Portsmouth CITY COUNCIL

Public Document Pack

NOTICE OF MEETING

HEALTH OVERVIEW & SCRUTINY PANEL

THURSDAY, 23 NOVEMBER 2017 AT 2.30 PM

CONFERENCE ROOM A - SECOND FLOOR, CIVIC OFFICES

Telephone enquiries to Jane Di Dino 023 9283 4060 or Lisa Gallacher 023 9283 4056
Email: jane.didino@portsmouthcc.gov.uk lisa.gallacher@portsmouthcc.gov.uk

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

Membership

Councillor Leo Madden (Chair)
Councillor Steve Wemyss (Vice-Chair)
Councillor Yahiya Chowdhury
Councillor Alicia Denny
Councillor Gemma New
Councillor Lynne Stagg
Councillor Michael Ford JP (Fareham Borough Council)
Councillor Gary Hughes (Hampshire County Council)
Councillor Andrew Lenaghan (Havant Borough Council)
Councillor Mike Read (Winchester City Council)
Councillor Elaine Tickell (East Hants District Council)
Councillor Philip Raffaelli (Gosport Borough Council)

Standing Deputies

Councillor Dave Ashmore
Councillor Ben Dowling
Councillor Steve Hastings
Councillor Lee Hunt
Councillor Ian Lyon
Councillor Tina Ellis (Fareham Borough Council)

(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 5 - 12)

RECOMMENDED that the minutes of the previous meeting on 14 September 2017 be agreed as a correct record.

4 Portsmouth Looked After Children and Safeguarding (Pages 13 - 70)

The Care Quality Commission carried out a review into looked after children and safeguarding during the week commencing 17th July 2017, the final report is attached. The report indicated that an action plan is required to take forward the recommendations in the report.

The action plan for each of the organisations is attached and representatives from the following organisations are invited to give a progress report on this.

- PHT (representative TBC)
- Portsmouth CCG (Tina Scarborough, Head of Safeguarding and Public Safety.)
- Solent NHS Trust (Lesley Munro, Chief Nurse and Jonathan Prosser, Clinical Director for Children's' Services)
- Society of St James (Mike Taylor , Operations Director)

5 Solent NHS Trust Update (Pages 71 - 74)

Lesley Munro, Chief Nurse, will answer questions on the attached report.

6 PHT Quality Improvement Plan following the CQC inspection (Pages 75 - 108)

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

7 PHT Update (Pages 109 - 110)

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

8 Local Dentists Committee Update (Pages 111 - 120)

Keith Percival, Honorary Secretary, Hampshire & IOW LDC will answer questions on the attached report.

9 **CQC Update** (Pages 121 - 130)

Caroline Bishop, CQC inspection manager will answer questions on the attached report.

10 **Dates of Future Meetings**

For Members to note the dates of future meetings for 2018 as follows:

1 February - at 3pm
22 March - at 1:30pm
14 June - at 1:30pm
13 September - at 1:30pm
22 November - at 1:30pm

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

This page is intentionally left blank

HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held on Thursday, 14 September 2017 at 1.30 pm in the The Executive Meeting Room - Third Floor, The Guildhall

Present

Councillor Leo Madden (Chair)
Councillor Steve Wemyss
Councillor Yahiya Chowdhury
Councillor Alicia Denny
Councillor Lynne Stagg
Councillor Gwen Blackett, Havant Borough Council
Councillor Michael Ford JP, Fareham Borough Council
Councillor Mike Read, Winchester City Council
Councillor Philip Raffaelli, Gosport Borough Council

1. Welcome and Apologies for Absence (AI 1)

Apologies were received from Councillors Gareth Hughes, Gemma New and Elaine Tickell.

2. Declarations of Members' Interests (AI 2)

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

3. Minutes of the Previous Meeting (AI 3)

RESOLVED that the minutes of the meeting held on 29 June 2017 be agreed as a correct record.

4. Single Accountable Care System. (AI 4)

Paul Thomas, Integrated Discharge Service Lead, Portsmouth & South Hampshire and Rob Haigh, Executive Director, Portsmouth Hospitals' NHS Trust, Mandy Sambrook, Operations Director, Solent NHS Trust and Simon Nightingale, Commissioning Programme Manager, Portsmouth City Council introduced the report and explained that:

When the Integrated Discharge Service (IDS) started a year ago more than 4,000 bed days were being wasted. This has been reduced to 2,700.

Although the overall number of Medically Fit for Discharge Patients (MFFD) had not significantly reduced since June, the make-up of those patients had changed and their length of stay had reduced. The number in the Portsmouth system had reduced significantly. Today there are 57 MFFD patients from the Portsmouth area; 15 of whom have been waiting between 0 and 3 day for a complex discharge; 24 have been waiting for more than 3 days; fewer than 10 are waiting for residential solutions or domiciliary care and 8 will be waiting for physio or occupational therapy on the ward. There are significantly more MFFD patients from the rest of Hampshire. The numbers from there have not reduced as quickly. Recruitment of domiciliary care workers has been more of a challenge. An overall number of 108 MFFD patients would be optimal to enable flow through Queen Alexandra Hospital.

Shorter stays in hospital mean that patients require less care afterwards.

In response to questions, the following points were clarified:
On average, approximately 130 patients a day are discharged. On some days more patients are admitted than discharged.

The domiciliary care packages are reviewed regularly to ensure that people can do as much as possible themselves.

The focus is on alternatives to hospital care.

The Portsmouth team has significantly reduced the number of MFFDs by improving co-ordination to access to domiciliary care. Recruitment campaigns have been successful.

It is essential that patients are managed as efficiently and holistically as possible to ensure they receive responsive care that is appropriate for the individual. Many elderly patients do not require a long stay. Like children, they fall seriously ill very quickly but recover quickly also. The longer they stay in hospital, the worse the outcome for them. They often rely on daily activities, such as washing, cooking and shopping to keep fit. Longer stays also impact adversely on other patients who may have their elective surgery delayed.

Oher indicators for patients include length of stays, referrals to consultants and time to complete treatment.

The number of MFFD today would be higher if the co-ordinated approach was not in place.

Partners in the system meet weekly to review the progress made so far.

There is a limited number of Domiciliary Care Workers in Hampshire. Travel distances between visits are longer.

Some patients choose not to accept the option they are offered. It is important to manage patient expectations when they arrive. They may be offered a place at an interim place in a care home for a week or two free of charge. Portsmouth City Council care homes should be in a position to help soon.

The cost of care is greater at the start of a patient's stay. It is still significantly more expensive for a patient to stay in hospital than be at home with a significant care package.

Portsmouth City Council, Clinical Commissioning Groups and Hampshire County Council are committed to investing significant into resourcing domiciliary care more efficiently and effectively.

The focus must be on reducing the number of MFFD patients who have been waiting between 0 and 3 days to prevent them escalating.

Patients may prefer to be at home or a community hospital. It is important to work collaboratively innovatively together as a society.

A significant improvement will be noted in all areas by next summer.

South Central Ambulance Service is the only ambulance service to be rated as good by the Care Quality Commission. There are very few inappropriate conveyance to hospital.

Technical advances, better health and longevity mean that a broader range of treatments are available to a wider range of people and hospital stays are shorter.

This winter's flu is expected to be a virulent strain, so extra capacity is required at the hospital.

The panel noted that NHS and Social Care legislation allows 72 hours for plans to be made for discharging MFFD patients. It also noted that Hampshire County Council and Southampton University Hospitals deal with Delayed Transfers of Care (DToCs) rather than MFFDs.

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

5. Portsmouth Hospital's' NHS Trust - update. (AI 5)

Peter Mellor, Director of Corporate Affairs introduced the letter and in response to questions clarified the following points:

The trust regretted very much that it had needed the Care Quality Commission (CQC) to bring to its attention the problems which had been identified during their inspections.

An increasing number of patients with mental health issues are being admitted. There is one resident psychologist on duty during the day. The CQC had expressed concerns at the delay in accessing an expert in mental health issues to attend and an insufficient number of appropriately trained staff caring for the patient in the meantime.

The CQC also raised concern that not all staff had completed mandatory training. Most of the 7,000 staff are incredibly busy and some find it difficult to attend all of the necessary courses. Access to courses has been improved with more online training available.

PHT had been informed of the more serious findings on the day of the visits. Some of those issues have already been resolved. A Quality Improvement Programme will be discussed shortly with the Clinical Commissioning Group and NHSi. This will be published at the end of October.

The Emergency Department has been under severe pressure over the last two weeks; for no specific reason. This has resulted in some ambulances having had their handovers delayed and on one occasion an ambulance needed to be diverted to Southampton General Hospital. It compounds inefficiency if patients are placed in different wards or corridors – patients need to be in the right bed, within the right ward at the right time. The situation had improved slightly today.

There is a national shortage of staff in some specialities.

Since Brexit, some of the European nurses working in the trust had become very nervous about their future working in England. Some had already left to work in London to earn as much as possible over the next couple of years.

Staff morale is very good overall. They are mainly Portsmouth residents; stoic, loyal and resilient.

A number of nurses from the Philippines are due to arrive soon and at the end of the October newly qualified nurses will arrive. Portsmouth University had introduced a new three-year nursing degree earlier this year. Agency staff are often not as efficient as permanent staff as they need time to familiarise themselves with both the patients and the surroundings. The amount of clinical care that student nurses can perform is limited.

The new Chief Executive is creating a new executive management team.

The trust had been aware of many of the concerns identified by the CQC and was working to resolve them. Some of the failings identified had come as a shock.

The situation had not been helped by the lack of stability within the Trust board. The trust is on its third interim director of nursing and second chief operating officer in one year. A sustainable, consistent, high performing board with aclear direction is required. This is no excuse for the failings that had been identified.

The panel noted that it was waiting for a meeting with the new Chief Executive to be arranged.

RESOLVED that the report be noted and requested that an update on the Quality Improvement Programme be brought to the next meeting.

6. Big Health Conversation. (AI 6)

Nick Brooks, Senior Communications & Engagement Manager, Portsmouth, Fareham, Gosport and South Eastern Hampshire Clinical Commissioning Group introduced his report and in response to questions from the panel, clarified the following points:

The survey was self-selecting and not designed to be representative. There is a basic breakdown of the 300 respondees: mixed age; mostly white; 2/3 women and about one third were carers.

Hampshire residents are happier with the idea of specialist centres.

Many people are concerned with not getting quick access to their GPs.

There may be more involvement of the voluntary and community sectors.

Although there is more health information available than ever before, there is also confusion about how to access services.

People appear to understand the links between different parts of the NHS, and how investing in community-based care could have a positive impact on other services. People also value community-based care as a good thing in its own right, although there is concern about capacity.

RESOLVED that the report be noted.

7. Director of Public Health's Update. (AI 7)

Claire Currie, Public Health Consultant introduced the Director of Public Health's report and in response to questions from the panel clarified the following points:

Jason Horsley, the Director of Public Health has been in place since January. Claire has worked for Portsmouth City Council since April. Dominque Le Touze, Public Health Consultant works part time. Amy McCullough started in May and is a joint post with Southampton, she works part-time.

A map of all the community defibrillators is being drawn up and will be looked at to see whether they are located in high footfall areas and in accessible locations. This may lead to work if there are defibrillators which could be made more accessible such as locating them on the outside of a building rather than the inside.

If a defibrillator was funded by an organisation or community initiative it would not be moved.

A breathalyser scheme for nightclubs will be implemented in the next week or so and will run until December. Door staff will decide when to use the breathalysers. A pilot was carried out in Devon two years' ago and the door staff involved found that it reduced conflict because it depersonalises the situation when customers are refused entry. Fewer pre-loaded customers, means more money will be spent in nightclubs. A staff member who is a joint post between public health and community safety has built up a very good relationship with local businesses.

Drug related deaths are an issue in Portsmouth. It is an indicator where Portsmouth is rated red in the Public Health Outcomes Framework. It is rated the worst in the South East for drug related deaths with 7 deaths per 100,000 people. The average in England is 3.4.

An application has been submitted to the Public Health Transformation Fund to fund a project to encourage older, long term drug users to re-engage with treatment services. In other work a naloxone pen, like an epi-pen, will be made available which can be used in case of emergency which can save lives. This has been done in other parts of the country.

RESOLVED that:

- **The update be noted.**
- **Information on blue-lighting in public toilets to discourage drug abuse be sent to Councillor Raffaelli.**
- **The CQC report which contains the recommendations from the recent CQC inspection of services for looked after children and safeguarding be sent to the panel when published.**

8. Adult Social Care update (AI 8)

Angela Dryer, Deputy Director Adult Services introduced her report and in response to questions from the panel, clarified the following points:

The gap in the number of domiciliary care hours required has reduced from 550 ten days ago to 355 today. The update was given to demonstrate the variability in demand and supply within the market.

Hospitals or care homes that feel that an individual lacks the capacity to make a decision about accommodation or care and support are required to submit an application form to the Deprivation of Liberty team. A Best Interest Assessor and Section 12 Doctor will assess the situation and make a recommendation to a Senior Manager who authorises the decision. Relatives and /or a representative will be involved in the assessment. The decision may be appealed to the Court of Protection. A maximum penalty of up to £4,000/ week can be applied if it is decided that an individual has been illegally deprived of their liberty. To date, Portsmouth City Council has not been fined. Three years ago, the court determined that the correct procedure had not been followed but did not impose a fine.

At the hospital, much time has been wasted on inappropriate referrals to the hospital Social Work Team. This has been for a variety of reasons including hospital staff assuming that if a patient was old, they would automatically require social care. Some patients refuse offers of care made to them.

Communication and joint working as part of the Integrated Discharge Service is very effective and has significantly reduced delays in assessing people.

Portsmouth City Council owns Harry Sotnick Care Home and it is managed by Care UK. The Care Quality Commission identified areas that required improvement during its inspection in 2015/16. A follow-up inspection six months' later revealed that the situation had got worse. Concern was expressed regarding leadership and medicinal management. Care UK applied a self-imposed embargo on admitting people to the home until Spring 2018. A social worker is based in Harry Sotnick to support the home pre-empt any problems.

Given the current challenges in sourcing domiciliary care, an interim placement in a care home has proved successful in some cases as a short term measure. The 24 hour care at home pilot has now been mainstreamed and is providing good outcomes for individuals and some small savings as people are then having care at home rather than residential care.

The Learning & Development Team offers training to private providers at a minimum cost thanks to a grant it receives. The take up has been variable as small companies find it difficult to release staff and larger ones have their own training packages. One solution is to train one member of staff to train the rest of their team afterwards.

Adult Social Care has undergone two years of redesign through Systems Thinking. From receiving a customer request to providing a service hundreds of process steps were identified. Some of the processes have been redesigned and staff trained. The programme is continuing in other areas of the service

Assuming that every predicted saving is made and that there are no unforeseen pressures, the forecast for quarter 1 is £700,000 overspend. The risk margin varies. In the worst case scenario, the balance would be £1.5m deficit. The service is working hard to utilise the new Improved Better Care fund monies to transform social care and provide a sustainable way of working.

RESOLVED that the report be noted.

The meeting ended at 4:40pm.

.....

Councillor Leo Madden
Chair

This page is intentionally left blank

NHS
Portsmouth
Clinical Commissioning Group

Report To: HOSP

Report By: Tina Scarborough, Deputy Director Quality and Safeguarding

Report Date: 08 November 2017

Report Title: Portsmouth CCG Response to CQC's Children Looked After and Safeguarding (CLAS) Review in Portsmouth and Action Plan

Background

On Thursday 13 July 2017 CQC announced that they would be undertaking a review of Looked After Children (LAC) and Safeguarding Children across the health system in Portsmouth. The review was conducted under S48 Health and Social Care Act 2008. The inspectors were in Portsmouth from Monday 17 July to Friday 21 July. They visited Portsmouth Multi-Agency Safeguarding Hub (MASH), Health LAC service, Adults Substance Misuse Services, Adult Mental Health Services, three GP practices, Health visiting and School Nursing Services, Child and Adolescent Mental Health Service (CAMHs) and Portsmouth Hospitals NHS Trust including Emergency Department, Maternity Services and Children's Unit.

The Inspectors reviewed a range of documents, considered the experiences of 100 children by dip sampling to get flavour the services; they also spoke directly with parents and carers and tracked nine cases. In addition the inspectors met with the Designated Nurse safeguarding and LAC, Designated Doctor for Safeguarding children, Designated Doctor for LAC, Named GP for Safeguarding Children, Deputy Director for Safeguarding and Quality and a range of commissioners. They also spoke to the independent chair of the Safeguarding Children Board.

The final report was published on 19 September 2017

20170919 CLAS Portsmouth Final Rep

Action Plan

The CCG coordinated the submission of an action plan to CQC from all the providers involved by 17 October 2017. A draft version of the action plans were also shared with Portsmouth Safeguarding Children Board at an extraordinary meeting on 03 October 2017. Comments from this were incorporated into the action plans prior to submission to the CQC.

CQC Action Plan - 171017 with PH para

The action plan is monitored and followed up through CQC's regional compliance team.

PCCG Progress

Please see attached action plan that gives PCCG progress to date.
The two actions for the CCG only are progressing well.

- Recommendation 2.1: Training has been update and dates set.
- Recommendation 2.2: A DRAFT updated job description for the Designated Doctor for LAC has been prepared and circulated to key parties for comment.

The CCG are working with providers to deliver the remaining actions. PCCG are also engaged with the PSAB Improvement Board and reporting updates on action plans to PSCB.

Review of health services for Children Looked After and Safeguarding in Portsmouth

Children Looked After and Safeguarding
The role of health services in Portsmouth

Date of review:	17th July 2017 to 21st July 2017
Date of publication:	19th September 2017
Name(s) of CQC inspector:	Kaye Goodfellow Elaine Croll Jeffery Boxer Jan Clark Deborah Oughtibridge Hannah Daughtrey
Provider services included:	Portsmouth Hospitals NHS Trust Solent NHS Trust NHS Trust Society of St James
CCGs included:	NHS Portsmouth CCG
NHS England area:	South
CQC region:	South East
CQC Deputy Chief Inspector, Primary Medical Services and Integrated Care:	Ruth Rankine

Contents

Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Portsmouth. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including Clinical Commissioning Groups (CCGs) and NHS England.

Where the findings relate to children and families in local authority areas other than Portsmouth, cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

About the review

The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
  - the role of healthcare providers and commissioners.
  - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
  - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2015.
- Where we found areas for improvement in services provided by health registered services but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

How we carried out the review

We used a range of methods to gather information both during and before the visit. This included document reviews, interviews, focus groups and visits. Where possible we met and spoke with children and young people. This approach provided us with evidence that could be checked and confirmed in several ways.

We tracked a number of individual cases where there had been safeguarding concerns about children. This included some cases where children were referred to social care and also some cases where children and families were not referred, but where they were assessed as needing early help and received it from health services. We also sampled a spread of other such cases.

Our tracking and sampling also followed the experiences of looked after children to explore the effectiveness of health services in promoting their well-being.

In total, we took into account the experiences of 115 children and young people.

Context of the review

The population of Portsmouth taken at the last census in 2011 was 210,029. The majority (98.5%) of residents are registered with a GP practice that is a member of NHS Portsmouth Clinical Commissioning Group (CCG). The latest published information from the Child and Mental Health Observatory (ChiMat) shows that children and young people under the age of 20 years make up 24.1% of the population of Portsmouth, with 19% of school age children being from an ethnic minority group. Generally, data shows that the health and wellbeing of children in Portsmouth is mixed compared with the England average.

The proportion of children under 16 living in low income families is 24.0%, significantly worse than the regional average of 14.7% and the England average of 20.1%. Family homelessness is also significantly worse at 4.2 per 1,000 as opposed to 1.6 regionally and 1.9 for England. The number of children in care is greater than the regional and England average with 73, as opposed to 52 and 60 per 10,000 respectively.

The infant (aged 0 to 1 year) mortality rate is lower than the regional and England average with 2.6 per 1,000 live births as opposed to 3.2 and 3.9 per 1,000 respectively. Furthermore the child (aged 1 to 17 years) mortality rate is significantly lower to the region and the rest of England at 6.6 per 100,000, compared with 10.7 and 11.9 per 100,000 respectively.

The ChiMat data shows a generally poorer picture for the general health of children and young people in Portsmouth with most of the attributes measured being worse than the rest of England. A minority of those attributes are similar to or slightly better than the England average. For example, immunisation coverage for all children is better than the national average, including the coverage for children in care which is significantly higher than the local and national average.

The rates of hospital admissions due to injuries, for both children aged 0 to 14 and young people aged 15 – 24, is significantly lower than the local and national averages. Furthermore the number of hospital admissions of young people with mental ill health conditions and young people aged up to 19 for asthma are lower than the national average. However, hospital admissions for those over 15 years due to substance misuse and for young people over 10 years through self-harm are significantly higher than both the local and national averages. Admissions for young people under 18 due to alcohol specific conditions were similar to the national picture but worse than those regionally.

The rate of under 18 conceptions is higher than both the local and national average. Obesity in children aged 4 – 5 years and in children aged 10 – 11 years is worse than the region and but similar to England. The rate of children with one or more decayed, missing or filled teeth, however, is significantly better than both the region and the rest of England.

The Department for Education (DfE) provide annual statistics derived from outcomes for children continuously looked-after. As at March 2016, Portsmouth had 225 children who had been continuously looked-after for more than 12 months (excluding those children in respite care), 30 of whom were aged four or younger.

The March 2016 DfE data indicates that nearly all of Portsmouth's looked-after children (97.8%) had received an annual health assessment, well above the average regionally (86.8%) and for England (90.0%). Furthermore, 100% of looked-after children aged under five had an up-to-date development assessment as opposed to 83.2% for the rest of England. As mentioned above, the DfE data indicates that 95.6% of looked-after children were up-to-date with their immunisations, higher than the England average of 87.2% and regional average of 82.1%. In addition 93.3% of looked after children had received a dental check compared with 84.1% in England as a whole and 86.5% regionally.

The commissioning and provision of most health services for children and young people are carried out by NHS Portsmouth CCG. Commissioning arrangements for looked-after children's health are the responsibility of Local Authority and NHS Portsmouth CCG and provided by Solent NHS Trust looked-after children's health team. The Designated Nurse role is provided by NHS Portsmouth CCG and the Designated Doctor and operational looked-after children's nurse/s, are provided by Solent NHS Trust.

Acute hospital services are co-commissioned with Portsmouth CCG, South East Hants CCG and Fareham and Gosport CCGs.

0 – 19 years integrated community health services for children and families, are commissioned by the Local Authority and provided by Solent NHS Trust.

The child and adolescent mental health services (CAMHS) are commissioned by Portsmouth CCG and provided by Solent NHS Trust, as are the mental health services for adults.

Integrated sexual health services are commissioned by Local Authority and provided by Solent NHS Trust.

Child substance misuse services are commissioned as part of a local offer in the Youth Offending Team and the Early Help and Prevention Team, provided by the Local Authority. Adult substance misuse services are commissioned by Local Authority and provided by Society of St James Recovery service who sub-contract Solent NHS Trust to provide an element of the service. The Alcohol specialist nurse service is provided by PHT.

