5.2 The programme is reviewed regularly to take account of best available evidence and best practice from other areas.

Dr Jeyanthi John
Consultant in dental public health (Wessex)

Report written in collaboration with:

Lee Loveless
Advanced Health Improvement Practitioner
Public Health Portsmouth