Portsmouth CITY COUNCIL

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NOTICE OF MEETING

HEALTH OVERVIEW & SCRUTINY PANEL

TUESDAY, 23 FEBRUARY 2016 AT 9.30 AM

THE EXECUTIVE MEETING ROOM - THIRD FLOOR, THE GUILDHALL

Telephone enquiries to Jane Di Dino 023 9283 4060 or Lisa Gallacher 023 9283 4056
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Membership

Councillor John Ferrett (Chair)
Councillor Phil Smith (Vice-Chair)
Councillor Jennie Brent
Councillor Alicia Denny
Councillor Gemma New
Councillor Lynne Stagg
Councillor Brian Bayford
Councillor Gwen Blackett
Councillor Peter Edgar
Councillor David Keast
Councillor Mike Read
Vacancy, East Hampshire District Council

Standing Deputies

Councillor Ryan Brent
Councillor Margaret Foster
Councillor Aiden Gray
Councillor Hannah Hockaday
Councillor Lee Hunt
Councillor Ian Lyon
Councillor Sandra Stockdale

(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 of the meeting held on 2 February 2016 are attached for

approval.

4 Portsmouth Safeguarding Adult Board - Annual Report (Pages 7 - 38)

Robert Templeton, Chair of the Portsmouth Safeguarding Adults Board and Rachael Roberts, Service Manager will introduce and answer questions on the attached report.

5 Adult Social Care update (Pages 39 - 44)

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

6 Solent NHS Trust - mental health, St James and Baytrees (Pages 45 - 52)

Sarah Austin, Chief Operating Officer & Commercial Director will answer questions on the attached reports.

7 Drug and alcohol detoxification pathways in the city (Pages 53 - 56)

Barry Dickinson, Senior Programme Manager will answer questions on the attached report.

8 Portsmouth Hospitals' NHS Trust - update. (Pages 57 - 58)

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

9 Repatriation of Vectis Way (Phlebotomy) Blood Taking Clinic Proposal (Pages 59 - 64)

Janice Cloud, Matron for Out-Patients and Phlebotomy and Alison Fitzsimons General Manager and Head of Professions for Clinical Support, will answer questions on the attached report.

10 Portsmouth Clinical Commissioning Group update (Pages 65 - 68)

Dr Tim Wilkinson, Chair of the CCG Governing Board, will answer questions on the attached report.

11 Local Dentists' Committee - update. (Pages 69 - 74)

Keith Percival, Honorary Secretary, Hampshire & Isle of Wight Local Dentists' Committee will answer questions on the attached report.

12 Healthwatch - update (Pages 75 - 90)

Patrick Fowler, Healthwatch Portsmouth Consultant will answer questions on the attached report.

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, 2 February 2016 at 9.30 am at The Executive Meeting Room - Third Floor, The Guildhall

Present

Councillor John Ferrett (Chair)
Councillor Phil Smith
Councillor Jennie Brent
Councillor Alicia Denny
Councillor Gemma New
Councillor Lynne Stagg
Councillor Gwen Blackett, Havant Borough Council
Councillor Peter Edgar, Gosport Borough Council
Councillor David Keast, Hampshire County Council

Also in Attendance

Hampshire and Isle of Wight Pharmaceutical Committee
Paul Bennett, Chief Officer

Portsmouth City Council
Natasha Koerner, Integrated Personal Commissioning Programme Manager

Portsmouth Clinical Commissioning Group
Innes Richens, Chief Operating Officer

South Central Ambulance Service
Rob Kemp, Area Manager

Southern Health NHS Foundation Trust
Dr Chris Gordon, Director of Performance, Quality and Safety and Chief Operating Officer
Dr Lesley Stevens, Medical Director

1. Welcome and Apologies for Absence (AI 1)

Apologies for absence were received from Cllr Mike Read.

2. Declarations of Members' Interests (AI 2)

Councillors Peter Edgar, Jennie Brent and Gwen Blackett each declared a personal interest as they are on the council of governors at Portsmouth Hospitals' NHS Trust.

3. Minutes of the Previous Meetings (AI 3)

3 November 2015 Minutes

RESOLVED that the minutes of the meeting held on 3 November 2015 be confirmed as a correct record subject to the following amendment:

Page 3, minute number 4 paragraph 1 should read 'The Panel raised concerns that NHS England have not considered the impact of patients in Chichester and those all along the coast to Brighton if the vascular services are centralised in Southampton and asked that this be looked *at* and included in their next paper'.

Matters arising from 3 November 2015 Minutes

Minute number 4 - The Panel noted that the vascular services update would now be coming to the 15 March meeting.

Minute number 6 - Cllr Keast advised that he had attended a meeting with Peter Mellor, Director of Corporate Affairs and Business Development at PHT, and the commissioning officer at Hampshire County Council regarding the issue of Hampshire County Council being slow at providing care packages. The situation has improved considerably however this was an ongoing issue and was being monitored.

24 November 2015 Minutes

RESOLVED that the minutes of the meeting held on 24 November 2015 be confirmed as a correct record subject to the following amendments:

Page 1, minute number 1 - Cllr Stagg had submitted her apologies for absence.
Page 2, minute number 4, bullet point 4 should read 'Apart from the Somerstown Centre, the other most likely location for *the* new practice would be the John Pounds Centre'.
Page 4, minute number 4, should read 'Most GPs speak more than one language and *the* language line can be used if required'.

4. Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015 (AI 4)

Dr Chris Gordon, Director of Performance, Quality and Safety and Chief Operating Officer and Dr Lesley Stevens, Medical Director presented the report. Dr Gordon advised that the Mazars report had found that serious incident investigations were too slow. Southern Health acknowledges the recommendations in the report and the vast majority of them have been taken on board. As a result a number of measures have been put in place and there is a comprehensive action plan in place.
In response to questions from the panel, the following matters were clarified:

- The Corporate Panel was introduced 14 months ago to improve quality.

- Southern Health changed way that deaths are reported two months ago. When a death occurs they consider what could've been done to prevent it and what could be done to prevent it happening again. They will also decide whether an investigation needs to be carried out.
- Previously, a third of investigations were not completed to an adequate standard. The new process is that a decision will now be made within 48 hours of a death being registered, as to whether an investigation is required.
- Many of the deaths were in the community where the amount of contact with Southern Health is very small.
- There were a total of 10,000 deaths over four years of patients in contact with Southern Health. 91 of those who died were inpatients under the care of Southern Health. For all of these patients those cases that warranted investigation were investigated and families were involved in the process. 143 patients under their care died as a consequence of either suicide or probable suicide. The remaining patients who died were older patients in mental health units and the deaths were expected.
- The issue was therefore how they improve the system so that those cases that need investigating are done so to identify failings. Southern Health is working with commissioners and clinical staff to actively develop a system for taking the lead for investigating deaths in the community. Systems for mortality are well developed for acute hospitals so need to ensure the hospitals systems can be transferred across to the community setting. This needs to be led by the commissioners.
- There is national guidance in place and this is clear about in-patient deaths. It states that the average time for reporting serious incidents is 60 days. Southern Health is currently at 59 days which is much improved.
- The Action Plan will be resource intensive and Southern Health will be diverting additional financial resources into this to ensure it is embedded properly.
- Southern Health has a close working relationship with Hampshire Constabulary and one of the pieces of work is to look at suicide prevention. There are a number of different mechanisms for flagging up potential patients at risk of suicide with the police including identifying those patients frequently making demands on services. It is therefore vital to ensure that services are joined up to work in a consistent way.

Innes Richens, Chief Operating Officer of Portsmouth Clinical Commissioning Group was invited to give some information about the numbers of patients in the Portsmouth area. He advised that Portsmouth CCG was not a significant commissioner of services from Southern Health NHS Foundation trust; West Hampshire Clinical Commissioning Group has been co-ordinating the cross-CCG response to the report and has actively included Portsmouth CCG.

Innes advised there are four Portsmouth residents in Forest Lodge, two of these are funded by Portsmouth CCG. Of these, one is joint funded by the CCG and Portsmouth City Council and one is wholly Portsmouth City Council funded. These are reviewed annually and are reviewed on a weekly basis by

the Portsmouth Learning Disability Service community teams. Portsmouth CCG also commissions an eating disorders service from Southern Health and there are approximately 110 first outpatients appointments for Portsmouth residents each year. Portsmouth CCG also commission community services for people registered with GP's in Portsmouth who live in Hampshire.

The panel thanked Southern Health for their professional approach to dealing with this matter.

RESOLVED that the report and the comprehensive action plan from the independent review of deaths of people with a learning disability or mental health problem in contact with Southern Health Foundation Trust between April 2011 and March 2015 be noted

5. Hampshire and Isle of Wight Pharmaceutical Committee - update. (AI 5)

Paul Bennett, Chief Officer, Hampshire & Isle of Wight LPC introduced the report. In response to questions from the panel, the following matters were clarified:

- Competition between pharmacies is healthy and helps towards driving improvement and innovation. It is also important that pharmacies collaborate and co-operate to ensure patients have good access to services.
- The Local Pharmaceutical Committee is one of the consulted parties for applications for new pharmacies wishing to open in the area. They will considerer how consistent the application is with regulations and make comments accordingly. Ultimately, NHS England has responsibility for the final decision.
- There is a really important place for the self-care agenda and helping patients take better care of themselves is part of the strategy. An example is the 'know your numbers' blood pressure testing campaign which community pharmacies are helping to administer.
- With regards to training of pharmacy staff, pharmacists have to complete a minimum of five years study (including completion of a pre-registration year) leading to award of a Master of Pharmacy Degree and registration with the General Pharmaceuticals Council (GPhC). Pharmacists are supported by trained and GPhC registered technicians. Other team members working the pharmacy (typically on the medicines counter) will have, or be working towards, a recognised qualification.
- The control of entry regulations were introduced to ensure pharmacies cannot open wherever they like. The last government introduced amendments to the regulations with four specific measures which meant that pharmacies did not have to go through the same assessment process. This created a significant increase in the number of community pharmacies. The main exemption related to 100 hour pharmacies. These exemptions have since been removed so that new pharmacies cannot now automatically open next to an existing pharmacy and unmet need would have to be demonstrated.
- The Pharmacy First Scheme (minor Ailments Scheme) commissioned by the CCG encourages patients to visit their pharmacy for minor

illnesses or ailments. Service user figures are available for this. The LPC is also in the process of discussions with NHS England and the CCG on an urgent repeat medicine service to support patients who run out of their medication, typically at a weekend and who then have to rely on out of hours services or the ED. This can be have serious implications for patients so this new service should help to ease pressure on both hospitals and GP's.

RESOLVED that the report be noted.

6. South Central Ambulance Service - update (AI 6)

Rob Kemp, Are Manager introduced the report. In response to questions the following matters were clarified:

- There have been two recruitment drives since SCAS last reported to HOSP. They have also recruited staff from further afield including Australia and Poland. For these staff they ensure that they complete an approved course to be able to register with the HCPC.
- SCAS have introduced initiatives to develop and retain staff including increased responsibilities for band 6 paramedics and offering a certificate in Paramedic Practice. Staff are very dedicated and work incredibly hard and it is important to recognise this.
- SCAS are not invited specifically to comment on CQC inspections of care homes however they have a member of staff who works with community teams to spot patterns in care homes e.g. if they are constantly being called out for issues that a care home should be able to deal with.
- Conveyance rates have increased. Paramedics must ensure that correct decisions are made with patients and that they are safely referred however there are patients who call the ambulance service as they know they will receive a friendly helpful service and like the interaction they receive so it's about finding a balance.
- There are a number of mechanisms in place for providing psychological support to staff. Trauma Risk Management (TRiM) Practitioners are trained as first line spotters to review exposure to trauma and staff can refer themselves to TRiM support and occupational health. Colleagues are also very good at supporting others when they have been exposed to a traumatic incident.
- SCAS are maintaining response times for Portsmouth very well but there are some areas which are more difficult to reach including the south of Southsea. With regards to Hayling Island, paramedics are stationed a standby point at the bottom of Havant which serves Hayling Island.
- Paramedic courses at Portsmouth University are well subscribed and a lot of students train in this area. The course has provision for 60 students a year and the recent take-up has been about 20 a year, with 10 of these recruited for the area.

RESOLVED that the report be noted.

7. Integrated Personal Commissioning - an introduction (AI 7)

Natasha Koerner, IPC Programme Manager introduced the report. In response to questions the following matters were clarified:

- IPC is a national demonstrator site, trialling approaches to integrating health and social care at delivery and giving individuals more choice and control. This includes greater involvement in care and support planning for the individual, focusing on what matters to them, finding ways to allow them to exercise their right to an integrated budget and ensuring there are a variety of services and products available for them to purchase.
- IPC is not about saving money but looking at ways to improve experiences for health and/or social care customers and make these more efficient.
- Through IPC Portsmouth will have a better understanding of the total cost required to meet a person's needs, including primary care, prescriptions, social care, community health, etc.
- There are no local case studies available yet as year one has focused on coming up with the systems and processes required, however a trial using local residents is underway and will generate case studies, and these will be reported back to the HOSP.

RESOLVED that the report be noted.

The formal meeting ended at 11:50am

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Councillor John Ferrett
Chair

THIS ITEM IS FOR INFORMATION ONLY

Portsmouth CITY COUNCIL

Title of meeting:	Health Overview Scrutiny Panel
Subject:	PSAB Annual Report
Date of meeting:	23 February 2016
Report by:	Rachael Roberts, on behalf of the Director of Adult Services
Wards affected:	All

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1. **Requested by the lead Member for Health and Social Care**

2. **Purpose - For information only, for Panel to note.**

3. **Information Requested**

PSAB Annual Report

The report sets out the PSAB's achievements over the last year. The December meeting of the PSAB board will be used to agree the strategic priorities and work programme for 2016/17. A new independent chair has been appointed - Robert Templeton and he will take on the Chair's role at the December meeting of the PSAB

In 2014/15 the Board has focused on preparing for and implementing the Care Act.

One Safeguarding Adult Review (SAR) has been completed and a further one commissioned. Learning from these is being disseminated across all agencies and action plans are monitored and reviewed through the SAR sub group.

Appendices:
PSAB Annual Report 2014/2015

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

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

Title of document	Location
PSAB Annual Report 2014/2015	PSAB Jan 2016

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ANNUAL REPORT - 2014 / 2015

Safeguarding is everyone's responsibility"

REPORT FROM INDEPENDENT CHAIR - David Cooper

It has been an extremely busy year for Portsmouth Safeguarding Adults Board, and its partner agencies, as they prepared for the implementation of the Care Act 2014, during a period when safeguarding has dominated the news as never before. It is a compliment to all these agencies and their frontline staff that this report is able to demonstrate significant progress.

This years report is being presented in a rather different format than before, which we hope you will find both more informative and more accessible. Any comments you have on the new format would be most appreciated.

This will be my last report as Chair, as I will be stepping down from this role at the end of August. When I was appointed in 2013 I was asked to ensure the board was prepared to meet the requirements of the Care Act, which was coming into effect in April 2015, and I believe we have achieved this.

However, before looking at some of the key developments over the past year, I want to look at the national and local context in which safeguarding operates.

In June 2014 the safeguarding service in Portsmouth City Council and the multi agency joint working arrangements (including the Safeguarding Adults Board) were the subject of an external Peer Review, which found examples of good practice, a strong commitment to safeguarding, and good informal working arrangements amongst partner agencies.

As indicated above safeguarding work is becoming ever more complex, and the environment in which it is being delivered more challenging, and yet the board received some examples of some excellent work by front line staff, including colleagues in the Police who have worked hard to engage partner agencies in improved joint working to prevent the radicalisation of vulnerable adults, while NHS colleagues have given a heightened focus around the issue of female genital mutilation and the board received some examples of excellent person centred practice from social workers in Portsmouth City Council.

Following the Peer Review and the emergence of guidance around the Care Act, the board held a very successful Development Day, and agreed a new set of working arrangements and membership, reflecting its new statutory status. These have been implemented in a phased manner over the past year, and the 'new board' is now in place, and meeting.

Fragility of the care market - while there are some excellent providers, as national data published by Care Quality Commission (CQC) in April 2015 found, there remain large variations in the quality of care services with 1% rated as outstanding, 59% as good, but 31.9% as requiring improvement and 8.7% as inadequate. This picture is consistent with the Institute of Public Care's report for CQC into the state of the care market published last year. As we know that many of these care providers are facing real financial difficulties, and the planned introduction of the national minimum wage, though welcomed, will only add to these financial pressures.

Impact of financial austerity on adult social care - a budget survey by the Association of Directors of Adult Social Services in June 2015 highlighted the continued financial pressure on Adult Social Care, with central government cuts in budgets of £4.6 billion since 2010, and further cuts of £1.1 billion planned for 2015/16, which has resulted in fewer people receiving social care services; despite the efforts of local politicians to protect social care budgets. In Portsmouth this has resulted in an on-going financial squeeze on social care budgets, with further cuts planned.

Impact of continued organisational change - one response to managing the financial pressures faced by partner agencies, is through improved productivity ie 'doing more for less'. Which in turn has resulted in considerable organisational change in Portsmouth City Council, Hampshire Police, Probation and NHS, and this places real pressure on frontline staff working in public and voluntary services, as evidenced in a national survey undertaken by the Guardian newspaper, published on the 10 June, with 93% of respondents stating they were stressed at work all or part of the time. Yet these are many of the same staff working with the most vulnerable members of society.

Complexity of safeguarding - I have worked in the area of safeguarding for over 30 years, and it is difficult to recall a period when safeguarding was more in the news. The scenarios in which it operates is also becoming more complex, including human trafficking, heightened awareness of domestic abuse, cases of historic sexual abuse emerging post the Jimmy Saville revelations, and radicalisation which saw 6 young men from Portsmouth lured to fight in Syria. While the CQC, following a freedom of information request from the Observer newspaper (published on the 9 August 2015) revealed that regulators were notified of 30,000 allegations of abuse involving people using social care services in the first six months of this year; while the rate of allegations made in 2015 is double that of 2011. In Portsmouth while the number of allegations may not have increased, the number that were taken forward as investigations went up by a third. All of these factors create a very challenging context for safeguarding.

