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Portsmouth CITY COUNCIL

NOTICE OF MEETING

HEALTH OVERVIEW & SCRUTINY PANEL

THURSDAY, 16 JANUARY 2014 AT 9.30 AM

THE EXECUTIVE MEETING ROOM - THIRD FLOOR, THE GUILDHALL

Telephone enquiries to Jane Di Dino 023 9283 4060
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Membership

Councillor Peter Eddis (Chair)
Councillor David Horne (Vice-Chair)
Councillor Margaret Adair
Councillor Margaret Foster
Councillor Jacqui Hancock
Councillor Mike Park
Councillor Gwen Blackett
Councillor Dorothy Denston
Councillor Peter Edgar
Councillor Keith Evans
Councillor Mike Read
Councillor David Keast

Standing Deputies

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

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

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

A G E N D A

1 Welcome and Apologies for Absence

2 Declarations of Members' Interests

3 Minutes of the Previous Meeting (Pages 1 - 28)

4 **Hampshire & Isle of Wight Local Dentists Committee** (Pages 29 - 30)

Keith Percival, Hon Secretary will answer questions on the attached report.

5 **Amputation rate for diabetics** (Pages 31 - 34)

Allison Stratford, Associate Director of Communications and Engagement, Portsmouth Hospitals' NHS Trust and Darryl Meeking Consultant Diabetologist - Diabetic Foot Lead, Solent NHS will answer questions on the attached report.

6 **South Central Ambulance Service** (Pages 35 - 36)

Neil Cook, Area Manager, Portsmouth and South East Hampshire will answer questions on the attached report.

7 **Hampshire & Isle of Wight Pharmaceutical Committee** (Pages 37 - 40)

Sarah Billington, Chief Officer will answer questions on the attached report.

8 **Southern Health NHS Foundation Trust** (Pages 41 - 42)

Pam Sorensen, Interim Head of Communications & Engagement will answer questions on the attached report.

9 **Adult Social Care** (Pages 43 - 48)

Justin Wallace-Cook, Assistant Head of Adult Social Care will answer questions on the attached report.

10 **Dates of Future Meetings.**

20 February.
20 March.
12 June.
16 October.

HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held in the Guildhall on Thursday 17 October 2013 at 9:30am.

Present

Portsmouth members

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

Co-opted members

Councillors Gwen Blackett

Also in attendance

Healthwatch Portsmouth
Steve Taylor, Manager

NHS England (Wessex)
Julia Bagshaw, Head of Primary Care

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

Portsmouth City Council
Claire Budden, Senior Programme Manager
Dr Jeyanthi John, Consultant in Dental Public Health
Lee Loveless, Advance Health Improvement Practitioner
Matt Smith, Associate Director of Public Health & Primary Care.

Portsmouth Hospitals' NHS Trust.
Isabelle Gaylard, Head of Nursing for Emergency Medicine
Maria Purse, Managing Director for Emergency Medicine
Allison Stratford, Associate Director of Communications and Engagement

Solent NHS Trust
Sarah Austin Director of Strategy
Andrea Hewitt, Head of Marketing Communications
Susan Hogg, Clinical Lead, Portsmouth Rehabilitation and Reablement Team

Southern Health NHS Trust
Fay Presleton, Area Manager, Fareham & Gosport

38. Welcome and Apologies for Absence (Al 1)

Councillors Peter Edgar. Jacqui Hancock, David Keast and Mike Read sent their apologies.

39. Members' Interests (AI 2)

No interests were declared.

40. Minutes of the Previous Meeting(AI 3)

RESOLVED that the minutes of the meeting held on 13 June 2013 be confirmed as a correct record and be signed by the chair.

41. Update on Public Health Progress Following the Transfer of Responsibility and Health Information (AI 4).

Matt Smith, Associate Director of Public Health & Primary Care presented his report that had been circulated with the agenda and in response to questions from the panel, clarified the following points:

- The focus of the services is the recovery model.
- A key pillar of the Safer Portsmouth Partnership (PSP) is the reduction of crime and reoffending.
- He is chair of the Joint Commissioning Group which is part of the PSP. This looks at broader partnership issues.
- Work is being carried out to identify how information sharing could be improved.
- Substance misuse, smoking, obesity and alcohol misuse are currently commissioned separately. The Public Health team is looking at bringing these together in a more holistic approach.
- There is a strong focus on early years, the Personal, Social and Health Education agenda and the Healthy Schools Programme.
- The public message is being reviewed to ensure that the public understand how to access services and find information.
- A full range of healthy lifestyle services is provided.
- The Public Health team provides advice and support to the NHS regarding shaping services and to ensure that emergency plans are in place.
- Public Health services are linked to the outcome frameworks and demonstrate value for money.
- Although a significant amount of funding is invested in substance misuse, it is well recognised that alcohol misuse is a bigger problem.
- As part of the Making Every Contact Count initiative, the broader workforce is trained and takes responsibility for brief interventions.

Councillor Eddis suggested that more consideration be given to getting the message across particularly as public health is now the local authority's responsibility it is more accountable.

ACTION

Members be provided with the following:

- Copies of the Public Health Outcome Framework.
- The link to the Healthy Pompey website.

RESOLVED that the public health progress update following the transfer of responsibility and health information be noted.

42. Portsmouth Hospitals' NHS Trust's Update (AI 5).

Allison Stratford, Associate Director of Communications and Engagement and Maria Purse, Managing Director for Emergency Medicine, presented their report that had been circulated with the agenda and in response to questions from the panel, clarified the following points:

- More than 4,000 patients were involved in clinical trials last year.
- The average length of stay in hospital due to improvements in treatment has reduced.
- The NHS is a brand that covers many organisations.
- Transfers of care can sometimes delayed despite many organisations working together to ensure that the patient is in the appropriate place when they leave the hospital.
- Hampshire County Council and Portsmouth City Council commission different services for their patients. This can cause challenges for hospital staff as they have to ascertain the geography of the patient to determine the services that have been commissioned for that patient.
- There will be an increase in demand for community and social services over the winter months.
- The hospital provides a significant amount of health education and promotes health campaigns such as Stopober which encourages people to stop smoking.
- Nicotine patches are provided to patients to discourage them from going outside the building to smoke. E-cigarettes are not encouraged or provided on prescription.
- A smoking shelter is available away from the entrance for the public.
- Staff are not permitted to smoke in the hospital grounds.

ACTION

- In future the update letter is to include more details about the challenges the hospital faces.

RESOVED that Portsmouth Hospitals' NHS Trust's update be noted.

43. The Right Place, Right Time Community Lounge (AI 6).

Susan Hogg, Clinical Lead, Portsmouth Rehabilitation and Reablement, Solent NHS Trust, Fay Presleton, Area Manager, Fareham & Gosport Southern Health NHS Foundation Trust and Isabelle Gaylard, Head of Nursing for Emergency Medicine and Maria Purse, Managing Director for Emergency Medicine, Portsmouth NHS Hospitals' Trust presented their report that had been circulated with the agenda and in response to questions from the panel, clarified the following points:

- The lounge runs from 9am to 9pm, seven days a week.
- One third of patients are Portsmouth residents.
- The costs of the first six months' (December 2012 - May 2013) are provided in the report. A more in-depth review has commenced.
- Preventing readmissions leads to many hidden savings to the hospital.
- Faster turnarounds reduce the risk of patients becoming trapped in the acute system.
- Patients are assessed by a doctor at the Emergency Department.

- The staff in the lounge work closely with staff in the Emergency Department to understand when it is safe to arrange for patients to be transferred back home or to the appropriate community placement.
- Staff levels are sufficient to meet the current demand. However, these are continually reviewed.

Sarah Austin Director of Strategy, Solent NHS Trust asked the panel to note that there is collaboration between the commissioners and providers in Portsmouth and the rest of Hampshire.

Councillor Eddis noted that this lounge provides a good service.

RESOLVED that the report on the Right Place, Right Time Community Lounge be noted.

44. Solent Health NHS Trust's Update (AI 7).

Sarah Austin, Director of Strategy presented her report that had been circulated with the agenda and in response to questions from the panel, clarified the following points:

- Solent provides NHS podiatry services. Foot problems are being detected sooner with the new service, and overall demand is increasing.
- The council commissions free nail clipping services which are provided at Solent's premises. It is unusual for a local authority to provide this service. The service, whilst considered of value by the local population is taking up the same space as priority NHS services.
- Discussion is taking place with Portsmouth City Council at the moment on the location of this service.
- The nail clipping service does not need to be provided in a clinical setting.

Dr Hogan asked the panel to note that at the health centre where he works, podiatry services are provided but not by GPs.

Councillor Horne noted that many of his constituents use the free nail clipping service at the Paulsgrove & Wymering Healthy Living Centre. It is essential that service users are not disadvantaged if the service is moved.

ACTION

- The panel to be informed of the outcome of the discussions between Solent NHS Trust and Portsmouth City Council.
- Councillor Gwen Blackett to look into podiatry service provision in Havant.

RESOLVED that Solent NHS Trust's update be noted.

45. Guildhall Walk Healthcare Centre (AI 8)

Julia Bagshaw, Head of Primary Care, NHS England (Wessex) presented her report that had been circulated with the agenda and in response to questions from the panel, clarified the following points:

- NHS England (Wessex) commissions services at the Guildhall Walk Healthcare Centre (GWHC) for registered patients and the Clinical

Commissioning Group commissions urgent and unscheduled services.
- Over 5,000 people are registered with this practice.
- Many students choose to register with the GP surgery that is close to the university.
- Hampshire provides similar services using a different model.
- It has a very good rate of assisting people to stop substance misuse.