The last inspection of safeguarding and looked-after children's services for Portsmouth that involved the health services took place in May 2011. This was a joint inspection with Ofsted. At that time, the effectiveness of the arrangements for safeguarding children were judged to be 'adequate' and the effectiveness of services for looked-after children as 'good'. Recommendations for the providers arising from that review were considered during this review.

Ofsted carried out a single agency inspection of the local authority and the local safeguarding children board in June 2014. We have taken account of the findings of both of these inspections during this review.

All of the principal providers identified above have been inspected by the CQC through the course of 2015 and 2016. The findings of those inspections in relation to children and young people have been considered as part of this review.

The report

This report follows the child's journey reflecting the experiences of children and young people or parents/carers to whom we spoke, or whose experiences we tracked or checked. A number of recommendations for improvement are made at the end of the report.

What people told us

Young people and carers accessing CAMHS told us;

"CAMHS are fantastic and gave me loads of support when I had lots of issues."

"CAMHS are great – get to see them straightaway. I've never had to wait."

"When your own toolbox is empty, you can turn to them [CAMHS] for help. You can ring or email and get quick responses."

"I have regular contact with the [CAMHS] team, they build relationships with us all – they know who you are and know your children. The team are experienced, knowledgeable and accommodating."

Young people who have attended the Queen Alexandra hospital told us;

"I had to wait 5 hours in QA A&E once – they are a complete failure."

"I had fantastic treatment at QA once and was in and out straightaway."

Children and young people who are looked after and their carers talking about health assessments told us;

"We all have annual checks – it is a good experience but pretty much like going to the doctors."

"The clinic comes to them [the looked after child] which is great. Everything is around the child's choice and makes the health reviews a pleasure."

"I have had a different one [looked after children's nurse] every time. I think they should be the same one each time."

"The medicals are just a form filling exercise for the council. My [foster] mum knows more about my health and helps me get what I need."

The Children in Care Council said;

"We told the Doctor [for looked after children] at one of our meetings about consent section on the form, that it wasn't suitable for older children, and so they changed it which was good."

Foster carers told us;

"Once he became Looked After, investigations happened really quickly. He had a diagnosis, an EHC plan and a place in a specialist school within a year."

"I've never had a problem getting a GP appointment, I can get one the same day because he's in care."

"The dentist prioritises looked after children. They talk to children about hygiene and do a proper check."

"Opticians do not want yearly eye tests unless there's a problem. The looked after children's nurse listened to this and incorporated this into the health plan. I feel listened to."

"I've had stoma care and PEG training at a time that suits me, they accommodated my working hours. I feel very lucky."

A care leaver told us;

"There doesn't seem to be much support for older children who leave care – it all seems to stop when you are 18."

The child's journey

This section records children's experiences of health services in relation to safeguarding, child protection and being looked after.

1. Early help

1.1 An effective early help offer is identifying need and supporting families well across Portsmouth. Public health nurses are an integral part of Multi Agency Teams (MATs) based in localities across the city. An enhanced key worker system means that families are working with one professional to address need. This key worker is supported by a team of professionals who provide advice, guidance and supervision to ensure that a co-ordinated package of care is delivered through the trusted lead professional who is working closely with the family. During our inspection we saw evidence of how this approach was helping to address need at the earliest opportunity which can avoid escalation into formal child protection processes.

1.2 Booking documentation in maternity does not identify potential safeguarding risks posed by a pregnant woman's partner sufficiently well. New documentation is under procurement to aid the early identification risks to women and the unborn from partners with concerning behaviours. This is an improved assessment tool but does not include mental ill health and hence does not support a robust risk assessment. Records demonstrated a lack of individual practitioner professional curiosity to routinely risk assess partners or consistently record their details fully. The absence of one complete record that reflects escalating or de-escalating concerns restricts the full consideration of risks to women and the unborn from their partners. ***(Recommendation 1.1)***

1.3 Maternity staff do not consistently complete or record routine enquiry about domestic abuse. There is an expectation that midwives make this enquiry or ask the question about domestic abuse at least once as part of booking or at another time when it is safe to do so. However in records seen, completion of this enquiry was of variable standard and quality. Furthermore when a positive response is identified the level of risk was not measured using an appropriate tool to underpin any resultant action or plans to keep them safe. This practice limits the early identification of safeguarding risks to women and the unborn and subsequent action plans being made to manage risk they may experience from their partner. ***(Recommendation 1.1)***

1.4 Most pregnant women benefit from access to a range of specialist and lead midwives based on the needs of women. In the absence of a specialist midwife for substance misuse, community midwives care for expectant women and liaise with adult substance misuse services. We are unable to comment on the effectiveness of these arrangements as record keeping is fragmented which limits access to a complete patient record.

1.5 The recent introduction of a dedicated team of midwives (CORAL team) for women with additional vulnerabilities is encouraging. This provision includes specialist support for expectant women such as those using substances; young parents aged under 19 years; young people who are looked after or care leavers and other complexities. This approach will support women, who sometimes find it hard to access mainstream services, with consistent maternity care. It is too soon to measure the impact of this new service as bookings have only recently started when the team became operational in June 2017.

1.6 The assessment of risk in pregnant teenagers for child sexual exploitation (CSE) in midwifery is underdeveloped. There is no evidence of routine enquiry in relation to CSE being made and the shortened CSE risk assessment tool was not used. This means there is a risk that vulnerable expectant females are not being identified and safeguarded. ***(Recommendation 1.1)***

1.7 Templates developed jointly between the maternity service and GP leads, to capture pertinent information at the point of referral for maternity care, are not being used consistently or effectively by GPs. Most referrals seen from primary care lacked detail about any social elements or safeguarding history relating to women in their care. This limits the early identification of need and risk at the start of maternity care. ***(Recommendation 1.1)***

1.8 Vulnerable families are well supported through joint meetings between health visitors and GPs. Linked health visitors generally attend meetings at their linked GP Practices to discuss vulnerable people and share information which aids joint working to help meet the needs of children and young people. Although GP surgeries have a linked community midwife they are not routinely part of these meetings, nor are school nurses. Pertinent information from these meetings is shared with school nurses via the electronic system however this limits opportunity to jointly consider risks between disciplines, agree any resultant actions and plans to support ongoing care. ***This issue has been brought to the attention of the local authority public health team.***

1.9 Health visitors routinely make enquiries of women about the risk of domestic abuse at each of their 'healthy child programme' contacts, as long as it is safe to do so; more often if they are providing targeted support. This approach recognises that risks of domestic abuse can evolve due to changing family dynamics brought about by a new baby and ensures that health visitors understand those risks as they might apply to individual families they are working with.

The school nursing service provide emotional support to children with additional needs as part of their Universal Plus offer. For example, one young person who was experiencing anxiety and relationship problems due to low self-esteem and their appearance was well supported through enhanced contacts by the school nurse. The young person was then able to access additional services that met their particular needs. The outcome for this young person was improved resilience through the practitioner's restorative approach.

1.10 The Family Nurse Partnership service in Portsmouth effectively supports a small number of young women up to the age of 21 with their first pregnancy and up to the child's second birthday. This targeted service helps to meet any additional needs of this vulnerable cohort of young mothers through focussed interventions. Feedback from those accessing the service has been positive and personal outcomes for parents and infants have improved.

1.11 Children and young people in Portsmouth benefit from the provision of a fully integrated sexual health service. This provides children and young people with access to a range of services including advice, contraception, sexual health screening and treatments. The service is provided Monday to Friday with no weekend provision. There is a dedicated young person's clinic once a week with additional access available in the "all ages" service. Harder to reach children and young people benefit from access an outreach service which works flexibly with those who may not engage with the mainstream offer. Outreach staff report good links with the teenage pregnancy midwives which contributes to effective joint working and improves outcomes for children and young people.

1.12 Young people can only access support for substance misuse problems through MATs, unless they are open to youth offending or children's social care. Each MAT has a substance misuse practitioner who offers support predominantly in a consultancy approach to a key professional working with the young person to enable them to deliver drug and alcohol interventions. We were assured that if young person required specialist drug or alcohol direct work, this would be made available to them. At present this approach has not been formalised or underpinned by agreed policy or pathways to demonstrate how this would be facilitated. Given that this is a recent change it is too early to measure the impact on the quality of the services received by children and young people in Portsmouth and whether it meets their needs. ***This issue has been brought to the attention of the local authority public health team.***

1.13 The QAH adult emergency department do not have robust arrangements to identify and record details of the hidden child/children linked to adults attending with concerning behaviours. Staff do not routinely collect or record details of children associated with adults who attend the ED as standard and both the electronic patient record system and booking in documentation lack any prompts to ask about children's details. We did see examples of professional curiosity shown by triage staff, who as individuals were robust in their approach to identify children who may be at risk from adults with concerning behaviours, but this was not systematic or supported by formal processes. This means that the trust cannot assure itself that all vulnerabilities and risks to children resulting from the attendance of the adult are being routinely identified and as a result, some children may be left at risk. ***(Recommendation 1.2)***

1.14 When a child or young person attends the children's ED there are opportunities to identify and capture potential safeguarding information but the effectiveness of this is limited by inconsistent practice. Records examined showed good detail at booking in around who has accompanied the child to the hospital and their relationship to them which supports enquiries around consent and the appropriateness of this relationship. However, the 'mandatory' safeguarding screen contained on a child's electronic record, is at times, incorrectly completed or bypassed by practitioners. This tool is intended to prompt risk assessment of children for any safeguarding concerns and therefore if not used correctly, does not provide assurance that all children are subject to a thorough risk assessment of factors which may be linked to safeguarding concerns and therefore opportunities to safeguarding them may be missed. ***(Recommendation 1.3)***

1.15 Children and young people are able to access a full range of specialist mental health services. All referrals into CAMHS are made via a well-established Single Point of Access (SPA) team. To increase accessibility SPA workers operate a drop in services one night a week in a city centre hub, and school clinics held in two thirds of secondary schools once a fortnight. Practitioners reported a good uptake of the drop in sessions which allow young people to come and discuss any concerns they may have in an open manner.

A young person who was nearly 18 was taken to hospital emergency department, assessed by CAMHS and was admitted to the hospital as an inpatient. This was followed by inpatient CAMHS admission. Initially there was deterioration in the young person's mental health condition, requiring more intensive support but following this a good recovery was made and the young person was discharged to adult mental health services for ongoing community psychiatric support.

The records demonstrated effective joint working between adult mental health and CAMHS inpatient services, particularly in respect of planning for discharge from inpatient services, which enabled a smooth transition to ongoing care with adult mental health services.

1.16 Good progress is being made in identifying and assessing risk to children within adult mental health services. Adult mental health practitioners are routinely enquiring about children in initial assessments and we were advised that this included the identification of children in the client's household. The assessment pro-forma does not extend into exploring the wider circle of children or young people that the adult may have substantial contact with and this is an area for improvement.

1.17 Children of adults who misuse substances and access the adult recovery service are safeguarded well. The 'Think Family' approach is embedded within the adult Recovery service run by Society of St James (SSJ). Home visits are conducted as part of the assessment process with consideration for children at all stages. Case records reviewed were clearly child focused with sufficient detail about the child's presentation and demeanour and parental interaction. A bespoke and interactive electronic patient record system allows the service to clearly document relevant safeguarding information. This facilitates good identification of risk and the interactive genogram supports practitioners to consider other children living in the home, or those in care of the local authority. Examples seen thoroughly assessed the child's needs, explored the impact of the adult's substance misuse on their capacity to parent well and keep their children safe, as well as considering other environmental or familial factors which may have placed the child at risk. This is good practice.

1.18 The assessment of risk of CSE is underdeveloped in GP practices. Practices visited do not make use of the shortened CSE checklist in their assessments of children and young people. In one practice we could see that the template for this assessment was not easy to find and in another the GP was not aware of the shortened tool. Children and young people at risk of, or victims of, CSE accessing primary care may not have their needs fully assessed restricting their ability to be effectively safeguarded. ***(Recommendation 2.1)***

2. Children in need

2.1 Expectant women with mental health needs benefit from access to a specialist midwife for perinatal mental health. The specialist midwife carries a caseload of more complex cases and provides support and some input to women cared for by the community midwives. The specialist midwife provides two weekly clinics for high risk women that are well attended and there are plans to start joint clinics with the psychiatrist in September 2017.

X had a history of postpartum psychosis and had needed in-patient admission. When X became pregnant again, she contacted her previous adult mental health worker to advise her of the pregnancy. The practitioner responded appropriately; X was prioritised within adult mental health services, a risk assessment was completed and a care plan was put in place to support her and safeguard the unborn baby. Effective preventative and proactive joined up work was carried out, including home visits and good liaison with the perinatal midwife. A birth planning meeting took place and arrangements were put in place to meet X's specific needs. X was able to remain at home with her family during and after her pregnancy and hospital admission was avoided.

2.2 Portsmouth women experiencing low to moderate mental health difficulties are benefitting from a new locally delivered specialist perinatal mental health pathway introduced from April 2017 provided by Southern Health NHS Foundation Trust. This brings Portsmouth into compliance with NICE guidance as previously specialist treatment had to be accessed outside of Portsmouth. The new service offers domiciliary visits from a practitioner and a support worker although it is too early to evaluate the impact and outcomes of this new service.

2.3 There is a gap in service provision for some pregnant women who experience mental health crises whilst an in-patient on the midwifery unit. Portsmouth CCG have confirmed that the onsite crisis mental health team provide acute care for women who are inpatients on the maternity ward at first presentation but do not offer ongoing inpatient support. Therefore women who experience crises whilst an in-patient on the maternity ward, who are already open to a mental health service, are not able to receive support from the onsite crises mental health team. In one case a woman had to leave the maternity ward and attend a community clinic appointment. Furthermore, not all maternity staff have received training in mental ill health which may impact on their ability to effectively meet the mental health needs of women in their care in particular when in crisis. ***(Recommendation 3.1)***

2.4 Pregnant women who have a learning disability can be issued with a learning disability passport. However a recent audit has identified that not all staff are aware of these passports therefore limiting their ability to effectively support an expectant women with additional need. ***(Recommendation 1.4)***

2.5 Children in need and their families benefit from good involvement and support from health visitors and school nurses. These practitioners are active participants and key influencers in child in need processes. In records we looked at we noted that health visitors are always involved in team around the family (TAF) meetings and contribute an analysis of their work with families. Records relating to this work are consistently of a high standard, setting out the clearly the progress of the TAF towards meeting needs and the plan for forthcoming work. This is particularly beneficial in those cases when health visitors take on the role of lead professional when a child in need plan is stepped down to early help.

In one of the cases we looked at in the health visiting service we saw that a family who were receiving statutory intervention under a child in need plan were referred into the service for targeted support led by the family health visitor. There was a history of domestic abuse between parents, maternal ill-health, poor parenting skills and the children had some developmental delay.

Improvements in the family home and parenting had led to the stepping down of the child in need plan as it was agreed that the family's needs could be better addressed through a restorative approach led by a health visitor. The early help assessment, created as part of the step-down arrangements, identified specific outcomes within achievable timescales and were a continuation of those set out in the previous child in need plan.

Electronic records made by the health visitor provided good detail about the work carried out with the family towards meeting agreed outcomes. The health visitor also worked closely with other professionals, particularly within the school, to ensure the children were properly supported following an incident where the risk of domestic abuse was heightened.

The health visitor continued to work with the family to ensure that the children's needs are met within early help.

2.6 LSCB escalation processes, where there are areas of professional disagreement, are not always fully complied with by all school nurses. In one case we looked at we noted that a practitioner had a professional difference of opinion about the level of risk and the outcome of a child in need meeting. This was appropriately raised by the health practitioner concerned through an email to the social work colleague. However, when the issue remained unresolved there was no further use of the appropriate escalation process involving managers. In this instance there was a further delay of almost two months until the case was re-assessed by children's social care to consider statutory support as a child in need. ***This issue has been brought to the attention of the local authority public health team. (Recommendation 4.1)***

2.7 The integrated sexual health service provide specialist clinics in addition to their universal offer. There are dedicated appointments available for people with additional identified needs or vulnerabilities such as learning disability or child sexual exploitation risk. The appointments allow for more time to be spent with the individual to help identify and meet their sexual health and wellbeing needs. Records seen demonstrated evidence of good liaison across agencies with good joint working to meet the needs of vulnerable children and young people accessing this enhanced service.

2.8 However, arrangements for identifying risk in children and young people attending integrated sexual health services are too variable. We saw that whilst some records had alerts which had been added to indicate vulnerability, these were not always updated with the most recent information and did not fully reflect the child or young person's needs. ***This issue has been brought to the attention of the local authority public health team****. (****Recommendation 4.2*** *and* ***4.3****)*

2.9 The electronic record keeping system used in the integrated sexual health service does not fully support practitioners to ensure completion of the mandatory checks for domestic abuse and risk assessments for 16 and 17 year olds. Practitioners can bypass these fields and may miss opportunities to identify risk and intervene early to safeguard those in their care. Furthermore it does not support practitioners to record the details of children linked to adults that attend. This is a missed opportunity to aid the identification of hidden children linked to adults that present with concerning behaviours or where there may be risks to children such as female genital mutilation. ***This issue has been brought to the attention of the local authority public health team****. (****Recommendation 4.2****)*

2.10 Practitioners on QAH paediatric wards are not supported to effectively safeguard children and young people due to a lack of appropriate protocols or basic checklists to assist assessment and care planning for those who are mentally unwell or at risk of self-harm. There are no environmental risk assessments undertaken and no individual risk management plans developed for each child. The paediatric ward manager told us that a new risk assessment pro-forma is in development in partnership with the CAMHS liaison psychiatrist but the timeline for this to be introduced was unclear. In addition there has been very limited training received by paediatric nurses around supporting children with mental health needs. There are plans in place for CAMHS to train paediatric nurses with mental health competencies however this is only an interim measure. ***(Recommendation 3.2)***

2.11 In the QAH we saw case records for a child on the ward who had been assessed by a CAMHS practitioner that day, however a copy of the completed risk assessment was not provided to the ward staff and we were consistently told that these are never left with the ward. This means ward staff are not fully informed about how to provide best care and may not be sufficiently well-sighted on the risks of the child attempting serious self-harm. ***(Recommendation 3.2)***

2.12 Children and young people up to 16 years of age who attend A&E with self-harm or mental health concerns are usually seen quickly by CAMHS. However, the arrangements for those children aged 16 and 17 are less secure. Portsmouth CAMHS are part of a self-harm rota shared with Hampshire and the out of hour's service. Most young people this age, who present to A&E with self-harm or mental health concerns, are admitted into the paediatric ward where CAMHS are prompt in seeing the child on the same, or the following day. However there are concerns about young people aged 16 and 17 being placed on adult emergency department observation wards thus being seen by the adult mental health liaison team. Managers were aware that this is an area which needs to be addressed and made more robust but at present progress is at an early stage in finding a solution to rectify this situation. ***(Recommendation 3.3)***

2.13 Appropriate and timely arrangements are in place for children and young people who meet the threshold for acute CAMHS to be assessed by the CAMHS SPA and allocated onto a care pathway. Children are prioritised according to their needs and the majority are seen within 10 weeks. Appointments for those children with more acute needs are escalated and they are seen more quickly. Whilst a child or young person is waiting to access CAMHS they and/or their family are offered support through telephone contacts. This approach helps to reduce the feeling of isolation and stress for children and young people whilst waiting to access the service.

2.14 CAMHS have developed and successfully implemented a crisis care post to co-ordinate, deliver and evaluate care for children and young people with a focus on helping to prevent admission to hospital. This practitioner provides assessment, treatment and risk management of a young person as well as, supporting their family and network to plan for, and manage crisis.

2.15 We were not assured on the transition process for those young people who are turning 18 and have an ongoing problem with substance misuse. We were not provided with any evidence of a transition policy or care pathway to support transition into adult substance misuse services. This means that some young people may not benefit from a clear, planned handover into adult services. ***This issue has been brought to the attention of the local authority public health team.***

3. Child protection

3.1 Portsmouth City Council children's social care is introducing a restorative practice model to child protection work. The council reports that health agencies are well engaged with the introduction of this model and that health's uptake of training to support the model's introduction is positive. This approach supports increased consistency in child safeguarding practice across Portsmouth.

3.2 There is a clear, single point of referral into children's social care with an explicit expectation that contacts and referrals to the Multi Agency Safeguarding Hub (MASH) should be followed up in writing using the Inter-Agency Contact Form (IACF). The IACF has been revised in light of stakeholder feedback to provide more useful prompts and steer to practitioners making referrals. We saw one recent referral in the MASH from a student health visitor which was of excellent quality; setting out clear and concise details of the family circumstance. The concerns of the practitioner about risks of harm to the unborn were articulated succinctly but explicitly, facilitating effective decision-making in the MASH.

3.3 Referrals from health services to children's social care did not always include ethnicity or first language. A lack of understanding of ethnicity, cultural beliefs and norms and first language may impact significantly on the best delivery and provision of health support to a vulnerable family and clearly impede effective communication and engagement with a family.

3.4 The Portsmouth MASH has been established since November 2015 with effective input by a CCG funded full time health navigator complemented by a 0.8WTE health visitor working in the Early Help hub. The health navigator is a confident and valued partner in the day to day operation and decision making of the MASH.

We saw good examples of effective advocacy by the health navigator to ensure that health specific safeguarding risks were appropriately escalated when concerns had been referred into the MASH. The health navigator highlighted the impact on the health, wellbeing and safety of the young people as a result of not being taken to important medical (CAMHS and physical health) appointments by their parents. As a result of the health navigator being able to articulate the risk and impact, the cases were reassessed in the MASH and taken through section 47 child protection proceedings so that the health and wellbeing of the young people was safeguarded.

3.5 The MASH health navigator does not routinely discuss cases or request updates from health practitioners about children referred to children's social care but instead will access the electronic health records that are available. The effectiveness of this is reliant on having access to all record keeping systems in Portsmouth; the record having an agreed sharing right; and that it is up to date. However, in the case of one local GP Practice not using the shared electronic record system the navigator only has sight of hospital records to identifying any appointments or ED attendance.

3.6 In an attempt to increase contact between MASH and primary care, one GP has spent time visiting the MASH. This was a good opportunity for the practitioner to raise the understanding of how the MASH operates across primary care, thus facilitating stronger engagement likely to safeguard children more effectively.

3.7 Not all information regarding domestic abuse incidents is shared effectively with health professionals. Children and young people who live with domestic abuse are identified through police domestic abuse notifications that are sent to MASH services. However it is only the most serious incidents are entered onto the electronic health record system by the health navigator. This means the information is available to public health nurses and most GPs is limited.

3.8 Families who are living with serious domestic abuse are discussed at the local MARAC. Arrangements are well embedded for the health input to be co-ordinated through Solent NHS trust's safeguarding team. This ensures a consistent and summative presentation of that information where families have been supported by a number of different health professionals.

