Portsmouth CITY COUNCIL

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NOTICE OF MEETING

HEALTH OVERVIEW & SCRUTINY PANEL

TUESDAY, 26 JULY 2016 AT 9.30 AM

CONFERENCE ROOM A - SECOND FLOOR, CIVIC OFFICES

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Membership

Councillor Jennie Brent (Chair)
Councillor David Tompkins (Vice-Chair)
Councillor Alicia Denny
Councillor Leo Madden
Councillor Gemma New
Councillor Lynne Stagg
Councillor Brian Bayford
Councillor Gwen Blackett
Councillor David Keast
Councillor Mike Read
Councillor Elaine Tickell
Councillor Philip Raffaelli

Standing Deputies

Councillor Dave Ashmore
Councillor Ben Dowling
Councillor Hannah Hockaday
Councillor Lee Hunt
Councillor Ian Lyon

(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 - 6)

The minutes from the meeting on 21 June are attached for approval.

4 Systems Resilience Group's Plan (Pages 7 - 16)

This item will be introduced by Innes Richens, Chief Operating Officer/Director of Adult Social Services, NHS Portsmouth CCG and the following representatives will also be in attendance to answer questions from the panel:

Tim Powell	Chief Executive (interim) Portsmouth Hospitals NHS Trust
Angela Dryer	Deputy Director Adult Services, PCC
Sarah Austin	Chief Operating Officer, Solent NHS Trust
Sue Harriman	Chief Executive Solent NHS Trust
Sheila Roberts	Interim Chief Delivery Officer, Portsmouth, Fareham and Gosport and South Eastern Hampshire CCGs
Sue Damarell-Kewell	Programme Director System Resilience Fareham and Gosport and South Eastern Hampshire CCGs

5 Solent NHS Trust - update (Pages 17 - 18)

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

6 Portsmouth Hospitals' NHS Trust - update (Pages 19 - 20)

Peter Mellor, Director of Corporate Affairs, will answer questions on the attached report.

7 Mental Health Services Provision - particularly CAMHS. (Pages 21 - 24)

Stuart McDowell, Senior Project Manager, Integrated Commissioning Team and Sonia King, Better Care Centre Manager, will answer questions on the attached report.

8 Portsmouth Safeguarding Adult Board Strategic Plan Update (Pages 25 - 38)

Rachael Roberts, Service Manager and Robert Templeton, PSAB Chair will answer questions on the attached report.

9 Adult Social Care - update (Pages 39 - 44)

Angel Dryer, Deputy Director of Adult Social Services will answer questions on the attached report.

10 Southampton, Hampshire, Isle Of Wight and Portsmouth Health Overview and Scrutiny Panels Arrangements for Assessing Substantial Change in NHS Provision (revised June 2016) (Pages 45 - 58)

The Framework for assessing substantial change in NHS provision is attached. The purpose of this document is to agree the arrangements for assessing significant developments or substantial variations in NHS services across the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) Local Authority areas. The framework was refreshed in July 2016 and the panel is asked to agree this document.

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.

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HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held on Tuesday, 21 June 2016 at 9.30am at the The Executive Meeting Room, third floor, the Guildhall

Present

Councillor Jennie Brent (Chair)
David Tompkins
Leo Madden
Gemma New
Lynne Stagg
Elaine Tickell

1. Welcome and Apologies for Absence (AI 1)

Introductions were made.

The Chair asked that thanks be noted to Councillor Peter Edgar, Gosport Borough Council who was a valued member of the panel since its inception. She also welcomed Councillor Philip Raffaelli who replaced him and Councillor Elaine Tickell from East Hampshire District Council.

Apologies had been sent from Councillors Brian Bayford, Gwen Blackett and Mike Read.

2. Declarations of Members' Interests (AI 2)

No interests were declared.

3. Minutes of the Previous Meeting (AI 3)

RESOVLED that the minutes of the meeting held on 15 March 2016 be agreed as a correct record.

4. Portsmouth Hospitals' NHS Trust's Response to the Care Quality Commission's Report (AI 4)

Tim Powell, Interim Chief Executive and Peter Mellor, Director of Corporate Affairs, Portsmouth Hospitals' NHS Trust explained that:

- The Care Quality Commission made unannounced visits to the ED twice in February and twice in March.
- The board is very sorry for the failings highlighted in the report and hope that this will be a catalyst for instigating change.
- The ED was not fast enough to react to surges in demand and did not escalate early enough which had a serious impact on the ambulance service. An escalation process has now been agreed with the ambulance service.
- At times when there was high pressure in the ED, a jumberlance was used for four patients in order to free up other ambulances. Although these

patients were under the supervision of a paramedic, the board recognises that there were issues of privacy and dignity and they would be safer to be in the department.
- Improved leadership and accountability is key to improvement.
- The clinical presence in the management process has been strengthened, with senior doctors involved in decision making.
- It is recognised that the key to the success of the ED is management and Dr Rob Hague will join the trust on 18 July as the Executive Director of Urgent Care. He is a well-respected clinician and currently works at West Sussex which is rated as outstanding.
- The metrics are reported to the CQC every Thursday. These include performance on targets such as patients being seen by a nurse within 15 minutes of arrival, a doctor within an hour and being admitted or discharged within 4 hours.
- The metrics show some traction has been made. It is essential that this is sustained and work is happening to ensure that the programme is imbedded and delivers at pace.

In response to questions from the panel, the following points were clarified:
- Measures have already been put in place and the next 100 days will be critical. The trust must demonstrate that the plan has been implemented and that the metrics are moving. The CQC has the right to take action to escalate or de-escalate in the meantime.
- The flow through the hospital and management of discharges are also being scrutinised as this is crucial to the ED's performance as was highlighted in the report.
- Since the inspection, there is a more responsive service with more people are seen within the targets. The escalation process is activated earlier in order to deal with surges in demand. More patients have an estimated date of discharge at the day of their admission.
- It is better, but there is further to go. The bank holidays in April proved difficult but it is expected that by the end of June, 85% of patients will be admitted or discharged within 4 hours. Although it is still 10% lower than national target, it is progress. There has not been sufficient time for the trust to demonstrate that this is an ongoing trend.
- Every day a learning session is held to review the actions and outcomes of the last 24 hours. This is to ensure that the Urgent Care Programme is imbedded.
- The Urgent Care Committee, which is part of the Full Trust Board reviews weekly the metrics and the milestones and holds key people to account.
- The intensive scrutiny will continue for a considerable time.
- The demand will also increase until the system wide process is in place.
- Key - to successful running of the ED is management.

The Chair permitted Councillors Bryan Turner and James Walsh, Chair and Vice Chair of the West Sussex Health Adult Social Care Select Committee to ask questions and in response the following points were clarified:
- A significant amount of work is happening with NHS Improvements to ensure that the Board receives a high level of assurance and asks the correct questions.

- The CQC report highlighted that staff felt that they had lost their voice, despite the annual surveys. More is being carried out to increase engagement at all levels and staffing levels are being reviewed.
- Many patients can be discharged within 24 hours after receiving a diagnosis and a care plan. This is the equivalent of the day-surgery process.
- The D2 short stay unit is now in place.
- There is now a geriatric resource in the ED to respond to more quickly to the many attendees who are elderly and frail.
- More patients are moved to the Discharge Lounge before midday.

RESOLVED that the response be noted.

5. Update on Vascular Services (AI 5)

Dominic Hardy, Director of Commissioning Operations, Dr Liz Mearns, Medical Director. Pauline Swan, Vascular Programme Manager, Carol Wood, Head of Communications and Engagement and Mike Phillips, Vascular Surgeon, University Hospitals' Southampton NHS Foundation Trust introduced the report and explained that the recommendation previously presented to the HOPS had been approved through the NHS England internal assurance and management decision making authority via the Decision Making Business Case and the report of the engagement exercise was being presented.

In response to questions, they clarified the following points:

- Patients in Southsea with ruptured abdominal aortic aneurysms would be taken directly to Southampton General Hospital (SGH). Evidence shows that being taken to a specialist centre rather than a general hospital gives patients a better chance of survival even if the centre is further away. Patients can now be stabilised by ambulance staff for longer and be in constant communication with the hospital. If there is considerable congestion, patients could be taken to QA Hospital (QAH) by ambulance and then transferred by helicopter to SGH.
- The Isle of Wight has been part of the network with patients being transferred to Southampton for over 15 years. Patients have not reported any issues with these travel arrangements.
- During the day, there will be a vascular surgeon at QAH. Out of hours' cases will be dealt with on an individual basis. If necessary a surgeon would travel to QAH. It has not been necessary for a surgeon to travel to the Isle of Wight.
- There will be no changes to the screening services programme. Gosport has good screening services run by Portsmouth Hospitals' NHS Trust (PHT) based at the War Memorial Hospital.
- Many clinicians attended the engagement exercise at QAH.
- The Vascular Society recommended that high end services be concentrated in major trauma centres. This has the advantage of being easier for 1) the recruitment of vascular surgeons, 2) arranging the rota for study leave, sickness and holidays and 3) sharing expertise.

- Councillor Raffaelli is part of the patient Reference Group. Engagement will carry on with that group.

Mark Pemberton, Vascular Surgeon, PHT joined the meeting and explained that Portsmouth residents will have a better clinical delivery but some will have to travel further for treatment. They have been obliged to travel to London for heart surgery for a number of years and they have not reported that the travel was an issue.

RESOLVED that the report be noted and an update be brought to a future meeting.

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

Tracy Sanders, Chief Strategic officer and Innes Richens, Chief Operating Officer introduced the update and in response to questions, clarified the following points:

- Following the change of service at the Guildhall Walk Healthcare Centre (GHW), the impact on patients will continue to be monitored. The proactive communications plan is continuing to be delivered with both GHW and St Mary's Treatment Centre. Leaflets are available in the waiting area and receptionists have received training.
- Unregistered people who turn up at the GHW will no longer be eligible for treatment at the GHW but will be triaged to ensure that it is safe to ask them to attend their own GP surgery.
- The Hub is one of the possible venues for the new practice.
- GP surgeries can use their workforce flexibly in order to build up expertise or to improve patients' experience. There is a range of ways that the triage system is operated in the city with some surgeries employing clinicians to take initial telephone calls.