Dr Jim Hogan, Clinical Lead & Chief Clinical Officer presented his report that had been circulated with the agenda and added the following points:
- A significant number of patients are registered with a practice but choose to visit the GHWHC. In effect this means that the commissioners are paying twice for the GP service. After three visits, patients are encouraged to register with the GHWHC.
- The aim of the centre was to focus on homeless people and people with substance misuse issues.
- The centre has proved to be very successful.

RESOLVED that the important role that the Guildhall Walk Healthcare Centre plays in catering for the needs of people who are not registered with a GP be noted.

46. Portsmouth Clinical Commissioning Group's Update (AI 9).

Dr Jim Hogan and Innes Richens, Chief Operating Officer presented their report that had been circulated with the agenda and in response to questions from the panel, clarified the following points:
- Unscheduled care is a fractured system; all the services need to work together. The pilot front door service at the Emergency Department will start shortly and continue for 12-18 months.
- Currently a number of organisations provide patient transport services. Commissioning a single provider will improve coordination and reduce costs.
- Hampshire is the last county to adopt the summary care records system.
- The summary care record will move with the patient if they change practice.
- Patients are registered with a practice rather than with a particular GP. Dr Hogan informed the panel that at his practice, he manages a patient list and retains contact with them even if he cannot see them every time.
- It is often difficult to offer an appointment with the same doctor within the timescale requested.
- Improvements could be made to the way services work together.
- Longer term visions for the health service would be useful.
- Consideration must be given to how money is allocated to services. Some of the incentives are misaligned.
- Waiting times at the Emergency Department have improved over the last few weeks but remain a concern.
- Waiting times for cancer treatment are a concern.

ACTION
- A breakdown of patient transport around the city is to be sent to the panel.

- If possible, future letters to patients be amended to ensure it is clear that the summary care record would not contain a patient's full medical records.

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

47. NHS England (Wessex)'s Update (AI 10).

Ms Bagshaw tabled her report at the meeting and informed the panel that it will be informed as soon as the proposed steps are clarified.

ACTION

The terms of reference of the Senate will be sent to the panel.

RESOLVED that NHS England (Wessex)'s Update be noted.

48. Healthwatch Portsmouth (AI 11).

Steve Taylor, Manager presented his report that had been circulated with the agenda and in response to questions from the panel, clarified that Healthwatch Portsmouth:

- Signposts and advises the public and service users as appropriate.
- Demands responses from NHS organisations and to enter and view premises to talk to service users.
- Informs the Health Overview & Scrutiny Panel will be informed of any significant trends that are detected.
- Continues to raise public awareness of Healthwatch Portsmouth's role by giving presentations, using voluntary group networks and advertising.
- Provides training for Community Research Volunteers who carry out projects and report the outcomes back to Healthwatch Portsmouth. One example of a current project is reviewing how the city differentiates between people who have partial hearing loss and those who are completely deaf.
- Holds bi-monthly formal meetings and monthly development sessions.

  The Health Overview & Scrutiny Panel can refer issues to Healthwatch Portsmouth.

ACTION

The following information to be circulated to the panel:

- Healthwatch Portsmouth's terms of reference.
- A link to the report when published about how the city differentiates between people who are have partial hearing loss and those who are completely deaf.
- Six-monthly updates.

RESOLVED that Healthwatch Portsmouth's update be noted.

49. 2011-2012 Five-Year Olds Dental Epidemiology Survey in Portsmouth (AI 13).

The Chair agreed that this item be heard next.

Dr Jeyanthi John, Consultant in Dental Public Health (Wessex) and Lee Loveless, Advance Health Improvement Practitioner presented their report that had been circulated with the agenda and in response to questions from the panel, clarified the following points:

- At the start of school an opt in form is sent to parents for permission to examine children throughout their school life. For each examination an opt-out process is used.
- The chart on page 56 shows the margin for error.
- The main reason for non-participation is no response had been received from the parents/ carers.

RESOLVED that the Director of Public Health be asked to lobby Public Health England for a change to the guidance to allow schools to send consent forms for dental examinations to the parents of reception year pupils at the start of the school year rather than wait until the pupil is five years old.

Continuing Healthcare - Section 75 Agreements (AI 12).
Claire Budden, Senior Programme Manager presented her report that had been circulated with the agenda and in response to questions from the panel, clarified the following points:

- The buy-in from the Portsmouth Clinical Commissioning Group and Portsmouth City Council's Adult Social Care has been fantastic.
- Portsmouth City Council is the first local authority to do this and is sharing the best practice with others.

RESOLVED that the continuing healthcare - section 75 agreements be noted.

The meeting concluded at 12:15.

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Councillor Peter Eddis
Chair, Health Overview & Scrutiny Panel

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NHS England (Wessex)

Clinical Senate and Strategic Networks

Accountability and Governance Arrangements

Version 6.0

Document Location:

This document is only valid on the day it was printed.

Location/Path on shared drive:

Revision History:

Version number	Revision date	Author	Approvals
1	23rd April 2013	Debbie Kennedy & Janice Gabriel	Lucy Sutton
1.1	30th April 2013	Debbie Fleming	Debbie Fleming
2	27th June 2013	William Roche	
3	8th July 2013	Janice Gabriel	
4	16th August 2013	Keith Lincoln	(includes feedback from Oversight & Planning Group, Jul 13)
5	29th August 2013	Debbie Kennedy	Amendments to align with Role Description for Senate Council Member and Managing Conflicts of Interest & Standards of Business Conduct for Wessex Clinical Senate
6	4th September 2013	Sally Rickard	Amendments to SCN Terms of Reference to include purpose and define membership

Accountability and Governance Arrangements for Wessex Clinical Senate and Strategic Networks

1. Purpose

On April 2013, Strategic Clinical Networks were established nationally for four clinical areas:

- cancer;
- cardiovascular including renal, diabetes and stroke;
- maternity, children and young people;
- mental health, dementia and neurological conditions.

In addition, Clinical Senates were also established. In most cases, the Strategic Clinical Networks and Senate are co-terminous with the NHS England Area Team.

The purpose of the Clinical Senate and Strategic Networks are to provide an organisational model through which professionals, organisations and service users collaborate across organisational boundaries to deliver programmes which result in improved clinical outcomes and improved quality of patient care (NHS England March 2013). The Wessex Clinical Senate and Strategic Clinical Networks will work closely with Clinical Commissioning Groups and members of the Area Team on cross network issues, to provide independent, strategic clinical advice and leadership to all commissioners across the Wessex geographical area – that is, Hampshire, Dorset and the Isle of Wight - for the benefit of patients and the wider health system. The work of the Clinical Senate and Strategic Clinical Networks is facilitated by small support team. The Wessex Clinical Senate and Strategic Network Support Team is part of NHS England (Wessex) and is based at their offices in Southampton.

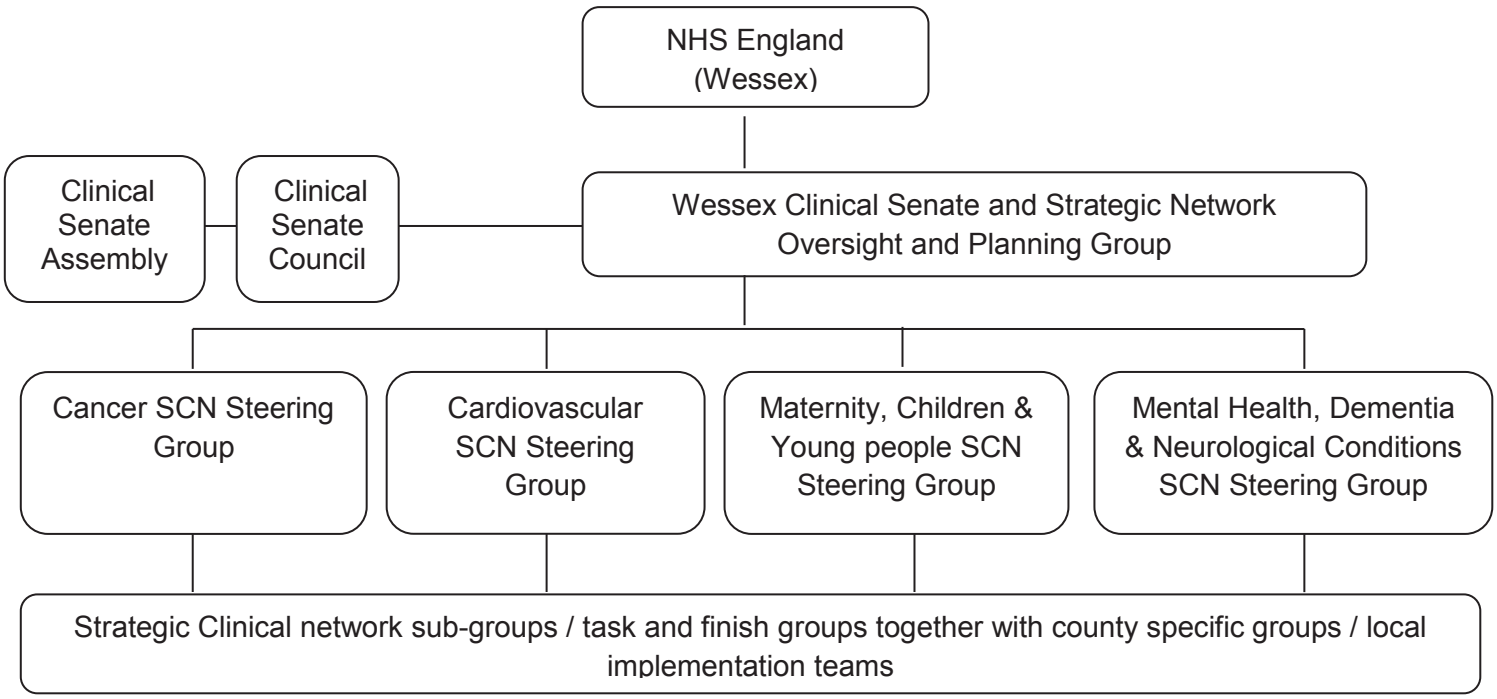
Working with their stakeholders and constituent organisations, including the Clinical Senates, the Strategic Clinical Networks will act as a vehicle for achieving continuous improvement where:

- A whole system approach is required to achieve improvement across a complex pathway of care involving multiple professionals and organisations;
- A co-ordinated, combined improvement endeavour is needed to overcome healthcare challenges, which have not responded to other improvement efforts.