3.9 We observed that primary care is not well engaged in the local MARAC arrangements and it was evident in GP practices visited that information sharing with MARAC is not well developed. Practices were not able to identify MARAC cases to allow us to assess the effectiveness and impact on children and young people accessing their GP. Not being aware of domestic abuse incidents limits the opportunity to link family members in primary care patient records, undertake any follow-up actions and keep the profile of these issues high in the service. ***(Recommendation 3.4)***

3.10 We saw evidence of good practice in safeguarding children and young people in GP practices visited. Children and young people that are looked after, subject to CIN plans or child protection plans are visible to GPs through the good use of alerts. This can support practice staff to consider the known vulnerabilities linked to the alert to inform their assessment of their presenting condition. GP practices visited reported though they had limited capacity to be able to attend child protection conferences they do submit reports. In one practice a report examined contained information about the children and all pertinent family members linked to children's social care involvement. This means that important information was shared and considered as part of the conference.

3.11 The majority of health practitioners across Portsmouth are routinely participating in child protection strategy meetings. Where a case is already known to a health practitioner, this practitioner or representative from the service will attend or participate in the strategy meeting; where this is a new case, then health are represented by the health navigator. Strategy meetings are held in venues across Portsmouth, including the hospital ED. This flexible approach helps to improve attendance from health partners and is good practice in line with national statutory guidance (Working Together 2015).

A student health visitor completed an antenatal home visit with Woman A and established a positive relationship with her. This opportunity to build a relationship in the ante natal period was instrumental in creating an environment where Woman A disclosed that she had experienced FGM as a child. The health visitor identified through observations and discussion that Woman A was not bonding with her unborn child and had not made preparations for the baby's imminent birth including the provision of necessary equipment.

Furthermore there was a volatile relationship with the baby's father and there had been previous domestic abuse. The health visitor made a comprehensive, well evidenced referral to MASH, setting out clear and concise details of the family circumstance with a clear analysis of risk. MASH arranged for an urgent pre birth assessment and a plan was put in place to protect the infant at birth.

3.12 Expectant women who are victims of FGM are identified through the effective use of a risk assessment tool and appropriate arrangements are in place to identify female children at risk of FGM. There are good pathways for women to access medical help at the perineal clinic with additional support in the community from a dedicated worker as part of southern domestic abuse service. In one case sampled, midwives identified possible risk to the two year old daughter of a woman affected by female genital mutilation and made a referral to children's social care to consider further risks to the child.

3.13 We were not assured on the robustness of multi agency planning to safeguard vulnerable newborn infants. Documentation held in health case records did not evidence robust multi-agency planning to safeguard vulnerable newborn infants. Multi-agency safeguarding pre and post birth plans were not evident in records sampled. As a consequence we could not review the quality of the agreed multi-agency plan to safeguard the unborn/new-born. It is not clear how this important information is shared to fully inform the ongoing care of women/unborn/new-born and ensure there is a complete safeguarding record. Highly visible safeguarding alerts are created by the safeguarding team at 34 weeks but these are single agency plans. In the absence of any agreed and shared multi-agency pre and post birth plan from children's social care, this alert is the safeguarding plan. This arrangement does not align with the LSCB Unborn and Newborn Baby Safeguarding Protocol (2016). ***(Recommendation 1.5)***

3.14 We saw strong child protection arrangements within health visiting and school nursing. Public health nurses working with children subject of a child protection plan routinely attend core group meetings. During core group meetings all practitioners provide updates on the progress of their work and rate progress according to a traffic light system. This is used as a summative assessment to report on progress for the review conference and helps accurate information to be presented to conference. Families benefit from having to review one comprehensive report rather than multiple reports from different practitioners. This is a recent initiative, however, and its effectiveness has yet to be formally evaluated.

3.15 Reports submitted by public health nurses for initial child protection conferences are of a very high standard. In all of the cases we reviewed we noted very detailed factual information supported by thorough analysis using an assessment framework. Reports are shared with families prior to conference which gives them the opportunity to challenge if necessary. This robust approach helps to ensure that decisions made at child protection conferences are evidence based and accountable.

3.16 School nurses carry out health needs assessments for every child subject of a child protection plan, a child in need plan or who is supported through early help. In assessments we looked at, the 'voice of the child' was prominent with clear identification of additional health needs. This means that health interventions are targeted for any particular child, in accordance with their wishes and feelings.

3.17 Home educated children and young people do not benefit from access to the school nursing service. Practitioners we spoke with were not able to identify this population and as a consequence this limits the provision of their service. It is well evidenced in findings from serious case reviews that this cohort of children can be particularly vulnerable. In a report to Portsmouth LSCB (July 2017) education and public health are taking steps to improve on this but it is in early stages. ***This issue has been brought to the attention of the local authority public health team.***

3.18 Children and young people are not benefitting from a cohesive and holistic approach to identifying and responding to potential risk of CSE within universal health services. We saw a number of cases within school nursing and family nurse partnership where the opportunity to identify and assess CSE risk had been missed. ***This issue has been brought to the attention of the local authority public health team. (Recommendation 4.3)***

A young person known to be at risk of CSE was brought into the QAH ED by ambulance due to injuries sustained from a road traffic accident. Given the presenting situation and associated risk factors, the assessment lacked professional curiosity and there was no evidence of exploration into the lack of parental supervision or appropriateness of the relationship with the person in the vehicle. Contact was made with Social Care however there was a missed opportunity to make use of the shortened CSE risk assessment which would have facilitated the opportunity to gather more information to inform work with this young person.

3.19 We saw evidence of safeguarding referrals made by practitioners in the children's ED describe risks to children well. However, this good practice did not always translate into a comprehensive discharge summary to the child's GP which could impact on effective safeguarding arrangements in the future. ***(Recommendation 1.6)***

A baby was brought in the QAH ED by parents for treatment. They disclosed that the baby suffered an accidental injury the previous day and now had swelling on the head. The clinician contacted children's social care to check if the family were known and it was confirmed that a series of assessments had been undertaken despite the father stating that they were not known to children's social care.

The child was found to have a fractured skull. The patient record demonstrated good observational recording by the clinician including noting delayed mobility in the injured child and detailed recording of his discussions with the father, including father not being truthful about contact with children's social care. The clinician also noted that the parents did not understand the seriousness of the injury to the child.

The GP notification letter, however, included none of the information regarding possible neglect and the clinician's concerns about parental capability and understanding.

3.20 Paediatric liaison arrangements are not sufficiently well developed to ensure timely information sharing arrangements following a child or young person's attendance at the QAH ED. Cases seen demonstrated that information was not shared in a timely manner and lacked sufficient detail meaning key child safeguarding information is not part of the child's community and primary care record and cannot be considered as part of any ongoing care assessment and planning. ***(Recommendation 3.5)***

3.21 The provision of a safeguarding liaison role being undertaken by a senior paediatric sister one day per week is a positive development. This will help to address issues around quality of information, however, given that all reviews undertaken are retrospective and only on cases where concerns have already been identified, there remains a delay in escalating concerns. Consequently we saw evidence in one record in the 0-19 service where the opportunity for early intervention by the school nurse had been missed. ***This issue has been brought to the attention of the local authority public health team. (Recommendation 3.5)***

3.22 Despite the introduction of the safeguarding liaison role, there is no operational oversight by a shift supervisor or lead practitioner in either Adult ED or Children's ED to ensure that all safeguarding issues have been identified and considered; that practitioners are making the optimum decision about whether a cause for concern is needed and what information this should contain. The content and quality of referrals to children's social care are not checked prior to their submission and we saw case examples of key information omitted from the safeguarding referral. This means that children and young people may not benefit from a timely and appropriate safeguarding response and experience delay in support being put into place to reduce risk. ***(Recommendation 3.5)***

3.23 CAMHS practitioners are engaged in child protection processes and this work is given high priority. Where appropriate staff attend meetings to provide consultation and strategies to other workers even if the child is not yet open to the service. Furthermore IACF are routinely completed to a good standard where risks to a child or young person's safety are escalating or when it has been identified that a child or their family would benefit from additional help.

3.24 CAMHS practitioners report they do not receive copies of the minutes relating to child protection meetings they may have attended. This does not give them opportunity to review the content of any plan or that their contribution has been accurately represented. It also means that they do not have a complete record and staff were aware that this process could be made more robust.

3.25 The quality of record keeping in adult mental health was good and information from other professionals was used effectively to inform risk assessment, care planning and decision-making. Relapse indicators and crisis plans generated paid good attention to the adult's parenting capacity and the impact on children of deteriorating parental mental health. Evidence seen in the records demonstrated effective joint working with children's social care and school however work with health visitors or school nurses was not as developed and it was not common practice to share crisis plans with these health professionals. This is a missed opportunity to ensure that all professionals who may be visiting the home can be well informed about early indicators of relapse and support parents into appropriate mental health support at the earliest stage. ***(Recommendation 4.4)***

3.26 Vulnerable children and young people who live in families with adults who have mental health illness and/or substance misuse are identified and safeguarded well. Managers and practitioners within adult services have a clear understanding of their roles and responsibilities in safeguarding children and young people while working with adult clients. We saw a number of case examples where practitioners from both services had identified safeguarding concerns, discussed these with their line manager in the first instance and made appropriate and good quality referrals. Recovery practitioner's records noted an appropriate level of challenge and escalation when a practitioner's concern of multi-agency management arose. Adult mental health practitioners attached additional risk assessments and mental health history information where it was useful to inform effective decision making in the MASH. This approach supports using specialist knowledge to inform risk assessment and decision making and safeguards children.

3.27 Adult mental health and substance misuse services routinely attend child protection conferences and key meetings. Contribution to meetings were of good standard providing analysis of potential risk to children to assist the decision making process. All records examined contained appropriate detail of the outcomes from meetings and practitioners are positively encouraged to maintain a prominent role in the child protection process. In most records seen we found evidence that minutes from conference and core groups were received and uploaded to the system providing clear evidence of their role within any plan around the child.

3.28 The highly visible safeguarding flagging system within the Recovery service electronic patient record system is consistently used to a high standard and captures any safeguarding concerns which link through to a dedicated safeguarding tab. This enables practitioners to quickly identify where there are safeguarding concerns with a child and store details of other key professionals, such as social worker and health practitioners. This good practice promotes multiagency working and ensures that relevant information is shared.

4. Looked after children

4.1 There is poor management, co-ordination and oversight of information and data regarding looked after children held by Solent NHS Trust. Information about looked after children placed out of area and waiting times and lists for both initial and review health assessments was not easily identifiable. This is recognised as an area for improvement and the team are developing processes to address this, however, the impact of this work was not evident at the time of this review.

4.2 Data supplied by Solent NHS Trust demonstrates variable completion in the timeliness of initial and review looked after children's health assessments. As a consequence not all children and young people who are looked after benefit from having their health needs assessed in a timely manner. ***(Recommendation 4.6)***

4.3 Arrangements in obtaining consent for health assessments are not sufficiently well developed with an over reliance on the looked after children's health team obtaining consent. Solent NHS Trust obtains consent for the physical examination but this does not extend to the gathering and sharing of information unless someone with parental responsibility is present at the medical, allowing full consent to be obtained. This means looked after children who attend without someone with parental responsibility may not have a comprehensive initial health assessment which can delay their access to other health services. ***(Recommendation 4.5)***

4.4 The most vulnerable looked after children are those placed out of area and we are not assured that this cohort benefit from access to timely and comprehensive health reviews. The looked after children's health team could not reliably identify this cohort and reported they often experience delays in having their health assessments completed. ***(Recommendation 4.6)***

4.5 Children and young people who are placed out of area are now benefitting from scrutiny of their health assessments and plans. The designated nurse for looked after children now quality assures all reviews and plans to ensure they meet Portsmouth's quality standards and that they are "fit for purpose" before authorising payment. This provides assurance that vulnerable children placed out of Portsmouth are having a thorough assessment of their needs.

4.6 We saw evidence of some good initial and review health assessments and health plans, however, the overall quality is too variable. Health plans are not always SMART and therefore not all children and young people benefit from focussed plans which drive forward improvement in their health care. In some review health assessments we saw a lack of input from GPs, and SDQs were not always utilised fully during the assessments. ***(Recommendation 4.7)***

4.7 It is positive that practitioners are increasingly exploring risk taking behaviours as part of initial and review health assessments. However, these assessments, are not consistently informed by a formal CSE risk assessment and this is a missed opportunity to systematically assess and identify CSE, especially as research shows us that this cohort of children are particularly vulnerable to exploitation. ***(Recommendation 4.7)***

4.8 GPs, health visitors and school nurses receive copies of looked after child's health care plans which means that they are able to consider the content alongside any consultations that they have with the child or their carer. Children who are looked after are part of the 0-19 enhanced case load which means that their care is prioritised.

4.9 The looked after children's health team do not monitor the implementation of the health action plans. We acknowledge that this is the overall responsibility of the child's social worker, however, this lack of ongoing involvement and accountability will result in review health assessments being viewed as episodic rather than a continuum of care.

4.10 Portsmouth has a significant number of unaccompanied asylum seeking children. There is recognition in health and social care that the experiences of children and young people who are seeking asylum can have a profound and long-term impact on their health and wellbeing. Health assessments seen for this cohort on the whole met their needs, though practitioners undertaking this work have not received any formal specialist training.

4.11 Children and young people who are looked after and their carers benefit from access to a dedicated CAMHS team where they are prioritised and are able to access services quickly. The looked after children CAMHS service provide mental health assessments, direct work with children and young people, including foster carers, and are actively involved in range of multiagency meetings to support the child or young person. This means that support can be accessed in a timely manner by a specialist team who understand the increased vulnerabilities and complexities of a child who is in care.

4.12 Looked after young people who continue to need support from adult mental health services when they are 18 benefit from a well co-ordinated transition. The looked after children's CAMHS service are proactive in their approach to transition and offer a drop in for care leavers alongside adult mental health services. Practitioners are sensitive to the needs of the young people and support is offered in locations such as children's homes and hostels where a number of looked after young people and care leavers are placed.

4.13 Unaccompanied asylum seeking children who are identified as needing support from the looked after children's CAMHS team are not able to access the service until they have experienced a period of stability in placement, education and emotional care. Although their carers can access CAMHS team for advice and consultation at any time, this approach risks delaying access to specialist or therapeutic services. We were not made aware of any audit to demonstrate the impact or effectiveness of this policy.

4.14 The looked after children's health team raised to Portsmouth CCG that there were a number of unaccompanied asylum seeking children who were not registered with a GP. Portsmouth CCG and the local authority identified that whilst GP practices accepted these individuals, they were not being supported by their carers and social workers to access the GP service. Portsmouth CCG and the local authority worked together in an attempt to improve access to health services for unaccompanied asylum seeking children by providing a letter to support registration with primary care. Whilst there has been no audit or evaluation of the initiative's effectiveness the local area has assured us that all unaccompanied asylum seeking children are currently registered with a GP.

4.15 Young people leaving care receive a pack that contains relevant and personal health information to support their adulthood journey. However, the looked after children's health team recognise that there is potential to further improve this and are exploring opportunities, for example within primary care, to strengthen the offer.

5. Management

This section records our findings about how well led the health services are in relation to safeguarding and looked after children.

5.1 Leadership and management

5.1.1 Portsmouth LSCB identified the need to strengthen the reporting arrangements by health partners and are setting up a formal health sub group. Membership has been agreed and will include NHS commissioned provider services as well as the named GP.

5.1.2 The local authority and its partner agencies are using outcomes from national inspections to benchmark safeguarding arrangements across the local area. Examples include JTAI deep dive topics and as a result, priority is being given to reviewing the local response to domestic abuse and to neglect. As part of this work, the partnership has begun to explore the engagement of dental practitioners in safeguarding arrangements, although this is at a very early stage.

5.1.3 Portsmouth City Council, Portsmouth Public Health and Solent NHS trust have committed to an ambitious remodelling of services, 'Stronger Futures', combining health and care teams within MATs to increase the care provided in the community, with a clear focus on early intervention and prevention. This transformation of the early help provision has been subject of a phased implementation since April 2017 with a projected completion date of October 2017. The programme is currently on trajectory to meet its deliverables and this indicates the considerable commitment to the remodelling of the offer by the Portsmouth City Council and Solent NHS Trust NHS trust.

5.1.4 Governance arrangements within PHT trust are not sufficiently robust to ensure that the trust board can be assured on safeguarding practice across the organisation. The named and specialist health professionals in PHT have a significant improvement agenda however we are not assured that there is sufficient capacity in the PHT safeguarding team to address the deficits and lead the necessary improvements. Our concerns are compounded by the absence of a clear workplan with measurable objectives which would help to identify resource, support effective prioritisation and monitor progress. ***(Recommendation 1.7)***

5.1.5 Data collection and reporting within the PHT is underdeveloped. The named professionals do not have access to any reports to enable them to identify patterns in referrals from departments across the organisation. The trust's IT system is not supporting effective safeguarding practice. We have shared our concerns surrounding the incorrect completion and bypassing of a 'mandatory' safeguarding screen and the timeliness and quality of information shared with community health services. Other examples include, incorrectly selected multiple choice safeguarding statements generated from the mandatory safeguarding screen which are pulled through to subsequent discharge documentation which could give false assurance to other practitioners in relation to risk.

5.1.6 Resourcing of the named professionals within Solent NHS Trust is not complaint with the RCPH Intercollegiate Guidance (2015). ***(Recommendation 4.8)***

5.1.7 The named GP does not have sufficient resource allocated to fulfil all the responsibilities of the role as identified in the RCPH Intercollegiate Guidance 2014. The current postholder has one weekly programmed activity for children's safeguarding. Opportunities to develop this role further are hindered by the current resources allocated to the role. ***(Recommendation 5.1)***

5.1.8 We have seen positive and effective safeguarding practice in primary care, however, this is not consistent across all GPs in Portsmouth. Where we saw good practice, flags on patient records clearly indicated vulnerability and information sharing was effective with all practitioners taking responsibility for safeguarding children.

5.1.9 The CCG identified and raised to the parenting board that there is a conflict of interest and lack of independence in oversight between the strategic and operational responsibilities of the shared designated and named doctor for looked after children. The CCG and Solent NHS Trust have acknowledged the need to resolve this. ***(Recommendation 2.2)***

5.1.10 It is positive to note that the looked after children's designated and named nurses are members of the corporate parenting board.

5.1.11 The named nurse for looked after children provide quarterly performance reports to commissioners and trust safeguarding lead. However, the annual report regarding looked after children is not yet available to consider as part of this review. Given the findings identified in this report we are not assured there is robust scrutiny and professional challenge from the trust board and the CCG which should drive forward improved provision and health outcomes for all looked after children.

5.1.12 In the absence of a substantive named midwife postholder at PHT, informal arrangements are in place with the named nurse providing the strategic input alongside the safeguarding midwife who is providing support operationally. We were given assurance that the post has been advertised and interviews are due to be held imminently.

5.1.13 In line with this inspection's findings detailed earlier, the recent audit completed in maternity appropriately identified the need to improve midwives routine enquiry of domestic abuse and the recording of this. The resultant action plan is SMART but the impact is limited at this stage given the findings of this review. The plan rightly prioritises the need to make this important enquiry but could be strengthened further by asking throughout the women's care; the offer of a women only appointment; or completion of risk assessments for those women giving a positive response. ***(Recommendation 1.7)***

5.1.14 The 0-19 service is currently undergoing workforce remodelling to ensure the Stronger Futures initiative is properly resourced although the impact of this is not yet realised. Although school age children benefit from the national child measurement programme (NCMP) at entry to and exit from primary school, it is evident that the need to carry out safeguarding work within the current resource has affected the capacity of the service to deliver other programmed work. Competing priorities has also impacted on the delivery of more preventative work and the absence of drop-in sessions in schools is a missed opportunity to identify vulnerable children via these opportunistic contacts. ***This issue has been brought to the attention of the local authority public health team.***

5.1.15 In reviewing the 0-19 services it became apparent that there is an unintended consequence on current practice of the local advice line operated by the MASH. Health practitioners can contact the MASH to seek advice on individual cases without revealing the name of the child or family concerned, this means that there is no record of the discussion or decision reached within children's social care. Whilst most health practitioners were making an entry in the health record of the discussion, we are concerned that important key information is not being recorded which may assist decision making by the MASH in future referrals where different practitioners express concerns about the same case.

5.1.16 There are well established strategic and operational multi-agency CSE arrangements in place in Portsmouth and partner agencies report that these are working effectively; making good use of hard and soft intelligence to identify "hot spots where young people may be vulnerable." A recent peer review of Portsmouth CSE arrangements by another local authority has been undertaken which has been helpful to local partners in taking this work forward. A shortened CSE assessment tool has been introduced across Portsmouth, however our review highlights that the use of this is not routinely embedded across all services which young people are likely to engage with, including school nursing, midwifery and primary care. The integrated sexual health service have a full risk assessment tool based on 'spotting the signs' however in records sampled it was evident that this was not always used where appropriate.

5.1.17 Positive action has been taken by commissioners and providers of services to meet the substantial increase in referrals to CAMHS. Local initiatives included the delivery of group work on anxiety and providing training on interventions for parents and workers. There has been a reduction in waiting times and positive feedback from those adults who have been involved in the training in supporting a child with emotional needs who reported that their skills and confidence in managing these issues had increased.

5.1.18 It is encouraging that PHT has met the national requirement in relation to child protection information sharing (CPIS) and the system is embedded. This is evidence of good local partnership working and a commitment to identifying vulnerable children and young people.

5.2 Governance

5.2.1 Record keeping arrangements in maternity are fragmented which prevents access to a complete record of women's care to include safeguarding information. Records kept by community midwives in community clinics are not accessible out of hours. Flags and alerts held on maternity electronic records are not visible to emergency department staff should the woman attend. As a consequence should women present to the maternity or the emergency department there is a risk that changes to the needs of women and the unborn whether escalating or de-escalating may not be known. ***(Recommendation 1.8)***

5.2.2 The quality of referrals to children's social care by the maternity service are of variable. Stronger referrals identified good articulation of risks and protective factors to the unborn or child but this good practice was not consistent in all records seen. In the absence of any robust quality assurance arrangements it is not clear how good practice is acknowledged and weak practice is sensitively challenged and improved. ***(Recommendation 1.9)***

5.2.3 Reports completed by midwives for initial child protection conferences do not benefit from a robust quality assurance arrangement. Some reports lacked sufficient detail and professional analysis of risks to the unborn and in one case did not align with the advice given by the safeguarding team. In the absence of any operational management or safeguarding team oversight it is not clear how this standard will be improved to achieve consistent practice that safeguards those in their care. ***(Recommendation 1.9)***

5.2.4 The completed section 11 audits by PHT and also GP surgeries visited regarding frontline and governance of safeguarding practice do not reflect the findings of our review. Responses given by partners were generally either 'outstanding' or 'good' but often this this was not supported by evidence or any rationale for their finding. In particular due to the absence of fully embedded risk assessments around domestic abuse, partner's presentation and child sexual exploitation identified in midwifery services it is not clear how a rating of outstanding was achieved.

