Portsmouth CITY COUNCIL

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NOTICE OF MEETING

HEALTH OVERVIEW & SCRUTINY PANEL

THURSDAY, 14 SEPTEMBER 2017 AT 1.30 PM

THE EXECUTIVE MEETING ROOM - THIRD FLOOR, THE GUILDHALL

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

Membership

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

Standing Deputies

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

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

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

A G E N D A

1 Welcome and Apologies for Absence

2 Declarations of Members' Interests

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

4 Single Accountable Care System. (Pages 11 - 32)

Portsmouth Hospitals' NHS Trust
Sheila Roberts, Interim Chief Operating Officer
Paul Thomas, Integrated Discharge Service Lead, Portsmouth & South East Hampshire
Rob Haigh, Executive Director

Solent NHS Trust
Mandy Sambrook, Operations Director

Portsmouth City Council
Simon Nightingale, Commissioning Programme Manager

5 Portsmouth Hospital's' NHS Trust - update. (Pages 33 - 44)

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

6 Big Health Conversation. (Pages 45 - 50)

Nick Brooks, Senior Communications & Engagement Manager, Portsmouth, Fareham & Gosport and South Eastern Hants NHS Clinical Commissioning Groups will answer questions on the attached report.

7 Director of Public Health's Update.

Claire Currie, Public Health Consultant will answer questions on the report that will follow.

8 Adult Social Care update (Pages 51 - 58)

Angela Dryer, Deputy Director Adult Services will answer questions on the attached report.

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HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held on Thursday, 29 June 2017 at 9.30 am at the Conference Room A, Second Floor, Civic Offices

Present

Councillor Leo Madden (Chair)
Councillor Alicia Denny
Councillor Gemma New
Councillor Lynne Stagg
Councillor Elaine Tickell, East Hamphsire District Council
Councillor Philip Raffaelli, Gosport Borough Council

1. Welcome and Apologies for Absence (AI 1)

The new HOSP Chair Councillor Madden welcomed everyone to the meeting, particularly the new members of the panel.

Apologies for absence had been received from Councillors Read, Wemyss, Hughes, Ford and Blackett.

2. Declarations of Members' Interests (AI 2)

There were no declarations of interest.

3. Minutes of the Previous Meeting (AI 3)

RESOLVED that the minutes of the previous meeting were confirmed as a correct record.

4. Sustainability and Transformation Plan (AI 4)

Mark Smith, Hampshire and IoW STP Programme Director introduced his report and explained that the STP has responded to lessons learned nationally and reflected this in its contents. He explained that as a result of the 5 year Forward View the number of delivery programmes had been increased to 11 (7 core programmes and 4 enabling programmes). He considered that they key change is around emergency care following the national push on this. Mark considered that the draft urgent and emergency care programme is perhaps the most important programme within the STP. This included effective patient flow and discharges and also included services such as 111 and extended GP practices which will all take pressure away from hospitals.

The second change was the children and maternity programme has been added to the STP. This included working on the early years agenda and this was still at an early stage.

Mark then summarised the remaining core programmes within the STP. The governance of the STP was explained using the diagram with the report papers. The far right of the diagram showed the local delivery systems (LDS) in place and Mark explained that they are working with each of the LDS to create their bespoke plans and decide how they will all work together. This will result in a local change plan for LDS for Portsmouth and South East Hants. The top of the diagram describes how the STP is governed. Project Managers meet monthly to review progress. The Executive Delivery Group consists of chief executives of the 22 organisations around the patch. The joint Health and Wellbeing committee will consist of all the chairs of the Health and Wellbeing Boards in the area. This has not yet met and the first meeting is likely to be in July. The Clinical Executive Group will act as an advisory group for the Executive Delivery Group.

In response to questions the following matters were clarified:

- The purpose of the STP is to ensure that services are joined up. There is a separate mental health programme; however mental health also runs through the other programmes as well including the Solent Acute Alliance programme. Mark said that mental health was not currently joined up and this is a priority of the STP. He said he would check whether there is member involvement on the Mental Health Acute Alliance group.
- The STP had not been re-issued to include the updated delivery programmes as the case for change remains the same. However Mark said he would take this back to colleagues to discuss whether to update the STP document and re-publish.

The panel were concerned about the lack of detail in the update provided and felt that there was no sense of progress being made. Members were also concerned that the joint Health and Wellbeing Committee had not yet met. Mark Smith said that this was a fair comment. Reporting was being made to the board and a summary of this now needs to go to the joint committee. The data is still very raw and work to make this more sophisticated is required. The board are starting to specify the key changes that need to take place in activity/finance however a more in depth performance report is required. In response to a follow up question Mark said that he there was not yet a 100% robust delivery plan in place. Each local system is starting to specify precise local interventions and some are struggling financially to close the gap.

RESOLVED that the update be noted and that an update will come back to a future meeting.

5. South Central Ambulance Service Update (AI 5)

The report was introduced by Tracy Redman (Head of Operations South East). Her role covers Fareham and Gosport CCG, South East Hants and Portsmouth CCGs and activity is broadly consistent amongst the three. In Portsmouth SCAS only convey 50% to hospital. All others are dealt with by either a telephone assessment, alternative pathways or by the paramedic

staff. The key focus is making sure the patient gets the right treatment whilst supporting the system as a whole. Performance data for Red patients is on target and there are less of these as they are the most serious cases. Green 30 means that need to be dealt within 30 minutes based on a telephone triage. SCAS do struggle to meet these targets at times. There is a new scheme in place which is looking to address long waits.

With regard to hospital handover delays there is a significant spike in the winter. This impacts on the service that they can deliver and also impacts on staff welfare.

In response to questions the following matters were clarified:

- The 300 lost hours this month was for Queen Alexandra Hospital alone. Although this is still unacceptable, this has reduced significantly since January when it was 1200 lost hours. It is a challenge to ensure consistency and SCAS are looking at why certain days are worse than others. Monday is always a busy day.
- When a 999 call is received whichever unit is available at the time will be sent - it is not always a paramedic first. SCAS will always try to get someone to the patient as soon as possible to assess.
- The Red 8 minute responses times are meeting targets.

RESOLVED that the update report be noted.

6. Crisis Resolution Home Treatment Team update (AI 6)

Southern Health

Charlotte Hope, Urgent Care Team Manager and Mark Nichols introduced their report. Charlotte explained that care navigators take administrative roles away from nurses for example bed finding, which frees up nurses for their other duties. Their team currently has 60 patients. The pilot study ran from Parkway in Havant and extended to Fareham to create 9 individual therapy sessions. The results and feedback from this was excellent and it was shown to prevent hospital admissions. There are no additional resources to extend the pilot and currently no confirmation whether this can be extended. Charlotte said that ideally they would want to look at resources in Fareham and Gosport, Havant and Waterlooville.

In response to questions the following matters were clarified:

- There is currently only one band 6 member of staff on shift each night who is the contact point for the whole of the South East. They would like to extend the availability of staff further to provide a better service.
- Christmas is either a very good or very bad time in terms of referral numbers. They will not try to stop patients being referred at this time and will provide visits on Christmas day. The level of referrals does vary though, for example when it is sunny weather there are less referrals or when there has been a national tragedy there tend to be more referrals as it can affect the emotional wellbeing of people.

- The number of referrals at night varies; Mark advised he has had nightshifts and only received 2 calls and other nights where there has been over 50 calls. Demand is increasing though and additional night cover is required.
- There were 103 referrals in May and 105 referrals in June. Many of these patients have difficulties coping with family breakdowns, redundancy etc. so it is about how the team can support them to cope with these changes.
- With regard to the pilot study Charlotte explained that the results of the study had been referred back to the local leadership meeting and they are waiting to hear about next steps.
- The service does spot purchase some beds from St James but also have their own beds.
- There is no suggestion that the team will be cut and Charlotte said that she was hoping it would be expanded due to demand.
- Morale of staff varies and improved massively after Christmas. It is a stressful job taking referral calls daily. There have been some unrealistic expectations and not enough staff. Charlotte said a morale survey is completed each month and employee of the month certificates issued to try and improve morale.

The panel considered that it was important to pursue whether the pilot study could be extended due to its positive results and it helping people stay out of hospital. Charlotte advised that a formal report had been produced and offered to send this to the panel which they accepted.

ACTION: - formal report on achieving CQUIN data from the pilot study to be sent to the panel.

Solent NHS Trust

James Dawson, Clinical Manager and Home Treatment Team introduced his report. He explained that he had been in post for the last 8 months. He explained that his staff work 9.22 hours over a 4 day week and have three days off due to working in a stressful environment. The service employs 10 band 6 mental health practitioners as well as one discharge liaison nurse, support time recovery workers. There is also 1 clinical psychologist and 1 cognitive behavioural therapist. There are two members of staff working every night shift. James said that similar to Southern the amount of referrals at night is unpredictable.

In response to questions the following matters were clarified:

- When asked about his thoughts on the STP, James said that he felt the themes within it were disconnected and he was struggling to understand the direction. James felt though that a lot of the discussions were taking place at a higher level so he would not be privy to many discussions.
- The team used to deliver day therapy and this was reasonably effective.
- With regard to the exclusion criteria and the CRHTT not accepting direct referrals, James explained that people are advised to seek an urgent GP appointment however they cannot be forced to make this. If

it is clear that a patient is acutely unwell, lacks insight and they are presenting with high risk there is an option for certain referrers (GP's) to request a 1983 MHA request which the CRHT can receive and process irrespective of the patients lack of insight. For known mental health patients who make contact with the service out of hours the CRHT will contact their care team in hours to alert them to the fact the patient may require additional support.

- Over the last couple of years a pilot study has been run at the university surgery to consider the rates of referral. Many students have no support structures in the city so can struggle with their emotional wellbeing. As long as they are registered with a Portsmouth GP they have a right to treatment.
- With regard to the all age service project James explained that he was unaware what the additional training costs would be to up-skill adult mental health staff within the CRHT to acquire the necessary skills and competencies to work with an older age group of patients e.g. dementia clients.
- If a Section 136 suite is full there is the ability for the patient to go into a neighbouring suite. There are nurses attached to a Section 136 Suite. Very often patients do not need to go into a Section 136 suite if they are consenting to care and assessment from mental health services. In this scenario emergency 999 services are aware they can contact the Portsmouth CRHT directly under Crisis Concordat (2014) principles and the CRHT will offer crisis assessment at Orchards if resources allow. This is happening in the city as the CRHT are adherent to the concordat where ever possible. This facility is the only way members of the public can directly receive a crisis assessment in Portsmouth from the CRHT without the need to see their GP first.

RESOLVED that the updates from both Southern Health and Solent NHS Trust on the Crisis Resolution teams be noted

7. Portsmouth Healthwatch Update (AI 7)

Siobhain McCurrach, Project Manager introduced the report. She explained that she has been in post since April. She advised that the Healthwatch Annual report was due to be published tomorrow and would be circulated to the panel members via email.

In response to questions the following matters were clarified:

- The public are very interested in the STP however it is such a huge topic to cover so it can be bewildering to people. Healthwatch are focusing on what the health service will look like locally rather than the STP as a whole. Also involved in discussions with appropriate people to look at what going to get involved with.
- The patient discharge survey will be conducted in July and will be telephone based. This will focus on patients who have used the urgent care pathway.
- The enter and view engagement work will include both good and bad care homes.

- With regard to mental health services being one of their priorities for this year, she advised that this would cover a broad range of ages. Conversations with managers were yet to take place but Siobhain hoped that this would also include mental health of children.