The Way Forward for Clinical Senates and *The Single Operating Framework for Strategic Clinical Networks* details the rationale for setting up the Clinical Senate and Strategic Clinical Networks, as well as providing details on the active engagement and involvement of the constituent organisations. Such engagement and involvement should be outlined in formal arrangements with all the constituent organisations. The Clinical Senate and Strategic Clinical Networks will have an Annual Accountability Agreement with NHS England, which will be reflected in their annual work plan.

2. Governance Arrangements

The work of the Clinical Senate and Strategic Clinical Networks will be assured through the following governance groups and reporting arrangements:



The Associate Director for the Wessex Strategic Clinical Networks and Senate is accountable to the NHS England (Wessex) Medical Director and will ensure robust accountability and governance arrangements are in place for the Wessex Strategic Clinical Networks and Wessex Clinical Senate.

3. Responsibilities

Through collaborative working the Wessex Clinical Senate and Strategic Clinical Networks will:

i. Deliver the full range of functions outlined in *The Way Forward for Strategic Clinical Networks*, *the Way Forward for Clinical Senates* and the accompanying *Single Operating Framework for Strategic Clinical Networks* as well as other supporting documents (including the guiding principles for patient and public involvement).

ii. The Wessex Strategic Clinical Networks will develop, implement and monitor an annual work-plan of quality improvement projects, which enable the achievement of outcome ambitions for patients. They will focus on a small number of large scale, high impact projects ('priority' quality improvement programme) while at the same time facilitating the on-going continuous improvement of a wider range of initiatives ('maintenance' quality improvement programme).

iii. The Wessex Strategic Clinical Networks will ensure the NHS Change Model forms the basis for improvement work, with an emphasis on using all levers including contracts and tariffs to drive change.

iv. The Wessex Clinical Senate and Strategic Clinical Networks work plans will be in keeping with commissioner plans as overseen by the Oversight and Planning Group, including financial plans and support the QIPP agenda.

v. The Wessex Clinical Senate and Strategic Networks will advise and make recommendations to NHS commissioners and providers of NHS services in support of the development, delivery and assurance of safe, clinically and cost effective whole pathways of care (from prevention through to end of life care).

vi. The Wessex Clinical Senate and strategic Networks will act as an 'honest broker' for complex and highly contentious issues relating to the quality improvement and quality assurance agenda.

vii. The Wessex Clinical Senate and Strategic Clinical Networks will promote the development and delivery of best practice, evidenced based care; with an emphasis on ensuring equitable, consistent high quality service provision and a seamless transition in care across the whole patient pathway.

viii. The Wessex Clinical Senate and Strategic Clinical Networks will foster a culture of clinical leadership and influence in the development, delivery and assurance of services. This will include defining and securing agreement about clinical input/engagement to ensure successful delivery of the Clinical Senate and Strategic Clinical Networks annual work-plan.

ix. A culture of patient and public involvement in the development and oversight of the Wessex Clinical Senate and Strategic Clinical Networks will be fostered, together with the delivery of their activities.

x. Systematic risk management processes will be used to identify, assess, manage and escalate risks associated with the delivery of the quality improvement programmes within the Wessex Strategic Clinical Networks.

xi. The Wessex Strategic Clinical Networks will ensure a co-ordinated approach to stakeholder engagement in the improvement agenda.

xii. The outputs and outcomes of both the Wessex Clinical Senate and Strategic Clinical Networks' activities will be published including performance standards and clinical outcomes measures together with an annual report.

xiii. The Wessex Clinical Senate and Strategic Clinical Networks will evolve; developing in accordance with the national policy direction and the needs of their local constituent organisations, adding value to the development, delivery and assurance of services.

xiv. Partnerships with the Wessex Academic Health Science Network, Health Education (Wessex), Public Health England and the Operational Delivery Networks will be developed within Wessex for the benefit of patient and population health; potentially including the use of support resources.

xv. The Wessex Clinical Senate and Strategic Clinical Networks will develop robust communications and effective relationships with all Directorates within NHS England (Wessex), in particular, the Medical and Nursing Directorates.

4. Key relationships

The Wessex Clinical Senate and Strategic Clinical Networks will need to forge enduring relationships with other elements in the new NHS and care architecture; namely:

- Local **Clinical Commissioning Groups,** that are responsible for commissioning the majority of local NHS services;
- All **Commissioners and providers** who are the constituent organisations of the Wessex Strategic Clinical Networks and Wessex Senate.
- **Health and Wellbeing Boards** as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities

- **Academic Health Science Networks (AHSN)** will bring together academia, NHS commissioners, providers of NHS services and industry to bring about collaborations on education, training, research, informatics, healthcare delivery and encouraging innovation to ensure the improvement of patient and population health outcomes and to stimulate wealth.
- **Public Health England** has been established to protect and improve the Nation's health and wellbeing and to reduce inequalities. The local units of Public Health England will provide a key source of information and data to help the Wessex Strategic Clinical Networks and Senate produce their informed opinions.
- **Health Education (Wessex)** will also be key partners, both in terms of identifying issues for the Clinical Senate's consideration or using outputs to inform local workforce plans.
- **Patients, carers, members of the public** that will be engaging with the planning of local services in a number of ways.
- **Members/representatives of the voluntary sector**.

5. Accountability

Strategic Clinical Networks and Clinical Senates are both non-statutory organisational models, providing advice and support for commissioners. As such, commissioners remain accountable for the commissioning of NHS services, whilst providers remain accountable for service delivery.

The Wessex Strategic Clinical Networks are accountable for working with partners to develop and implement a programme of quality improvement including the effective use of resources. Accountability for both the Wessex Strategic Clinical Networks and Wessex Clinical Senate is through the NHS England (Wessex) Medical Director to the Regional Medical Director and the Area Director for NHS England (Wessex).

The Regional Medical Director will endorse the annual Strategic Clinical Networks and Senate work-plans, giving delegated authority to the Strategic Clinical Networks and Senates for delivery against these plans. The Area Director is responsible for the overall performance of the Area team, and delivery of the annual work programme.

The Regional and Local Medical Directors will together:

- Receive a quarterly accountability report, supporting resolution of risks and issues where required;
- Endorse Strategic Clinical Network and Senate recommendations, where required, for local approval and adoption.

6. Values

The Wessex Strategic Clinical Networks and Clinical Senate will work within the values of NHS England. Central to our ambition is to place the patients and the public at the heart of everything we do. We are what we want the NHS to be – open, evidence-based and inclusive, to be transparent about the decisions we make, the way we operate and the impact we have.

7. Decision Making

The expertise and leadership of both the Clinical Senates and strategic Clinical Networks enable them to be advisory bodies making recommendations in support of safe, sustainable high quality and cost effective care for the prescribed conditions. They have the ability to make both reactive (in response to constituent organisation and member requests) and proactive recommendations. These recommendations will be communicated to the Wessex Strategic Clinical Networks and Clinical Senate Oversight and Planning Group for ratification.

The clinical and managerial leads will foster a culture that promotes collective decision making for the benefit of patients. They will also have an 'honest broker' role in facilitating agreement between professionals and organisations to secure improvement.

Decision making ultimately remains with the constituent organisations, although it is expected that Strategic Clinical Networks and Clinical Senate recommendations will be endorsed, unless a constituent organisation can provide clear evidence for an alternative course of action.

8. Issues and Risk Management

The Wessex Strategic Clinical Networks and Senate support team will be responsible for the identification, assessment, management and escalation of risks and issues to the delivery of their strategy and annual work-plan; together with wider systemic risks to the commissioning and provision of quality services, for the four clinical areas.

Issue and risk management will take the form of:

- Engaging with the relevant Clinical Commissioning Groups and/or Specialised Commissioning Groups and providers, through facilitation and advice;
- Liaising through existing fora, defined by commissioners in accordance with local governance frameworks, or established specifically on a case by case basis;
- Making recommendations for action and associated contingency plans to the relevant governance group. It is expected that Wessex Strategic Clinical Networks and Wessex Clinical Senate recommendations will be supported unless a commissioner(s) or provider(s) can provide clear evidence to the contrary.
- Consulting with the NHS England (Wessex) Medical Director and/or Regional Medical Director where appropriate. This may include further escalation e.g. to Monitor or the NHS Trust Development Authority.
- Publishing advice on outcomes to relevant constituent organisations and relevant governance groups.