Achievements of the Board over the past year - the main focus of the boards work over the past year has been in preparing, and implementing the Care Act , which came into effect in April 2015 and placed the Safeguarding Board onto a statutory footing for the first time. This has involved working with the 3 other local safeguarding boards (Southampton, Hampshire and Isle of Wight) in reviewing all our local procedures; providing training in the new working arrangements; generally raising awareness amongst staff and the public etc.

As indicated above safeguarding work is becoming ever more complex, and the environment in which it is being delivered more challenging, and yet the board received some examples of some excellent work by front line staff, including colleagues in the Police who have worked hard to engage partner agencies in improved joint working to prevent the radicalisation of vulnerable adults, while NHS colleagues have given a heightened focus around the issue of female genital mutilation and the board received some examples of excellent person centred practice from social workers in Portsmouth City Council.

Following the Peer Review and the emergence of guidance around the Care Act, the board held a very successful Development Day, and agreed a new set of working arrangements and membership, reflecting its new statutory status, and these have been implemented in a phased manner over the past year, and the 'new board' is now in place, and meeting.

Challenges facing the Board - But of course the Peer Review, the Safeguarding Adult Review inquiries, and the work of the board over the past year has also evidenced that there is much more which needs to be done to strengthen the joint working arrangements;

- Partner agencies need to work together to ensure that the board has access to more robust quality and performance information, to support improved safeguarding monitoring arrangements.
- Further work needs to be done to communicate and widen the governance of safeguarding across PCC, and there needs to be increased Council Member engagement in safeguarding at board level and across the wider system.
- More consideration needs to be given to 'making safeguarding personal' as a way of ensuring better outcomes and involvement of people experiencing safeguarding concerns.
- The new board will need to take a more strategic approach, taking into account the impact of the Care Act, the wider remit of safeguarding, and this in-turn requires enhanced financial and other support for the board (which has been much lacking) to manage both the pending changes in personnel over the next few months, and to respond in the long term to the demands facing safeguarding in future years.
- Finally I would like to take this opportunity to thank the board support staff, all board members, other colleagues, and members of the public for their support in my role as chairperson over the past 18 months or so. The board has agreed to appoint a new independent chair, and I would also like to offer them my best wishes for the future.

David Cooper
Independent Chair

THE CARE ACT 2014

The Act came into force in April 2015.

Clauses 42-48 of the Care Act provides the statutory framework for protecting adults from abuse and neglect from April 2015. Provisions include:

- Make or cause to be made, enquiries if it believes an adult is experiencing or at risk of experiencing abuse or neglect
- Arrange for independent advocacy to be available for those who may have difficulty in participating in any enquiries.
- Establish a Safeguarding Adults Board (SAB) to coordinate efforts across all partner agencies to safeguard adults with care and support needs.

  Ensure the SAB produces an annual report detailing it's achievements for the year alongside a strategic plan outlining it's main objectives and how they will be met.
- Conduct Safeguarding Adult Reviews in accordance with S44 of the Act, where someone who is experiencing abuse or neglect dies or there is concern about how authorities acted, to ensure lessons are learned.
- New ability for Safeguarding Adults Boards to require information sharing from other partners to support reviews or other functions.
- Abolition of the existing power (under section 47 of the National Assistance Act 1948) for local authorities to remove people from their homes.
- Provide information about services available in the area that can prevent abuse and support people to safeguard themselves.

Care Act 2014

ACHIEVEMENTS OF THE PSAB IN RELATION TO THE CARE ACT

- Portsmouth Safeguarding Adult Boards are implementing changes required under the Care Act.
- Partners agencies have been requested to audit how they are implementing the Care Act locally
- A Safeguarding Adults Board has formed including review and revision of previous Board arrangements and the appointment of an Independent Chair.
- We have worked in partnership with neighbouring local authorities (4LSAB)to update the Pan Hampshire Multi Agency Safeguarding Policy and Procedures in light of the Care Act .
- A Designated Adult Safeguarding Manager (DASM) responsible for the management and oversight of individual complex cases has been ap-

Chapter 1– Local Demographics

Local Demographics

Portsmouth is a port city located in Hampshire on the south coast of England. It is the most densely populated area in the UK outside of London with an estimated population of 205,100, of which approximately 79.3% are over 18 years of age. Portsmouth has a predominantly White British ethnic population; 84% . Of the 16% Black and Minority Ethnic population the ethnicities with the highest representation are Bangladeshi, Indian, Chinese, Black African, Mixed White and Asian and Other White.

Portsmouth is ranked 76th most deprived out of 326 local authorities in England (Indices of Multiple Deprivation 2010), with 15% of the city's population experiencing income deprivation.

Vulnerable Groups

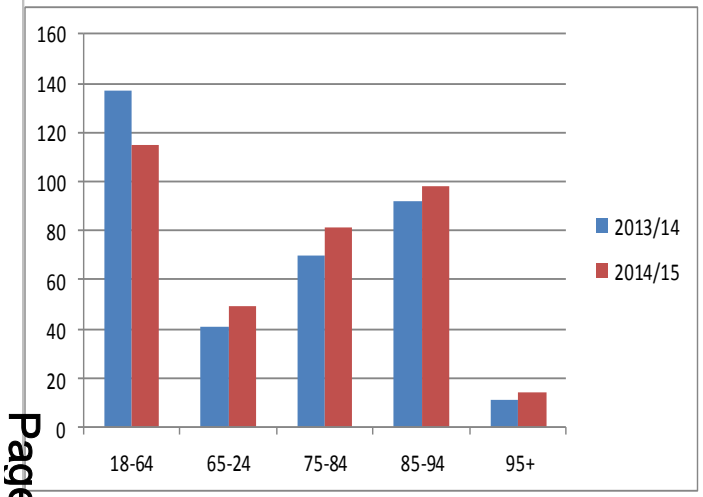
It is impossible to offer a complete picture of adults at risk in Portsmouth because, despite the best efforts of local services to identify, engage with, and support adults who are being harmed or are at risk of being harmed, some abuse or neglect may be hidden. What we do know is that we need the support of all services and the local community to raise awareness of what constitutes a safeguarding concern.

Abuse of vulnerable adults can take many forms, including financial, physical, emotional or linked to households where there is domestic abuse, substance misuse and mental health issues.

This annual report starts by looking at the categories of adults at risk in Portsmouth who have been identified by the local authority and other agencies as in need of protection as a result of their vulnerability.

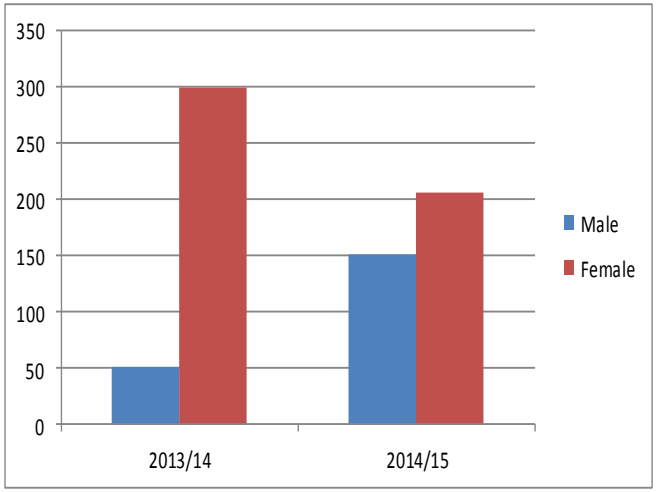
Statistical Analysis– Referral Breakdown

Referrals by Age 2013/14 and 2014/15



The graph above shows the number of referrals received in 2013/14 and 2014/15, that were considered under the Pan Hants Multi-Agency Safeguarding Procedures. The number of alerts raised over the last two years has remained steady at 1300 per annum. However the number of concerns requiring a safeguarding response under the Pan Hants Multi-Agency Procedures has from 239 in 2013/14 to 357 in 2014/15 indicating that there is increased awareness of what constitutes a safeguarding concern within the city.

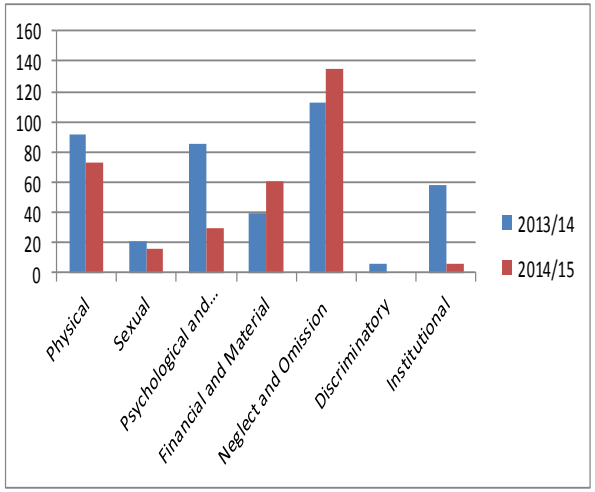
Referrals by Gender



The graph above shows the contrast of referrals by gender received in 2013/14 and 2014/15.

More concerns are raised about women than men in Portsmouth, this is in line with the national picture.

Referrals by Risk Type 2013/14 and 2014/15



The graph above is a comparison of the risk types that are referred. Although there is an upward trend in the year 2014/15 for Neglect and Acts of Omission, this could be due to a raised awareness in this area of Safeguarding work .

The statistics suggest a reduction in Institutional abuse but this is likely to be a result of changes to recording practice. Some safeguarding concerns occurring in care home settings are being recorded as Neglect or Omission, where previously they may have been recorded as institutional abuse.

National developments and local response

The Francis Report investigated the failings at the Mid Staffordshire Foundation Trust was published in February 2013. Since then, issues of patient safety, quality of care and a culture of collective leadership have been in the public eye more than ever. This was shortly followed by the Government publishing its response to address poor quality care in NHS services.

In February 2013, the Home Office introduced a new definition of 'domestic abuse' which has been extended to include incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.

In April 2013, Health and Wellbeing Boards were established and became a statutory requirement. The PSAB has established links with the Portsmouth Health and Wellbeing Board and has developed a joint working protocol.

In April 2015 the Care Act became law. This Act places safeguarding adults on a statutory footing, providing a much welcomed legislative framework to support the work of the local authority and partner agencies. The Act re-affirmed the importance of embedding the six principles of safeguarding into the practice of all partner members of the safeguarding adults boards

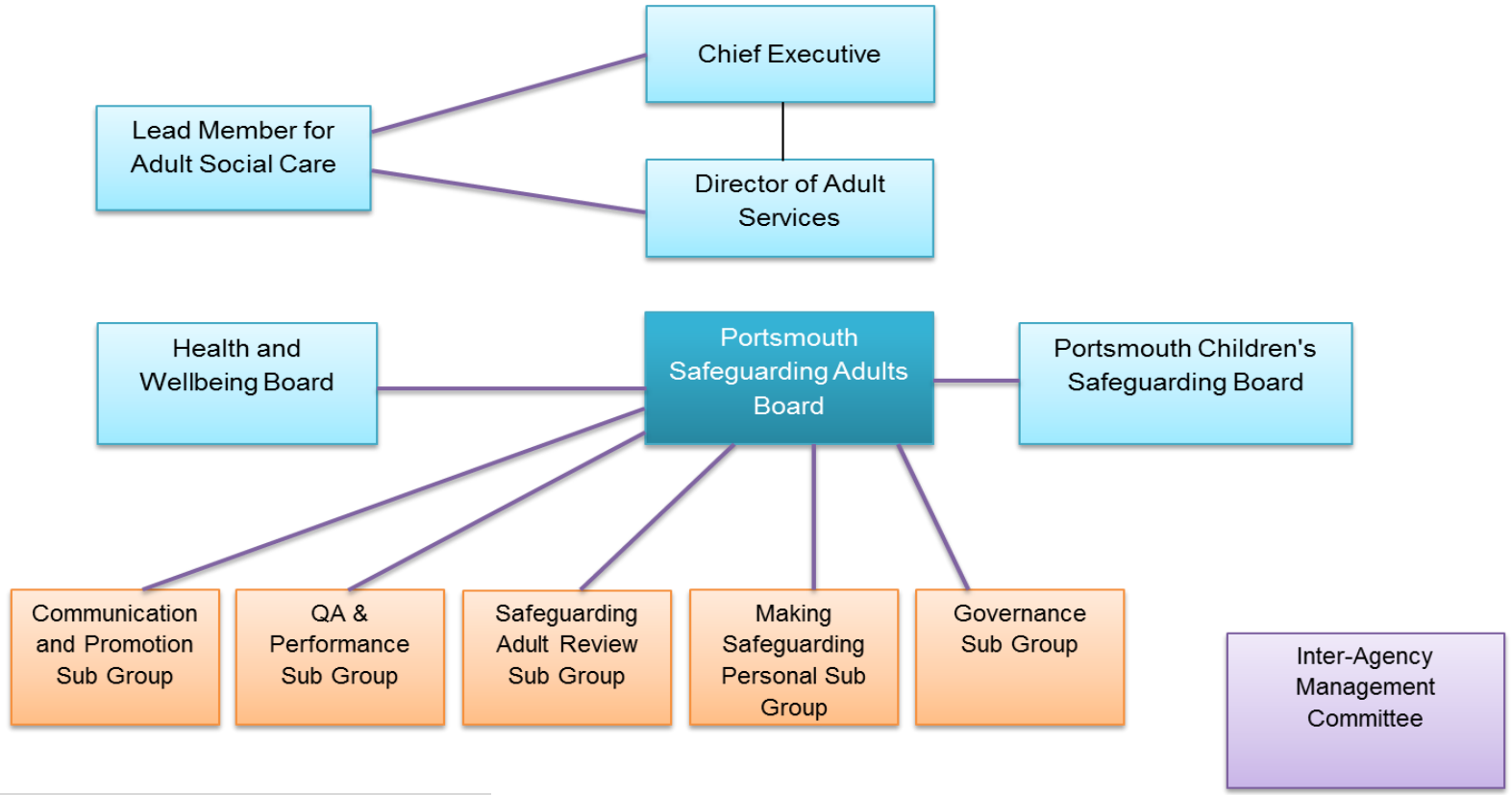
Six principles of Safeguarding

- **Empowerment**
  People being supported and encouraged to make their own decisions and informed consent.
- **Prevention**
  It is better to take action before harm occurs.
- **Proportionality**
  The least intrusive response appropriate to the risk presented.
- **Protection**
  Support and representation for those in greatest need.
- **Partnership**
  Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability**
  Accountability and transparency in safeguarding practice.

CHAPTER 2

What is the Portsmouth Safeguarding Adults Board?

The Portsmouth Safeguarding Adults Board (PSAB) aims to promote awareness and understanding of abuse and neglect. Its work is to generate community interest and engagement in safeguarding issues to ensure "Safeguarding is Everyone's Business". The well-being and safety of local people is our main concern and we adopt a zero tolerance stance on the abuse, neglect or discrimination of any person, including people at risk or in vulnerable situations in any setting. Our aim is to ensure there is effective partnership working at the local level, whenever concerns are raised, so that agencies work in a co-ordinated way. We work proactively with care providers to address any concerns raised about their service to ensure that local people have access to good quality and safe care when they need it.



The role and duties of Safeguarding Adults Boards (SABs) Director of Adult Services

The Director of Adult Services has specific responsibilities under statutory guidance issued by the Department of Health. These include:

- Maintain a clear organisational and operational focus on safeguarding adults.
- Make sure relevant statutory requirements and other national standards are met.
- Make sure Disclosure and Barring Service (DBS) standards are met.

The Director is also responsible, through the appointment of an effective Independent Chair, for ensuring :-

- That the SAB continues to develop an independent, objective and authoritative identity.
- The SAB will have clear independent leadership and strategic vision.
- That partners work effectively together to safeguard adults at risk in their area.
- To ensure adult safeguarding maintains a high profile across all agencies, organisations and communities in the city.
- The SAB will evaluate its effectiveness in scrutinising safeguarding work across all partner agencies.
- The SAB will work collaboratively with the other SAB's locally to reduce repetition and share the same working documents / strategies etc., particularly where organisations work across more than one Board.

The Purpose of a Safeguarding Adults Board

The overarching purpose of a SAB is to:

- Assure itself that local safeguarding arrangements are in place as defined by the Care Act
- Prevent abuse and neglect where possible
- Provide a timely and proportionate responses when abuse or neglect has occurred.

The SAB must take the lead for adult safeguarding across its locality and oversee and co-ordinate the effectiveness of the safeguarding work of its member and partner agencies. It must also concern itself with a range of matters which can contribute to the prevention of abuse and neglect such as the:

- Safety of patients in local health services
- Quality of local care and support services
- Effectiveness of prisons in safeguarding offenders

Core duties: -

SABs have three core duties. They must:

- Develop and publish an Annual Strategic Plan setting out how they will meet their strategic objectives and how their member and partner agencies will contribute.
- Publish an annual report detailing how effective their work has been.
- Arrange Safeguarding Adult Reviews for any cases which meet the criteria for such enquiries.

Portsmouth Safeguarding Adults Board and its Sub-groups

SAB (Safeguarding Adults Board): The strategic multi-agency steering group with statutory responsibility for the oversight and co-ordination of safeguarding activity across Portsmouth.

QA (The Quality and Performance Subgroup): Responsible for the production of effective management information and governance to the PSAB.

SAR (The Safeguarding Adult Review Subgroup): Responsible for the commissioning of and learning from Safeguarding Adult Reviews.

MSP (Making Safeguarding Personal): This sub group will help develop a culture within safeguarding services that ensures that the way we respond in safeguarding situations enhances the involvement, choice and control of adults at risk, alongside improving their quality of life , wellbeing and safety.

Fire Safety Development Group: Responsible for co-ordinating the learning and review of fire deaths and serious injury from a fire. (note this a 4 LSAB group).

Communication and Promotion of Safeguarding: Responsible for ensuring effective communication from the SAB as well as between partners and members of the board.

Governance: The Governance Subgroup is responsible for the review and development of multi-agency safeguarding policy and process that impacts upon all members of the SAB in terms of workforce and service users.

Training (The Training and Development Subgroup): Responsible for co-ordinating the development of multi-agency learning across the 4 LSAB and in Portsmouth we will be developing a training sub group to address the specific training needs of staff working across the city .

SABs primarily achieve their goals indirectly, through their agency members and through their partnerships with other boards and agencies. However, SABs may wish to commission some work themselves and secure funding to enable them to do so. This may, for example, be to test out an approach or to promote some research.