5.2.5 It is of concern that the current arrangements to upload key child protection documentation onto the 0-19 health records are ineffective. Delays in administrative processes within the business support unit and inconsistent processes, where some hard copies of documents and letters from other agencies were held in hard copy in files in cabinets, means that the electronic patient record is incomplete and important information is not always available to support decision making and inform patient care. ***(Recommendation 4.9)***

5.2.6 There is an effective system for assuring the quality of the contribution of health visitors and school nurses to child protection conferences and of the content and detail in early help assessments. This was evident in every case we looked at in the 0-19 service where good detail in factual information, the level of analysis and the setting of generally SMART objectives was of a high standard. The effective application of the restorative approach by practitioners in this service is leading to delivery of relevant and meaningful change in the outcomes for children.

5.2.7 Records in integrated sexual health service did not contain copies of referrals or reports submitted to children's social care which means the patient record is incomplete. As a consequence we could not review the quality of this important safeguarding practice. In the absence of any formal quality assurance of referrals we cannot see how the trust are assured on safeguarding practice within this service. ***(Recommendation 4.10)***

5.2.8 The paediatric liaison sister at QAH, as part of her safeguarding role, has recently begun to meet the practitioner to review findings of her weekly audit and these meetings are recorded with a view to contributing to the quarterly safeguarding reports made by the PHT named nurse to the safeguarding committee. However, the record of this meeting that we saw, did not include discussion of the quality of referrals that have been reviewed and any remedial or developmental activity undertaken with individual practitioners to ensure continuous improvement. ***(Recommendation 1.7)***

5.2.9 Progress is being made to improve understanding of work practices and information sharing between the Children's ED and community paediatric services. Regular meetings are taking place, with a recent focus on increasing compliance with the LSCB bruising policy.

5.2.10 Adult ED practitioners making entries into the electronic patient record system, are identifiable for the most part only by name rather than by role. It is considered good practice to include this level of detail to ensure robust professional accountability.

5.2.11 The named doctor was not able to give assurance that the peer review process which takes place on a 6 monthly basis is compliant with Royal College guidance. The approach reported does not align with Royal College of Paediatric and Child Health guidance. The named doctor has a planned meeting with the community paediatricians who undertake monthly peer review in order to inform the revision and strengthening of the PHT peer review model.

5.2.12 CAMHS practitioners are not always able to access the patient record during consultations. CAMHS practitioners reported significant delays in access the electronic patient record system at 'peak' times. Not being able to access clients records, especially for duty workers in SPA team presents concerns for effective safeguarding practice. ***(Recommendation 4.9)***

5.2.13 There is inconsistency in how adult mental health services are identifying and flagging children and vulnerability in adult health records. Records reviewed highlighted variation in where the details of children were recorded. On most cases seen, children's names and dates of birth were in free text in the "risk" section instead of in fields within the clients demographic details which would ensure the details of the children are drawn through the record. The presence of children was not always immediately clear on opening the record and there was poor use of the alert facility on the electronic patient record system. Some records did not have an alert even though there were children known to be at risk or where there was known to be a potential risk to staff when visiting a client. Effective use of alert systems are an essential component of robust risk assessment and can be vital in ensuring the safety of staff and clients. ***(Recommendation 4.9)***

5.2.14 Safeguarding referrals from adult mental health and Recovery practitioners are quality assured by service and team managers prior to them being submitted. Records seen contained clear analysis of risk and protective factors to help inform decision-making in the MASH.

5.2.15 On the whole records seen demonstrated good liaison between health services. Sharing of information was facilitated by easy access to other health agency's records via a shared electronic patient record system which is used by all but one GP practice in Portsmouth. A visit to this GP practice indicated that despite a lack of information sharing protocols it was found that information sharing between this practice and the community health teams about vulnerable children and families is generally effective.

5.2.16 We have seen evidence of very recent improvement in the recording and utilisation of risk assessments within adult substance misuse. Practitioners are starting to utilise the comprehensive risk assessment within the electronic record system more effectively and this is supporting better oversight of risk to children in families where adults misuse substances. However, this is a new initiative and we are aware that some service users have not had an updated risk assessment since 2015. Failure to appropriately update risk assessments means there is potential that significant changes to the risk that the adult service user poses to a child may go unreported and this is unacceptable. ***This issue has been brought to the attention of the local authority public health team. (Recommendation 6.1)***

5.2.17 There are no internal formal quality assurance arrangements of initial and review health assessment completed for children and young people who are looked after. External audits by NHS Wessex of initials, reviews and OOA health assessments have been achieved. Random sampling undertaken by named doctor to oversee standard of practice is in place but this is ad-hoc. This approach to quality assurance limits the opportunity to highlight good practice and improve weaker standards. ***(Recommendation 4.7)***

5.2.18 Looked after children health professionals recognise that there are areas for improvement and are seeking ways to address known gaps. Standard operating procedures were reported to be in development to support consistency and improvement but these were not available to review. The pace to support improvement was not well evidenced during this review. This has been challenging though as the named nurse for looked after children has only been in post since April 2017 and the named and designated doctor for looked after children has been off work for a period of time.

5.3 Training and supervision

5.3.1 The MASH health navigator has appropriate child safeguarding and paediatric nursing experience and has appropriately undertaken level 4 safeguarding training. She reports feeling well supported in her role with access to training and development opportunities and receiving monthly supervision from the associate designated nurse alternating with the MASH service manager.

5.3.2 Compliance with safeguarding training within PHT is reported as improving though rates within maternity do not currently meet either CQC or local KPIs. Level 3 training remains single agency as the trust has found it difficult to release staff to attend the PSCB two day multi-agency training. The trust named nurse reports that she is planning to work with the PSCB in developing level 3 topic-based short workshops and sessions to ensure that PHT staff needing level 3 training are able to access a multi-agency component to this in line with best practice. If practitioners are not able to access training this limits their ability to identify safeguarding risks and respond effectively to protect those in their care.

5.3.3 Newly qualified midwives have access to support and band seven staff are available to support their developing practice. However, newly qualified midwives do not benefit from a more structured and formal approach to developing their competence around safeguarding as part of their preceptorship. This is a gap and a missed opportunity to effectively standardise best practice in protecting children across the service. ***(Recommendation 1.10)***

5.3.4 Maternity staff have not all received any dedicated training about caring for the mental health needs of women. This is particularly pertinent for those women that experience crisis given the reported challenge in accessing specialist psychiatric care for women that are mentally unwell on the ward. ***(Recommendation 1.4)***

5.3.5 Within PHT all community band seven midwives are trained to provide supervision. Audit data from May 2017 indicates that safeguarding supervision it is not well established and we were unable to locate any evidence of supervision on patient records. Regular supervision is an integral part of a practitioner's development and supports effective safeguarding practice. ***(Recommendation 1.11)***

5.3.6 Group supervision is in place for the paediatric specialist nurses, including the paediatric diabetes specialist nursing team, and also other staff groups who have regular contact with children. However, supervision arrangements across the ED department remain underdeveloped and staff are not benefiting from regular opportunities for support, reflection and constructive challenge to practice. ***(Recommendation 1.11)***

5.3.7 The safeguarding supervision model in use in the 0-19 service is effective and is research based. This enables managers to understand practitioner's case-loads and ensure equitable allocation of work. It also allows more complex cases to be identified when additional supervision may be offered. Practitioners also access monthly group safeguarding supervision where individual cases are discussed among peers and any learning is distilled and shared. Supervision discussions are guided by a templated format, and were seen documented on patient records using the same format, that considers the child's situation, risks, protective factors and planned actions. This ensures there is a clear rationale for any decisions or actions derived from the supervision.

5.3.8 Compliance with Level 3 safeguarding training in the 0-19 service is good. All practitioners receive safeguarding training that meets the appropriate level of the relevant guidance for specialist staff. Although this training is delivered primarily through the trust's single agency safeguarding training programme, practitioners also have access to the PSCBs multi-agency training events. Data supplied by the provider indicates that all of the 0-19 staff are up to date with this training except for those small number of staff who are long-term absent.

5.3.9 Integrated sexual health service team have access to safeguarding supervision in a range of formats such as part of a six weekly education day or as ad-hoc with a safeguarding lead if required. We saw evidence of facilitated case discussion and sensitive professional challenge with appropriate actions evident. All staff have accessed one half day training for peer and safeguarding supervision.

5.3.10 PHT have been proactive in taking the initiative to train their health practitioners who are likely to care for children and young people who are looked after on the particular complex needs and vulnerability of this cohort of children. Professionals reported that the event went well and although it is too recent to evaluate the impact of the training, there are plans to repeat the event annually to ensure looked-after children retain a high profile in ED.

5.3.11 There is a good offer from the looked after children's CAMHS and looked after children's health team to foster carers. The looked after children's CAMHS service provides consultation and training to professionals and foster carers giving opportunities to reflect and better understand the needs and behaviours of the young person. They promote the most appropriate approaches to helping them manage the child's distress and to enable them to feel safe and offer telephone support where required. The looked after children's health team offer training and support to foster carers around the initial and review health assessment processes as well as the health needs of children and young people who are looked after.

5.3.12 CAMHS offer effective consultation, supervision and training to a number of multiagency partners, upskilling them in face to face work with children and young people. Barnardos workers and CAMHS have good access into children's homes, hostels, school and other key partners around the city, supporting practitioners working with vulnerable children helping with recognition of risks to the young person, and offering insight into their emotional and mental wellbeing, as well as developing strategies to help keep them safe.

5.3.13 Safeguarding supervision arrangements within CAMHS service have recently been strengthened. Each member of staff within CAMHS now has regular clinical and managerial 1:1 supervision which routinely incudes a focus on safeguarding and discussion about the action plan and what needs to happen to keep the child or young person safe.

5.3.14 Solent NHS Trust safeguarding team has recently introduced group safeguarding supervision to adult mental health multi-disciplinary staff including the in-patient unit on a monthly basis. This is a positive development facilitating reflective practice as case examples are discussed. A complex case study review has also been recently facilitated in the adult mental health multi-disciplinary team. The service found this multi-disciplinary case analysis useful and there are plans to hold a similar event. This is helping to support continuous improvement in safeguarding practice in Solent NHS Trust adult mental health.

5.3.15 Managers in adult mental health provide monthly 1:1 supervision to practitioners and all case discussions include a focus on safeguarding and whether the practitioner is appropriately identifying concerns. However, managers have not undertaken any safeguarding supervision training to facilitate and support staff as is best practice.

5.3.16 Safeguarding training within adult mental health services is not sufficiently equipping practitioners with the skills to identify and assess risk so that the hidden child is adequately protected. Adult mental health practitioners undertake level 2 safeguarding training, with service managers undertaking level 3, this is not compliant with the Intercollegiate Guidance. ***(Recommendation 4.11)***

5.3.17 Adult mental health practitioners interviewed were not aware of the new model of child protection case conferences being introduced by children's social care and have not undertaken any training. We are aware that the manager of the adult mental health A2I service is working with the MASH to roll out joint training for adult mental health and children's social care practitioners.

5.3.18 Similarly training within the adult Recovery service is not compliant with the intercollegiate guidance, however records seen showed evidence of effective safeguarding practice. Managers provide regular one to one supervision which includes case discussion utilising a comprehensive safeguarding matrix which pulls data from the electronic record system to provide assurance on a number of risk factors relating to clients and any linked children. Safeguarding discussions were evident in records seen, including the plan of action to minimise risk factors highlighted. However, as managers are not undertaking safeguarding training at an appropriate level, this does not equip them to oversee highly complex safeguarding work effectively. ***(Recommendation 4.11)***

5.3.19 Looked after children professionals have access to a range of training to support compliance with inter-collegiate guidance. Nursing staff have access to looked after children supervision and the named nurse has access to regular supervision from the designated nurse. Community paediatricians have regular management supervision but peer, case supervision is not formalised and is completed under an ad-hoc approach which does not fully align with best practice guidance set out by the Royal College of Paediatrics and Child Health.

5.3.20 Training for looked after children staff about needs of unaccompanied asylum seeking children does not appear well developed. The designated doctor has undertaken some informal training, however, we did not see implementation of tailored, evidenced based assessment of health need when sampling initial health assessments, reviews or in general health records when an unaccompanied asylum seeking child accessed health services.

5.3.21 Primary care staff access a range of training to support their compliance with safeguarding requirements. This includes online, face to face with safeguarding leads and TARGET training with input regularly to this by the named GP. Practices visited used locums from one agency that gave assurance that staff met requirements for safeguarding children. The named GP reported being well supported by designated professionals in undertaking their role.

Recommendations

1. Portsmouth Hospitals NHS Trust should:

1.1 Ensure that all expectant women receive a comprehensive assessment of risk and vulnerability, to include exploration of domestic abuse, mental health, partner behaviour and exploitation and that appropriate advice, support and care is made available to them through a co-ordinated package of support.

1.2 Improve the identification, assessment and recording of risk to children of adults who attend ED with concerning behaviours.

1.3 Ensure that all children who attend the children's ED have a comprehensive risk assessment to ensure that they are safeguarded appropriately and that all practitioners are compliant with the trust's policy and processes.

1.4 Ensure that expectant women with mental ill health or learning disability are cared for by practitioners who are trained to meet their needs.

1.5 Ensure that unborn and newborn babies are protected effectively and evidence compliance with the LSCB Unborn and Newborn Baby Safeguarding Protocol.

1.6 Improve the content of the GP summary report following attendance at ED to include any safeguarding concerns or risk to a child or young person.

1.7 Improve the safeguarding and governance arrangements throughout the trust so that the trust board is able to be assured of effective safeguarding practice throughout the organisation.

1.8 Improve record keeping arrangements within midwifery services so that practitioners have access to a complete record.

1.9 Improve the quality of child protection referrals and reports within midwifery services so that they are of a consistently high standard and support the identification and ongoing assessment of risk to the unborn and newborn infant.

1.10 Ensure that newly qualified midwives demonstrate competency in child protection practice as part of their preceptorship.

1.11 Ensure that all staff who work with children who may be vulnerable or be supported through a child protection or child in need plan are accessing safeguarding supervision in line with trust policy.

2. Portsmouth CCG should:

2.1 Support primary care in the introduction, implementation and evaluation of the local risk assessment tool for CSE in young people so that victims may be identified and supported at the earliest opportunity.

2.2 Ensure the arrangements and job descriptions for the designated and named doctor for looked after children are compliant with the intercollegiate guidance and that there are clear accountability arrangements for the strategic and operational responsibilities for each postholder.

3. Portsmouth CCG, Portsmouth Hospitals NHS Trust and Solent NHS Trust should:

3.1 Ensure that expectant women or post natal women who are cared for as an in-patient on the midwifery wards and have an acute mental health crisis can access adult mental health services following an agreed care pathway.

3.2 Ensure that children and young people who are suffering from mental ill health or have self harmed and are admitted to the acute paediatric ward are appropriately safeguarded through thorough risk assessments and cared for by practitioners who have received training in mental health illness in this age group.

3.3 Agree and implement a care pathway to support young people between 16-18 years who attend ED with mental ill health or self harm to ensure that their mental health and physical care needs are met and that they are safeguarded effectively.

3.4 Ensure that the local MARAC arrangements are fully inclusive of all partners, including primary care.

3.5 Improve paediatric liaison arrangements between the ED and the 0-19 service by ensuring that concerns are being appropriately identified and that there is timely sharing of attendance by children or young people to support effective intervention.

4. Solent NHS Trust should:

4.1 Work with partners to ensure effective implementation of the LSCB escalation policy to address areas of professional disagreement.

4.2 Improve the identification, assessment and recording of risk to children and young people within the integrated sexual health service.

4.3 Improve the identification, assessment and recording of risk around CSE within the 0-19 service.

4.4 Ensure that all practitioners who are working with families where there are adults with mental ill health and vulnerable children share information appropriately, including adult mental health recovery and crises plans.

4.5 Work with partners to improve the arrangements for initial and review health assessments to ensure that appropriate consent is obtained at the earliest opportunity to minimise delay in carrying out assessments for looked after children.

4.6 Improve the collection of data to inform timely planning of health assessments for children and young people who are looked after, including those children placed out of Portsmouth local area.

4.7 Ensure that all looked after children receive high quality health assessments that are informed by robust assessment of risk, including scores from SDQs and information from GPs and that these reviews are informing SMART health care plans that are improving health outcomes.

4.8 Review the capacity of the named professionals to ensure compliance with RCPH Intercollegiate Guidance 2015.

4.9 Ensure that patients' electronic records are a complete record of their care, contain flags to highlight vulnerability and risk, contain all key documentation and are accessible during patient consultation.

4.10 Improve arrangements for record keeping and quality assurance with in the integrated sexual health service.

4.11 Ensure that the training needs analysis for adult mental health services is complaint with the RCPH Intercollegiate Guidance 2015 and local LSCB policy and that adult mental health staff access training according to guidance.

5. Society of St James and Solent NHS Trust should:

5.1 Ensure all service users have current risk assessments recorded on their client record and that any safeguarding risks have been identified and escalated.

5.2 Ensure that the training needs analysis for the adult recovery service is complaint with the RCPH Intercollegiate Guidance 2015 and local LSCB policy and that recovery staff access training according to guidance.

Next steps

An action plan addressing the recommendations above is required from Portsmouth CCG within **20 working days** of receipt of this report.

Please submit your action plan to CQC through childrens-services-inspection@cqc.org.uk The plan will be considered by the inspection team and progress will be followed up through CQC's regional compliance team.

This page is intentionally left blank

CQC Action Plan - Review of Health Services for Children Looked After & Safeguarding in Portsmouth

Portsmouth Clinical Commissioning Group PCCG

Number	Recommendations	Actions	Assigned To	Completion Due Date	Progress	Comments/Evidence
2.1	Support primary care in the introduction, implementation and evaluation of the local risk assessment tool for CSE in young people so that victims may be identified and supported at the earliest opportunity.	1. Deliver further train the trainer courses. 2. Explore IT solutions to ensure that Primary Care use the shortened tool for all 18 year olds requesting sexual health or contraceptive advice. 3. Monitor number of referrals from health agencies to MASH related to concerns regarding CSE. 4. Audit GP awareness of CSE and local tools.	Sarah Shore, Associate Designated Nurse	1. 30.11.17 2. 31.01.18 3. 30.06.18 4. 30.06.18		
2.2	Ensure the arrangements and job descriptions for the designated and named doctor for LAC are compliant with the intercollegiate guidance and that there are clear accountability arrangements for the strategic and operational responsibilities for each postholder.	1. Meet with Solent NHS Trust to explore options. 2. Review and update Job Descriptions. 3. Separate Roles and functions of the Named and designated LAC Posts.	Tina Scarborough Deputy Director Safeguarding and Quality	31.12.17		
3.1	Ensure that expectant women or post natal women who are cared for as an in-patient on the midwifery wards and have an acute mental health crises can access adult mental health services following an agreed care pathway.	1. Confirm Commissioning arrangements. 2. Support review of perinatal mental health services. 3. Facilitate Solent NHS Trust, PHT and Perinatal services to develop a clear care pathway.	Tina Scarborough Deputy Director Safeguarding and Quality	1. 31.08.17 2. 30.11.17 3. 31.01.18		
3.2	Ensure that children and young people who are suffering from mental ill health or have self harmed and are admitted to the acute paediatric ward are appropriately safeguarded through thorough risk assessments and cared for by practitioners who have received training in mental health illness in this age group.	1. Work with PHT to deliver their action plan to address this.	PSCB and PSAB Joint Children and Adults PHT Safeguarding Improvement Project Board	TBC		
3.3	Agree and implement a care pathway to support young people between 16-18 years who attend ED with mental ill health or self harm to ensure that their mental health and physical care needs and are met and that they are safeguarded effectively.	1. Work with PSCB to develop Self Harm pathway for young people. 2. Audit pathway once embedded.	PSCB and PSAB Joint Children and Adults PHT Safeguarding Improvement Project Board	TBC		
3.4	Ensure that the local MARAC arrangements are fully inclusive of all partners, including primary care.	1. Work with MASH Board and MARAC Steering Group to develop and plan new model for Portsmouth ensuring the Health Services are involved in the new process.	Tina Scarborough Deputy Director Safeguarding and Quality	This work is being managed via the Community Safety Partnership.		
3.5	Improve paediatric liaison arrangements between the ED and the 0-19 service by ensuring that concerns are being appropriately identified and that there is timely sharing of attendance by children or young people to support effective intervention	1. Support Solent NHS Trust and PHT to improve information sharing.	PSCB and PSAB Joint Children and Adults PHT Safeguarding Improvement Project Board			

This page is intentionally left blank

CQC Action Plan - Review of Health Services for Children Looked After & Safeguarding in Portsmouth

Solent NHS Trust

Number	Recommendations	Actions	Assigned To	Completion Due Date	Progress	Comments/Evidence
3.1	Ensure that expectant women or post natal women who are cared for as an in-patient on the midwifery wards and have an acute mental health crises can access adult mental health services following an agreed care pathway.	This action needs to be led by PHT, and perhaps coordinated by the CCG, we of course contribute to any working party / task and finish group				
3.2	Ensure that children and young people who are suffering from mental ill health or have self harmed and are admitted to the acute paediatric ward are appropriately safeguarded through thorough risk assessments and cared for by practitioners who have received training in mental health illness in this age group.	This action needs to be led by PHT, and perhaps coordinated by the CCG, we of course contribute to any working party / task and finish group				
3.3	Agree and implement a care pathway to support young people between 16-18 years who attend ED with mental ill health or self harm to ensure that their mental health and physical care needs and are met and that they are safeguarded effectively.	This action needs to be led by PHT, and perhaps coordinated by the CCG, we of course contribute to any working party / task and finish group				
3.4	Ensure that the local MARAC arrangements are fully inclusive of all partners, including primary care.	This action needs to be led by the CCG, we of course contribute to any working party / task and finish group				
3.5	Improve paediatric liaison arrangements between the ED and the 0-19 service by ensuring that concerns are being appropriately identified and that there is timely sharing of attendance by children or young people to support effective intervention	PHT/Safeguarding Team Lead. SNHST Children's services to work with PHT and the safeguarding team in developing this model	Professional Lead for Children			
4.1	Work with partners to ensure effective implementation of the LSCB escalation policy to address areas of professional disagreement.	Safeguarding Team in training Child and Family services to ensure that all staff are aware of the Conflict Resolution/Escalation Policy which is available in the 4 LSCB Procedure Manual	Professional Lead for Children	10.9.17		
4.2	Improve the identification, assessment and recording of risk to children and young people within the CASH service.	1 - SH is meeting with their IT provider to review an alternative RAT that is nationally recognised. The service will review this and if it is superior to the tool that is currently being used, it will be implemented and made mandatory for anyone under the age of 18. 2 - SH have asked their IT provider to add a review button to the RAT for young people that attend the clinic regularly. This will also be discussed on the 27th September. 3 - The Safeguarding leads for SH will be completing a monthly audit of all patients under the age of 18 to review the notes to ensure the RAT that assess risk of CSE and domestic abuse has been completed or reviewed and updated, and any relevant safeguarding concerns addressed. Outcome of this audit will be presented at the services monthly clinical governance meeting and lessons learnt shared with the wider team. 4 - Staff will be reminded of the importance of completing and reviewing the RAT via email, a newsflash and at team meetings.	Professional Lead SH	Meeting planned for 27th September		
4.3	Improve the identification, assessment and recording of risk around CSE within the 0-19 service.	Complete a training programme for staff in the 0-19 service in identification of CSE. On S1 to incorporate a recording to show that CSE has been considered and completed accordingly.	K Slater	1.10.17		
4.4	Ensure that all practitioners who are working with families where there are adults with mental ill health and vulnerable children share information appropriately, including adult mental health recovery and crises plans.	Staff to be reminded of the importance of sharing information with others service in order to ensure the welfare of a child.	Professional Lead AMH	1.11.17		
4.5	Work with partners to improve the arrangements for initial and review health assessments to ensure that appropriate consent is obtained at the earliest opportunity to minimise delay in carrying out assessments for LAC	Discussion with Social Care colleagues on obtaining consent for assessment.	J Gonde / S Shore/ E Wilson	1.11.17		