RESOLVED that the update report be noted.

8. Adult Social Care Update (AI 8)

Due to unforeseen circumstances Angela Dryer the Deputy Director of Adult Services was unable to attend to present the report today. The panel requested that Angela bring the report to their meeting in September.

9. Learning Disability Transformation Programme update (AI 9)

The report was presented by Mark Stables, Service Manager Integrated Learning Disability Service. He advised that John Attrill sent his apologies for today as he was currently in hospital after suffering a heart attack. The panel wished John a good recovery. Mark gave the panel two examples of how the patient day service had helped patients though organising activities for them which had helped them to become more independent. One carer had said to Mark recently that they had been very worried about the changes to the service however they could now see that this was the best thing and the day service is wonderful.

In response to questions the following matters were clarified:

- The new developments are saving money a stepped approach over several years. Working with providers to find best solution to do this. This year spend has reduced
- The PFI for Russets at Hilsea has 15-20 years left. The council pay a large amount of money for this. Options include using the building for adult services or try and get out of the contract to use the building for something more appropriate.
- With regard to apprenticeships for people with learning disabilities, Mark said that the chance of employment at the end is not discussed. People are chosen for apprenticeships that have a clear aspiration. It is about being realistic and focussed.
- The panel praised Mark for his approach to the transformation programme. Mark said that it was down to him having an amazing team and also good working relationships with his contacts in the finance and housing teams understanding the vision.

RESOLVED that the update be noted.

10. Portsmouth Clinical Commissioning Group update (AI 10)

The report was introduced by Tracy Sanders, Chief Strategic Officer and Nick Brooks, Communications Officer.

In response to questions the following matters were clarified:

- With regard to workforce, Tracy said that competition is an issue and smarter ways of retaining staff were needed. 860 people were recruited across Hampshire last month. 810 people were lost and 700 of these were the same people who moved positions.
- The Aligned Incentive Contract does spread the risk and is about giving hospital the certainty about income. The Aligned Incentive Contract will help overcome obstacles and is about paying people to deliver an outcome. It is early days however PHT and the CCG are fully focussed on this.
- With regard to the Queens Road surgery closure, as of yesterday 80% of patients had been re-registered at other GP practices. The capacity is there in other surgeries and patients have been supported through this process.

The Big Health Conversation

Nick Brooks summarised the engagement that had already taken place on the Big Health Conversation. The first phase had started in spring. Phase 2 will begin in July/August.

In response to questions the following matters were clarified:

- There were nearly 2,000 respondents across the patch however the response from Portsmouth was disappointing with 311 respondents. The figures in the report are just a sample and the free text section of the questionnaires is now being reviewed. At this stage Nick advised that there was an idea about the general directions and now needed to put in the detail.
- Survey respondents recognised that the NHS needed to change. Respondents were asked about seven day access to NHS services and there was no clear answer. The three main preferences were urgent care should be a priority for weekends (36.6%); all NHS services should be available every day (29.7%) however 22.4% believed that there were already enough NHS services available at the weekend.
- Phase 2 would have greater weighting on face to face discussions with the public.

The panel felt that the initial results from the engagement were encouraging and would welcome an update at a future meeting.

RESOLVED that the update be noted.

11. Southern Health Foundation Trust - Update (AI 11)

Mark Morgan, Director of Operations for Mental Health, Learning Disability and Social Care presented the report. He added that there had been an incident at Melbury Lodge in Winchester in 2015 where a patient had been able to climb onto the roof and had fell causing injuries that will affect him for the rest of his life. There had been other incidents where patients had managed to climb onto the roof. The CQC had prosecuted the Trust and the case was heard in court today where the Trust pleaded guilty. The judge

adjourned the case for sentence to October. It was likely that the Trust would be required to pay a fine.

Following the CQC inspection earlier in the year the warning notice had now been lifted and excellent progress was being made on the action plan. With regard to leadership of the Trust, he explained that interviews for the Chief Executive Office would take place on 18 July and the new chairman would be in post from Monday 3 July.

The panel were impressed with what they had read in this report and heard today, particularly with staff communication. The panel were also pleased to note that the trust had admitted that they were in the wrong regarding the incident at Winchester and taken full responsibility and done very well at rectifying the situation.

RESOLVED that the report be noted.

12. Dates of Future Meetings (AI 12)

The panel noted the dates of future meetings as follows:

Thursday 14 September 2017
Thursday 23 November 2017
Thursday 1 February 2018
Thursday 22 March 2018

All meetings will start at 1:30pm.

The formal meeting endedat 12.50 pm.

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Councillor Leo Madden
Chair

Report to: Health Overview & Scrutiny Panel

Date: 14th September 2017

Report By: Mandy Sambrook, Operational Director Integrated Adults Services and Mental Health Services Portsmouth Care Group (Solent NHS Trust)

Simon Nightingale, Adult Social Care Senior Business Manager

Paul Thomas, Integrated Discharge Service Lead (Queen Alexandra Hospital), Southern Health Trust

Subject: Update on the Accountable Care System (ACS)

1. Purpose of Report

To Provide an update on the Accountable Care System (ACS) - specifically:

- The impact on Delayed Transfers of Care and Patients Medically Fit for Discharge
- The Integrated Discharge Service (IDS)
- Solent NHS Trust Community Services

2. Recommendation

That the Health Overview & Scrutiny Panel notes the content of this report

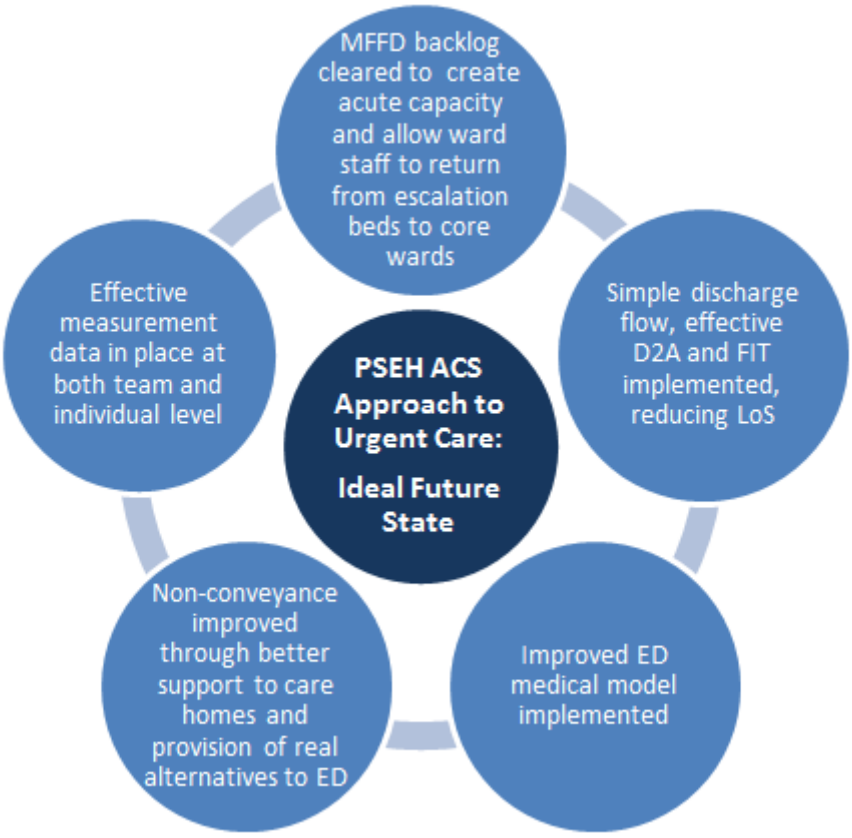
3. The impact on Delayed Transfers of Care and Patients Medically Fit for Discharge

3.1 In June 2017, an initiative to clear the backlog[1] of medically fit for discharge (MFFD) patients at Portsmouth Hospitals NHS Trust (PHT) as one element of the solution to achieve the ideal future state for PSEH urgent care services was agreed.

3.2 The below diagram demonstrates that there are several initiatives that needed to be implemented to achieve the future state. On 05 April 2017, the PSHE ACS Board agreed the first 3 priorities to achieve the ideal future state:

- Clear MFFD backlog-a one off initiative
- SAFER – simple discharge flow- requiring full implementation as 'business as usual'
- New medical model in the emergency department (ED)- requiring full implementation as 'business as usual'

[1] Throughout this report the term 'backlog' is used to describe the demand gap against current business as usual levels.



3.3 The delivery of these three programmes is crucial to achieving flow (particularly MFFD and SAFER) and quality in the emergency department. Our view is that clearance of the MFFD backlog will enable SAFER to be more successfully implemented.

3.4 In addition to the first 3 priority areas, there are other specific areas that will need to be addressed in time. Although these were not seen as the immediate priorities, their implementation is necessary to create the improvements required to be able to manage urgent care demand and flow effectively. Specifically these initiatives are:

- Full implementation of the frailty interface team and Integrated discharge service
- Reducing length of stay through the introduction of a dedicated Frailty Unit.
- Reduction in Care home conveyance to ED
- Reduction in Faller conveyance to ED

3.5 The number of patients at PHT who were declared medically fit for discharge, but who were still in hospital back in June 2017 – the "MFFD backlog[2]" was consistently around 250 patients. This represented over

[2] Taken from 0 days to longest stay medically fit

4000 bed days lost and contributed to clinical harm, likely to have long term impact on the re-ablement potential of individuals.

3.6 Although the IDS and discharge to assess (D2A) models have been in place since September 2016, they have struggled to deliver the expected outputs for various reasons, including:

- Other supporting systems had not been in place e.g. SAFER, Bedview, electronic reporting
- Continual increase in the number of referrals to IDS – due to rising patient complexity or lack of understanding of wards of the IDS role, lack of collaborative working between the wards and IDS – patients are referred with the expectation IDS will take over the discharge completely
- Resources in place are not maximised - inappropriate patients in pathway 2 beds because of hospital status
- The system is used to being in crisis

3.7 Instead of relentlessly focusing on the root cause of delays, there has been too much effort focusing of the problems that are demonstrably not the root cause and expending effort on initiatives that cannot possibly solve the issue.

3.8 Patients declared MFFD do not need to be in an acute bed, but they may require further support in the community. Patients who require further support can be discharged into one of 3 pathways:

- Pathway 1: home with support – for patients whose needs can safely be met at home and who are cognitively/physically safe between visits. Some of these patients will be End of Life (EoL)[3].
- Pathway 2: community rehab bed – for patients who are unable to return home and require further rehabilitation and reablement
- Pathway 3: complex assessment – for patients who are unable to return home, have complex needs and may need Continuing Health Care (CHC). Some of these patients may be EoL, if they are unable to return home to die.

