Portsmouth CITY COUNCIL

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NOTICE OF MEETING

HEALTH OVERVIEW & SCRUTINY PANEL

THURSDAY, 22 MARCH 2018 AT 1.30PM

CONFERENCE ROOM A, SECOND FLOOR, THE CIVIC OFFICES

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If any member of the public wishing to attend the meeting has access requirements, please notify the contact named above.

Membership

Councillor Leo Madden (Chair)
Councillor Steve Wemyss (Vice-Chair)
Councillor Yahiya Chowdhury
Councillor Alicia Denny
Councillor Gemma New
Councillor Lynne Stagg
Councillor Michael Ford JP
Councillor Gary Hughes
Councillor Andrew Lenaghan
Councillor Mike Read
Councillor Elaine Tickell
Councillor Philip Raffaelli

Standing Deputies

Councillor Dave Ashmore
Councillor Ben Dowling
Councillor Lee Hunt
Councillor Ian Lyon
Councillor Tina Ellis

(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 Welcome and Apologies for Absence

2 Declarations of Members' Interests

3 Minutes of the Previous Meeting (Pages 3 - 10)

4 Adult Social Care - update. (Pages 11 - 18)

Andy Biddle, Acting Deputy Director, Adult Social Care will present the attached report.

5 Portsmouth Hospitals' NHS Trust - update. (Pages 19 - 30)

Chris Adcock, Director of Finance will answer questions on the attached report.

A report on the proposed move of the elective spinal service will follow.

6 Solent NHS Trust - update. (Pages 31 - 56)

Sarah Austin, Chief Operating Officer and Christopher Box, Associate Director of Estates and Facilities Management will answer questions on the attached report.

7 Sustainability Transformation Plan.

Richard Samuel, Senior Responsible Officer for the Hampshire and Isle of Wight Sustainability and Transformation Partnership will answer questions on the report that will follow.

Members of the public are now permitted to use both audio visual recording devices and social media during this meeting, on the understanding that it neither disrupts the meeting or records those stating explicitly that they do not wish to be recorded. Guidance on the use of devices at meetings open to the public is available on the Council's website and posters on the wall of the meeting's venue.

HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held on Thursday, 1 February 2018 at 3.05 pm at The Executive Meeting Room - Third Floor, The Guildhall

Present

Councillor Leo Madden (Chair)
Councillor Steve Wemyss
Councillor Yahiya Chowdhury
Councillor Alicia Denny
Councillor Lynne Stagg
Councillor Gary Hughes, Hampshire County Council
Councillor Andrew Lenaghan, Havant Borough Council
Councillor Philip Raffaelli, Gosport Borough Council

1. Welcome and Apologies for Absence (AI 1)

Apologies for absence had been received from Councillors Gemma New, Mike Read, Elaine Tickell, Michael Ford and Tina Ellis (as Cllr Ford's deputy).

Councillor Hughes advised he would need to leave at 4:20pm as he had another council meeting to attend in Hampshire.

2. Declarations of Members' Interests (AI 2)

Councillor Steve Wemyss declared a non-pecuniary interest as he works for the NHS.

3. Minutes of the Previous Meeting (AI 3)

RESOLVED that the minutes of the meeting held on 23 November 2017 be agreed as a correct record.

4. South Central Ambulance Service - update. (AI 4)

The report was introduced by Tracy Redman, Head of Operations South East. She explained that one of the major developments that had taken place since her last update was the National Ambulance Response Programme which had been piloted across the UK over the last few years and went live on 31 October 2017 with full implementation of the programme.

The idea is to make the service more efficient and puts the patient at the heart of everything. There are three key changes 1) it gives call handlers more time to determine what is wrong with the patient, 2) changes to staff rotas allowing staff to focus on the more serious patients by sending an ambulance only to the most poorly patients 3) changes to the categories of calls as detailed in the report.

In response to questions, the following matters were clarified:

- With regard to the performance indicators detailed on page 13, Ms Redman explained that the mean is the average response time which is the target. The mean national target for category 1 patients is 7 minutes. In November the mean for Hampshire was 7.17 and Portsmouth 6.03.
- The admission avoidance programme is working so far. SCAS covers the Thames Valley and Hampshire. South East Hampshire has 48% admission avoidance which is one of the best in the country for admission avoidance. SCAS is continuing to work on improving this. They are working with colleagues from occupational therapy for patients who may need medical assessment and trying to keep people in their homes as that is where they want to be.
- All staff receive an element of mental health training within their basic training which includes training on the Mental Health Capacity Act. These are mandatory training sessions for all staff. There is a mental health lead in the Trust. Mental health is a massive subject and they do not have capacity to ensure that all staff receive additional training on mental health.
- In response to a question on how well SCAS was achieving the new National Ambulance Response Times at a local/post code level, Ms Redman did not have the specific data with her on whether there are inconsistencies with different postcodes. Part of their remodelling is to look at where their assets are located but there will always be outlying areas where there are concerns. Ms Redman said she could provide this for the panel.
- SCAS have a satellite station in Gosport which is manned 24 hours a day.
- SCAS is now rated as good overall and Ms Redman was not specifically aware without going back to the CQC report whether they were still at Requires Improvement for response times.
- SCAS has a patient experience department that deals with complaints, compliments and concerns which are all recorded. If an investigation is required this will take place in the agreed timescales.
- With regard to avoidance and whether they had seen an increase of time with the patient to achieve the outcome, Ms Redman said the evidence suggested that it has not happened. With the remodelling they have put specialist paramedics in cars to the lower acuity calls who are likely to be signposted somewhere else ensuring appropriate decisions are made in a reasonable timeframe. Paramedic Ambulances are sent to the higher acuity patients who are more likely to need a transporting resource.

ACTIONS - members requested the following information from Tracy:

- Ms Redman to confirm how well SCAS was achieving the new National Ambulance Response Times at a local/post code level.

RESOLVED that the update report from South Central Ambulance service be noted.

5. Community Pharmacy South Central - update (AI 5)

The report was introduced by Debby Crockford, Chief Officer Community Pharmacy South Central. She explained that it was a couple of years since the HOSP last received an update and it had since changed its name from the Hampshire and IoW Pharmaceutical Committee to the Community Pharmacy South Central.

In response to questions, the following matters were clarified:

- With regard to the transfer of care around medicines (TCAM), Ms Crockford explained that the 10% of elderly patients who are discharged on the same medication they went into hospital with, this was across the whole population. With elderly patients there is currently a focus on polypharmacy. This is where patients are on a large number of medications. Often elderly people are on a lot of different medications, some being prescribed to overcome the side effects of others, which increases the overall quantity of medicines to be taken. Medication reviews can help identify what medication is helping the patient and what is not essential and could be stopped. When patients are discharged from hospital, their medication has often been changed. Without effective communication and support (TCAM) it can happen that these changes are not implemented.
- Work is progressing across Wessex on introducing an electronic referral to their chosen pharmacy when a patient is discharged from a hospital stay. IT issues have meant that progress has been faster in some parts than others, for example Queen Alexandra Hospital has a different system to University Hospital Southampton. Ms Crockford said she believed an IT solution had been found for QAH and she hoped it would be introduced later this year.
- More pharmacies are delivering the Pharmacy Urgent Repeat Medicines (PURM) compared to the NHS Urgent Medicines Supply Advanced Service (NUMSAS) which is a pilot service that has been extended until September this year.
- If complaints are received these can be dealt with through the Local Pharmaceutical Committee and sometimes the CCG. Every pharmacy must complete an annual community pharmacy patient questionnaire (CPPQ) and the results of this now have to be included on the NHS Choices website. Ms Crockford advised she did not have access to individual pharmacy's CPPQ results.
- With regard to wastage of medicines that have been prescribed to patients who have then passed away, Ms Crockford said the best way to stop oversupply was really good use of repeat dispensing. If

patients regularly communicate with their pharmacy, it is possible to establish what they actually need and avoid creating a stockpile of medicines at home that could remain unused.

- There was, for a while, a service where pharmacists visited patients at home after discharge from hospital. As part of this service, permission was requested to look at their medicine cabinet to check whether drugs were in date and whether people had far more than they required. Sometimes patients keep ordering medication that they are not taking as they think they will be chastised for not taking their medication if the prescriber finds out, which is not the case. Another service that pharmacies can offer is called synchronisation where they ask patients to bring in their medications to check what they have. Often patients are on three or four medications that run out at different times, so for ease patients often order all their medication at once meaning they build up a surplus of some of them. It needs an open and honest conversation about what a patient is actually taking and then calculating how much they require to bring each medicine in line with any others. Ms Crockford said she believed that patients going into hospital are now being told they need to take in their medication with them.

- It costs the NHS more to administer the collection of prescription tax than they make from it. In Scotland and Wales, however, there is no prescription tax. Ms Crockford said personally she felt it would be better to either abolish the prescription tax, or charge everyone, regardless of age and condition, a small fee. She encouraged members to look at the plan for community pharmacy in Scotland as she felt this was a wonderful vision.

- The PURM service is available in Gosport but Ms Crockford was not sure about whether the NHS Urgent Medicines Supply Advanced Service was in Gosport but said she would be very surprised if there were not any pharmacies offering this. Pharmacies are required to display the range of NHS services that they offer and also advertise this on the NHS Choices website.

Pharmacies closing due to financial pressures, following the Government's cuts in pharmacy funding, is a widespread issue but the number of prescriptions being issued has continued to rise. The healthcare environment is very challenging and has contributed to the Government wanting to move to a more service focussed contract with community pharmacy, which the LPC wholly supports as long as there is fair remuneration to make this sustainable.

RESOLVED that the update report be noted.

6. Portsmouth Clinical Commissioning Group- update. (AI 6)

The report was introduced by Innes Richens, Chief of Health and Care Portsmouth. He referred to the section of the report on winter pressures and

wished to express his appreciation to the frontline staff who worked over the Christmas and New Year period.

In response to questions the following matters were clarified:

- The CCG always try to encourage staff to take up the offer a free flu injection. There are however a couple of issues with this as it depends on the international experts getting the right strain.
- The CCG count people who have had the flu injection through their own schemes or by relying on staff to volunteer that information but not all staff do this
- They are working with GP practices to extend access and creating non urgent appointments at weekends. Part of plan to extend primary care access. Initial reviews are that there has been really good take-up and has been welcomed by patients, although there is always more that can be done.
- The CCG have also put together a care homes team pilot and have a team of GPs and nurses who are working with a couple of care homes in the city. This is increasing the clinical support to residents to avoid unnecessary trips to QA Hospital. Initial reports show that this has reduced trips to QA by 40% and the CCG are now looking at getting this offer out to all care homes in the city and this is very encouraging.
- The primary reason of working with the voluntary sector was not to link with combating loneliness but this could be linked. The main thing is that loneliness is a key thing and many would like the opportunity to get out and meet other people. This will help the CCG target is domiciliary care help with their healthcare.
- Mr Richens said he did not have the numbers of cancelled or delayed elective operations in November available but he would ensure these were supplied to the panel. He was in agreement with the CEO of PHT that need to make sure people that are currently going into hospital with urgent issues are treated in the hospital and discharged. The CCG and PHT are reviewing the number of patients sitting in hospital routinely to discharge patients who are ready to leave.
- There are a number of people in supported living accommodation with support around them either out of city or they want to come back into city, or accommodation they are in is not adequate. The NHS and council are looking to revitalise on of the buildings on the east side to bring people back into the city who want to.
- There is a need for interim bid but have beds in other buildings such as Edinburgh House and some in the independent sector. The city has enough beds but they are not all being used to capacity. The majority of patients want to go home from hospital which is right, so pressure is on domiciliary care. Last week for example for delays to the hospital social care team there were 8 patients. One was waiting for a care home bed and the rest were awaiting a care home package.