RESOLVED that the update be noted.

7. Wheelchair Services (AI 7)

Jane Warren, Commissioning Project Manager introduced the report and in response to questions, clarified the following points:

- Only new service users will be affected by the changes.
- There will be no changes for end of life service users.
- The length of time a service user will have to wait for a wheelchair will depend on their clinical priority.

The Chair expressed concern that organisations seem not to know how to contact the wheelchair service and are not giving appropriate information to service users.

The panel confirmed that the engagement carried out is appropriate and sufficient.

RESOLVED that the report be noted.

8. Director of Public Health's update. (AI 8)

Janet Maxwell, Director of Public Health introduced the report and noted that education is key to preventing health problems and reducing the pressure at the Emergency Department at QAH which had been discussed earlier on the agenda.

In response to questions from the panel, she clarified the following points:

- Recruitment for Director of Public Health for both Portsmouth City Council and Southampton City Council will start this summer with the new Director expected to start early next year.
- Healthy Living Pharmacies offer services to support people with smoking cessation, weight loss and substance misuse. Pharmacies have a high footfall as many people go there in the first instance when they have a health concern.
- Fratton ward has recently received lottery funding.
- Work to regenerate Charles Dickens ward has included setting up the John Pounds Centre and improving community centres.
- The communities will be asked what they want and work will be prioritised accordingly.
- Work to identify women at risk of major health problems before they conceive has been renewed and support for their children in the early years and primary schools will continue.
- Feedback from secondary school teachers indicates that they are concerned about the mental health and wellbeing of their pupils but the focus from Government is on GCSE results.
- It is important that the work is carried out to look into the complex and unintended consequences of the digital age e.g. bullying, sexting and exploitation.
- Responsibility for public health moved to unitary and county councils. Hampshire County Council's Director of Public Health manages public health in Gosport.
- The alcohol health team has a strong presence at QA Hospital.
- Despite the fantastic work carried out by the air quality team, there is a serious problem with air quality in the city because of urban density, the high volume of lorries and other traffic. Much work has been done to improve traffic flow but the only way to make a difference is to reduce the number of cars on the road. The affects are worse in deprived areas, where poor lifestyle choices exacerbate the health effects.
- The public health team work closely with planners to encourage developers to consider environmental issues.

RESOLVED that the report be noted.

9. Healthwatch update to include mystery shop report on GP practices (AI 9)

Patrick Fowler, Consultant at Healthwatch Portsmouth introduced the report and in response to questions from the panel explained that:

All surgeries were contacted as part of the mystery shopping activity.

- Visits by patient representatives as a follow up will cover topics such as reviewing the reception service, physical environment, information, signposting, patient involvement and access to appointments. Locations are determined on which surgeries the volunteer patient representatives come from.
- Healthwatch has fed into the process that the CCG uses to assess GP surgery merges.
- The mystery shopping activity highlighted some inaccurate information being given out by surgeries. This has been fed back to individual practices and will be checked through an ongoing monitoring process.
- Photo identification is not required as part of the process to register with a GP - this has been confirmed to all practices, especially those asking for this form of ID. Healthwatch Southampton also found instances where would-be patients were told that photo identification is required to register with the surgery.

RESOLVED that the report be noted.

10. Dates of Future Meetings (AI 10)

RESOLVED that the following meeting dates be agreed:

26 July.
4 October
6 December.

The meeting ended at 11.45 am.

Portsmouth and South East Hampshire Health System

System Resilience Group and Urgent Care Delivery Plan

Update for the Portsmouth Health Overview and Scrutiny Panel
June 2016

Contents:

- Overview, structure, role and responsibilities of the System Resilience Group
- Objectives, outcomes and performance indicators
- System resilience work plan summary – overall
- System resilience work plan summary – urgent care
- Urgent care improvement plan summary (supplied as separate Excel spreadsheet)

Introduction

The System Resilience Group (SRG) provides the strategic and operational leadership across the health and social care system of SE Hampshire, Portsmouth and Fareham and Gosport CCGs for both urgent and emergency and planned care for the populations it serves. All partners across the system jointly shape and co-ordinate the planning, integration and delivery of care to create safe, responsive, effective, high quality accessible services which are good value for taxpayers by local providers.

Purpose

- To come together and work across boundaries to ensure operational resilience, matching resources with demand, to improve patient experience and clinical outcomes in both urgent and planned care;
- To enable systems to deliver high quality, safe services and optimise all parts of the health and social care system to eliminate waste of resource;
- To understand the impact and align the planning and delivery of planned care with unplanned care across the whole system.

Membership

- The SRG comprises accountable officers /chief operating officers and clinical leaders representing the local health and social care community. Additional representatives will be invited to attend, as required.
- Organisations involved include NHS Portsmouth, South Eastern Hampshire and Fareham and Gosport CCGs, Portsmouth Hospitals NHS Trust, Solent NHS Trust, Southern Health NHS Foundation Trust, South Central Ambulance Service, NHS England (Wessex), Hampshire County Council, Portsmouth City Council

Key Functions

- To ensure that capacity planning is undertaken and agreed jointly across the whole system simultaneously and on an on-going basis, based on local needs and a robust understanding of the pressures and drivers in the local system;
- To co-ordinate and pro-actively drive operational delivery across the whole system, reviewing and revising regularly as required, providing oversight and holding leads for work programmes to account;
- To monitor delivery against plans, outcomes, KPIs and funding allocations
- To access, share and undertake detailed analysis of the full range of appropriate data to support evidenced based decision making;
- To use local, national and international best practice to shape and model services that are fit for the local population;
- To clearly identify interdependencies between services and plans across unplanned and planned care;
- To benchmark against local and national peers.

SRG Outcomes and Key Performance Indicators

Our vision for urgent and emergency care

Simple to navigate, sustainable, patient-centred, high-quality urgent and emergency care integrated system providing 24/7 access that ensures patients are seen by the most appropriate professional at the right time in the right setting.

Our patient priorities

- Make it easier to see a GP
- Make it easier to know where to go for urgent and emergency care
- Know what alternatives are to get seen outside ED
- Take greater responsibility for our own health
- Develop more services that are closer to home to support people to stay in their own home

Outcomes for the SRG

- Capacity planning is resilient and sustainable year-round in order to ensure all NHS Constitution rights and pledges are met, and exceeded where possible – including 18 week RTT; cancer waiting targets, diagnostics waiting targets and A&E waiting targets;
- There is efficient and smooth patient 'flow' throughout the whole system from patient referral/ contact to discharge/ handover;
- There is robust system accountability in place with members holding each other to account for work stream delivery
- A high measure of patient satisfaction within all elements of the unplanned and planned care systems is consistently achieved;
- Financial balance and sustainability is maintained across the whole system.
- Consistent and proactive system leadership is developed and supports the delivery of resilience and sustainability.
- There are a range of robust outcome measures for each individual work stream

Systems Resilience Structure and Objectives

Delivering Improved Performance & Sustainability

Systems Resilience Group

- Overarching system sustainability and associated financial sustainability/affordability based on prioritized decision making
- Delivery of safe, effective and prompt care in appropriate settings that fit patients' requirements
- Minimizing inappropriate ED attendances
- Minimizing inappropriate hospital admissions
- Health and Social Care system flow
- Avoiding delayed discharges
- Minimizing inpatient bed-days (LOS)
- Embedding principles of good practice throughout all pathways and systems

Operational Delivery Group

- Development and delivery of operational plans, and KPIs
- Performance management against delivery milestones and KPIs
- Identification of interdependencies
- Communication Programme to wider staff
- Escalation of risks and issues to SRG

Urgent Care

- Delivery of the NHS Constitution and A&E Standards;
- Safe high quality urgent care pathways
- System wide patient flow
- Effective integrated discharge planning;
- Integrated escalation processes;
- Timely and accurate information.

Planned Care

- Delivery of the NHS Constitutional Targets and RTT waiting times targets
- Reduction in LOS and delayed discharge;
- Cancer Pathway resilience;
- Timely and accurate planned care dashboard;
- Key specialty reviews.
- Improved patient experience

Primary & Community Care

- Integrated out of hospital capacity
- Primary Care workforce;
- Community Nursing resilience;
- MDT & Risk stratification;
- ERS @ Home;
- PRRT.