9. Reviewing Accountability and Governance Arrangements

Over time it is expected that the governance arrangements for all Strategic Clinical Networks and Clinical Senates will need to be revised and potentially strengthened to reflect the new evolving NHS system, including potential linkages with Academic Health Science Networks.

10. Terms of Reference

Detail describing how the groups will operate with membership and frequency of meetings is given in the Appendices. Below is a summary of their main objectives.

10.1. Oversight and Planning Group (OPG)

The Wessex Strategic Clinical Networks and Clinical Senate Oversight and Planning Group sets and monitors the work plans of both the Wessex Strategic Clinical Networks and Clinical Senate. Although it is also a non-statutory group, it maintains the authoritative power on matters relating to network and senate activity plan. It will support statutory commissioning and provider organisations through an effective communications strategy approved by the NHS England (Wessex) Area Director. It reviews all Strategic Clinical Network and Senate priorities, considers cross-cutting themes, aligning them to outcomes. The Overview and Planning Group establishes and agrees the work programmes for the Wessex Strategic Clinical Networks and Clinical Senate to include outcome or geographically-based work undertaken by the Quality Improvement Leads. The Overview and Planning Group reviews the work of Strategic Clinical Networks and Senate and considers whether their priorities need to be referred to the Senate or vice versa.

10.2. Clinical Senate

Clinical Senates will help Clinical Commissioning Groups, Health and Wellbeing Boards and NHS England to make the best decisions about healthcare for the populations they represent by

providing clinical advice and leadership at a strategic level. Clinical Senates will not be focused on a particular condition. Instead they will take a broader, strategic view on the totality of healthcare within a particular geographical area, for example providing a strategic overview of major service change. They will be non-statutory advisory bodies with no executive authority or legal obligations and therefore they will need to work collaboratively with commissioning organisations**.**

The Clinical Senate is comprised of the Senate Assembly and the Senate Council.

10.2.1. Clinical Senate Assembly

The Clinical Senate Assembly will encompass a wide range of clinical professions, across the entire spectrum of NHS care, covering the five domains of the NHS Outcomes Framework. Members may also be members of professional bodies, trade unions, the third sector or other bodies such as Public Health England or Health Education England.

The purpose of the Clinical Senate Assembly is to achieve broad stakeholder engagement in the work of the Wessex Strategic Networks and Clinical Senate. Its' role is not a decision-making one although it could deliberate on high-level issues once they have been discussed by the Senate Council. The Clinical Senate Assembly should be asked to comment on the Clinical Senate work plan and have an on-going role in identifying "experts" in different specialties (e.g. acute, emergency care etc.) and in the formation of sub-groups around topics for future consideration of the Senate Council.

Members should attempt to decouple their institutional obligations from their advisory role and they may need to avail themselves of external assistance and support in order to help them to do that (e.g. via clinical leadership training). The Assembly should also be an opportunity for the development of clinical leaders. It is recognised nationally that the Assembly may be very large as its membership will be drawn from the many Health, Social Care and Voluntary Sector organisations in the area.

10.2.2. Clinical Senate Council

The Clinical Senate Council is a core 'steering' group of members of the Clinical Senate Assembly. The Council should receive objective data and information, and also views and opinions from a broad range of generalist and experts invited to give evidence to the meetings as the need arises. Other Wessex Strategic Clinical Networks, Clinical Commissioning Groups and NHS England will be able to refer 'topics' or issues to the Clinical Senate Council provided that they set out a case in writing in advance that the topic or issues meet its acceptance criteria:

Acceptance criteria of Wessex Clinical Senate	
1	The decision on the solution to the problem has not already been made in the health system. If a decision has been made, the Clinical Senate Assembly will be able to assist in providing the public profile on service changes, but NHS England states that the Clinical Senate should not revisit the issue[1].
2	The patient outcomes which are affected by the issue can be measured in direct or indirect ways.
3	The service change is major in that it will impact a whole system and is beyond the remit of a single commissioner.
4	The benefits of the change can be easily communicated across the health and social care economy in an 'end to end' story.
5	There is active visible sign off for the change proposed from senior leaders or the 'high interest, high influence' stakeholders as identified by the topic or issue analysis in Wessex.
6	The sponsors or owners of the change who have requested advice are willing to commit the time necessary to complete the change, the number of people required to execute it and any other resources required (e.g. financial, external consultants).

[1] Clinical Senates, The Way Forward, 25th January 2013

The Senate Council will normally hear evidence and views in open session but will retire to formulate its advice in closed session. The consensus advice of the Senate Council will be published and all members of the Senate Council will be expected to promulgate the consensus view.

10.3. Strategic Clinical Networks

There are four Strategic Clinical Networks: cancer, cardiovascular (including stroke, diabetes and renal conditions), maternity and children, mental health (including dementia and neurological conditions). Each of these networks will have a Steering Group which is responsible for assisting with the implementation of the 2013/2014 work plan, providing advice and support on the two strategic priorities and quick wins identified in the network. There may be a need for more sub groups in the networks which cover several care groups such as Maternity and Children, Mental Health, Dementia and Neurological Conditions. The initial steering groups will develop the cross-cutting themes in the work plan such as rehabilitation, early diagnosis etc. and it is likely that their membership will change over time to encompass those stakeholders who have knowledge and interest in these cross-cutting themes. Each network will have a stakeholder engagement strategy as part of the overall Wessex Strategic Clinical Networks and Senate Stakeholder Engagement and Communications Plan which will in turn be part of the overall NHS England (Wessex) one.

Appendix A

Terms of Reference of the Oversight and Planning Group

1. Membership

This group is the overarching body for the Senate and individual Strategic Clinical Networks, but needs to have no more than 12-14 members in order to successfully discharge its executive function. Membership is therefore:

- NHS England (Wessex) Area Director, Medical Director and/or Nurse Director
- Associate Director for Wessex Clinical Senate and Wessex Strategic Clinical Networks.
- Senate Chair
- Senate Manager
- Wessex Strategic Clinical Network representatives (1 x Clinical Director and 4 x Strategic Clinical Network Managers)
- Clinical Commissioning Group representative x 1 on behalf of Commissioning Assembly
- Public Health representative x1
- Health and Wellbeing Board representative x1
- Health Education (Wessex) representative x1
- Academic Health Sciences Network representative x1

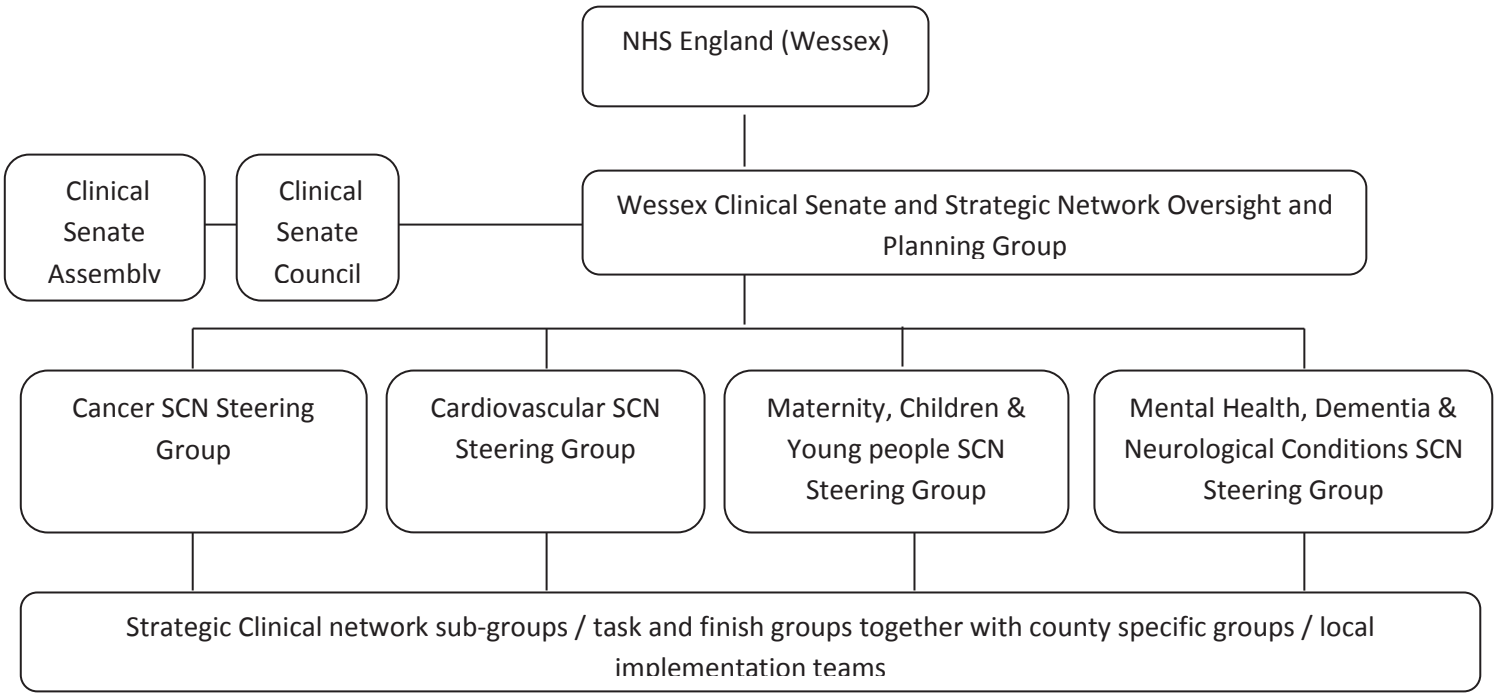
A patient representative will be invited to attend once NHS England (Wessex) has an agreed Patient and Public Engagement and Experience Strategy.