Quality Assurance and Performance Sub-Group

Aims:

- Consistent and robust outcomes for vulnerable adults.
- The monitoring of performance against the PSAB work plan.
- The sharing and application of learning and experience from practice in Portsmouth and across the UK, including from safeguarding adult reviews and audits.
- Audit the effectiveness of safeguarding arrangements across local partner agencies.
  Monitoring of the consistency of threshold decisions.
- The group will monitor performance of safeguarding, and provide a quarterly report to the PSAB, and annual summary report as part of the PSAB annual report.

Achievements during 2014/15 have been:

- Building on Data sets developed by 4 LSAB.
- Regular meetings with multi agency partners

Safeguarding Adult Review Sub-Group

Aims:

- To act as a subgroup of the Portsmouth Safeguarding Adults Board (PSAB) to ensure the responsibilities of the Board are carried out in respect of safeguarding adult reviews and other forms of learning reviews activities.
- To ensure there is a clear process for commissioning and carrying out of safeguarding adult reviews and other forms of learning review activities within Portsmouth

Achievements during 2014/15 have been

- Bi– Monthly meetings with good representation across partner agencies .
- PSAB commissioned a serious case review (before the Care Act 2014 legislation) in May 2014 and the full report was published on the website in September 2015. Learning from this review was disseminated to agencies via the Board and actions are being monitored by the subgroup.
- A further SAR has been commissioned into another case and its findings are likely to be published in the 2016.

Making Safeguarding Personal

Aims:

- To promote Making Safeguarding Personal through all its work streams.
- Oversee the rewrite of relevant documentation to ensure that documents are person centred in relation to safeguarding.
- To compile an audit tool, carry out audits and report findings to the QA and performance sub group and then to the PSAB.
- To facilitate effective ensure that Making Safeguarding Personal is embedded in practice.

Achievements during 2014/15 have been:

- Developing an outcome focused feedback form.
- Involvement in developing person led literature.
- Developed an audit tool to measure practice against the key principles embedded in making safeguarding personal.

Communication and Promotion of Safeguarding

Aims:

- To raise awareness of safeguarding and communicate that safeguarding matters to everyone.
- To launch/communicate to the public the PSCB and PSAB websites and Adults' single assessment framework during Safeguarding Week 22-28 June.

Achievements during 2014/15 have been:

- Activity has included editorial promotion and interviews with key stakeholders. Safeguarding messages disseminated during Safeguarding Week at a multi-agency event in Guildhall Square.
  Internal communications, videos and social media also used to spread the word.
- Editorial coverage for Safeguarding week equivalent to £1800 advertising spend.
- 212 page hits / 139 unique views / hits to PSCB site.
- 227 page hits / 111 unique views / hits to PSAB site.
- Increased referrals and leads during the week and one alert as a direct result of the event.

CHAPTER 3

Local Safeguarding Representatives

NHS
Portsmouth
Clinical Commissioning Group

Key Developments/Achievements:

- Appointment of a CCG Quality Assurance Nurse for care homes and domiciliary care across the City.
- CCG safeguarding week in August 2014, including training to the executive board.
- Increased integration and information sharing across the CCG safeguarding and quality teams.
- Strong attendance, facilitation and participation at the PSAB and associated sub-groups.
- Safeguarding element of the quality schedule for health providers revised and strengthened in preparation for 2015-2016 contracts.
- Funding made available for MCA and DoLS across health and social care which included conferences across both statutory and independent providers and funding further Best Interests Assessors.

Roles and Responsibilities

CCG's are the major commissioners of local health services and need to assure themselves that the organisations from which they commission have effective safeguarding arrangements in place.

Safeguarding is embedded in the clinical decision making of the organisation, with the authority to work within local health economies to influence thinking and practice.

The Designated Nurse acts as a clinical expert and strategic leader to offer advice and support for other health professionals in provider organisations or to the Board.

Actions in Relation to the Care Act 2014

Basic awareness training presentation revised to include the Care Act, making safeguarding personal, domestic abuse, modern slavery and self-neglect.

CCG staff, GP's and primary care have received a Care Act briefing.

Care Act has been part of the safeguarding adult report to the CCG Quality and Safety Executive Group, which reports to the clinical executive committee.

Care Act is part of the quality schedule for major health providers.

Designated Nurse for Safeguarding Adults has been appointed as the Designated Adult Safeguarding Manager (DASM)

Designated Nurse is part of the Serious Incident Requiring Investigation (SIRI) panel and critically analyses quality issues relating to safeguarding and MCA within healthcare. This is replicated for complaints.

Queen Alexandra Hospital (QAH)

Within the hospital the year covered by this report has been a busy one, the main concerns have been raised in relation to visitors of patients and not necessarily from concerns raised within the hospital and of hospital staff. There has been a 30 % increase in alerts, however, a large proportion of these alerts were not substantiated. There has been improvement and an increase in staff within the hospital, Anne Taylor is the lead nurse and the DASM. There are also Service Area Lead Nurses for each clinical service areas who have an enhanced level of safeguarding training . Monthly reports are gathered and reported to Governance and Assurance groups .

Themes of alerts

* Poor care (6 substantiated)
* Allegation of neglect or actors of omission .

Achievements

* QAH had a full CQC inspection—evidence of strength within safeguarding.
* Fully involved in PSAB and some sub groups.
* Involvement in Safeguarding Awareness Week.
* QAH specific safeguarding week in October 2014 – variety of training delivered particularly in relation to DOLs/ MCA/ Domestic Violence.

Domestic Violence

Specific DV and Violence policy introduced and there was a pledge in relation to a Public Health responsibility. A media release supported this in 2014. Some challenges in the hospital around the impact of increases in DOLs referrals - QAH are undertaking a consultation, with partner agencies, in relation to DOLs .

Year ahead

Increasing support in team (admin), preparation for the Care Act , audits to re focus, safeguarding activity.

Integrated Commissioning Unit (ICU)

The unit jointly commissions services on behalf of the CCG, social care and public health .

They are also responsible for contract monitoring of services and as such can play a crucial role for the board and safeguarding The ICU can ensure that within contracts there are some specific contractual obligations in regard to safeguarding for providers . This can include requirements linked to the training of staff to recognise and act on safeguarding concerns.

Within ASC for Portsmouth there is direct liaison with the Safeguarding Team ensuring a seamless approach to preventative work for Adults at Risk .

How the ICU have actively supported the PSAB in the year 2014 :-

* Membership of the PSAB
* Contributing towards the Quality Assurance and Performance sub group
* Contributing to Safeguarding Adult Reviews and SAR action plans

All ICU staff will receive training in basic awareness of Safeguarding.

NHS England

In relation to safeguarding adults, NHS England is able to provide an overview on its achievements over the past 12 months:

- A training audit conducted in Primary Care GP practices across Hampshire, Southampton, Portsmouth and IOW had 73 responses of which 9 were from Portsmouth. Results were shared with the 4LSAB Safeguarding Workforce Development Sub-Group early in November 2014 and has informed a targeted approach in training GP practice safeguarding leads in Hampshire including Portsmouth.
- Two NHS Wessex Safeguarding events which included updates on FGM, Human Trafficking, Prevent, MCA/DoLS were held for designated nurses and named GPs across Wessex.
- The Wessex Safeguarding Forum was set up in 2013 to enable:-
  - Underpinning system accountability through peer review-based assurance and other sources of intelligence to identify local improvement priorities.
  - Identification and sharing of best practice across the local health system.
  - Leading and driving of improvement in safeguarding practice across the local NHS system, working closely with the LSCB/SAB as appropriate.
  - Membership includes designated nurses, named GPs and LAC nurses.
- SCIE Training - Local Safeguarding Boards are required to maintain a local learning and improvement framework that supports the regular conduct of reviews and audits beyond those meeting the statutory Serious Case Review (SCR) criteria. To this end SCIE training was funded by NHS England and offered to Board members across Wessex including Portsmouth. In 2013/14 a total to 106 members were trained.Joint work with Wessex Local Medical Committee (LMC) was undertake in preparing a number of learning videos focused on safeguarding adults / MCA and DOLs
- Joint work with Wessex Local Medical Committee (LMC) was undertake in preparing a number of learning videos focused on safeguarding adults / MCA and DOLs
- A Wessex-wide Primary Care Safeguarding Newsletter has been developed, raising awareness of training courses and sharing lessons - positive feedback received from primary care clinicians
- An internal process has been agreed with health partners for managing level 3 safeguarding alerts: The procedures have been designed to explain simply and clearly how NHS England (Wessex) should manage Level 3 multi-agency safeguarding investigations and work together with internal and external partners to protect people at risk and establish whether there are lessons to be learned from the incident. Furthermore, this protocol provided guidance on how lessons are identified, how they will be acted upon and what is expected to change within a given timescale; and as a result to improve practice. This is being updated in line with the Care Act 2014 and guidance related to Sec 42 enquiries.

This year NHS England has responded to a total of five alerts and contributed to two adult reviews in Portsmouth.

Healthwatch Portsmouth is an independent service provided for all people of all ages and circumstances in Portsmouth. We gather views and experiences of local people on the way health and social care services are provided so they are given a chance to speak up about services across the city. We collect local information through community engagement events and one-to-one advocacy to ensure people who plan, run and check services listen to people who use these services.

At the heart of Healthwatch are 8 statutory functions which include supporting the involvement of people in commissioning and scrutiny of local services, making reports and recommendations about how services could or ought to be improved, providing advice and information about access to these services, making recommendations to Healthwatch England to advise the Care Quality Commission to conduct special reviews, along with making recommendations to Healthwatch England to publish reports about particular issues.

With reference to safeguarding responsibilities, any concerns that are highlighted through the team's contact with people, whether at community events or through one-to-one advocacy and support around complaints, will be raised with the local safeguarding team to consider and follow up as necessary.

Healthwatch Portsmouth would welcome the development of the strategic which should consider as priorities some of the following :

Care Act and MSP – hearing the persons voice at all times

* Information and promoting awareness – annual event etc.
* Agreeing assurance data – what and how we plan to use
* Learning from SAR's

Until the Care Act 2014 came into force on 1 April 2015, there was no English law that dealt specifically with safeguarding adults who might be at risk of abuse or neglect.

Age UK Portsmouth is a local Voluntary Sector organisation which supports Portsmouth City Council and its Emergency Services by working in partnership to ensure safeguarding support for the most vulnerable older people in our Portsmouth and South East Hampshire community.

Various Local Safeguarding Adult Board Sub-Group meetings in the City are attended by the Charity's Chief Executive Officer to ensure continuity and consistency of purpose across all services offered by Age UK Portsmouth.

'Safeguarding is everybody's business' refers to the importance of everyone being alert to possible signs of abuse or neglect and acting on their concerns.

We consciously promote best communication between all of our own service teams, which is essential to recognising the links between domestic abuse, Adult abuse and abuse of vulnerable adults. Age UK Portsmouth engages holistically with, and signposts victims to, appropriate support networks in order to reduce risk to both vulnerable adults, and their carer's.

As with many services in Portsmouth, the Charity has had to evolve dramatically and rapidly to enable it to meet the challenges of its own donation and legacy income reduction whilst supporting more older person need than it has ever faced in its entire 75 year history.

Incorporating a clear understanding of what a safeguarding issue might look like, we ensure awareness is built into everything we do, with a goal to not only appropriately support recognition of safeguarding concerns but better yet, to develop interventions that encourage prevention.

'Safeguarding is personal', is intended to emphasise the importance of adults at risk being as involved as possible in any safeguarding process.

Throughout 2015, Age UK Portsmouth has consciously developed staff understanding of what a safeguarding issue might look or even sound like which gives them a heightened awareness of options that our Information and Advice (I&A Team can offer, support or report whilst working with the person directly throughout the safeguarding process.

Our I&A Team has doubled its number of dedicated staff and volunteers during the last year, and within the first quarter of 2015 the Team has outstripped and met the projected dramatic increase in demand on its actions from 2014. The Team is led by our Safeguarding Officer who understands that safeguarding issues can arise from housing deprivation, financial distress; within family disputes and neighbourhood differences. The I&A Team often face these emotional and distressful situations on a daily basis in order to assist and support a way out of, or through, each older person's safeguarding dilemma.

Safeguarding training is also supported for our I&A Team by our national brand partner organisation Age UK, and that provision with respect to vulnerable adults now includes the Care Act, which has been incorporated into I&A training sessions.

In some cases older people choose not to report their abuse, perhaps because they are afraid that it will damage a relationship that is very important to them. It can be so hard to know what to do. Sometimes it will still be right to override their wishes if, for instance, the perpetrator may be placing other persons at risk too. In this situation they may want to seek advice without initially disclosing the identity of the person they are worried about. They can do this by contacting the I&A Team at Age UK Portsmouth.

Hampshire Constabulary is a key stakeholder in the partnership response to safeguarding the most vulnerable in our community throughout Hampshire. Over the last 12 months, despite financial restraints, the Constabulary has continued to prioritise safeguarding.

The Constabulary structure has had to change to enable it to meet the challenges of a reducing budget and still deliver a quality service. One of the changes to safeguarding is the Safeguarding and Offender Management Teams (OMT) being incorporated into the Neighbourhoods and Prevention strand. The senior officers leading Safeguarding, Offender management and Neighbourhood policing all report back to a single Chief Superintendent, to ensure a coordinated approach. Also, the various Local Safeguarding Adult Board sub group meetings now have selected police attendees, to ensure continuity and consistency across the Hampshire 4LSAB structure. Incorporating Safeguarding and the OMT into the Neighbourhood and Prevent strand has combined the experience of these teams with the Neighbourhood Policing Teams (NPT - aka Beat Officers and PCSOs) to ensure a truly community focused service. This has encouraged better communication between the teams, which is crucial, having regard to the recognised links between domestic abuse, adult abuse and abuse of vulnerable adults. NPT has taken ownership for medium risk domestic abuse victims by engaging and signposting victims to support networks, thus reducing the risk to both adults and their children

In the second half of 2014/15, and coinciding with the Force structure change, Hampshire Constabulary has instigated a wide-reaching Safeguarding training programme for staff throughout the Force. This input is provided for staff managing first contact, through to the outcome stage and gives them a better understanding of risk indicators as well as options that put victims at the heart of the police response. This is an on-going training programme.

Specific training in respect to vulnerable adults includes the Care Act, which has been incorporated into Investigator and NPT training sessions. The Investigator training schedule is almost complete and the NPT schedule has commenced, with completion predicted around October 2015. NPT officers now have rotational 3 month attachments to the Safeguarding Teams to hone their skills in 'live' cases and attend Adult Safeguarding Conferences.

The national implementation of Clare’s Law (DVDS - Domestic Violence Disclosure Scheme) and Sara’s Law (CSOD - Adult Sexual Offences Disclosure) has contributed to the safeguarding of both adults and children by the disclosure of the risks an identified person poses to potential victims. It is estimated that there will be over 400 disclosure considerations in the year 2015/16, which will allow a person to make informed decisions around the risk to themselves and their children in respect to their intimate (ex)partners.

What did we do? How well did we do it?

Management of Fire Risk in a Social Care Provision - Training

Throughout 2014-2015, Hampshire Fire and Rescue Service have continued to support the Local Authorities and partner agencies of PSAB in providing training in the management of fire risks within a social or domiciliary care provision. This training package is delivered by HFRS Community Safety Officers and is available free of charge to the partner agencies (including their commissioned service providers) of the PSAB

Multi Agency Fire Risk Conference

Hampshire Fire and Rescue Service remains fully committed to delivering a multi agency approach towards the continuous monitoring and management of fire risks for adults identified as being at high risk of serious injury or death due to fire.

Home Safety Referral Pathway and High Risk Home Safety Visit

During 2014-2015, as an outcome of the Hampshire Fire and Rescue Service Home Safety Project, the Service developed a comprehensive risk assessment tool. This self assessment tool provides a mechanism for partner agencies to ensure a person presenting safeguarding concerns can be identified at the earliest opportunity and through submitting this information to HFRS, will ensure an appropriate level of intervention can be provided. A high risk Home Safety visit will be conducted by a local HFRS Community Safety Officer within 72 hours .Operational Response risk information will be gathered to ensure HFRS respond effectively to any reported incidents involving the 'adult at risk', with pre planned arrangements (enhanced attendance, flagging of address with Fire Control etc. Where necessary, Multi Agency action planning (Fire Risk Conferences) and support in devising Care Plan actions for the continuous monitoring and review of the risks being presented.

Appointment of HFRS Lead Safeguarding Officer

In December 2014 Hampshire Fire and Rescue Service appointed a full time Lead Safeguarding Officer. The Lead Safeguarding Officer undertakes the Designated Safeguarding Adults Manager (DSAM) responsibilities on behalf of the Service, as per the duties detailed within the Care Act 2014. The Lead Safeguarding Officer is primarily responsible for embedding fire vulnerability within the Safeguarding environment and ensuring HFRS are discharging their safeguarding responsibilities appropriately with Local Authorities and partner agencies. Other responsibilities include the following:

- Internal and external auditing of all HFRS Safeguarding activities.
- Managing the Safeguarding policies procedures (ensuring they are reflective of the Hampshire Safeguarding Multi Agency Policy and Procedures).
- Managing the Safeguarding training packages of HFRS.
- Referring fire deaths and serious injuries for Multi Agency reviews as per the HSAB Learning and Review Framework.