Key Enablers

- **Capacity & Demand Modelling**
- **Analytics, data support, KPI development**
- **IT and interoperability**
- **Workforce, education and training**
- **Programme management**
- **Communications**
- **Governance**

Systems Resilience Work Plan Summary

Urgent Care	Planned Care	Primary & Community Care	Programme Management
Lead Organisation: PHT	**Lead Organisation:** PHT	**Lead Organisation: CCG**	**Workstream 1:** Analytics, data support, KPIs
Working Group Operational Delivery Group	**Working Group: Operational Delivery Group**	**Working Group: Operational Delivery Group**	**Workstream 2:** Demand and Capacity Modelling
Workstream 1: Admission Prevention	**Workstream 1:** RTT Performance	**Workstream 1:** Integrated out of hospital transformation	**Workstream 3: Governance,** Project management Tools and Support
Workstream 2: PHT Improvement Programme	**Workstream 2:** Specialty Reviews	**Workstream 2:** Primary Care Workforce	**Workstream 4:** Accountability Framework
Workstream 3: Integrated Discharge Pathways / FIT	**Workstream 3:** Cancer targets	**Workstream 2:** Transforming the Frailty Pathway	**Workstream 5:** Communications and Engagement
Workstream 4: Escalation			**Workstream 6:** Quality
			Workstream 7: Supporting Delivery of the UECN plan

Urgent Care Work Plan Summary

Preventing Admissions

111 – central clinical advice hub , alignment of quality urgent care services to deliver 24/7 access to clinical assessment, advice and treatment

Out of Hours- Contract review new model with direct booking, right place care

Urgent Care Centres –increased utilisation of UCC and reduction in minor activity in A&E

Primary and Community Care response – new models of care and financial flows, specific schemes to provide safe high quality care closer to home e.g. catheter care, acute visitng service, pharmacy support

Non-Conveyance – Reduced attendances through alternative and pre-emptive support for high intensity users and GP triage

Care Homes – reduced admissions through anticpatory care planning, community nurse suppor, improved training, medication reviews

PHT Improvement Programme (* for more detail please refer to accompanying spreadsheet)

Emergency Department – streamlined pathways to reduce handoffs, improved quality and safety and delivery of targets

Medical Model- unselected medical take, consultant review in 8 hours, increased discharges from medical take

Short Stay Model – implmentation of pathway leads to increase in short stay patients and improved bed occupancy rates

Acute Medical Unit – assessment and review up to 24 hours, direct admissoin of GP patients and appropriate ward transfers

Ambulatory Care- increase in the number of patients assessed and treated through ambulatory pathways

SAFER Ward Discharge Planning- professional standards and best practice guidelines

Acute Frailty Model – comprehensive assessment , specialty based frailty care , silver phone support, reduced admissions

Site Operations-realtime bed management, standard operating procedures

Integrated Discharge Pathways

Integrated discharge service
Streamlined solution to enable safe and timely discarge supported by trusted assessment framework, training and education

Discharge to Assess
Patients are 'turned around' or discharged when assessment fit and have assessments and non acute care at home/ close to home

FIT – through front door frailty assessment, MDT support to mobilise community response for those not requiring acute admission, supporting <72 hour discharge

Escalation

Revised Triggers

Framework Review

Glossary

AEC	Ambulatory emergency care		**MFFD**	Medically fit for discharge
AMU	Acute medical unit – takes admissions from ED for further assessment		**OOH**	Out of hours
CHC	Continuing health care		**OT**	Occupational therapy
CUR	Clinical utilisation review - a tool to help staff apply clinical criteria to determine most appropriate form of care		**PRRT**	Portsmouth Rehabilitation and Reablement Team
D2A	Discharge to assess		**RTT**	Referral to treatment – 18 weeks is the national performance measure
ED	Emergency department (A&E)		**SAFER**	Programme to support improved patient flow in hospitals
ERS at home	Enhanced recovery and support service at home (Hampshire County Council and Southern Health scheme)		**SPA**	Single point of access
FIT	Frailty and intervention team		**UCC**	Urgent care centre
HIU	High intensity users		**UECN**	Urgent and emergency care network
HOT clinics	Community clinics intended to support/ease demand on hospital services, including A&E			
KPIs	Key performance indicators – measurements of performance for NHS			
LOS	Length of stay			
MCP	Multi community specialty provider (being developed through the Vanguard programme in Fareham/Gosport and SE Hampshire)			
MDT	Multi-disciplinary team			

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SRG Delivery Plan Summary Draft 1