The panel echoed their thanks to the frontline staff who work very hard but particularly during the winter months.

ACTION: The number of scheduled operations that were cancelled in November to be provided for the panel.

RESOLVED that the update report be noted.

7. Southern Health NHS Trust (AI 7)

The report was introduced by Mark Morgan, Director of Mental Health and Learning Disability. He added that the Mazars report had been considered by their full board earlier in the week and that has been used as independent assurance on their progress against their action plan.

Mr Morgan also referred to some work the trust are doing with all of the local CCGs, PHT and Solent to streamline the system to have a single point of access for mental health services. Currently there are a range of different services and it is too complicated for patients. Work is taking place during April, May and June. The Trust are working with all statutory sectors and patients to redesign that.

In response to questions, the following matters were clarified:

- Some of the targets on the Building Confidence have not been met. One of the issues about patients receiving assessment within timescale is around elective care capacity waiting for community therapies. It is vital to have the right workforce in the right place to deal with this. For older peoples mental health delayed transfers of care are quite significant issue for the Trust. This is also the case for community rehabilitation beds but these affect Hampshire residents only.
- The Patient and Family Engagement report focussed around people whose loved ones had died whilst in their care mostly in the community services and where patients had completed suicide. The Niche Grant Thornton Assurance report was published after that which followed six families and carried out a detailed review to see how they had experienced that care. They noted a significant improvement of the experiences of relatives and how they had engaged with them. The Trust now has a lead executive director who makes contact with the family and oversees the investigation, and a family liaison officer who works with families and supports them.
- The focus of HSE prosecutions is around the systems and processes that the Trust has in place. The Trust has made significant changes following both the incidents they were prosecuted for in 2012 around risk assessments for patients with epilepsy and ligature work have been significant areas of focus. Approximately £9 million on improving ligature work has been spent within the Trust.
- The possible rating from Grant Thornton, the external assurance company, graded three areas as 'A' and two areas as 'B'. The Trust asked them to return after six months to do a follow up as the Trust

wanted to get a better rating for the quality of investigations. The main area they want them to better on is the quality of investigations. This will be reviewed again in six months' time. It is expected that the review will be completed in six months. The Panel requested an update report will be given to the panel following this report.

- There were about 38 areas where the CQC had said there is more they must do as detailed in appendix C of the report. An example of is one of the concerns that remains is risk assessments which is something they have spent a great deal of time. When the CQC originally visited approximately two and a half years ago the level of risk assessment completions documented was 40%. It is now at 96% and the CQC said this needs to be reviewed in one year. The Trust are seeking to continuously review this. The CQC acknowledge the Trust have done a lot but there is still more to do.

- The focus has changed now to older people with mental health issues. Part of the improvement is to ensure all healthcare organisations are continuing

- With regard to the STP, Mr Morgan said he believed the public will see an action today and he liaises regularly with his opposite number at Solent. Their main area of focus is access to services and making this less complicated. The STP is encouraging providers to work together around the needs of the individual and their job as an organisation to make it easier to the patient to navigate.

The Panel noted that the Trust had made large improvements since the CQC inspection and an update on the Grant Thornton review to come back to the panel at their next available meeting.

RESOLVED that the update report be noted.

The formal meeting ended at 5.00 pm.

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Councillor Leo Madden
Chair

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Title of meeting:	Health Overview and Scrutiny Panel
Date of meeting:	22 March 2018
Subject:	Adult Social Care Update on Key Areas
Report by:	Andy Biddle, Acting Deputy Director of Adult Services

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1. Purpose of Report

1.1. To update the Health Overview and Scrutiny Panel on the key issues for Adult Social Care during 2017.

2. Recommendations

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

Update on Key Areas

3. Overview

3.1. Portsmouth City Council Adult Social Care, (ASC) provides support and advice to adults aged 18 years and over who require assistance to live independently. This may be the result of a disability, long term health condition or frailty associated with growing older. Our aim is to help people have as much choice and control as possible over how their needs for care and support are met. For some, when independent living is no longer possible, we will help people find the longer term care arrangements that best suit them.

3.2. Following the systems thinking intervention work ASC's purpose is defined as:

- Help me when I need it to live the life I want to live

3.3. This overall purpose is service wide and overarching. For specialist areas within the service the wording may change slightly to reflect the work undertaken but is able to be linked back to the overall purpose of the service.

3.4. ASC provides a service to approximately 7,000 people throughout the year with a staff compliment of 800. (600 full time equivalent posts) undertaking a wide variety of roles, both in commissioning and direct delivery of services.

4. Summary

4.1. During 2017/18 ASC were faced with a number of key challenges

Demand for Services:

- ASC Continues to see an increase in the demand for older people with complex needs requiring larger packages of care.

- The number of older people receiving domiciliary care from ASC per week as of March 2017 was 957 people at a total weekly cost of £138,843.72 (£145.08 pw per person). By December 2017, this had reduced to 946 people, but the cost had risen to £159,604 (£168.71 pw per person). A significant part of this pressure is an increase of 10% in the number of people receiving domiciliary care funded at £150 to £200+ per week between March 2017 and December 2017. In addition to this budget pressure, the shortage of domiciliary care has meant that ASC have had to seek care from providers at prices outside that which the Council would normally expect to pay for domiciliary care. The percentage of the ASC spend on these '3rd tier' providers has increased from 9% in March 2017 to 18% in December 2017.

- The emphasis on care in people's own homes is reflected in less people in Portsmouth placed in residential care homes:
  258 (March 2016)
  242 (March 2017)
  230 (December 2017)

- In addition to the increase in needs of older people in the city is the rise in the number of people with challenging behaviour resulting from a learning disability. Within Portsmouth, 90 people account for £7.1m of our expenditure.

- There have been a significant number of residential homes/nursing homes in Portsmouth which received an adverse inspection from the Care Quality Commission and either ceased operation or imposed an embargo on new admissions. This impact was felt particularly at the end of 2017 and residents from 3 closing care homes had to be relocated.

- There is a waiting list for assessment in community Social Work and Occupational Therapy, growing since October 2017 and exacerbated by team absences and the workload generated by reviewing support packages when providers receive poor CQC reports.

- The situation in relation to domiciliary care remains challenging with regular hours of care unfilled. This situation is variable, but there has been a significant gap in hours needed to fulfil statutory obligations since January 2017. During 2017, there were several incidences of instability in the domiciliary care market from providers 'handing back' care packages they could not provide for, to staff changing agencies or agencies withdrawing from the market to embargos on new referrals following adverse CQC inspections. All of these exacerbated the pressure on the market by restricting the availability of domiciliary care further in Portsmouth. The gap in available care has begun to reduce from January 2018 onward, with the addition of domiciliary care for people in receipt of

Continuing Health Care hours provided by Solent NHS Trust however capacity remains significantly limited.

New Court Work:

- The number of applications for Deprivation of Liberty authorisations have continued to rise in Portsmouth:
  786 (2014/15)
  1473 (2016/17)
  1688 (2017/18, projected based on December 2017 figures)

- As expected, the Supreme Court also made a significant judgement during 2017 that related to Local Authorities where they know or 'ought to know' about arrangements that constitute a Deprivation of Liberty in domestic settings. This judgement extends the responsibility for Local Authorities to apply for a Deprivation of Liberty authorisation where people without the capacity to make a decision may be being deprived of their liberty. It is not yet possible to scope the financial impact of this judgement, but it is highly likely to increase responsibilities and therefore costs.

Acute Hospital Pressures:

- Pressure on ASC to discharge patients from the acute hospital setting continues to be a challenge. Staffing levels in the Hospital Social Work team, (part of the Integrated Discharge Service) have been under particular pressure and locum staffing has been contracted to fill the gaps created by absence and recruitment/retention. Numbers of patients awaiting allocation to a Social Worker have been a significant issue and we have worked in partnership with Portsmouth Clinical Commissioning Group to access some of the Department of Health winter pressures funding to tackle this challenge.

Funding and Budget Pressures:

- The projected 17/18 gross annual expenditure for adult social care (ASC) activities is £62.9m. This is funded from a variety of sources. The majority is from the ASC council cash limit budget of £42.4m. ASC funding also relies on income (client assessed charge for care) which is anticipated to be £11.1m in 17/18.

- ASC is also funded by monies transferred from the NHS in order to support social care activities. In 2017/18 this NHS funding via the Better Care Fund (BCF) is projected to be £7.3m.

- In the Spring Budget of 2017 the Chancellor announced additional grant funding of £2 billion to social care in England over three years, with £1 billion available in 2017/18.

- The conditions for use of this fund were specified as:

- meeting adult social care needs;
- reducing pressures on the NHS (including supporting transfers of care from hospital);
- ensuring the local social care provider market is supported.

- In Portsmouth, the total of this funding is £8.5m over 3 years and a 'Transformation Fund' framework has been put in place to be used to invest in the transformational change of adult social care. Authority to allocate funds to schemes in support of these objectives is delegated to the Director of Adult Social Care and s151 officer, in consultation with the Cabinet Member for Health and Social Care.

- PCC's objective in the use of the transformation fund is to deliver the ongoing remaining savings requirement (i.e. after funding all likely demographic and other cost pressures), and to prepare the service to be able to make further savings beyond 2019/20 as the austerity period continues.

- Schemes agreed thus far include, assistive technology; development of the voluntary and community sector in Portsmouth; staffing in in-house residential homes to deliver improved care; investment in housing and support for clients with learning difficulties; development of transition care home beds; investment in supported living for adults with Mental Health difficulties; developing new models of care to effectively and safely manage people's health and care needs in the community.

- Whilst all residents in the three homes that closed in December 2017 were found a new place to live, this added to budgetary pressure, as placements were more expensive in many cases.

- Savings for 2017/18 have proved to be challenging, whilst some savings plans have delivered greater benefits than anticipated, others have not been realised, giving additional pressure in year and adding to the deficit for 2018/19.

- Pressures that have materialised in 2017/18 have included residential care costs for people with mental health problems, residential and day care costs for people with a learning disability and pressures on agency staffing in the PCC owned and managed residential units for older people.

5. Savings

5.1. The saving target for 2018/19 is £946k and progress against savings are reviewed monthly within the service and discussed with the portfolio member. The likely 2018/19 starting deficit is £2.3m, which will occur without further action, however the assumption is that this deficit will in practice be lower than this starting position. The current transformation fund process will culminate in a deficit reduction strategy to attempt to manage this deficit. The budget position continues to be reported in line with council procedures.

6. Priorities for 2017/18

6.1. The priorities set out in the previous HOSP report are reproduced below with progress against each of them.

- To ensure all registered services are adhering to the Care Quality Commission (CQC) regulations & outcomes laid out under the CQC '5 Key Lines of Enquiry'. An associated outcome was to review the current PCC residential homes and plan and support the implementation of the changes that ensure CQC compliance and sustainable quality change

    - Angela Dryer established the 'turn around team' in January 2017, as highlighted in the previous HOSP report. This was in response to adverse CQC reports around Shearwater and Harry Sotnick House.

    - A new training programme is underway with PCC care staff to ensure that the requirements of the Care Certificate are fulfilled. Policies and procedures are being standardised across PCC homes. In providing greater activities across dementia services, we have purchased two Tovertafel tables in our units, these are devices that engage and stimulate people's senses and provide enjoyable activity. The quality team, a mixture of appointed professionals and lay inspectors have been interviewed and appointed and will begin to work with the sector to improve outcomes and inspection results in 2018.