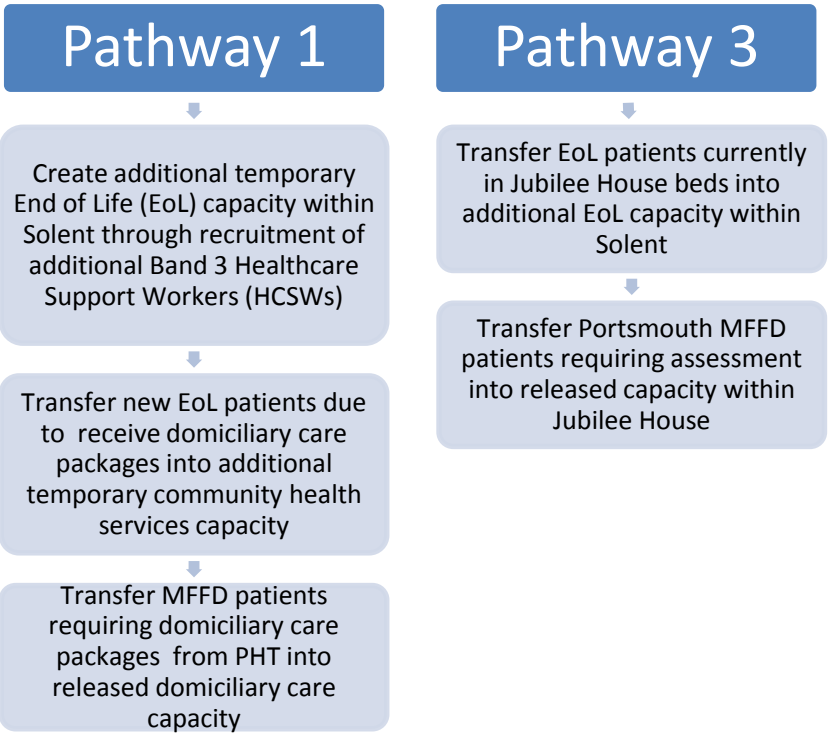
3.9 PHT have identified the optimum length of stay for any patient once medically fit should be no longer than 7 days. Our ambition is to aim for the D2A business case targets. Some MFFD patients at PHT were waiting significantly longer than this, caused by a number of potential reasons:

- Patient is awaiting assessment

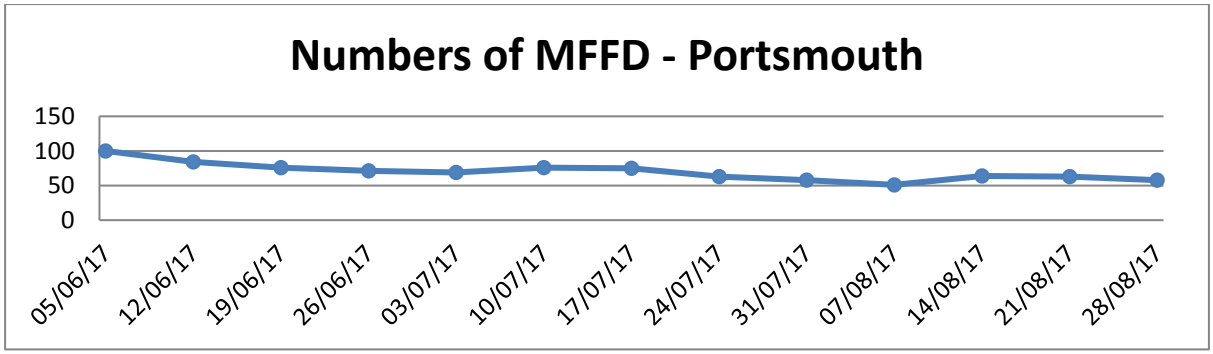
[3] Throughout this report EoL care is determined as patients with a life limiting illness who are in the last stages of life (4-6 weeks) or Fast Track Continuing Healthcare (NHS England – National Framework for Continuing Healthcare).

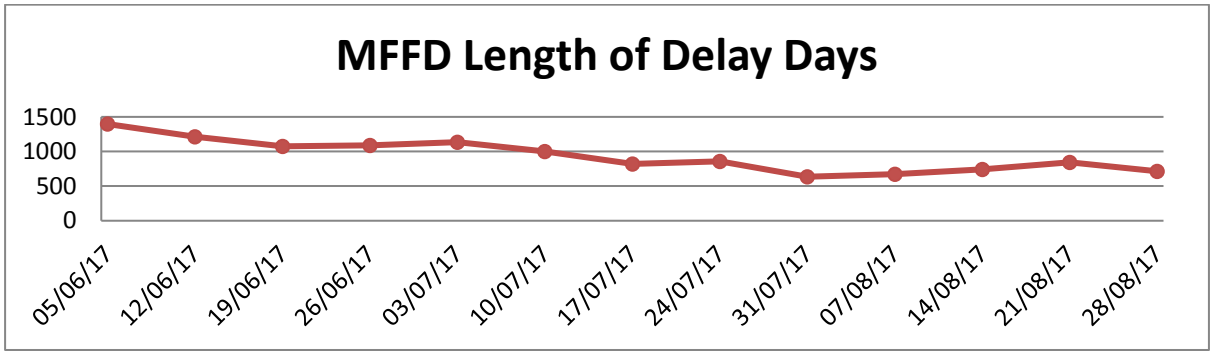
- Patient is awaiting an appropriate care package
- Patient is awaiting a community rehab or complex assessment bed to become available
- Patient is awaiting funding agreement
- Patient is awaiting equipment

3.10 The intention to clear the MFFD backlog at PHT to the agreed level of no one waiting more than 7 days for the Portsmouth system was to create temporary additional capacity outside of hospital (in both pathway 1 and pathway 3). This would be achieved by:



3.11 As can be seen from the below graph and accompanying evaluation presentation, the Portsmouth response to clearing the MFFD backlog has been successful in that it, along with other initiatives, has reduced the length of stay of patients. However, due to the other elements (Safer and New Medical Model) not yet being implemented, the desired outcome to close escalation beds within PHT and to be in a position now to decommission this End of Life service has not been realised.





3.12 The next steps for the additional temporary End of Life (EoL) capacity within Solent is to move resources to the community to prevent admissions to the PHT where possible along with ownership over cases and better interface with the 'front door' services of PHT to ensure patients do not stay in PHT any longer than is absolutely necessary.

4. The Integrated Discharge Service (IDS)

4.1 The Vision

To develop and implement an expert complex discharge team, that works in a seamless and integrated way across partner organisations both health and social care. The Integrated Discharge Service (IDS) will proactively 'pull' and case manage a range of patients with complex discharge needs and progress these patients safely to discharge via an appropriate pathway (usually Discharge to Assess – D2A.)

The model is focussed on the team providing a service to the wards of the Queen Alexandra Hospital (QAH) by providing expertise and advice in the safe and effective discharge of patients with complex discharge needs and acting as an expert to support discharge planning for the wards.

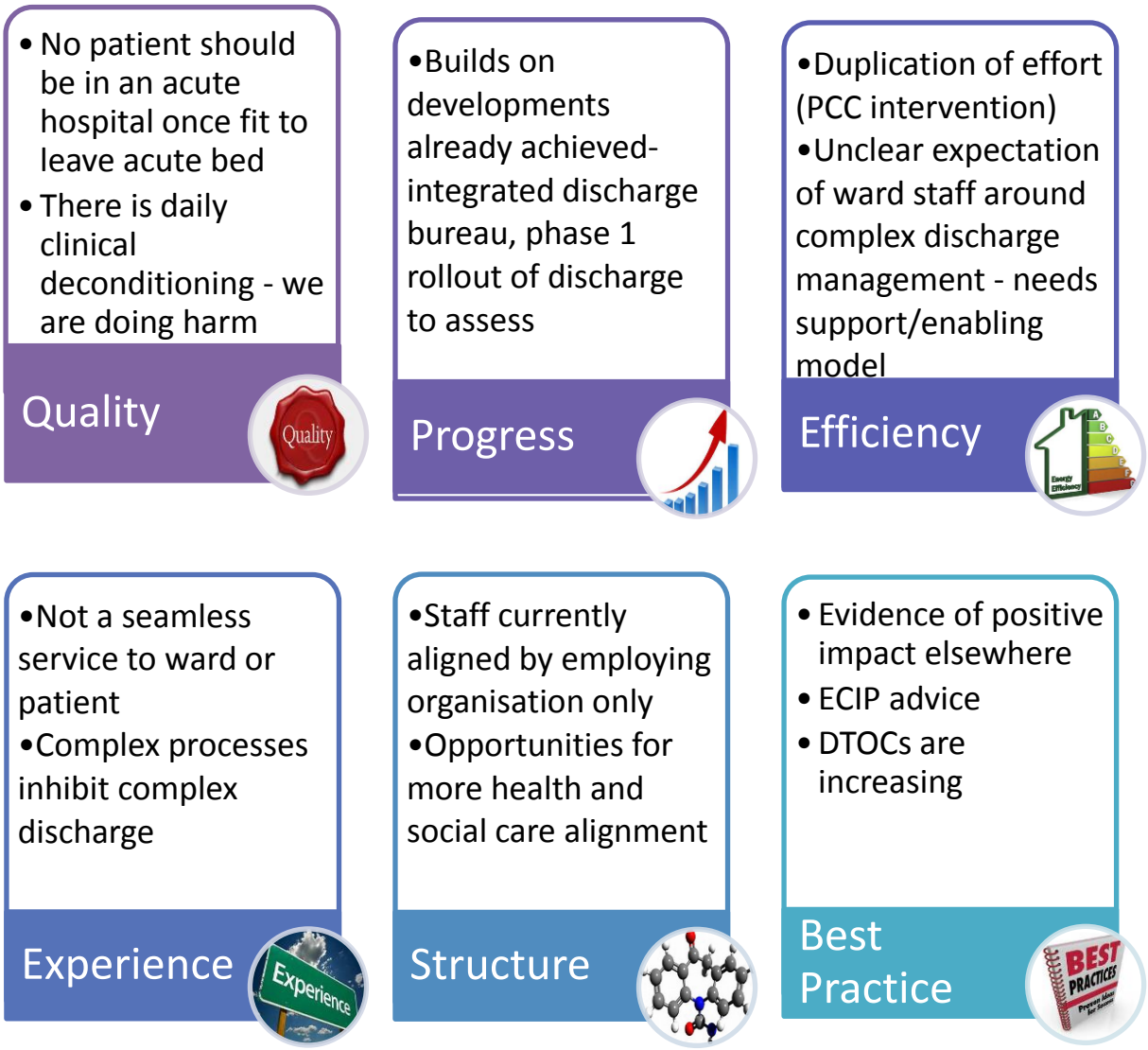
4.2 The Aims

- There is a need to provide a service to support the discharge or transfer of patients with complex needs as soon as they are medically stable to leave the acute hospital.
- There is a system cost benefit in reducing length of stay (saved bed days.)
- Early identification of patents with complex discharge planning needs is essential to ensure potential discharge issues are identified early in the patient pathway, and mitigate the risk of delayed discharge.
- To enable the effective use of discharge to assess pathways and available community capacity.
- To improve the quality of care and patient experience by providing high quality discharge options.
- To provide a consistent level of service, and reduce unnecessary duplication through the use of a trusted assessment model.

4.3 What difference does it make?

- Reduces LOS
- Reduces DTOCs
- Reduces MFFD figure
- We stop doing harm by enabling patients to leave hospital when they should
- Benefits to ED 4 hour target
- Happier staff – what we do adds value and we feel we are making a positive difference to people's lives
- Enables D2A to succeed
- Improves relationships with wards – mutual support and engagement

4.4 **Rationale to support the model**



5 Solent NHS Trust Community Services

The original case for Solent was to implement discharges for the EOL pathway, early indications in the pilot demonstrating that there was not the appropriate case load of patients within acute system to meet the EOL criteria in the business case.

Solent NHS Trust was responsive and developed contingency plans to ensure they could move patients to enable flow through the system.

This required a review of patients delayed in both QAH pathways and community beds. This also enabled the review of EOL cases within community nursing.

