Portsmouth CITY COUNCIL

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NOTICE OF MEETING

HEALTH OVERVIEW & SCRUTINY PANEL

THURSDAY, 14 JUNE 2018 AT 1.30 PM

CONFERENCE ROOM A - 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 Gemma New (Vice-Chair)
Councillor Jennie Brent
Councillor Hugh Mason
Councillor Judith Smyth
Councillor Steve Wemyss
Councillor Elaine Tickell
Councillor Michael Ford JP
Councillor Philip Raffaelli
Councillor Gary Hughes
Councillor Mike Read
Councillor Rosy Raines

Standing Deputies

Councillor Jason Fazackarley
Councillor Jo Hooper
Councillor Ian Lyon
Councillor Tom Wood
Councillor Sarah Pankhurst

(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 held on 22 March 2018 be agreed as a correct record.

4 **Update on oral health improvement** (Pages 13 - 18)

Claire Currie, Consultant in Public Health, Portsmouth City Council and Dr Jeyanthi John, Consultant in Dental Public Health, Public Health England South East (Wessex) will answer questions on the attached report.

5 **Public Health Update.** (Pages 19 - 78)

Dr Jason Horsley, Director of Public Health, will answer questions on the attached report.

6 **Hampshire & Isle of Wight Sustainability and Transformation Partnership** (Pages 79 - 124)

Michelle Spandley, Chief Finance Officer for the Hampshire and Isle of Wight Sustainability and Transformation Partnership will answer questions on the attached reports.

7 **Portsmouth Looked After Children & Safeguarding - Progress against actions of the CQC Action Plan** (Pages 125 - 216)

Tina Scarborough, Deputy Director Quality and Safeguarding, NHS Portsmouth Clinical Commissioning Group will present the attached report.

The following representatives will be available to answer questions:

- Claire Currie from Public Health.
- Sarah Thompson from PHT
- Angela Anderson from Solent NHS Trust
- Mike Taylor from the Society of St James

8 **Proposed move of the Elective Spinal Service from Portsmouth Hospitals' NHS Trust.** (Pages 217 - 250)

Paul Bytheway, Chief Operating Officer at PHT will answer questions on the attached report.

9 **Portsmouth Clinical Commissioning Group - update.** (Pages 251 - 260)

Jo York, Head of Better Care, will answer questions on the attached report.

10 **Healthwatch Portsmouth Update** (Pages 261 - 270)

Siobhain McCurrach, Healthwatch Portsmouth Project Manager will answer questions on the attached report.

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

Date Not Specified

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HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held on Thursday, 22 March 2018 at 1:30pm in the Civic Offices.

Present

Councillor Leo Madden (Chair)
Steve Wemyss
Alicia Denny
Lynne Stagg
Michael Ford
Philip Raffaelli

1. Welcome and Apologies for Absence (AI 1)

Apologies had been received from Councillors Chowdhury and Hughes.

2. Declarations of Members' Interests (AI 2)

Councillor Wemyss declared non personal, non-prejudicial interests: he works for the NHS and rents out his drive to nurses.

3. Minutes of the Previous Meeting (AI 3)

RESOLVED that the minutes of the meeting held on 1 February 2018 be agreed as a correct record.

4. Adult Social Care - update. (AI 4)

Andy Biddle, Acting Deputy Director Adult Social Care introduced the report and in response to questions, clarified the following points:

One of the causes of Delayed Transfers of Care (DTOCs) in 2017 has been insufficient availability of domiciliary care staff. Historically, care has not been an attractive career choice, often carers are paid the minimum wage. One of the potential solutions to availability is to create an in-house service that can also respond in a timely way.

There are 5 transition care home beds in Edinburgh House and currently 8 in private nursing homes.

No government funding will be given to Local Authorities for dealing with deprivation of liberty authorisations. In September 2017, four Local Authorities were unsuccessful when they took the government to court arguing that funding should be provided for this new burden.

There is a clear definition of what constitutes a DTOC. Medically Fit For Discharge (MFFDs) are not necessarily DTOCs.

He had not read Hampshire's Operating Model regarding DTOCs.

There had been a persistent issue in 2017 with numbers of people awaiting assessment from Hospital Social Work. In order to address this, more locum

staff have currently been recruited. Working as an Integrated Discharge Service is the right thing to do and on some wards, there is a ward-based social worker. Although it is not easy to recruit to Hospital Social Work roles, Hampshire County Council and Portsmouth City Councils' recruitment is improving.

There is a current pressure in adult social care whereby some care staff 'sleep-in rates' have been increased and there is a question over how pay will be backdated. This becomes an additional issue if staff are transferred under TUPE regulations to a different provider, as the potential liability for the back pay could transfer with them. This has an effect on tendering new contracts.

The council has standards of care for care home providers and works with providers to ensure that the care delivered is of an acceptable standard. A Turn-Around Team has been established and a Quality Team is in the process of being set up with the Clinical Commissioning Group to monitor progress in the homes where standards are not at expected levels and work with the providers to meet expected care standards.

The council is working to develop supported living environments and hopes to move away from traditional residential care for some people where this is appropriate and can meet their needs.

If providers are unable to meet needs and give back domiciliary care packages, the council looks for other providers. If this is not possible, the ultimate fall-back position can be a temporary residential placement to meet needs.

There continue to be significant challenges to Adult Social Care in Portsmouth which stretch the service and its budget. There are plans/strategies being drafted to provide services differently and to try to meet the financial challenges.

5. Portsmouth Hospitals' NHS Trust - update. (AI 5)

Chris Adcock, Director of Finance introduced the finance update and in response to questions, explained that:

PHT lost out on the Transformation Fund. It only received £1.7m for the first quarter.

The trust has changed its end of 2017/18 target from a surplus of £9.7 million to a deficit of £36.8 million.

The savings requirement for 2017/18 was more than £40 million.

He welcomed the government's announcement to increase nurses' pay. The potential benefits from this pay increase had not yet been calculated. Staffing costs have been increasing. The trust has extensive plans regarding recruitment and retention of nurses.

The delivery plan for savings in 2018/ 19 will be formalised for 2018/19.

The strategy which informs the financial plans is expected to be published in July.

The Chief of service for Critical Care, High Dependency Unit, Anaesthetics and Theatres appointment as Clinical Director of Finance will be key to ensuring that the finance plans are as connected to the day to day work as possible.

Cost Improvement Days have been introduced where staff are invited to give their suggestions.

The panel was disappointed that it had not been informed as soon as the trust knew that it would not be able to meet its end of year financial target.

Action
The trust agreed that it would inform the panel of any changes to its financial trajectory sooner in future.

Chris Adcock then introduced the DTOC update and in response to questions, explained that the DTOC figures for the first week of February were: PHT had 53 patients; 33 of whom came under the responsibility of Hampshire County Council and 20 Portsmouth City Council. For the week ending on 9 March, there were 59 patients for HCC and 15 for PCC.

The panel noted that these figures did not tally with those that had been given previously.

Christ Adcock could not explain the difference in the figures but assured the panel that the figures published with the agenda were correct.

Action.
It was agreed that in future the DTOC figures would be given in terms of numbers of patients not percentages.

There were no questions about the Carillion report.

RESOLVED that

1. **The finance, DTOCs and Carillion updates be noted.**
2. **There was insufficient information on the proposed spinal service change to make a decision and requested that the report be brought to the next meeting.**

6. Solent NHS Trust - update. (AI 6)

Sarah Austin, Chief Operating Officer introduced the report and in response to questions, explained that:

The focus on getting patients home should start as soon as possible, not just at the end of their stay. The mantra 'Why not home? Why not today?' should be at the forefront of their nurses' minds. Some Solent nurses are located in

the A&E department in order to develop a good relationship with patients and their families as early as possible in their journey through the hospital.

The target is to have no more than 108 Hampshire and Portsmouth medically fit for discharge (MFFD) patients held up in a bed at QA Hospital. For Portsmouth patients, the target they work to is 49. The challenges include delays at A&E, the flow through the hospital and the capacity outside to pull people home.

The number of MFFD is currently 190; 64 of these are Portsmouth patients. It is important to consider the amount of time a patient has been waiting to leave the hospital. Of these 64 MFFD, 20 have been waiting over 7 days; 10-15 between 3 and 7 days and the rest of the patients have been waiting up to 3 days. Some patients are old and frail and it would not be appropriate to rush their transfer.

A smaller number of MFFD are DTOCs.

She is very proud of how the Portsmouth system is working together to improve discharge services for patients.

Patients no longer have to wait so long for care packages.