Other organisations in the health economy will contribute to the membership of the Strategic Clinical Networks or Clinical Senate.

2. Frequency of Meetings

The group will meet at least four times year, or more frequently as required. Agenda and accompanying papers will be sent to members at least ten working days in advance of the meeting, with minutes being available no more than ten working days following meetings.

3. Governance Arrangements



4. Quorum

Meetings will be quorate when there is at least one representative from:

- Clinical Commissioning Group
- NHS England (Wessex)
- Clinical Senate
- 4 x Wessex Strategic Clinical Networks
- Associate Director or Strategic Clinical Network Manager

Appendix B

Terms of Reference Clinical Senate (Draft to be considered by Senate Chair)

1. Membership of Clinical Senate Council

Each Clinical Senate Council meeting will have in the region of 15-16 attendees including the support team. This restricted membership should enable it to perform its decision-making function. Members will be drawn from the interest area sub-groups of the Clinical Senate Assembly to represent commissioners and providers of a typical end to end pathway. The Clinical Senate Council should aim to reach a consensus decision on issues referred to it:

- Independent chair (appointed position)
- Associate Director Clinical Senate and Strategic Clinical Networks
- Senate Manger
- Patient/ public representative in partnership with Health Watch (when the strategy has been agreed)
- Clinical Commissioning Group lead
- NHS England (Wessex)
- Public Health representative
- Health and Wellbeing Board representative
- Health Education (Wessex)
- 4 Clinical Directors
- Academic Health Science Network/tertiary care organisations
- Multi-professional clinicians from community, primary and secondary care organisations

Members may contribute in person, by written or electronic communication. The Council is not intended to be a standing committee. There will be the opportunity before meetings for the Oversight and Planning Group to review its membership to decide whether the current membership have the knowledge or interest to consider the next topic/issue.

Substitutions can be made by the chair. Where a member is unable to attend a meeting, their parent organisation or constituency may propose a deputy in advance of the meeting for consideration and approval by the chair. Additional experts will also be invited from the Assembly or externally by the chair to give evidence on specific topics or issues at meetings. The Council will make recommendations which will then be considered by the Oversight and Planning Group. If there are too many interested parties, the Senate Chair will agree attendance based on the following criteria:

- impact on professional training within the topic/issue area
- impact on professional leadership within the topic/issue area
- the level of their interest in clinical policy relating to topic/issue area
- the level of their influence in clinical policy relating to topic/issue area
- Their ability to enhance the multi-professional nature of the Clinical Senate Council's membership

1.1. Frequency of Meeting

At least quarterly, the agenda and accompanying papers will be sent to members at least fifteen working days in advance of the meeting, with minutes being available no more than ten working days following meetings.

1.2 Quorum

The Chair, Senate Manager or Associate Director and sponsoring commissioner should be present at every meeting.

2. Membership of Clinical Senate Assembly

Membership should be broad, may form in sub groups for expertise i.e. acute providers, Mental Health, public and patients and drawn from the following:

- NHS England (Wessex)
- Clinical Leads for Strategic Clinical Networks, Operational Development Networks, Local Professional Networks and other recognised local networks

- Clinical Commissioning Group Clinical Leads and others in clinical leadership roles
- Medical Directors and Directors of Nursing of Provider Trusts
- Health Education (Wessex)
- Patients and the Public
- Social Care (Adults and Children)
- Academic Health Science Networks
- Specialised Commissioning Clinical Reference Group members
- Public health representatives (Public Health England and Local Authority)
- Royal Colleges
- The wider clinical community so that all clinical disciplines, care settings and geography covered by the Clinical Senate are reflected e.g. Medicine, Nursing, Midwifery, Allied Health Professionals, Clinical Scientists, Pharmacists
- Local Medical Committees, Local Optometric Committee and Local Pharmaceutical Committee
- British Medical Association
- Health Watch England
- Health Oversight and Scrutiny Committees
- Health and Wellbeing Boards

2.1. Frequency of Meetings

The Senate Assembly will meet twice or three times a year. The agenda and accompanying papers will be sent to members at least fifteen working days in advance of the meeting, with minutes being available no more than fifteen working days following meetings. The Senate Assembly will receive advance notice of the issues which have been referred to the Clinical Senate Council.

2.2 Quorum

There is no quorum for this meeting.

Appendix C

Terms of Reference Strategic Clinical Networks Steering Groups

1. Purpose

The Strategic Networks are to provide an organisational model through which professionals, organisations and service users collaborate across organisational boundaries to deliver programmes which result in improved clinical outcomes and improved quality of patient care (NHS England March 2013). The Wessex Strategic Clinical Networks will provide independent, strategic clinical advice and leadership to all commissioners across the Wessex geographical area – that is, Hampshire, Dorset and the Isle of Wight - for the benefit of patients and the wider health system. Working with their stakeholders and constituent organisations, including the Clinical Senates, the Strategic Clinical Networks will act as a vehicle for achieving continuous improvement where:

- A whole system approach is required to achieve improvement across a complex pathway of care involving multiple professionals and organisations;
- A co-ordinated, combined improvement endeavour is needed to overcome healthcare challenges, which have not responded to other improvement efforts.

2. Membership of Strategic Clinical Network Steering Groups

Each Strategic Clinical Network Steering Group will be chaired by the Clinical Director and the Network Assistant/administrator will attend. Relevant Strategic Clinical Network Managers and/or Quality Improvement Leads will also attend where work plan items are being discussed. There should be representation from commissioners and providers who have knowledge and interest in the work plan. The membership should be restricted to avoid duplicating that of the former cardiovascular and cancer clinical networks which were operational as well as strategic. It will differ slightly depending on the network and the membership does not need to be representative, but the core membership should consist of:

- Clinical Director (appointed position)
- Network Assistant/ Administrator
- Strategic Clinical Network Manager or Quality Improvement Lead as appropriate for themes.
- Patient/ public representatives (when the strategy has been agreed)
- Commissioning representatives (e.g. CCG children's commissioning leads)
- Provider representatives
- Clinical leads

1.1. Frequency of Meeting

At least quarterly. The first meetings will follow the Stakeholder Engagement events which will be held in May and June 2013 after which the membership will be confirmed. The agenda and accompanying papers will be sent to members at least ten working days in advance of the meeting, with minutes being available no more than fifteen working days following meetings.

1.2. Quorum To be determined.

HAMPSHIRE AND ISLE OF WIGHT LOCAL DENTAL COMMITTEE

Secretary's Report

PART ONE:

Overview:

The Hampshire and Isle of Wight LDC is one of two LDCs within the Wessex Area Team (WAT), which is one of the largest Area Teams in England. The two LDCs are successfully and actively communicating and meeting on a regular basis to resolve and promote a synergistic approach to identified (locally/nationally led questions and concerns) representative matters that lie within the WAT.

It has been considered by both LDCs that a strategic retention of separate LDC identities is presently of fundamental importance and therefore some of the liaison meeting agenda items individually reflect dedicated and area specific representative issues on behalf of one of the two separate constituencies, which obviously extend over a large geographical area with very different needs and concerns – rural and inner city.

The Chair of the LPN/LDN is yet to be appointed and the LDCs are hopeful that they will be on the selection panel for this pivotal post. It is believed that this will be advertised on NHS jobs in the very near future.

There has been limited success with Health and Well being Board engagement in our area but steady progress has been made with Portsmouth and Southampton H&WBBs through the Consultant in Dental Public Health and the joint Director of Public Health. An initial meeting has been held with the Health Partnerships and Strategic Business Manager Public Health Southampton City Council and thereby facilitated an increased awareness of the contribution that the H&IOW LDC can make to council decisions made by the Portsmouth and Southampton H&WBBs in connection with the JSNA and the Joint Health and Wellbeing Strategies. It is hoped to build on this opportunity to provide professional and representative input outside of the Health and Wellbeing Board meetings to aid in decisions that affect local practitioners and patients. The LDC will draw on skills and strengths within its membership to achieve this.

PART TWO:

Taking the Next Steps: The past and future adaptation to the timetable of NHS change from an LDC perspective.

Keith Percival
Hon Sec
16th January 2014

Diabetes Foot Care in Portsmouth

Background:

Data published in early 2011 showed wide geographical variation in amputation rates in people with diabetes across the country. Portsmouth City PCT was identified as having the second highest major amputation rates for the years 2007-2010.

Diabetes related amputation has a dramatic effect both on a person's quality of life and their life expectancy.

Every 30 seconds a lower leg is lost to diabetes somewhere in the world
Evidence shows that 95% of all diabetes related amputations are preceded by at least one foot ulcer. In most cases, diabetic foot ulcers and amputations can be **prevented**. It is estimated that up to **85% of amputations** could be avoided
(International Diabetes Federation, 2005)

The prevention starts with the early discovery of foot problems in people with diabetes. Comprehensive education of all patients about diabetic foot problems is advocated; assessment in primary care to identify a person's foot risk with onward referral to the right team, combined with early and appropriate intervention by a wide range of health care professionals (podiatrist, orthotist, tissue viability nurse, Diabetologist, vascular surgeon, orthopaedic surgeon, radiologist, microbiologist, community nurse and general practitioner) all contribute to the reduction in amputation rates.