The presentation accompanying the report demonstrates flow was created throughout the system both at PHT and Community Services into PRRT. The teams

offering support to EOL care in community nursing from a health and social care perspective benefiting patients.

The ability to mobilise this project was reliant on current teams flexing their criteria and back filling with bank and agency whilst HCSW recruitment induction and training was ongoing.

Trajectories and targets to support the MFFD discharge has been challenging as highlighted within the report.

The key deliverable in this area is to focus on admission avoidance and turn around at the front door.

The original trajectory was based at the back log at that time, with continued increase of patients coming onto the MFFD further work is required to understand the DTOC and MFFD differential with a developing focus on patient safety and continued support in the pathway.

Mandy Sambrook, Operational Director Integrated Adults Services and Mental Health Services Portsmouth Care Group (Solent NHS Trust)

Simon Nightingale, Adult Social Care Senior Business Manager

Paul Thomas, Integrated Discharge Service Lead (Queen Alexandra Hospital), Southern Health Trust

Evaluation Medically Fit For Discharge Pilot

Mandy Sambrook Operational Director

Linda Stead Integrated Operational Manager

Suzanne Hogg Urgent Care and System Lead

Simon Nightingale Portsmouth Commissioning Manager

Aims and Expected Outcomes of the provision of the End of Life Service

- To provide personal care to end of life patients who meet the referral criteria for the service.
- To provide choice for end of life care patients who wish to receive care at home.
- To support the system to enable patients that are medically fit for discharge from acute care to be discharged in a timely and safe manner.
- To use the learning and monitoring, to inform long-term modelling piece of work.
- To give real choice to patients that wish to die at home.

EXPECTED OUTCOMES:

- Reduction in the delayed transfers of care for Portsmouth 'fast track' patients being discharged from hospital or Jubilee.
- Reduction in the numbers of delayed transfers awaiting care packages from Spinnaker, PRRT.
- Reduction in the numbers of delayed transfers awaiting Pathways 1 and 3 from QAH.
- A reduction in the numbers of DSTs undertaken for Portsmouth patients in QAH.
- Overall reduction in the numbers of MFFD patients for the Portsmouth system.
- An increase in patients that wishes to die at home, being accommodated.
- An increase in domiciliary care capacity within the domiciliary care sector (from ICS).

Implementation

- From the outset, the project ran into difficulties, due to recruitment difficulties (HCSWs) and a lack of patients that met the referral criteria in the early weeks.
- Data informing project inaccurate based on EOL pts for fast track in community and overnight requirement: Wrap around support.
- On the 5.07.17, the service agreed that there needed to be an urgent review of the pathway, to make recommendations on how to meet the trajectory within the 16 weeks timeframe, prior to the onset of winter pressures.

QUALITY

- Training and Induction for all new HCSW implemented (timely).
- Review of Overnight Capacity.
- Quality Impact Assessment within Solent.
- Additional Training Required to meet food preparation standards for HCSW.
- Mortality review for all EOL patients undertaken.
- Supervision and review HCSW survey.
- Integration into community nursing teams delivering locality model.

Alternative delivery plans.

- Weekly meetings daily ops monitoring to review all MFFD and pull.
- Review of all wards and community nursing to pull and admissions avoidance.
- Accept referrals 7 days a week
- Review with private sector capacity to support.
- Commitment to 5 a week into integrated teams increasing over time.
- Immediate start to taking bridging packages that have a start date from PHT into PRRT.
- Collaborative approach for PRRT and Community Nursing, central to patient requirement.
- Review of Business Case moving forward.

Lessons Learnt and Good Practice

LESSONS LEARNT

- HCSW cannot deliver in isolation: Multi Disciplinary Team approach required
- Training and Induction timely
- Two pathways required to maintain flow from Acute and Community Beds: PRRT and Community Nursing EOL
- EOL night sitting and support requirement for isolated patients
- Analyses of data needs to be more robust and accurate

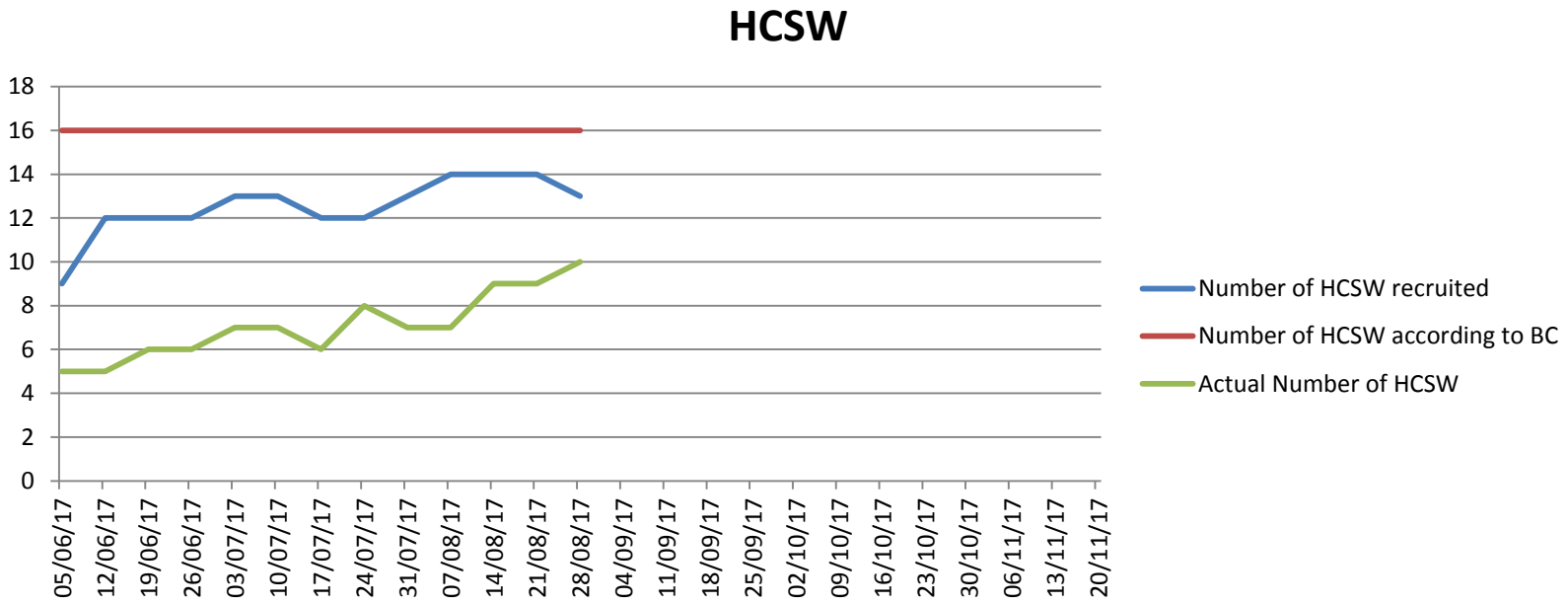
GOOD PRACTICE

- Flexibility and early identification
- Collaboration across organisations
- Patient satisfaction HIGH
- Achieved FLOW in system Portsmouth
- Responsive to system need
- Quality Assured
- Resilience and Sustainability
- Forged relationships

Developments

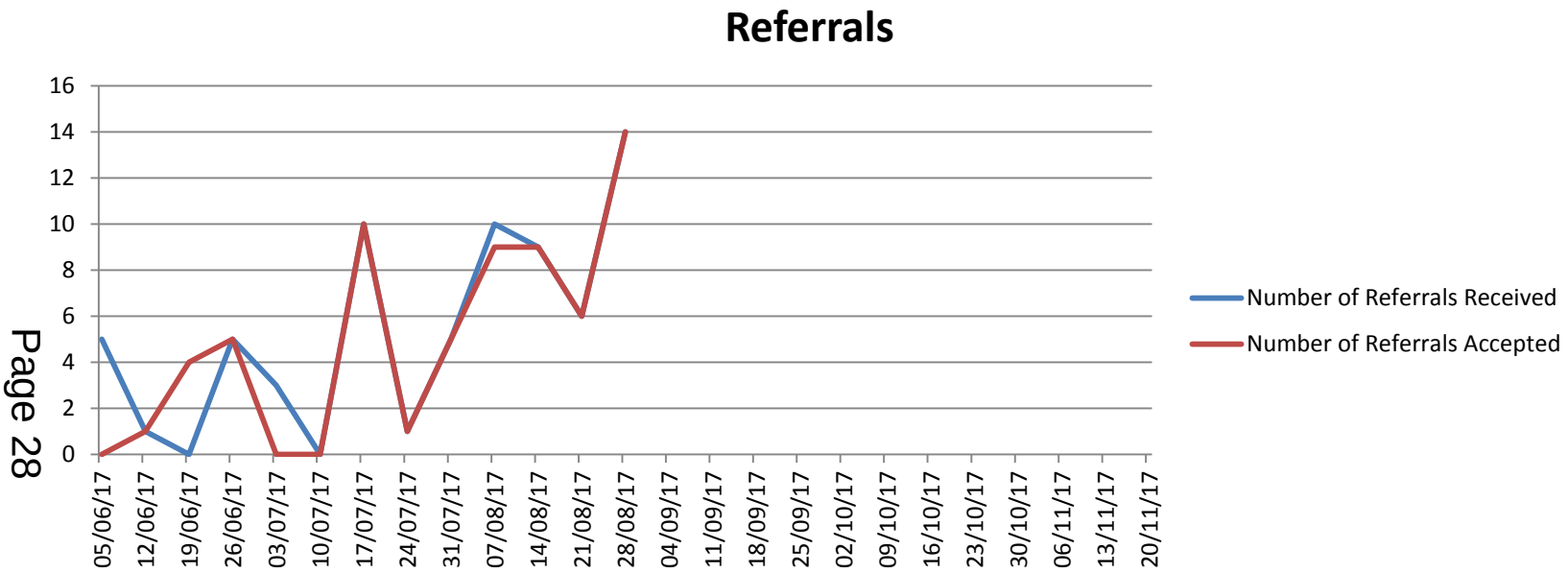
- The development is a foundation for the future in new models of care for keeping patients in the community.
- Learning will be shared and used in developing patient pathways from acute and community.
- The resource will continue to be utilised in modelling the requirements for hospital avoidance and community response Urgent and focused on current pathways of PRRT and Community Nursing EOL.
- Working with Local Authority to Develop Portsmouth Community Neighbourhood Project.
- Reviewing and developing the Portsmouth MCP and intensivist roles.