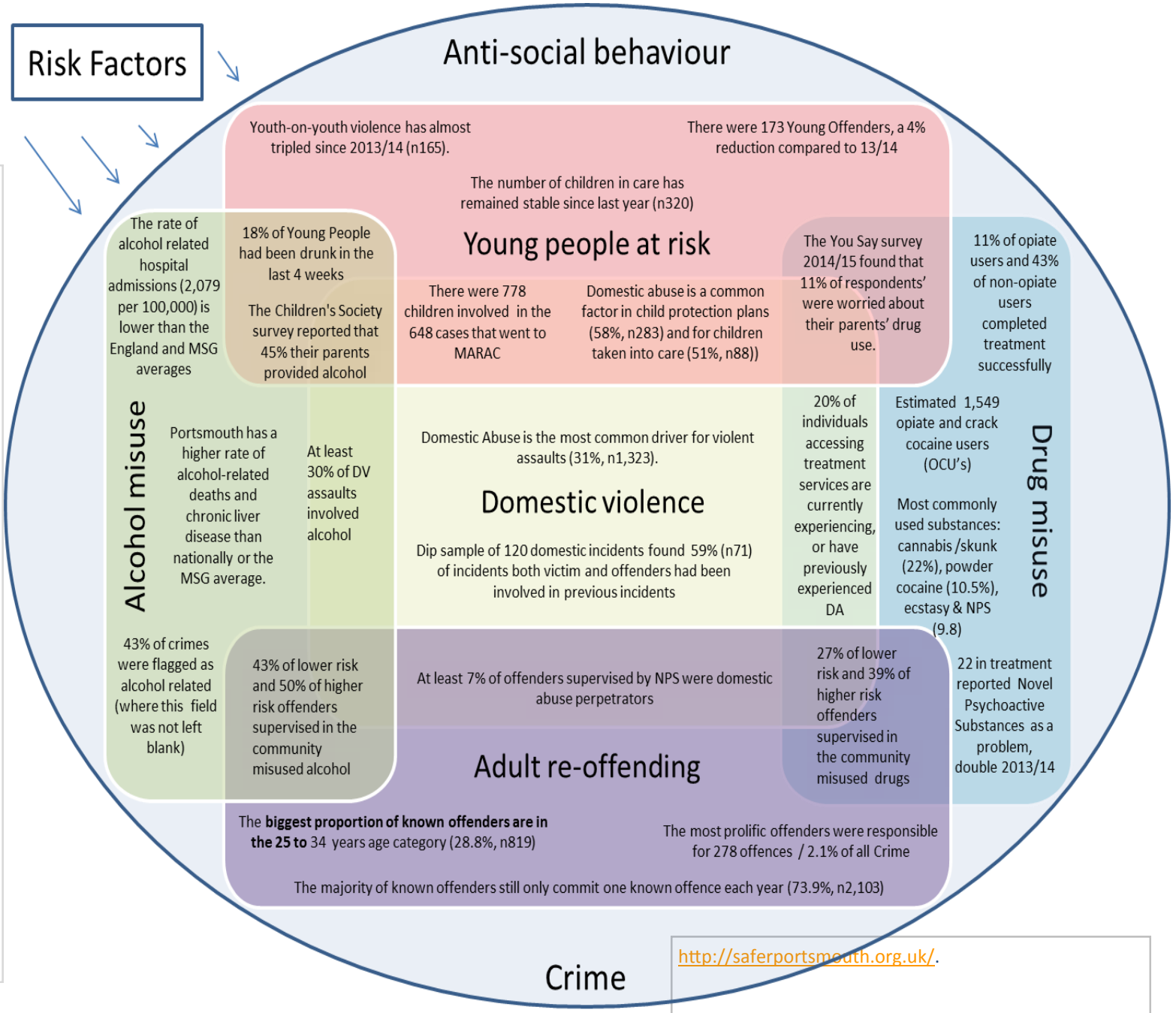
safer portsmouth partnership
reducing crime and substance misuse

Portsmouth Partnership (SPP) is responsible for reducing crime and substance misuse in Portsmouth, making the city a safe place to live, visit and work.

Our Priorities are t reduce:

- **Anti-social behaviour**
- **Alcohol Misuse**
- **Drug Misuse**
- **Violence and Abuse**
- **Young People at risk**
- **Offending**

Risk Factors



http://saferportsmouth.org.uk/.

Solent Healthcare

Comparison of the Number of Alerts - and Number of contacts to the Safeguarding team for advice during: 2013/14 and 2014/5.

Solent Safeguarding Team records a range of all safeguarding information to support It in delivering the service. Over the last year the team has continued to make improvements to the type of information the team would like to collect.

In the later part of 2014/15 the team has started to be supported by Solent's Business Change Manager and Solent HQ. The team look forward to working on this new development.

There is a significant reduction in the numbers of Alerts sent to the Local Authority between 2013/14 and 2014/15. This is linked to the Solent Safeguarding Team's training, over the last two years, on when and what to alert.

In the past, alerts were sent linked to concerns that could and should be simply managed by the Alerter themselves and at times via the virtual wards or in a multi agency meeting. The multi-agency safeguarding process should be carried out in direct response to individuals experiencing abuse or neglect and where other approaches have not been able to resolve the preventing risks.

In this context, multi-agency safeguarding arrangements are the exception rather than the norm and are used to respond to the critical few cases that cannot be resolved by other means, or where the risks are very high.

In contrast to this there is a marked increase in contacts to the Solent Safeguarding Team for advice regarding staff concerns.

Priorities and Challenges for 2015/2016

The impact of the Care Act 2014, on adult safeguarding practice cannot be over estimated and the lack of capacity in the Team will compromise effective joint working with our partners and within Solent. Training, Advice to Staff and Supervision however remains a high priority for the team.

2015/16 will proof to be a challenging year

- **Key work stream that will take priority in 2015/16 is work to ensure compliance with the 'Care Act 2014'.**
- **Developing Solent's Designated Adult Safeguarding (DASM) role and Framework**
- **The development of Solent's Safeguarding Policy and procedures in line with Multi-Agency Policy Guidance and Toolkit.**
- **Roll out a programme of roadshows on 'safeguarding and the New Act'' to each service area.**

CHAPTER 4

ACHIEVEMENTS 2013/2014

Update on Annual Report from 2013/2014

Priority Areas and Action update on priorities 2014/2015

The PSAB has an agreed vision, objectives and terms of reference, with 4 subgroups and 3 regional and inter-Board work streams taking forward its agreed priorities. It has formally agreed to work to Pan Hampshire's multi agency policies and procedures to safeguard adults from harm. The table below summarises the priority areas and gives an update on these areas for this year to date.

	SUMMARY OF PRIORITY AREAS	PROGRESS TO DATE	RAG
1	Develop effective governance arrangements for the PSAB	• Constitution - awaiting sign off • Comprehensive procedures on PSAB Website	
2	Communication and Promotion of Safeguarding	• Activity has included editorial promotion and interviews with key stakeholders. • Safeguarding messages disseminated during Safeguarding Week at a multi-agency event in Guildhall Square. • Internal communications, videos and social media also used to inform. • 227 page hits / 111 unique views / hits to PSAB website. • Increased referrals and leads during the week and one alert as a direct result of the event. • Comprehensive Communication strategy developed. • Links with PSCB to ensure that messages delivered are holistic.	

CHAPTER 4

ACHIEVEMENTS 2013/2014

	SUMMARY OF PRIORITY AREAS	PROGRESS TO DATE	RAG
3	Personalisation (Making Safe-guarding Personal)	• Developed Audit tools for MSP • Set up MSP sub group • Developed TOR • Service users representative on subgroup • Feedback form developed.	
4	Quality Assurance	• Developed a Sub group and TOR • Ensure a wide multi agency involvement • Developing data sets that are consistent with other LSABs	
6	Training Development and Learn-ing	• Worked with other LSABs in developing Learning and Development Strategy • Ensured that there are learning opportunities on the PSAB website • PSAB held 2 Self Neglect workshops. • Agreed to develop Portsmouth training group for this year	
8	Develop and deliver Safeguarding Adult Reviews, ensure clear pro-cess for managing reviews and disseminating learning (learn from other cases that do not meet the threshold of SAR to ensure con-tinued learning)	• Learning and Review Framework embedded • SAR completed • Ensured learning from SAR cascaded	

Glossary

This glossary is not an exhaustive list, but explains some of the key words or terms that have been used in this report.

4LSAB Four Local Safeguarding Adults Boards covering Hampshire, Portsmouth, Southampton and the Isle of Wight.

Abuse includes physical, sexual, emotional, psychological, financial, material, neglect, acts of omission, discriminatory and institutional abuse.

ACPO (Association of Chief Police Officers), an organisation that leads the development of police policy in England, Wales and Northern Ireland.

ADASS (Association of Directors of Adult Social Services) is the national leadership association for directors of local authority adult social care services.

Adult Services arrange social care and support for adults who need extra support. This includes older people, people with learning disabilities, physically disabled people, people with mental health problems, drug and alcohol misusers and carers. Adult social care services include the provision by local authorities and others of care homes, day centres, equipment and adaptations, meals and home care Adult social care also includes services that are provided to carers.

Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need.

Alert is a concern that a person at risk is or may be a victim of abuse, neglect or exploitation. An alert may be a result of a disclosure, an incident, or other signs or indicators.

Central Referral Unit is where all adult safeguarding referrals to the police are received, risk assessed, graded and allocated for action by the most appropriate police team and/or partner agency.

CCGs (Clinical Commissioning Groups) were formally established on 1 April 2013 to replace Primary Care Trusts and are responsible for the planning and commissioning of local health services for the local population.

Clinical Governance is the framework through which the National Health Service (NHS) improves the quality of its services and ensures high standards of care.

Community Safety Partnerships bring agencies and communities together to tackle crime within their communities. Community Safety Partnerships (CSPs) are made up of representatives from the responsible authorities, these are Police, police authorities, local authorities, Fire and Rescue authorities, Clinical Commissioning Groups and Probation

CPS (Crown Prosecution Service) is the government department responsible for prosecuting criminal cases investigated by the police in England and Wales.

CQC (Care Quality Commission) is responsible for the registration and regulation of health and social care in England.

DASH (Domestic Abuse, Stalking and Harassment and 'Honour'- Based Violence) risk identification checklist (RIC) is a tool used to help front-line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence.

Disclosure and Barring Service (DBS) was established in 2012 through the Protection of Freedoms Act and merges two former organisations, the Criminal Records Bureau and the Independent Safeguarding Authority. The DBS is designed to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults. The DBS search police records and barring lists of prospective employees and issue DBS certificates. They also manage central barred lists of people who are known to have caused harm to vulnerable adults.

DOLS (Deprivation of Liberty Safeguards) are measures to protect people who lack the mental capacity to make certain decisions for themselves. They came into effect in April 2009 using the principles of the *Mental Capacity Act 2005*, and apply to people in care homes or hospitals where they may be deprived of their liberty.

Domestic Homicide Reviews are commissioned by local Safer Communities Partnerships in response to deaths caused through domestic violence. They are subject to the guidance issued by the Home Office in 2006 under the *Domestic Violence Crime and Victims Act 2004*. The basis for the domestic homicide review (DHR) process is to ensure agencies are responding appropriately to victims of domestic abuse offering and/or putting in place suitable support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

Family Group Conferences (FGC) are used to try and empower people to work out solutions to their own problems. A trained FGC coordinator can support the person at risk and their family or wider support network to reach an agreement about why the harm occurred, what needs to be done to repair the harm and what needs to be put into place to prevent it from happening again.

HealthWatch is the new independent consumer champion created to gather and represent the views of the public. It exists in two distinct forms - local Healthwatch and Healthwatch England at a national level. The aim of local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. Local Healthwatch has taken on the work of the Local Involvement Networks (LINks).

Health and Well-being Board a statutory, multi-organisation committee of NHS and local authority commissioners, co-ordinated

by the local authority which gives strategic leadership across Hampshire regarding the commissioning of health and social care services.

MAPPA (Multi-agency Public Protection Arrangements) are statutory arrangements for managing sexual and violent offenders.

MARAC (Multi-agency Risk Assessment Conference) is the multi-agency forum of organisations that manage high risk cases of domestic abuse, stalking and 'honour'-based violence.

MASH (Multi Agency Safeguarding Hub) is a joint service made up of Police, Adult Services and the NHS. Information from different agencies is collated and used to decide what action to take. This means the agencies will be able to act quickly in a co-ordinated and consistent way, ensuring that the person at risk is kept safe.

Mate Crime occurs when a person is harmed or taken advantage of by someone they thought was their friend. There is limited information on the prevalence of Mate Crime nationally, however there has been an increase in the number of safeguarding alerts that involve Mate Crime across Hampshire in recent years.

Mental Capacity refers to whether someone has the mental capacity to make a decision or not. The Mental Capacity Act 2005 and the code of practice outlines how agencies should support someone who lacks the capacity to make a decision.

NHS (National Health Service) is the publicly funded health care system in the UK.

OPG (Office of the Public Guardian), established in October 2007, supports the Public Guardian in registering enduring powers of attorney, lasting powers of attorney and supervising Court of Protection appointed deputies.

PALS (Patient Advice and Liaison Service) is an NHS service created to provide advice and support to NHS patients and their relatives and carers.

Safer Neighbourhood Teams are local police working with local people and partner agencies to identify and tackle issues of concern in their area to make neighbourhoods safer.

SAR (Safeguarding Adult Review) undertaken by a Safeguarding Adults Board when a serious case of adult abuse takes place. The aim is for agencies and individuals to learn lessons to improve the way in which they work.

SIRI (Serious Incident Requiring Investigation) is a term used for serious incidents in the NHS requiring investigation. It is defined as an incident that occurred in relation to NHS-funded services resulting in serious harm or unexpected or avoidable death of one or more patients, staff, visitors or members of the public.

Wilful Neglect or Ill Treatment is an intentional or deliberate omission or failure to carry out an act of care by someone who has care of a person who lacks capacity to care for themselves. *Section 44* of the *Mental Capacity Act 2005* makes it a specific criminal offence to wilfully ill-treat or neglect a person who lacks capacity .

APPENDIX

Membership of PSAB

David Cooper	Independent Chair
Robert Watt	Director of Adult Services , PCC
Angela Dryer	Assistant Head, Adult Services , PCC
Tracy Keats	Designated Safeguarding Nurse, Clinical Commissioning Group
Preeti Sheth	Director , Integrated Commissioning Unit
Rachel Loveridge	Operations Manager, Probation
Nicky Priest	Assistant Director Nursing, NHS England
Janet Maxwell	Director , Public Health , PCC
Rachael Roberts	Senior Manager, Adult Social Care, PCC
Lorraine Burton	Safeguarding Board Manager, PCC
Steve Foye	Area Manager , Community Safety, Hants Fire Service
Steve Apter	Assistant Chief Officer, Community Safety and Service Transformation, Hants Fire Service
Fran Williams	Head of Safeguarding , Solent NHS Trust
Carol Elliott	Healthwatch Board Advisor
Bruce Marr	Hidden Violence and young People's Service Manager , PCC
Maria Middleton	Senior Partnership Manager, DWP
Mandy Rayani	Chief Nurse, Solent NHS Trust
Liz Donegan	Action Hants
Debbie Corti-Young	Hampshire Care Association
David Powell	Chief Superintendent , Hants Constabulary
Cathy Stone	Director of Nursing PHT
Adrian Dunsterville	Inspection Manager, CQC
Owen Buckwell	Director of Housing and Property, PCC
Dapo Alalade	GP Executive Lead, Clinical Commissioning Group
Natalie Beckett	Safeguarding Board Administrator

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

Date: **23 February 2016**

Report by: **Robert Watt, Director of Adult Services**

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

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 January 2016.

2. Recommendations

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

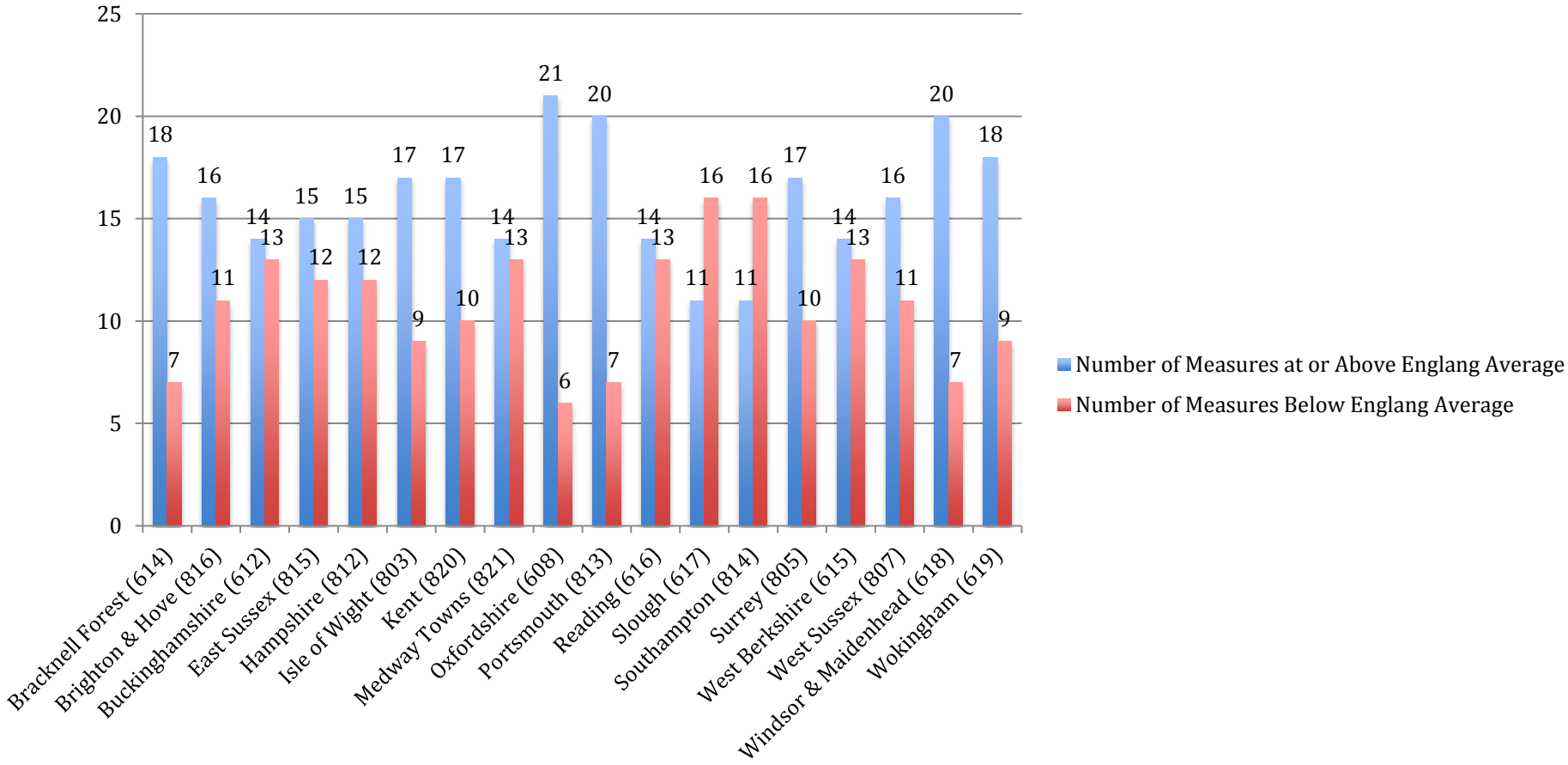
3. Update on Key Areas

3.1 Performance:

The Adult Social Care Outcome Framework (ASCOF) measures how well the care and support system achieves the things we would expect for ourselves and for our friends and relatives, such as quality of life and social inclusion. Of the 27 measures that ASCOF covers, we are above the England average in 20 this year. When we compare this to our nearest neighbours, Portsmouth is second only to Oxford. We rank above Southampton, which has 16 measures above the national average, and Hampshire with 15. (See chart on next page).