4.6	Improve the collection of data to inform timely planning of health assessments for LAC, including those children placed out of Portsmouth local area.	Improve communication between Social Care and LAC CLA nurses to casehold rather than sharing cases to enable lead clinician and ownership. SOP development in place, ongoing work with S1 and database team.	K Slater /E Wilson	1.11.17		
4.7	Ensure that all LAC receive high quality health assessments that are informed by robust assessment of risk, including scores from SDQs and information from GPs and that these reviews are informing SMART health care plans that are improving health outcomes.	Develop ways of improving SDQ return rate currently 38% Named Nurse to audit review health care plans including peer review and NHS Wessex. Training programme East and West on SMART health care plans Guidance reviewed and circulated to clinicians, SOPs under development.	E Wilson/J Gonde	1.3.17		
4.8	Review the capacity of the named professionals to ensure compliance with RCPH Intercollegiate Guidance 2015.	Mental health services to review the capacity of named professionals against the suggested guidance	Shared with CCG	C Smith		
4.9	Ensure that patients' electronic records are a complete record of their care, contain flags to highlight vulnerability and risk and contain all key documentation and are accessible during patient consultation.	Children's - to review with IG the inputting of child protection meetings onto S1 that need to be deleted after 2 years of being removed form a CP plan, this is to be incorporated into a Trust SOP. Audit of LAC alerts to be completed yearly. AMH Mental health service are to review their use of flags, and provide guidance for staff regarding when these MUST be used and agreed at governance meeting.	Professional Leads	Immediate Actions complete in Childrens		
4.10	Improve arrangements for record keeping and quality assurance with in the CASH service.	1 - All staff have been asked to ensure they put an alert on the EPR for any patients that are vulnerable. 2 - The service will work with MASH to develop a process to enable an upload of the electronic safeguarding referral into the patients EPR and to ensure the outcome of the referral is fed back to the service and documented in the patient EPR. This is going to be part of a Quality Improvement project for the service. 3 - The Safeguarding Lead Nurses will be completing a monthly audit of all patients under the age of 18 who have not had a RAT completed or reviewed and updated. The outcome of the audit will be presented at the monthly Clinical Governance meetings. If clinicians have not completed the RAT it will be discussed in one to one's and performance managed if required. Lessons learnt will be shared with the wider team.	Professional Lead SH	1 - Alert on notes September 2017 2- Upload of referral to SH EPR October 2017 3- September 2017		
4.11	Ensure that the training needs analysis for adult mental health services is complaint with the RCPH Intercollegiate Guidance 2015 and local LSCB policy and that adult mental health staff access training according to guidance.	Mental health services to review their safeguarding training against the suggested guidance.	Professional Lead AMH	1.11.17		
5.1	Ensure all service users have current risk assessments recorded on their client record and that any safeguarding risks have been identified and escalated.	This relates to CSE risk assessments Training has been arranged for HV/ SN/FNP/ Sexual Health service on the CSE risk assessment tools. A programme of audit will then be established in HV/SN/ FNP to ensure this has been embedded Last training session planned for 18/10/17	Kate Slater	18.10.2017		

CQC Action Plan - Review of Health Services for Children Looked After & Safeguarding in Portsmouth

Society of St James

Number	Recommendations	Actions	Assigned To	Completion Due Date	Progress	Comments/Evidence
5.1	Ensure all service users have current risk assessments recorded on their client record and that any safeguarding risks have been identified and escalated.	An Audit of all files will be undertaken by the Senior Recovery Workers of case loading staff. The audit will look for:- 1. A risk assessment to be in place. 2. Where there are dependents, that a PRAM/SAM has been completed. 3. Review current risk assessments to identify where there are changes that these have suitable management plans. 4. A regular sample audit is put in place quarterly	Anna Jackson	Weds 6th Sept - Audit discussed at team meeting and SRW's tasked to audit files. Audit to be completed by Weds Nov 1st 2017. Scheduled reports booked from March 2018		
5.2	Ensure the training needs analysis for the adult recovery service is compliant with the RCPH Intercollegiate Guidance 2015 and local LSCB Policy and that recovery staff access training according to guidance.	PCSB offer six modules safeguarding - NBT training environment. All staff will be booked onto a course. Also to look at options for training with the CCG	Anna Jackson	Weds 6th Sept - Audit discussed at team meeting and SRW's tasked to book staff. The completion of this action will be reliant on the number of training places available.		
Added: Paragraph 1.4 (not noted as a recommendation but opportunity to understand whether this arrangement is working effectively)	In the absence of a specialist midwife for substance misuse, community midwives care for expectant women and liaise with adult substance misuse services. We are unable to comment on the effectiveness of these arrangements as record keeping is fragmented which limits access to a complete patient record.	Contact with midwife added as a field for caseworkers to complete. This action need to be recorded in the case notes.	Darren Carter	Weds 3rd October 2017		

This page is intentionally left blank

CQC Action Plan - Review of Health Services for Children Looked After & Safeguarding in Portsmouth						
PORTSMOUTH HOSPITALS NHS TRUST						
Number	**Recommendations**	**Actions**	**Assigned To**	**Completion Due Date**	**Progress**	**Comments/Evidence**
1.1	Ensure that all expectant women receive a comprehensive assessment of risk and vulnerability, to include exploration of domestic abuse, mental health, partner behaviour and exploitation and that appropriate advice, support and care is made available to them through a co-ordinated package of support	1.1.1 New maternity notes to be updated to include a comprehensive safeguarding risk assessment and a safeguarding and support plan. 1.1.2 Background to current domestic abuse risk assessment arrangements to be explored to gain understanding of decision and contribute to review of whether this arrangement should continue. 1.1.3 The four questions in the shortened child sexual exploitation (CSE) risk assessment tool will be embedded into the safeguarding risk assessment we plan to include in the new maternity notes. 1.1.4 Audit to be undertaken to measure compliance with the use of the new referral form and the quality of the information contained in the referral form.	1.1.1 - 1.1.3 Named Midwife for Safeguarding Children 1.1.4 Senior Midwifery Manager Community & Public Health	Mar 31 2018		
1.2	Improve the identification, assessment and recording of risk to children of adults who attend ED with concerning behaviours.	Mandatory safeguarding children risk assessment to be incorporated into the IT system for adults attending ED with concerning behaviours.	Emergency Department Consultant and OCEANO lead & Named Doctor for Safeguarding Children	Mar 31 2018		
1.3	Ensure that all children who attend the children's ED have a comprehensive risk assessment to ensure that they are safeguarded appropriately and that all practitioners are complaint with the trust's policy and processes.	Current mandatory safeguarding children risk assessment on IT system for children attending ED to be reviewed and enhanced as appropriate.	Emergency Department Consultant and OCEANO lead & Named Doctor for Safeguarding Children	Mar 31 2018		

1.4	Ensure that expectant women with additional mental health or learning disability are cared for by practitioners who are trained to meet their needs.	1.4.1 All band 7 Clinical Lead Midwives, Specialist Midwives and vulnerable families team Midwives, who have not undertaken mental health training within the last 3 years, to do so. 1.4.2 Mental health training to be incorporated into maternity mandatory training plan for inclusion in training days at least every 3 years. 1.4.3 Awareness of the Learning Disability passport to be raised within the maternity service.	1.4.1 - 1.4.3 Clinical Lead for Midwifery Practice Education	Mar 31 2018		Maternity mandatory training 2015/2016 included a 1 hour mental health training session. Maternity mandatory training 2017/18 includes a mental health simulated training scenario. Vulnerable families team midwives received mental health training 17/07/17.
1.5	Ensure that unborn and newborn babies are protected effectively and evidence compliance with the LSCB Unborn and Newborn Baby Safeguarding Protocol	1.5.1 PHT's system of writing maternity alerts at 34/40 to be reviewed as not currently in line with 4LSCB protocol. 1.5.2 Maternity service to support partner agencies in Portsmouth and Hampshire to embed the development of multi agency pre and post birth plans.	1.5.1 & 1.5.2 Named Midwife for Safeguarding Children	Mar 31 2018		
1.6	Improve the content of the GP summary report following attendance at ED to include any safeguarding concerns or risk to a child or young person.	1.5.1 Audit being undertaken to determine the extent to which the information on GP discharge summaries correlates with the safeguarding children risks documented in the free text. 1.5.2 Awareness to be raised within the Emergency Department of the need to take care when inputting data onto OCEANO.	1.5.1 & 1.5.2 ED Matron	1.5.1 Mar 31 2018 1.5.2 Nov 31 2017		

1.7	Improve the safeguarding and governance arrangements throughout the trust so that the trust board is able to be assured of effective safeguarding practice throughout the organisation.	1.7.1 External whole system review of safeguarding being undertaken as part of PHT Quality Improvement Plan. Phase 2 to include child safeguarding. 1.7.2 Terms of reference for the Safeguarding Committee to be reviewed. 1.7.3 Appoint a Head of Safeguarding (Adults and Children) at an 8C, new strategic level post. 1.7.4 Workload of Safeguarding Children Team to be reviewed 1.7.5 Maternity service to identify opportunities during the maternity pathway when women are seen alone and ensure that these opportunities to ask the routine domestic abuse screening questions are maximised. 1.7.6 Safeguarding children supervision arrangements in ED to be improved and clearly recorded.	1.7.1 - 1.7.3 Associate Director of Nursing supported by the Director of Nursing 1.7.4 Head of Safeguarding 1.7.5 Named Midwife for Safeguarding Children 1.7.6 Named Nurse for Safeguarding Children	1.7.1 Timeline starting 20/09/17 1.7.2 Completed 1.7.3 As soon as possible 1.7.4 - 1.7.6 Mar 31 2018	1.7.3 Appointment has been made, start date TBC.	
1.8	Improve record keeping arrangements within midwifery services so that practitioners have access to a complete record.	1.8.1 Mapping exercise to be undertaken to map current record keeping arrangements. 1.8.2 Task and finish group to implement a maternity wide change of record keeping arrangements.	1.8.1 Named Midwife for Safeguarding Children 1.8.2 Named Midwife for Safeguarding Children	1.8.1 Dec 30 2017 1.8.2 Mar 31 2018		
1.9	Improve the quality of child protection referrals and reports within midwifery services so that they are of a consistently high standard and support the identification and ongoing assessment of risk to the unborn and newborn infant.	All referrals and reports to be signed by a band 7 midwife, for quality assurance purposes, before they leave the organisation.	Named Midwife for Safeguarding Children	Dec 30 2017		
1.10	Ensure that newly qualified midwives demonstrate competency in child protection practice as part of their preceptorship.	Competency document to be produced and incorporated into the existing preceptorship programme for newly qualified midwives.	Clinical Lead for Midwifery Practice Education	Dec 30 2017		
1.11	Ensure that all staff who work with children who may be vulnerable or be supported through a child protection or child in need plan are accessing safeguarding supervision in line with trust policy.	Safeguarding children supervision arrangements to be audited against PHT supervision policy and local safeguarding children board standards.	Named Nurse & Named Midwife for Safeguarding Children	Mar 31 2018		

3.1	Ensure that expectant women or post natal women who are cared for as an in-patient on the midwifery wards and have an acute mental health crises can access adult mental health services following an agreed care pathway.	Robust support to be secured from onsite mental health liaison team for maternity inpatients experiencing an acute mental health crisis.	Senior Midwifery Manager Community & Public Health and Specialist Perinatal Mental Health Midwife	Completed		Gap in service provision for women experiencing an acute mental health crisis was highlighted at quarterly perinatal mental health pathway meeting with multi agency stakeholders. Commissioning arrangements in relation to the support offered to maternity services from the onsite mental health liaison team have been strengthened.
3.2	Ensure that children and young people who are suffering from mental ill health or have self harmed and are admitted to the acute paediatric ward are appropriately safeguarded through thorough risk assessments and cared for by practitioners who have received training in mental health illness in this age group.	3.2.1 Paediatric service documentation to be updated to include a safeguarding children risk assessment. 3.2.2 Paediatric service documentation to be updated to include an environmental risk assessment for this group of children. 3.2.3Paediatric Unit: All band 7 Senior Ward Sisters, Specialist Nurses, band 6 Ward Sisters and Safeguarding Leads who have not undertaken mental health training within the last 3 years, to do so. 3.2.4 Mental health training to be incorporated into Paediatric Unit mandatory training plan for inclusion in training days at least every 3 years. 3.2.5 Paediatric service to support partner agencies in ensuring they share their risk assessments in a timely manner to inform ongoing clinical care and safeguarding	3.2.1 & 3.2.2 Paediatric Senior Sister 3.2.3 & 3.2.4 Paediatric Practice Educator 3.2.5 Paediatric Matron	Mar 31 2018		
3.3	Agree and implement a care pathway to support young people between 16-18 years who attend ED with mental ill health or self harm to ensure that their mental health and physical care needs and are met and that they are safeguarded effectively.	Standard operating procedure (SOP) to be produced and embedded for young people 16 to 18 years of age requiring observation in the adult observation bay.	W&C Head of Nursing	Completed		SOP has been developed, ratified and launched within ED. Compliance will now be monitored via audit.
3.4	Ensure that the local MARAC arrangements are fully inclusive of all partners, including primary care.	PHT to work with partner agencies in Portsmouth and Hampshire to achieve appropriate inclusion.	Named Nurse & Named Midwife for Safeguarding Children and Adult Safeguarding Lead	Mar 31 2018		

3.5	Improve paediatric liaison arrangements between the ED and the 0-19 service by ensuring that concerns are being appropriately identified and that there is timely sharing of attendance by children or young people to support effective intervention	3.5.1 Scoping of paediatric liaison arrangements across wider acute health providers and 0-19 services to be undertaken. 3.5.2 PHT to work with partner agencies to develop a solution to the identified gap in service provision.	Named Nurse for Safeguarding Children and Head of Nursing Emergency Medicine	Mar 31 2018		

This page is intentionally left blank

Solent NHS Trust Update to Portsmouth City Council Overview and Scrutiny Panel

November 2017

Phase 2 St Mary's Hospital

As part of the strategic estates plans for health and social care provision in Portsmouth, services will continue to move from the St James Hospital Site to purpose built facilities at Block B, St Mary's Hospital. Services that will relocate to St Mary's include: Older Persons Mental Health Community Teams, Physiotherapy and outpatient therapies facilities. Pharmacy Services at St Mary's will also benefit from an upgrade to allow better receipt of deliveries and enhances patient consultation areas. Facilitating the moves will require an extensive redevelopment of Block B at St Mary's, which is currently largely vacant, but not fit for future purposes.

Solent NHS Trust made a £10.3million bid to Department of Health for "Wave 1" STP Capital Grant money early in 2016/17, but was unsuccessful. A new bid has been submitted to the "Wave 2" fund for the same amount, which if approved will lead to work commencing from Spring 2018, lasting for around 12 months. In the interim, whilst the decision about "Wave 2 funding" is pending; Solent NHS Trust has applied for a loan to NHS Improvement to begin work on the St Mary's Block B site.

CQC Inspections Update

Following the CQC comprehensive inspection in June 2016: CQC has undertaken follow up visits in the Summer and Autumn of 2017 to service areas where specific improvements were required. Children and Young People's Mental Health Services were re-inspected and re-rated as "Good". Substance Misuse Services were also re-rated as "Good". The results of these inspections can now be viewed on the CQC website.

In September 2017, CQC published their "Review of health services for Children Looked After and Safeguarding in Portsmouth". This was a system-wide assessment of services provided to Looked After Children and their families and of Safeguarding services and standards. The review covered Portsmouth Hospitals Trust, Portsmouth City Council, Society of St James and Portsmouth CCG. CQC made service specific recommendations for improvement – 8 of which were for services provided or partly provided by Solent. There were another 6 recommendations for services, led by other organisations to which Solent will make a contribution to the improvement action. An action plan has been completed and there are no risks to the completion of any actions.

CQC also made a follow-up visit to two special schools in Portsmouth - Mary Rose and Rosewood - that are supported by Solent NHS Trust staff. They noted improvements to prescribing, medicine management and record keeping practice – singling out Rosewood especially for its high standard of care planning. This inspection was not intended to produce a formal re-rating for these services; focussing only on the “Safe” domain. CQC have issued a letter to Solent detailing their findings, which we are responding to by updating our Action Plans for these services.

Kite

The Kite Unit is a small community ward, based at the St James Hospital site that specialises in the rehabilitation of Acquired Brain Injury, specifically where this is associated with challenging behaviour. Kite is commissioned by CCGs across Hampshire as part of a brain injury pathway and was moved to the St James site, from Knowle Hospital – Fareham, when that site was redeveloped. In January; the Kite Unit will be relocated to Western Hospital in Southampton to be on the same site as the other Hampshire-wide neurological unit – Snowdon. This will help patients benefit from a concentration of neurological rehabilitation expertise at a single location.

CQC National Review of Mental Health Services for Children and Adolescents

At the end of September 2017, CQC published a national review into the quality and responsiveness of mental health services provided for children and adolescents. A particular finding was that waiting lists for specialist CAMHS were often long and that pathways between services were often fragmented and difficult to navigate. The CQC Inspection of Solent CAMHS reflected the national trend, with long waiting times to access Cognitive Behaviour Therapy and Autism assessments a particular issue. Although the CAMHS service in Portsmouth reviewed its care pathways, staff deployment and therapy offer, since the initial inspection; the rate of referrals to CAMHS in the city continued to rise resulting in only modest improvements in waiting times by re-inspection in August 2017. The service was however rated as “Good” in Safe and Effective domains and rated “Outstanding” for Caring by CQC. Work on internal team processes has continued, however and Portsmouth CAMHS now have the shortest referral to treatment times in England and all patients requiring treatment at specialist CAMHS level are now able to commence within 18 weeks of referral.

Trust Financial Position and Forecast

All NHS Organisations have to agree an annual financial “control total” with NHS Improvement, as part of the single oversight framework. The control total is the amount of surplus, or deficit that an organisation is expected to achieve at year end.

Solent NHS Trust and NHSI agreed a year end forecast position of £1.5 million deficit, which Solent is on course to achieve.

Matthew Hall

Deputy Chief Operating Officer – Portsmouth

Solent NHS Trust

This page is intentionally left blank

NHS
Portsmouth Hospitals
NHS Trust

Agenda Item 6

QUALITY IMPROVEMENT PLAN 2017

Contents

Introduction

The Quality Improvement Plan (QIP) for Portsmouth Hospitals NHS Trust attempts to address a number of concerns into the quality of care received by patients. The Care Quality Commission (CQC) rated the trust as "Inadequate" for medical care and safety in Emergency Care.

The Board is committed to understanding the root causes behind the failings in care provision and to systemically address those underlying causes. This will ensure that changes are made so that patients receive consistent, high-quality care and Portsmouth Hospitals NHS Trust becomes the employer of choice.

The Board will apply focus and rigour to ensure the delivery of the plan. The Board will also start work to create the conditions that allow staff to do their job well by removing blocks to success and managing risks to delivery. Partner agencies have kindly offered their support to the Trust and this is warmly welcomed. The CCG, local authorities, Healthwatch, NHS Improvement, NHS England and others will play a key role in scrutinising the assurance processes to ensure they are robust.

A core facet of the plan is the engagement of frontline staff in the improvement journey and alignment to the Quality Improvement Strategy. This will ensure the impact of the Improvements is understood and take advantage of the expertise and knowledge of staff as well as patients to ensure the plan is delivered. It will also start to signal a common purpose and priority for the organisation that is owned by frontline staff.

The Board is committed to ensuring that the Quality Improvement Plan is delivered at pace. Working with all staff in the Trust and with the support of partner organisations and agencies, the Board is confident that the plan will deliver an improved outcome at the next CQC inspection. Furthermore, by developing and embedding a culture of continuous improvement and supporting frontline staff to improve services through innovation, the Board has set the ambition to be rated "Good" by 2019 and "Outstanding" by 2020.

Trust Profile

Queen Alexandra Hospital (QAH) started life more than a century ago as a military hospital. Today it is one of the largest, most modern hospitals in the region, with 1,200 beds housed in light, bright, infection resistant en-suite wards.

The current hospital was first opened by Princess Alexandra in 1980 before undergoing a major redevelopment to create a modern and 'fit for purpose' hospital, which was completed in 2009.

Included within our modern buildings are:

- 28 theatres - with four dedicated endoscopy theatres
- Two purpose-built interventional radiology suites, three MRI scanners, three CT scanners and a PET scanner
- State-of-the-art pathology laboratory
- Neonatal Unit, Level 3
- Hyper Acute Stroke Unit
- Superb critical care facilities

We provide comprehensive secondary care and specialist services to a local population of 675,000 people across South East Hampshire. We also offer some tertiary services to a wider catchment area in excess of two million people.

In the last year we saw:

- Over 73,000 planned admissions to hospital
- Over 141,000 Emergency Department attendances
- Over 566,000 outpatient appointments
- Over 54,000 emergency admissions
- Over 5,700 births in our maternity units
- We employ around 7,000 people making us the largest employer in Portsmouth

Recruiting and maintaining an effective workforce is a major priority and our strong partnerships with the Ministry of Defence, Carillion and NHS Professionals - who provide our temporary workforce helps us to achieve the goal of maintaining safe services for all of our patients.

Our Trust strategy has not been developed in isolation. We have an important role to play within the local health economy and we are a key player in the delivery plan of the Hampshire and Isle of Wight Health (HIOW) and Care System Sustainability and Transformation Plan (STP). This recognises the challenges we face, our vision for HIOW and the action we are taking to address our challenges and deliver our vision.

Single Item Quality Surveillance Group meeting

The Trust attended a Single Item Quality Surveillance Group on 22nd September 2017 led by NHS Improvement/NHS England involving partner organisations, commissioners and regulators. The purpose of the meeting was to look at wider surveillance and quality at a local, regional and national level and work with the Trust and System around identified quality concerns.