1

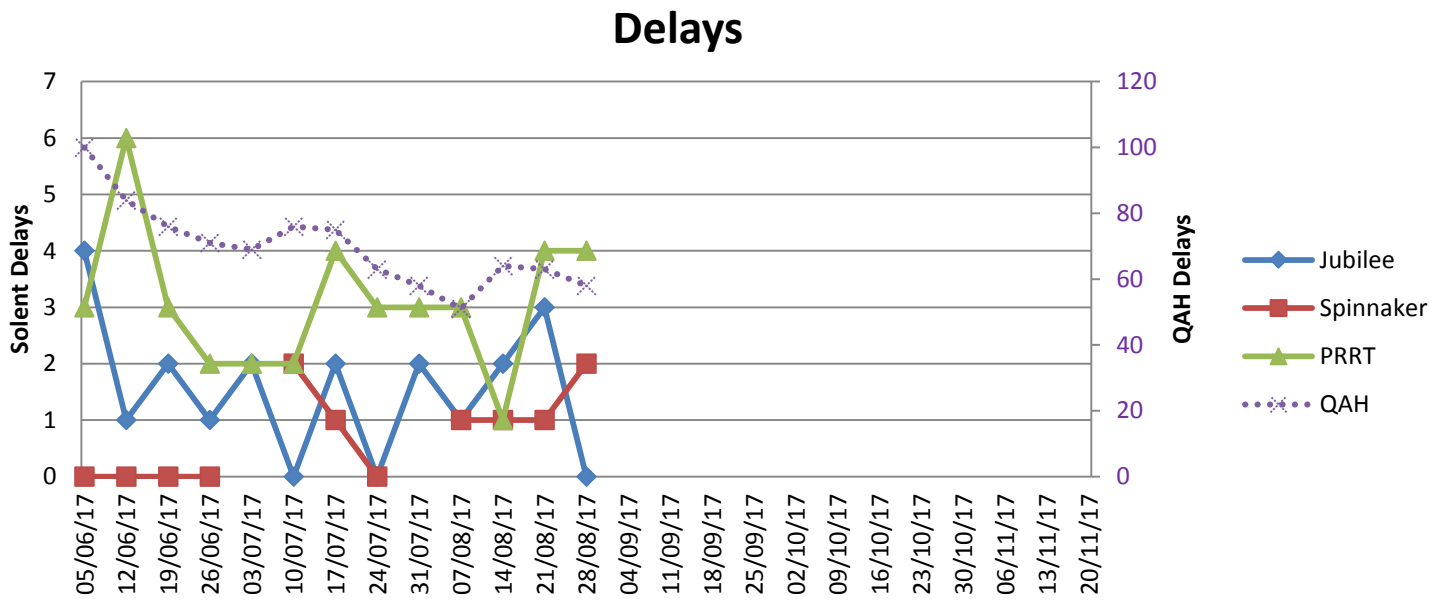


Business case 16. Recruitment has been difficult and required several panels. Final interviews scheduled for September.

2



Total number of packages delivered by 31.08.17 =62.


Delays
Solent Delays
QAH Delays
0
1
2
3
4
5
6
7
0
20
40
60
80
100
120
05/06/17
12/06/17
19/06/17
26/06/17
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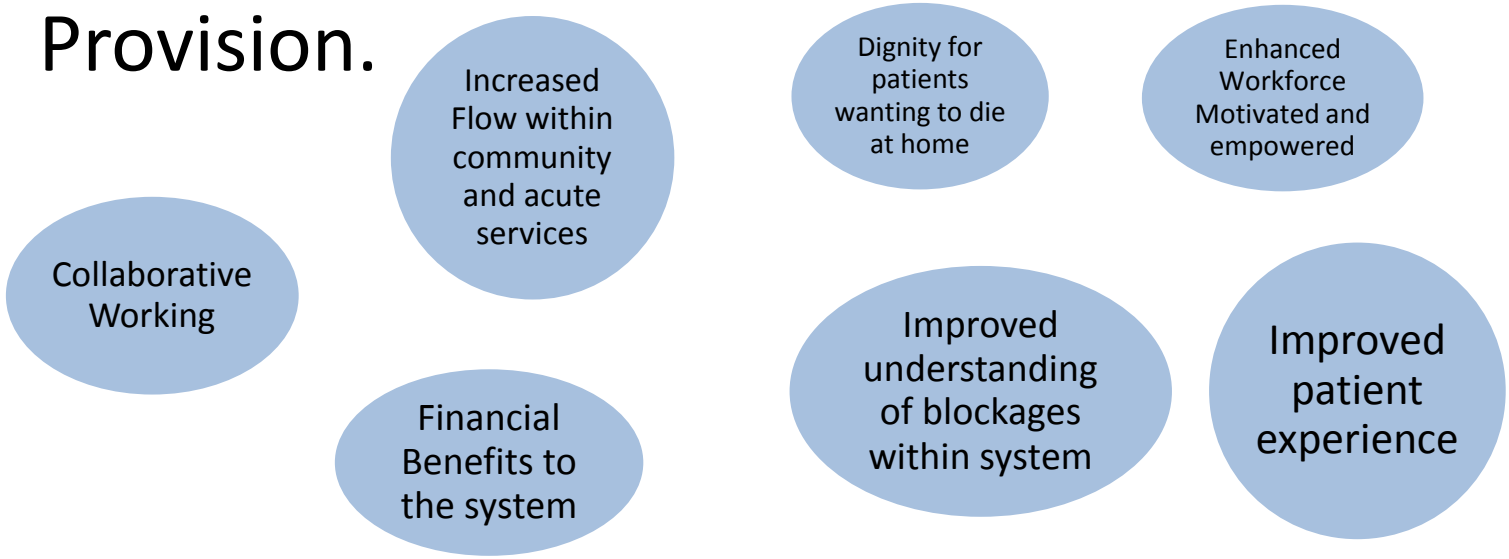
23/10/17
30/10/17
06/11/17
13/11/17
20/11/17
Jubilee
Spinnaker
PRRT
QAH

OUTCOME:

- Considerable benefits to the system and Patients across Health and Social Care Provision.



Foundation for future models of care

Solent NHS
NHS Trust

Next Steps

- Continue the pathway developments in preparation fro Winter pressures.
- Continue to monitor benefits in maintaining flow.
- Develop and Scope Portsmouth Community Neighbourhood Project.
- Integrated pathways review model in PRRT post perfect week.
- Transform service delivery in partnership.

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Portsmouth Hospitals NHS
NHS Trust

Mark Cubbon
Chief Executive

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Cosham
PORTSMOUTH, PO6 3LY
Tel: 023 9228 6376

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

29 August 2017

Via Email

Dear Chair

Update letter from Portsmouth Hospitals NHS Trust

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

I am delighted to have joined Portsmouth Hospitals NHS Trust in the role of Chief Executive, which started on 31 July and I very much look forward to working with you. My background is within the NHS, an organisation that I am passionate about. I trained as a nurse, working in critical care and cardiology. I then moved in to general and senior management roles within the NHS and held Executive roles in a number of high profile London Hospital Trusts before working as Regional Chief Operating Officer for the Midlands and East at NHS Improvement. I am committed to working with patients, championing the best outcomes for each and every one.

I published my 100 day plan in my first week for all to see. My focus is tackling challenges and focussing on stabilisation of the hospital trust. I have four key priorities:

1. Strengthening leadership
2. Addressing urgent care and patient flow challenges
3. Resolving quality and governance issues
4. Developing a plan for financial stability

You will be aware that the Care Quality Commission published their report into emergency, urgent and medical services at Queen Alexandra Hospital. The report made difficult reading and we have fallen short in some key areas, but I am confident that we can and will do better.

I am convinced that we have the skills, dedication and ambition to address all the issues raised by the CQC and ensure we give the best possible care we can to every patient. Since the inspections in February and May the Trust has made some significant and important changes, including strengthening the joint working of our doctors and nurses in the emergency department, urgent and medical services. We have also seen very significant improvements for vulnerable patients, including those who have mental health issues. We have active, early risk assessments in our Emergency Department, a Mental Health Liaison Team, working much more closely together and much stronger cross organisation working with colleagues from partnership organisations.

I am working hard to build stable leadership capability for the Trust and am delighted to welcome Dr John Knighton as our new medical director; John brings a lot of experience to the board and has overseen 'outstanding' rated services at the Trust.

I am also making a number of new appointments to my Board and I am appointing a new Chief Nurse and Director of Communications and Engagement to ensure we better engage with our patients, partners and community.

I will be also focused on a number of initiatives in the coming months to ensure all of our attention is patient focussed. Already in action, but needing a roll out across the whole hospital, is some superb work on the 'Red2Green' campaign. This approach is being used to reduce internal and external delays and can make a real difference to a patient's experience of care. We hope to make this a standard approach across the hospital ensuring we are all respecting the patient's time.

We will also be focused on 'PJ paralysis' which aims to get patients up out of bed and moving. This is a remarkably simple initiative which stops patients deteriorating. This is important because 65% of patients admitted to our hospital are 65 or older and a person over 80 who spends 10 days in a hospital bed will lose 10% of muscle mass. This could be the difference between going home and going to a home.

My colleague Peter Mellor will be happy to further expand on this information and answer any other questions that you might have at the meeting.

Kind regards

Mark Cubbon
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Twitter: @MCUBBON.NHS

Care Quality Commission

Portsmouth Hospitals NHS Trust

Queen Alexandra Hospital

Quality Report

Queen Alexandra Hospital
Southwick Hill Road
Cosham
Portsmouth
PO6 3LY
Tel: (023) 9228 6000
Website: www.porthosp.nhs.uk

Date of inspection visit: 16, 17 and 28 February, 10 and 11 May 2017
Date of publication: 24/08/2017

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Urgent and emergency services	**Requires improvement**
Medical care (including older people's care)	**Inadequate**

Summary of findings

Letter from the Chief Inspector of Hospitals

Portsmouth Hospital NHS Trust is located in Cosham, Portsmouth. The main site provided by this trust is the Queen Alexandra Hospital, which is a 975 bedded District General Hospital providing a comprehensive range of acute and specialist services to a local population of approximately 610,000 people. The trust provides specialist renal services to a population of 2.2 million people across Wessex.

We carried out an unannounced inspection of the Queen Alexandra Hospital on 16, 17 and 28 February 2017, where we inspected the medical care services and the emergency department. We returned on 10 and 11 May 2017 and inspected the key question of 'well led' for Portsmouth Hospital NHS Trust. As part of this later inspection in May 2017 we visited the emergency department, four medical care wards and the Acute Medical Unit (AMU) to review ward to board governance arrangements. During our May 2017 inspection we identified concerns in both the emergency department and medical care wards and AMU, which have been reported on in this February 2017 report. To view our findings and report from the inspection of 'well led' for the Portsmouth Hospital NHS Trust please refer to our website.

We inspected and rated urgent and emergency care and medical care. Urgent and emergency care has been rated as requires improvement overall, and medical care has been rated as inadequate overall.

Our key findings were as follows:

Urgent and emergency care:

- The hospital was not performing well against the national four hour A&E standard; with 67-71% of all patients in the ED being seen within four hours.
- Twelve hour Decision to Admit (DTA) trolley breaches had risen rapidly with 226 recorded between January and March 2017.
- Not all incidents were reported within urgent and emergency care were graded correctly, or investigated thoroughly. Which meant opportunities to learn from incidents were missed.
- The service did not consistently adhere to duty of candour legislation and ensure patients and their families were given open communication when incidents occurred.
- Risk assessments had not been completed or updated for patients who had been in the department for more than 12 hours.
- Patients with mental health conditions were only assessed for their risk of deliberate self-harm which meant other risks may not be identified.
- Staff knowledge of mental health conditions and the Mental Health Act (MHA) 1983, was not sufficient to be able to safely care for patients in mental health crises.
- Staff did not observe patients with a mental health problem often enough, meaning patients had the opportunity to leave the department without challenge.
- There were insufficient staff numbers in the Emergency Decision Unit (EDU) to care for patients who attended the department with a mental health problem. Staffing was not always adjusted according to acuity and demand at any given time.
- Young people (as young as 15 years old) were admitted to the EDU with patients with mental health conditions without additional safeguards being applied.