Due to the way Adult Social Care is funded, it is difficult to compare performance measures across areas with differing local challenges and levels of affluence. However a study recently published in the Municipal Journal, compared the ASCOF measures with the amount of money spent by each council on Adult Social Care. Out of all the councils in the UK that provide Adult Social Care services, Portsmouth ranked fourth for overall value for money. This is a reflection of the hard work and dedication of staff who continue to provide a quality service in the face of budget pressures. It also highlights the challenge we face in meeting ongoing savings targets.

Overview Performance of 27 National ASCOF Measures By Council 2014/15 Actuals



3.2 Director of Adult Services (DASS):

The HOSP will be aware that the current Director of Adult Services (statutory role of Director of Adult Social Services - DASS) will be leaving the service in the near future, at a date yet to be confirmed (at time of writing). A proposal to bring together a new senior management role, working across Adult Social Care and the Clinical Commissioning Group, was agreed by the Council's Employment Committee in December. The merging of roles will enhance the existing good working relationships in the City and bring us a step further towards fully integrating health and social care. This is consistent with the themes in the 'Blueprint' for how Health and Social Care will be delivered in Portsmouth in the future. https://www.portsmouth.gov.uk/intranet/documents-internal/hlth-health-and-care-portsmouth- blueprint.pdf

Details of the new role are still be finalised and will need to take into account how the statutory role, title and functions of Director of Social Services will be performed.

3.3 Budget:

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

Since the last report the savings target has been revised with the service expected to find £1,104,500 by April 2017. This is in addition to meeting approximately £2.4m savings required from 2015/16. Savings proposals have been agreed by the Council which affect all parts of Adult Social Care and the services it is able to provide.

There are also a number of existing and anticipated pressures during the course of 2016/17 which will place an additional strain on the resources available to us. The current demand for domiciliary care and Learning Disability support services is such that it is proving difficult to meet the savings targets required in those areas. In addition, the New Minimum Wage is expected to result in increased costs of care. Whilst the government is allowing a 2% increase in council tax specifically to meet these costs, it is strongly anticipated that this will fall someway short of what is required, making Portsmouth a net loser, placing the city in the bottom 20 of unitary councils to benefit, or otherwise, from this new power.

3.4 Hospital acute services:

Portsmouth Hospitals Trust remains under pressure from high numbers attending the Emergency Department. Community Health, Social Care and Voluntary Sector services are working hard to ensure those people who require ongoing community support, and can be discharged safely, are returned home as quickly as possible.

The Department of Health have commissioned an Emergency Care Improvement Programme (ECIP) as part of a review of 28 hospitals across the country that have faced particular challenges in managing high levels of demand. Those undertaking the programme of work will be reporting on their recommendations for improvements to all system partners over the next few weeks.

3.5 Safeguarding:

Since the last report a new Independent Chair of the Safeguarding Board has been appointed and arrangements are in place to appoint a Board Manager.

The Safeguarding Annual Report will be presented to HOSP for noting at today's meeting.

Priorities for 2016/17 will be agreed at the forthcoming Safeguarding Board in February.

3.5.1 **Mazars Report** (Southern Health NHS FT)

This report summarises the findings of an Independent review of deaths of people with a Learning Disability or Mental Health problem who were in contact with Southern Health NHS Foundation Trust, April 2011 to March 2015. The focus report is very much on the reporting and investigation of incidents. Officers of both HCC and PCC have been invited to take part in meetings to understand what recommendations and actions will arise from the report, however much is concentrated on internal leadership, processes and communication.

3.5.2 Gosport War Memorial

Further to the announcement made in Parliament on 9 December 2014 by the Minister of State for Care and Support, an Independent Panel has been set up to review documentary evidence concerning care of families' relatives and subsequent investigations into their deaths in Gosport War Memorial Hospital.

The remit of the Panel will be to:-

- Consult with the families of the deceased and of those treated to ensure that the views of those affected are taken into consideration.
- Obtain, examine and analyse documentation from relevant organisations and individuals.
- Produce a report that hopes to add to public understanding of the events and their aftermath.

We will be assisting the Panel with any request for information regarding former patients who may be been known to Adult Social Care.

3.6 Multi-disciplinary locality teams

Plans for co-location of Adult Social Care and Solent NHS staff were put on hold before Christmas to ensure there was a strong focus on managing winter pressures and hospital discharges over the Christmas period. It is anticipated that co-location, as described in the previous report, will now take place in May.

A successful event held in December brought together the respective workforces of Solent NHS and ASC to foster joint understanding of how we can work better together in a new integrated service. The event included screening of a DVD, made with participants from both organisations, which was sponsored by Health Education Wessex.

3.7 Learning Disabilities

3.7.1 Transforming Care

The Winterbourne View scandal, exposed by the Panorama programme, shocked the nation. It led to the Government pledge to move all people with learning disabilities and/or autism inappropriately placed in such institutions into community care and a national strategy was created to:

- Get people out of hospital who do not need to be there anymore.
- Supporting people in crisis to avoid going to these types of hospitals.
- Developing community services to reduce crises.
- Safeguarding and monitoring peoples care.

Nationally the targets set have not been achieved, however in Portsmouth the number of people placed in this type of setting is very low, currently 6 people. Based on population figures Department of Health estimates may have expected that figure to be nearer 34 beds.

3.7.2 Residential Care to Supported Living

Since 2001 Portsmouth has been moving away from a reliance on registered residential care, creating supported living arrangements in cooperation with independent sector providers, Housing Associations and the City Council Housing Department. In 2013 of the combined number of people in Residential Care and Supported Living setting, 52% were in Residential Care Settings and 48% in Supported Living. A target was set in the Learning Disability Development Plan that by the end of 2016 we aim to reduce the number in residential care to 40% Care and increase to 60% those in

Supported living. That target has almost been achieved and currently of the 270 people either in Residential Care or Supported Living 42% are in Residential Care and 58% in Supported Living.

The latest supported living development is to redevelop Corben Lodge in Milton. The existing building is remaining and will be converted into three separate dwellings, with four bedrooms in each. Twelve people have already been identified all of whom currently live in Residential Care. The bulk of the work is internal but there will be some changes to the outside, such as new entrances and landscaping, all of which can be considered enhancements.

Although we proud of our supported living strategy there is a continual need for the city to place greater emphasis on independence, self-determination and helping people choose who they live with. Supported Living is not simply a change in model or arrangements. There is also the need to develop a greater range of housing and support options that avoid returning to large group living.

Robert Watt
Director of Adult Services

Solent NHS Trust

Baytrees Detoxification Unit
Report for Portsmouth Health Overview and Scrutiny Committee

Solent NHS Trust, 12 February 2016

1 Purpose of this report

1.1 This report provides an update regarding the viability of the Baytrees detoxification unit in Portsmouth.

2 Introduction and background

2.1 The Baytrees inpatient unit in Portsmouth provides residential detoxification programmes for people with drug and/or alcohol issues. The unit, provided by Solent NHS Trust, comprises 23 beds and was historically funded through two block contracts: one with Portsmouth City Council (PCC) for 11 beds, the second with Hampshire County Council (HCC) for 11 beds. The remaining (accessible) bed was historically used flexibly.

2.2 PCC cancelled their block contract arrangement in April 2013 and entered into a framework agreement. Bed occupancy reduced further from July 2015, after the contract for Hampshire substance misuse services was transferred from Solent to a new provider, following a competitive tender process. The change in contracts and change in demand for inpatient detoxification services has resulted in the unit not receiving referrals to the levels previously experienced.

2.3 Over the past 6 months the Trust has been exploring a range of opportunities to secure the future viability of the Baytrees Detoxification Unit in Portsmouth, including:

- Increasing our marketing activity
- Adapting our offer
- Working with new partners
- Exploring the private market
- Seeking block booking/risk share agreements with existing commissioners

3 Summary outcome of increased commercial activity

3.1 Unfortunately the effort the Trust has invested in increased marketing and exploration of other opportunities has not had a sustained positive affect on occupancy rates. To a large extent this is because the drive from public sector commissioners has been away from inpatient detox and towards community-based programmes.

3.2 In order for Baytrees to be viable, 17 of the 23 beds need to be occupied consistently every day. During Q2 2015/16, the busiest quarter to date this year, 11 beds were occupied on average each day. Baytrees is forecast to be £450k in deficit by the end of this financial year.

4 Trust Board consideration

4.1 In January 2016, following careful consideration, Solent NHS Trust's Board reluctantly concluded that the Baytrees service does not have a sustainable future. The Trust cannot sustain the current position whereby other services need to make savings in order to cover a loss-making service.

5 Staff engagement

5.1 On 26 January, the day after Trust Board, Solent's Chief Operating Officer, Operations Director and Operations Manager met with the staffing team at Baytrees to inform them that sadly, despite all our efforts, the Trust is no longer in a position to continue to run the Baytrees service.

5.2 Staff were informed that the Trust intended to talk to commissioners about ceasing provision of the service and the team discussed next steps with regard to the impact of this decision for staff members, commissioners and our service users. A written summary of the meeting and consultation papers were subsequently circulated. All staff have now entered a formal consultation process regarding the closure of the unit, in line with the Trust's Organisational Change policy.

5.3 This consultation process began with a staff consultation event during the week of 08 February and will last for 30 days. During this time, each staff member will have a 1:1 session with either their line manager or another manager and, where possible, HR. The purpose of this session is to discuss the formal consultation process, discuss skills and qualifications, clarify staff members' views and preferences and confirm that every effort will be made to find suitable alternative employment for staff within the Trust or wider NHS services.

6 Commissioner engagement

6.1 On 27 January, the Trust wrote to local commissioners and providers who hold budgets for residential detoxification, including Hampshire City Council, Portsmouth City Council, Southampton City Council, Inclusion the Isle of Wight Recovery Integrated Services and CRI as well as commissioners from neighbouring counties who have purchased beds at the unit. The letter summarised the current position and asked commissioners to work in partnership with the Trust to carefully and safely decommission the service and agree a joint approach to manage the process, reduce the impact on clients and ensure full engagement with Overview and Scrutiny committees. This was followed up with a conference call with the main commissioners on 10 February. A further call is scheduled for 17 February.

6.2 The Trust will work with commissioners – as well as the Hampshire provider, Inclusion – to look at alternative ways in which we may be able to support people with drug and/or alcohol issues who require detoxification in the future.

7 Service user engagement

7.1 The Trust is working with commissioners and provider services in the community to identify the best way of communicating the proposed closure of the unit. This may involve posters, written information and visits from the senior manager team for our most frequent/local referrers.

7.2 Service users will begin to be informed once the decision has been discussed at Overview and Scrutiny Committees.

8 Next steps

8.1 The Trust has established a project team who will work with commissioners and other partners to safely decommission the service, ensuring full engagement with all stakeholders and service users.

8.2 The Trust has made a commitment not to close the unit prior to the end of the financial year 2015/16; however whilst the unit continues to operate at a loss, other Trust services are impacted. In addition, the value of the therapeutic environment and efficacy of group programmes is reduced while only a few of the 23 beds are in use. It is therefore the Trust's preferred position to close the unit from the beginning of the financial year 2016/17, whilst engaging with commissioners and ensuring all processes meet the requirements of local Overview and Scrutiny Committees.

Portsmouth Community Care Estate Review (Phase 2)

Update for the Health Overview and Scrutiny Panel on planned service moves

February 2016

1. Background

1.1 NHS Property Services, Portsmouth City CCG and Solent NHS Trust are working in partnership with the City Council and other system stakeholders on a two phase programme of work aimed at ensuring that community health services in Portsmouth are being delivered from the most suitable and cost-effective buildings and facilities available.

1.2 Phase 1 of this two phase programme was completed in 2015 and saw the relocation of multiple services from the St James' site to various locations, primarily to St Marys Hospital. These relocations have enabled the disposal of part of the St James', which has now transferred ownership to the Homes and Communities Agency.

1.3 Since the last HOSP update in October '15, a Phase 2 Business Case has been produced outlining the scope and model for delivery of a programme of works to enable the release of a further area the St James' campus and completion of the overall project. This Case was agreed by the respective Solent NHS and Portsmouth CCG Boards in January '16.

1.4 Further to this agreement, Solent NHS have agreed to fund the design development of all schemes contained within the Business Case to enable full submission to the Trust Development Authority (TDA) in August '16. This submission will include Tendered figures required for construction and delivery of the project.

1.5 The projects within the Phase 2 Business Case to be worked up include

a) St Marys B Block Refurbishment
   This project will involve the full refurbishment of the currently unoccupied St Marys B Block to provide a purpose built, modern healthcare environment. It will include the provision of a permanent Pharmacy base on the ground floor, a relocated podiatry suite and outpatients department from the St James site on the first floor, and clinical support hub on the second floor.
b) Junior Drs Mess Relocation
   The Junior Doctors Mess currently occupies part of the St James' Main Block, this project seeks to re-provide that accommodation in Baytrees, a Solent NHS building on the retained section of the St James' site.
c) SJH Infrastructure
   To enable the disposal and anticipated redevelopment of the St James' site, it is necessary to relocate the infrastructure that is currently fed via the Main Block to outlying retained buildings. This will include the re-provision of an emergency generator.
d) SJH ICT Infrastructure

Along with primary infrastructure and services, the ICT infrastructure will need to be demobilised. This will involve a combination of physical relocations and the transition to off site ICT infrastructure.

e) SMH Catering
This project will enable the main Central Processing Unit function currently based at St James' Hospital, and serving a number of locations, to relocate to St Marys. It will include the provision of sufficient cold storage for patient meals.

f) The Limes Remodelling
Doctors offices currently based within the St James' Main Block will be relocated to The Limes building on the same site. This project will repurpose existing identified rooms to enable this move.

g) SMH MSCP
A Multi Storey Car Park will be constructed at St Marys Hospital consisting of two decks and providing an additional 135 parking spaces. This increased capacity will allow for the increase in staff and patient activity when services move across from St James'.

1.6 Following the above noted recent respective Board approvals, the programme of work has progressed into detailed design. Formalised user group meetings have been set up to ensure that this design meets the clinical aspirations of staff and patients. The fully designed and Tendered schemes will be submitted in a Full Business Case to the TDA in August '16, with overall completion programmed for December '17. With the site vacated, NHSPS would then progress disposal in the January '18.

1.7 In line with the Solent project process and TDA guidelines, this detailed design development will include both staff and patient consultation and consideration as an inherent contributor to final proposals. It is envisaged that patient engagement will be take the form of a series of presentations and informal meetings. The aspirations of staff to provide a high quality facility are supported by the Trust Board and in line with National NHS guidance.

1.8 Following delivery of this programme of work, Solent will occupy and retain Freehold Ownership of part of the St James' Hospital site. This 'retained portion' will include Falcon House, Baytrees, Kite, The Limes, Oakdene and Orchards.

1.9 Upon successful completion of this programme of work it is envisaged that a further review of Solent occupation take place to build upon these successes and offer further system and patient benefits. As a first phase of this further review, Solent intend to bring forward a separate HOSP related to the future use of the Oakdene building.

1.10 Fully in line with the recently completed Portsmouth CCG Strategic Estates Plan, and the NHS Five Year Forward View, this significant first step in the Plans delivery will act as a catalyst for services to both co-locate and integrate. Current discussions again build on this platform and propose further integration and relocation of teams, particularly to St Marys Hospital, as outlined again in the PCCG SEP and Solent Clinical and Estates Strategies.

1.11 The investment and rationalisation proposals under Portsmouth Community Care project will continue to improve local facilities and patient care ensuring that more financial resources are dedicated to meeting the needs of patients rather than maintaining buildings that are no longer required.

Portsmouth Care Group – Mental Health Inpatient Transformation Scheme.

Purpose of paper

This short report is to alert system partners to a current estates consolidation scheme proposed by Solent NHS Trust in Portsmouth, provide a synopsis of the project - including the rationale for undertaking the service changes - and present an overview of risks, challenges and mitigations.

Introduction

Each year, every NHS organisation has to plan to deliver financial efficiencies, between 4-6% of its overall budget. This is because real-terms income decreases with the annual "tariff deflator" (around1.8%) and the cost of provision rises with annual pay awards, incremental pay-spine increases and the increased price of consumables and equipment (around 3.6%).

In Portsmouth NHS community and mental health services have reached the point at several junctures over the past 10 years; where further savings cannot be made without some redesign. One productive area for improving spend is in reviewing how current estate is utilised with a view to rationalisation. This is particularly the case where care delivery has moved from a bed based to a community based model, resulting in poor use of current wards. Better deployment of beds can result in reduced estates use and more efficient use of staffing.

This paper highlights an estates based scheme which may fall within the remit of CCG and HOSP oversight; in that it present some changes to how services are delivered to people in Portsmouth.

Proposal

At present Mental Health inpatient services are provided in three units in Portsmouth (Limes, Orchards and Oakdene) all on or close to the St James site in Locksway Road. There are currently 6 ward areas – a total of 78 beds. Through reconfiguration of ward location– all the current functions could be provided within only 2 units (Limes and Orchards), by re-commissioning an empty "mothballed" ward on the Limes, moving two separate under-used Older Persons wards into a single 22-bed unit and moving Oakdene Ward into the vacated space at Limes. This would reduce total number of beds to 72, without any loss of service. Efficiencies are released through reduced estates footprints and better use of staffing establishments.

Undertaking the scheme requires some minor estates works, but is relatively straightforward and could be completed by the end of February 2016, subject to the necessary approvals.