    - ASC contracts with Care UK to meet the needs of people who require residential care with nursing in Harry Sotnick House. This contract is due to end in March 2018 and negotiations are ongoing regards Hampshire County Council operating the home for a temporary period, (18 months to 2 years). This is based on Hampshire's existing experience in operating 10 nursing homes, (8 of which are rated as 'good' by CQC). The work required to get to this stage has been substantial and will continue, whilst the future provision of care at Harry Sotnick is determined.

- Complete Roll-in of systems thinking across OPPD services.

    - Since October 2017, the OPPD interventionist has been running a series of small group training interventions with Assistant Team Managers and Team Managers. This has enabled leaders to expand their learning around the Vanguard Method for Systems Thinking and prepare them to embed management according to this method in their practice.

- Configure OPPD service model focussed on re-ablement and prevention of unnecessary hospital admission.

- A Transformation Fund bid has been submitted to create an in-house care team to respond to the needs of people living at home to ensure ASC are able to meet their Care Act duties. As part of the transformation and financial strategies, the work will be focussed on supporting independence and using personal and community assets to help meet outcomes. This development is also part of the effort to ensure people have the right care at the right time and are not conveyed to hospital where there are other options to support them at home. Measures are being developed to model the number of people and likely impact on outcomes and budget. Once this has been completed recruitment will commence.

- This bid also supports the next stage from colocation to integration with Solent NHS Trust. The Rapid/crisis response will be one that meets people's health and care needs. As the persons' needs de-escalate, the team will work with the community teams to support the person remain independent and reduce potential of escalating again.

- Achieve savings targets.

  - As detailed above, work continues to meet the savings targets set for 2017/18. Achieving these targets is a significant challenge, not least because a number of schemes identified have taken longer to come to fruition than anticipated.

- Agree integrated working methods with community health provider.

  - Senior Managers from ASC and Solent NHS Trust are working with staff to understand the needs of the people both organisations serve and which area would most benefit from integrated working. An area has been identified to trial new approaches and data is in the process of being analysed.

- Replace client record system for ASC.

  - The project to replace the current client record system is underway, there have been some disappointing delays in managing the configuration of this new system. These focussed around gaining data migration agreements and signing the contract in order to secure the test environment. A project manager is now in place and the work is beginning to take shape. The current estimated go-live date is October 2018.

- Re-tender domiciliary care contract

  - The existing contract was extended to enable a new specification that accounts for outcome focussed services and the new model of reablement/admission avoidance to be developed.

    - With the increase in domiciliary care costs, a domiciliary care Board has been established to monitor patterns and trends in the market.

    - The Systems Development Board has recently approved an intervention to understand how domiciliary care operates in Portsmouth and experiment with different ways of working.

- Tender for bed based care home resources for people with challenging behaviour.

    - Initial tender for this was unsuccessful, so further work in being done to look at all possible options

- Tender/renew Community Equipment Store contract.

    - The current contract is likely to be extended for 12 months to enable a more detailed specification to be developed and consider more widely the options available for providing equipment for independent living in the community

Signed by:

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Portsmouth Health Overview and Scrutiny Panel
Update from Portsmouth Hospitals NHS Trust, March 2018

Finance

On 25 January 2018 Portsmouth Hospitals NHS Trust issued a public statement about its revised financial position. This outlined that we had changed our projected financial position for the end of the financial year in 2017/18 from a surplus of £9.7 million to a deficit of £36.8 million. A briefing document with further background is attached in Appendix A.

On joining the Trust as Chief Executive on 31 July 2017 our Chief Executive Mark Cubbon made clear that one of his four key priorities was stabilising and improving the Trust's financial position. Since then we have taken some immediate actions including;

- Appointing a new leadership team to provide the organisation with stability and renewed focus. The new Chair was appointed in November 2017 and the new Board and Executive team has been in place since 8 January 2018.
- Commencing a financial turnaround programme to revisit all major investments
- Commencing a comprehensive review of our Board and committee governance and reporting structure which will be complete by the end of March 2018
- Appointing a Financial Turnaround Director to focus on returning the Trust to financial sustainability
- Commencing the development of a five year Trust strategy. Alongside this we will develop a three year plan focused on stabilisation, recovery and transformation.

The Trust has a plan in place and has been delivering at pace to ensure that we meet the projected deficit of £36.8million by the end of the financial year on 31 March 2018. From the outset we have been clear that patient care will not be compromised in order to deliver the savings and Mark Cubbon has had discussions with Healthwatch Portsmouth and other key stakeholders to provide reassurance on this point. The measures we have implemented in the last quarter of this financial year include greater controls on our spending on agency staff, limiting our discretionary spend whilst ensuring all clinical spend is protected and delaying our commitment to large projects until the new financial year in April. We have established a Financial Recovery Board chaired by the Chief Executive which meets fortnightly and has oversight of delivery of the financial plan.

As we come towards the end of the current financial year we are also focusing our attention on ensuring we have a robust plan in place to deliver the savings required in 2018/19. The savings target we have identified for 2018/19 is £35million. Whilst this is an ambitious target it is one we believe is realistic and achievable and plans to identify the savings required are at an advanced stage. We have hosted a series of 'Action Days' for staff which are focused on generating savings ideas which are then developed into fully costed plans and evaluated to ensure there is no detrimental impact on quality of care. These have had a good level of engagement from our staff and at the current time we are in a strong position to start the new financial year.

We have appointed Matthew Wood, Chief of service for Critical Care, HDU, Anaesthetics and Theatres as Clinical Director of Finance to ensure additional scrutiny and ensure we avoid detrimental impacts on quality arising from our savings plans.

One of the reasons behind the Trust's historical deficit, as identified in the financial investigation undertaken by NHS Improvement, was a lack of financial engagement at all levels. The Trust leadership is clear that each member of staff has a role to play in helping us to address the problem, so a programme of staff involvement and engagement has been implemented. Matthew Wood is supporting this work as Clinical Director of Finance to strengthen our engagement with clinical staff across the Trust.

The Trust Board is clear that we have a duty a duty to our patients, our local community and the wider health economy to deliver the savings required and we will rightly be held to account. We do not underestimate the seriousness of the situation or the risks of not delivering our plan, however we are confident that by delivering the plans we have set out for 2017/18 and 2018/19 this will put us on a firm foundation to deliver the financial sustainability that the Trust requires.

DTOC data for the previous 3 months

The latest available figures for Delayed Transfers of Care (DTOC) are provided at Appendix B.

Radiology update

On 19 July 2017 the CQC undertook an unannounced inspection of the diagnostics imaging department at the Queen Alexandra Hospital. During the inspection the CQC looked in particular at the reporting of chest x-rays and the processes in place to ensure that any backlog in reporting was managed. The inspection report was published on 1 December 2017.

The investigation highlighted delays in reporting some chest x-rays and as a result CQC took enforcement action against the Trust which required us to take immediate action to address the concerns raised. As soon as the concerns were raised with us following the CQC's inspection in the summer of 2017 we immediately put in place a range of improvements. All chest x-rays from the Emergency Department (ED) are now formally reported by a trained specialist in addition to being interpreted by the requesting ED clinician, as per our existing policy.

There have been staffing capacity issues within the radiology department and we know that this is a challenge that is reflected nationally. To help alleviate this we are training dedicated reporting radiographers, with further training also being offered to clinical staff.

The CQC identified a backlog of 23,000 images of chest x-rays from the preceding 12 months had not been formally reviewed by a trained specialist. We set a target of clearing this backlog by the end of February 2018 and this has now been completed. This process has identified a number of serious cases of missed lesions. Each of these instances is being managed through our SIRI process and we are in contact with those patients directly to explain the action we are taking. It should be emphasised that even one instance of serious harm to a patient is too many, but the numbers have been lower than had been first feared.

To provide additional assurance we also commenced an independent investigation into the backlog to determine the root cause and the findings from this independent investigation are expected to be presented to our Trust Board in May 2018. The Trust's policy for reporting x-rays has now been revised with input from independent experts and a Harm Review Group has been established to oversee compliance with the policy on an ongoing basis.

Portsmouth Hospitals NHS
NHS Trust

Portsmouth Hospitals NHS Trust
Financial recovery briefing note, 25 January 2018

Background

The financial position of Portsmouth Hospitals NHS Trust has unfortunately been declining for a number of years. The challenges faced by the organisation in delivering savings and balancing the books date as far back as 2012/13.

For the current financial year (2017/18) the Trust agreed with our regulator NHS Improvement that we would deliver a surplus of £9.7 million. The level of savings that the Trust needed to make to achieve this was more than £40 million, a figure which was much higher than before and in fact was over double the amount that had been saved in previous years. The reason for the scale of the savings was the result of the debts that had been building up over a number of years. The size of the task to deliver this amount of savings was vast and we acknowledge that we did not have robust enough plans in place to deliver them.

2017/18 financial position

We began the financial year acutely aware of the scale of both the challenge and level of change across the system required to deliver our financial targets. It became clear to us by the summer of 2017 that the target of delivering a £9.7 million surplus was no longer realistic and wouldn't be achieved. The risk of us not delivering on our financial plan for this year has been highlighted on a number of occasions. Therefore since July 2017 we have been working closely with NHS Improvement to agree on what we believe is a realistic figure to work towards for our projected position at the end of the current financial year in March 2018.

Today we have publicly changed this figure from a surplus of £9.7 million to a deficit of £36.8 million. Clearly this is a significant change in our financial position and the purpose of this briefing is to explain more about why we find ourselves in this position and how we will go about tackling it to bring the organisation back onto a sustainable financial footing.

Reasons for the deficit

The Trust has a new leadership team in place and a key part of the work that has been carried out in recent months has been detailing the history of the organisation's finances and understanding the reasons why we find ourselves in this difficult position. As well as the work carried out internally we have worked with independent financial advisers who reviewed our forecast for the year, and with NHS Improvement who carried out a detailed Financial Investigation in July 2017.

As a result of this work we now have a clear understanding of the reasons for the deficit which are summarised below.

- A lack of clear vision and strategy for the organisation and instability in the Executive team and Trust Board led to a failure to look beyond the short term. In addition the Board has historically been more focused on operational rather than strategic issues. Trust finances haven't been a significant item on the Board agenda and this has filtered down into the organisation.
- A culture across the Trust in which finances have not been prioritised or effectively owned by some clinical services has contributed to under delivery of savings.

- Historically investments were made which weren't adequately supported by a business case or a strong evidence base.
- Despite a good understanding of the financial challenge facing the trust, financial engagement at all levels across the trust is not strong at all levels.
- Limitations exist in the capacity and capability in the Trust to deliver the savings required

Actions we have taken

On 31 July 2017 Mark Cubbon joined the organisation as Chief Executive and made clear that one of his four key priorities was stabilising and improving the Trust's financial position. Since then we have taken some immediate actions including;

- Appointing a new leadership team to provide the organisation with stability and renewed focus. The new Chair was appointed in November 2017 and the new Board and Executive team has been in place since 8 January 2018.
- Commencing a financial turnaround programme to revisit all major investments
- Commencing a comprehensive review of our Board and committee governance and reporting structure which will be complete by the end of March 2018
- Appointing a Financial Turnaround Director to focus on returning the Trust to financial sustainability
- Commencing the development of a five year Trust strategy. Alongside this we will develop a three year plan focused on stabilisation, recovery and transformation.