Summary of findings

- We were not assured that the processes for safeguarding children were effective, or that the bruising protocol for actual or suspected bruising was being followed.
- There were missed opportunities to improve the service. Whilst some improvements with regards to the effectiveness of the area had been noted there were many risks within the department which had not been addressed, or had worsened. The governance system was not addressing these concerns in the emergency department.
- There had been some improvement initiatives in the ED such as the navigator nurse and pitstop and some good areas of practice noted.However, ED performance was showing a downward trend for some areas of performance.
- Staff did not always complete daily checks on emergency equipment within the ED.
- Some specialty consultants were resistive to the medical take model which meant there were delays in patients receiving specialist assessment and/or treatment in the ED.

Medical Care:

- Overall, the quality of care on the medical wards in relation to emergency medical care was very poor.
- Not all incidents were categorised correctly. The quality of investigations was poor, and lessons to be learned or care and service deliver problems were not always identified.
- The trust did not consistently adhere to duty of candour legislation and ensure patients and their families were given open and honest communication when incidents occurred.
- Medicines management policies were not always followed in the acute medical unit and medical wards to protect the safety and wellbeing of patients.
- Patient confidential information was not stored securely and documentation was not always accurate or updated in a timely manner.
- Staff did not always consistently follow infection control procedures on medical wards.
- Consent to treatment was not always obtained in line with the Mental Capacity Act (2005).
- Staff administered medicines covertly and we did not find evidence that appropriate plans of care were in place for patients who required chemical and physical restraint.
- The inspection team had significant concerns about the safety and care of vulnerable people such as frail older persons or patients living with dementia.
- Staff caring for patients living with dementia did not always carry out a dementia assessment or use the dementia pathway.
- Staff did not always recognise or act appropriately in response to serious safeguarding concerns. Staff did not have sufficient knowledge of essential legislation and procedures in order to safeguard patients.
- Staff we spoke with did not have knowledge of the trust's pain assessment tool for patients who could not verbalise their pain.
- There were gaps in the care documentation for the most vulnerable patients who were at high risk of pressure sores.
- Patients, some of which were deemed at risk of malnutrition were not assisted with their meals.
- The trust did not always declare mixed sex breaches as they occurred in line with current guidelines.

Summary of findings

- There were significant concerns regarding the flow of patients throughout the urgent medical pathway. The acute medical unit (AMU) had bed occupancy significantly higher than the England average and escalation areas were consistently in use. This affected waits for cardiac and renal day case procedures. .
- Patients were moved both during the day and night for non-clinical reasons to aid bed availability.
- Some staff were frustrated and demoralised. Levels of staff sickness and staff turnover on AMU were above the England average and showing an upward trend.
- Staff did not feel listened to or connected to senior management. Allegations of bullying and harassment had been made directly to CQC and not all staff were aware of the process to raise concerns within the trust.
- Department risk registers did not always reflect the current risks or demonstrate risks were effectively reviewed or managed.
- Although some strategies were in place to improve the acute medical pathway, there was no evidence to show these had been embedded or had a significant impact on patients' care. . We could not evidence any significant or sustained improvements in medical care since our previous inspections.
- There were shortages of junior medical staff and consultants on AMU. Nursing shifts were not always filled which meant unwell or vulnerable patients did not receive the appropriate level of care and supervision. Staffing was not always adjusted according to acuity and demand at any given time.

We found the following areas of good practice:

- Patients and their relatives told us they generally felt they were well cared for while in the ED.
- Patients were given hot food and drinks if their transfer from the ED was delayed.
- Patients arriving at the ED were seen and assessed quickly by a senior doctor or nurse.
- Staff in the ED followed infection control procedures to reduce the risks cross-contamination.
- ED staff felt more connected with senior managers than on previous inspections and were engaged with initiatives to drive improvements.
- Staff in the ED treated patients and their relatives with dignity, respect and compassion.
- TARN data showed better than national average outcomes for patients with severe or life threatening injuries.
- Between November 2016 and March 2017 93% of patients said they would recommend the A&E service to family and friends, higher than the national average of 87%
- The introduction of pitstop provided a rapid assessment and treatment to patients who attend the Emergency Department.
- The trust had an identified pathway for patients living with dementia that included assessment, liaising with the older persons' mental health team and discharge planning

For the areas of poor practice the trust needs to make the following improvements.

Importantly, the trust must:

- Staff working with patients must have sufficient knowledge and skills to care for patients presenting with mental health condition.
- Staff within the emergency and medical areas must have sufficient knowledge of the Mental Health Act (MHA), 1983, so they understand their responsibilities under the Act.

Summary of findings

- Ensure that all clinical staff have knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards, and implement them effectively.
- Systems must be in place to ensure that the risks of detained patients, including the risk of absconding, are fully assessed and mitigated where possible.
- Review the processes for the safeguarding of vulnerable adults and children to ensure that safeguarding processes work effectively across all services.
- Safeguards must be put in place when children or young people are admitted into adult environments such as the EDU to ensure they are sufficiently safeguarded from avoidable harm.
- Ensure the Local Safeguarding Children Board protocol for the management of actual or suspected bruising must be followed in all situations where an actual or suspected bruise is noted in an infant that is not independently mobile.
- Staff mandatory training should be above the hospital's own target of 85%.
- Patients should not be transferred from ambulance trolleys in the corridor outside pit stop.Staff should move the patient to a more discreet area before attempting transfer, unless urgent transfer is required due to the patient's clinical condition.
- Patients waiting in the corridor for a space to become available in the 'pit stop' area should be either observed by staff at all times or have means of summonsing immediate help if required.
- Staffing numbers and skill mix of staff working in all areas must reflect patient numbers and acuity which should be adjusted according to variations in need.
- Staff in the medical services must follow the trust's medicines management policy to ensure that medicines and prescribed, stored and administered appropriately.
- Patients in the ED must be seen by a senior medical doctor in a timely way following referral to medical services.
- The acute medical model must be immediately reviewed to ensure that patients are seen by a treating physician and treated at the earliest opportunity.
- Equipment must be checked as per individual ward protocols to ensure it is safe and ready for use.
- Risk assessments must be completed to assess the range of risks to patients being cared for in escalation areas. These must take account of environmental factors such restricted access to curtains, call bells and oxygen. These risks must be mitigated where possible.
- Improve quality of incident grading and classification to ensure that they are escalated and investigated appropriately.
- Improve the undertaking of duty of candour and being open following incidents.
- Improve flow through the hospital to prevent patients being cared for in the ED for longer than necessary.
- Patients must not wait on trolleys for more than 12 hour periods in line with national standards.
- The hospital must declare mixed sex breaches as they occur in line with Department of Health guidance.
- Improve processes to enable staff to safely speak up about concerns. All staff must know how to raise issues regarding bullying and harassment.
- Protect patient's confidentiality through safe storage of records.

Summary of findings

In addition the trust SHOULD ensure:

- Conversations between the navigator nurses should be held in a private area to preserve the patient's dignity and respect.

Following the inspections of the Queen Alexandra Hospital in February and May 2017 we took immediate action to ensure the safety of patients. We have taken this urgent action as we believe a person will or may be exposed to the risk of harm if we did not do so. Details of this action are included at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	**Requires improvement** 	The emergency department has been rated requires improvement overall. With effective and caring rated as good, responsive and well led rated as requires improvement and safety rated as inadequate. Incidents were not always thoroughly investigated which meant actions were not identified and lessons were not being learnt. Some daily checks on emergency equipment were not routinely carried out. Staff compliance with mandatory training requirements fell short of the hospitals target of 85%. Staff knowledge of mental health conditions and the Mental Health Act (MHA), 1983, was not sufficient to be able to safely care for patients in mental health crises and meet the needs of all patients in this area. There were insufficient staff numbers in the Emergency Decision Unit (EDU) to care for patients with a mental health condition. Staff did not observe patients with a mental health condition often enough, which meant that patients had the opportunity to leave the department without challenge. Patients were assessed only for their risk of deliberate self-harm. This meant patients were experiencing other psychiatric disorders may not have their risks accurately identified. Vulnerable young people were admitted into the EDU with adult patients, many of which were in mental health crises. We were not assured that the processes for safeguarding children were effective within the emergency department or that the bruising protocol for actual or suspected bruising was being followed. Patients waiting in the corridor were not always observed by staff and had no means of summoning urgent help if required. Flow through the department was often compromised by a lack of available hospital beds. The hospital was not performing well against the national four hour A&E standard, with 67-71% of all patients in the ED being seen within four hours. Twelve hour trolley decision

to admit breaches had risen rapidly with 226 recorded between January and March 2017. There were delays for patients referred to acute medical services to be seen by a senior medical doctor.
However,
Patients and their relatives told us they generally felt they were well cared for while in the department.
Patients arriving at the department were seen and assessed quickly by a senior doctor or nurse.
Staff were aware of infection control procedures.
Security staff were the only staff group who demonstrated excellent knowledge and understanding of the Mental Health Act, 1983 and the Mental Capacity Act, 2005.
TARN data showed better than national average outcomes for patients with severe or life threatening injuries.
There had been increased staff engagement via lunchtime drop-in sessions and multi-disciplinary staff engagement meetings.
The development of the new pitstop area had reduced the number of patients who had to wait in the corridor and helped to reduce the amount of time it took for patients to see a doctor.

Medical care (including older people's care)

Inadequate ●

Medical care has been rated Inadequate overall.
With safe, caring, effective and well led rated as inadequate and responsive rated as requires improvement.
Overall the care provided within this service was very poor. Staff did not always recognise and act appropriately in response to serious safeguarding concerns. Consent to care and treatment was not always obtained in line with the Mental Capacity Act (2005). Staff administered medicines covertly and we did not find evidence that appropriate plans of care were in place for patients who required chemical and/ or physical restraint.
Staff did not robustly assess, monitor or manage risks to patients. Risk assessments had not been completed or updated for all the escalation areas and additional beds in use. Vulnerable patients such as frail older persons and patients living with dementia did not have their needs appropriately assessed and risks for those patients were not sufficiently mitigated.

Summary of findings

Medicines management policies were not always followed in the acute medical unit (AMU) and medical services. Patient confidential information was not stored securely. Staff did not always consistently follow infection control procedures. Staff did not always respond to patients when they asked for assistance. On some occasions, the inspection team had to request that staff intervene to maintain patients' safety. Patients, some of which were deemed at risk of malnutrition were not assisted with their meals.

The trust did not always declare mixed sex breaches in line with current guidelines. Not all incidents were reported, and some were categorised incorrectly. Care and service delivery failures were not always correctly identified during investigations of incidents. The trust did not consistently adhere to duty of candour legislation and ensure patients and their families were given open and honest communication when incidents occurred.

AMU had bed occupancy significantly higher than the England average and escalation areas were consistently in use. Patients were moved both during the day and night for non-clinical reasons to aid bed availability. Patients did not have timely access to discharge from hospital.

Staff were frustrated and demoralised. Levels of staff sickness and staff turnover on AMU were above the England average and showing an upward trend. Staff did not feel listened to or connected to senior management. Allegations of bullying and harassment had been made directly to CQC and not all staff were aware of the process to raise concerns within the trust.

Governance processes were not effective at identifying risks and improving the safety and quality of care and treatment. There was no clear or formal strategy to improve the urgent medical pathway and we could not evidence any significant improvements since our inspection in September 2016. The urgent medical pathway was still medically led and not all consultants were supporting necessary changes in the urgent medical pathway.

Not all staff had completed their mandatory training and the compliance for some staff groups was significantly lower than the hospital target. Not all

Summary of findings

staff completed safeguarding adults training to the appropriate level. Competency assessments for both permanent and agency nursing staff were not always in place.
However,
There was a standardised pain assessment tool was consistently in use which supported the management of pain in patients who could communicate verbally. Some patients and relatives praised the care they received on the renal day unit (RDU) and AMU.