Project Name:	SRG Delivery Plan
Accountable Group:	SRG
PM Support:	SDK

Milestones	Key Actions	Original Completion Date	Revised Completion Date	Action Status	Status Update	Action Owner(s)	Delivery Target	Delivery Target Status at Q1
Preventing Admissions - a reduction in attendances and admissions								
Project scope and outline	Scope work programmes currently in place against national local vision, undertake gap analysis	**7.6.16**	**30.6.16**	**Complete**	Initial programmes scoped. Additional detail required for us in Directory of Services (DOS) App. Gaps in mental health and palliative care info	TD	Reduction in ED attendances overall. Each scheme has established outcome measures	
	Review demand and capacity mapping, develop proposals to be delivered through MCP and other work streams	**31.7.16**		**In Progress**	Identification of priority work streams underway and will be presented at the next work stream group on 3.8.16	TD		
111 retender process	111 retender process complete	**31.10.17**		**Not Due Yet**	Additional actions will be included once project plan has been developed and signed off	TD	Number of quality and activity measures within contract	
Out of Hours retender process complete	Out of Hours retender process complete	**31.1.18**		**Not Due Yet**	Additional actions will be included once project plan has been developed and signed off	TD	Number of quality and activity measures within contract	
Urgent care centre provision improved	Agree and implement revised Urgent care centre model to improve service utilisation	**from 31.7.16**		**In Progress**	Working group established to review options	LD	reduction in minors breaches	
Primary and Community Care response in place	Local Hub model developed and tested in Gosport, Portsmouth Hub under development outcome based commissioning programme including payment and contracting mechanisms	**31.3.17**		**In Progress**	programme established and scoping underway	TC	measure to be developed as part of scoping work	
	Specific schemes:IV service, catheter care, acute visiting service, pharmacy support	**31.3.17**		**In Progress**	programme established and range of schemes in place. Further work to be undertaken to identify priorities	PAG		
Non conveyance schemes established	SCAS service development, non-conveyance and paramedic development schemes in place (HIU)	**30.9.16**		**In Progress**	GP non conveyance scheme in place in SE Hampshire and part of Portsmouth Acute visiting service. High Intensity Users project providing paramedic support and education is due to commence in September	RK	reduction in patients conveyed	
Care Homes work programme developed and agreed	Identification of schemes in place. Review of good practice nationally	**30.6.16**		**Complete**	Initial work programme agreed	SDK		
Care Homes work programme implemented	Agree and implement key schemes through Vanguard and Blueprint working groups	**TBC**		**Not Due Yet**	detailed activities to be signed off by sub group	WG		
PHT Improvement Plan								
Improve Performance in A&E to achieve 4 hour target through improved systems and processes, professional standards and workforce changes	Implement ED ambulatory area	**1.6.16**		**Complete**		MM	78% by June 16, 85% by Dec 163, 89% by March 17. 95% of patients assessed in 15 mins (62% - Sept 16, 95% - Dec 16)	4 hour target - 82% June. 15 min assessment - 68% in June
	A&E capacity and demand and staffing model developed	**31.5.16**	**30.6.16**	**Overdue**	capacity and demand modelling completed and staff model to be discussed with ECIP on 15/6/16. Streaming pilot underway to remove delays in the	SH		
	Review A&E consultant job plans	**30.6.16**		**Complete**		SH		
Increase the use of Ambulatory Emergency Care to assess, diagnose and treat patients. Increase the use of rapid access specialty clinics to provide urgent specialist opinion and reduce admissions	Review AEC pathways	**31.5.16**		**Complete**		HB	33% AEC target by 16.9.16	21% in June
	AEC reconfiguration	**31.7.16**	**31.12.16**	**Not Due Yet**	commencement date early sept works to be completed by end of Dec. 16	LW		
	AEC Implement HOT clinics	**31.10.16**		**Not Due Yet**	Work in progress	AB		
establish unselected medical take model with clear lines of responsibility and accountability as per professional guidelines	Medical take model commenced	**1.6.16**		**Complete**			85% occupancy in AMU by 16.9.16. number of patients with a length of stay(LOS) over 24 hours	patients with LOS over 24 hours - 38% in June
	standard operating procedures developed, agreed and in place	**30.6.16**		**In Progress**		HB		
	review ways of working and agree structure for the longer term	**30.6.16**		**In Progress**		AB		
Establish the Acute Medical Unit (AMU) with strong clinical leadership and capacity to accept patients from ED within 30 minutes of decision to admit and primary care referrals for up to 24 hours	AMU recruitment of Med techs/assistant roles	**30.6.16**		**In Progress**	All posts recruited to with start dates in July	AFC		
	AMU capacity and escalation process in place	**5.8.16**		**In Progress**		LF		
Increased focus on effective and timely turnaround of short stay patients to facilitate discharge within 24 hours in AMU and 72hours on the Short Stay Unit	Short Stay pathway commenced	**26.4.16**		**Complete**		MR	65% patients on short stay pathway by 8.7.16	64%- June
	Short stay ward open	**1.6.16**		**Complete**		MR		
establish early comprehensive interdisciplinary assessment band signposting for patients over 75 years to support the reduction in avoidable admissions. Set up an acute frailty unit with up to 18 beds with a <72 hour length of stay	Acute frailty pathway additional consultant hours	**30.4.16**		**Complete**		AB	MOPRs 95% bed capacity by 31.7.16. Additional 3 A&E patients over 75 years per day are not admitted	Discharges in <72 hours 42% June
	Pathway design and plan	**30.4.16**		**Complete**		MP		
	close E4 escalation beds	**31.07.16**		**In Progress**	closure on track for completion midday July	SE		
	Implement silver phone function	**1.5.16**	**31.10.16**	**Overdue**	scoping completed, model being developed	AB		
	competency framework and training completed	**31.5.16**		**In Progress**	completed for staff in post and commenced for newly appointed staff	AB		
	implement 'pull' model for complex discharges complex of frail older people	**31.8.16**		**Not Due Yet**		AB		
	open frailty unit	**30.9.16**		**Not Due Yet**		AB		
	implement frailty outreach team	**7.10.16**		**Not Due Yet**		SE		
Establish specialty based frailty care	develop in reach model business case for surgical and medical specialty patients	**31.3..17**		**Not Due Yet**		AB		
To improve discharge processes and delivery across the hospital	SAFER roll out to wards	**31.3.17**		**Not Due Yet**	commenced, roll out programme agreed at UCIP Board C5/6 and D2/Sus in June. E7/8 and AMU - July	MGk	33% of discharges before 12pm by 9.9.16. 100% of ward patients with an estimated date of discharge (EDD)	discharges by midday - 21% in June. Ward patients with an EDD - 87% in June
	Relocate discharge lounge	**30.4.16**		**Complete**		MGk		
Fit for purpose Operations function and team structure including bed overview, effective on call/ escalation and flow management	centralisation of Ops flow team, new rotas, transfer team in place	**31.7.16**		**Not Due Yet**	Medicine flow completed, surgery and Medicine for Older people - end of July, rest of the hospital- end of August	GMc	No 12 hour trolley breaches. No non-clinical bed moves between midnight and 6am. Number of escalation beds.	
Integrated Discharge Planning								
Development of integrated discharge service, Discharge to assess and frailty intervention team proposals with resource requirements and return on investment case for change.	review of winter pilot and scoping completed	**31.3.16**		**Complete**	Awaiting final financial/ risk share assessment by all partners, additional review by Transformation lead with recommendation. Subsequent finance meeting held in June - still unresolved issues around financials and ORCP monies. To be discussed at SRG Ops on 7th July. Review at SRG 14th July. sign off by 31.7.16	LD		
	business case developed and approved	**30.4.16**	**31.7.16**	**Overdue**		Work stream leads		
	Review and reinvestment of winter monies	**30.3.16**	**31.7.16**	**Overdue**		Finance Directors		
Overall programme success criteria established	performance standards and reporting, governance processes in place	**30.6.16**	**30.7.16**	**In Progress**	Review of action plans being undertaken to utilise expertise of Transformation lead. Community bed referral pilot delayed to explore IDS pull model alongside some bed functionality alignment, creating a more flexible D2A Pathway 2 bed pool.	DA		
Robust programme management in place	delivery lead appointed	**30.6.16**		**Complete**				
	Revised task and finish groups established	**31.7.16**		**Complete**				
	Agree pilot area, methodology and operationalise pilot	**31.7.16**		**In Progress**				
Robust integrated discharge service processes and systems developed and adopted by multi-disciplinary teams	community bed direct referral pathway in place	**30.6.16**	**31.8.16**	**In Progress**	This has been paused whilst review of model has been undertaken	MC		
	IDS assessment processes and professional standards in place	**30.6.16**	**31.8.16**	**In Progress**	To include electronic single referral form and assessment fit guidance. Latter signed.	DA		
	IDS Hub model agreed - referral management, capacity oversight, streaming, advice and guidance	**31.8.16**		**In Progress**	model developed and to be signed off post visioning event prior to testing and implementation	Provider leads		
Accommodation	IDS accommodation identified and in place	**30.6.16**	**31.8.16**	**In Progress**	Estates changes in Lancaster building cost prohibitive therefore alternative option under discussion with PHT and awaiting decision.	DA		
Workforce implications understood and plans for both interim and longer term solutions in place	interim rostering in place	**31.7.16**		**In Progress**	draft rotas have been completed	Provider leads		
	outstanding recruitment completed to support IDS and D2A delivery	**31.6.16**	**31.10.16**	**Not Due Yet**	Dependent on Business Case decision	COOs		
	D2A/IDS/Assessment fit training programme delivered (ward staff)	**30.6.16**	**30.10.16**	**In Progress**	IDS visioning event planned for 20/7 and training workshops in August for Board rounds and trusted			
	IDS ward links in place to support all adult inpatient wards at PHT	**30.9.16**		**Not Due Yet**	Currently being scoped. Partners to complete matrix by 11.7.		50% in place by 30.6.16, 100% by 30.9.16	
	trusted assessor model in place with clear permissions and responsibilities	**30.9.16**	**30.9.16**	**Not Due Yet**	development of trusted assessment framework - following 20.7.16 event.	DA	50% trained by 30.6.16, 100% by 30.9.16	
IDS pathways developed approved and established	additional capacity mobilised for Portsmouth pathway 1&2	**30.9.16**	**31.10.16**	**Not Due Yet**	Dependent on Business Case decision	SH		
	review and remodel of OT pathway	**30.9.16**		**Not Due Yet**		SH		
	Hampshire pathway 3 review including inpatient areas	**30.9.16**		**In Progress**	planning meeting set up. Will need to be fast-tracked to ensure adequate D2A Pathway 3 capacity before end October 2016	PT/MH		
	Remodel CHC pathway in Portsmouth	**31.12.16**		**Not Due Yet**		SH/SN		
Monitoring and Report Progress	performance targets delivered - discharges per week	**31.3.17**		**Not Due Yet**	draft D2A KPIs being revised	Work stream leads	186 by Q1, 216 by Q2, 233 by Q3.	
	performance targets delivered - MFFD patients waiting longer than 24hrs from decision	**31.3.17**		**Not Due Yet**		work stream leads	160 Q1 - Q3, 60 by Q4	As at 18.7.16 - 170 patients
	performance targets delivered - 5% reduction in stranded patients	**31.3.17**		**Not Due Yet**			28 fewer patients occupying beds	
Escalation								
Escalation	Review of escalation process	**31.8.16**		**In Progress**	Commenced - by partners for each organisation and collectively for the system	SR/ SRG Ops group	TBC	
Emergency Planning	assurance process again by partner and system	**30.9.16**		**Not Due Yet**		SR		
Business Continuity	assurance that in place for all areas partners and system and plan for full review in two years	**TBC**		**Not Due Yet**		SR		
Seasonal Resilience Planning	to re-establish a resilience group for partners and CCGs which sits under the SRG operational group and provides assurance on seasonal plans	**TBC**		**In Progress**	Stocktake under way will be completed by 18th July and reviewed at Operational Group	SR		
SRG Information Support								
establish working group	set up group to provide system wide intelligence for SRG	**31.3.16**		**Complete**	Group established and meetings held fortnightly	SDK	TBC	
Performance Dashboard development	develop agreed system wide metrics to support the system plan including quality performance	**31.5.16**	**30.6.16**	**Complete**	Draft metrics agreed and developed. These will be tested with SRG and refined over the coming months.	IG/OG		
	monthly performance report with narrative and analysis agreed and commenced	**30.6.16**	**Review monthly for the next 3**	**In Progress**	Process in place and first draft with real data to be presented to SRG on 14th July	IG		
Business Intelligence programme	develop a wider programme of system intelligence, planning information and targeted	**31.7.16**		**In Progress**	proposal to be presented at SRG on 16.6.16	SB/MK/RM		
	deliver initial work programme	**31.3.17**		**Not Due Yet**	projects identified for detailed info support are Nursing homes, DTOCs and escalation	IG		
SRG Development Programme								
Review of SRG function and delivery	Undertake initial diagnostic and agree development programme	**30.4.16**		**Complete**		AS/SDK	TBC	
SRG Development programme	Session 1 Establish core purpose of the group	**2.6.16**		**Complete**		AS/SDK		
	Session 2 Review Practices	**14.7.16**		**Complete**	Action plan developed and underway	AS/SDK		
	Session 3 Improving process to affect better quality of outcomes	**TBC**		**Not Due Yet**		AS/SDK		
	Session 4: Power - maximising shared leadership	**TBC**		**Not Due Yet**		AS/SDK		
Leadership	Individual support sessions to improve governance and assurance of SRG	TBC		**Not Due Yet**		AS		
Best practice	Review good practice from other SRGs and present/ implement findings	30.9.16		**Not Due Yet**		SDK		

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Solent NHS Trust Update to Portsmouth City Council Overview and Scrutiny

July 2016

CQC inspection

The intensive visits by the CQC took place wc 27th June. We hosted 67 inspectors, who carried out a comprehensive review of the majority of Solent services. The inspection itself continues until the 14th July, with unannounced visits to our services, in and out of hours, and many requests for additional data.

We have received some preliminary feedback from the CQC following the announced inspection which has identified areas of good practice and some areas for improvement. The CQC are clear that their feedback is only preliminary at this stage as the unannounced visits and continuing data requests will provide additional information. We are keen to work with our partners in areas for improvement as and when they are confirmed.

We will continue to engage with you to discuss the feedback we have received so far. We do not expect to receive our formal assessment until September or October, but will ensure that you are kept informed of any updates before then.

Moving forward to implement the Portsmouth Blueprint

May and June heralded an important step on our journey towards team around the person.

We co-located adult's health and social care teams, and collocated children and family multi agency teams in Civic and Medina House in the city. We have already seen the benefit of closer working and are now planning the next stages of our journey towards integrated working

We continue to work with the GP Alliance to take forward two important projects; one to ensure that people with frailty have a multidisciplinary review between geriatricians, GPs and community nursing teams, and the other to try to better manage urgent care demands on both primary care and the emergency department. We are creating an urgent care hub in partnership between the Primary Care Alliance and Solent NHS Trust

We continue to support PHT in delivery of their urgent care performance. A business case to identify those with frailty in the emergency department to ensure they are appropriately assessed and their care managed effectively, and also to ensure early supportive discharge, is currently being concluded with the ambition to fully implement in the autumn.

Operational matters

<u>Staffing pressures</u>

We have for the last 18 months, had significant staffing vacancy levels in community nursing which has resulted in service delivery problems. The vacancy rate is moving in the right direction and we expect to be nearing a manageable figure after the summer. Generally the teams are managing their workloads better and feedback from service users is improving

There appears to have been a rise in the acuity of mental health problems in the community and as a consequence we have seen a rise in the number of people requiring intensive inpatient care. This has created pressures on service from police, through to urgent care facilities (section 136 suites). The recent closure of intensive care beds in Southern NHSFT is also noted.

The reductions in public health funding for Health Visiting coupled with reductions in training funding for health visitors, will result in the need to revisit the role and population coverage that this important service provides

Financial pressures

The plan for 2016-17 is a deficit of £4.5m. Whilst months 1 and 2 are broadly in line with plan, there remain significant financial gaps that are not yet resolved in the Portsmouth system.

Sarah Austin COO 13th July 2016

Portsmouth Hospitals NHS
NHS Trust

Tim Powell
Interim Chief Executive

Trust Headquarters
F Level, Queen Alexandra Hospital
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Cosham
PORTSMOUTH, PO6 3LY
Tel: 023 9228 6770

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

11 July 2016

Dear Chair

Update letter from Portsmouth Hospitals NHS Trust

I write to provide the Health Overview Scrutiny Panel with an update from Portsmouth Hospitals NHS Trust.