Rationale

Over the first two quarters of 2015/16 – total mental health bed usage across the St James sites has consistently been far lower than the number of beds in commission. This reflects a trend over the past 5 years towards greater provision of care out of hospital. Reductions in bed usage have been particularly marked for older people in the past two years, as a result of improved clinical processes and leadership. Planned commissioned improvements in community services have decreased the number of beds required in Older People's Mental Health (OPMH). The beds in service for older people are currently divided into two wards at the Limes Unit:

- Appleby Ward – 14 Beds - "functional" (depression and Psychosis) focus.
- Kitwood Ward – 14 beds - "organic" (dementia) focus.

The current layout of wards has also left a redundant empty 8 bedded ward area within the Limes (Brooker Ward), which was originally designed for long-stay patients who had been transferred from wards within the old St James site. This is a space that obviously could be much better utilised, since there are ongoing costs to retaining the ward – but no identified source of income.

National benchmarking (NHS Benchmarking) indicates that the population of Portsmouth requires 13 beds in total for older adults with mental health problems; based on average utilisation across the whole of England. Therefore reducing from 28 beds to 22 retains Portsmouth in the top quartile for bed availability nationally. In 2015 and 2016 there have been no instances of greater than 22 older adults in Portsmouth requiring admission. The average bed utilisation across the two units has been 63% (66% Kitwood, 60% Appleby). Staff consultation has taken place and there are high levels of clinical confidence that 22 beds in the configuration suggested will be comfortably sufficient. This has also been further tested recently when the purpose of Appleby Ward was altered for a three week period during system escalation and a single OPMH Ward of 14 beds was adequate for admission needs, with up to 13 beds in use; a maximum 4 of which were for "functional" patients.

Combining the two OPMH wards into a single unit enables better staff utilisation. The Clinical Director, OPMH Consultants Group and Clinical Matron have redesigned a new staffing establishment for the unit, which provides better staff:bed rations than on the previous separate wards.

Re-siting Oakdene does not change the number of mental health beds available for Working Age adults. Staff and service users have been fully involved in the discussions about re-siting Oakdene and are supportive of the move to the new environment.

Challenges, Risks and Mitigation

All ward areas have been built within the past 10 years and are well fitted out to a modern specification. All are suitable for mental health inpatients of any age. Each Unit has access to its own garden space and can be adapted to have its own separate entrance. There are no intrinsic estates challenges for the re-siting of the mental health wards in the manner described and the adaptions required are of a purely pragmatic nature. The following are identified challenges and risks, together with plans for their mitigation.

Oakdene Utility

The current Oakdene Unit has facilities for patients to cook their own meals, as part of their rehabilitation. It was initially believed that the Appleby area would require some adaption to allow a larger patient kitchen to enable this to continue; however on-site testing by the clinical team has shown that these adaptations are unnecessary.

Oakdene also has a self-contained flat to allow 1 patient to "test-out" independent living, before moving to their own accommodation. There is not the ability to build this into Appleby Ward; so we will continue to seek a community based solution together with housing and delivery partners.

OPMH functional and organic split

The current Limes Unit has two separate wards, in which people with different presentations can be nursed separately. This is to allow older people with greater frailty to receive care away from more active and challenging patients. Although Kitwood and Brooker are connected by a common core and will be operated as a single unit; patients will continue to be separated into the two areas within the unit, based on their individual needs. Brooker

Safe staffing

The altered configuration of wards required a review of nursing and allied health professional establishments to ensure that we would have a safe level of staffing within the new environments. This was completed and exceeds current ratios – creating a safer staffing level.

Ligature Points

The Brooker area was not originally designed as ligature proof, but in re-commissioning the area – it has been re-fitted to make it safe for a "functional" group of patients who may present a deliberate self-harm risk.

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Report to: **Health Overview & Scrutiny Panel**
Date: **23rd February 2016**
Report by: **Barry Dickinson, Commissioning Programme Manager, Integrated Commissioning Service**
Subject: **Drug & Alcohol Treatment Pathways Update Briefing**

1. Purpose of the Report:

To update the Health Overview & Scrutiny Panel of the current drug and alcohol detoxification and treatment pathway in the City following the re-modelling of services in 2013 and proposed further remodelling for 2016.

2. Recommendation:

This update is provided to inform the panel of the effectiveness of previous changes implemented and to notify the panel of proposed re-commissioning to meet council budget saving requirements in 2016.

3. Background:

A report was provided to the panel in 2011 concerning a review of substance misuse services which recommended a change in the detoxification pathway to introduce greater choice and efficiency in purchasing in-patient placements. The new recovery pathway model was implemented in July 2013 following consultation and a procurement exercise.

The shift to the new model involved creating an assessment and recovery planning hub which includes volunteer peer brokers supporting key workers to engage people with personal recovery plans and commissioning psychosocial and medical interventions. For individuals requiring medically supported detoxification interventions we moved away from a single provider block contract to a framework arrangement with a total of 16 providers which has enable us to match individuals to the most appropriate and economically advantageous placement for their individual needs.

4. Funding and Activity

In the financial year prior to the change to the new model (2012/13) spending on drug and alcohol treatment services for the City's residents from all commissioning agencies totalled £4,829,889. The comparable spending for 2015/16 is £3,404,498. This reduction has been achieved through the more effective commissioning and case management arrangements implemented as total numbers of people engaging with treatment has remained stable at approximately 850 - 950 people per year.

Expenditure on in-patient and residential detoxification admissions has reduced from approximately £760,000 in 2011/12 to approximately £260,000 in 2015/16. This has been achieved by reducing the number of repeat admissions, increasing the use of non-medical residential rehabilitation placements and increased use of community based detoxification.

A key aim of the remodelling was to increase the number of people achieving

sustainable recovery from drug and alcohol treatment. Whilst this is difficult to measure definitively, the usual proxy measure used by Public Health England is to look at the proportion of people who successfully complete treatment and do not re-present within six months. Performance against this measure is reported quarterly through the national drug treatment monitoring system. Portsmouth's performance against this measure has improved since the current model was implemented; commissioning areas are evaluated in comparator groups with localities sharing the most similar characteristics in relation to demographics, size, indicators of deprivation etc. Having previously struggled to achieve above average rates of successful completions, Portsmouth has consistently achieved top quartile performance and for the past year have been the best performing of the MSG (most similar group) in achieving successful completions for opiate users.

5. Impact of potential closure of Baytrees Unit

The Health Overview and Scrutiny panel will be aware that NHS Solent are proposing to close the Baytrees detoxification unit due to declining demand and consequent economic unviability of the service. Whilst the loss of this facility will have an impact for Portsmouth, this will be mitigated by our ability to purchase from other providers on the framework and our continued shift to increasing the use of community and home detoxification wherever it is safe and effective to do so.

In 2011/12 there were approximately 250 admissions to Baytrees for Portsmouth residents. This has reduced significantly to approximately 50 over the period from April 2014 to December 2015. We are confident that we will be able to meet the needs of Portsmouth residents requiring in-patient detoxification through alternative commissioning arrangements already established.

6. Plans for further remodelling

Whilst the current delivery model for drug and alcohol services has delivered improved outcomes and has received positive feedback through consultation with stakeholders, the council wide requirement to achieve further cost savings has necessitated a further remodelling to fit a reduced budget. Savings to the Adult Social Care and Public Health budgets for 2016/7 will mean a cut of approximately £410,000 funding available for drug and alcohol services, with a proposed similar further cut for 2017/8. In view of the requirement to achieve these savings we are planning to procure a new delivery model, through a single tender process. The aim of a using a single tender is to reduce management and organisational overheads as much as possible. Whilst this should reduce the impact on service delivery, it is inevitable with funding reductions of this size that some delivery capacity will be reduced.

The procurement timetable proposed is to publish tender documents in March, to be in a position to award a new contract in June and commence delivery of the new service from October 2016.

7. Equality and Diversity

An equality impact assessment is being undertaken as this proposal is likely to involve a significant service change. However, we will not be able to fully detail the likely negative

impact until we have received the tender submissions, as our intention is to detail the desired outcomes as per the current service model and request providers to suggest the most effective model to deliver as many of these as possible within the available resources and innovative approaches to mitigate any potential negative effect from reduced resources..

8. Consultation

To date we have conducted consultation sessions with stakeholders including current provider managers and staff, service users and carers and GPs through public stakeholder engagement meetings and through an online consultation survey which received 150 completed responses. The results of this feedback will be used in framing the tender documents and in prioritising interventions and outcomes within the retendering process.

Barry Dickinson, Commissioning Programme Manager

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

Our Ref: UW/sm/res/1327

5 February 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. We have had a busy and successful few months since my last update.

We continue to see a very challenging time for NHS colleagues across the country. In the national headlines we have seen much commentary on the NHS' financial constraints; unscheduled care pressures; missed national targets; ever increasing demand on services and of course the junior doctors' strike action. We have not been immune to many of these pressures ourselves. Indeed, we are going to end the year with a financial deficit, which most hospital Trusts in the country will be reporting.

Despite relentless high demands on our unscheduled care pathway, we continue to be a very well performing hospital Trust. Our reputation for patient centred care continues to grow and we were delighted with being recognised as among the best when the Care Quality Commission (CQC) ranked us as outstanding for the levels of care we give our patients in their 2015 inspection. This is something we continue to be hugely proud of.

This winter is proving to be one of the most difficult and challenging in the history of the NHS. Locally we have been working with our health system partners in a programme called ECIP (Emergency Care Improvement Programme). This is supported by the Department of Health, the NHS Trust Development Authority, NHS England and Monitor.

ECIP is a clinically led programme designed to offer intensive practical help and support to urgent and emergency care systems to deliver improvements in quality, safety and patient flow. The programme has a particular focus on improving whole system performance across health and social care in the winter months when emergency care systems are working under additional pressure. It is focusing on 28 urgent and emergency care systems across England that are under the most pressure, helping implement measures to improve patient outcomes, experience and to meet national standards.

We continue to provide outstanding, well led services. I am delighted that our maternity services have recently been highly rated by new mums. As part of the Care Quality Commission's annual maternity survey, published last month, patients gave feedback about all aspects of their care at Portsmouth Hospitals Maternity services. New mums were asked about their labour and birth, how staff interacted and how they were cared for after the birth.

Their responses reflected the high quality of the service. 98% said their partner was able to be involved as much as they wanted, 95% said that they were either able to get a member of staff's attention within a reasonable time, or that a member of staff was with them throughout the whole birth. An incredible 97% said they had confidence and trust in staff caring for them. We are one of the higher scoring services locally and it is something we can be very proud of.

I have often reported on our innovation and research work, of which I am extremely proud. We are again at the forefront of clinical research as we took part in a ground breaking clinical study published in the Lancet and appearing in national news. This has found that ovarian cancer screening may cut deaths by a fifth. The results from the world's biggest ovarian cancer screening trial suggests that screening, based on an annual blood test, may help reduce the number of women dying from the disease by around 20%.

Ovarian cancer was diagnosed in 1,282 women during the 14-year study of more than 200,000 post-menopausal women aged 50 to 74, of whom 649 had died of the disease by the trial end in December 2014. The study showed a delayed effect on mortality between the screening and control arms, which became significant after the first seven years of the trial. The research team are now following up the study for three more years to establish the full impact of ovarian cancer screening. The early results suggested that approximately 15 ovarian cancer deaths could be prevented for every 10,000 women who attend a screening programme that involves annual blood tests for between seven to 11 years.

I am also delighted that our Hepatology department has climbed to number one in the country for clinical trial recruitment, out of 42 large acute NHS Trusts. This is a huge achievement and illustrates the hard work and determination of the team to provide their patients with the very best care.

Our Hepatology team, and other clinicians within the hospital, work very closely with the Director for Public Health, Dr Janet Maxwell, which is a partnership that we greatly value. We do however recognise that we still have much to do. We are different to our neighbouring city Southampton, even though it is only 20 miles away from us. Our population here in Portsmouth is older than the national average and our demographic is poorer and notably sicker than the surrounding geography. All of the public health indicators show complex needs, as our population has a higher prevalence for diabetes; stroke; heart disease; respiratory illnesses; obesity and liver disease. We will continue to work together for better outcomes for our patients and local people.

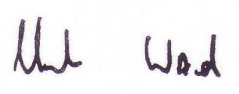
I was also recently delighted to cut the ribbon at the re-launch of the Portsmouth Enablement Service, which changed its name to better reflect the positive work of the staff and the attitude of the service users. The centre, in St Mary's Community Health Campus, is one of only 40 such centres across the UK, and sees more than 1,600 patients every year.

Finally, it is no surprise that we have been recognised as among the top NHS places to work, and a prestigious award was given to us by the Health Service Journal, Nursing Times and NHS Employers. Indeed the latest results from the national annual staff survey is showing further improvements and our organisation is rated highly as both a place to work and receive treatment. As the second largest employer in the city we have much to offer and are committed to making a wider contribution.

The Trust has been highly successful in the apprenticeship scheme and has achieved national recognition for this. This is proving to be a great source for future recruitment as the vast majority of apprentices that have been trained have gone into full time employment within the hospital Trust.

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 on 23 February. I also continue to offer my 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



Ursula Ward MSc MA
Chief Executive

Portsmouth Hospitals' NHS Trust - Repatriation of Vectis Way (Phlebotomy) Blood Taking Clinic Proposal for HOSP

Name of Responsible (Lead) NHS Body: Portsmouth Hospitals NHS Trust

Brief Description of the Proposal: The hospital trust is seeking to repatriate the (phlebotomy) blood taking clinic. The current location was only meant to be a temporary location, set up to support Portsmouth Hospital's need to meet demand for blood taking. The move will be back to its correct location at QA. This will offer an improved patient experience, with more staff cover and back up from acute medical services if needed. A walk in service will remain on offer with extended hours of service.

Vectis Way Blood taking clinic was opened in 2003 because the facility at QA at that time was too small and the waiting area was inadequate. Vectis Way was a temporary location within our business planning and chosen as it was only 0.6 miles from the main hospital site. The clinic at Vectis Way currently provides walk in access for blood tests from 0745-1230 Monday to Friday (exclusive of Bank Holidays) and is staffed by 2 phlebotomists from PHT.

The new QA hospital was built in 2009 with an integrated blood taking outpatient department and waiting area. It was originally shared with an Orthotics clinic and therefore not large enough to repatriate the demand from Vectis Way. However at the end of 2015 this clinic area became solely occupied by phlebotomy and allowed for an increase from 4 to 6 blood taking areas and a waiting area dedicated to patients waiting for a blood test. QA is now available to patients 0745-1645 Monday to Friday (exclusive of Bank Holidays) and will be staffed by 6 phlebotomists (currently staffed by 4). The staff from Vectis Way will become part of the dedicated QA team.

The proposal is to repatriate the clinic in Vectis Way at the end of this current financial year. The staff will move to QA and the economies of scale of money saved from rent; rates; waste -disposal; cleaning; transportation of samples to the laboratory etc. (which is in excess of £24K per annum) will be used to support an improved service to patients across the hospital and other outpatient areas.

Description of Population affected: Currently up to 120 patients per day can be seen in Vectis Way from 0800-1230 Monday to Friday. Unfortunately patients arriving before the clinic opens have to wait outside in the open air. Patients attend the clinic for blood tests for a number of reasons, to monitor their anticoagulation treatment and for tests ordered by clinicians at PHT, or because they cannot get a suitable appointment for a blood test at their GP practice. The service at QA will provide a wider choice of opening hours and patients will no longer have to wait outside. Phlebotomy staff will be relocated to QA and will be working within a larger team with the direct support and supervision of their manager and supervisors.

Confirmation of Health Overview Scrutiny Committees contacted:

Name of Key Stakeholders Supporting the Proposal: Alison Fitzsimons (General Manager and Head of Professions for Clinical Support), Janice Cloud (Matron for Outpatient's and Phlebotomy)

Criteria for Assessment	Yes/No/NA	Comments/Supporting Evidence
Case for Change 1. Is there clarity about the need for change	**Yes**	Vectis Way was set up as a temporary location. It has been used longer than intended and now the phlebotomy service is moving back to its correct location at QA. More

(e.g. key drivers, changing policy, workforce considerations, gaps in service, service improvement)		staff, better patient experience with the back up of acute medical services will be added value to the move. **Environment:** Vectis Way clinic is situated at the rear end of a chemist and has an enclosed waiting area which is available only after staff arrive to open up. Patients currently arrive early to ensure they get their test completed and there is often a queue of patients waiting outside in all-weather awaiting the arrival of the phlebotomists. QA has an enclosed waiting area and there is access to the hospital and other facilities prior to the arrival of the phlebotomy team. There is also a refreshment area close to the QA Blood Taking Outpatient clinic. There are no such facilities in Vectis Way apart from a water machine. The environment at QA will provide a purpose dedicated clinical space specifically designed for phlebotomy, this is not the case at Vectis Way **Improved Access:** Vectis Way is currently only open between 0745-1230, the service at QA will be available 0745-1645. **Governance:** If patients become unwell in Vectis Way the phlebotomists summon support via the 999 service, at QA there is the support of the resuscitation team on site. **Workforce**: Vectis Way is manned by 2 phlebotomists. If there is sickness or leave QA staff have to provide cover or the Vectis Way service is cancelled or reduced. Staff at Vectis Way only have phone contact with their supervisors and managers and at QA they will have the direct support and supervision of their supervisors and manager. **Value for money**: The service at Vectis Way costs PHT in excess of £24K per annum exclusive of staffing. This can be better used to support a more flexible service to our patients.
2. Has the impact of the change on service users, their carers and the public been assessed?	**Yes**	An audit of the numbers of patients attending Vectis Way has been undertaken and this identified that up to 120 patients per day use the service. A transport survey and reasons for using a walk in service has also been undertaken. The majority of patients use the clinic because they do not have to make an appointment, this will not change once the clinic moves back to QA. They also say it is convenient as they can have their test and do some shopping at the same time, QA is only 0.6 miles from QA and is on the same bus route as Vectis Way.
3. Have local health needs and/or impact assessments been undertaken.	**Yes**	Transport survey, attendance audit, mapping of location, public transport links and access have been undertaken.
4. Do these take account of: a) Demographic considerations	**Yes**	Vectis Way is 0.6 miles from QA, it is on the same bus route as QA. The number 2 and 3

		bus run every 10 minutes from Portsea Island to Paulsgrove. There are no public parking spaces in Vectis Way, nearest parking is the pay and display public car park or Tesco car park which is intended for customers only. Patients are also able to use the clinic at SMH by appointment Mon-Fri 0700-1700hrs if they choose to. This is also run by PHT and the appointment number is 023 92680275 and this is 3.2 miles south of Vectis Way.
b) Changes in morbidity or incidence of a particular condition	**N/A**	This is already considered during commissioning of phlebotomy.
c) Impact on vulnerable people and health equality considerations.	**Yes**	QA provides a more suitable environment with access to senior phlebotomists, acute medical support and larger, more private cubicles.
d) Potential reductions in care (e.g. falling birth rate)	**Yes**	By moving the staff to QA they can also be used more flexibly and support the wards and emergency areas.
e) Comparative performance across other health providers.	**Yes**	We have been consulting with commissioners for the last 12 months over community phlebotomy services.
5. Has the evidence base supporting the change proposed been defined? Is it clear what the benefits will be to the service quality or patient experience?	**Yes**	The service will be provided in a more suitable environment, access will be improved in line with the extended hours of service proposed, staff will be more supported and have direct access to their supervisors and manager and patients who become unwell will receive immediate support via the appropriate teams which are accessible at QA.
6. Do the clinicians affected support the proposal?	**Yes**	Clinicians are pleased that samples will no longer have to be transported from Vectis Way to the pathology laboratory at QA. Instead they will be dispatched immediately using the internal vacuum transportation system, results will also be available sooner. GP patients will have improved access due to the proposed extended opening hours of the service at QA. There will be no reduction access or capacity.
7. Is there any aspect of the proposal contested by the clinicians affected?	**No**	Not at the current time.
8. Is the proposal supported by GP commissioners?	**Yes**	We have met with the Commissioning CCGs in December 2015.
9. Will the proposal extend choice to the population affected?	**Yes**	Extended hours of service. Vectis Way is currently only open between 0745-1230, QA will be available 0745-1645