Delivering the revised forecast

The focus of our efforts until the end of March 2018 is on ensuring that we meet the revised forecast deficit for this financial year and delivering the plan for savings in 2018/19. There are a number of plans already being implemented which are being overseen by the newly appointed Financial Turnaround Director. Importantly, we are committed to ensuring that patient care will not be compromised in order to deliver the savings and each savings plan will be subject to a detailed quality impact assessment. Instead our plans focus on implementing strict controls on our spending and ensuring we get the best possible value for money through all of our transactions.

It is well known that the Trust faces a number of operational pressures which could affect our ability to deliver our financial plan and we are monitoring these risks and taking action where necessary. As with many NHS Trusts we face a challenge to reduce the amount of money we spend on temporary and agency staff. A large amount of work is underway to improve our control of, and planning for, the amount of money we spend in this area.

An important part of helping to reduce our spending is limiting the amount of additional money we spend on staff to help ease the pressures that we have experienced this winter. Managing the additional demands on the hospital during winter has meant opening more beds for periods when pressures are at their peak, and this in turn means spending more on temporary staff. We are continuing to work with our partners across the local health system to create more joined up services which will mean a better service for patients as well as a more efficient way of working.

Moving to a financially sustainable future

The Trust Board is clear, and has affirmed its commitment today to bringing the organisation's finances back onto a sustainable footing. We have a duty to our patients, our local community and the wider health economy to deliver the savings required and we will rightly be held to account. We do not underestimate the seriousness of the situation or the risks of not delivering our plan. However we are confident that by delivering the

immediate actions set out for this financial year, implementing the organisational strategy later this year and ensuring that we have a robust plan in place for the next three years we will secure the financial stability that our population needs and deserves.

We will provide information and updates on the progress we are making towards our revised target in this financial year and provide further information on our future plans as they develop.

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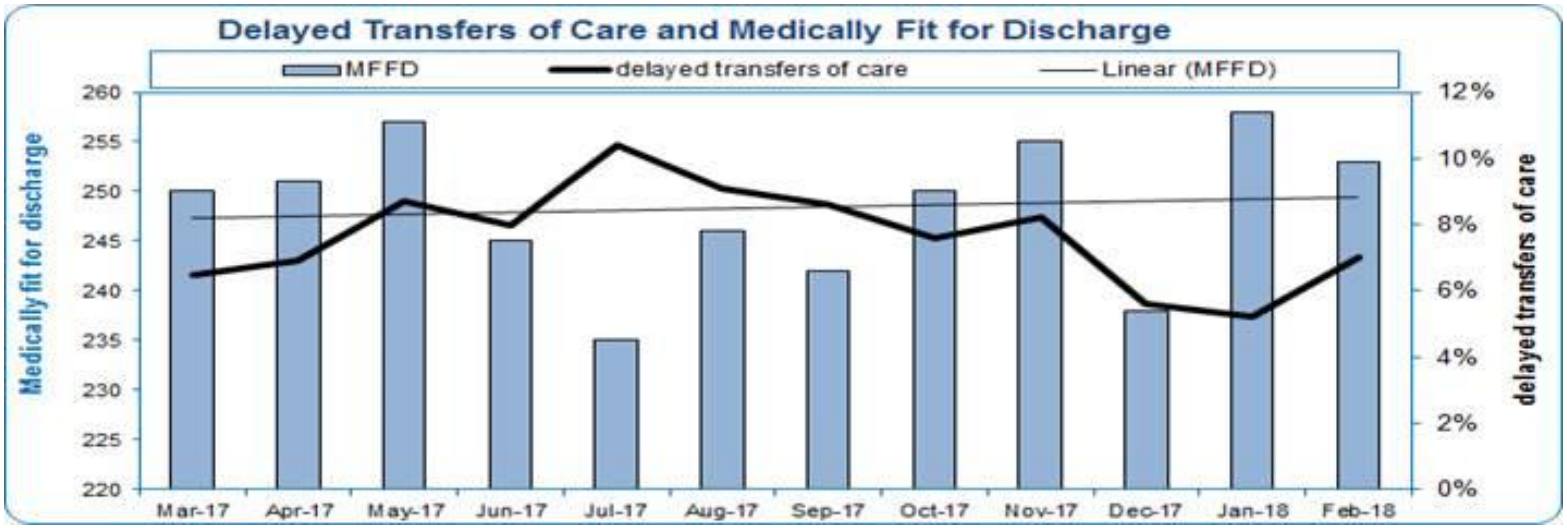
Appendix 2: DTOC statistics

	Delayed Transfers of Care				
mth	Target (%)	17/18 Monthly	17/18 Yr. to date	16/17 Monthly	16/17 Yr. to date
Apr-17	3.5%	6.90%	6.87%	3.3%	3.3%
May-17	3.5%	8.70%	7.81%	5.1%	4.2%
Jun-17	3.5%	8.00%	7.88%	5.1%	4.5%
Jul-17	3.5%	10.40%	8.47%	5.4%	4.7%
Aug-17	3.5%	9.10%	8.58%	6.2%	5.0%
Sep-17	3.5%	8.60%	8.55%	5.8%	5.2%
Oct-17	3.5%	7.60%	8.41%	9.0%	5.7%
Nov-17	3.5%	8.20%	8.38%	6.9%	5.8%
Dec-17	3.5%	5.60%	8.07%	4.9%	5.7%
Jan-18	3.5%	5.20%	7.79%	5.1%	5.7%
Feb-18	3.5%	7.00%	7.72%	6.3%	5.7%
Mar-18	3.5%			6.5%	5.8%



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Briefing note: Carillion's provision of facilities management services to Portsmouth Hospitals NHS Trust

Background
Carillion Plc entered into insolvency on 15 January 2018 along with a number of subsidiary companies in the group. All companies will continue to operate, providing continuity of public services, until further notice. The purpose of this briefing is to provide an overview of the measures the Trust has put in place to ensure that services to our patients continue to be provided safely and to a high standard.

Overview of services provided
In common with a number of NHS Trusts Portsmouth Hospitals NHS Trust use Carillion PLC to provide some facilities management services. The full list of services they provide is as follows:

- Estates Services including Energy and Utilities;
- Portering Services;
- Receipt and Distribution;
- Catering Services;
- Security Services;
- Car Parking;
- Pest Control;
- Helipad fire control
- Waste Services;
- Domestic Services; and
- Helpdesk Services.

Action we have taken
We have been aware of these emerging circumstances for some time and have planned extensively for this scenario to make sure that services to our patients continue without disruption. All of our facilities remain open as normal, and patient appointments are unaffected.

We have well-practised organisational resilience through our business continuity processes, and we are working closely with ProjectCo - who under the PFI Project Agreement are responsible for the on-going delivery of Facilities Management services.

We are operating our services as business as usual and are working closely with Project Co to ensure that any potential issues are identified early and escalated where necessary. We are also in discussion with neighbouring Trusts to ascertain any mutual aid support that could be provided should the need arise.

Communications
The announcement about Carillion's future will have been unsettling for all staff and we are communicating with them through their line management teams to provide reassurance on the steps we are taking. At Portsmouth we are proud that we have a strong relationship with our local Carillion colleagues and we have worked alongside each other as one organisation, always putting the patient first. We are extremely grateful to Carillion colleagues for their continued hard work and recognise the difficulties the recent announcement may bring. As outlined above, our services remain open as normal and patients should turn up for their appointments as planned. This information has been made available on our website and through our social media channels.

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Briefing note: Provision of Facilities Management services at Portsmouth Hospitals NHS Trust

Update: 19 January 2018

Following Carillion PLC, and subsidiaries, entering into liquidation on Monday 15 January this briefing provides an update on the implications for the provision of services at Portsmouth Hospitals NHS Trust and the action being taken to mitigate any risks.

Service continuity
Importantly there has been no impact on the delivery of services, or clinical care in the hospital. We are continuing to operate our services as business as usual, with all of our facilities remaining open and patient appointments unaffected. Therefore, it has not been necessary to activate our formal business continuity plan. We have held daily meetings this week at both operational and strategic level to monitor and manage any impacts to our services, should they arise, and we continue to work closely with ProjectCo (who under the PFI Project Agreement are responsible for the on-going delivery of Facilities Management services) to ensure any risk to services is identified early and mitigated effectively. We are actively monitoring events and our business continuity plan provides an escalation route if anything arises which may threaten the safe running of the hospital.

We are working closely with ProjectCo to ensure a smooth transition of FM services to a new supplier in the coming weeks. We will provide a full update about this as soon as we are able.

Supply chain
You may have seen commentary in the media about risks to the ongoing payment of suppliers. Resolving any concerns from suppliers has been a priority action for us, especially as many of our small to medium suppliers are members of our local business community. Our Facilities Management (FM) staff and ProjectCo remain in discussion with suppliers, and any concerns are escalated to the Official Receiver's Special Manager - who is responsible for ensuring that Carillion's services are continued until a replacement provider is in place.

Staff members
Since the announcement on Monday about Carillion's future, each and every member of support staff has reported for work, ensuring that there has been no disruption for our patients. Our local FM management team has been hugely supportive and impressive in how they have responded to the situation. The professionalism and dedication at all levels, during what is an unsettling time for them personally has been exemplary and demonstrates why they are an integral part of our team in Portsmouth. We have written to every member of FM staff to thank them for the continuing important work that they do on behalf of our patients.

Understandably there have been some anxieties among staff about the future arrangements and Project Co continue to be in communication with all affected FM colleagues to ensure they are kept up to date with developments. As you might expect, local trade union representatives have been in communication with their members and we are grateful for the advice and support they have, and will continue to provide to staff.

We will continue to keep you informed, however should you have any questions in the meantime please do get in touch.

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HOSP Portsmouth update – March 2018

Estates

Portsmouth Estate Rationalisation Phase 2 – St James' Hospital and St Mary's Community Health Campus

As part of strategic estates' plans for health and social care provision in Portsmouth, services will continue to move from the St James' Hospital site (SJH) to purpose built facilities at Block 'B', St Mary's Community Health Campus (SMCHC).
The SJH/SMCHC site redevelopments have been identified as 'fast followers' by the Department of Health; this is positive news. A decision is expected to be confirmed in the Spring of 2018 and this scheme is now likely to commence in the early part of 2018/19.

Services that will relocate to SMCHC include:

- Older Persons Mental Health Community Teams
- Physiotherapy and outpatient therapies facilities

Facilitating the moves will require an extensive redevelopment of Block 'B' at SMCHC, which is currently largely vacant, but not fit for future purposes.

The scheme also includes the refurbishment of St Mary's 'C' Block; St James' site infrastructure and Services as well as St James' ICT infrastructure and wayfinding.

Capital grant
We made a £10.3million bid to Department of Health's Sustainability and Transformation Partnerships (STP) Capital Grant funding and advised Hampshire and Isle of Wight STP that we had applied to NHS Improvement for an interim loan, to enable the project to progress.

The loan application was approved and confirmed in early January 2018. However, the loan offer includes a requirement for significant expenditure in 2017/18, which is unlikely to be achievable due to the timing of the approval.

Discussions are, therefore, taking place with NHS Improvement and Department of Health regarding the transfer of this portion of the approved funding into the 2018/19 financial year.

Due to the overall delay with approval of funding the scheme design is currently being reviewed in line with current and future system requirements to ensure it continues to be able to deliver the most effective and efficient solution.