Reasons for delays include:

- Patients waiting for the discharge to be processed by a social worker. This can vary between 2 and 15 patients.
- Patients waiting for a 'discharge to assess bed'. Some additional beds have been bought recently. It often takes time for a suitable bed to be located and then for families to be content.
- Transferring patients to care homes. Finding the right care home can take a lot of time.

She is determined to reduce the number of MFFD patients to improve their chance of independent living at home.

<u>Action</u>
The MFFD and DTOC figures from the A&E Delivery Board Report will be sent to the panel in future.

In response to questions about the estates paper, she and Christopher Box, Associate Director of Estates and Facilities Management explained that:

Early engagement with service users and their families is the key to a successful transfer.

They thought that the plans for Oakdene had been brought to a previous HOSP meeting.

The empty buildings on the St James' Hospital site would need considerable investment to repurpose them for another use.

The Orchards is for acute mental health patients and includes an intensive psychiatric care unit. There is a proposal to collocate mental health crisis services with physical health services at QA.

Proposals for capital investment are awaiting confirmation.

The funds for the travel plans at St Mary's is now available.

The discussions with Portsmouth Football Club are due to conclude shortly over parking options for staff working at St Marys.

There are strict eligibility for staff parking permits on the St Marys site. Staff parking has worked well over the previous six months. Additional spaces are required for staff who only stay on site for 20 minutes. Staff are informed that they are expected to park courteously.

An onsite multi storey car is not an option because it would be against the council's planning policy and national planning policy. The cost of building and running it would not be covered by the projected income.

They have applied for both a loan and a grant from the Department of Health for the phase 2 development of St Marys. If a grant is received, the loan would be paid off immediately. The loan would be 0.5% of their turnover (£280m).

The panel noted that it had enquired whether the Oakdene building could be used for discharge transition beds and had been told that more domiciliary care is required, rather than additional beds. Members also noted that ambulance response times had been requested for Gosport and Fareham.

The trust has received a very good staff survey result. The trust was top of the category for similar trusts.
It is recognised that staffing pressures continue, and staff often work above and beyond their contracted hours.

Action
Ambulance response times for this area would be requested from South Central Ambulance Services on the panel's behalf.

RESOLVED that the updates on the estates, P&SE Hants Integrated Care and the staff survey be noted.

7. Hampshire and Isle of Wight Sustainability and Transformation Plan. (AI 7)

Richard Samuel, Senior Responsible Officer for the Hampshire and Isle of Wight Sustainability and Transformation Partnership introduced the report and in response to questions, explained that:

Following engagement with the Local Authority members and officers it was agreed that the Health & Wellbeing Boards would be the Health & Wellbeing Alliance to advise the STP rather than be a sub-committee.

The statutory organisations within the Partnership have plans to address an anticipated financial gap of £577m by 2021.

The partnership comprises 24 statutory organisations; all historically had separate aims, misaligned positions and were competing for funding. There was competition between them regarding expenditure. It was a very complex situation. In the first year of operations, the Portsmouth & South East Hampshire network in particular established a clear sense of purpose, structure and delivery. He identified that we need to build on the existing arrangements to allow for more effective decision making as systems.

The partnership recognised that it needs to improve benefits realisation but this takes time. It is focused on quality improvements in terms of ED performance, reducing costs etc.

The partnership does not have direct governance authority over trust delivery. Health & Wellbeing Boards have legislative responsibility functions.

The partnership and individual organisations have been working with NHS England and NHS Improvement to identify the process by which incentive funding is allocated.

The points of delivery had been identified with the programme of implementation and outcomes; these correspond with what was set out in the original plan published in October 2016.

The progress made against core strategic aims, e.g. Southern Health (Mental Health, Learning Disability and Community Services), sustainability of clinical services on the Isle of Wight, transforming Care Services across North and Mid Hampshire, is monitored monthly. The aim of the partnership is clear: it is to deliver benefits. The key milestones have been achieved. It is recognised that to deliver the scale of transformation required, enhanced delivery and governance arrangements are required. Statutory organisations need to be more integrated and more accountable.

He sat on the Vascular Steering Board for three years with the Chief Executive Officers and Clinical Leads from across Hampshire & Isle of Wight. A significant amount of work was carried out negotiating between partners.

Partners within the STP determine the nature of eating disorder services that are required across the whole footprint; the CCGs decide on the locations based on their knowledge of the area and working with providers and local communities.

The Mental Health Alliance and Children's Partnership Board set out the priorities for the respective services.

The panel noted that the STP plans that were published in October 2016 had the same governance structure as set out in the latest plans.

Members said it was aware that PHT, F&G CCG and SEH CCG (by virtue of visibility via the HOSP or other medical committees or Boards) were significantly over their Control Totals and that their understanding from the media is that many other Trusts within Hampshire and the IoW are also in severe financial straits. They therefore found that gross "overspending" position hard to reconcile with the claim that the STP is delivering the substantial financial savings.

Queries were raised about the governance structures for the STP. This included the establishment of a Joint Health and Wellbeing Committee to "govern and oversee the change". Richard Samuels suggested that this was at the behest of the Local Authorities but that he would welcome greater political leadership, perhaps through the Health & Wellbeing Alliance operating as a joint committee across the four local authorities..

The panel noted that as indicated in the PowerPoint handout that "the Partnership is not a statutory body/constituted in law" and that the local organisations to date, the STP had not felt the need to "establish governance structures that formally delegate responsibilities or powers to the Partnership."

The panel discussed the establishment of the a Joint Health and Wellbeing Committee across Hampshire and Isle of Wight and recognised that in the absence of formal delgation of responsibilities or powers to the Parternship, it was understandable that (political) Local Authorities had not yet established such a joint committee.

Richard Samuel noted the development of the afore mentioned Health and Wellbeing Alliance and offered to provide further background information describing the proposal for the Health and Wellbeing Board Alliance.

Actions.
The following information was requested:

1. Confirmation that the deliverables which were detailed in the STP Delivery Plan Final Draft 21 October 2016, and then added to by the Core Programme Update in June 2017, were still captured by the Sustainability and Transformation Partnership plans. The KPIs and other measures of success for the various deliverables would be included.

2. Evidence of the claimed savings to date and the projected/ planned future savings these would be related to the original savings detailed in the STP i.e. closing the £577m gap by 2020/21 (using £60m of the STP fund) to deliver a break even position by then.

3. Confirmation that the STP will undertake further work in that period to deliver a "surplus financial position" thereafter.

4. Details of the current governance.

5. Materials to demonstrate its role in the delivery of the Wessex Vascuar Surgery Network

RESOLVED that the report be noted.

The formal meeting ended at 4:30pm.

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Councillor Leo Madden
Chair

Title of meeting:	Health Overview and Scrutiny Panel
Subject::	Update on oral health improvement
Date of meeting:	14th June 2018
Report by:	Claire Currie, Consultant in Public Health, Portsmouth City Council Dr Jeyanthi John, Consultant in Dental Public Health, Public Health England South East (Wessex) Dr Verna Easterby-Smith, Dental Practice Advisor/Clinical Director (Dental), NHS England –South (Wessex)
Wards affected:	All

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1. Purpose

1.1 To update Members of the Health Overview and Scrutiny Panel Members on:

- Oral disease and need for prevention
- Access to Dental Care in Portsmouth
- Oral health promotion in schools
- Oral health in older adults

2. Recommendations

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

3. Background

3.1 The 2012 Health and Social Care Act deferred responsibility for oral and general health improvement to Local Authorities. The Local Authority requirement is detailed in Section 17 of the NHS Bodies and Local Authorities Regulations, 2012.

4. Oral disease and need for prevention

4.1 Dental decay is still widespread in the population despite being a largely preventable disease through embedding simple advice into a daily routine. Although levels of dental decay have fallen over the last few decades, inequalities still exist with those in most deprived groups experiencing the highest levels of disease.

4.2 18.1% of five year olds in Portsmouth had tooth decay compared to 24.8% in England in 2014/15. This was measured through visual examination on a positive consent basis. As such, data quality may affect how reliably the findings represent true prevalence of tooth decay. Questions have been included in the 2018 survey of year 8 and year 10 school pupils asking about oral health behaviours (e.g. frequency of tooth brushing), school absence related to dental treatment and presence of dental disease.

4.3 Inequalities in oral health persist into adulthood. The burden of disease is higher in adults than children as dental decay continues to be a problem and there is the added risk of periodontal (gum) disease. Periodontal disease can lead to tooth loss due to the destruction of soft tissue and bone in the mouth.

4.4 Good oral health helps with eating and speaking and is integral to general health and wellbeing. Keeping children healthy is particularly important as they are growing, learning to speak and socialise. Poor oral health can lead to pain, difficulties with eating and sleeping and missed days off school or work.