You will be aware that the Care Quality Commission (CQC) carried out an unannounced inspection in February. This was a review focusing specifically on unscheduled care. Their findings were published in a report on 9 June.

The hospital was clearly under massive pressure during their inspection, and they observed an emergency department, and hospital, that was very congested. In some instances this negatively impacted on patient experience.

We fully accept the inspector's findings and have already made changes since their visit. Our first priority has been to decongest the Emergency Department (ED). We have changed the way in which some patients are admitted to the Acute Medical Unit, stopping the referral of patients who do not need the clinical skills of the ED team and promoting the fact that GPs can refer urgent patients directly to ambulatory services and our outpatients' clinic.

Our second priority has been to reduce the number of medically fit patients who are delayed in hospital by making our care more consultant-led, increasing the number of times a patient is reviewed each day by a senior doctor and working more closely with our health and social care community colleagues to remove delays in the patient treatment and discharge pathway.

We have taken steps to comply with the enforcement action, issued in the s31 Notice by the CQC. We immediately ensured the large multi-occupancy ambulance, known as the 'jumbulance' is no longer in use; we have appointed a senior leader, Dr Rob Haigh, as the Executive Director for the Emergency Care pathway; we have put in place an escalation system and provide the CQC with daily monitoring information which is provided on a weekly basis.

Through our internal Urgent Care Improvement Programme (UCIP), we are identifying patients who are expected to have a short stay in hospital when they are admitted. We will prioritise tests and investigations, reviews and referrals and increase the focus on reducing delays to patient discharge.

We continue to work with our health system partners on a number of initiatives and we are progressing well in our Emergency Care Improvement Programme (ECIP), which focuses on improving performance across both health and social care, helping to further improve outcomes and patient experience and we strive to ensure we provide the very best care for our patients, who are at the centre of everything we do.

I am delighted that despite the unscheduled care pressures and resulting operational challenges the overall performance across all quality measures remains strong. The Trust is forecasting achievement of 5 of the 8 national cancer standards. Our Referral to Treatment (RTT) performance also remains strong.

The Trust achieved its financial plan in 2015/16, albeit at a considerable deficit position of £23.5m at year end. This year the financial improvement target has been set at £32.2m as part of the planned budget surplus of £1.2m.

I hope that this update has been informative, and my colleague Peter Mellor, Director of Corporate Affairs, will be delighted to further expand on this information or answer your queries at the HOSP meeting. We continue to offer our hospitality to you if you would like to come and visit the hospital, to view for yourselves the patient centred care we are provide.

Kind regards

Tim Powell
Interim Chief Executive

Portsmouth CITY COUNCIL

Title of meeting: HOSP Meeting

Subject: CAMHS Performance & Early Help Commissioning Intentions

Date of meeting: 26th July 2016

Report by: Stuart McDowell, Commissioning Project Manager, Integrated Commissioning Service

Wards affected: All wards

1. **Purpose**

To update HOSP members on the performance of Child and Adolescent Mental Health Services (CAMHS) in Portsmouth and describe what the commissioning plans are with regards to commissioning an Early Help service for Children and Young People that do not meet the criteria for CAMHS.

2. CAMHS Service Description

- CAMHS is a multi-disciplinary service providing a range of effective, evidence based assessments, treatments and support for children and young people (0-18) from all ethnic and cultural backgrounds where there are concerns about their mental health. Referrals are accepted from any professional in health, education, social services and the voluntary sector.

- All referrals initially go through the CAMHS Single Point of Access (SPA) which was implemented in early November 2014. The purpose of the SPA service is to provide easy and equitable access for children, young people and their families with the aim of reducing wait times and more effective decision making around appropriate therapeutic interventions which meet identified mental health needs.

- The CAMHS extended team provides longer term individualised treatment interventions designed to address the needs of children and young people and their families/support networks who have serious to severe mental health disorders.

3. Eligibility Criteria for CAMHS

The service accepts referrals for children and young people up to their 18th birthday and who meet the following criteria:

Depression
Where the difficulties are beyond age-appropriate mood variation, unrelated to life events, have an impact on daily living.
Self-harm
Where there is concern about self-harm, in context of other difficulties including overdose cases.
Anxiety
Where it is affecting the child/young person's development or level of functioning and is out of proportion to the family circumstances.
Obsessional Compulsive Disorder
Where the difficulties are beyond age-appropriate checking and ritualistic behaviours and unrelated to life events.
Eating Disorders
Where there is concern in relation anorexia and bulimia
Complex developmental problems
Significant delay in the acquisition of appropriate social skills. Difficulties with the child's peer group relationships. Unusual or very fixed interests - Bizarre or unusual behaviours.
Moderate To Severe learning disability and enduring challenging behaviour/mental health
Challenging behaviours associated with moderate to severe learning disability
Specific or Social Phobias
Where there are difficulties in attending school or college and prolonged absenteeism in the absence of anti-social disorders e.g. stealing, school truancy. Severe and emotional upset experienced including fearfulness/anxiety/temper/acute misery.
Response to bereavement
Child is experiencing significant distress following a death that has occurred within traumatic circumstances eg suicide of a parent
Post-Traumatic Stress response
Where a child/young person continues to demonstrate hyper-vigilance, avoidance, flashbacks, or a marked increase in unexplained temper tantrums or episodes of other distress.

Waiting times for CAMHS

The current waiting times for CAMHS services are as follows:

- Urgent – 24 hours
- Priority – 72 hours
- Routine – 3-4 weeks
- CAMHS Extended team - 12 weeks

Telephone contact is attempted with all referrals within 2 working days

- Commissioners are confident that Solent NHS Trust provides a safe, effective and high performing CAMHS service for Children and Young People in Portsmouth and this assessment has been verified by the National Quality Network for Community CAMHS who audit the service on a regular basis and report positive outcomes.

Future Commissioning Intentions

- As a result of undertaking a comprehensive stakeholder consultation exercise and health needs assessment recently we know that what's needed in the city is greater support for young people and families that don't meet the threshold for CAMHS services but who need support none the less with building resilience and developing coping strategies that supports early intervention and prevention.

- We know that a significant number of referrals to the CAMHS Single Point of Access so roughly 45% do not meet their eligibility and a high proportion of those young people will be referred onto other early help services such as Off the Record who deliver informal support, 1-1 counselling and information to young people aged 11 - 25. At present Portsmouth Clinical Commissioning Group funds Off the Record and this funding is due to come to an end in December 2016. The demand for Off the Record is significant which has led to the service having to instigate a waiting list.

- It is our intention to commission an Early Help (pre CAMHS) service that supports Children and Young People up to the age of 25 and their families that is flexible and responsive to their individual needs; is able to deliver a range of evidence based therapeutic interventions; has open referral pathways that include self-referral and referral from CAMHS either where they do not meet eligibility or as part of their step down support/discharge plan.

- This service will be operational as from January 2017 and will be a key step in supporting children, young people and their families across the city in promoting good mental health wellbeing and resilience whilst also providing the vital support that is needed to prevent more serious mental health problems developing in the future. The impacts of this will benefit both health and social care commissioned services.

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Portsmouth Safeguarding Adults Board

Update to The Health Overview and Scrutiny Panel

Portsmouth Safeguarding Adults Board

Overview

- Review of the Board
- Legal context
- Vision
- Strategic Priorities
- Next Steps

Portsmouth Safeguarding Adults Board

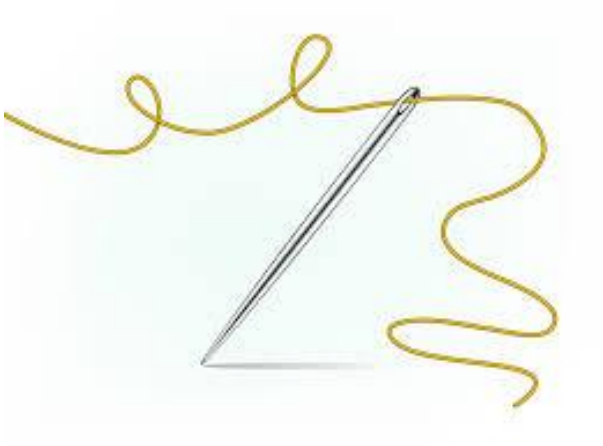
Legal Context

- The Care Act 2014 put a duty on the local authority to establish an SAB
- Objective is to help and protect adults at risk of abuse or neglect
- SAB may do anything necessary or desirable to achieve this aim
- Develop and publish a Strategic Plan
- Publish an annual report detailing how effective our work has been
- NHS and police must nominate members with required skills and experience
- Statutory safeguarding adults reviews (s. 44)
- Duty to provide information to an SAB (s. 45)

Mission

Safeguarding adults is everyone's business. It depends on people understanding and doing the following things:

- being aware of the risks of abuse and neglect that vulnerable adults can face
- knowing what help is available
- understanding their responsibilities
- working together to report and investigate concerns
- working together to prevent abuse and neglect



The Portsmouth Safeguarding Adults Board will ensure that organisations work together to achieve all of these things in order to protect adults at risk.