The scheme is considered to be well developed and demonstrates transformation, patient benefit, value for money, deliverability and supports financial sustainability within the STP through demand management. Works are due to begin on site in September 2018 with completion expected 13 months later.

Kite Unit

The move of the Kite Unit from Minstead Ward at St James' Hospital to Western Community Hospital (WCH) has proved extremely successful.

The relocation of this service, for patients with acquired brain injury, aimed to centralise care in a modern, purpose built facility. The additional benefits of being co-located with other specialist neurological rehabilitation facilities at WCH have included increased access to specialist staff and equipment.

Whilst many of patients accessing this service come from across the Hampshire region, the majority come from the surrounding areas of Southampton, making the new location ideal. Clinical staff, patients and carers were fully engaged with the move throughout the design process and provided valuable input into the new ward. Handover took place on 15 January and since the staff and patients have moved in there has been extremely positive feedback on the layout and configuration of the unit.

Oakdene

Oakdene is a Solent owned building that has been declared surplus.

Portsmouth City Council (PCC) identified Oakdene as a potential site for a planned specialist unit to increase mental health pathway in Portsmouth. The refurbished unit is planned to provide 24/7 support for individuals with higher need in a shared living environment, enabling them to achieve a greater degree of independence, whilst having the support to maintain it for the rest of their lives.

Successes have been achieved in other areas of supported living such as learning disabilities, where better control of upwardly spiralling costs and improved outcomes and independence for individuals has been achieved.

The current property would be substantially altered and refurbished to provide new supported living beds and would take a range of individuals from across current residential care placements to provide accommodation for specialist supported living units with 24/7 support on site.

Oakdene is expected to attract out of area clients who are currently residing in an institutional setting. The facility will include 10 single accommodation units, one 2-bedroom unit and 5 shared specialist accommodation units.

The disposal process began in November and PCC has confirmed agreement to the Heads of Terms, instructing the in-house solicitors to proceed with the purchase, which should be concluded by the end of April 2018.

St. Mary's Community Health Campus

Parking

We confirmed with the scrutiny panel in March 2017 that we had received advice from the planning department that suggested that there would be many reasons for declining our application for the development of a new, multi-storey car park, including planners concerns that it ran counter to the National Planning Policy Framework and a number of policies within the Portsmouth Plan.

Since then, we have been looking to align ourself with Portsmouth City Council's sustainability plans, whilst increasing our green credentials. An Access and Transport Policy has been approved by the Trust Management Team and there has been extensive consultation with employees across our sites. The draft policy is currently with the Employee Engagement Sub-group; following this, it will go the Policy group for final approval.

In line with the approach being adopted by NHS Trusts across England, we are actively looking at car sharing schemes, reduced public transport costs and access to bicycle ownership. Addressing the potential for increased local traffic on old infrastructure has seen the Trust look further afield for parking alternatives, including the potential for a short-term agreement with Portsmouth Football Club for the use of their facilities.

Finance
Our Year To Date (YTD) position is a deficit of £1.3m (YTD budget: deficit of £1.4m).

The forecast out-turn position has improved by £150k. We are now forecasting a deficit of £1.35m (plan: deficit of £1.50m). If delivered, we will receive additional Sustainability and Transformation Fund (STF) monies on a £1 for £1 basis and will be able to participate in the distribution of the STF bonus pot; these would improve the reported deficit further.

Flu take up
We are pleased to report that as at end of January, 70% of our front line staff had taken up flu vaccinations. This is a significant achievement as it shows how committed our staff are to protecting those who come into contact with our services and colleagues. Ideally, we would want all our staff to be protected but we are proud of how the majority of our staff have responded to calls to take up the flu jab.

Staffing pressures
We continue to experience challenges across all our services in terms of recruitment, absence and retention. This is replicated in our neighbouring NHS trusts. Despite this, staff are maintaining services and we monitor safety and quality continuously and keep a very close eye on hot spots.

A package of measures from new recruitment, new grades of staff, significant emphasis on the health and wellbeing of the workforce, improving line management and conducting thorough analysis of reasons for absence and resignations is helping direct our effort.

CQC – Children Services
CQC inspectors revisited two specialist schools – Mary Rose Academy (Portsmouth) and Rosewood Free School (Southampton) – where we provide care to looked after children.

Inspectors had noted 'significant concerns' during their initial inspection in June 2016. We are pleased inspectors noted improvements to prescribing, medicine management and record keeping practice when they revisited. This report removed the last 'inadequate' on our overall rating grid.

A final report can be found on the Care Quality Commission website www.cqc.org.uk/directory/R1C

The inspection was not intended to produce a formal re-rating for these services as inspectors mainly looked at the 'safe' domain. The overall rating for the services we provide at the schools remains as 'requirements improvement'.

Winter pressures
The winter pressures in the Portsmouth and South East system have required a significant operational response. Despite creating additional bed and care capacity, the pressures remain.

There have been significant access issues with the domiciliary care market and that has been a contributor to the **capacity** problems, along with access to care home beds. Support for Portsmouth Hospitals Trust's urgent care remains a priority and Portsmouth City has made recent progress which is to be commended.

The Council and Solent NHS Trust are working strongly together and there is a commitment to create a different and more resilient out of hospital system (further explored in the MCP paper). The pressures within Solent NHS Trust are being monitored continuously and with oversight in the care group and at Trust level.

Staff survey results (*See also graphic attached)*
We are pleased to report that, despite numerous challenges over the last year, our staff survey results reflect that our staff have continued to place patients' care as a priority. The results show that many of our staff have a strong reporting culture, which will help us learn. They feel able, and are encouraged, to report errors, near misses and incidents. There are a lot of other positive findings, which we have summarised the results in the attached graphic. Of course, there are areas we need to improve on to help our staff deliver great service.

System Working

1. **Portsmouth and SE Hants Integrated Care (***separate paper/presentation slides attached***)**

System Working Arrangements

February 2018

20.02.18: Version 6/TS

Introduction

Last year system partners agreed a framework to support the establishment of the Portsmouth and SE Hampshire accountable care system and shape the emerging agenda. There continues to be unanimous support from all organisations and their leaders to work collaboratively together as an local system and it is critical that the governance/ decision making arrangements develop to ensure that the system drives forward and delivers the outcomes set out in the Portsmouth and South East Hampshire System Improvement Plan, approved by Boards in recent months.

With this in mind the system leadership team has proposed amendments which will support the original principles of this collaboration and are defined as:

- The commitment to work as a system -sharing outcomes, resources, challenges and solutions to collaboratively improve the health and social care for the people of Portsmouth and South East Hampshire
- The need to focus on improving our services, not structural change;
- The need to focus on service effectiveness and efficiency and not just money;
- The need for Health and Care to be equal partners.
- The opportunity for clinicians across primary, secondary and community care to work together to resolve problems and transform services;
- The need to embed an empowered and innovative culture within the local health and social care system
- The requirement to ensure that delivery and recovery are improved immediately and sustained.

These revised arrangements aim to provide greater clarity of, and reduce duplication in decision making, ensure full and appropriate representation of partner organisations and focus on delivery of outcomes.

It is proposed that the alignment of relevant partnership and system wide groups and committees will occur over the next few months and a timeline is set out later in this document. This will ensure that statutory arrangements continue to be met and the changes fit with developments elsewhere including STP recalibration.

As an System Board we have agreed the following system objectives

As the organisations with responsibility for health and care in Portsmouth and South East Hampshire we have come together to deliver the following objectives:

❶ To **deliver long-term improvements in health and care outcomes**, supporting residents to stay well, reducing inequalities and reducing avoidable illness.

❷ To **improve the quality and safety of health and care services**, with all services assessed by the CQC and Ofsted to be 'good' or better, and increasing proportions of people reporting a positive experience of, and greater involvement in their care.

❸ To **deliver the agreed waiting time standards for health and care services**, by making fast and tangible progress in urgent and emergency care reform, strengthening general practice, community and social care services, improving mental health and planned care services.

❹ To **manage services within the money available,** delivering substantial system efficiencies and moderating the growth in demand for health and care services.

In order to deliver these objectives we are committing to:

❶ **Agree and deliver a single system improvement plan** to restore and improve service quality, performance and financial health, with clear and agreed priorities. The immediate priority is to deliver significant improvements in urgent and emergency care performance.

❷ **Establish a new way of working together,** where our organisations and teams are aligned around a common purpose, with clarity about roles and responsibilities, with stronger operational 'grip' and a culture that enables leaders and frontline staff to work together to drive and deliver the improvement plan. As providers and commissioners we are increasingly taking collective responsibility for population health and resources in Portsmouth & South East Hampshire

We have developed a single system improvement plan in which we agreed to

1. **Develop a single operating plan for the Portsmouth and South East Hampshire System for 2018/19**. In the past we have tried to 'add together' the individual plans of each organisation in the system, once they are finalised, to create a system plan. This time we will start by creating an overall system plan, setting out the system priorities, key transformation programmes, and financial strategy, which will inform the development of the operating plans of each provider and commissioner.
2. **Ensure that CCG funding for providers for 2018/19, and the incentives in contracts, are consistent with the agreed system plan**.
3. **Build a coherent clinical leadership body for the system**, bringing together clinicians from providers and commissioners; acute, mental health, primary and community care, with social care, to take overall responsibility for the development of a clear and compelling clinical vision, aligning care professionals with the delivery of that vision, and providing clinical leadership to the redesign of services and pathways, across the system.
4. **Create a single, shared business intelligence function in Portsmouth and South East Hampshire**, and where it makes sense establish shared back office functions, in order to simplify processes, and to reduce duplication and waste.

A **programme of service transformation and improvement** is in place to deliver this vision. We have organised our improvement activity into four programmes:

- **Urgent and Emergency Care**: to improve urgent care access and performance, reduce demand, reduce harm, and manage clinical variation, enabling the system to meet A&E and Delayed Transfers of Care targets
- **Community Health and Care:** to prevent ill health, increase early intervention and build the strong, sustainable primary and community care services required to proactively manage the needs of the population at home and the community
- **Elective demand and capacity:** to improve how we manage demand for elective care, and to redesign how we provide elective care, ensuring demand and capacity are in balance to enable constitutional targets to be met.
- **Mental Health:** to improve the quality of and access to mental health care for adults and children

How does our system approach assist in the delivery of our individual organisational objectives?

- Local clinicians and system leaders have identified a set of shared priority areas that are fundamental to the sustainability of all local NHS and care organisations.
- We recognise that traditional approaches and individual organisational working will not deliver the transformation and financial recovery necessary for this system
- Urgent care, community health and care, elective care, mental health and children's services will be the focus of our collective effort to drive improvement and deliver financial sustainability in this system
- Having a system approach to these priority areas ensures that the whole system coalesces around our collective priorities and that each programme takes an accountability on behalf of all partners to deliver the agreed system objectives

The transformation of urgent care for example is all our responsibility. The impact of not transforming is damaging to all organisations from a quality and financial perspective. Traditional approaches to managing this issue through internally focused, binary or contractual approaches has not resulted in safer delivery or sustainable financial recovery.