4.5 Substantial healthcare resource is spent each year treating tooth decay. Children who have tooth decay and are unable to cooperate with treatment under a local anaesthesia are referred for dental extractions under a general anaesthesia, which carries its own risks. In 2016/17 over 300 children in Portsmouth had general anaesthesia for dental extractions due to tooth decay.

4.6 Portsmouth City Council Public Health Directorate and the University of Portsmouth Dental Academy won a South East 'Dragon's Den' bidding process run by the Research, Translation and Innovation Directorate, Public Health England in March 2018. This secured funds to develop an evidence-based animation to promote good oral health to young families, based on key messages in the 'Delivering Better Oral Health' toolkit. The animation is currently being co-designed with families and the impact on oral health behaviours from showing the animation in a Family Hub setting (i.e. a setting frequented by parents and children up to 19 years of age, but predominantly under 5 year olds) will be evaluated.

4.7 To encourage good oral health, Public Health Portsmouth actively supports relevant and trusted national campaigns such as Change4Life's Sugar Smart app. Using a range of routes, including social media, online and print media key oral health messages are delivered to target audiences, particularly families in areas of higher deprivation who we know tend to have poorer oral health.

5. Access to dental care in Portsmouth

5.1 Dental access is important as is an opportunity to provide oral health promotion advice as part of regular check-ups. All children should be advised to visit the dentist regularly as soon as the first tooth erupts. Health Visitors play a key role in championing health promotion in the early years which includes oral health promotion. Some Family Hubs in the city also provide free toothbrushes on an ad hoc basis while stocks remain, but provision will not continue.

5.2 NHS England – South (Wessex) commissions all NHS General dental services in Portsmouth. Routine dental care is available from 26 general dental practices (high street dentists) in Portsmouth.

5.3 Solent NHS Trust dental service provides dental care for children and adults who have additional conditions/ needs. This includes care under sedation and general anaesthesia for those who cannot be treated safely using local anaesthesia as well as domiciliary care to private residences and care homes.

5.4 The City is fortunate to have the University of Portsmouth Dental Academy who are commissioned by NHS England to provide routine dental care. Patients are treated by final year dental students from King's College, London alongside the University student dental nurses, student therapists and student hygienists. They are supported by experienced and supervised dental professionals and provide high-quality care for free to more than 2,500 local people every year. In addition the Dental Academy work to improve access to some hard to reach groups.

5.5 Dental attendance rates in Portsmouth are similar to national figures. Attendance is generally highest in children between 5 and 17 years of age, when compared to other groups (over 60%). This may be because parents have increased awareness due to messages from schools.

5.6 Dental attendance is very low in 0-2 year olds (less than 20% of this population attend in any year) and there is a need to promote dental attendance as soon as teeth erupt to enable children and their carers to get early advice on how to keep teeth healthy.

5.7 NHS England - South (Wessex) have designed some pilot innovation projects for General Dental Practice for implementation in 2018/19 where practices have applied to take part. These focus on improving oral health in some hard to reach groups; 1) to offer oral health advice and treatment to those who are homeless, 2) encourage attendance at the dental practices for toddlers, 3) to provide examinations and treatment for residents of specific care /residential homes, 4) to improve the support offered to their dental patients with diabetes as there are clear links with poor oral health and diabetes.

6. Oral health promotion in schools

6.1 The University of Portsmouth Dental Academy deliver their 'BrushUp' supervised tooth brushing programme targeted to children from Year R to Year 3 at schools in the more deprived areas of Portsmouth. The Dental Academy helps schools implement the programme, trains teachers and provides ongoing support. In addition, a dentist from the Dental Academy visits the school to conduct dental screening (visual examination for decay) and an application of fluoride varnish of the consented children twice a year. For year 2/3 pupils, healthy eating talks are also offered.

6.2 A recent survey of schools in Portsmouth undertaken by the Portsmouth City Council public health team reported approximately a quarter of secondary schools (2 out of 7 respondents (11 schools in total)) and a third of primary schools (9 out of 27 respondents (41 schools in total)) specifically cover oral health as part of their Personal, Social, Health and Economic (PSHE) lessons.

6.3 Healthy eating is closely linked to oral health due to the common risk factor of sugar and therefore advice to prevent tooth decay also contributes to the prevention of overweight and obesity. In Portsmouth, although similar to the national average, it remains the case that more than one in four (27.0%) children in Year R and four in ten (40.4%) children in Year 6 at school are overweight or obese. The Portsmouth City Council Education Department work with local authority maintained schools to achieve

Bronze Food for Life accreditation and national nutritional guidelines within school meal provision. This includes promoting water, rather than sugary drinks.

6.4 2018/19 is the first year of the Healthy Pupils Capital Funding (HPCF) where money generated through the Soft Drinks Industry Levy (SDIL) or 'sugar tax' is allocated to schools via the relevant responsible body. Portsmouth City Council is the responsible body for local authority and voluntary aided schools. HPCF guidance encourages spending to increase children's and young people's physical and mental health by improving and increasing availability to facilities for physical activity, healthy eating, mental health and wellbeing and medical conditions.

7. Oral health in older adults

7.1 National reports indicate that more people are keeping their teeth as they grow older. From the last national Adult Dental Health Survey in 2009, 6% of the adult population had no natural teeth (a strong relationship with increasing age and no natural teeth was evident) and 86% of adults had what is considered to be a "functional dentition" that is at least 21 teeth or more. Older adults often have complex fillings, crowns and bridges which require daily cleaning and professional maintenance. Many may have additional health issues creating problems with delivering care. There is no data describing dental health of older people in Portsmouth.

7.2 As people get older, the need to maintain a good state of dental health becomes important in order to maintain a healthy diet which in turn contributes to good health and wellbeing and good quality of life. It is desirable to minimise the risk of need for complex dental treatment procedures when there is a greater likelihood of complicating factors. This is becoming an increasingly bigger problem with the aging population with older patients likely to have more co-morbidities.

7.3 Dementia is increasing within the population and in these vulnerable patients, poor oral health can cause pain and affect eating, which may then affect health and wellbeing. Providing day-today care can become increasingly difficult and interventions distressing for individuals. It would therefore be useful for those diagnosed with dementia, to have early discussions with their dentist regarding the long-term care of their dental health. Discussions continue as part of the dementia steering group to embed oral health advice to be offered at or near the point of a dementia diagnosis.

7.4 Domiciliary care is available for those who cannot attend for dental care, whether in their own homes or in residential care settings. This includes patients with dementia. These are generally provided by dental teams specially trained to manage patients with special care requirements. This is an expensive service to provide, but more importantly, the range of treatment which can be provided are limited by the setting, as well as the patient's co-morbidities and ability to cooperate.

8. Key messages

8.1 Tooth decay is preventable. Prevention and early intervention is key to reducing tooth decay in the child and adult populations. Dental treatment costs have a significant impact on the local health economy.

8.2 While data shows Portsmouth had a lower prevalence of tooth decay compared to the England average (2014/15), understanding the true prevalence remains difficult to ascertain.

8.3 Portsmouth is fortunate to have the Dental Academy, University of Portsmouth, who delivers important oral health promotion targeted toward schools in more deprived areas. Additional initiatives are also in place.

8.4 Individuals diagnosed with dementia should be encouraged to have a dental check-up as soon as possible after diagnosis. This enables dental treatment needs to be considered and appropriate treatment plans agreed whilst each person is able to consider their wishes and provide consent.

8.5 Creating an environment where healthy foods and drinks, which are low in, or which contain no sugar, are easily available to everyone is important in supporting good oral health and good general health.