Board Review

What works well:

Have met regularly
Have made links with other strategic boards
Have secured dedicated board admin and management
Have an independent chair
Beginners mind-set

Challenges:

Ownership at a senior level
How do we involve service users?
Agreeing priorities
Agreeing a 'manageable' data set
Need - clear accountability and structure

Portsmouth Safeguarding Adults Board

Subgroups Review

What works well:

SAR subgroup - PSAR recognised some of our failings and started to put them right

Beginners mindset: new Chair, new Board Manager and new Administrator

Explore what other groups there are and how they link e.g. slavery groups, Prevent Board, MCA/DoLS group

Challenges:

Attendance at subgroups, linked to need for purpose and direction

Must link subgroups to priorities so there is a clear programme of work, that sub group members will want to sign up to deliver

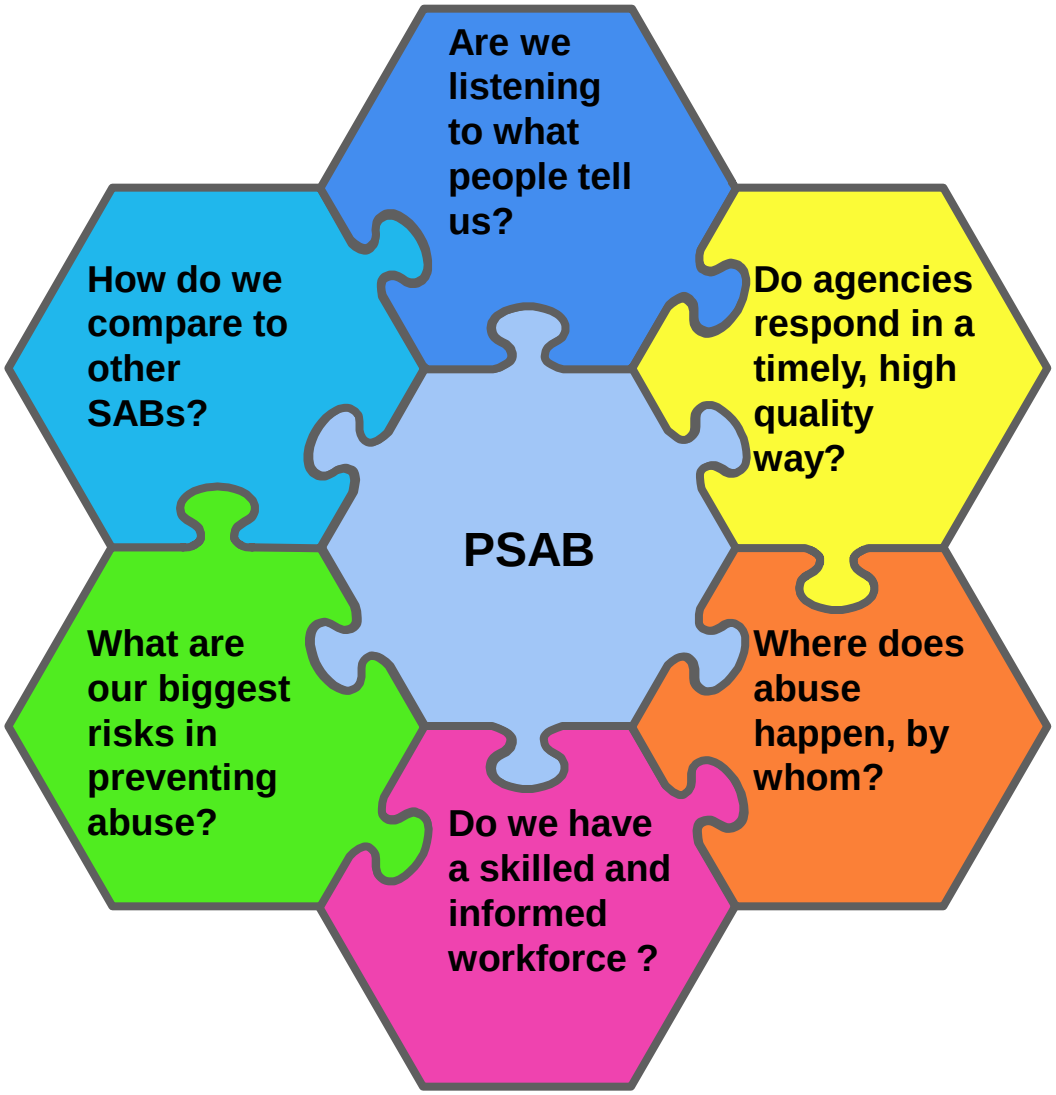
Building links to other boards - and links to other sub groups

Need clear TOR's with accountability

Develop mechanisms to support Chairs

Portsmouth Safeguarding Adults Board

PSAB Safeguarding Assurance

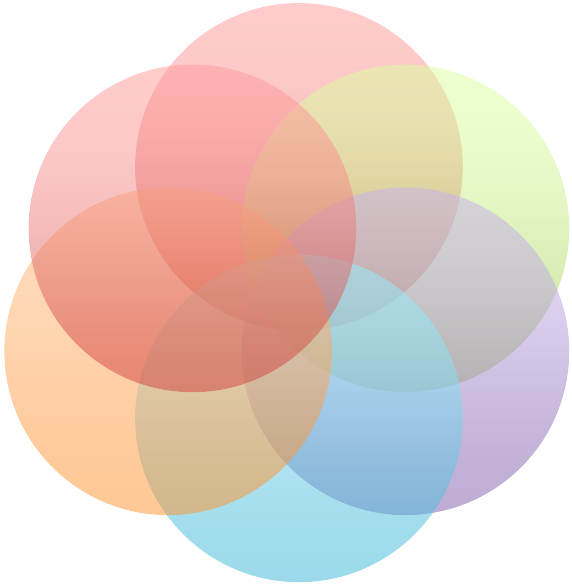


Portsmouth Safeguarding Adults Board

Priorities

Leadership and Governance

Public awareness



Workforce

Quality and intelligence

Learning from Safeguarding Adults Reviews (SARs)

Data - Knowing our population

Making Safeguarding Personal

- The PSAB aims to ensure that adults are safeguarded in a way that supports them in making choices and having control about the way they want to live.
- The PSAB will involve people with care and support needs, carers and the wider community in each of its priority areas.

Objective 1

- To know what data is currently collected by all partner agencies and understand what it is telling us.
- To ensure that data collected relates to the PSAB's vision

Knowing our population

Portsmouth Safeguarding Adults Board

Objective 2

- To commission safeguarding adult reviews and ensure that learning from them and other reviews, local and national, is tangibly embedded into local practice.

Learning from Safeguarding Adults Reviews (SARs)

Objective 3

- To have the whole workforce, including statutory and non-statutory agencies, skilled to safeguard adults.
- To ensure the application of learning from SAR's is evidenced in practice.
- To ensure that learning and development reflects a local need and is responsive to change

Workforce Development

Objective 4

- To fulfil our requirements under the care act to help and protect adults who have needs for care and support, who are experiencing or are at risk of abuse or neglect.
- Be robust in holding staff, the partner agencies and the PSAB and its Chair accountable.
- Be part of a wider network of partnerships to ensure safeguarding is understood and effective throughout Portsmouth.

Leadership and Governance

Next Steps

- Wider consultation: Mid July – Mid August
- Health and Wellbeing Board – September
- Published by the end of September, followed by the publication of the Annual Report in December.

Portsmouth Safeguarding Adults Board

Report to: **Health Overview and Scrutiny Panel**

Date: **26 July 2016**

Report by: **Angela Dryer, Deputy Director of Adult Services**

Subject: **Adult Social Care update on key areas**

1. Purpose of the Report

To update the Health Overview and Scrutiny Panel on some of the key issues for Adult Social Care up to July 2016.

2. Recommendations

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

3. Update on Key Areas

3.1 Performance:

In the previous HOSP update, the Adult Social Care Outcome Framework (ASCOF) measures were detailed, and it was outlined that:

Out of all the councils in the UK that provide Adult Social Care services, Portsmouth ranked fourth for overall value for money, as a reflection of the hard work and dedication of staff who continue to provide a quality service in the face of budget pressures. This also highlighted the challenge we face in meeting ongoing savings targets.

There are some clear issues with the ASCOF and SALT, (Short And Long Term care) returns. Due to the volume and scope of the data collected, by the time it's published it's usually at least 6 months after the end of the financial year it's relevant to. An additional challenge in providing data for 2015/16 has been the change in IT systems for partner agencies resulting in them being unable to extract meaningful data to feed our national returns at this stage.

We are anticipating early access from NHS Digital to the preliminary national data to be released between late summer - mid autumn once HSCIC has completed its initial validation of our 15/16 data submissions (primarily SALT & ASC-Finance returns).

3.2 OPPD Assessment Service Intervention

The community based Social Work/Occupational Therapy and Hospital based Social Work teams have been undergoing a "Systems Thinking" intervention, working to the "Vanguard Method" at the direction of the Cabinet Member for ASC. This is a 3 stage process - the first involves understanding the work

that is being done by the teams and classifying work that is not related to achieving service user purpose as waste, ("check"). The second stage allows for experimentation with live cases carried out by a small team to assess whether it is possible to achieve service user purpose without the waste work, ("redesign"). Examples include a shorter assessment and removing some of the ceilings for authorisations. All actions that are proposed are checked to ensure they are legal and proportionate. The Intervention Team are currently engaged in the third stage, ("roll in") involving training all staff how to work without waste steps, thus improving customer experience by intervening in a more timely and effective way.

A fundamental part of this process is designing measures for the service which relate to the people of Portsmouth who use the service and what is important to them. This will mean that the national measures will become less relevant as they have not been set by our service users and do not enable leaders to act on the ASC system to improve it.

Whilst the ASCOF and other national measures will continue to be available to HOSP, ASC will increasingly focus on development of local measures and these will be remitted to HOSP as soon as they start to be gathered. These will provide meaningful, accurate data around Demand, Capacity, Capability, Quality, Financials and Customer Satisfaction. For this last measure we'll be asking every single service user for a score out of ten and be able to report on it. The purpose of gathering data will change from supplying data nationally and benchmarking with other Authorities to gathering data locally and using this to improve the system to the benefit of service users in Portsmouth.

3.3 Director of Adult Services (DASS):

In the last update report, HOSP were advised that there would be changes in the DASS role. In April 2016 Innes Richens Chief Operating Officer (COO) for Portsmouth Clinical Commissioning Group (PCCG) was appointed to a joint role, taking on the statutory function of the DASS as well as continuing in the role of COO for PCCG. A Deputy Director (Angela Dryer) was appointed As Adult Services lead within Portsmouth to provide strategic and operational leadership and ensure effective management for all operational and strategic functions of adult social care services.