- Individual organisations will hold the system to account for delivery of the agreed programmes, but given the system is all of us, then this means the Chief Executives and their Governing Bodies holding each other to account, led by the system convenor

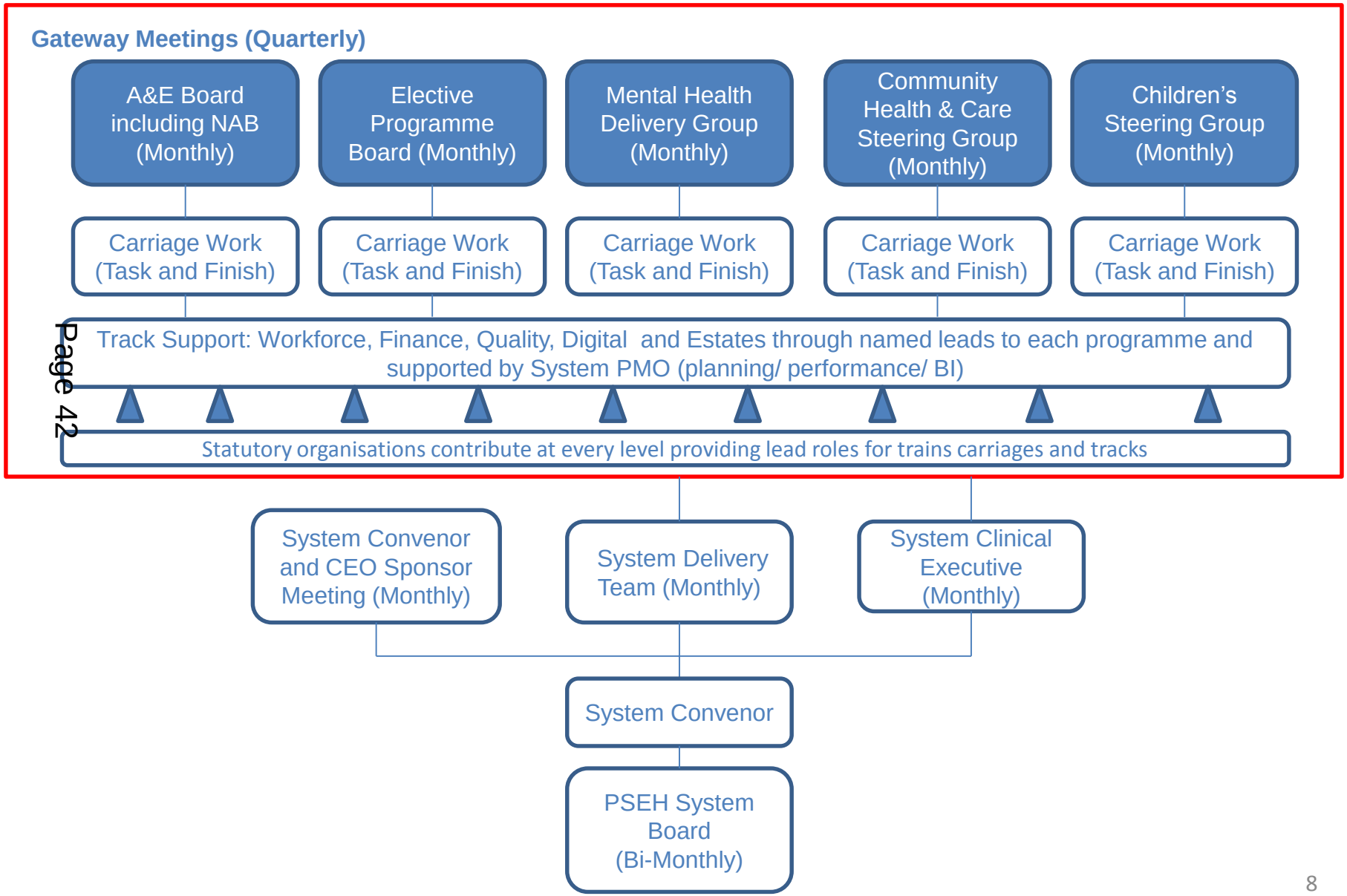
Our focus is on delivering the immediate improvements and transformational change through the following programmes of work

Programme	Aim	Work streams	Leadership	Outcomes /Metrics
Urgent Care	Improve flow, reduce LOS, reduce conveyance and admissions and avoid harm. Use performance measurement to support accountability and improvement.	Frailty including Acute frailty unit and FIT, IDS/ D2a, DOS development, non-conveyance, primary care access, GP Streaming and UTC, 111/OOHs *Priority Focus: MFFD, Medical Model, SAFER*	**Exec Sponsor -** Mark Cubbon, CEO PHT **Clinical Lead** – Dr Elizabeth Fellows, Clinical Chair PCCG **SRO** - Sarah Austin, COO Portsmouth & Commerical Director, Solent NHS Trust **Groups:** A&E Board (monthly), A&E Ops Group (fortnightly), Task and finish groups for each project.	Improved performance in 4 hour ED wait, 12 hour trolley waits, occupied bed days, Effective use of escalation beds, Reduction in avoidable attendances and admissions,
Community Health and Care 	System approach to accelerate the new models of integrated primary and community care. Includes mental health, children , long term conditions, local MCP development and delivery of GP Forward View.	• Population Health • Prevention • Urgent out of hospital care • Ongoing care • Highest care needs • Enablers • *Priority focus: frailty, care homes, End of Life*	**Exec Sponsor**- Innes Richens, Chief of Health & Care Portsmouth, PCCG **Clinical Leads**-Dr Rumi Chappia, Director Portsmouth PCA & Dr Donal Collins, Director, South Hants PCA **SRO**- Sara Tiller, Director of Primary Care Development, Hampshire Partnership CCGs **Groups:** New Care Models Delivery groups, weekly task and finish groups	Primary care sustainability Increased capacity for LTC and complex case management Improved patient management and experience, Reduction in A&E attendances and emergency admissions including care homes, Reduction in acute outpatient and elective activity, Reduction in LOS

Our focus is on delivering the immediate improvements and transformational change through the following programmes of work

Programme	Aim	Work streams	Leadership	Outcomes /Metrics
Elective Care 	Elective pathways across Portsmouth and South East Hampshire are managed in the most efficient way ensuring that patients are seen in an appropriate setting and timeframe.	Improve waiting list management processes at PHT, halt growth in demand through referral management with GPs in Surgery, Urology and MSK. Address demand/ capacity in urology , fully implement e-referrals	**Exec Sponsor** – Dr Linda Collie, Chief Clinical Officer & Clinical Leader, PCCG **Clinical Lead** –Dr Richard Jones, Cardiologist, PHT **SRO-** Lyn Darby, Dep Chief Commissioning Officer, Hampshire Partnership CCGs **Groups** - Elective Care Board (monthly), Task and finish groups for projects	RTT , diagnostic and cancer target delivery
Mental Health 	Service transformation to create sustainable system wide solutions to mental health service delivery challenges	Current state analysis, system redesign workshops and implementation Priority focus: Psychiatric decision unit, single system bed management , system wide role development	**Exec Sponsor** - Nick Broughton, CEO Southern Health **Clinical Lead-** Dr Dan Meron, Chief Medical Officer, Solent **SRO-** Suzannah Rosenberg, Dir of Quality & Commissioning, PCCG **Groups -** Mental Health Partnership Board (monthly) , Task and finish groups	Increased numbers of people receiving early support, reduced numbers requiring medical interventions, improved management in secondary care, improved resource utilisation,
Childrens 	To be developed in 2018			

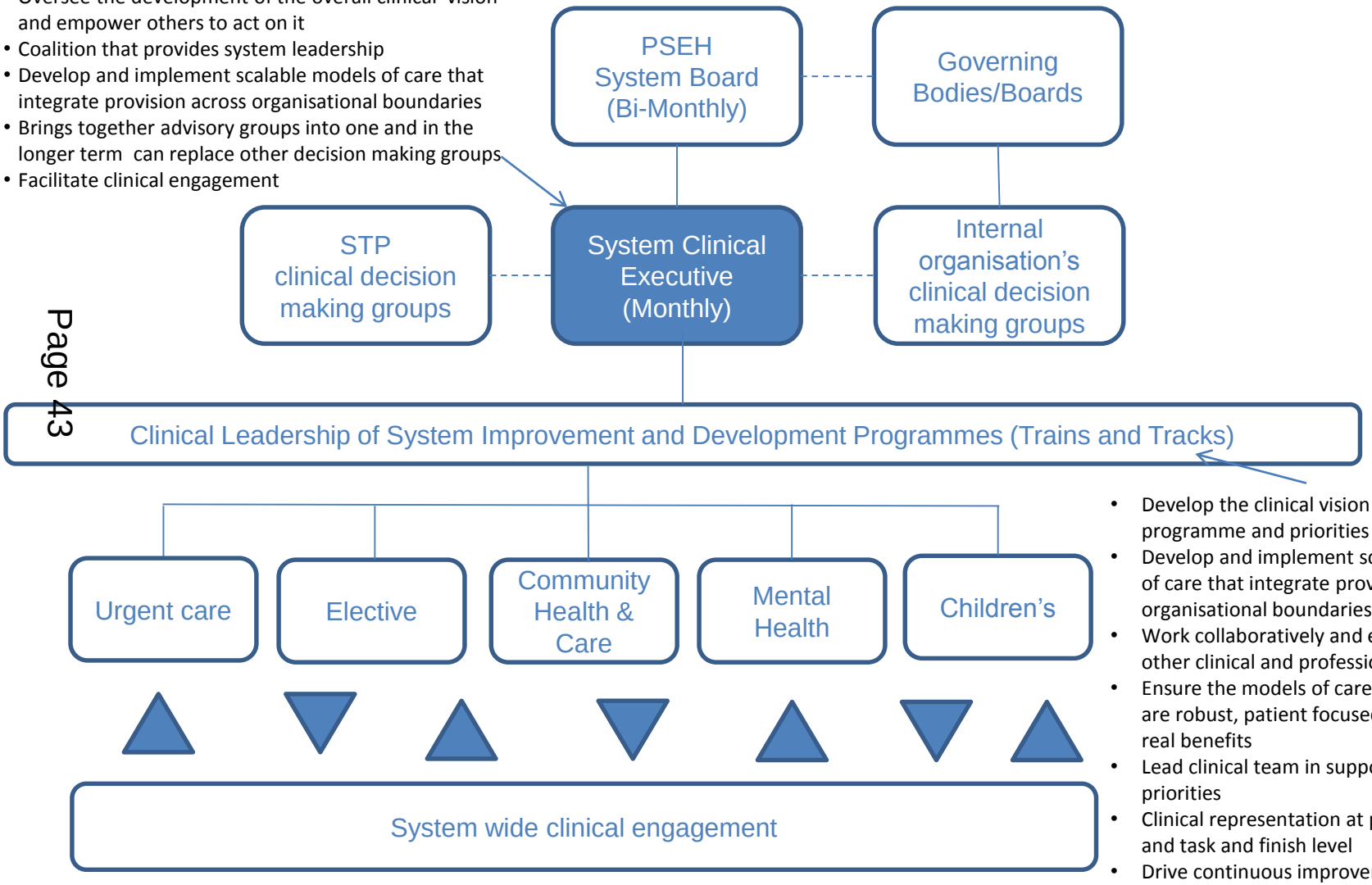
The programme arrangements must be streamlined, transparent and flexible to enable effective and efficient decision making and action



Collaborative and cross boundary clinical leadership is a critical enabler of accountable care, supported by a clear structure that delivers appropriate accountability and authority