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Public Health Update

Dr Jason Horsley
Director of Public Health

Progress against business plan for 17-18

- See Q4 Business plan report

Health Protection

- Vaccinations and Screening – commissioned and provided through NHSE and PHE – we have assurance function and also additional work to use our comms mechanism to encourage uptake
  - See separate report on Breast Cancer screening from PHE/NHSE in light of recent issues identified with screening algorithm
  - Vaccination coverage in general still good, childhood vaccines very good, and while some adult vaccine levels (esp flu) are below the targets they are still well above the national averages
  - Cancer screening rates still generally below national averages for breast/cervical/bowel
- Team continues to work closely with PHE to manage outbreaks of infectious diseases

Health and Wellbeing Strategy and PH business plans

- Essentially finalised, accepted by the H&WBB, now going back to member organisations for acceptance / ratification
- Business plan for 18-19 essentially complete – working with new portfolio holder to finalise

Commissioned activity

- Drug and Alcohol Services
- Sexual Health Services

- 0-19 services and progress in recommissioning health visiting

Drug and Alcohol Services and risks in this area

- Contract with Society of St James generally performing well, no significant concerns
- Numbers in treatment for drugs have fallen very slightly in the last year, as have successful completions – focus for the service has been on maintaining those using more damaging substances (opioids predominantly)
- For alcohol numbers in treatment have risen, but successful completions have fallen.
- Additional initiatives
  - Alcohol in-reach to the QA to work in collaboration with alcohol nurse service there
  - Additional pilot of harm reduction worker for drug services that is focussing on homeless and using a lowered threshold for prescribing treatment
  - "Systems Thinking" review of SSJ provided services may allow for more efficient ways of working to be implemented over the next year, with increased focus on meeting peoples needs.
- Risks
  - Potential for fentanyl and its analogues to enter street opioid supplies – very strong opioids (~100-400 times stronger than heroin) – risks increasing drug related deaths and could contaminate more recreational drug supplies
  - Need to review approach to licensing and look at additional harm reduction measures in light of tragic events at Mutiny Festival

Sexual Health Services

- Contract with Solent NHS Trust
- 17-18 was first full year of current contract
- Generally performance has been good, however significant concerns about increasing demand and the impact this could have on provider/commissioner budget sustainability
- Need to review activity to see which aspects of the work they do has best impact in terms of identifying disease early and allowing treatment to prevent onward transmission
- Risks
  - National trend for increase in syphilis
  - Challenges with shortages of Hep B vaccines were managed last year, now hoping supply is returning to normal

Children's services

- Health visiting and school nursing work being included in the model for children’s directorate overall young peoples services
- Recommissioning progress for this has been reasonable
- Risks – need to reduce budgets, current mandate is very specific and may stifle innovation in delivery options

Risk Factors for non-communicable diseases

- Smoking
  - continued delivery of smoking cessation through wellbeing team – performance affected by combination of restructure and IT
  - Working well with hospital trust to move to a completely smoke-free site
- Obesity / diet / physical activity
  - Implemented initiatives to increase activity in children
    - Daily mile / golden mile
    - Pompey monsters
  - For adults – GoodGym running groups, Ping, cycling initiatives
  - Working with planning and transport to maximise environmental opportunities for improving physical activity

Wellbeing team

- Team has undergone significant restructure
  - Necessitated by reductions in the public health grant
  - This has reduced overall capacity in the team
  - Recognise that even with three times the budget, this service could never address the overall need in Portsmouth (rough estimates = 30-40,000 smokers, around 100,000 people who would benefit from weight loss, unknown proportion who could benefit from reducing their alcohol intake). So it has to focus its work.
- Currently redesigning the way the team works
  - Recognising that previously we have probably tried to offer more than the team was able to deliver
  - Improving how responsive the team is to individuals requests when they are referred to the service
    - More timely responses
    - Less reliant on face to face "you come to us" model of delivery
  - Recognising that the bulk of our referrals come through GP practices and that this is where we need to focus our responses
  - Question about what is the most effective way to focus the work
    - On people with the most health problems or
    - On people who are the most or least motivated to change
- Will continue to review the effectiveness and evidence from other areas

Areas we are being asked to do more by the public

- Air quality
  - Number of deputations from interest groups and members of the public, as well as MEP and others
  - In general have recognised that while there are a range of elements contributing to poor air quality, the best health benefits could be achieved through a modal shift in transport for the city – getting people to take more journeys by active transport
    - Because this means both reduction in a key source of pollution, but more importantly the additional benefits of regular physical activity
    - Recognising that the biggest challenge to this is in building the infrastructure to make this safe and pleasant
    - Also recognising the significant behaviour change this would need to effect to work
  - As a public health team we are working with the transport team and planning team to look at how we can improve the evidence base for action as well as help secure any future funding in this area.
    - DPH chairing officer group on potential plans for improving air quality compliance – incorporates key delivery partners including transport, planning and the port.

Areas we are being asked to do more internally and with partners

- Violent crime and drugs
  - Looking at opportunities to implement harm reduction approaches to serious and violent crime, working closely with colleagues in Hamps Constabulary and Children's services
  - Will need to review potential measures to reduce drug related litter, particularly sharps
- Need to increase strategic intelligence capacity to ensure the JSNA process continues to evolve

Major challenges

- Achieving budget targets for this year will be challenging
  - PH Grant reduction requires a further saving of ~500k
  - Additional cost pressures from rising demand for services and inflationary pressures
- Likely to require further reductions in services – working with partners to decide how these can best be achieved while minimising impact on population health and protecting services to the most vulnerable
- Further uncertainty about arrangements for funding after the PH grant is due to end after 2019-20
  - No explanation yet of how funding will be allocated in 2020-21
  - Recent consultation by DH on mandation of services – awaiting there response to this
  - Also awaiting health and social care green paper and potential for this to impact on PH – unsure how this will also impact on STP and Portsmouth Blueprint implementation

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Key function: Reduce smoking and tobacco use towards the national average from current baseline

Objective	2017 Baseline (where known)	Key progress Q1	Key progress Q2	Key progress Q3	Key progress Q4	RAG rating
Continue to work with Trading Standards to limit the trade of illicit tobacco		Retail visits - 5 visits joint operation day (prior to festival season) of action with police, licensing and immigration in Southsea (19/04). 6 visits (04/04) (one owner of all 6 premises) with Fire Safety Officer when raised concerns over adjoining accommodation (fire breaks/doors/separate alarm systems). 10 (19/06) visits Fratton & Milton to carry out Community Alcohol Partnership survey one year on (24 visits still to do). Chalk spray wall/pavement by licensed premises with U18 - Proxy purchasing it's illegal. 5 visits (05/05) with Police re Op Sceptre (knife crime). Entered visits to record on APP - share relevant intel with Police/HMRC/TSSE Follow up visits - 5 following the test purchase failures in March advice given & expectations to compliancy, training/records viewed. 7 visits (04/05) following test purchase failures in April and revisit 2 from March failures 2 visits (06/06) follow up to breaches of licensing compliancy Test purchasing (Sunday 23/04) 1 for Eliquid (2nd failure) 5 re-tests alcohol 28 tests alcohol (5 failures)	1 - Number of retail visits - advisory and retail inspections 7 visits to retailers checks and advice given 14 visits to Community Alcohol Partnership area (Fratton & Milton) to complete retailer surveys, one year on 5 visits for the DoH mini project through TSSE to check compliancy with SPoT (standardised packaging of tobacco) and TRPR (tobacco related products regs re flavours) seized products at 4 out of the 5 visits Entered findings to APP and shared if relevant with Police/HMRC/Immigration 2 - Follow up visits 4 follow up visits after test purchase failures in July Office interview one retailer re failure & proposed conditions 2 follow up visits after test purchase failures in September so far 3 - Number of test purchases conducted 14th July 14 visits - 6 failures - 5 retests from April 1 failed 2nd time 29th September 12 visits - 4 failures - 4 retests from July 1 failed 2nd time 4 - Enforcement days Saturday 16th September search dog day for illicit tobacco PACE interview 20/07/2017 PACE interview 22/08/2017 5 - Products seized Cigarettes - 8004 sticks Hand Rolling Tobacco - 7,000g Alcohol - 4 ltrs spirits as stolen goods Blunts (wraps) - seized 74 packets as flavoured Fruit shisha - 450g 6 - Public awareness days 2 illegal tobacco roadshows Friday 15th September in Commercial Road and Sunday 17th September at Fratton Family Festival These 2 days also ended up being days when tobacco products were seized on the Friday from a seller in Commercial Road - selling from backpack and shopping bag and on the Sunday when a retailer seen from pavement outside with packets on sales counter roadshow on the Friday Friday 101 people were interested/we spoke with them 76 were aware of illegal tobacco 43 had been offered illegal tobacco 39 wanted it out of their community (3 said they didn't want it out of the community, they smoke it due to cost) 29 illegal tobacco keep it out leaflets were given out (we only give to those interested not blanket bomb) 3 wellbeing contacts made (leaflets given) 6 reports of businesses & sellers received (some intel shared with HMRC) 3 reports duplicated and proved on day to be reliable intelligence Sunday Spoke at length with 42 people 16 were aware of illegal tobacco 16 had been offered it 12 wanted it out of their community 10 illegal tobacco/keep it out leaflets given out 1 wellbeing/stop smoking leaflet given out 9 reports of businesses & sellers received* (some intel shared with HMRC) one shop already received inspection by TS and illicit tobacco products seized Community Alcohol Partnership (Fratton & Milton) stall at Fratton Family Day Sunday 17th September set up and ran with Rob Anderson-Weaver 7 - Representations made to Licensing Committee in respect of alcohol applications or licence reviews 1 due for hearing early November. Working on another after 2 juvenile test purchase failures for alcohol Another in mind if continues with non-compliancy	Report from TS still to follow: Link to outcome for prosecution for illegal tobacco. https://www.portsmouth.co.uk/news/crime/illegal-tobacco-worth-10-000-found-in-portsmouth-shop-1-8351793 Currently undertaking independent e-cigarette/vaping traders to ensure are compliant with new regulations. Further roadshows being planned for the year ahead. This are well attended and bring good intelligence from members of the public on illegal sales for tobacco	Retail visits - 59 Day of Action with Licensing Police in North End of city, compliancy checks 6 visits. 1 advice and materials provided to Kebab House now wanting to sell cigarettes. Follow up visits - January - 2 re-visits checked now compliant with licensing conditions. Requested voluntary removal from sale and return to supplier of 3 products when noted on sale during Licensed Premises Inspection - counterfeit and Toys (Safety) Regs 2011, toy broke on handling and no EU contact re Minions and Sponge Bob Square Pants 'eggs' and no food expiry date. Also a plug, pins too small General Product Safety Regs and BS1363. February - 3 re-visits TS supplied Proxy Watch materials now premises agreed to new licence conditions and to discuss licence variation at another considering Reducing the Strength (no beers, ciders in plastic bottles above 6.5%). A last visit to Seven Days to see if any improvement before submitting Review Application to licensing raised on-going issues. Shared intel with Licensing and Hampshire Fire Safety Officer finding structural alteration at one premises. Test Purchasing - None but in last two weeks received new intel from Police and members of public so planning next TP Op. Training Sessions - Preventing Under Age Sales Training Course held at the Civic 16 attended. (£50 pp total £800.00). Work prior invites to retailers, collecting fees, reworking training power point presentation to include changes/updates - ecigs, acid, ammonia. Making up course packs, training materials and hand-outs. Following course marking assessments, printing certificates and re-test assessment for 3 failures. Products Seized - Although on the DoH project for e-liquids some non-compliant products identified the retailers volunteered to remove from sale and dispose of or return to producer/supplier. Some stock out of date by 1 to 2 years. DoH project RR2 Phase 2 seized - Smokeless Tobacco - Hakim Pury Zarda 3 tins, Dulal Misti Zarda 8 pots, Chaman Bahar 1 tin. Hand Rolling Tobacco - 1 pack 10g. Reviews - Worked on review during January and February whilst attempting to give guidance to premises to comply, submitted early March for Seven Days requesting committee revoke Premises Licence due to non-compliancy and serious breaches of Premises Licence. Review consists of 25 pages of evidence. Findings will be used by Licensing Section to prosecute after review. Prosecutions - January - 2 afternoons in court for DLight (counterfeit tobacco). Guilty plea, sentenced 200 hours community service, fine/costs £1,585. Premises now closed. Good coverage in Portsmouth News with request from both BBC TV and Portsmouth News to do future presentation/article. February - 1 PACE interview with interpreter. Voluntary disposal of goods, unlikely to re-offend - selling from back pack/shopping bags in Commercial Road. Pre-interview work interview script, identify offences. Follow up work consideration reports for Manager Regulatory Services. March - 2 PACE interviews one with interpreter - consideration for prosecution.	