3.4 Budget:

How Adult Social Care is funded remains a key concern for the city.

The introduction of the New Minimum Wage, as anticipated, has led to an increase in care costs. The 2% precept money has been fully allocated to Social Care. This increase in council tax, has assisted in meeting this pressure, but the amount received has been fully utilised in offsetting higher costs to providers.

The increased number of Deprivation of Liberty Safeguard applications has also produced a significant budget pressure. A number of councils are currently challenging the government on the impact of this legislation and the lack of funding allocated to LA's to manage the pressure.

3.5 Safeguarding:

Since the last report the Portsmouth Safeguarding Adults Board (PSAB) has held a successful development day which has resulted in an agreed set of priorities which will shortly be published as the board's strategic plan and presented to the Health & Wellbeing Board in September 2016

A Board Manager has been appointed, currently on a temp contract running until the end of March 2017. This arrangement will be reviewed in the new year with a view to making a permanent appointment.

A Safeguarding Adult Review has recently been completed and the final report and recommendations has been published on the PSAB website

Portsmouth has also seen a significant rise in the number of applications made under the Mental Capacity Act's Deprivation of Liberty Safeguards (DoLS). This applies to people who live in care establishments or hospitals and who lack the mental capacity to consent to be in the placement and are deemed to be subject to "constant supervision and control". In order for the DoLS to be applied the individual is assessed by a specially trained Doctor and Best Interest Assessor. The views of those supporting the individual including family members are sought; Independent Advocacy is also provided if there is no one to carry out the representative role. The application is then authorised by a suitably trained Senior Officer.

In 2014/15 786 applications were managed. This rose to 1460 in 2015/16. Indications for the 1st quarter of 2016/17 are that this number is likely to further increase during this financial year.

3.6 Multi-disciplinary locality teams

The District Nursing and Physiotherapy teams employed by Solent NHS Trust moved in to the Civic Buildings and Medina House in May 2016 and are now co-located with their PCC employed Social Work and Occupational Therapy colleagues. This will enable both organisations to begin discussing the shape of a future integrated service, in line with the Portsmouth Blueprint.

3.7 Learning Disabilities

3.7.1 Having a Good Day

We will have decommissioned 66% of the in-house day services by mid-July. We have completed the tender process for the Health and Independence, Work and Community Connection Services. Named workers will use a simple planning tool which we have developed to finalise which services people will use and the outcomes that the services will be expected to deliver. Allocation of banded rates will provide indicative personal budgets. None of contracts will be Block' so individuals will be able to use Individual Budgets effectively.

Social Enterprise continues to flourish with a growing range of options;

- Looking after the main railway stations
- Creating furnishings and recycling
- Walking dogs in conjunction with the Cinammon trust in order to support older people's ability to keep their pets
- Running craft groups in older persons homes
- Delivering Library books to housebound people
- Running a number of cafes across the city
- Maintaining gardens
- Working in Southsea Library
- Working as an artistic enterprise, exhibiting and selling

Service users are working in a structured way to develop learning and skills with employment as a clear and realistic goal for some.

3.7.2 Respite

We have produced a Transformation Plan which has been shared with Carers who form part of a steering group. The central aim is to reduce use of Residential Respite and develop alternatives; specifically an Outreach Service, a Buddying Service and discrete accommodation and support for emergency placements and for people who require a smaller quieter environment. Funding has been granted to adapt the two properties adjacent to Russets to provide the last and work will be completed by September.

3.7.3 Integrated Team

The move to single line management has led to a step change in terms of integrated working.

There is now significantly improved engagement in shared responsibilities across the Team and increased flexibility of roles in terms of supervision, duty oversight for example.

3.7.4 Collaboration/Advocacy

We now have established monthly carer meetings and regular Carer and Service User newsletters. Service Specifications for new services include a requirement to support self-advocacy and the involvement of service users and carers in setting and measuring quality indicators. We are involved in co-production in terms of Housing and Support and Respite transformation. The Partnership Board has been re launched very successfully with increased membership and better focus. All user groups will feed into and will be informed by the activity of the Board. Volunteer trainers have been established and will eventually be floated as a Social Enterprise. The Learning Disability Champion is now a Portsmouth City Council employee and based at the Kestrel Centre.

3.7.5 Transition

The Preparing for Adulthood working group is made up of a mix of service users, carers and professionals and feeds into both the Learning Disability Partnership Board and Priority Five Board. We have been successful in becoming a National Demonstration site focussed on ensuring that

- Education Health and Care Planning process delivers improved outcomes

- The planning process supports effective joint commissioning

This work is dovetailing with work on Transforming Care and Personal Health Budgets

3.7.6 Transforming Care

While the number of inpatient placements remains relatively extremely low work is underway regarding people 'at risk'. Services for this group will be the focus of the next stage of the Day Service Transformation. Respite Services are being modified and a new resource will be available in September for people who find larger settings problematic. A major build for 12 people will shortly be underway to replace two existing resources. The emphasis throughout will be on minimising the level of discrete provision and supporting integration and this process has successfully begun via the Day Services Transformation.

Angela Dryer
Deputy Director Adult Services

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Southampton, Hampshire, Isle of Wight and Portsmouth Health Overview and Scrutiny Committees: Arrangements for Assessing Substantial Change in NHS provision (revised July 2016)

Purpose and Summary

1) The purpose of this document is to agree the arrangements for assessing significant developments or substantial variations in NHS services across the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) Local Authority areas.

2) It describes the actions and approach expected of relevant NHS bodies or relevant health service providers and Local Authorities with health scrutiny functions when proposals that may constitute substantial service change are being developed and outlines the principles that will underpin the discharge of each parties' role and responsibilities.

3) The document is the fourth refresh of the 'Framework for Assessing Substantial Service Change' originally developed with advice from the Independent Reconfiguration Panel (IRP)[1] and updates the guidance relating to the key issues to be addressed by relevant NHS bodies or relevant health service providers when service reconfiguration is being considered. Emphasis is placed on the importance of constructive working relationships and clarity about roles by all parties based on mutual respect and recognition that there is a shared benefit to our respective communities from doing so.

4) This framework was amended in 2013 following the publication of 'The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013'[2]. These regulations followed from changes made to local authority health scrutiny in the Health and Social Care Act 2012. Subsequent guidance has been produced by NHS England[3] and the Department of Health[4] on health scrutiny, and this framework has been consequentially updated.

5) The legal duties placed on relevant NHS bodies or relevant health service providers and the role of health scrutiny are included to provide a context to the dialogue that needs to be taking place between relevant NHS bodies or relevant health service providers and the relevant local authority/authorities to establish if a proposal is substantial in nature. In this document, the term 'NHS' and 'NHS bodies' refer to:
   - NHS England
   - Clinical Commissioning Groups
   - NHS Trusts and NHS Foundation Trusts

[1] http://www.irpanel.org.uk/view.asp?id=0
[2] http://www.legislation.gov.uk/uksi/2013/218/contents/made
[3] https://www.england.nhs.uk/wp-content/uploads/2015/10/plan-ass-deliv-serv-chge.pdf
[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/324965/Local_authority_health_scrutiny.pdf

6) It is intended that these arrangements will support:
   - Improved communications across all parties.
   - Better co-ordination of engagement and consultation with service users carers and the public.
   - Greater confidence in the planning of service change to secure improved outcomes for health services provided to communities across Southampton, Hampshire, the Isle of Wight and Portsmouth.

7) Section 242 of the NHS Act places a statutory duty on the NHS to engage and involve the public and service users in:
   - Planning the provision of services
   - The development and consideration of proposals to change the provision of those services
   - Decisions affecting the operation of services.

8) This duty applies to changes that affect the way in which a service is delivered as well as the way in which people access the service.

9) Section 244 of the NHS Act 2006 places a statutory duty on relevant NHS bodies or relevant health service providers to consult Local Authorities on any proposals for significant development or substantial variation in health services. NHS organisations will note that this duty is quite distinctive from the routine engagement and discussion that takes place with Local Authorities as partners and key stakeholders.

10) Significant development and substantial variation are not defined in the legislation but guidance published by the Department of Health and Centre for Public Scrutiny on health scrutiny make it clear that the body responsible for the proposal should initiate early dialogue with health scrutineers to determine:
    1. If the health scrutiny committee consider that the change constitutes a significant development or substantial variation in service
    2. The timing and content of the consultation process.

11) Where it is agreed that a set of proposals amount to a substantial change in service, the NHS body or relevant health service provider must draw together and publish timescales which indicate the proposed date by which it is intended that a decision will be made. These timescales must also include the date by which the local authority will provide comments on the proposal, which will include whether the NHS Body has:
    - Engaged and involved stakeholders in relation to changes; and,
    - Evidenced that the changes proposed are in the interest of the population served.

    It is therefore expected that the NHS body or relevant health service provider works closely with health scrutineers to ensure that timetables are reflective of the likely timescales required to provide evidence of the

above considerations, which in turn will enable health scrutiny committees to come to a view on the proposals.

12) The development of the framework has taken into account the additional key tests for service reconfiguration set out in the Government Mandate to NHS England. Where it is agreed that the proposal does constitute a substantial change the response of a health scrutiny committee to the subsequent consultation process will be shaped by the following considerations:
    - Has the development of the proposal been informed by appropriate engagement and involvement of local people and those using the service? This should take account of the relevant equality legislation and be clear about the impact of the proposal on any vulnerable groups.
    - The extent to which commissioners have informed and support the change.
    - The strength of clinical evidence underpinning the proposal and the support of senior clinicians whose services will be affected by the change.
    - How the proposed service change affects choice for patients, particularly with regard to quality and service improvement.