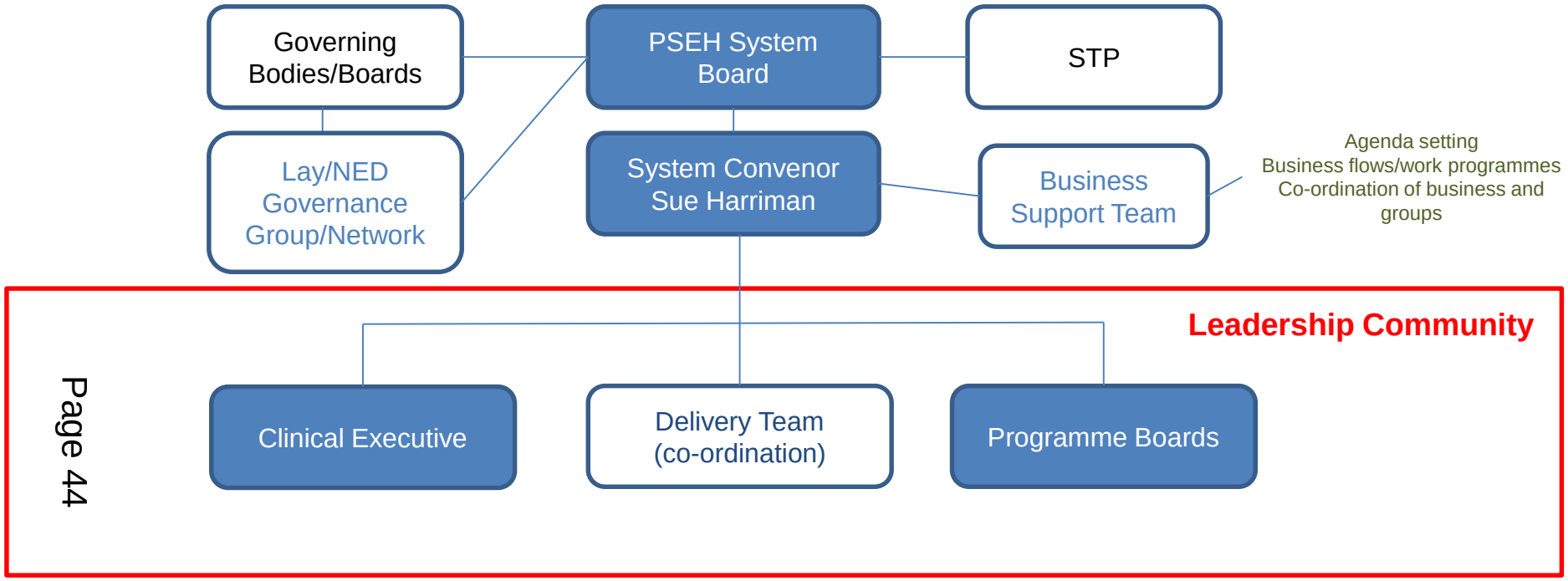
Clinical Executive Functions

- Senior clinical leaders from partner organisations and System Programme Clinical Leads
- Oversee the development of the overall clinical vision and empower others to act on it
- Coalition that provides system leadership
- Develop and implement scalable models of care that integrate provision across organisational boundaries
- Brings together advisory groups into one and in the longer term can replace other decision making groups
- Facilitate clinical engagement



- Develop the clinical vision for the programme and priorities for redesign
- Develop and implement scalable models of care that integrate provision across organisational boundaries
- Work collaboratively and engage with other clinical and professional groups
- Ensure the models of care implemented are robust, patient focused and deliver real benefits
- Lead clinical team in support of the priorities
- Clinical representation at programme and task and finish level
- Drive continuous improvement

We have created an overarching structure in order for partners to make decisions, allocate funds and hold each other accountable for delivering outcomes



- PSEH System Board is final arbiter of system decisions, with senior representation from all partner organisations
- Focus is on delivery actions with less frequent meetings and reduction in duplication
- Clinical Executive aligns current system clinical leadership groups to form one decision making group focused on transformation
- System Improvement Programmes have a steering group/board and gateway meetings, supported by the system PMO, reporting through Gateway meetings to the System Board
- Development programme teams meet as and when required and report progress through System Delivery Team to the Board
- System Delivery Team focus is overall co-ordination and delivery of the enabling and supporting functions and processes and include subject experts and senior partner representatives
- System Finance Board focuses on recovery, sustainability and business rules and aligned with the system PMO
- Leadership Community comes together periodically for strategy, horizon scanning and development

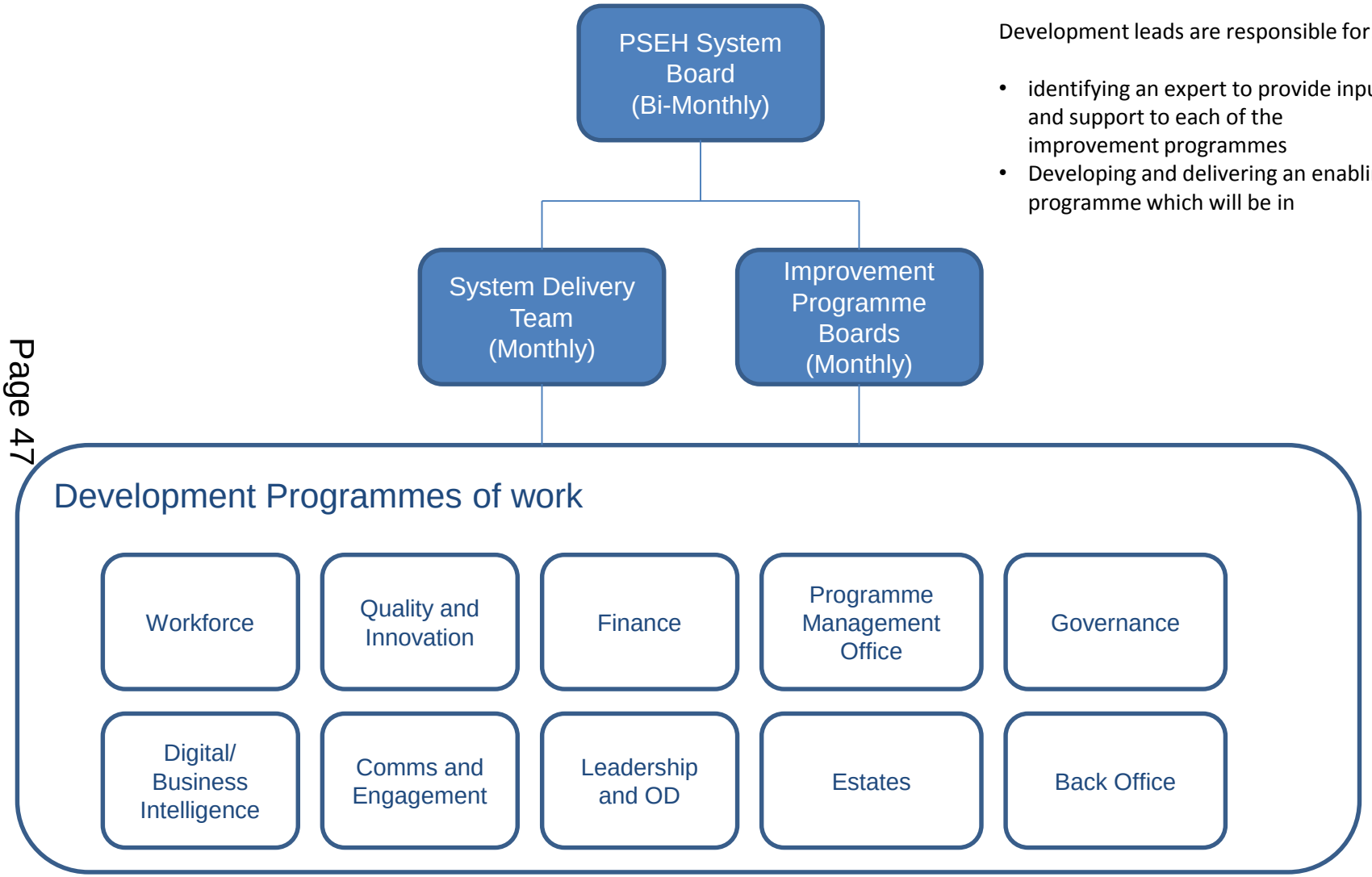
System decisions are made through these groups supported by delegated authority and collective responsibility

	Functions/ Decisions
Partnership Organisation Board/ Governing Body	• Approval of PSEH system programmes of work and any delegated authorities to be provided to any specific Programme Board or the PSEH System Board • Agreement of level and existence of a delegated budget to be managed by the PSEH System Board • Approval of any system agreement, for example, setting out the return on investment • Agreement of the application of the system financial framework by programme or project • Agreements/ Approvals are subject to the delegated authorities vested in the Executive Members attending the System Board
Portsmouth and South East Hampshire System Board	• Agreement of the overarching System strategy and oversight of transformation plan • Approval of PSEH System agreement • Approval of resource allocation , delegated budget and return on investment within the System to an agreed amount • Make decisions based on risk and return, in line with any delegated limits and/or any agreed financial framework or otherwise make recommendations to organisational Boards where delegations exceed the authority of Executive Officers • Agree recommendations to individual partner Boards re type and level of delegated authorities, including budget and allocations across partners to ensure delivery of the programmes • Representation of each of the partner organisations • Oversight for system plan actions for which each organisation is responsible. • Approve system communications, including promotion of positive action has resulted from a system programme • Take decisions to address any performance management issues of any System programme to ensure resources are being applied appropriately • NB: in reaching decisions, the System Board will have due regard to the Lay Member/Non-Executive Governance Working Group and System Clinical Executive
System Improvement Programmes/ Gateways	• Make recommendations to System Board and make decisions delegated to the programmes • Accountable for delivery of each programme • Oversee planning, delivery of programmes, risks to delivery and mitigation actions • Ensure outputs are defined , appropriate and measurable • Make resource decisions at programme and sub-programme level • Ensure the adequacy of implementation plans with particular reference to clinical engagement and impact on quality • Ensure communications across the programme are delivered to the delivery teams and to the System Board • *Gateway meetings:* undertake assessment of current programme performance and make recommendations to improve programme success. • NB: in reaching any decisions or recommendations, each Programme Board will have due regard to the Lay Member/Non-Executive Governance Working Group and the System Clinical Executive

System decisions are made through these groups supported by delegated authority and collective responsibility

	Functions/ Decisions
PSEH System Clinical Executive	• Provide expert clinical input into system transformation • Make recommendations to the PSEH System Board on clinical strategy • Approve recommendations to the relevant Programme Board re the level and type of clinical resource/intervention required for each project • Provide senior clinical representation and decision making on behalf of partner organisations • Agree recommendations on communications and wider clinical engagement • Decide whether clinical risks have been adequately identified and mitigated and escalate where appropriate to the System Board
PSEH System Lay/ NED Governance Group	• Responsible for lay and NED engagement in the development of system governance and assurance • Review options and make recommendations on system governance to the PSEH System Board • Agree recommendations to the Programme Boards, to PSEH System Board and to the relevant Partner Organisational Board, on the adequacy of the assurance and decision-making processes • Provide advice and guidance to Programme Boards over the governance including communications of each programme and project • Central oversight of governance checkpoints • Oversight and review of key governance risks including mitigation and escalation
PSEH System Delivery Team	• Make recommendations to PSEH System Board • Develop management and business support functions and hold leads to account for delivery • Agree leadership development programmes within the delegated budget • Determine the adequacy of business support functions, including communications for the programmes • Report business risk and proposed mitigations to the PSEH System Board • Agree priorities for escalating to the PSEH System Board (Agenda Setting) • Oversight of single plan including finance and activity, • Responsible for overarching communications and engagement activities • Responsible for system leadership development

Development programmes provide subject expert support in each of the improvement programmes as well as the overarching management of the business and support functions



Development leads are responsible for:

- identifying an expert to provide input and support to each of the improvement programmes
- Developing and delivering an enabling programme which will be in

Appendices

Meeting Functions and Membership

- PSEH System Board
- System Lay/ NED Governance Working Group
- System Improvement Programme Boards and Gateways
- System Clinical Executive
- Finance Partnership Board
- System Delivery Team

System Improvement Programme role outlines

System Meeting Functions and Membership

Portsmouth and South East Hampshire System Board

Chair : Sir Ian Carruthers, Independent Chair

Membership: The System Board is constituted of Chairs, Chief Executive Officers ,Chief Officers and lay members from partner organisations across the Portsmouth and South East Hampshire Health and Social care system, as set out below. Representatives from NHS Improvement/NHS England, the HIOW STP and the Wessex LMC are invited to also attend.