Delivery of smoking cessation through Locally Commissioned Services (LCS) and the wellbeing service		WBS Smoking data are reported one quarter behind. Q4: 265 set quit date with 146 successfully quit (55%). 8 pregnant women set quit date with 1 successful quit.	Smoking data reported one quarter behind Q1 2017/18 data for WBS & LCS: 210 set quit date 99 achieved 4 week quit	Smoking data reported one quarter behind Q2 17/18 data for WBS & LCS: 212 set quit date 92 achieved 4 week quit	Smoking data reported one quarter behind Q2 17/18 data for WBS & LCS: TBC set quit date TBC achieved 4 week quit	
Continue work with maternity services and within secondary care, promoting screening, brief advice and referral		There has been further training with midwives. Maternity have agreed to put in a business case from their contracts department for more carbon monoxide monitors.	PH now attend the Maternity Contract Review meetings to have input in to SATD activity.	Participating in task and finish group led by Public Health England to undertake CLeaR assessment with maternity services to tackle smoking at time of delivery.	Hampshire and Isle of Wight wide maternity contract has gone out to all Public Health teams in SHIP for input in to PH outcomes and metrics and a collective public health response has been put forward. Invitation for CLeaR assessment has gone out to all involved with a partnership meeting scheduled.	
Support inclusion of stop smoking support in the 0-19 programme and through supporting a whole-school smoke-free policy		There are no dedicated pathways for provision of smoking cessation or prevention programmes for 0-19. Opportuntities are currently being examined through mapping the pathway.	No updates - this development work is still on going	Following wellbeing service restructure, a meeting is organised with the early help and prevention team to ensure a smooth pathway for stop smoking approach. Whole school approach included in children's physical health and wellbeing strategy for Portsmouth.	The Wellbeing Service will support young people aged 15+ to stop smoking. This is the agreed pathway following the meeting with the early help and prevention team.	

New initiatives / transformational

Objective	Name	Target Date	Key progress and milestones towards completion	Completed (Y/N)	On track (RAG rating)	Director's Year End Commentary
Present and gain agreement on a Tobacco Control action plan for QA Hospital which will include Stop Before the Op objectives and commitment to a smoke-free site	*Amanda McKenzie*	**By end Q1**	The smoke-free collaboration plan has been presented to the QA Hospital smoke free committee as well as the respiratory lead and lead for commissioning and quality. The committee endorsed the plan. Now work is underway to put the plan in to action and set a date for becoming smoke-free. Smoke Free date of 1st October 2018 agreed.	Y		This work has progressed reasonably well, especially considering the upheaval caused through the redesign of the wellbeing service. There are still significant challenges for reducing smoking in pregnancy, although there are signs this will be a priority area for the STP and an opportunity that health colleagues can add impetus to this work through the upcoming recommissioning of maternity services across the region.
Set up a community taskforce group in a defined area of Portsmouth to work towards a voluntary smoking ban in children's playgrounds in that area.	*Amanda McKenzie*	**By end Q2**	Action group has met and a briefing paper has been created. Have looked at examples from other areas. Next actions are to get feedback from park users and stakeholders. Request for target date to be moved to end Q4 to allow for weather and purdah	N		
Review stop smoking medication guidance used in LCS and wellbeing service	*Kathryn Richardson*	**By end Q2**	Completed in Q1	Y		
Redesign wellbeing service for implementation	*Vanguard team / Alan Knobel / Dominique Le Touze*	**By end Q3**	Vanguard re-design process complete. Full roll out has been delayed due to the hold in the implementation of the supporting IT case management and reporting system, but interim plans are in place, and full roll out can now begin.	Y		
Develop a workplace stop smoking and e-cigarette policy, in conjunction with Human Resources, for Portsmouth City Council	*Amanda McKenzie*	**By end Q3**	Draft policy created and has gone to HR Policy Office and been put in to HR policy format, with agreement of Jon Bell (Director of HR). Next steps is to go out for consultation.	N		
Develop a policy statement on electronic cigarettes for Portsmouth	*Amanda McKenzie*	**By end Q4**	As above	N		
Stop before the Op implementation will be monitored through STP milestones	*Amy McCullough / Amanda McKenzie*	**By end Q4**	Being monitored according to STP milestones (reporting to STP Prevention Board). Currently on track or ahead of STP milestones.	Y		

Key function: Improve physical activity rates from current baseline with a focus on walking and cycling						
Objective	**2017 Baseline (where known)**	**Key progress Q1**	**Key progress Q2**	**Key progress Q3**	**Key progress Q4**	**RAG rating**
Provide public health evidence and support to the Local Transport Plan and Local City Plan		Working with Transport Team on proposed Old Portsmouth Area Traffic Study, providing PH strategic input and advice.	Submission made to Local City Plan consultation, which included evidence on the potential physical and mental health benefits of planning policy.	Continuing input to Local Plan with health data. PH have been asked to be on the working group for planning developments in Commercial Rd, North End, Fratton.	No further update	

Support the implementation of the local Air Quality strategy		Modelling by the central govt Joint Air Quality Unit has estimated that Portsmouth within compliance levels by 2021. We are supporting Transport with Local Air Quality Plan to reach compliance in shortest possible time.	Public Health continue to support the implementation of the Air Quality Strategy, and the DPH has met with the new Director of Regeneration to share approaches and priorities.	Ongoing support with advice and data where requested.	Public Health input to the Air Quality Board has been agreed	