Where we were: 2010

- One multidisciplinary (MD) diabetic foot clinic provided at St Mary's Hospital run by Diabetologist and Podiatry team from Solent NHS Trust.
- Diabetic Foot pathway for the acute foot problems for hospital care in place, however the pathway of care that did not direct patients with new diabetic foot ulcers to a specialist MD clinic
- Lack of dedicated foot care education for people with diabetes leading to a lack of self care and awareness of foot problems
- Low rates of referral and late referrals to specialist podiatrists (only 50% of patients with major amputations had seen a podiatrist and less 5% attended a multidisciplinary clinic)
- Low rates of foot examination in primary care / lack of education for health care professionals about diabetic foot problems
- Delayed and inadequate access to orthotic services for provision of appropriate insoles / footwear for pressure offloading
- Poor access to Orthopaedic specialists and limited access for "gold standard" off loading by "total contact casting" for troublesome diabetic foot problems

Changes:

A new pathway of care directing everybody with a diabetic foot ulcer to a specialist Multi disciplinary Podiatry & Diabetologist clinics run three times per week (creating more appointments) with same day access to:

- Radiology reporting (X rays)
- Microbiology advice (Infection management)
- Early access to vascular surgery (where surgery is indicated)
- Access to Orthopaedics with fast access to contact casting
- Fast access to orthotics services
- Access to a dedicated foot ulcer clinic run by Solent NHS Trust Podiatry

To allow this to happen, the MD clinic was relocated from St Mary's to the Diabetes Centre at QA clinics

- To support this, there has been the development of community diabetes model with same day telephone and email advice and 2 visits to every GP surgery twice a year to update on service developments and provide diabetes education and advice to specific patients
- Introduction of diabetes foot education module free to all HCPs 4 times per year to incorporate a standard Diabetic foot assessment tool and "know your foot risk"
- Review and improvements in the Orthotic service provision which goes out to tender next year
- Development of diabetes care document to incorporate foot examination and know your risk for all patients with diabetes
- Foot education provided directly to patients at Diabetes Patient conference annually

Outcomes:

Amputation rates in those with diabetes already declining sharply in Portsmouth although measure should take many years to filter through as this is a long term complication of diabetes

August 2011	53 major amputations in preceding 3 years
January 2012	48 major amputations in preceding 3 years
January 2013	36 major amputations in preceding 3 years

The rate of major amputations has fallen from 2.3 per 1000 adults with diabetes to 1.4 per 1000 compared to national average of 1.1

Recurrent (repeat) admissions for diabetic foot disease, those patients admitted once to QA then a second for the same problem, is for the first time comparable to the national average

Future:

- Working with Portsmouth Hospitals to improve inpatient foot care provision through the provision of a dedicated inpatient diabetes podiatry service and improving orthotic provision
- Looking at current multidisciplinary foot clinics to see if a 5 day service is required providing greater capacity (more appointments) – more funding is needed for this to meet the ongoing demand
- Working with Solent NHS Trust Podiatry to provide a 6 day acute foot service in the community
- Working with Portsmouth Hospitals to move towards 7 day diabetes cover
- Working with colleagues in vascular surgery and orthopaedic surgery to improve communication and management of complex patients with diabetic foot problems

National guidance states that anyone who develops an acute foot complication (foot ulcer / Charcot) needs to see members of the Diabetic foot MDT within 24 hours. The vision is to get to that point for Portsmouth and this will dramatically impact on the amputation rate.

In conclusion, the Diabetic foot service is changing and Portsmouth Hospital Trust, Solent NHS Trust and Primary care are working jointly to improve the foot outcomes for patients with diabetes. These new developments do need ongoing sustainable funding to provide the best care for anyone who presents with a diabetic foot complication.

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South Central Ambulance Service NHS
NHS Foundation Trust

South Central Ambulance Service NHS Trust
HOSP Portsmouth update January 2014

New South East Hampshire Resource Centre

The new resource centre is reaching the latter stages of development with the formal handover to the trust expected in the next week or two and this will be clarified on Friday 10th January 2014, following the next site meeting. All of our ambulance staff in the South East have visited the site during the initial stages and we have provided continual updates through our team meeting time, the staff are very positive and looking forward to taking up residence. Once the handover is complete we will undergo a period of 'snagging' and then the set up of SCAS based equipment. This will then facilitate our move to the site which will be undertaken in a stepped approach with some of the satellite stations being introduced initially, and Portsmouth (Eastern Road) being the final move, this is expected to take approximately a month with a view of introducing and experiencing working from the new site on a hub and spoke basis in a timely manner .

The site itself has been designed to a good specification and is certainly going to provide an excellent facility for the ambulance staff across the area. It is also offering an excellent training and base facility for the teams as well as improving the management of the resources across the patch.

Standby locations

We have continued to work with varying organisations to establish standby points across the area as well as retaining our current facilities. It has been considered that the introduction of new sites for facilitated standby needs to be rationalised as we introduce the way of working rather than rush them through as our requirements may alter. We will be retaining our current estate and will dispose in line with new standby locations. We continue to analyse our demand and any demographic changes which impact on our service provision and request that if there is any further assistance this group can assist with we would be more than happy to discuss.

As previously mentioned we will be retaining a Rapid response car site on the Gosport/Fareham peninsula to ensure adequate responses are available at all times and this is a separate piece of work as it requires a slightly higher specification.

General Information

The Service has had a difficult period with demand across the area at between 4-7% on last year. This has been difficult to reconcile with no specific change in operations to facilitate the rise. Some individual days have seen rises of 20% against last year.

We have continued to work hard with our commissioners and our stakeholders within the local Health Economy to maintain services to an acceptable level and whilst we continue to provide a service well above national standards in the Portsmouth area, we have experienced some occasions where this has dropped below our expected levels.

As part of a local initiative of working more closely with other health care providers in our area, we are using the a new performance data program. This allows us to input key performance data on a daily basis so that our partners can see how we are performing and if any pressures are occurring which may affect our partners. This also gives us the ability to understand the work pressures that are affecting our partners and through a program of daily conference calls we are able to identify and discuss any potential issues and act accordingly

The acuity of patients has increased over recent weeks with medical conditions being at the forefront of the problems encountered, this is generally expected at this time of year and we have worked very closely with our health partners in Winter Planning.

Performance

	Year To Date%	
	R1/8	R19
SCAS	76.02	95.54
South East Hants	79.51	96.97

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Urgent and Emergency Care- Making better use of Community Pharmacy

Last year, NHS England committed to reviewing the provision of urgent and emergency care as part of a drive to promote more extensive seven-day services in the NHS, and to build a safe, more efficient and sustainable system for the future. The Urgent and Emergency Care Review under the chairmanship of Professor Sir Bruce Keogh was established at the beginning of 2013 to support this, and aims to:

- Put patients and the public first;
- Create consensus among clinicians on options for organising urgent and emergency care;
- Produce evidence to support proposed models of care, based on quality, workforce and economic considerations; and
- Create a climate in which clinical commissioning groups (CCGs) can commission for change and improvement in their localities.

Alongside the launch of the review, NHS England introduced the A&E Improvement Plan in May 2013. This resulted in the formation of Urgent Care Working Groups (UCWG) in each area of the country. These groups have been working locally to support the delivery of the 4 hour A&E operational standard.

Context

Demand on hospital resources has increased dramatically over the past 10 years, with a 35% increase in emergency hospital admissions and a 65% increase in secondary care episodes for those over 75 years.

- Last year, there were over 21 million visits to A&E or nearly 60,000 attendances every day;
- There were 6.8 million attendances at walk in centres and minor injury units in 2012/13, and activity at these facilities has increased by around 12% annually since these data were first recorded a decade ago;
- The average number of consultations in general practice per patient rose from 4.1 to 5.5 per year between 1999 and 2008;
- Attendances at hospital A&E departments have increased by more than two million over the last decade;
- The number of calls received by the ambulance service over the last decade has risen from 4.9 million to over 9 million; and
- Emergency admissions to hospitals in England have increased year on year, rising 31% between 2002/03 to 2012/13.

A combination of factors, such as an ageing population, out-dated management of long-term conditions and poorly joined-up care between adult social care, community services and hospitals accounts for this increase in demand over time. Compounding the problem of rising emergency admissions to hospital is the rise in urgent readmissions within 30 days of discharge from hospital. There has been a continuous increase in these readmissions since 2001/02 of 2.6% per year.