Actions identified from the meeting:

Action	Organisation
Quality Oversight Group to identify specific actions which will enable the group to close down	NHS Improvement/ NHS England
The system to identify what is required to enable self-regulation	System convener
System approach to resolve urgent care improvements	All Organisations
Trust to liaise with HEE re their offer of support	Portsmouth Hospitals NHS Trust
System to produce a work programme for each organisation	All organisations
Liaise with Chief of Service Acute Medical Unit (AMU) regarding Acute Frailty Network for the Quality Improvement approach for the whole system	NHS England

The Trust currently has three Section 31 Enforcement Notices imposed on the registration with the CQC:

1. Acute Medical Unit (AMU) regarding adequate staffing relating to patient acuity, crowding of the GP referral area with fortnightly reporting on compliance.
2. ED and Mental Health relating to suitably qualified and competent staff in EDU, risk assessment and care planning of patients with mental health problems, oversight of patients with mental health concerns or safeguarding issues, correct application of MCA and DoLS with weekly reporting against the conditions.
3. Diagnostic and screening procedures in relation to resolving the backlog of radiology reporting and ensuring robust processes to report images taken with weekly reporting against the conditions.

The Trust has also been issued with a Section 29a Warning Notice, which requires significant improvements to be madein various aspects of clinical care and governance by 31st October 2017.

Within the February and May 2017 CQC reports there were a number of ‘must do’ actions and one ‘should do’ action. To address the shortcomings identified within the reports the Trust has worked on identifying key aims and causes and has undertaken a number of staff and patient engagement events.

CQC Report Findings 2017

The reports following the CQC inspections inspected Urgent and Emergency Services and Medical Care at QAH on the 16th, 17th, 28th February and 10th and 11th May were published on 24th August.

The following ratings have been applied:

	Safe	Effective	Caring	Responsive	Well-led	**Overall**
Urgent and Emergency Services	Inadequate	Good	Good	Requires Improvement	Requires Improvement	**Requires Improvement**
Medical Care	Inadequate	Inadequate	Inadequate	Requires Improvement	Inadequate	**Inadequate**

Figure 1 identifies the persistent concerns raised by the CQC and the root causes identified by the Trust.

Persistent problems	Relevant root causes
Board ownership	A, B, F
Lack of strategic view	A, B
Valuing the basics of care	C, G, I, K, M
Medicines management	C, G, I, M
Care of vulnerable patients (mental health, safeguarding, dementia)	C, G, I, J, K, L, M
Low staff morale	A, B, C, D, H
Poor patient flow	A, B, C, D, E, H, J
Poor governance	C, F, I, J
Poor risk management	I, J, M
Culture of bullying and inability to raise concerns	A, B, D, H

Root causes identified following CQC report

A. Board portfolios unclear

B. High turnover and proportion of interims in the leadership team

C. Roles, responsibilities and accountability was not clear and not reinforced

D. Leadership not visible and leaders not responsive to incidents

E. Revised Medical Model not implemented

F. Trust has not maintained a usable Board Assurance Framework

G. Inconsistent application of fundamentals of care

H. Lack of performance management

I. Not knowing what good is or looks like

J. Controls and processes unclear or failing

K. Lack of risk assessment and care planning

L. Staffing establishment

M. Staff knowledge, competence and expertise

Trust Board Response

The Trust Board have acknowledged that the CQC reports made difficult reading and have accepted the findings without reservation; acknowledging that the Trust had clearly fallen short in some key areas.

Since the inspections in February and May 2017, the Trust has made some significant and important changes, including strengthening the joint working of our doctors and nurses in the emergency department and medical care. We have improved how we care for our most vulnerable patients, including those who have mental health issues. We now have active, early risk assessments in our ED, a Mental Health Liaison Team working closely together and stronger cross-organisational working practices with colleagues from partners. The Trust Board have made it clear that secrecy, not speaking up and not working together for the good of all our patients has no place in our Trust.

The Trust Board consider 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. The successful implementation of this Quality Improvement Plan linked to the Quality Improvement Strategy will ensure that improvements are made and sustained for all Trust's services.

Developing a Culture of Continuous Improvement

Patients are at the heart of everything we do at Portsmouth Hospitals NHS Trust and we are committed to improving quality and achieving excellence in all that we do. Our aim is to be one of the most successful NHS Trusts in Caring for Patients, Caring for Each Other and Working towards a Happier, Healthier Portsmouth Community. We are committed to developing A Culture Of Learning And Doing Things Differently and supporting continuous Quality Improvement (QI), as advocated within NHS Improvements "Developing People, Improving Care" (2016) document.

For QI to be successfully embedded by all staff at all levels, a culture of improvement that spans the organisation is required. Strong leadership is key to the development of an improvement culture, and organisations that have successfully implemented QI strategies have demonstrated improvements in standards and outcomes across all aspects of care. QI is distinctly different to audit and has been shown to bring about more sustained improvement as it enables those with the experiences to explore and co-create the process, resulting in it being more likely that the whole organisation will 'own' the approach.

Early Board level support and backing are cited as being critical success factors; at PHT the Board have committed to delivering the Quality Improvement Aims, which will be underpinned by the development of a new Quality Improvement Strategy (2018-2021).

Quality improvement aims

- Valuing the basics
- Moving beyond safe
- Supporting vulnerability in patients
- An organisation that learns
- Leading well through good governance

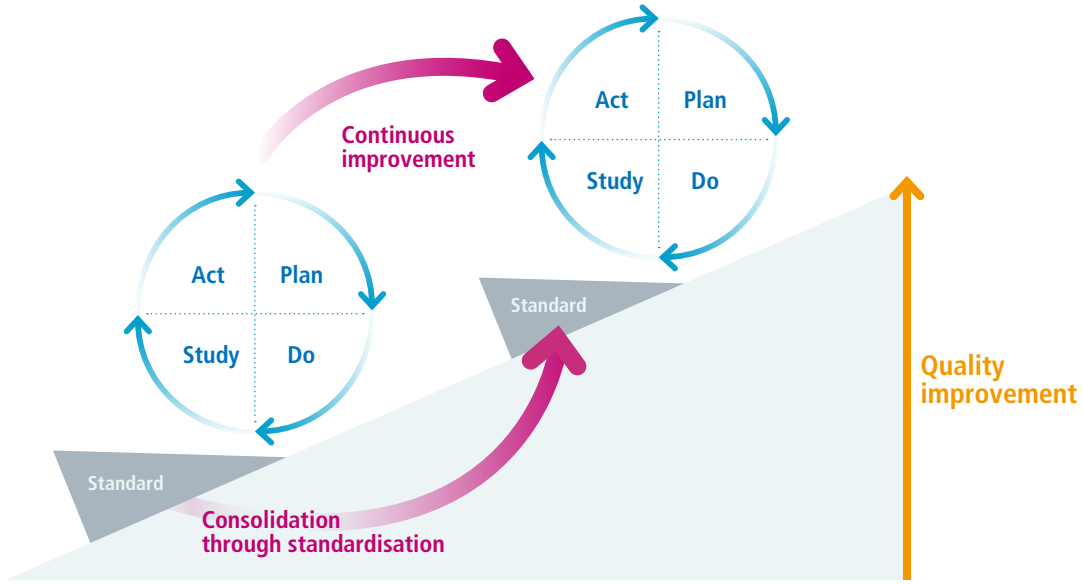
The Quality Improvement Strategy (2018-2021) is currently being developed with stakeholder engagement and once delivered will ensure that effective QI skills are embedded and locally owned. In order to support the implementation a number of actions have already been agreed:

The Quality Improvement Strategy stakeholder events have identified the QI aims and seven themes underpinning the aims.

The development of a virtual 'Portsmouth Improvement Academy' led by a triumvirate of a doctor, a nurse/midwife/ Allied Health Professional (AHP) representative and a service manager. This Triumvirate will support the delivery of the agreed QI Strategy using QI training to build capability and capacity amongst the workforce. The vision of the 'Portsmouth Improvement Academy' is to oversee a 'hub' of QI Facilitators whose role will be to train, mentor and support staff working through QI projects.

The Trust will adopt the Institute for Healthcare Improvement (IHI) Model for Improvement (MFI) as our chosen QI methodology. It is simple for all staff to use and is a widely understood methodology that has been successfully used in many healthcare settings. Furthermore it builds on the existing knowledge and skills of many of our staff, and harnessing that enthusiasm and knowledge from frontline staff will enable us to make progress faster. The MFI utilises the Plan, Do, Study, Act (PDSA) cycle to facilitate change from the front line, thus encouraging altered behaviours, working together, creative thinking, and fundamentally, using measurement to guide improvement (Figure 2).

Figure 2: Demonstrating Change by the use of the Model for Improvement (MFI) and Plan, Do, Study, Act (PDSA) Cycle



Quality Improvement Plan (QIP)

The QIP brings together all the actions that the Trust believes to be the most important. The Trust also believe that gaining traction on these will deliver the improvements necessary to achieve the short-term goal of an overall Trust CQC rating of at least "Requires Improvement" by March 2018 and the longer-term ambition of an overall Trust CQC rating of "Good" by 2019, and an "Outstanding" by 2020.

Whilst the issues were identified within the Urgent and Emergency Services and Medical Care, we acknowledge that these findings are potentially translatable across the whole organisation. The identified aims align to the Trust Quality Account Priorities for 2017/2018.

The plan to achieve "Requires Improvement" is very detailed and will form the basis of our work plan for the next year. Simultaneously, we will introduce, implement and start to embed the Quality Improvement Strategy.

We will approach our Improvement Plan through:

- Robust leadership to drive recovery
- Focused Board oversight and scrutiny
- Executive Accountability for delivery of improvement plans
- Building strong leadership at all levels within the Trust
- Extensive staff engagement to drive innovation
- A rigorous QI approach throughout the organisation
- Supported Programme and Project management
- A single reporting structure for Board, Commissioners and Regulators
- Support and work with our partners
- Support and involvement from patients, service users and the public
- Relationships with the Acute and Mental Health Alliances
- External support from experts to address capability

We will be evidence-based and will systematically monitor and test progress as well as look to outstanding organisations elsewhere to see how they do things and learn from research.

Quality Improvement Aims

Once the five aims were identified, we held an engagement exercise to inform frontline staff and ensure they were all understandable. Each of the aims has an Executive Sponsor who will work with the Clinical Lead to ensure delivery of the improvements.

Valuing the Basics

Executive Sponsor: Chief Operating Officer

- Patient at the centre
- Holistic care
- Courageous discussions
- Involving patients, families and carers.

Organisation that Learns

Executive Sponsor: Medical Director

- Zero tolerance of bullying
- Behaviours and compassion
- Right staff, right skills
- Staff engagement.

Supporting Vulnerability in patients

Executive Sponsor: Director of Workforce and Organisational Development

- Safeguarding
- Mental Health
- Dementia
- Mental Capacity Act and Deprivation of Liberty.

Moving Beyond Safe

Executive Sponsor: Director of Finance

- Urgent care
- No 'avoidable' deaths
- Stop harm to patients
- Right patient, right bed.

Leading Well through Good Governance

Executive Sponsor: Chief Nurse

- Leadership at all levels
- Role clarity, responsibility and accountability
- Standardising and consistency in processes
- Being open and transparent.

Governance and Assurance

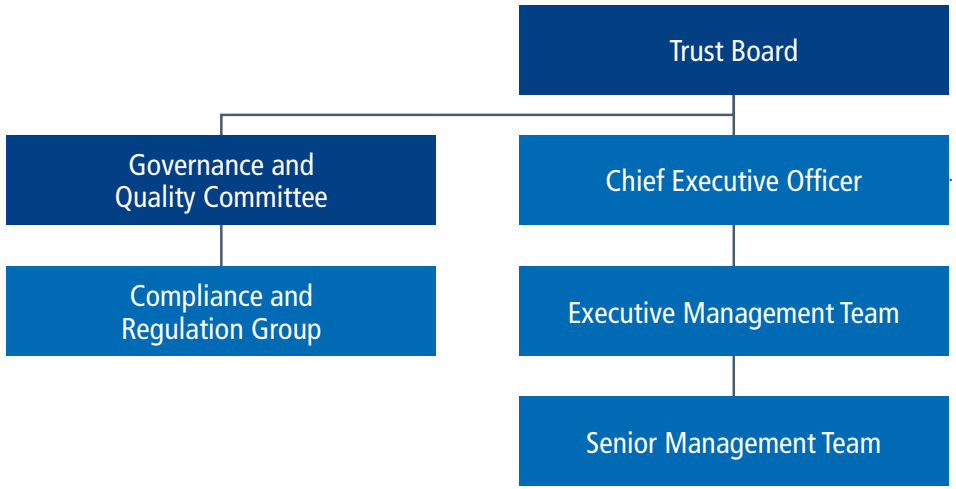
A rigorous reporting programme both internally and to key stakeholders is now in place.

The Trust has established a Compliance and Regulation Group (CRG) that meets weekly to provide oversight and seek assurance against operational delivery of improvement plans. Currently this is chaired by the Chief Nurse until the Director of Strategy, Governance and Performance is in post. The CRG reports to the Governance and Quality Committee, which is a sub-committee of the Board.

Sitting alongside the internal governance arrangements is the Quality Improvement Plan Oversight Group (QIPOG), which is responsible for ensuring that as a health system there is ownership of issues and action taken to deliver system-wide improvements. Whilst the QIPOG has no formal reporting line into the Trust it provides external assurance to the Chief Executive and Executive Management Team.

The Governance Structure

Reporting Structure



NHS Improvement/NHS England Quality Improvement Plan Oversight Group

- A Non-Executive Director chairs the Governance and Quality committee and will hold the executive sponsor to account for each area of the Quality Improvement Plan
- Regular updates will be provided by the executive sponsors to the senior management team and any issues will be escalated to the executive management team
- Five keys enablers have been set up to support the Quality Improvement Plan aims
- These enablers will be designed to establish the structures, capabilities, buy-in, and vision necessary to achieve change on a large scale.

Key Enablers

1. Valuing the Basics

The CQC raised significant concerns about the safety and care of vulnerable patient, such as frail older people or patients living with dementia. There were gaps in the care documentation for the most vulnerable patients who were at high risk of pressure sores. Patients, some of which deemed as high risk of malnutrition were not assisted with their meals. Staff did not always consistently follow infection control procedures. Staff the CQC spoke to did not have knowledge of the Trust pain assessment tool for patients who could not verbalise their pain.

We recognised that we had significant work to do to improve some fundamentals within basic nursing care. Immediately following the CQC inspection, all nurses were required to re-read their NMC - The Code and to report that they were practising within The Code.

The Trust held a 'Supporting vulnerable patient information event' on Friday 8th September 2017, with a focus on the fundamentals of care. This information day launched the start of a series of mandatory training sessions.

Specific actions

- 1.1 Patient at the centre
- 1.2 Holistic care
- 1.3 Courageous discussions
- 1.4 Involving patients, families and carers

1.1 Patient at the centre

Action	Outcome	Completion
Single sex accommodation requirements for patients are maintained and a system to report breaches is in place	All breaches are reported and investigated appropriately	Complete
Re-launch the protected meal time initiative	Ensure meal times are protected enabling improved nutrition	31/12/2017
Pilot patient centred questions as part of bedside handover to formally recognise patient involvement with every shift handover	Patients and their families or carers are involved in the care planning process	31/12/2017
Embed the principles of the "if you had 1000 days left to live" (TODAY programme) to value patient time as the most important currency in healthcare	Principles embedded in every day practice	31/03/2018
Following the End PJ Paralysis campaign embed the principles into practice	Principles embedded in every day practice	31/03/2018

1.2 Holistic care

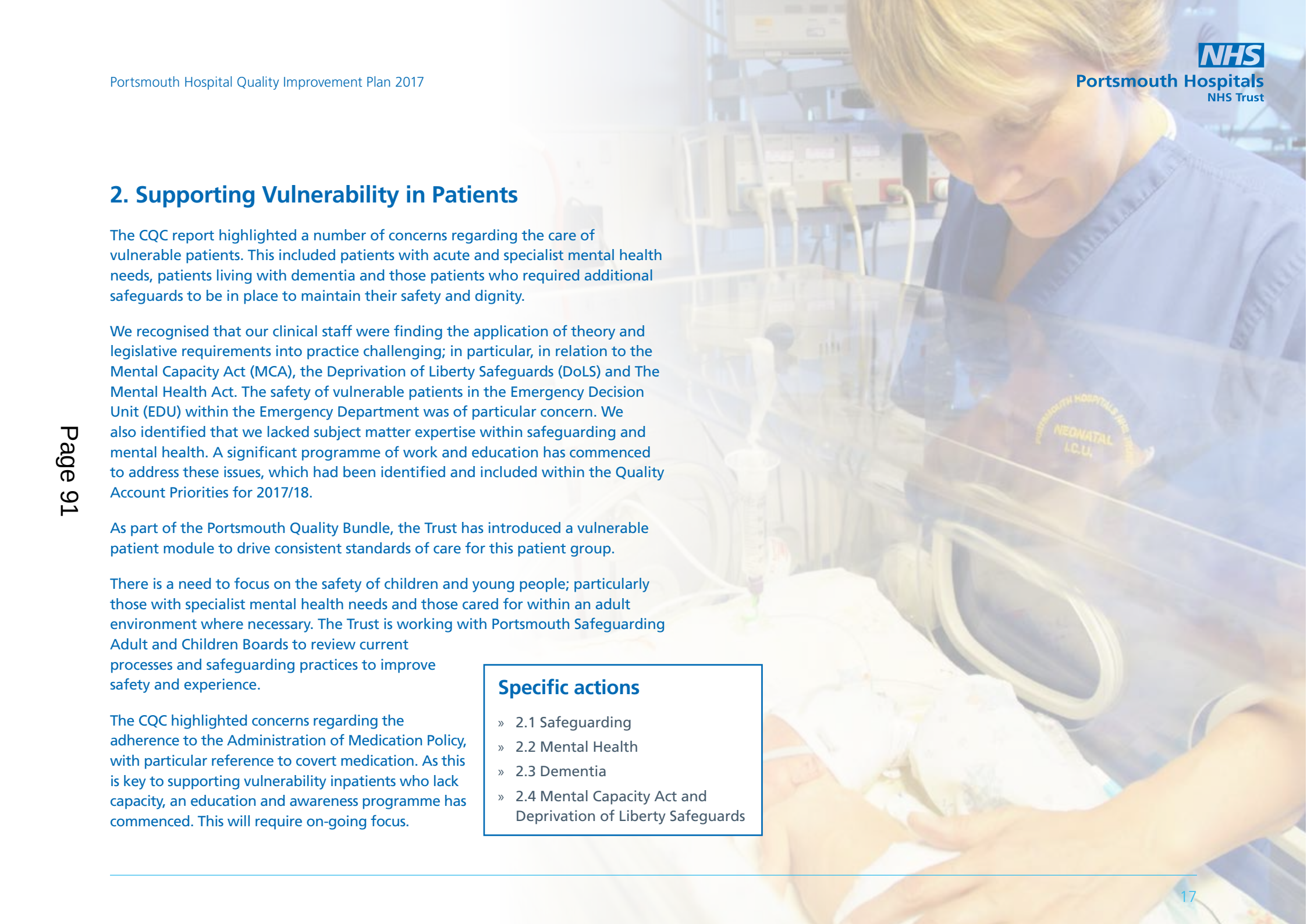
Action	Outcome	Completion
Patients receive individualised nursing care	Every patient has an individualised nursing care plan	31/12/2017
Improve dignity for patients through improvements in continence care	Dignity maintained for patients	31/03/2018
Review nursing documentation to facilitate the provision of holistic care	Streamlined documentation which supports and evidences care provision	31/03/2018

1.3 Courageous discussions

Action	Outcome	Completion
Embedding the principles of 'No decision about me without me' so patients are involved in making decisions about their care and treatment	Care will be delivered in partnership with patients to meet their needs and appropriate advocacy as required	30/06/2018
Implement the principles of Achieving Priorities of Care (APOC)	Allowing patients and families to have a dignified death in line with their wishes	30/06/2018

1.4 Involving patients, families and carers

Action	Outcome	Completion
Implement patient engagement strategy *Get Involved* (2017-2020) to strengthen patient engagement across all services at PHT	Patient engagement strategy to be ratified by the board so that patients and carers will be involved in all service re-design/improvement initiatives	31/12/2017
Promote the Friends and Family Test (FFT) throughout the organisation, with particular focus on the Emergency Department, to increase the response rate to at least the England average of 24% and to ensure compliance with the contractual requirements	Increased FFT response rate and positive recommendations for Emergency Department to be at, or above, the England average	31/03/2018
Strengthen and embed the Being Open Policy	Staff actively involve and discuss care issues with patients and families in an open and meaningful way as part of their everyday care	31/03/2018



2. Supporting Vulnerability in Patients

The CQC report highlighted a number of concerns regarding the care of vulnerable patients. This included patients with acute and specialist mental health needs, patients living with dementia and those patients who required additional safeguards to be in place to maintain their safety and dignity.

We recognised that our clinical staff were finding the application of theory and legislative requirements into practice challenging; in particular, in relation to the Mental Capacity Act (MCA), the Deprivation of Liberty Safeguards (DoLS) and The Mental Health Act. The safety of vulnerable patients in the Emergency Decision Unit (EDU) within the Emergency Department was of particular concern. We also identified that we lacked subject matter expertise within safeguarding and mental health. A significant programme of work and education has commenced to address these issues, which had been identified and included within the Quality Account Priorities for 2017/18.

As part of the Portsmouth Quality Bundle, the Trust has introduced a vulnerable patient module to drive consistent standards of care for this patient group.

There is a need to focus on the safety of children and young people; particularly those with specialist mental health needs and those cared for within an adult environment where necessary. The Trust is working with Portsmouth Safeguarding Adult and Children Boards to review current processes and safeguarding practices to improve safety and experience.

The CQC highlighted concerns regarding the adherence to the Administration of Medication Policy, with particular reference to covert medication. As this is key to supporting vulnerability inpatients who lack capacity, an education and awareness programme has commenced. This will require on-going focus.