Impact on Service Users		
		Will be available 0745-1645Service re-provided at QA, 0.6 miles from Vectis Way. There will be no reduction in access or capacity.
10. Will there be a change in access as a result of the service changes proposed?	**No**	
		Should be same or reduced, remains a walk in.
11. Can these defined in terms of:		Same bus service, public parking issues similar in Cosham High Street and QA.
a) waiting times?	**Yes**	QA is 0.6 miles-(1000 yards) from Vectis Way and SMH 3.2 miles.
b) Transport (public and private)	**Yes**	
c) Travel time	**Yes**	Patients have raised concern over parking charges at QA, however there is no free public parking at Vectis Way for patients and QA has ample pay and display parking and direct route bus stops.
d) Other (please define)		
12. Is there any aspect of the proposal contested by the people using the service?		CCGs December 15, audits of patients Jan 16.
Engagement and Involvement		
13. How have key stakeholders been involved in the development of the proposal?		
14. Is there demonstrable evidence regarding the involvement of:		Audit Jan 16.
a) Service users, their carers or families	**On-going**	CCGs Dec 15.
b) Other service providers in the area affected	**Yes**	HOSP Jan 16
c) The relevant Local Involvement Network(s)	**Yes**	January Newsletter, staff daily briefings
d) Staff affected	**On-going**	
e) Other interested parties (please define)		The service is to move back from the temporary location which was used longer than intended to its correct location at QA.
15. Is the proposal supported by the key stakeholders?	**Yes**	The service is to move back from the temporary location which was used longer than intended to its correct location at QA. The hours of service on offer will be extended and the walk in service will continue when relocated back to QA.
16. Is there any aspect of the proposal that is contested by the key stakeholders? If so what action has been taken to resolve		

this?		Patients have said that they like not having to make an appointment for their blood test and the walk in facility will remain in place when the service has moved back to QA.
Options for Change		
17. How have service users and key stakeholders informed the options identified to deliver the intended change?	**Yes**	A risk assessment was undertaken and it is on the CSC register, parking, transportation, patient access and flow were all assessed as part of the proposal.
18. Were the risks and benefits of the options assessed when developing the proposal?	**Yes**	
19. Have changes in technology, including new drugs been taken into account?	**N/A**	There will be no change in capacity or access.
20. Has the impact of the proposal on other service providers been evaluated?	**Yes**	The location is only 0.6 miles away and the original move was temporary and chosen due to its proximity to QA.
21. Has the impact on the wider community affected been evaluated (e.g transport, housing, environment?)	**Yes**	This will improve flexibility and staff support and there will be no reduction in workforce.
22. Have the workforce implications associated with the proposal been assessed?	**Yes**	By moving the service back to QA it is more sustainable. The service will be more cost effective as equipment and staffing will be in one place and samples will be received by the laboratory at QA directly and not have to be transported from Vectis Way to QA.
23. Have the financial implications of the change been assessed associated in terms of: a) Capital b) Sustainability c) Risks	**Yes**	The moving back of the clinic from its temporary location to its correct location will provide more staff and better patient experience with the back up of acute medical services, samples will get to the laboratory for testing quicker and results available in a more timely manner. The staff will have access and support from their supervisors and line managers and patients will have access to the most senior, experienced phlebotomists who are based at QA.
24. How will the change improve the health and well being of the population affected?	**Yes**	

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10 February 2016

Cllr J Ferrett
HOSP Chair
Members Services
The Civic Offices
Guildhall Square
Portsmouth
PO2 2AL

Dear Cllr Ferrett,

This letter is intended to update you and the members of the Portsmouth Health Overview and Scrutiny Panel on some of work the Clinical Commissioning Group has been involved with since our last update in November.

I have set out a brief summary of a few key issues within this letter but please do contact me if you need more information about any of these.

Portsmouth Blueprint

Members will be aware that the document *'A Proposal for Portsmouth: A Blueprint for Health and Care in Portsmouth'* (September 2015) was presented to and endorsed by the Portsmouth Health and Wellbeing Board (as well as the CCG's Governing Board) in September 2015 and has also been reviewed by the Portsmouth City Council Cabinet.

The document essentially sets out a strategic blueprint for how health and care could look in the city at the end of the next five years. It has been developed through the work of the Portsmouth Health and Care Executive (PHCE) comprising senior representatives from the following city partners:

- NHS Portsmouth Clinical Commissioning Group
- Portsmouth City Council
- Solent NHS Trust
- Portsmouth Hospitals NHS Trust
- Portsmouth Primary Care Alliance

At its meeting in December 2015 the Health and Wellbeing Board received an update on progress to date in a paper which also looked at proposed next steps for the programme.

Whilst many details of the Blueprint are still being developed, there is a strong desire by the partners to make progress where we can to achieve better services for the public and greater efficiency for the public purse. Momentum and the demonstration of our commitment to improve local delivery are powerful drivers and need to come from the top to empower the local health and wellbeing system. Considerable progress can be made within the existing legal provisions and the collaborative approach adopted by the partners, and we are already looking at financial and governance arrangements locally to see what scope there might be to align approaches more closely and thus provide a framework through which we can explore further developments over the next few months.

Given the significance of this project, representatives of the CCG would of course be happy to return to HOSP as and when appropriate, to ensure that panel members are fully briefed as progress is made.

Primary care – sustaining viability for the future

Members will be aware of the pressures facing primary care both locally and nationally – demand for services, the number of GPs nearing retirement, and fewer medical students choosing general practice to take their place. A key element for the Portsmouth Blueprint is the consideration of how out of hospital care, and in particular, primary care services can move forward in a sensible, sustainable way over the next few years. As commissioners of these services, we are engaging with our GP members on developing new approaches for the future that can help alleviate these pressures.

The Blueprint proposes a different way of working for primary care services, one that retains the GP as the basis for the service but with a wider workforce which sees individual GP practices working together or merging to provide services collectively for the City.

For that to happen we will need to work with local GPs, our NHS partners and the local community to develop commissioning models to support this.

While this work continues, however, it is likely that we will continue to see local GP practices put forward solutions and proposals to deal with more immediate pressures that some now face. This may see some working together on an informal ‘alliance’ basis or more formally through a merger. Practices are required to engage with their patient population before any decision about mergers is taken and the proposals are considered fully by the CCG through its Governing Board and/or Primary Care Commissioning Committee.

Information about recent merger proposals can be found on our Governing Board papers or, if Panel members prefer, we can provide a more comprehensive update in a future briefing.

Guildhall Walk Healthcare Centre

As the Panel will be aware the formal consultation process runs until Friday 19th February. We expect to present a proposal on the future of Guildhall Walk, which will include a full, independent analysis of the feedback we have received, to the Panel on Tuesday 15th March, and to our Governing Board on Wednesday 16th March.

Services for people with long term conditions

We have now moved into the second phase of our work to seek the views of patients and service users locally about their experiences of living with a long term health condition, how they feel about the health services in place to support them and how they would like models of care

to be provided in future. We are undertaking this work in conjunction with Fareham/Gosport and South Eastern Hampshire CCGs.

The first phase of this project was a survey which brought us over 700 responses, around half of which were from people who had been living with a long term condition for more than ten years. The results make interesting reading and a summary is available here:

http://www.portsmouthccg.nhs.uk/Downloads/Consultations/Long%20Term%20Conditions/LTCs%20Final%20Results%20Nov%202015.pdf

In headline terms:

- **In terms of being involved**: 59% reported feeling 'Very' or 'Quite' involved in their care. But that does mean, of course, that 40% currently don't feel able to say that although some would indicate that it varies.
- **Receiving 'joined up' care**: again around 40% of respondents didn't feel able to say that the care they received was provided through organisations working in a joined up way
- **People wanted to see**: more information, to help them manage their condition themselves, and convenient consultations with longer appointments – there was also support for an approach in future that focused on supported being provided in the community and at primary care level rather than in an acute hospital setting, although a strong cohort of people still were in favour of regular hospital appointments.

There is much for us to consider here and so the next phase of this work is to run some focus groups that will provide us with the opportunity to discuss these findings in a lot more detail. We are now running a few of these working with local groups such as Breathe Easy, diabetes groups and others.

Mental health services for veterans - NHS England engagement

A period of engagement regarding mental health services for veterans has been started by NHS England.

The survey is aimed specifically at CCGs, veterans and their acquaintances, charities and support groups, and mental health professionals, however anyone with an interest in the field can participate.

All of the supporting information is here: https://www.engage.england.nhs.uk/survey/veterans-mental-health-services.

The deadline for responses is 5pm on 31 March 2016.

All responses to the engagement will be reviewed and analysed to help inform a report that will be made available on the NHS England website and shared with interested groups. This will help to inform decisions on commissioning arrangements for future veterans' mental health services.

City leads Wessex in dementia diagnoses

Since our last update we have learned that Portsmouth continues to lead the way locally in terms of dementia diagnosis in primary care.

The latest figures from NHS England show that, in November 2015, the estimated dementia diagnosis rate in Portsmouth for December 2015 was 72.1%, the highest score in the NHS England Wessex area.

The average dementia diagnosis rate across the whole country in that period was 67.2%. Other diagnosis rates from Wessex areas include: Fareham and Gosport (64.1%); South Eastern Hampshire (66.1%); Southampton (71.4%), and the Isle of Wight (64.3%). The positive figures reflect a huge amount of hard work which has been put in by local practices and partners - supported by CCG staff.

The diagnosis rates, of course, are based on an estimated number of people who have dementia - in Portsmouth for November that estimate was just over 2,000 people. Work goes on to ensure that a still great proportion of people who are affected by forms of dementia are identified at the earliest possible point, to ensure that they can be offered the best available support.

CCG relocation

The CCG HQ office is relocating to in the Civic Offices from Monday 15 February.

Our full address will be:

CCG headquarters
4th Floor
1 Guildhall Square
Portsmouth
PO1 2GJ
Phone: 023 9289 9500.

Moving to the Civic Offices has many advantages for us – not least because of the close working relationship we already enjoy with the City Council, and our two organisations have many combined priorities and a shared vision for future health and social care provision in Portsmouth. Our future Governing Board meetings will now be held in the Civic Offices and will be advertised on the CCG website and elsewhere.

New CCG chair

Dr Elizabeth Fellows has been appointed as the new chair of the CCG. The move follows Dr Tim Wilkinson's decision to step down after years of service to the boards of the CCG and its predecessor commissioning organisation, the Portsmouth City Teaching Primary Care Trust.

Dr Fellows, a GP in Southsea, has been on the CCG Executive since its inception and will take up the post from April 1st, for an initial period of three years.

With best wishes

Dr Jim Hogan
Chief Clinical Officer

HAMPSHIRE AND ISLE OF WIGHT LOCAL DENTAL COMMITTEE

Report to Portsmouth City Council (HOSP): February 2016

The Annual LDC Officials' Day was held on Friday the 4th December in London and Sara Hurley the new Chief Dental Officer for England delivered the Keynote Speech to the 170 nominated LDC representatives. Sara's speech was refreshingly empathetic and reassuring and she demonstrated that she was aware of the current problematic commissioning and contracting issues with NHS England. Sara was very keen to look at new preventative oral health initiatives and she discussed the emerging Vanguard sites with special focus on diet control support. The CDO discussed the option of dental team diversification with the dentist as the leader of the team. The new CDO felt that future revalidation in dentistry should be owned and designed by dentists. Sara mentioned aspirational access targets of 75% for adults and 85% for children, which is quite a hike from the current state of 53% and 69.6% respectively. Sara was concerned that in the future there may be a shortage of dentists as currently only around 23,000 are making claims for treatment within a £900 million budget (88.9 million UDAs) which equates to around £75 per head. The CDO felt that there were enduring but no emerging themes. There were so many questions but not enough time to air some important issues but hopefully these will be addressed as the CDO visits all the regions of NHS England in the coming months.

John Milne the Senior National Dental Advisor CQC gave his update which included reassurances that the new and emerging inspection process will always be relevant and carried out by a Dental Specialist Advisor in attendance with the CQC Inspector. The future development of identifying notable practices showing good compliance with standards was advised. CQC will not rate dental practices for the foreseeable future.

Other Current LDC Activity during November and December saw the final Joint LDC, NHSE, PHE meeting and the first replacement meeting was held on the 22nd January 2016 which was a two part meeting with a new (2nd part) Dental Oral Health Meeting component. The first much shorter part of this meeting will continue to be dedicated to joint performance and contractual concerns and queries raised by the two LDCs in NHSE (Wessex) and the second part will involve a much more diverse, area based stakeholder group that includes local authority and CCG input which will commence consideration of wider agenda items e.g. children's oral health.

A Dental Commissioning Group has also been set up and the second meeting took place on the 28th January. This important group on which the two LDCs sit, feeds directly into the Board of NHSE (Wessex) and it is a recommendation rather than a decision making group. This group not only

looks at commissioning dental services but also at layers of contract performance data to quality assure commissioned services.

The Future for LDCs is a recent paper developed by the Hampshire and Isle of Wight LDC Secretary and is meant to be an aide memoir/reference document for dentists within our constituent area to rationalize LDCs' and this committee's activities but with an eye to future developments within our NHS provider/performer representative remit:

LDCs in England and Wales have been in existence since the birth of the NHS in July1948 and have survived many organizational upheavals but since the National Service Act 2006 the changes have been more significant, culminating in the major changes in 2013 emanating from the Health and Social Care Act 2012 whereupon 152 PCTs were replaced by 211 CCGs.

Many LDCs have struggled to maintain their coterminosity with firstly the 27 Area Teams before 2015 and now with the sub-regional offices of NHS England. This area specific problem and associated representative costs might be solved by association, federation or indeed by merging LDCs to provide an efficient and more dynamic representative input. At the very least LDCs should consider meeting with neighbouring LDCs to share representative common ground.

LDCs are one of four local representative committees that may or may not be recognized or actively consulted by sub-regional offices of NHSE with a number of existing and future roles that potentially benefit NHS England, patients and constituents.

Clearly, LDCs are currently 'at 'risk' of marginalization and therefore it is of paramount importance that we secure our role as an important and valid representative stakeholder within various facets of the organizational NHS/Local Authority 'new world'.

LDCs created in statute are funded through the statutory levy (SL) to perform a plethora of representative duties. The SL funding also covers the expenses incurred by committee members/officers and supports the funding requirements of the associated administrative burden that is a consequence of this significant role. The H&IOW LDC also collects voluntary levy contributions that are aligned with other funding activities such as the British Dental Guild and the BDA Benevolent Fund.

FUTURE and CONSOLIDATED ROLES IN WESSEX

- Core membership of the Local Dental Network (LDN) is essential. This is a chance to influence the commissioning strategy of the LDN which is the commissioning heart of the sub-regional office of NHSE (Wessex) and thereby promote GDP membership of the emanating Task and Finish Groups that will address specific tasks orchestrated by the LDN. LDC members are well aware that education and training support will be necessary for GDP providers and performers as the commissioners

address the emerging problems of commissioning services, for example tier 2 non-specialist providers. LDCs may through the BDA and LDC Conference motions help to influence the tier 2 training/accreditation programmes that are currently under discussion with Eric Rooney and the two faculties (FDS and FGDP). It is important that two Wessex LDCs provide valid and informed commissioning advice that protects providers, services and patients e.g. the future re-commissioning of time limited PDS Agreements in orthodontics.

- Membership of the emerging new (Final draft National Commissioning Guides directed Managed Clinical Networks (MCNs) that are likely to be more formalized with a constitution, terms of reference, financial structure/accountability. These new MCNs will be somewhat different to the older and current versions of these peer review type groups. MCNs and other groups going through gestation are consultant/specialist led but LDC members can bring a sense of realism and non-conflicted advice to the table as champions of primary care providers and for example provide updated 'real world' comparisons between the 2006 contract and the emerging contract reform prototypes. Should we consider that LDCs might be involved in the development of future *Strategic Clinical Networks* that CCGs employ? LDCs should be aware that NHSE works on national policies with some local flexibility.

- Representative funding of GDPs within the new structures is an issue for the two LDCs and no doubt both committees will need to further debate in depth how this use of the statutory levy can be justified. We and other GDPs need to be 'in it to win it' and to exert our directive influence. The restrictions and limitations of the existing contract and contract reform need to be aired and understood by commissioners and non-clinicians.