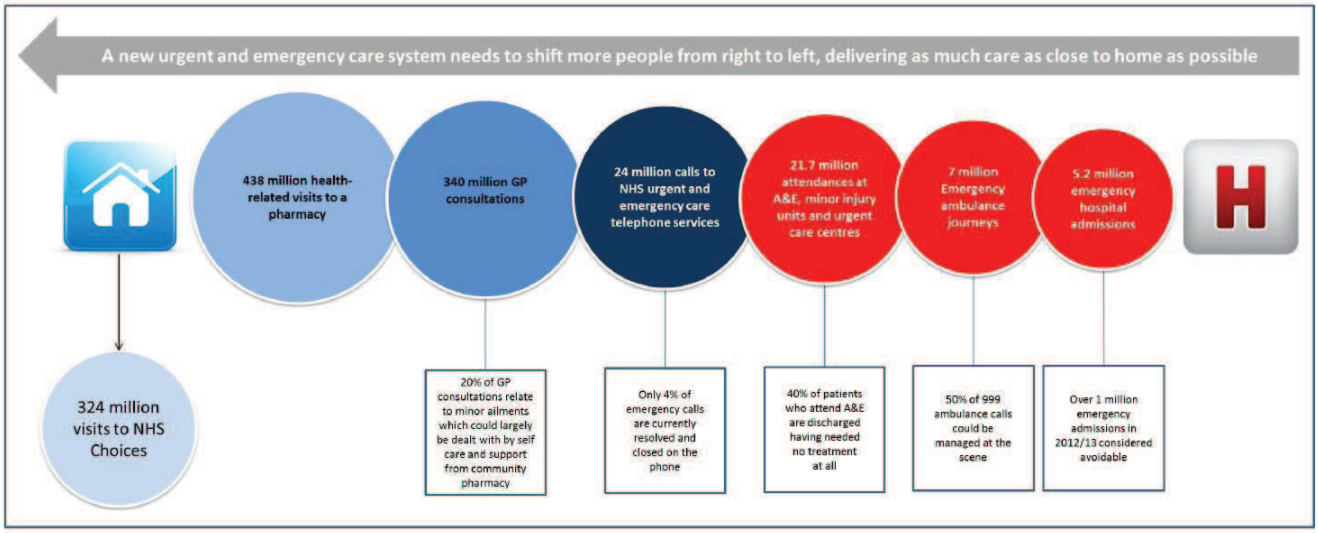
The Review so far

The Evidence base from the Urgent and Emergency Care Review was published in June 2013 and highlighted the role that pharmacies could play in providing accessible care and helping many patients who would otherwise visit their GP for minor ailments. It concluded that:

Community pharmacy services can play an important role in enabling self-care, particularly amongst patients with minor ailments and long term conditions.

The report describes a tide of rising demand and expectations from the public, who access care and support from a range of emergency and urgent care providers. The system is however confusing for patients and those working in the NHS and this does not help the provision of efficient and high quality care.

The report says that most urgent care problems are not life-threatening; for these problems patients need help, advice and simple treatments delivered as close to home as possible. The vast majority of people already seek and receive treatment and care for their urgent and emergency care needs in the most appropriate setting. However, it is also known that millions of people every year could receive advice and treatment closer to home. There is a huge opportunity to shift treatment and advice from acute hospital based services to home or close to home as highlighted by the following diagram:



Community pharmacies can have an important role in managing demand for urgent and emergency care services and diverting patients away from A&E.

The role of community pharmacy

It is agreed that a transformation of urgent and emergency care is required and the importance of the role that community pharmacies can play in this agenda has been recognised. Community pharmacies can support provision of care and reduce demands on GPs, NHS 111 and A&E in four areas:

- Supporting people to self-care
- Supporting people to live healthier lives
- Optimising the use of medicines
- Supporting people to live independently

1. Supporting people to self-care

Around 80% of all care in the UK is self-care and this is an area in which community pharmacy can make a real difference. Many people presenting at A&E or at GP practices could self-care with support from a community pharmacy. Evidence has shown that:

- 8% of A&E visits involve consultations for minor ailments, costing the NHS £136 million annually;

- 18-20% of GP workload is accounted for by minor ailments with 90% of those consultations being solely for minor ailments; and
- This equates to 57 million consultations a year and a cost of £2bn.

The NHS community pharmacy contractual framework includes;

- Support for self-care - the provision of advice and support by pharmacy staff to enable people to self-care for minor illness. This may involve the sale of an over the counter (OTC) medicine; and
- Signposting - referring people to other healthcare professionals or care providers when support beyond what the pharmacy can provide is necessary.

The local commissioning of a Minor Ailments Service has been shown to help reduce demand on other service providers. These services allow the pharmacy to provide OTC medicines at NHS expense in order to manage minor illness. In particular they help divert people away from GP practices who would otherwise seek a GP consultation and prescription because they receive free prescriptions.

2. Supporting people to live healthier lives

The provision of healthy living advice already forms part of the NHS community pharmacy contractual framework.

Community pharmacies will participate in up to six public health campaigns per year. The campaign topics, chosen by NHS England, could be selected to help modify public behaviours that can increase pressure on urgent and emergency care services, for example:

- Identification of alcohol use and brief advice, using validated assessments such as AUDIT-C; and
- Heatwave and 'Keep Warm, Keep Well' campaigns.

Provision of Emergency Hormonal Contraception in pharmacies, either sold over the counter or supplied at NHS/local authority expense can help avoid attendances at GP practices, out of hours and walk in centres and A&E. Flu vaccination of target groups can also help contribute to reducing pressure on emergency and urgent care services.

3. Optimising the use of medicines

It is estimated that up to 50% of medicines to treat long term conditions are not taken as prescribed. The consequence of this can be that long term conditions are not managed optimally. Adverse drug reactions also account for 6.5% of unplanned hospital admissions, and over 70% of these are avoidable.

The NHS community pharmacy contractual framework includes two services to help patients optimise the use of their medicines:

- Medicines Use Review (MUR) where a pharmacist undertakes a structured adherence centred review with patients on multiple medicines; and
- New Medicine Service (NMS) where a pharmacist supports patients with selected chronic conditions using new medicines.

MURs and NMS can also be used to support people recently discharged from hospital, in order to reduce the risk that confusion with their medicines leads to re-admission to hospital.

Other community pharmacy services which can be commissioned locally include:

- Emergency supply of medicines at NHS expense – to reduce out of hours and A&E attendances when patients run out of prescribed regular medication;
- Provision of rescue packs for COPD and other at risk patients – to support rapid management of disease exacerbations; and
- Palliative care schemes – to ensure availability of specialist medicines in primary care needed during end of life care.

4. Supporting people to live independently

Community pharmacies provide a range of services to help support people to live independently in their own homes, including:

- Home delivery of medicines to the housebound;
- Support with re-ordering repeat medicines; and
- Reminder aids to support medicines use.

Other community pharmacy services which can be commissioned locally include:

- Falls assessment services – to reduce the risk of medicines related falls;
- Concordance services- specific adjustment to support patients; and
- Re-ablement services - to support people with their medicines following discharge from hospital.

Sarah Billington
Chief Officer
Jan 2014

Southern Health NHS
NHS Foundation Trust

Communications and Engagement
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6 January 2014

Cllr P Eddis
Health Overview and Scrutiny Panel
Portsmouth City Council
Civic Offices
Guildhall Square
Portsmouth
PO1 2BG

Dear Cllr Eddis

On behalf of colleagues in Southern Health NHS Foundation Trust and specifically colleagues who lead the South East Hampshire Integrated Service Division, please find below information that we hope will offer members some insight with regard the key issues that are, or will, have some impact locally.

A representative from the services will be present at your meeting on 16 January and will of course be pleased to answer and questions members may have.

South East Hampshire Integrated Service Division (ISD)

Operations

During December, the ISD has been performing a significant role in the delivery of enhanced emergency capacity management within the Portsmouth and South East Hampshire health economy. This has included the commissioning of an additional 6 beds at Gosport War Memorial hospital to support discharges from the Queen (QA) Alexandra Hospital. In addition senior representation from the ISD has been present at the daily discharge planning meetings at QA in the period before and over the Christmas period.

In December members of the ISD team attend a workshop with Solent NHS Trust, Portsmouth Hospitals NHS Trust and the local Clinical Commissioning Groups (CCGs) to further development the future model of care for older patients and those with long term conditions. The outputs from this session, will inform the commissioning intentions for 2014/15 and 2015/16, which is intending to deliver improved integration of the service model across the providers.

Performance and Outcomes

The ISD continues to perform well on key operational metrics with measures to improve reported performance, gaining traction. Improved reporting has been evident in End of Life performance, Rapid Response delivery and in the reporting associated with leg ulcers.

The ISD has reached an agreement with the CCGs regarding the current QIPP(Quality Innovation Productivity and Prevention) challenges both on a non and recurrent basis.

There has been a significant recruitment drive across all inpatient Older Peoples Mental Health (OPMH) units and this continues. There are also improved control mechanisms in place to support the clinical teams to manage their temporary staffing useage.

Quality

The revised ISD governance structure was implemented from December 2013, with a quality programme which transcends the division. This new structure includes a Professional Advisory Group and a Band 7 Development Programme. In addition the local Clinical Quality Reporting Meeting (CQRM) has become well established with improving programmes of reporting and collaboration between the commissioners and the ISD.

Since November 2013 the ISD has received 2 formal reports from the CCG following visits to Petersfield and Gosport War Memorial hospitals. Both reports are exceptionally complementary about the standards observed during the visits and have made some suggestions on making these even better. The key area of feedback relates to the standards of the accommodation from which the services operate. Both sites have significant investment programmes planned to improve the clinical environment, although in the meantime some essential repairs are being undertaken.

The Head of Professions has been taking a leading role within the local health economy in support of the CCGs programme to eradicate pressure sores. In addition the ISD is also supporting a health economy wide initiative to reduce the levels of falls and associated harm.

The new process for the management of SIRIs (Serious Incident Requiring Investigation) has been fully implemented with the ISD reporting no breaches of the reporting standards. This improvement is a key indicator of the priority the ISD places on continuous improvement of our services and the opportunity for learning.

Workforce

The ISD has successfully recruited to the Bed Manager role which will support the OPMH beds in the first instance and will develop to cover Community Hospital inpatient provision.

We are currently considering redesign of services in relation to the full integration of physical health, mental health and therapy provision around geographical areas. We are, as you would expect, making plans for robust communication and engagement with key stakeholders in order to ensure they are fully involved and can influence our proposals.