Specific actions

- 2.1 Safeguarding
- 2.2 Mental Health
- 2.3 Dementia
- 2.4 Mental Capacity Act and Deprivation of Liberty Safeguards

2.1 Safeguarding

Action	Outcome	Completion
External review of Child Safeguarding in Emergency Department to identify any gaps in safeguarding procedures	Fully compliant with safeguarding children procedures.	31/12/2017
External review of safeguarding processes and training material (CCG, Safeguarding Boards and local authorities) for both adult and child safeguarding	External assurance of internal processes and education programmes	30/11/2017
Strengthen the Adult Safeguarding Team and leadership	To have the capacity and subject matter expertise to support the organisation in delivery of statutory requirements	31/01/2018

2.2 Mental Health

Action	Outcome	Completion
External review of Trust compliance against the requirements of the Mental Health Act	Identified areas for improvement and associated action plan	Complete
Ensure adequate staff with the correct skills to care for patients with acute and specialist mental health needs	Patients cared for by appropriately trained and skilled staff	Complete
Improve governance, oversight and key stakeholder relationships	Identify Executive lead for Mental Health and Establish Mental Health and Mental Capacity Board chaired by a Non-Executive Director	Complete

Ensure risk assessment of patients with acute and specialist mental health needs in the Emergency Department are undertaken	By March 2018 the percentage of patients being risk assessed will exceed 90% consistently	31/03/2018
Ensure appropriate care plan and intervention in place for patients with acute and specialist mental health needs in the Emergency Department	Individualised care plans and intervention based on accurate risk assessment to improve safety	31/03/2018
Trust-wide environmental review to assess the risks of managing patients with acute and specialist mental health needs	Completion of audit	31/03/2018
Enhance staff education and awareness regarding mental health	Staff can display improved understanding and awareness of their responsibilities under the Mental Health Act	31/03/2018

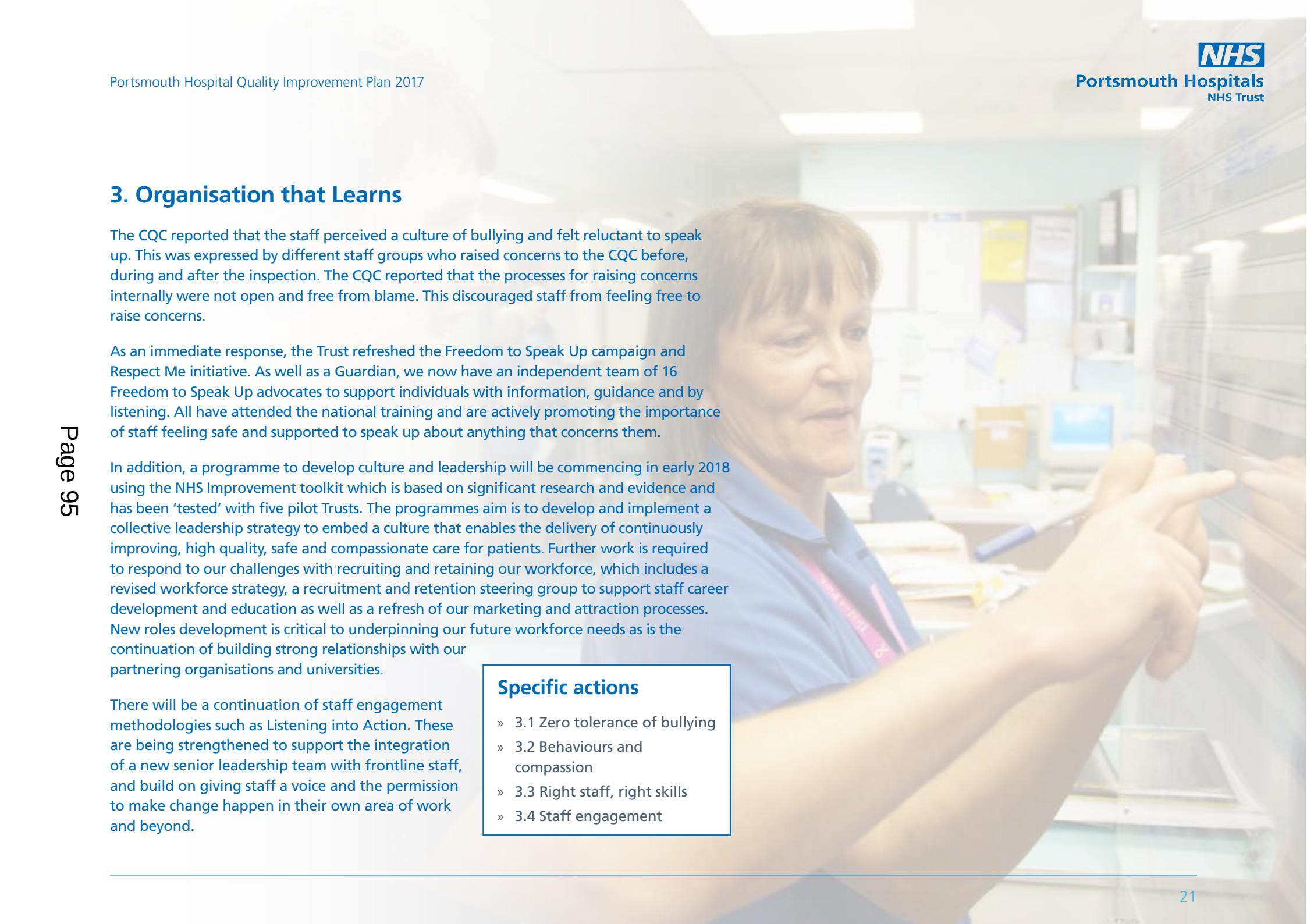
2.3 Dementia

Action	Outcome	Completion
Recruit a lead Dementia Nurse Specialist	Develop and delivery of a strategy in line with NHS Improvement Dementia Assessment and Improvement Framework (October 2017)	31/12/2017
Audit the consistent use of the 'This is Me' document	Completion of audit	31/12/2017
Implement reminiscence trolleys in every ward	Trolleys available in all wards	31/12/2017
Increase activities available for patients living with dementia	A variety of activities available to support stimulation and distraction therapies	31/03/2018

Review the dementia screening process to ensure it fits with clinical practice	Achieve the national standards for dementia screening to meet or exceed 90%	31/03/2018
Improve the support for carers of patients living with dementia	Appropriate signposting and improved awareness of the Carers Cafe	31/03/2018

2.4 Mental Capacity Act and Deprivation of Liberty Safeguards

Action	Outcome	Completion
Strengthen the governance arrangements around DoLS to ensure timely assessment	Discharge our legal responsibilities under the MCA/ DoLS to keep patients safe in our care	31/12/2017
Weekly clinical review of patients under MCA and DoLS, including documentation	Completion of audit and direct feedback to clinical staff to improve learning	31/03/2018
Implement a revised education and training programme for all clinical staff regarding MCA and DoLS	Staff have the confidence to translate the theory into clinical practice demonstrated through the improved care and safety for vulnerable patients	31/03/2018
Intensive focused training for all staff on application of the MCA in practice	Improved understanding and documentation regarding Mental Capacity Assessments and Best Interest Decision Making	31/03/2018



3. Organisation that Learns

The CQC reported that the staff perceived a culture of bullying and felt reluctant to speak up. This was expressed by different staff groups who raised concerns to the CQC before, during and after the inspection. The CQC reported that the processes for raising concerns internally were not open and free from blame. This discouraged staff from feeling free to raise concerns.

As an immediate response, the Trust refreshed the Freedom to Speak Up campaign and Respect Me initiative. As well as a Guardian, we now have an independent team of 16 Freedom to Speak Up advocates to support individuals with information, guidance and by listening. All have attended the national training and are actively promoting the importance of staff feeling safe and supported to speak up about anything that concerns them.

In addition, a programme to develop culture and leadership will be commencing in early 2018 using the NHS Improvement toolkit which is based on significant research and evidence and has been 'tested' with five pilot Trusts. The programmes aim is to develop and implement a collective leadership strategy to embed a culture that enables the delivery of continuously improving, high quality, safe and compassionate care for patients. Further work is required to respond to our challenges with recruiting and retaining our workforce, which includes a revised workforce strategy, a recruitment and retention steering group to support staff career development and education as well as a refresh of our marketing and attraction processes. New roles development is critical to underpinning our future workforce needs as is the continuation of building strong relationships with our partnering organisations and universities.

There will be a continuation of staff engagement methodologies such as Listening into Action. These are being strengthened to support the integration of a new senior leadership team with frontline staff, and build on giving staff a voice and the permission to make change happen in their own area of work and beyond.

Specific actions

- 3.1 Zero tolerance of bullying
- 3.2 Behaviours and compassion
- 3.3 Right staff, right skills
- 3.4 Staff engagement

3.1 Zero tolerance of bullying

Action	Outcome	Completion
Freedom to Speak Up promotion week	Staff feel confident and know how to raise concerns	Complete
Identification and training of 16 Freedom to Speak Up advocates	Staff feel confident to raise concerns without recrimination	Complete
Appointment of Freedom to Speak Up Guardian	Staff feel confident to raise concerns without recrimination	Complete
External review of leadership behaviours to identify areas to identify areas where leadership values and behaviours need challenging and improving	Improved national staff survey results and reduction in employee relations' cases. Reduction in bullying and harassment concerns raised by staff	31/03/2018

3.2 Behaviours and compassion

Action	Outcome	Completion
Implement Multidisciplinary Schwartz round	Provide a safe and supportive environment for staff to share and learn from their experiences, improve staff morale and team working	Complete
Provide education on embedding trust values and behaviours into Job Planning rounds with consultants	Increase compliance with Job planning on CRMS	31/03/2018
Map all recruitment processes and align to trust standard	Ensure value based recruitment process is applied to all staff groups	31/03/2018

Implement NHSI Culture and Leadership Programme	Develop a culture that enables and sustains continuous improvement of safe, high quality and compassionate care	31/08/2018
Revision of Nursing, Midwifery and Allied Health Profession Strategy	Improve compassionate care and engagement with frontline staff	31/12/2018

3.3 Right staff, right skills

Action	Outcome	Completion
Further overseas recruitment	Reduction in vacancy rate and temporary workforce spend	On-going
Implement plans for revised and new roles to support difficult to recruit posts	Reduction in vacancy rate and temporary workforce spend	31/01/2018
Audit compliance with local induction process	All staff will receive a supportive and helpful local induction	31/01/2018
Revision of workforce strategy	Clear and current written strategy in place to address workforce priorities	28/02/2018
Recruitment and Retention event	Improved understanding by staff of opportunities to develop their careers and the benefits available to new employees	31/08/2018
Board / Director development programme to be developed and implemented	New Board are clear on priorities, their shared and individual objectives and are effectively executing their responsibility as a board	31/08/2018

3.4 Staff engagement

Action	Outcome	Completion
Introduce monthly forums for the junior doctors to meet the Medical Director and Chief Registrar	To improve staff engagement with the Junior Medical staff who work in a transient role	Complete
Introduce monthly forums for the Consultants to meet the Medical Director and Chief Executive Officer	To improve staff engagement with the Senior Medical staff	Complete
Widen the attendance at the professional forum for Nurses and Midwives	To improve engagement with the Nursing and Midwifery force to strengthen Board to Ward	30/11/2017
Staff Big Conversations personally hosted by the CEO	Staff report feeling more engaged and able to make changes happen in their own area of work	31/12/2017
Introduce an annual staff engagement calendar of events	Staff report increased levels of engagement	31/12/2017

4. Moving Beyond Safe

The CQC reported many patient safety issues, which included concerns regarding the management of incidents, safety in the urgent care pathway, patient moves and outlying from speciality bed base and general concerns regarding the risk to patients in respect of safeguarding vulnerability.

As a minimum, the Trust must provide safe care to patients and so patient safety is of the highest priority to address. Patent safety is about working to prevent errors in healthcare that can cause harm to patients.

When patient's start to physically deteriorate, it is important that the change in vital signs is picked up and, that this change in the patient's condition is responded to with appropriate escalation in care so that the patient receives correct and timely monitoring, referral and treatment. Wessex Patient Safety Collaborative has partnered with the Trust to support patient safety scale up projects across Wessex. The Trust is implementing the Time to Act innovation.

In addition, there has been further focus on learning from deaths, including the introduction of Mortality Review Panels to review deaths. Patients are reviewed by a clinical panel, within 48 hours of death, and the 'Avoidability of Death'recorded, as well as Trust learning points. The cause of death and comorbidities are elucidated and recorded. Referrals are made to the coroner, as a Safety Learning Event, as a SIRI, or for the relevant department to review at their Mortality and Morbidity meetings.

The Trust is implementing a number of safety initiatives in relation to the urgent care pathway to improve safety and patient experience.

Specific actions

- 4.1 Urgent care
- 4.2 No 'avoidable' deaths
- 4.3 Stop harm to patients
- 4.4 Right patient, right bed

4.1 Urgent care

Action	Outcome	Completion
Implementation of revised Medical Model of care	100% of patients will be reviewed by a consultant within 14 hours of admission to hospital	Complete
Development of a robust urgent care transformation plan and a delivery structure	To improve the quality of care in the unscheduled care pathway	30/11/2017
Implementation of the patient flow bundle 'SAFER'	Improve patient journey and experience by reducing unnecessary waiting	31/03/2018
Implementation of the Red 2 Green day initiative	Reducing delays in hospital care and associated risks to patients	31/03/2018

4.2 No 'avoidable' deaths

Action	Outcome	Completion
Implementation of the Learning from Deaths policy	Policy published, implemented and embedded in practice	31/12/2017
Training in Structured Judgement Review	Consistent approach to reviewing patient deaths to improve learning	31/12/2017
Further roll-out of the Mortality Reviews across all specialities	All deaths are reviewed and any identified learning shared across the organisation	31/03/2018
Implementation of the Time to Act initiative	Patient's condition received appropriate escalation to ensure patients receive the correct and timely monitoring, referral and treatment	31/07/2018

4.3 Stop harm to patients

Action	Outcome	Completion
Pilot the Model for Improvement (MFI) and Plan, Do, Study, Act (PDSA) Cycle for reducing pressure damage	Aid staff in prioritising care, highlighting which patients are high risk of pressure damage	31/03/2018
Establish a senior safety team under the leadership of the Medical Director and Chief Nurse	Team in place to set the strategic direction for safety and drive the changes needed	31/03/2018
Standardisation of clinical handover documentation	Consistent completion of handover documentation to ensure patient safety	30/04/2018
Introduce a Six Month Safety Sprint concept	Improved outcome measures associated with » Deteriorating patients » Sepsis » Learning from events and feedback » Learning from deaths	31/08/2018
Initiate consultant ward round standards	Improved communication of patient pathway	31/05/2018
Undertake assessment of safety culture using the Cultural Barometer	Baseline assessment complete and improvements required identified with a reassessment date	31/08/2018

Trust-wide roll out of the NHS Improvement Falls Collaborative initiative	A prompt review of all patients who have fallen to ensure appropriate strategies are in place to prevent further patient falls A reduction in the number of injurious falls	31/12/2018

4.4 Right patient, right bed

Action	Outcome	Completion
Utilise the functionality within BedView to allocate the right patient to the right bed.	Right patient in the right bed every time, reducing the need for patient moves and outliers	31/12/2017
Revise all Standard Operating Procedures in relation to patient flow within the Operations centre	Clear procedures to reduce patient moves, outliers and length of stay	31/12/2017

5. Leading Well Through Good Governance

The CQC identified that the quality of incident investigations was very poor and that there was limited evidence or assurance that lessons learned from incidents were implemented. There were concerns highlighted relating to grading of incidents and the application of Duty of Candour. The CQC identified the need to review governance processes and reporting functions to ensure they are fit for purpose and to ensure risks were identified and managed, to include a review of the Board Assurance Framework.

The Trust has commenced an external review of its governance arrangements. This includes a full review of the Board Assurance Framework and Risk Management Strategy.

Specific actions

- 5.1 Leadership at all levels
- 5.2 Role clarity, responsibility and accountability
- 5.3 Standardising and consistency in processes
- 5.4 Being open and transparent

5.1 Leadership at all levels

Action	Outcome	Completion
Introduce Board to Ward Quality rounds	Standardised approach to Board to Ward rounds that demonstrate engagement with frontline staff	28/02/2018
Improve the compliance rate and quality of appraisals	Meeting or exceeding 85% target and that staff report a meaningful appraisal	31/03/2018
Support the Trust key leadership programmes	Staff in leadership roles will feel confident to lead and manage their services	31/03/2018
Recruit to board vacancies substantively	Substantive board will be in post	31/03/2018
Agree and introduce a Board Development Programme	Improved board relationships and establishment of a high performing board	31/08/2018

5.2 Role clarity, responsibility and accountability

Action	Outcome	Completion
All nursing staff to sign that they have read and understood the NMC – The Code	Nurses to be aware of their accountability as a Registered Nurse	Complete
Review and standardise nursing job descriptions	Nurses are clear about their role and responsibilities	30/11/2017
Improve the compliance rate and quality of appraisals	Meeting or exceeding 85% target and that staff report a meaningful appraisal	31/03/2018

5.3 Standardising and consistency in processes

Action	Outcome	Completion
Undertake an external governance review	Introduce revised Board Assurance Framework, Corporate Risk Register, Risk Management Policy and Strategy, Corporate Governance Arrangements and Divisional Governance arrangements to ensure a standardised integrated approach	31/01/2018
Investing in business intelligence which will enable triangulation of data to determine the quality of care being provided in individual care areas. Introduce a revised performance framework	Improved understanding of metrics and delivery against performance management framework	31/01/2018
Increase the number of staff trained in Root Cause Analysis methodology and risk management	Demonstrate organisational understanding of risk management and improve the quality and learning from incident investigations	31/03/2018
Improve incident management processes to foster learning and improve effectiveness	Consistent grading/investigation of incidents and ensuring there is shared, organisational learning	31/03/2018
Protect patients confidentiality through safe storage of records	Confidentiality maintained	31/03/2018
Define key nursing metrics (no more than 10) which measure the key component of care delivery and introduce standardised 'How are we doing boards'	Staff on the frontline nursing staff have a clear understanding of the care they are delivering to patients against defined standards	31/05/2018

5.4 Being open and transparent

Action	Outcome	Completion
Building relationships with stakeholders and partners in line with the Chief Executive's 100-Day Plan	Improved working relationships across the health economy that benefit patients	30/11/2017
When significant incidents are being investigated, patients or family will be asked for their input to setting the terms of the investigation, and updated as investigations progress"	Improved involvement of patients and family when significant incidents occur	30/11/2017
Investing in business intelligence which will enable triangulation of data to determine the quality of care being provided in individual care areas. Introduce a revised performance framework	Improved understanding of metrics and delivery against performance management framework	31/01/2018
Strengthen and embed the Being Open Policy including the application of Duty of Candour legislation	Staff actively involve and discuss care issues with Patients and families in an open and meaningful way as part of their everyday care. There are no breaches of Duty of Candour legislation	31/03/2018
Protect patients confidentiality through safe storage of records	Confidentiality maintained	31/03/2018
Define key nursing metrics (no more than 10) which measure the key component of care delivery and introduce standardised 'How are we doing boards'	Staff on the frontline nursing staff have a clear understanding of the care they are delivering to patients against defined standards	31/05/2018

porthosp.nhs.uk
Quality Improvement Plan 2017

@QAHospitalNews

PPCEJ1017

This page is intentionally left blank

Portsmouth Hospitals NHS
NHS Trust

Mark Cubbon
Chief Executive

Trust Headquarters
F Level, Queen Alexandra Hospital
Southwick Hill Road
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

10 November 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.

Every NHS Trust has been preparing for winter and in Portsmouth we are taking measured and proactive steps to ensure we are in the best possible shape for the months ahead. We will continue to work with our key partners throughout this period and key developments which we have implemented are:

- Temporary changes to the amount of elective inpatient orthopaedic work we do to create additional short term bed capacity on the hospital site. We are not stopping inpatient elective orthopaedic work, but we will be doing less than we normally do for a short period of time. This is a planned development to support the delivery of sustainable changes to our urgent care pathway.
- We have launched a new frailty unit which will help us make sure we have enough elderly care capacity to meet the anticipated increase in demand from our frail elderly population. Our Acute Frailty Unit (AFU) will require a very close relationship with our partners and will help us provide even better care for some of our most vulnerable patients. The unit will build on the great service provided by our Frailty Interface Team and there's lots of evidence that says this sort of unit can significantly reduce the need for a prolonged hospital stay and the reliance on on-going services following a hospital admission.
- We have identified additional CT scanning capacity to be provided on site throughout the winter months, which will increase the availability of urgent scans for our patients.
- We have refreshed our urgent care improvement programme to deliver improvements to flow across the QA site.

Our Red2Green campaign – simply put rules and an approach to help reduce the amount of time our patients wait unnecessarily - has now been launched and it is fantastic to see so many of our staff now adopting this approach each day. Red2Green allows visibility of all delays to patient care and/or their discharge home. When we can see where the problems are and we can quantify them, we are much better placed to tackling them.

Over the last few months we have seen an increase in the number of patients going home via the Discharge Lounge. This is great news as it frees up beds earlier in the day for patients coming into

hospital and we've seen an increase in the number elderly frail patients being discharged in less than 72 hours. We however recognise there is still more to do, but efforts so far are without doubt delivering improvements to the patient experience.

As part of my 100-day plan I made a commitment to strengthen leadership across the Trust. I recently announced the appointment of Paul Bytheway, who started on 1st November, as our substantive Chief Operating Officer. Most recently Theresa Murphy has been appointed Chief Nurse. Theresa is currently working with us on a part time basis as our Interim Director of Nursing and she will take up the role of Chief Nurse on 1 January 2018. I will be announcing the appointment to Director of Strategy, Governance and Performance in the near future.

I am also delighted to confirm that Melloney Poole OBE has been appointed as our new Chair to the Trust Board. She replaces Sir Ian Carruthers who held the role from June 2014, and Mark Nellthorp, Non-Executive Director, who ably held the Interim Chair role for five months. Melloney has also been a Non-Executive Director in the NHS since 1993 serving on the Boards of three NHS Trusts before being appointed to the role of our Chair. Melloney has a background in corporate, charity and public administrative law as a solicitor spanning 25 years, gaining private sector, commercial and corporate experience before joining the public sector in 2003. She is also the Vice Chair of the Health Foundation.

We published our Quality Improvement Plan on 31 October. This sets out our approach to delivering sustainable quality improvements for our patients and staff. This plan has been created with input from many of our staff, and has also been reviewed and shaped by a number of our patients. We will be publishing monthly progress reports to ensure all actions are kept on track and to allow us to share the progress we intend to make as an organisation.

I hope that this summary has been of interest to you. 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
Chief Executive
Portsmouth Hospitals NHS Trust
Tel: 023 9228 6770
Email: mark.cubbon@porthosp.nhs.uk
Twitter: @MCUBBON.NHS

H&IOW Local Dental Committee: Secretary's Report

8th November 2017

INTRODUCTION

- **Local Dental Committees in England and Wales were established in 1948 at the inception of the NHS. Established in statute under Section 45b of the 1977 NHS Act as modified by the 1999 Health Act. Included in the NHS Act 2006.**
- **Health and Social Care Act 2012: 152 PCTs replaced by 211 CCGs.**
- **NHS England 13 sub-regions of 4 regions.**
- **There are 110 LDCs in the UK (96 E&W).**
- **NHS England nationally, regionally and locally recognise and consult with LDCs on matters of local and regional dental interest and following the NHS reforms in 2006 they also consult on local commissioning and the developments surrounding the provision of NHS dental services.**
- **Local Authorities engage with the LDC.**

NHS England-South (Wessex): The level of clawback (recovered commissioned activity) monies in Wessex for 2016/17 was over £7.8 million compared with £5million the previous year. In 2016/17 additional non-recurring activity was allowed up to 120% and even higher in some special cases. In 2016/17 the non-recurring activity commissioned was £1million in Units of Dental Activity (UDAs) and £1.6 million in Units of Orthodontic Activity (UOAs) and the proposed over activity commissioned for this current year will equate to a figure that is in excess of the previous year. The finite amount of extra non-recurring activity will not be identified until the month 6 data has been evaluated but assurances have been given to contractors that are already engaged in this programme of longer term (up to 2018/19) non-recurring UDA activity. This extra activity is not linked to last year's recovery monies (clawback) but mostly from flexible UDAs released from renegotiated contracts. Flexibly rebased contracts with one large corporate provider are mostly responsible for a major part of the expected recommissioned activity which is likely to be in the region of £4 to 5million. Clearly, contractors who take up this extra activity, having satisfied the acceptance criteria such as no current performance or contractual concerns do have a logistical problem inasmuch they require additional staff and increased clinical time/facilities to absorb this extra activity.