- Constituent support was a theme expressed by David Geddes at a recent joint NHSE/LRC meeting. What might this support look like? LDCs operate PASS, WISDOM and equivalent pastoral schemes for self-referring dentists in low levels of difficulty and the H&IOW LDC has trained Appraisers, Mentors and Coach/Mentors that in conjunction with Health Education England help more serious cases of dentists in difficulty and up to GDC fitness to practice levels. GDPs have never been at a greater career risk than they are now with not only a draconian and perverse regulator but also from the perils of CQC, NHSE data scrutiny/NHS Protect and the National Performers List regulations. Occupational Health and PCS support is diminishing for dental teams and it is possible that the Disclosure and Barring Service will be taken over by umbrella organisations – should the LDCs 'step up to the plate'?

- Education support – The H&IOW LDC already provides CPD events that are normally non-core and this is an area that could be developed further into a more protective and informative career/business/regulatory awareness training resource for our constituents.

- Performance panels –The two LDCs in Wessex already provide non-voting invited members to sit on NHSE Performance Panels ie Performance Advisory Groups (PAG) and NHSE should be encouraged to provide the same level of training that has been employed for the voting Discipline Specific Practitioners that are funded by NHSE. The H&IOW LDC will continue to develop peer appraisal skills that signpost and support the personal development of our constituents and identify early signs of difficulty.

- Regular Joint LDC/PHE/NHSE liaison Group meetings are a good discussion contact point between the various local NHS stakeholders and especially as NHSE (Wessex) staff no longer attend LDC meetings. As mentioned earlier in this report it is concerning to note that contact between the LDCs and the contracting team of NHSE (Wessex) is under threat. The LDCs sit on the core group of the Local Dental Network (LDN) but this only addresses commissioning decisions.

- Meetings with other LRC groups can be beneficial to share commonality of purpose e.g. Local Pharmaceutical, Local Optometry and Local Medical Committees. The five-year forward view, vanguard sites, multidiscipline provider sites and co-commissioning (CCG) should be of interest to all providers of primary care. The H&IOW LDC regularly meets with both the Hampshire based LOC and the LPC to share local intelligence.

- The two Wessex LDCs have voting members that sit on the local NHSE (Wessex) Contract Recommendation Panels that consider contract performance and the outcomes from the internal contract and BSA monitoring processes.

- Liaison with patient representative groups e.g. local Healthwatch is important to help both groups to understand service provision to patients and the operational difficulties under the 2006 dental contract.

- The LDC websites, newsletters, social media and group email contact are essential means of communication between the LDC and its constituents. Published useful and up to date information is invaluable.

LDCs still have a very important role to play but the LDCs in Wessex must be flexible, entrepreneurial, knowledgeable, reasonable and provide positive support within our representative envelope.

LDCs in Wessex must also bring an informed and extra dimension of engagement with the NHS health care systems that govern the lives of dentists and to the benefit of patients.

The CDO visited Wessex on the 9th,10th and 11th of February to engage with the whole of the area's dental workforce. The LDC Chairman and Secretary were given the opportunity to exchange intelligence and views in a short interview slot on the 10th February. The two LDCs in Wessex organised an evening event in St Mary's Stadium, Southampton on the evening of the 9th

February for 170 delegates. The evening event was opened up to NHS dental teams, NHSE representatives and dentists working in secondary care so that they could hear the new CDO‘s vision for the future and also it was an opportunity for the CDO to assess the morale of the Wessex primary dental care workforce.

Keith Percival
Hon Sec
H&IOW LDC

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healthwatch Portsmouth

Health Overview & Scrutiny Panel Update
23rd February 2016

Introduction

- Healthwatch Portsmouth is the **local**, **public led**, **independent** group that make sure people's voices are heard in decisions about health and social care services.

- **Funded** by central government **via** Portsmouth City Council, one of **152 local projects** under umbrella of Healthwatch England.

- Healthwatch Portsmouth Board **decide the priorities** for the team to focus on.

- Staff team of 3, plus volunteers.

Our 8 statutory functions:

1. Promote / support local people in **commissioning, provision and scrutiny** of local services.

2. Enabling people to **monitor** standards and **inform improvements**

3. Obtaining **local views** and making these known.

4. Producing reports / **recommendations for service improvements** to commissioners / providers.

5. Provide **information & advice re access** to services so choices made.

6. Forming **views on standards** – sharing this with Healthwatch England.

7. Making recommendations to Healthwatch England to advise CQC to make **special reviews.**

8. Provide **intelligence to Healthwatch England…**

Where have we been in last 6 months?

Foodbank

British Red Cross

QA Hospital

Beneficial Foundation

Library

St Mary's Hospital

Cross Cultural Men's' Group

Lip reading group

Parent & Carers' Board

Health Cafe

Community Days

Portsmouth Disability Forum

Veterans Outreach Service

PRENO

Portsmouth Parents Voice

Carers' Centres

St Mary's Treatment Centre

GP Practices

Guildhall Walk

OCD support group

Families Moving Forward

Recovery Cafe

Work Programme

What have we achieved?

Our activities sit within four key ‘work streams’:

1. Community Engagement
2. Advocacy (NHS complaints)
3. Projects
4. Signposting / Information

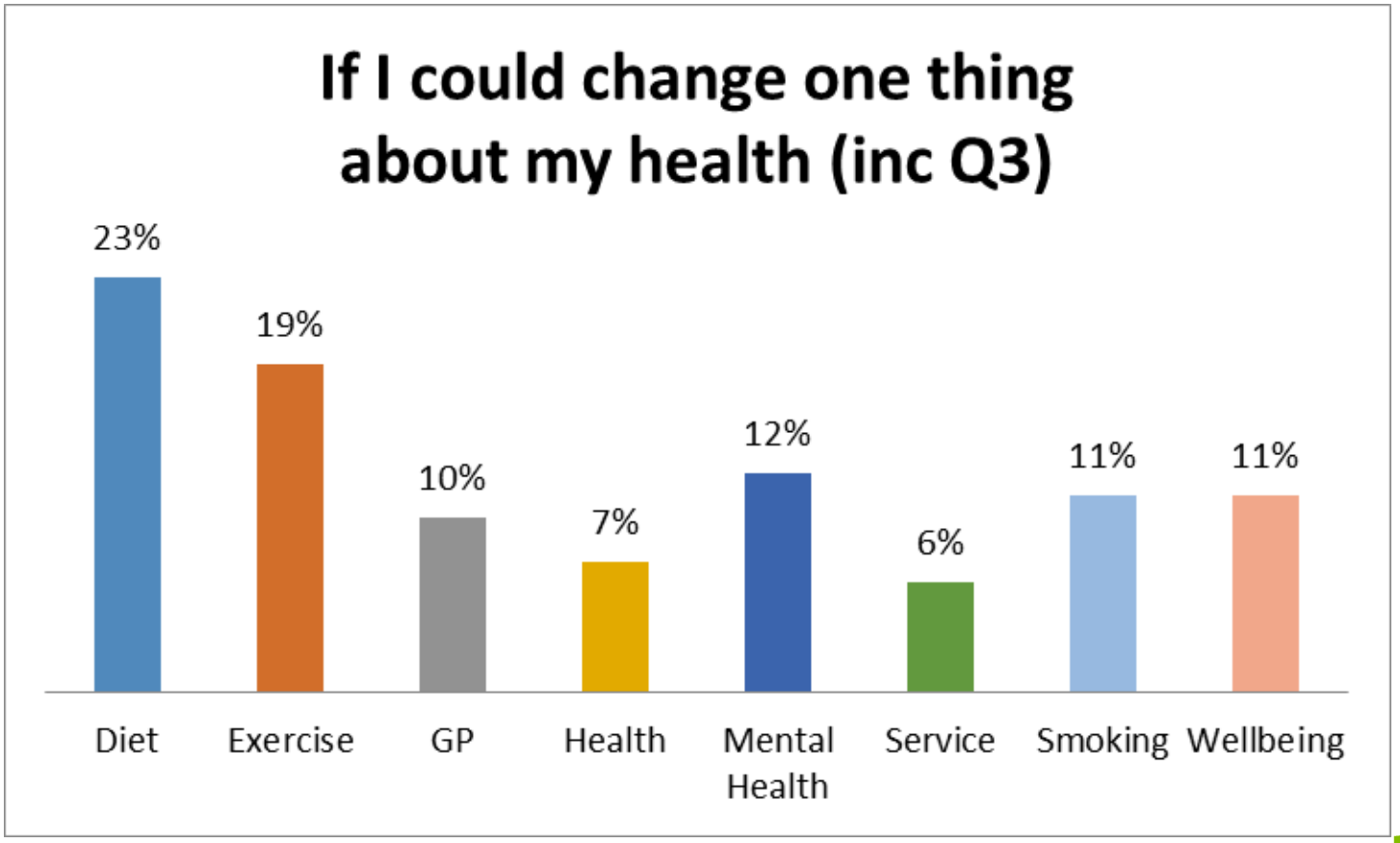
What have we achieved? Engagement

- ✓ Increased awareness of who we are and what we do
- ✓ Portsmouth Race Equality Network Organisation (PRENO) health events
- ✓ Board meetings – inc HOSP chair, Wellbeing Team, Leads re Blueprint
- ✓ Public involvement in commissioning (Wessex Community Voices – http://www.healthwatchportsmouth.co.uk/story/working-together-wessex-community-voice-film & https://wessexvoices.wordpress.com)
- ✓ Lip reading group film with Healthwatch Hampshire (https://www.youtube.com/watch?v=tLxWZD3uuSg&feature=player_embedded)
- ✓ Volunteer training – 'Enter & View' / 'What is the NHS?'
- ✓ System to follow up poor Care Quality Commission (CQC) reports

What are we doing next? Engagement

- ✓ Wider information collection & follow up strategy – inc website
- ✓ Links with providers to be 'critical friend' / 'conduit' for feedback - GPs, Dentists, Residential Care Homes, main foyers – Enter & Views.
- ✓ Comment on GP merger processes
- ✓ Mystery shopping findings and recommendations
- ✓ QA 'walk through' and patient experience of A&E, discharge and non-specialised wards
- ✓ Shared volunteers and menu of opportunities
- ✓ Widen public involvement in commissioning…

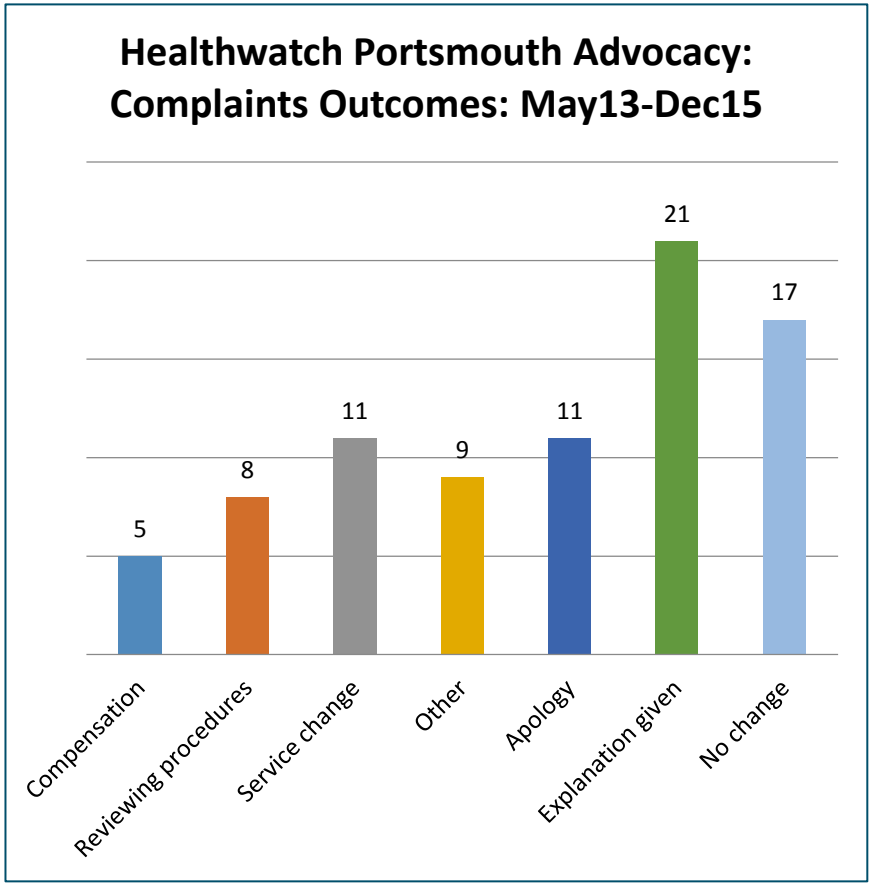
One change?

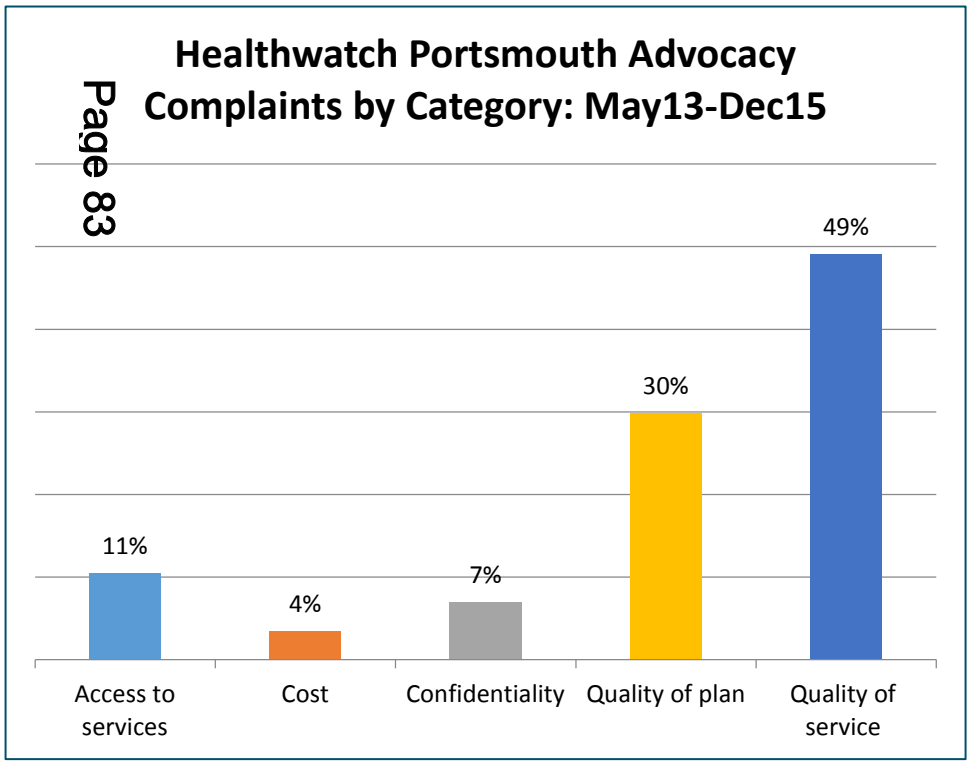


Summary of responses to a question asked of Portsmouth residents

What have we achieved? Advocacy

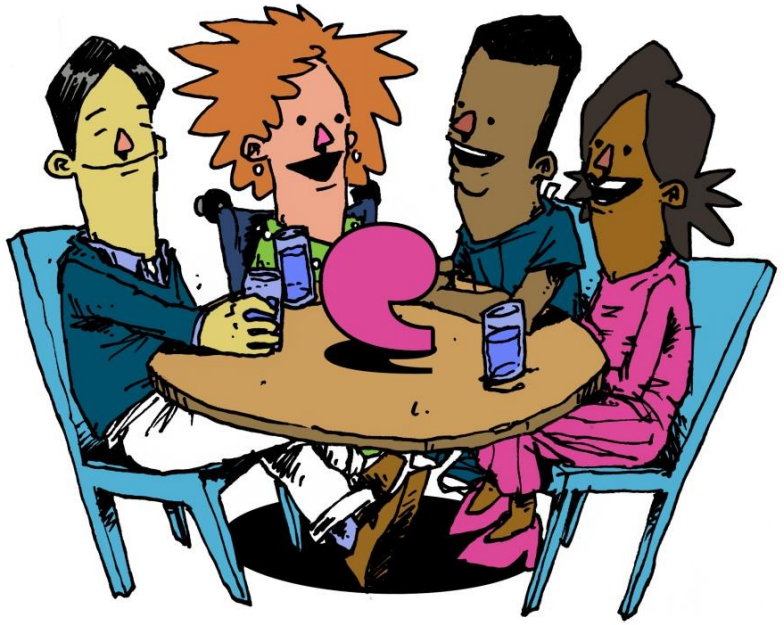
- ✓ Caseload management
- ✓ 58 people helped with 1 or more complaint
- ✓ Average age of client = 51 years old





What are we doing next? Advocacy

- ✓ Widening referral sources
- ✓ Follow-up strategy to check actions put into practice
- ✓ Better use of data
- ✓ Provider workshops to build capacity
- ✓ Peer support groups…



What have we achieved? Projects

- ✓ Bowel Cancer – link between access to screening and deprivation (University of Portsmouth)
- ✓ Mapping patient / user engagement networks (Junior Doctors)
- ✓ Guildhall Walk – walk-in consultation – 300+ responses, input into engagement plan
- ✓ Wheelchair services (Healthwatch Board Member with Portsmouth Disability Forum)…

What are we doing next? Projects

- ✓ Cancer project – Part 2: Barriers (& solutions) to screening
- ✓ Mapping engagement networks – work with CCG/PPG & engagement leads
- ✓ Health outcomes for people with learning disabilities – including barriers to service & accessible information…

What have we achieved? Information

- ✓ 650 members
- ✓ 2,500 followers on social media (Twitter/Facebook)
- ✓ 18,000+ website hits & 32,000 total page views (July-December 2015)
- ✓ Online directory containing 850+ services averaging 2,240 searches per month

What are we doing next? Information

- ✓ ‘Tripadvisor’ style online feedback opportunities
- ✓ Database (CRM) to improve data collection & reporting
- ✓ Review satisfaction with Healthwatch Portsmouth

Summary

- ✓ Established good foundation & connections

- ✓ Next phase – to build
  - Visits & data collection
  - Recommendations for improvements
  - Sharing of good practice
  - Increase networks /awareness
  - Volunteer development
  - Public involvement in commissioning
  - Joint-working opportunities…

= Impacting & influencing local services by local people

Find out more at: www.healthwatchportsmouth.co.uk

Thank you for your time. Any questions?

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