New initiatives / transformational

Objective	Target Date	Key progress and milestones towards completion	Completed (Y/N)	On track (RAG rating)	Director's Year End Commentary
Present at the Portsmouth Head Teachers Forum to promote the Daily Mile in primary schools	By end Q1	Presented at the Headteachers Forum on 3rd May. Presentation well received, this was followed up with a piece in the schools bulletin, a meeting with PSHE leads and a letter to school governors.	Y		Good progress - a simple intervention making a difference to a large number of children already
Increase the number of primary schools who take part in the Daily Mile/Golden Mile each quarter	By end Q1 By end Q2 By end Q3 By end Q4	Currently 3 primary schools are registered taking part in Daily Mile and 3 in Golden Mile additional comms was sent to school governors, school newsletters and PSHE leads. Comms pieces developed including case studies on Golden and Daily miles for spring promotion under the banner of 'going the extra mile' 6 further schools have expressed an interest in setting up through the PSHE survey	Y		
Hold the first meeting of the 'Active Portsmouth Alliance' and continue each quarter	By end Q1 By end Q2 By end Q3 By end Q4	Active Portsmouth Alliance established, first meeting held on 18th May with 23 attendees from a wide variety of organisations including Cycling UK, Portsmouth University, Bhlive, Energise me and Friends of the Earth, as well as Public Health, active travel, tackling poverty, housing and transformation from the local authority. Meetings are ongoing and membership has steadily grown. Will be developing a Portsmouth action plan dropping out from the regional physical activity strategy released at the end of January 2018.	Y		A good example of partnership work which has got off to a strong start
Develop a proposal with Pompey in the Community to support people maintaining physical activity at key transitions. Specifically for women with young children (or specific clinical areas such as pulmonary rehab, stroke rehab, cardiac rehab)	By end Q1	Initial discussions took place with PITC around submitting a bid to Sport England. This bid was unsuccessful but three additional joint bids have been put together since and are awaiting responses. The Alliance continues to target various streams to support joint outcomes of group.	Y		The bid application was not successful but the process of submitting the bid did allow for formation of a group to look at opportunities across the city to improve physical activity.
Develop a proposal to create sustainable access to affordable bikes for active travel across Portsmouth	By end Q2	A bid was developed to look at introducing a 'Bike Library' into the city to initially support low income workers across the city who are currently inactive. A scheme is now in place in Portsmouth.	Y		

Develop a workplace policy on physical activity, in conjunction with Human Resources, for Portsmouth City Council	**By end Q2**	A working group has been developed and work around physical activity is a significant element of this process. Specifically, working with facilities colleagues to put stair signage in the building to encourage use. Information to target musculoskeletal conditions will be available on the Intranet.	N/A		Workplace health work has focused internally this year. Consideration is needed for how to take this forward.
Host a Healthy Streets seminar	**By end Q2**	See note An opportunity has arisen to host a Transport and Public Health Summit in **February 2018** supported by Landor Links. This will supersede the plan for a Healthy Streets seminar, as the Health Streets model will be included.	N/A	N/A	
Use JSNA to develop a series of lay briefings to develop a common understanding of the links with health and wellbeing for PCC departments to influence the built environment e.g. 'transport and health' and 'housing and health'	**By end Q2**	This area is to be linked with workplace health offer as we look at individual departmental needs and both inward and outward facing health offer	N		Working to influence the built environment remains an opportunity to take forward in 2018
Present an action plan to implement a Healthy Streets approach for Portsmouth to the Health and Wellbeing Board	**By end Q3**	Bid was submitted to the PH Transformation Fund for funding to landscape Winston Churchill Avenue using health Streets approach, which was rejected. Alternative solutions being sought to introduce a Healthy Streets approach in working practice. Plan to be on the Planning Working Groups for redesigning Commercial Road, North End, Fratton and Cosham, where a Healthy Streets approach will be adopted.	N/A		
Present Portsmouth Health and Wellbeing Planning Guidance to the Health and Wellbeing Board	**By end Q4**	This has not been completed this year and remains an opportunity for taking forward in 2018.	N		

Key function: Mitigate against the ill-health effects of child poverty from current baseline

Objective	2017 Baseline (where known)	Key progress Q1	Key progress Q2	Key progress Q3	Key progress Q4	RAG rating
Membership of and provide and public health advice to the Portsmouth Poverty Taskforce		Mark Sage will be joining PCC's new Suicide Prevention Action Partnership (Public Health), to identify the links with poverty and financial hardship and action required.	Suicide Prevention Action Plan: Objective 2: links SP with Anti-Poverty Co-ordinator. Specific outcomes to be mapped by Q3.	Suicide Prevention & tackling Poverty Actions mapped in SP Action Plan. Sign off on Plan to take place at February 2018 Health & Wellbeing Board. Implementation activity to commence Q4.	Q3 action complete Ongoing support to Portsmouth Poverty Taskforce.	
Delivery of 0-19 services and monitoring health outcomes against the Memorandum of Understanding with Children's Services		Input into setting health visitor key performance indicators. Input into early help and prevention team contracting monitoring meeting. MoU being finalised.	Attending the Healthy Child Programme Overview Group as assurance process for public health outcomes	Working alongside colleagues in the children's families and education department to provide oversight to redesign of the health visiting offer, monitor the 0-19 offer through the Healthy Child Programme Overview Group and consider future procurement options.	Developed profile to monitor Healthy Child Programme outcomes and early child development through the ages and stages scores.	
Promotion of restorative practices in the 0-19 agenda		Supporting restorative practice as a key principle underpinning work of the children's department.	Supported bid put forward to the public health transformation fund using restorative approach for family conferences	Designing evaluation to assess application of restorative practice training by practitioners in practice.	Evaluation underway. As part of understanding how Portsmouth is tackling adverse childhood experiences, a paper was taken to the Safer Portsmouth Partnership recognising the role of restorative practice in this.	
Continuation of support to the infant feeding action plan		Supporting the Healthy Weight Quality Improvement Project. Active member of the PHE SE region task and finish group to increase healthy start vitamin uptake.	Chair Infant feeding strategy group meetings. Supporting the plan and implementation of the annual infant feeding workshop.	Annual Infant Feeding Workshop held on 11th January. 34 attendees.	Infant feeding priorities for Portsmouth have been set by the Infant Feeding Strategy Group for 2018/18	

New initiatives / transformational

Objective	Target Date	Key progress and milestones towards completion	Completed (Y/N)	On track (RAG rating)	Director's Year End Commentary
Report strategy for prevention of learning disabilities to the public health senior management team	**By end Q2**	This work has not yet been completed due to a mix of reduced capacity and also a lack of easily available reliable data on LD in the city – we will review this in the next years business plan.	N		Through work this year we have highlighted with a range of partners and providers the impacts that adverse childhood experiences have on children's outcomes, and how these are often associated with child poverty, and are actually more likely to be the mechanism through which child poverty results in poor outcomes for children. We are also working with / supporting the children's services to look at actions that help to reduce the negative impacts of ACE for those already
Develop a workplace health policy, in conjunction with Human Resources, for parents / guardians which includes a focus on promoting mental wellbeing and resilience in Portsmouth City Council	**By end Q2**	In-line with PH Workplace Health initiative: Mental health action plan has been completed. This includes a range of interventions. Including by not confined to building on and developing mental health and wellbeing, which includes building resilience, training (Connect 5). Connect 5 (brief intervention in mental health and wellbeing) rolled out via MLE. Mental health and wellbeing self-help information for staff and managers available via the Intranet.	Y		
Develop a plan to be reported to public health senior management team to protect children and families from hazards, injuries and unexpected accidents in the home	**By end Q3**	This work has been completed. Portsmouth is doing well in this area and this has been a useful piece of work to assess what we are doing against national quality standards.	Y		

Report child poverty needs assessment to public health senior management team	**By end Q4**	Young people at risk section of the Safer Portsmouth Partnership community safety needs assessment completed. This work considered to be of importance and prominence for the city and therefore was substituted with the needs assessment initially specified.	Y		exposed, and also working with children and police to develop harm reduction strategies that reduce the risk of children being exposed to ACE.
Report oral epidemiology survey findings to the public health senior management team	**By end Q4**	Scoped proposed approach with PHE dental public heath consultant and Southampton colleagues. Options appraisal completed to consider how this requirement is met. Survey questions included in the 2018 YouSay survey.	N		

Key function: Reduce self-harm and suicide from current baseline						
Objective	**2017 Baseline (where known)**	**Key progress Q1**	**Key progress Q2**	**Key progress Q3**	**Key progress Q4**	**RAG rating**
Address bullying and self-esteem, Child Sexual Exploitation reduction and of awareness of self-harm in the PSHE/Healthy schools programme and through supporting a whole-school mental health and well-being approach		Active member of the Wellbeing Subgroup for schools. This group is developing an implementation plan for the Wellbeing and Resilience Strategy to be embedded in all schools in Portsmouth. Support the Early Help & Prevention team develop a PSHE traded service offer to schools / youth services. Self-harm needs assessment completed and discussed at the Childrens Safeguarding Board. Agreed for steering group to be convened to discuss, agree and prioritise recommendations.	Failed to recruit to PSHE development officer post. Awaiting confirmation of next steps from the Early Help & Development Team.	An on-line PSHE survey has been distributed to all primary and secondary schools in the city to identify their needs. Young people PSHE focus groups have been organised for the end of February to ensure young people's view are included in any recommendations.	Findings from PSHE survey & focus groups currently being completed. Amendment to PSHE development manager job description currently underway. Aim to have someone in post by September 2018 for the start of the next academic year.	