NHS
Portsmouth
Clinical Commissioning Group

"YOUR BIG HEALTH CONVERSATION"
Progress report – September 2017

1 INTRODUCTION

During February and March the three clinical commissioning groups (CCGs) serving the Portsmouth and south east Hampshire area began the "Your Big Health Conversation" process.

The engagement activity is designed to support the development of new systems of NHS care both within Portsmouth, and across the wider local health economy. However, the engagement in the early part of 2017 was very explicitly intended simply as 'phase one' of a longer process. The initial phase was intended to do two specific things – to begin a 'plain English' conversation with local people about the challenges facing the NHS in this area and the likely consequences of those challenges, and secondly to start the process of gathering feedback about potential changes to services in the future.

It is important to note that this process is not a formal public consultation, and does not currently relate to any specific decisions concerning service change. The feedback received to date is intended to inform the next steps, but does not dictate them.

2 ENGAGEMENT TO DATE

A survey was developed to be disseminated across the local area. The questionnaire was available online, and hard copies were distributed.

The survey was promoted in a variety of ways – it was prominent on the websites of all three local CCGs, it was promoted via social media, and news media, and also through a network of contacts in the city – partner organisations, stakeholders, GP surgeries and Patient Participation Groups, and other patient and public representative groups.

3 WHO RESPONDED

Across the whole local health system – the areas covered by the CCGs serving Portsmouth, Fareham and Gosport, and South Eastern Hampshire – there were a total of 1,950 responses. Of those, 311 were from people reporting that they were resident in the PO1 – PO6 area.

Of that group, almost 32% were aged under 45 (a notably higher proportion than was the case for the sample as a whole), and only 19% were aged over 65 (far lower than the overall sample). Only 24% of the Portsmouth respondents were male (35% across the full sample), 89% described themselves as white (94%), 24.5% described themselves as having a disability (20%), almost 38% reported that they cared for an adult friend or relative (37%), and 28% said they had dependent children (17%).

4 FREE TEXT RESPONSES

The scrutiny panel has previously seen the quantitative results from phase one, in a paper submitted for the June meeting, which was augmented by a very superficial textual analysis which only looked at the frequency with which words and phrases were mentioned. What follows is a broader assessment of the qualitative ('free text') responses – these questions were a mixture of two types of questions: stand-alone enquiries seeking people's views on a particular topic (for example what the priorities should be for mental health services), and also "Why do you say that?" prompts for people to explain the reasons for giving a particular response to a previous question.

What should the local NHS do differently?

The most common response was also perhaps the least surprising – many people tended to see this question in terms of resources, although not necessarily purely financial resources. "We need more staff", "Waiting times need to be shorter", the need for more or longer appointments were a recurring theme.

Fewer people referred to wanting specific changes to how services could be accessed, although for a minority this was key – "more walk-in clinics", more appointments at weekends and evenings were the most common responses here.

Another notable theme was the declared preference for local, community based care services. Many respondents saw this as a 'good' in itself, but there was also a sense that people felt that strengthened community services were valuable because of the potential impact they could have elsewhere in the system – especially in terms of easing pressure on the acute sector.

Although the overall numbers were small there was a discernible subset of people who felt that charges should be considered – either for people "misusing" the system by missing appointments, or for people from overseas. Again, only a small number cited a need for better staff behaviour/attitude, relatively few people made unprompted references to the need for better mental health care, and some people felt that money needed to be redirected from back-office/managerial staff to frontline teams.

"Why do you say that?" (Whether the NHS should focus more on community services, on acute services, on mental health services, or does not need fundamental change).

Echoing a theme from the earlier question, and a frequent theme throughout the survey, people expressed the view that a greater emphasis on community services had a beneficial impact across the whole of the local health system. People talked of community services "easing pressure" both in A&E specifically, or hospitals more broadly. There were also repeated references to "bed blocking", and the perception that investment in the community would reduce that number of people unable to leave their inpatient ward – both in terms of getting people discharged from hospital more quickly, but also in terms of how community-based services could stop people needing to be admitted in the first place.

A smaller group just felt that primary and community-based care was the natural, and best, place to invest regardless of wider considerations. People felt that it should be the "first port of call" as a matter of course, and that hospitals should be a last resort, not the default option.

The free text responses did also reveal a number of concerns and criticisms. Most notable amongst these was the sense that people already felt dissatisfied with the way that the NHS – and particularly primary care – was currently coping with demands. Phrases like "I can't get an appointment now", and "we don't have enough GPs now" were not uncommon.

"Why do you say that?" (Whether the NHS should invest more in community services – even if that meant redirecting resources from acute hospitals – to reduce "bed blocking").

There were several similarities between the answers to this question, and the earlier question about whether the NHS needed to rebalance resources between community/acute/mental health sectors.

Once again, respondents demonstrated a basic preference for community-based care – in this context that is notable because the question explicitly set out the notion of a trade-off, that a greater focus on community services may accompany a reduction in the resources for acute hospitals. And once again, there were two distinct sub-themes – those who just saw community-based care as the best, most natural and sensible approach, and those who felt that a greater focus on services close to people's homes was the right option because of the impact it could have in lowering demand for care elsewhere kin the local system.

A minority of people explained their preference for hospital-based care, although few people saw this as a good in itself. Respondents were far more likely to endorse hospital-based care as the best choice in certain circumstances – "sometimes you need their expertise", or "some treatments just aren't available in the community".

There was a relatively small group of respondents who effectively disputed the choice that was being put before them. For this group, the NHS does not need to rebalance the way it spends its resources – it just fundamentally needs more investment. "You can't cut beds", or "hospitals need more beds, not less", or "the NHS needs more money", were typical comments from this group, alongside some others who felt "you need to have both" (increased investment in community and acute services).

"Why do you say that?" (How can the NHS reduce demands on GPs).

The responses suggest that, for a significant number of people, seeing only a GP is not necessarily the be-all and end-all it is often assumed to be. There were a large number of comments expressing the view that other staffing groups (nurses and physios were named in the question) were quite capable of giving people the care they needed: "nurses are highly skilled", and "other members of staff can help – it doesn't need to be a GP". It is worth noting that this group of comments significantly outweighed the number of people expressing the view that "it is my right to see a GP" if that is what they wanted to do.

There was a strong sense of frustration from some that too many people did not display enough common sense, or resilience, and that they needed to take more personal responsibility for keeping themselves well. "People just want instant fixes", "people just need to use more common sense", "people are too quick to go running to their surgery".

Importantly, very few people volunteered the view that pharmacies could play a greater role in offering people alternatives to their GP surgery – that is despite extensive efforts on behalf of the NHS to promote the role of the pharmacy as a key community resource.

"Why do you say that?" (Whether people would be prepared to receive some, specialist, care in larger regional departments rather than at their local hospital).

The most common answer can be summarised as "it's a no-brainer", as most respondents felt that the prospect of better care and better results outweighed the convenience of a particular service being close to home. For many, this was a straightforward truth, and although there was a small number of people who felt that caveats needed to apply – for instance, "there needs to be a limit, though…Southampton maybe, but Bournemouth would

be too far" – that was a more marginal approach. Other comments in this vein included "specialist care is going to be best – that's the point".

A smaller group of people favouring this approach also cited more practical concerns. There was, for some, the sense that – regardless of what might be ideal – it is simply impractical to expect all hospitals to have highly specialist teams working in all specialties. "It just isn't viable" and "you just can't have everything on your doorstep".

On the other side there were clear and understandable concerns about the potential prospect of some services being further away. This group can be very broadly divided into two – the larger group which sees greater distance as a problem in itself because of cost (particularly for those without their own transport), difficulty (especially for the frail and elderly), stress, and parking, and a second group which felt that more remote specialist departments would make it harder for friends and relatives to visit people in hospital. Comments here included "emotional support is part of the recovery process", and "people would be isolated".

There were also minor themes relating to specialisation being seen as particularly efficient for the NHS, and a relatively small number of comments to the effect that all hospitals should be the same, and should all specialise.

"Why do you say that?" (What do people understand by the term "seven day NHS").

Interestingly, although only about one-third of the sample had declared that they felt that all NHS services should be available, seven days a week, the most common free text responses on this topic related to the need for round-the-clock care to be available. "You get ill seven days of the week", or "illness doesn't stop at weekends" were typical of the views expressed on this subject.

A smaller but notable group also made the case for seven-day cover, although clearly prioritised urgent care rather than routine services: "If it's urgent you need help whatever day it is, but if it's not so urgent it can wait until Monday". Fewer people still made the case for the importance of easier access for routine services, usually citing the difficulties that working people may have in accessing care and advice outside the traditional working day, or questioning why they should need to take time off work to get NHS help (or indeed, saying that they simply were not able to take time off).

Among those who were not advocating a more fundamental expansion of weekend services, there were two reasons which were most evident.

For many, it was simply not practical to talk about opening more services on Saturday or Sunday: "We don't have enough staff now", or "services can't cope as it is, so how are they supposed to do more?"

For others, the question itself was essentially considered to be redundant – they pointed to the fact that the NHS was already a 24/7 service. Typically these responses concluded: "The NHS already operates seven days a week", or "if someone needs care at the weekend there are enough services already".

This question was also interesting for what people *didn't* say. Although the national debate about seven-day services has focused largely on issues of safety and quality (particularly revolving around the specific issue of weekend admissions to hospitals, and associated mortality rates), that theme was raised by very few of the sample.

What are the biggest priorities for improving mental health care?

Unlike several of the other questions, this produced a relatively mixed picture, with no clear themes emerging obviously above others. Perhaps predictably, the issue of timely access was the most commonly-cited priority – both in terms of actual waiting times, but also in terms of more convenient access arrangements. People said that they wanted "shorter waiting times", and "quicker access to the support", as well as "more drop-in clinics" and a smaller number who wanted greater opportunities to be able to self-refer to get help.

Other themes were relatively evenly-spread. There were a number of people calling for more, local, inpatient and specialist capacity, but also a group which wanted to see a greater emphasis on community-based support, and more help to keep people living independently at home.

Perhaps surprisingly, the number of people simply calling for more resources – both funding, and trained staff – was relatively low, and there were also only limited numbers of people calling for a greater focus on early intervention, crisis response, and child and adolescent services. It should be noted that there were somewhat fewer substantive responses to this question, reflecting the fact that fewer people had direct experience of mental health services.

What should be the biggest priorities for improving social care?

This question had the lowest response rate, because of the relatively small number of people who have direct experience of social care services. However, it also produced perhaps the most unexpected findings.

The most frequently-cited response – by far – did not relate to the actual delivery of services at all, either in terms of resources, access, or quality. The most common response actually related to service integration. Time and again people called for health and care services to be more seamlessly combined – "pooled budgets", "closer working arrangements", "NHS and social care teams working together", and "make services more joined up" were common refrains.

Of the other responses, there were general calls for better, or more, help to support people to live as independently as possible within their own homes, and some people made the specific call for carers to be given more time to be able to look after people.

Among the more marginal themes there were those asking for carers to be better paid, to have better working conditions, and/or to be better trained, to enable a more skilled and motivated workforce.

5 NEXT STEPS

The findings from the first phase of the "Your Big Health Conversation" were never intended to support or endorse any particular decision or course of action – rather they were intended to support and inform further engagement work.