The current situation is not ideal as contracts remain fixed at their core value and these offers of extra activity are not normally announced until well into the

contractual year usually in the early/mid- autumn period. Orthodontic contracts that achieve up to 102% are able to achieve 100% of their contracted activity the following year ie they are not restricted to 98%. The LDC believes that if this additional activity was recurring it would give these participating practices a more favourable profile with their relevant finance institutions and give staff greater longer - term security. The 2 LDCs are alarmed that despite the NHS local team's best efforts, this year on year underperformance in our area causes £2 to £3 million or more to be lost from NHS dental care service provision every year. Large corporate organisations seem to be particularly vulnerable due to recruitment issues and there is also the possibility that the private treatment option is an area of active development.

NHS England –South (Wessex) is not minded to embrace the Chief Dental Officer's (CDO's) check by one initiative due to the pressure on its resources and below there is a draft children's oral health improvement initiative. More recently the LDCs within the Wessex Dental Commissioning Group looked at this and some other proposed enhanced services/incentives with 4 innovative service specifications that should commence 1st November 2017 for 12 months. These are:

- Children's Oral Health Improvement Service-Under 5s Toddlers Groups
- Oral Health Services for Care Homes in Wessex
- Diabetic Screening and Supporting Patients with Diabetes in Primary Care Dental Practices
- Oral Health Services for the Homeless across Wessex

The LDCs have highlighted with the local team the plight of contractors that have signed Standard NHS Contracts for advanced mandatory activity. The major problem is superannuation and the local team deny that this is type of contract is inappropriate. The reasoning is that this is secondary care activity being moved into primary care and is therefore outside the Statements of Financial Entitlements (SFE).
This is a win/win situation for NHS England as they shift activity from more expensive secondary care into primary care but without taking steps to mitigate the financial consequences for General Dental Practitioner (GDP) practices in primary care.
Currently, this concern is being pursued by The General Dental Practice Committee (GDPC) and letters have been exchanged with Rosamond Roughton Director of NHS Commissioning but as yet no solution has been agreed. Ros will be succeeded by Dominic Hardy in the very near future.

The current south regional orthodontic procurement programme and the associated Dynamic Purchasing System) DPS continues to cause concern as orthodontic providers are unsure whether or not they will have a contract. A letter has been distributed advising orthodontic providers that their contracts will be extended to 31st March 2019. Two orthodontic procurement stakeholder engagement events have been organized on the 8th and 9th November (Winchester) in Wessex. These engagement (market briefing) events which are open events are scheduled for two hours commencing at 7.00pm and having viewed the large number of slides (around 30) it will be quite a challenge to present all the details of this extremely important commissioning (service procurement) process within the 2 hour slot. The slides are viewable on the H&IOW LDC website www.hiowldc.org . Seemingly, there will be

little time for questions and indeed these events will not be an open forum for questions. Questions will be submitted on the event's feedback form which will need to be returned within 7 days and these will be included in a list of FAQs published on the website.
They are aware that they will need legal advice on some of these questions.
Delegates will receive data and lotting map details and these have already been published.
NHS Commissioning Support Unit (CSU) representatives will speak at these meetings and it is essential that LDCs send a representative to their local event.
There are 99 lots with 17 of these in Wessex. Contractors that intend to bid will need to opt in to stage 2 and unlike stage 1 of the DPS there will be one chance only to get it right.
The project timeline is the 15th January 2018 when the first procurement will be issued and it is recognised that those uploading the intend process may need help.
The DPS closes 10 days before the procurement goes live and appeals after receiving a comprehensive debrief after the evaluation of the bid will be within 10 days.
There are plans to undertake extensive panel evaluation training to achieve consistency. The LDC has highlighted that corporate and other larger organisations have a distinct advantage inasmuch they have more resources, experience and tend to saturate the market with multiple applications and very often under different names.
Mobilisation plans will be required even where it is the incumbent contractor and it essential that they have NHS.net accounts and that their Information Governance (IG) is at level 3.
The LDC is very concerned that the initial commissioning intentions in some areas eg the IOW may well jeopardize future orthodontic service provision with longer waiting times for treatment.

A concern has been raised by the LDCs about the provision of Individual Funding Requests (IFR) referral services by specialist listed individuals who are not on the National Performers List (NPL). It is felt that this is not a level playing field.

The two LDCs met on the 7th November to discuss many of the items raised in this report and to reassess the percentage Statutory Levy before the LDC meeting on the 8th November.

A universal hot topic concerns the Wessex Cardiac Forum Position Statement which can be found on the LDC website www.hiowldc.org This was mentioned in the minutes of the LDC meeting held on the 13th September and has been raised as agenda items in the Special Care and Oral Surgery Managed Clinical Networks (MCNs).
Both of the LDCs in Wessex are still concerned that NHS England-South(Wessex) does not recognize the British Dental Guild rate for GDP attendance at any of its network (Local Dental Network (LDN)/MCN) meetings. Clearly, this does not encourage GDP involvement in the clinical commissioning process and therefore the clinically leading element is predominantly specialist based. The LDCs do not believe that hospital based consultants and specialists have a grasp of all the realities of general dental practice and it is essential that GDPs are adequately remunerated for

their time away from their practices. It may be that alternative recompense could be agreed as a contractual concession.

Other LDC Matters: The LDC was represented by the Secretary (regional representative) at the recent General Dental Practice (GDPC)/LDC Regional Liaison Group meeting where many of the current issues in Wessex were highlighted as agenda items:

- Electronic Referrals – cross border referrals in orthodontics are still an issue
- DERS systems – Chief Dental Officer's preference
- National Performers List management – Performance Advisory Group attendance
- Practitioner Advice and Support Scheme (PASS), Clinical Audit and Peer Review – the work of the Regulation of Dental Services Programme Board
- Orthodontic Procurement/Dynamic Purchasing System – Pan South
- Commissioning non –recurring activity – Units of dental Activity/Units of Orthodontic Activity
- Use of the NHS Standard Contract eg Prison and Intermediate Oral Surgery contracts
- LDC Officials' Day – 01.12.17
- LDC Conference motions/GDPC responses
- Charges for OPGs – work in progress
- Triennial representative elections – British Dental Association (BDA) GDPC, Country Councils

There was a presentation on the NHS England paper '**Freedom to speak up in Primary Care'.** This was published at the end of 2016 as a response to a consultation during the year. It provides guidance to primary care providers on supporting whistleblowing in the NHS. The main thrust is to support staff when raising concerns about the delivery of primary care services to patients and the management of the matter raised. As dental practices are small organisations with small internal structures it is suggested that a Freedom to Speak Up Guardian could provide an independent and confidential contact where a practice team member would be able to express their concern within the practice. It is further suggested that LDCs will work with NHS England to support local Freedom to Speak Up Guardians' nominations and establish a network of Guardians so that in turn NHS England can offer support and guidance.

The LDC website has been continually updated and we are particularly anxious to ensure that all the referral forms and any associated criteria are up to date. More links have been incorporated into the referral form section. The NHS Net Mail Application Procedures will be retained on the website as a longer-term item.

Taxable income for high street dentists continues to fall with a decline of nearly 35% in real terms since 2006. Practice owners incomes have fallen by over £45k and associates by over £20k. A recent House of Commons debate (12.09.17) on access to NHS dentistry highlighted the '*Toxic Choice'* between quality dental treatment and business sustainability. The Government's fall-back position is Contract Reform (Steve Brine MP Minister responsible for dentistry) but this is presently a potentially

flawed and underinvested option that has significantly deviated from the original vision of Professor Jimmy Steele.

Hepatitis B vaccine shortages continue and moves are being made by BDA with PHE to ensure that dental nurses fall into the higher-priority group as they are at imminent and high risk of exposure. However, the current advice for dental professionals:
https://www.gov.uk/government/publications/hepatitis-b-vaccine-advice-for-dental-professionals
The published guidance clarifies that all dental professionals undergoing Exposure Prone Procedures (EPPs) should be vaccinated as usual but vaccinations for dental nurses should be deferred as they do not routinely carry out EPPs and are therefore classified as lower priority. They should be referred if they suffer a sharps injury and need post-exposure prophylaxis. Foundation dentists who are due a routine booster should defer until early 2018 and can continue in practice as the benefit has been identified as 'small'.
This will revert to the previous recommendations once vaccine levels have stabilized to pre-shortage levels.

The LDC is aware that Managed Clinical Networks (MCNs) will be going through changes as guidance is distributed down from NHS England. In particular we are aware that the MCN Chairs will be appointed through a formal selection process with defined and funded sessional activity. The MCNs should be linked to the Local Dental Network's (LDN's) priorities and local commissioning plans. It is believed that existing arrangements will evolve into the prescribed models and frameworks.

The Hampshire and Isle of Wight LDC regularly attends the University of Portsmouth Stakeholder Group meetings and recently attended the launch of the newly refurbished Dental Team Clinic.

The LDC intends to continue with its programme of Continuing Professional Development events in 2018 and the first two topics will be *The Future of Dentistry- Prof Nairn Wilson and Contract Reform Update from a prototype practice - Nick Forster and Claudia Peace from St James Dental Practice*, *General Dental Council and particularly the new CPD requirements from 2018.*

Salaried Services:

Single Point of Referral – Minor Oral Surgery (MOS) referrals continue to increase 2015/16 – 28,172 referrals processed; 2016/17 – 29,784 referrals processed; 2017/18 processed so far 13,034 referrals with a forecast of out-turn at year end of 31,200 referrals. Monthly rejection rate is 15% of referrals received mainly due to incomplete information on the form and radiographs not being of diagnostic quality.

Orthodontic referrals approximately 1500 referrals per month 2015/16 – 17,049 referrals processed; 2016/17 18,561 referrals processed; 2017/18 processed so far 7,651 referrals with a forecast out- turn of 18,362 referrals. General Anaesthetic (GA) referrals - Waiting times for treatment under GA at all provider sites has increased. A meeting is planned to see if there is capacity for more GA sessions/lists at Southampton General Hospital and/or Lymington. Lists were reduced by 50% however, whereas before on the paediatric list 80 children per

month were seen it is now only 27. Additional GA lists are being sought at other sites to include Winchester, Portsmouth and Basingstoke. Epidemiology Surveys – the children's survey is complete and feedback is awaited. The next national survey which should commence later this year is targeted at adults attending general dental practice and is currently being piloted. The survey involves contacting and visiting 10 GDP practices in each Local Authority (LA) area to interview at least 20 patients and carry out a basic examination. It is unlikely that this will be commissioned locally.

NHS Solent NHS Trust

SPECIAL CARE DENTAL SERVICES – Clinical Director Denise Mattin

Background

The Special Care Dental provides dental services for people who have special needs. This includes provision of oral care for adults who have a physical, sensory, intellectual, mental, emotional or social impairment or disability or more often a combination of these factors.

The service also provides treatment for children who are unable to obtain care from a general dentist including children with a learning disability, medical or physical disability, those who are uncooperative at the dentist and those with certain dental conditions.

We have 16 clinics across the whole of Hampshire and also provide treatment under General Anaesthesia at hospital sites in Winchester, Southampton Portsmouth and Basingstoke. We also provide services in prisons on the Isle of Wight and Winchester.

In the Portsmouth area we have clinics at Somerstown, Eastney and at the Poswillo Centre with clinics at Havant and Gosport nearby. We also provide domiciliary services for people who are housebound or living in care homes and who are not able to access our clinics.

We are able to provide treatment under local anaesthesia, local anaesthesia and sedation or in some cases under General Anaesthesia. We have a range of equipment to facilitate access for our patients including wheelchair recliners and hoists.

Due to increasing referrals for adults with special needs requiring treatment under General Anaesthesia we have managed to secure a further day per month at QA Hospital Portsmouth where more complex patients may be treated.

This year we have focused on Accessible Information for our patients and have produced a wide range of leaflets and signage to help them access our services.

Accessible Information (AI) Overview 2017/2018

NHS Solent NHS Trust

Accessible Information Standard 	**Q. What does the Accessible Information Standard do?** • The Accessible Information Standard aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services. • The Standard tells organisations how they should make sure that people get support from a communication professional if they need it, and about changing working practices to support effective communication. • By law (section 250 of the Health and Social Care Act 2012), all organisations that provide NHS care or adult social care must follow the Standard in full from 1st August 2016 onwards.
Receive information and correspondence in formats they can read and understand 	**Q. What does the Standard include?** • The Standard says that patients, service users, carers and parents with a disability, impairment or sensory loss should: • Be able to contact, and be contacted by, services in accessible ways, for example via email or text message. • Receive information and correspondence in formats they can read and understand, for example in audio, braille, easy read or large print. • Be supported by a communication professional at appointments if this is needed to support conversation, for example a British Sign Language interpreter. • Get support from health and care staff and organisations to communicate, for example to lip-read or use a hearing aid.
Example of Accessible Information communication tools developed and used by the Special Care Dental Service	**Visit to the Dentist** 

Heather Hatherley (Nov 2017)

This is what people in Portsmouth said about our service. We monitor this on a monthly basis.

Special Care Dental Service

Portsmouth Area—Quarter 3 –2017

NHS Solent NHS Trust

At Solent NHS Trust we want to provide the best possible experience we can for the people who use our services and their relatives and carers.

The most frequently used words in the free text comments

Patient comments received for the 3 months ending Quarter 3.

The staff have always been fantastic with my son
Staff are knowledgeable -patient with my son's needs.
Very polite and understanding, un-judgemental of my circumstances
Exceptional service, really friendly staff couldn't of done anymore to help me out
Friendly service they always call or text a reminder very flexible with dated and times. They are very helpful and accommodating with my sons special needs.
My daughter was treated with dignity & respect.
Was made to feel calm. relaxed through every session - explanation. thank you

Key challenges facing the service in future years
Elderly and Domiciliary care

Not only are people living longer but they also have more of their own natural teeth. In addition many of these people will also have more complex medical conditions such as dementia, strokes and Parkinson's disease and often multiple co morbidities. Some of these will be on a variety of medications which may have an effect on the provision of care which will provide a challenge to our service and especially to our domiciliary care service. Prevention of dental disease and early detection of disease is very important in this age group. In addition carers in care homes will need training and support to help to ensure their residents are able to maintain a healthy dentition.

Bariatric care

The numbers of patients who are overweight or obese is increasing. Most dentists will have dental chairs that will take up to 20-22 stone maximum. We will need to ensure that we have appropriate equipment in our clinics to accommodate these patients including access to wheelchair recliners, bariatric chairs, bariatric wheelchairs and hoisting facilities. Waiting accommodation and increased surgery space will also be required as well as bariatric toilet facilities. Many of these patients will also have conditions related to their obesity such as diabetes and cardiovascular disease which will impact on their care.

Increasing case complexity including mental health issues and more challenging behaviour

Our data has demonstrated over the last few years increasing complexity of patients in all age groups but particularly so in those over 65. We are also noticing patients with more challenging behaviour as we treat people with dementia and those mental health issues. Recognising this we are increasing the numbers of staff who are trained to deliver treatment under inhalation sedation and intravenous sedation to cope with dental treatment. This will increase the amount of time we have to allocate to each patient to provide care.

Denise Mattin
Clinical Director
Solent Special Care Dental Service

AND

Keith Percival
Honorary Secretary
Hampshire and Isle of Wight Local Dental Committee

This page is intentionally left blank

Our next phase of regulation: a more targeted, responsive and collaborative approach

Name Caroline Bishop
Inspection Manager Hospitals
Date December 2017.

Evolution, not a revolution

more integrated approach that enables us to be **flexible** and **responsive** to changes in care provision

more targeted approach that focuses on **areas of greatest concern**, and where there have been improvements in quality

greater emphasis on **leadership**, including at the level of overall accountability for quality of care

closer working and **alignment** with NHS Improvement and other partners so that providers experience **less duplication**

Consultations on our proposed changes to inspections

CLOSED

20 December 2016 – 14 February 2017

New care models and complex providers

Cross sector changes to assessment frameworks

Updated guidance for registration of learning disability services

Changes to **Hospitals** inspection methodology

CLOSED

12 June – 8 August 2017

Changes to **Adult Social Care** inspection methodology

Changes to **Primary Medical Services** inspection methodology

Clarifying how we define registered providers and improving the structure of **registration**

Updating guidance on Fit and Proper Person Requirements

Early 2018

Changes to **Independent Acute** inspection methodology

A joint consultation on Use of Resources with NHS Improvement is expected in Winter 2017

Strengthen and simplify

Our changes to how we regulate providers represents an evolution of our assessment framework.

Strengthen

- Based on learning over the past three years and changes in the sectors
- Not ‘raising the bar’ for providers
- Providers to be able to demonstrate how they are developing and adapting

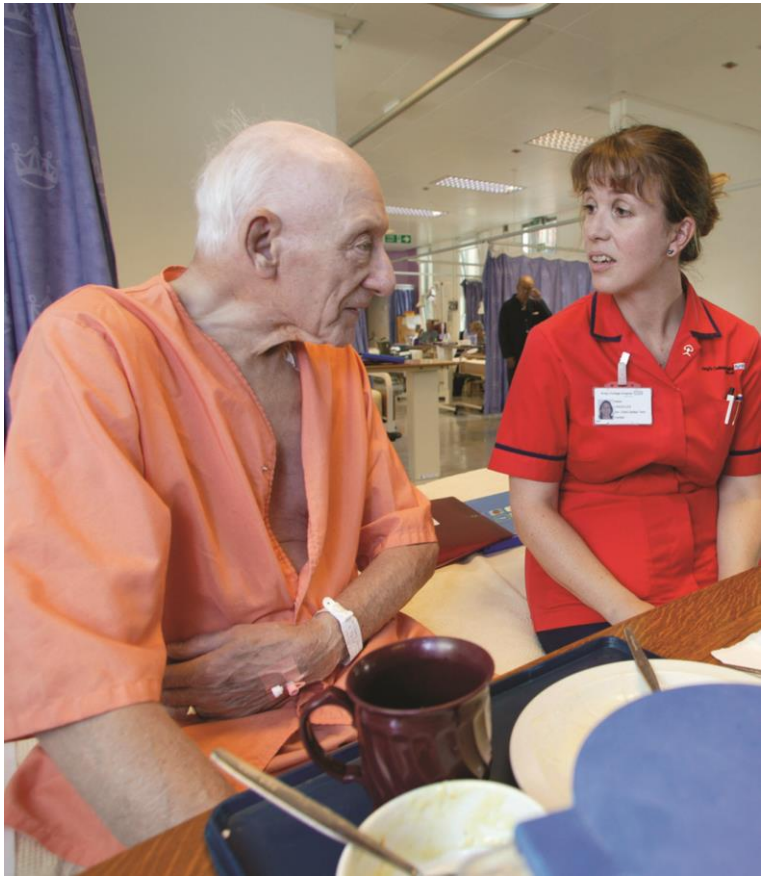
Simplify

- Aligning the questions we ask of different sectors
- Promote a single shared view of quality
- A simpler process to reduce regulatory burden on providers

NHS trust inspections – what we have changed

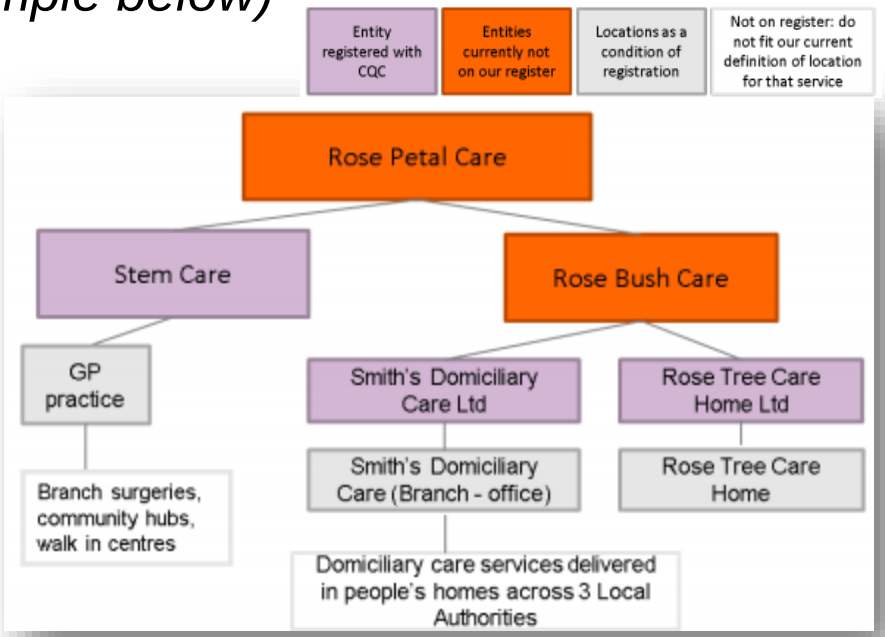
Changes to KLOEs and inspection methodology

- Focus our inspections where we have the greatest concerns or services that might have improved
- Develop our local relationships with providers, with Healthwatch and local and regional public organisations
- Accommodate new models of care
- Align our approach with NHS Improvement to avoid duplication



Changes to registration

- Any providers registered with us will remain registered
- We will also register related organisations who have accountability for quality and delivery of care
- We will develop our register so that it informs the public about ownership of providers, what services are provided, to whom and where to find these services *(example below)*
- We will introduce digitalised provisions to collect information and make this available to providers
- We will implement in a phased way across different types of providers from 2018/19



Example B: *Our next phase of regulation: Consultation 2, CQC*

information sharing.

How local councillors and scrutiny can share information with CQC

There are lots of ways councillors can share information with CQC about people's views and experiences of local services and to let us know what council scrutiny is doing and finding to improve healthcare and social care.

It will help if councils can keep us updated about scrutiny officers' and chairs' contact details. Our inspection teams would like to know about your scrutiny plans, scrutiny findings as well as final reports, and evidence gathered from providers and other stakeholders through scrutiny. Evidence from your communities about their experiences of care is particularly useful.

Working together

How CQC works with councillors and council scrutiny

As part of our new approach to inspections, we want to build on and strengthen our relationships with council scrutiny and regional scrutiny networks in the following ways:

A strong local relationship

- CQC's local relationships with council scrutiny are vital to make sure that information and insight about the quality of local services is not overlooked.
- CQC inspection teams will work together to coordinate their contact with councils and council scrutiny and this will be led by the local CQC hospital inspection manager. The hospital inspection manager, or one of their inspectors, will be in contact with their local scrutiny chair/officer at least every three months either by phone, email or a meeting. There may be more frequent contact if councillors or council scrutiny have shared information with CQC about local services and the information needs to be discussed.

Portsmouth Hospitals NHS Trust

Inspection earlier in the year covered Medicine, ED and Well Led. Inspection Report has been published and we continue to work closely with the Trust.

A small focussed inspection was undertaken in July 2017. Report is due to be published in November 2017.

Thank you

www.cqc.org.uk

enquiries@cqc.org.uk

@CareQualityComm