New initiatives / transformational					
Objective	**Target Date**	**Key progress and milestones towards completion**	**Completed (Y/N)**	**On track (RAG rating)**	**Director's Year End Commentary**
Present self-harm needs assessment to public health senior management team	**By end Q1**	Self-harm needs assessment completed. Preliminary recommendations presented to the Children's Safeguarding Board on 19th July 2017. Board agreed with paper recommendations to convene a group of representative stakeholders to discuss and prioritise recommendations, and agree next steps.	Y		The suicide prevention action plan has been approved. It is a credible plan with mechanisms in place for implementation. More work is needed to address self-harm.
Formulate action plan to implement recommendations of self-harm needs assessment, as appropriate	**By end Q1**	Self-harm needs assessment completed. Stakeholders have met and agreed so set up a self-harm sub-group reporting to the suicide prevention partnership. Will develop specific self-harm actions once the suicide prevention plan is in place. Expect to develop these during Q4.	On-going		
Establish Suicide Prevention Action Group	**By end Q1**	First meeting convened 21st June. Subsequent meeting monthly to work up TOR, membership, action plan.	Y		
Present suicide prevention strategy and multi-agency action plan to the Health and Wellbeing Board	**By end Q2**	Multi-agency: x6 Priority Suicide Prevention Action Plan draft complete through a series of working groups. To be presented to the Health & Wellbeing Board on 25th October 2017.	Y		
Set up task and finish groups to implement suicide prevention multi-agency action plan	**By end Q3**	Suicide Prevention Action Plan draft has been signed off at the Health and Wellbeing Board, February 2018. Task and finish groups have started to begin the delivery phase.	N		

Key function: Reduce rates of drug related deaths from current baseline

Objective	2017 Baseline (where known)	Key progress Q1	Key progress Q2	Key progress Q3	Key progress Q4	RAG rating
Ensure full implementation of the drug and alcohol treatment service, using active contract management to improve cost effectiveness and good outcomes		Service fully implemented, and being actively contract managed.	Service fully implemented, however there has been a significant drop in the number of alcohol clients accessing treatment. This is being addressed by the provider.	The service provider has commenced in-reach into QA to improve joint working with the Alcohol specialist nurses. A Harm Reduction worker has commenced in post, this is aimed at getting older and vulnerable drug users, such as homeless, on to 'low threshold prescribing', to improve reduce illicit drug use, improve their health and reduce deaths amongst these high risk groups.	Low threshold prescribing has commenced, engaging hard to reach clients, who are at greatest risk of a drug related death	
Support inclusion of awareness of drug related harms in the PSHE/Healthy schools programme		Awaiting appointment of PSHE development post in the Early Help team	Failed to recruit to PSHE development officer post. Awaiting confirmation of next steps from children's families and education colleagues	An on-line PSHE survey has been distributed to all primary and secondary schools in the city to identify their needs. Young people PSHE focus groups have been organised for the end of February to ensure young people's view are included in any recommendations.	Findings from PSHE survey & focus groups currently being completed. Amendment to PSHE development manager job description currently underway. Aim to have someone in post by September 2018 for the start of the next academic year.	

New initiatives / transformational

Objective	Target Date	Key progress and milestones towards completion	Completed (Y/N)	On track (RAG rating)	Director's Year End Commentary
Convene a multi-agency workshop to determine high impact local actions across primary and secondary care, drug services and Portsmouth City Council to reduce drug related deaths	By end Q1	We have not held a single multi-agency workshop, but have held a number of separate sessions and meetings with key stakeholders, which is informing the development of the action plan. We are also sharing best practice with Southampton City, who are developing a similar plan. An audit of deaths in 2017 is due to be completed shortly. This will give 3 years data to understand the causes of drug related deaths in the city and enable better targeting of resources.	Y		Work has progressed well on this area this year, however the number of deaths both locally and nationally are very concerning and reflect a rise in the levels of opioid use. In the next years business plan we will outline plans to improve access to and engagement with treatment and also to mitigate the impacts of emerging new threats such as the risk of fentanyl being added to existing street drugs."
Present multi-agency action plan on preventing drug related deaths to the Health and Wellbeing Board	By end Q2	Plan developed, with additional funding from the Public Health Transformation Fund. An additional Harm Reduction Worker and the provision of low threshold prescribing will target high risk older opiate users who are not engaged in treatment. Plan to extend the provision of Naloxone to drug users and carers. Audit of deaths from 2015 and 2016 has been undertaken with Coroner's information. A drug related death review group has been established with actions being implemented.	Y		
Form group and hold first biannual meeting of a drug related death monitoring group with the first meeting to be held	By end Q3	The group have been formed and work is ongoing with partners	Y		
Confirm a Portsmouth commitment to provision of primary healthcare care to people who are homeless	By end Q3	No further development of this work, however there is wider strategic work considering the needs of homeless, which this now fits under. This objective forms part of the forthcoming homelessness strategy	N		

Key function: Reduce unwanted pregnancy from current baseline						
Objective	**2017 Baseline (where known)**	**Key progress Q1**	**Key progress Q2**	**Key progress Q3**	**Key progress Q4**	**RAG rating**
Increase the uptake of long-acting reversible contraceptives (LARC) in general practice, maternity and terminations of pregnancy pathways through on-going promotion		LARC activity being monitored. Scoping survey to determine qualified practitioners available in Portsmouth to increase activity complete.	Scoping feasibility of a "buddy" system LARC LCS	Scoping the training requirements and associated costs of upskilling GPs and practice nurses to provide LARC and exploring the possibility of providing a training bursary to encourage more GPs to train. Have started discussions with both the CCG and Solent regarding increasing LARC uptake in Primary Care, and using Solent to meet higher end LARC need.	Behavioural insights letters have been circulated to GP practices to encourage uptake of the LARC LCS offer. Scoping work underway to explore recordings of IUCD removals in primary care. This work will be ongoing into next financial year.	
Maintain the sexual health contract with Solent, ensuring relevant Public Health outcomes are met		Ongoing business as usual. Awaiting contract to be signed by Solent.	Ongoing business as usual. Contract signed.	Ongoing business as usual.	Discussions ongoing with Legal and Solent around overheating activity and financial implications/responsibilities	
Support inclusion of awareness of unwanted pregnancy in the PSHE/Healthy schools programme		Awaiting appointment of PSHE development post in the Early Help team	Failed to recruit to PSHE development officer post. Awaiting confirmation of next steps from children's families and education colleagues	An on-line PSHE survey has been distributed to all primary and secondary schools in the city to identify their needs. Young people PSHE focus groups have been organised for the end of February to ensure young people's view are included in any recommendations.	Findings from PSHE survey & focus groups currently being completed. Amendment to PSHE development manager job description currently underway. Aim to have someone in post by September 2018 for the start of the next academic year.	

New initiatives / transformational					
Objective	**Target Date**	**Key progress and milestones towards completion**	**Completed (Y/N)**	**On track (RAG rating)**	**Director's Year End Commentary**
Present findings of the terminations of pregnancy needs assessment and action plan of recommendations to the public health senior management team	**By end Q2**	Needs assessment completed and presented to members of PH senior management team. Action plan complete and DPH briefed.	Y		Developing a model whereby long acting reversible contraception (LARC) is offered to women to prevent repeat removals of children has taken precedence in the later part of the year. Good progress has been made on all aspects of this work and will continue in the next year.
Send letter to GP practices reporting findings of practice level analysis of HIV testing rate applying a behavioural insights approach	**By end Q2**	Letters due to be sent out in Q4 - so that able to report on activity for whole of financial year and compare to previous financial years.	N		
Send letter to GP practices reporting findings of practice level analysis of LARC uptake applying a behavioural insights approach	**By end Q3**	Letters to be sent out by the end of February 2018 - and at the same time will be asking practices to sign-up to the LES for the next financial year. Completed Q4	Y		

Publish the 2018 Pharmaceutical Needs Assessment (PNA) for Portsmouth which will include an assessment of gaps in provision of EHC by end March 2018	**By end Q4**	Development of PNA on track. Draft PNA approved for consultation on 20th September 2017. Consultation completed. Final PNA presented to Health and Wellbeing Board on 21st February which was approved. Published 1st April 2018.	Y		Completed in line with statutory requirement.