Frequency: 6 meetings per year.

Functions:

- Maintain a focus on the improvement of quality and experience for local people and set the foundation upon which the local system can implement the medium and long term goals of the Hampshire and Isle of Wight Sustainability and Transformation Plan.
- Develop the mechanisms and outcomes to jointly take accountability for population health .
- Support the turnaround and transformation of the local system through delivery of the single system improvement plan and priorities.
- Provide representation of each of the partner organisations and commit to deliver the actions and initiatives for which each are responsible.
- Create the leadership environment and effective relationships to enable transformational change
- Operate as the single decision making body aligning incentives to reduce fragmentation and improve outcomes

System Board Membership

- Sir Ian Carruthers - **Chair,** Special Adviser to the PSEH System
- Sue Harriman - **PSEH System Convener,** and Chief Executive, Solent NHS Trust
- Nick Broughton - Chief Executive, Southern Health NHS Foundation Trust
- Dr David Chilvers - Clinical Chair, Fareham & Gosport CCG
- Dr Linda Collie -Chief Clinical Officer & Clinical Leader, Portsmouth CCG
- John Coughlan - Chief Executive, Hampshire County Council
- Mark Cubbon - Chief Executive, Portsmouth Hospitals Trust
- Councillor Liz Fairhurst - Cabinet Member for Health Hampshire County Council
- Dr Elizabeth Fellows - Clinical Chair, Portsmouth CCG
- Margaret Geary – Lay member, Portsmouth CCG
- Will Hancock - Chief Executive, South Central Ambulance Service
- Susanne Hassleman - CCG Lay Member Hampshire Partnership CCGs
- Lynne Hunt - Chair Southern Health NHS Foundation Trust
- Maggie MacIsaac - Chief Executive, Hampshire Clinical Commissioning Group Partnership
- Melloney Poole - Chair, Portsmouth Hospital NHS Trust
- Dr Barbara Rushton – Clinical Chair, South East Hampshire CCG
- Lena Samuels - Chair, South Central Ambulance Service
- Dr Alistair Stokes - Chair, Solent NHS Trust
- Councillor Luke Stubbs - Cabinet Member for Health Portsmouth City Council
- David Williams Chief Executive, Portsmouth City Council

System Meeting Functions and Membership

Lay/ NED Governance Group

Chair : Suzanne Hasselman, lLay Member, South East Hampshire CCG/ Mick Tutt, Non Executive Director, Solent NHS Trust

Membership: A Governance representative and a NED/Lay Member representative from each partner organisation from health and social care

Frequency: As business needs indicates but no less than four meetings per year

Functions:

- Ensure Lay Member and NED representation and engagement in the development of emerging governance concerning the System working arrangements
- Seek support and representation from each of the partner organisations Board/ Governing Body
- Ensure governance processes enable timely decision making by sovereign organisations' respective boards/ governing bodies
- Seek independent advice and national intelligence to inform thinking
- Central oversight of governance checkpoints
- Oversight and review of key governance risks including mitigation and escalation

Initial work programme

- Develop an evolving scheme of delegation
- Establish Lay Member/ NED engagement network
- Review of Compact
- Communication back to organisations on governance, risks and progress

Improvement Programme Boards and Gateways

Chair: Executive Sponsor

Frequency: Monthly Programme Board meeting, Quarterly Gateway meeting

Membership: SRO, Clinical Lead, programme delivery team

Functions:

- Make recommendations to System Board and make decisions delegated by the System Board to the programme
- Accountable for delivery of the programme
- Oversee planning, delivery of programmes, risks to delivery and mitigation actions
- Make resource decisions at programme and sub-programme level
- *Gateway meetings:* undertake assessment of current programme performance and make recommendations to improve programme success.

Initial work programme:

- Review current clinical groups in system and develop a plan to align, focus and reduce duplication
- Develop the System Clinical model
- Provide focused clinical leadership on priority improvement programmes
- Lead wider clinical engagement across the system

System Meeting Functions and Membership

System Clinical Executive (Monthly)

Chair: Dr Elizabeth Fellows, Clinical Chair, NHS Portsmouth CCG

Frequency: Usually Monthly

Membership: Clinical Leads for improvement and enabling programmes , Partner organisation Clinical leads, to bring together system, organisational and locality leadership

Functions:

- Lead system transformational change providing expert clinical input into redesign
- Decision making forum for system clinical strategy, making recommendations to the System Board
- Responsible for creating shared and distributed leadership to ensure joint ownership
- Identify priority work programmes to deliver system benefits
- Provide senior clinical representation and decision making on behalf of partner organisations
- Facilitate clinical engagement across the system

Initial work programme:

- Review current clinical groups in system and develop a plan to align, focus and reduce duplication
- Develop the System Clinical model
- Provide focused clinical leadership on priority improvement programmes
- Lead wider clinical engagement across the system

Finance Partnership Board (Monthly)

Chair: Andy Woods, Chief Finance Officer, Fareham and Gosport CCG and South Eastern Hampshire CCG

Frequency: Monthly meeting

Membership: Finance Directors for each Partner Organisation

Functions:

- Development of immediate recovery plans, and delivery of the system financial plan
- System budget setting, management and monitoring
- Creation of sustainable financial model and supporting business rules/ governance arrangements

Initial work programme:

- Identification of PSEH system resource requirements and risk share arrangements
- Financial framework and principles
- Resource mapping programme

System Meeting Functions and Membership

System Delivery Team

Chair – Programme Director

Membership: System Convenor, Leads for Delivery, Quality and Innovation, Transparency, Governance, Workforce and OD, Communications and Engagement, Finance , PMO, Clinical Executive Chair, Programme Director, Organisation Partner Leads

Frequency: Delivery team will usually meet monthly, wider Leadership Team usuallyQuarterly

Functions

- Ensure alignment of STP and PSEH System programme plans, taking responsibility to meet the appropriate performance and assurance required by the STP
- Oversee the development and delivery of a single PSEH System plan and alignment of individual organisational plans
- Design of implementation strategies and infrastructure planning
- Develop the management and business support functions of the system and hold subject leads to account for delivery
- Provide oversight of the development and delivery of the overarching enabling programmes
- Ensure business support resources are appropriately allocated for each Improvement Programme, ensuring alignment of Improvement and development/ enabling programmes
- In relation to all business support services, identify and ensure risks and issues are appropriately mitigated and managed
- Develop the mechanisms and outcomes for the system to jointly take accountability for population health
- Ensure effective reporting processes are in place to enable oversight of delivery of the system Improvement plan and associated benefits realisation at the PSEH System Board
- Agree leadership development programmes within the delegated budget
- Agree priorities for escalating to the PSEH System Board (Agenda Setting)
- Support the PSEH System Board in delivery of its TORs and functions.

Initial work programme

- Development and Implementation of the overarching System Improvement Delivery Plan
- Development and implementation of the overarching communications and engagement plan for the system
- Development of business model and the PMO function
- Clarity on and inclusion of STP priorities in local plans and local plans into STP priorities
- Support development of leadership programmes

PSEH System Improvement Programmes: Roles and Teams

Each Improvement programme has been prioritised by the PSEH System to deliver step change in collective performance, patient safety and quality and deliver system efficiencies over and above schemes in place within individual organisations. This requires focused and accountable leadership with dedicated support from those already involved in the priority areas plus technical experts. An overarching design principle of system delivery is to focus and consolidate attention and resource on improvement areas.

Whilst the SRO roles to date have been paying attention to issues 'at the top of the triangle' they risk dislocation from current efforts and BAU performance assurance. This proposal suggests bringing all current provider and commissioner efforts together into single programmes.

SRO

- Accountable for delivery of the programme
- Recognised as the leader of the change
- Holds programme lead to account for delivery of all projects
- Ensure the outcomes of change are fully exploited
- Makes certain that any recommendations or concerns from Gateway reviews are met or addressed before progressing to the next stage
- Ensures strategic fit and benefits realisation

Programme Director/ Lead

- Accountable for delivery of each of the projects
- Manage the change programme
- Responsible for reporting progress of the programme to the PMO and Gateway process
- Holds project managers to account for delivery of their projects
- Supports project managers to manage risks and dependencies ,
- Ensures benefits realisation
- To ensure BAU is delivered including regulatory reporting
- To create a team of individuals who account for 100% of the above effort (nothing outside the box)

Executive Sponsor

- Provide guidance, support and act as point of contact for the SRO
- Point of escalation to the convenor
- Hold selves and other CEOs to account for delivery

Clinical Lead

- Develop the clinical vision for the change and provide guidance on priorities for redesign
- Work collaboratively and engage with other clinical and professional groups to ensure sign up and commitment
- Promote and support an evidence based approach to programmes of work
- Ensure the models of care implemented are robust, patient focused and deliver real benefits
- Lead clinical team in support of the priorities

Project Managers/ Project Team

- Commit to delivering a system improvement over an above organisational requirements
- Work collaboratively with others to deliver a set of agreed benefits
- Provide specific technical or operational expertise
- Provide information and performance analysis
- Undertake BAU activities including regulatory reporting

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2017 NHS Staff Survey headlines

NHS Solent NHS Trust

55.8% of people took part

3.86* Engagement score (increase from 3.83* in 2016 and above the average of other comparable trusts: 3.79*)

Out of 22 NHS key findings we had:

15 better than average

0 worse than average

The majority of the questions show an improvement on last year

Here are some areas where the improvement is significant

The care of patients/ service users is my organisation's top priority
79% Increase of 4%

I would recommend my organisation as a place to work
59% Increase of 3%

The team I work in have a shared set of objectives
77% Increase of 3%

My organisation takes action around errors, near misses or incidents
79% Increase of 3%

I am satisfied with the support I get from my immediate manager
76% Increase of 4%

My immediate manager can be counted on to help me with difficult tasks
78% Increase of 3%

I have had training, learning or development in the last 12 months
77% Increase of 5%

My immediate manager asks for my opinion before making decisions that affect my work
63% Increase of 3%

My immediate manager is supportive in a personal crisis
80% Increase of 3%

Areas which people scored the same:

- The way we work together in our teams
- The quality of our non-mandatory training
- The opportunities we give for career progression, regardless of background
- The difference you feel you make to patients
- The action we take to help you manage your health and wellbeing

Areas which people scored lower:

I am satisfied with my level of pay
32% Decrease of 6%

I am working additional unpaid hours
66% Decrease of 3%

I had the opportunity to talk about the Trust values and my development needs during my appraisal
63% Decrease of 2%

Next steps

Look out for your team reports. Your manager will talk with you about next steps and the actions you can take as a team.

Over the coming weeks we will be communicating the Trust results with you in more detail. You can find the Trust survey report on SolNet within Staff Zone.

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