I do hope this update has been helpful

With best wishes

Yours sincerely

P Sorensen

Pam Sorensen
Interim Head of Communications and Engagement

Agenda Item 9

Report to: Health and Social Care Scrutiny Panel

Date: 16 January 2014

Report by: Robert Watt, Head of Adult Social Care

Presented by: Justin Wallace-Cook, Assistant Head of Adult Social Care

Subject: Adult Social Care update on key areas

1. Purpose of the Report

1.1 To brief the Health and Social Care Scrutiny Panel on recent developments in Adult Social Care since the previous report in June 2013.

2. Recommendations

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

3. Update on Key Areas

3.1 ASC Budget

Adult Social Care continues to face significant financial challenges, with £4.7m savings to find in 2013/14 and a further £3.2m in 2014/15

Whilst we hope to avoid a further reduction in posts as was necessary in this financial year, savings will be required from direct provision and commissioning of services.

Budget proposals were put before the council in November and consultation will now take place with any service users that may be affected by these proposals.

3.2 ASC Development Projects

As part of our ongoing strategy to improve residential and independent living facilities for vulnerable people across the City, the following projects are underway.

Extra Care Sheltered Housing (ESCH):

- Caroline Square
  - New extra care facility developed on the site of the former residential home, Caroline Lodge, providing 43 apartments which will be available for rent with on-site care as well as catering and hairdressing facilities.

- Maritime House

  - Work has commenced on the site of the former residential home, Alexandra Lodge, to build 80 extra care apartments for rent as well as a 20 bed reablement unit.
  - Completion is programmed for late January 2015 with the apartments being available to rent from February 2015 onwards.

- Longdean Lodge

  - Formerly a long stay residential home for older people, Longdean now provides short term re-ablement and respite.
  - The plan was to re-provide for these services and develop the site to provide more extra care facilities, however, Housing 21's bid for £2.5m to the Department of Health for grant funding a 50-flat extra care facility was unsuccessful.
  - Opportunities still exist for Housing 21 to be awarded grant monies from future "slippage monies" or for PCC's Housing Services to include this scheme in their development programme
  - Any development would commence once the Victory Unit has transferred to their new premises in February 2015 with completion expected in June/July 2016.

- New Dementia Care Residential Home - East Lodge:

  - East Lodge site allocated to scheme by Cabinet.
  - An external architect has been engaged & detailed surveys of the site completed.
  - Conditional planning permission received on 4 December for a 72-bed residential care home for older people with dementia.
  - Commencement of works from September 2014 with completion planned for October 2015.
  - Closure in principle of Edinburgh House & Hilsea Lodge approved for transfer to new facilities.

3.3 <u>Care Bill - Reforming Care and Support</u>

What does the Care Bill do?

Part 1 of the Care Bill sets out to reform adult care and support in England: It delivers many of the commitments in the *Caring for our Future* White Paper. It also provides for a new capped costs system for funding care and support, based on the recommendations of the Dilnot Commission.

The Bill's focus is to:-

- ensure that people's **well-being**, and the outcomes which matter to them, will be at the heart of every decision that is made;
- put **carers** on the same footing as those they care for;

- create a new focus on **preventing and delaying needs for care and support**, rather than only intervening at crisis point;
- put **personal budgets** on a legislative footing for the first time, which people will be able to receive as direct payments if they wish.

The Bill aims to make care and support **clearer and fairer**, by:

- reforming the funding system for care and support, by introducing a **cap on the care costs** that people will incur in their lifetime.
- ensuring that people do not have to sell their homes in their lifetime to pay for residential care, by providing for a new **universal deferred payments scheme**;
- providing for a **single national threshold for eligibility** to care and support;
- giving new guarantees to ensure **continuity of care** when people move between areas, to remove the fear that people will be left without the care they need;
- including new protections to ensure that **no one goes without care if their providers fails**, regardless of who pays for their care;
- new provisions to ensure that young adults are not left without care and support during their **transition to the adult care and support** system.

Progress to Date

The Bill completed its House of Lords stages on 29 October 2013 and was presented to the House of Commons on 30 October 2013. This is known as the first reading and there was no debate on the Bill at this stage.

This Bill is expected to have its second reading debate on a date to be announced.

Portsmouth Adult Social Care will continue to follow the progress of the Care Bill through the parliamentary process and will be setting up a Project Group to consider any actions we need to take in order to meet the requirements of the legislation.

3.4 <u>The Better Care Fund (BCF) formerly The Integration And Transformation Fund (ITF)</u>

The crisis facing the Health and Social Care system is well documented with significant demographic challenges and cuts to public sector funding.

- 1.9m with 3 or more chronic conditions growing to 3 million by 2026
- Number of people aged over 85yrs doubling between 2013 and 2030
- The '100 Club' of centenarians has grown fivefold in the past 30 years and 25% of all children born today are expected to live beyond the age of 100.
- In addition, Adult Social Care budgets reduced by £2.68bn/20% 2010-13.

Changes are therefore required in approaches to meeting care needs, as the present system is unsustainable and cannot meet predicted demand. The emphasis is therefore now to move from a model of 'repair' to one of 'prevention', moving money toward initiatives that prevent ill health and deterioration in health. The creation of the BCF, a pooled fund of £3.8bn, is aimed at addressing this.

Why the Fund Matters

The BCF provides an opportunity to create a shared plan for the totality of health and social care activity and expenditure. However, changing services and spending patterns will take time. The BCF plan for 2015/16 needs to be finalised early in 2014 and form part of a five year strategy.

Integrating services calls for a change in our current arrangements to sharing information, staff, money and risk. There is already excellent practice in some areas of the local system that now needs to be replicated everywhere.

Details of the BCF

The BCF is not new money. The £3.8bn pool brings together NHS and Local Government resources that are already committed to existing core activity. The fund will be made up of:-

- £1.9bn NHS funding
- £1.9bn based on existing funding in 2014/15 that is allocated across the wider health and social care system comprising:
    - £130m Carers' Breaks funding
    - £300m CCG reablement funding
    - £354m capital funding (including £220m of Disabled Facilities Grant)
    - £1.1bn existing transfer from Health to Social Care.

The requirements of the fund are likely to significantly exceed existing pooled budget arrangements. Councils and CCGs will, therefore, have to redirect funds from some existing provision to shared programmes that deliver better outcomes for individuals. This requires a new approach to delivering services and setting priorities, and presents Councils and CCGs, working together through their Health and Wellbeing Board, with an opportunity to shape sustainable health and care for the foreseeable future. In practice this will mean working with provider services to achieve the best outcomes for local people. It will undoubtedly require disinvestment from acute services to those in the Community that provide rehabilitation and reablement.

The Government has made clear that part of the fund will be linked to performance. But as yet there is no detail on how this “pay-for-performance” element will work.

The Expectations of the BCF

There are a number of assumptions and expectations as to the changes required if the Health and Social Care system is to become sustainable.

- The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, there will be flexibility in how this investment in social care services is best used.

- The local authority will agree with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and Wellbeing Boards will be the natural place for discussions between the Board, clinical commissioning groups and local authorities on how the funding should be spent.

- It will also be a condition of the transfer that local authorities and clinical commissioning groups have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.

- In addition there will be an expectation that:-
    - 7 day services are provided,
    - There is better data sharing between Health and Social Care,
    - There is a joint approach to assessments and care planning with:-
        - Accountable professionals
        - Single Point of Access to Health and Social Care
        - Community Geriatrician involvement
        - Agreement on consequential impact of changes in the acute sector.

Stakeholder event and next stage

The Health and Social Care Partnership (HaSP) held a stakeholder day on 7 November, involving partners from across the health and social care system, to elicit their views on what should be included in the initial BCF plan, which will be submitted early in the New Year. This plan will be agreed with the Health and Wellbeing Board.

3.5 Safeguarding

The new Pan Hampshire Safeguarding Policy and Procedures are now being worked to, with emphasis on a person centred approach to safeguarding and full involvement of people in the process.

As part of a restructure of safeguarding services, the Team will now deal with complex and institutional cases, and provide advice and guidance to others as requested. New modular training has been developed to reflect new policy, and more multi agency training is also being commissioned.

An Independent Chair for the Portsmouth Safeguarding Adult Board has recently been appointed.

3.6 Carers - Review of Services

A review of carers' services was completed at the end of the summer 2013.

The report contains options for how the service may be configured in future, however because the new care bill will have implications for carer services it has been decided to not change the current model until this is implemented post March 2015. Whatever model is decided the following recommendations will be taken account of in any service development:

1. Continuing the success of the support groups by providing guidance and support to help them evolve into well-facilitated, self-sustaining forums.
2. Building on the success of the self-assessment process, further develop personalised support and resilience for individual carers.
3. Outreach work is key to the success of the service. Effective networking and relationship management across voluntary and statutory sector services is essential.
4. The service needs to target the following groups with unmet needs: BME carers, working and working age carers, and older carers.
5. The service needs to be formally specified, targeted and monitored regularly.

On the 26 November 2013 an open event for carers and professionals was held inviting them to comment on the review and suggest ways forward regarding the recommendations. We have also consulted with carers centre staff and are awaiting feedback from the wider staff group which will close on the 17January 2014. Following this we will finalise our action plan with priorities for the coming year. This will be monitored by the Operational Carers performance management group, a new group specifically, set up to drive forward the action plan.

Robert Watt
Head of Adult Social Care
January 2014