13) NHS organisations and relevant health service providers will also wish to invite feedback and comment from the relevant Local Healthwatch organisation. Local Healthwatch has specific powers, including the ability to refer areas of concern to health scrutineers and Healthwatch England, and also specific responsibilities, including advocacy, complaints, and signposting to information. Health scrutiny committees expect to continue good relationships with patient and public representatives and will continue to expect evidence of their contribution to any proposals for varying health services from the NHS.

14) The framework attached at Appendix One identifies a range of issues that may inform both the discussion about the nature of the change and the response of health scrutiny committees to the consultation process. The intention is that this provides a simple prompt for assessing proposals, explaining the reasons for the change and understanding the impact this will have on those using, or likely to use, the service in question.

15) The framework is not a ‘blueprint’ that all proposals for changing services from the NHS / relevant health service provider are expected to comply with. The diversity of the health economy across the Southampton, Hampshire, Isle of Wight and Portsmouth area and the complexity of service provision need to be recognised, and each proposal will therefore be considered in the context of the change it will deliver. The framework can only act as a guide: it is not a substitute for an on-going dialogue between the parties concerned. It is designed for use independently by organisations in the early stages of developing a proposal, or to provide

a basis for discussion with health scrutineers regarding the scope and timing of any formal consultation required.

17) Although it remains good practice to follow Cabinet Office guidance in relation to the content and conduct of formal consultation, health scrutiny committees are able to exercise some discretion in the discharge of this duty. Early discussions with the health scrutiny committee whose populations are affected by a proposal are essential if this flexibility is to be used to benefit local people.

18) Any request to reduce the length of formal consultation with a health scrutiny committee will need to be underpinned by robust evidence that the NHS body or relevant health service provider responsible for the proposal has engaged, or intends to engage local people in accordance with Section 242 responsibilities. These require the involvement of service users and other key stakeholders in developing and shaping any proposals for changing services. Good practice guidance summarises the duty to involve patients and the public as being:
    1. Not just when a major change is proposed, but in the on-going planning of services
    2. Not just when considering a proposal, but in the development of that proposal, and
    3. In decisions that may affect the operation of services

19) All proposals shared with health scrutiny committees by the NHS body or relevant health service provider – regardless of whether or not they are considered substantial in nature - should therefore be able to demonstrate an appropriate consideration of Section 242 responsibilities.

20) Individual health scrutiny committees will come to their own view about the nature of change proposed by an NHS body or relevant health service provider. Where a proposal is judged to be substantial and affects service users across local authority boundaries the health scrutiny committees concerned are required to make arrangements to work together to consider the matter.

21) Although each issue will need to be considered on its merits the following information will help shape the views of health scrutiny committees regarding the proposal:
    1. The case of need and evidence base underpinning the change taking account of the health needs of local people and clinical best practice.
    2. The extent to which service users, the public and other key stakeholders, including GP commissioners, have contributed to developing the proposal. Regard must be given to the involvement of ‘hard to reach groups’ where this is appropriate, including the need for any impact assessment for vulnerable groups.
    3. The improvements to be achieved for service users and the additional choice this represents. This will include issues relating to service quality, accessibility and equity.

4. The impact of the proposal on the wider community and other services. This may include issues such as economic impact, transport issues and regeneration as well as other service providers affected.
5. The sustainability of the service(s) affected by proposals, and how this impacts on the wider NHS body or relevant health service provider.

22) This information will enable health scrutiny committees to come to a view about whether the proposal is substantial, and if so, whether the proposal is in the interest of the service users affected.

23) The absence of this information is likely to result in the proposal being referred back to the responsible NHS Body or provider of NHS services for further action.

24) If an NHS body or relevant health service provider consider there is a risk to the safety or welfare of patients or staff then temporary urgent action may be taken without consultation or engagement. In these circumstances the health scrutiny committee affected should be advised immediately and the reasons for this action provided. Any temporary variation to services agreed with the health scrutiny committee, whether urgent or otherwise, should state when the service(s) affected will reopen.

25) If the health scrutiny committee affected by a proposal are not satisfied with the conduct or content of the consultation process, the reasons for not undertaking a consultation (this includes temporary urgent action) or that the proposal is in the interests of the health service in its area then the option exists for the matter to be referred to the Secretary of State. Referrals are not made lightly and should set out:
- Valid and robust evidence to support the health scrutiny committee's position. This will include evidence that sustainability has been considered as part of the service change.
- Confirmation of the steps taken to secure local resolution of the matter, which may include informal discussions at NHS Commissioning Board Local Area Team level.

<u>Guiding Principles</u>

26) The four health scrutiny committees and panels in Southampton, Hampshire, the Isle of Wight and Portsmouth work closely in order to build effective working relationships and share good practice.

27) Health scrutiny committees will need to be able to respond to requests from the NHS or relevant health service providers to discuss proposals that may be significant developments or substantial variations in services. Generally in coming to a view the key consideration will be the scale of the impact of the change on those actually using the service(s) in question.

28) Early discussions with health scrutiny committees regarding potential for significant service change will assist with timetabling by the NHS and avoid delays in considering a proposal. Specific information about the steps, whether already taken or planned, in response to the legislation and the four tests (outlined in paragraph 12), will support discussions about additional information or action required. NHS organisations should also give thought to the NHS' assurance process, and seek advice as to the level of assurance required from NHS England, who have a lead responsibility in this area.

29) Some service reconfiguration will be controversial and it will be important that health scrutiny committee members are able to put aside personal or political considerations in order to ensure that the scrutiny process is credible and influential. When scrutinising a matter the approach adopted by health scrutiny committees will be:
    1. Challenging but not confrontational
    2. Politically neutral in the conduct of scrutiny and take account of the total population affected by the proposal
    3. Based on evidence and not opinion or anecdote
    4. Focused on the improvements to be achieved in delivering services to the population affected
    5. Consistent and proportionate to the issue to be addressed

30) It is acknowledged that the scale of organisational change currently being experienced in the NHS coupled with significant financial challenges across the public sector is unprecedented. Consultation with local people and health scrutiny committees may not result in agreement on the way forward and on occasion difficult decisions will need to be made by NHS bodies. In these circumstances it is expected that the responsible NHS body or relevant health service providers will apply a 'test of reasonableness' which balances the strength of evidence and stakeholder support and demonstrates the action taken to address any outstanding issues or concerns raised by stakeholders.

31) If the health scrutiny committee is not satisfied that the implementation of the proposal is in the interests of the health service in its area the option to refer this matter to the Secretary of State remains.

32) All parties will agree how information is to be shared and communicated to the public as part of the conduct of the scrutiny exercise.

Appendix One – Framework for Assessing Change

Key questions to be addressed

Each of the points outlined above have been developed below to provide a checklist of questions that may need to be considered. This is not meant to be exhaustive and may not be relevant to all proposals for changing services

The assessment process suggested requires that the NHS or relevant health service providers responsible for taking the proposal forward co-ordinates consultation and involvement activities with key stakeholders such as service users and carers, Local Healthwatch, NHS organisations, elected representatives, District and Borough Councils, voluntary and community sector groups and other service providers affected by the proposal. The relevant health scrutiny committee(s) also need to be alerted at the formative stages of development of the proposal. The questions posed by the framework will assist in determining if a proposal is likely to be substantial, identify any additional action to be taken to support the case of need and agree the consultation process.

Name of Responsible (lead) NHS or relevant health service provider:

Name of lead CCG:

Brief description of the proposal:

Why is this change being proposed?

Description of Population affected:

Date by which final decision is expected to be taken:

Confirmation of health scrutiny committee contacted:

Name of key stakeholders supporting the Proposal:

Date:

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
Case for Change 1) Is there clarity about the need for change? (e.g. key drivers, changing policy, workforce considerations, gaps in service, service improvement) 2) Has the impact of the change on service users, their carers and the public been assessed? 3) Have local health needs and/or impact assessments been undertaken? 4) Do these take account of : a) Demographic considerations? b) Changes in morbidity or incidence of a particular condition? Or a potential reductions in care needs (e.g due to screening programmes)?		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
c) Impact on vulnerable people and health equality considerations? d) National outcomes and service specifications? e) National health or social care policies and documents (e.g. five year forward view) f) Local health or social care strategies (e.g. health and wellbeing strategies, joint strategic needs assessments, etc) 5) Has the evidence base supporting the change proposed been defined? Is it clear what the benefits will be to service quality or the patient experience? 6) Do the clinicians affected support the proposal? 7) Is any aspect of the proposal		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
contested by the clinicians affected? 8) Is the proposal supported by the lead clinical commissioning group? 9) Will the proposal extend choice to the population affected? 10) Have arrangements been made to begin the assurance processes required by the NHS for substantial changes in service? **Impact on Service Users** 11) How many people are likely to be affected by this change? Which areas are the affecting people from? 12) Will there be changes in access to services as a result of the changes proposed? 13) Can these be defined in terms of a) waiting times?		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
b) transport (public and private)? c) travel time? d) other? (please define) 14) Is any aspect of the proposal contested by people using the service? **Engagement and Involvement** 15) How have key stakeholders been involved in the development of the proposal? 16) Is there demonstrable evidence regarding the involvement of a) Service users, their carers or families? b) Other service providers in the area affected? c) The relevant Local Healthwatch?		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
d) Staff affected? e) Other interested parties? (please define) 17) Is the proposal supported by key stakeholders? 18) Is there any aspect of the proposal that is contested by the key stakeholders? If so what action has been taken to resolve this? **Options for change** 19) How have service users and key stakeholders informed the options identified to deliver the intended change? 20) Were the risks and benefits of the options assessed when developing the proposal? 21) Have changes in technology or best practice been taken into account?		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
22) Has the impact of the proposal on other service providers, including the NHS, local authorities and the voluntary sector, been evaluated? 23) Has the impact on the wider community affected been evaluated (e.g. transport, housing, environment)? 24) Have the workforce implications associated with the proposal been assessed? 25) Have the financial implications of the change been assessed in terms of: a) Capital & Revenue? b) Sustainability? c) Risks?? 26) How will the change improve the health and well being of the population affected?		