The findings to date suggest some interesting questions which need further exploration. For example, people may seem to be prepared – indeed perhaps keen – to see more services delivered close to their homes, but how does the NHS do that in the best way, and in a way which does best supports the acute sector to remain strong? How does the NHS balance local expectations (and national policy) regarding seven day services, against the resources available? How does the NHS acknowledge the apparent willingness of local people to see health professionals other than GP, but ensure that people feel they are getting the care that suits them, not the care which merely suits the NHS?

The next phase of Your Big Health Conversation will move away from the largely theoretical approach of the engagement work to date, and instead focus on presenting people with more tangible 'now and in the future' scenarios. It will set out to people how particular groups of people – for instance elderly people with several long-term conditions, parents with young children, someone who has recently been discharged from hospital – will currently receive their NHS care and support, and then sketch out how this might change in the coming years. The intention would be to capture people's views about each of the specific scenarios – what sounds attractive, and why? What is there which concerns people, and why? What needs to be considered, which perhaps hasn't yet been addressed?

The next stage will also mark a move away from relying solely on the web-based survey method of phase one, and seek to devote more energy to face-to-face interaction, with more proactive targeting of relevant audiences.

Initially the hope was that the second phase would begin in the summer, although this is now more likely to begin later in 2017. The expectation is that a further engagement phase (as a minimum) will still be required after the second phase is complete, to allow the NHS to set out in greater detail where the thinking has reached in terms of how the city's NHS may look in the coming years, and how people may access support.

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

Date: **14 September 2017**

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

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

1. Purpose of the Report

To update the Health Overview and Scrutiny Panel on some of the key issues for Adult Social Care up to August 2017.

2. Recommendations

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

3. Update on Key Areas

3.1 Overview:

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

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

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

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

ASC provides a service to approximately 6,000 people throughout the year with a staff compliment of 800 (600 full time equivalent posts) undertaking a wide variety of roles, both in commissioning and direct delivery of services.

4.0 Summary of 2016/2017

During 2016/17 ASC were faced with a number of challenges, not all of which were predictable. These included:

- **Demand for services:**
- ASC has seen an increase in the demand for older people with complex needs requiring larger packages of care. Supporting people to remain at home is what the majority of people tell us they want. This has led to increase in the average weekly cost of people with needs being supported to remain at home.
    - The number of older people receiving domiciliary care from ASC per week as of March 2016 was 951 (via either a Direct Payment (DP) or direct provision) at a total weekly cost of £118,897.16 (£125.10 pw per person). By March 2017 this figure had changed to 957 people at a total weekly cost of £138,843.72 (£145.08 pw per person).
- Whilst the figure above shows an average increase per week in costs, what it does not reflect is the fact that in March 2016 57.51% of people receiving domiciliary care had packages costing less than £100. This reduced to 46.80% by March 2017. Conversely 17.39% of people's packages cost over £200 in March 2016, a figure which increased to 21.95% by March 2017.
- This increase in cost for domiciliary care was due not only because of increased complexity, but also because ASC successfully supports people to remain at home longer, which is reflected in the statistics relating to:
    - Residential care - seeing a reduction in numbers from 258 (March 2016) to 242 (March 2017)
    - Nursing care - seeing a reduction from 147 (March 2016) to 140 (March 2017).
- **New legislation and Court Judgements**

  Of all of the precedents handed down by the Courts that affect ASC, by far the majority concern Deprivation of Liberty. There have been 23 significant judgements that impact on practice in the last 2 years. Which has seen the number of applications since The "Cheshire West" judgement alone increase from 786 in 2014/15 to 1473 in 2016/17. The Supreme Court Judgement in 2016 and subsequent legislation is likely to extend the duty relating to Deprivation of Liberty to people within their own homes. At this stage it is impossible to estimate the impact that this will have on demand and capacity.
- **Acute Hospital Pressures**

  Pressure on Portsmouth ASC to discharge patients more quickly from the acute hospital setting has increased significantly. With the Discharge to Assess model and a general expectation that as soon as a referral is received the team assesses and discharges the patient, care costs and demand on the limited capacity of the provider market to respond, as well as challenges in recruiting and retaining staff within the hospital team saw an increase in delayed transfers of care attributable to ASC, with awaiting allocation being a significant issue. Following some analysis undertaken at the hospital team it was identified that in excess of 40% of referrals for Social Work input from Hospital wards were found to be inappropriate. The introduction and

imbedding of the Integrated Discharge Bureau at QA has had the inevitable teething issues which have impacted on the work of the Social Work team. The team now aim to see people and triage them on the day the referral is received, which has reduced the inappropriate referral significantly and seen an improvement in the number of people awaiting assessments from the team in the hospital.

- **Funding and budget pressures**

  The 16/17 gross annual expenditure for adult social care (ASC) activities was £64.5m. This is funded from a variety of sources. The majority is from the ASC council cash limit budget of £43.4m. ASC funding also relies heavily on income (client assessed charge for care) which was anticipated to be £9.4m in 16/17.

  ASC is also funded by monies from the NHS. This is central Government policy that part of the NHS allocation is transferred to Local Authorities in order to support social care activities. In 2016/17 this NHS funding will come via the Better Care Fund (BCF) which is £7.1m.

  In addition to the increase in population of older people is the rise in the number of people with challenging behaviour resulting from a learning disability. Within Portsmouth, 90 people account for £7.7m of our expenditure.

- **Market sustainability**
- Significant challenges exist in respect of the local market for social care, including cost and sustainability of some services, in particular where there are low rates of pay to staff; local authority rates being challenged as insufficient to provide quality services; and the ability to retain a suitably qualified workforce in competition with surrounding local authorities.
- Whilst ASC has reduced the number of people who are placed in residential care and increased the number of people in receipt of care and support in their own homes, there continues to be a need for nursing home care placements. ASC contracts with Care UK to provide 62 beds in Portsmouth, (in Harry Sotnick House) and the home have had a voluntary suspension in place in 2016/17 which has recently been lifted. This self-imposed suspension has impacted on ASC as it has required placements, which would have been made within Harry Sotnick House to be found elsewhere.
- The environment of the domiciliary care market both nationally and locally is a complex one, a mixture of large national and smaller regional or local companies employing carers often from a limited pool of people, with a growing demand for services. Providers pay staff varied rates, though many use the National Living Wage, (previously National Minimum Wage). A recent court judgement has also legislated for staff who cover 'sleep-in'

shifts to be paid at least the NLW for the entire shift, again increasing cost for providers and PCC

- The national state of the market as reported through the media and regulatory bodies has highlighted concern over the state of domiciliary care; providers 'handing back' Local Authority funded contracts and here; a lack of domiciliary care capacity; the increased cost of domiciliary care; and the overall fragility of the market. In addition, National commentators focus on market funding and linking standards directly to funding.
- During 2016/17 2 domiciliary care providers ceased providing care within Portsmouth. The transfer of packages from these two providers amounted to 820 hours of care per week and affected 75 ASC funded clients as well as a number of privately funded individuals.
- The situation in relation to domiciliary care remains challenging with approximately 550 hours per week currently needed. This situation is variable and reviewed regularly.

- **Better Care Fund**
- The aim of the BCF is to bring about greater integration of Health and Social Care through the pooling of resources. Although creating a pooled fund it is not new money, rather that which is already in the Health and Social Care system now being brought together to enable organisations to integrate services, share risk, and agree priorities.
- Since its announcement in 2013 we have been working closely with local NHS partners to see how we will put in place the principles behind the BCF and how we will make the diminishing resources we have work to best effect.
- The BCF currently funds fieldwork resources, (Social Work and Occupational Therapy) for Older People and people with Physical disabilities and funds the community connector scheme, engaging with people to help manage social isolation and prevent development of need for social care in the future.
- At the spring budget of 2017 the government announced additional monies for adult social care for the next three years, known as the Improved Better Care Fund (iBCF). For Portsmouth the amount equates to approximately £7m over the three years. ASC and the finance support services have produced a financial strategy which sets out the criteria for access to these funds to ensure bids for the money demonstrate sustainable transformation.

5.0 Budget & Savings

- The outturn position for ASC showed a £700k overspend position for 2016/17.

- The saving target for 2017/18 is £1.3m. Progress against savings are reviewed monthly within the service and discussed with the portfolio member. Budget position reported in line with council procedures.

6.0 Priorities for 2017/18

It is proposed that updates against these priorities are reported through the quarterly letters

- To ensure all registered services are adhering to the Care Quality Commission (CQC) regulations & outcomes laid out under the CQC 5 Key Lines of Enquires.
    - As of August 2017 our 3 in house care homes for older people with dementia and our in-house respite unit for people with a learning disability were all rated as requiring improvement at their last inspection. Improvement plans have been developed to address issues raised.
    - The Shared Lives service and Portsmouth Reablement and Rehabilitation Team (PRRT) were rated as Good
- To ensure a fit for purpose training programme for care staff is in place to meet the requirements of the Care Certificate.
    - A new training programme is underway with our care staff to ensure that the requirements of the Care Certificate are fulfilled
- Standardise policies, processes and procedures across the residential services to provide a robust and consistent approach to care for our most vulnerable service users.
    - Significant progress has been made in this area, with a far more consistent approach now in place.
- Provide a detailed and structured activities programme across the dementia services.
    - Work is underway to involve volunteers and community groups to have a greater input into the care homes to supplement the Activities Co-ordinators.
- To work with external partners and third sector to bring new experience to people with dementia & work with social enterprise arenas'.
    - See above
- Complete Roll-in of systems thinking across OPPD services and re-design ASC's initial point of contact.
    - All fieldwork staff in OPPD have now completed the Roll-in process. The ASC Helpdesk has completed the check and redesign phase and presentation on this is due in early September for senior leader to make a decision regarding Roll-in.

- Configure OPPD service model focussed on re-ablement and prevention of unnecessary hospital admission.
    - Work is underway to scope what the service will look like and will be one of the first programmes of work submitted under the iBCF financial strategy. This will also look at options around more effective hospital discharge options and use of existing resources both internally and externally as well as identifying gaps.
- Appoint a Principal Social Worker - **Completed**
- Appoint a lead interventionist and complete systems thinking interventions across all areas of ASC - **Completed**
- Achieve savings targets.
    - Work continues to meet the savings targets set for 2017/18. Achieving these targets is a significant challenge, not least because a number of schemes identified have taken longer to come to fruition than anticipated.
- Agree integrated working methods with community health provider.
    - Senior Managers from ASC and Solent NHS Trust are working with staff to look at a single care plan and referral routes between agencies. Staff are currently co-located and working well together. A joint staff survey has been completed in 1 locality and is being rolled out to the other 2 localities during September.
- Agree a service offer for people with autism.
    - Revision of existing strategy underway
- Replace client record system for ASC.
    - Agreement for replacing the current client record system has been formalised. ASC will be moving to TPP SystmOne, which is used by Solent NHS Trust and the vast majority of GP's within Portsmouth. This will enable a single record for citizens which can be accessed by health and social care partners, with the consent of the individual.
- Re-tender domiciliary care contract.
    - The existing contract is likely to be extended for a further 12 months. This will enable the new models of admission avoidance, reablement to be developed to enable a more robust and sustainable domiciliary care tender to be developed
- Tender for bed based care home resources for people with challenging behaviour.
    - Initial tender for this was unsuccessful, so further work in being done to look at all possible options
- Tender/renew Community Equipment Store contract.
    - Update to be provided in next report

Angela Dryer

Deputy Director Adult Services

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