Key function: Reduce health and social care need in later life						
Objective	**2017 Baseline (where known)**	**Key progress Q1**	**Key progress Q2**	**Key progress Q3**	**Key progress Q4**	**RAG rating**
Improve co-ordination of volunteer and third sector input throughout PCC; working with the Directorate of Community and Communication, Independence and Wellbeing Team - Adult Social Care; and the CCG		BB Supporting Dir. Community and Communication with 'Project Bridge' which brings together PCC, PH, CCG and VCS to provide seamless support for clients. Initial meeting of Project Bridge has taken place (DLT also attended) to meet and understand the issues. BB supporting working groups and next stakeholder meeting set for Sept 2017.	The Portsmouth Together team has now moved to sit within the Directorate of Community and Communications.	DLT sits on 'Project Bridge' to provide representation from PH. Scope for future involvement as project evolves, keeping a watching brief. Current project relates to Sitting Service and is not directly with PH purview.	Continued input into the development of social prescribing in the city - funding contribution from the public health transformation fund agreed earlier in the year.	
Improve population vaccination coverage (seasonal influenza, shingles)		Had introductory meeting with health protection colleagues and requested assurance given to DPH through quarterly meetings. Trainee attended working group. PCC seasonal influenza vaccination offer planned.	Identified one primary school not accepting offer of school aged immunisations. Meeting arranged with NHS England screening and immunisation team. PCC staff seasonal influenza vaccinations co-ordinated by public health team.	Regular attendance at NHS Wessex screening and immunisation group. Promoted information regarding seasonal influenza vaccinations to frontline social care staff in additional to usual access routes.	Met with the headteacher of the primary school not accepting offer of school aged immunisations - a full discussion was had and progress made in gaining assurance that the offer of vaccination would be discussed with parents.	

New initiatives / transformational					
Objective	**Target Date**	**Key progress and milestones towards completion**	**Completed (Y/N)**	**On track (RAG rating)**	**Director's Year End Commentary**
Establish partnership and identify opportunities for public health input to Safe and Well visits	**By end Q1**	Working with Lou Wilders and Project Bridge to identify ways of working collaboratively with health and social care, and community and voluntary sector to address need.	Y		This year the public health team has not focused to a large extent on older adults. However, we have contributed meaningfully where our skills have been requested such as input into an ageing healthily project with the CCG and communities and communications directorate, and on modelling future demand on social care residential homes.
Evidence review of assistive technology	**By end Q1**	Evidence of most effective AT interventions reviewed and presented to DPH&ICS. Project lead and emphasis for review have changed, so the review may require amending to identify those population groups who may benefit most from AT.	Y		
Implement MECC training for Safe and Well	**By end Q2**	This project has been halted to allow for the Wellbeing Team restructure. It is anticipated that this will be followed up with the new team once recruitment is complete in late November. The plan has restarted since the restructure, with MECC training an	Y		

		ongoing training offer from the Wellbeing Service.			

Key function: Reduce the impact of the 'toxic trio'

Objective	2017 Baseline (where known)	Key progress Q1	Key progress Q2	Key progress Q3	Key progress Q4	RAG rating
Promote Alcohol Identification and Brief Advice (IBA) in secondary care: e.g. using Vitalpac at QA		Working with Portsmouth Hospitals NHS Trust to develop a plan to roll out IBA across inpatient wards in 18/19	Engaging with PHT who are seeking to improve their systems to implement this fully as part of a new CQUIN from April 2018	No change since Q2. IBA goes live for inpatients at QA during Q1 of 18/19	IBA goes live at QA in Q1 2018/19 for all inpatients, as part of the Preventing ill-health CQUIN	
Promote alcohol IBA in primary care: Increase referral from GP surgeries through Alcohol Awareness training to staff; IBA training to pharmacies and other professionals		Pharmacies are delivering alcohol brief advice, as part of locally commissioned services.	Ongoing work, however scope to deliver this could be impacted by the service review and savings affecting the Wellbeing service	No further change, Wellbeing service has been going through a service review/redesign.	Referrals to the Wellbeing service remain low. A joint initiative between the Wellbeing service and the Recovery Hub is being investigated to offer a distinctive service for alcohol clients.	
Implement improved and more integrated supported housing for drug and alcohol users, work with The Society of St James and Portsmouth City Council partners to expand accommodation (housing and day service), providing an increased number of supported housing and move-on bed spaces		An additional 9 bed spaces of move on have been provided by better use of buildings, with a further 11 to come in future months.	The homeless day service has relocated from 1st Sept. freeing up the previous building in Kingston Road to be converted into move-on accommodation.	Conversion work being undertaken on Kingston Road premises.	Complete	
Partnership working with Portsmouth City Council Licensing Department, Trading Standards and the Police's Licensing and Violent Crime Team		Partnership working is effective between the different staff teams, communication is excellent.	This continues to be effective. Public Health will be providing additional support to Trading Standards in the coming quarter, particularly around under-age sales - this includes delivery of the PUAS course to Off sales venues	No change from previous quarter.	Ongoing, business as usual now	
Fully engage with and support the Safer Portsmouth Partnership multi-agency complex cases priority work, developing a multi-sectoral approach to meeting their needs		Updated report have gone to SPP with recommendations and progress.	Ongoing work by the Safer Portsmouth Partnership	No change from previous quarter.	Ongoing work by the Safer Portsmouth Partnership	

Work closely with the domestic abuse lead and the Safer Portsmouth Partnership to support the domestic abuse agenda, especially where it interplays with substance misuse by providing public health input to domestic abuse strategy group		Public Health are active members of the Domestic Abuse strategy group	Recently reviewed the domestic abuse data collection and updated performance measures within adult substance misuse.	No change from previous quarter	Ongoing, business as usual now	
Ensure domestic abuse screening takes place within substance misuse services and appropriate support and onward referral is provided		Monitoring of domestic abuse screening and referral is undertaken as part of contract monitoring.	As above	No change from previous quarter	Ongoing, business as usual now	

New initiatives / transformational

Objective	Name	Target Date	Key progress and milestones towards completion	Completed (Y/N)	On track (RAG rating)	Director's Year End Commentary
Submit consultation response on the Statement of alcohol licensing policy	*Rob Anderson-Weaver / Alan Knobel*	**By end Q1**	Consultation response submitted, and accepted - PH contribution included in SLP	Y		We work closely with our Licensing team and the police to ensure responsible retailing of alcohol. Public Health continues to be pro-active in this area
Help the licensing committee and others involved in licensing to recognise the health and wellbeing benefits of reducing access to alcohol (especially high strength, low cost), cigarettes and drugs through delivery of development sessions	*Rob Anderson-Weaver / Alan Knobel*	**By end Q2**	Public Health information and evidence included in the Licensing Statement of Policy, where appropriate. Work ongoing with other responsible authorities to make representations	Y		As above
Develop shared objectives and projects to improve alcohol retailing in the city	*Rob Anderson-Weaver*	**By end Q3**	**Pubwatch** Two new Pubwatch's have been set up and supported by PH, one is Football related/specific and the other in the Northern Quarter of Portsmouth. Both aim to improve standards of alcohol retailing in On sales community and reduce alcohol related violence. **Best Bar None** Venues have been approached through the Cities six Pubwatch's to gage potential interest in this Best practice based scheme - BBN's national coordinator is keen to get the scheme back in Portsmouth after seven year hiatus	Y		As above

			The purpose of the Best Bar None Scheme • To reduce alcohol related crime and disorder • To build a positive relationship between licensed trade, police and local authorities and the private sector • To improve knowledge and skills of enforcement and regulation agencies, licensees and bar staff to help them responsibly manage licensed premises • Process of becoming recognised by BBN includes meeting minimum standards and culminates with a high profile award night with category winners and an overall winner • Responsible owners are recognised and able to share good practice with others • Highlight how operating more responsibly can improve the profitability of an individual business and attractiveness of a general area Responsible authorities have been approached through PH led licensing meetings. Police and Fire brigade are supportive of the initiative. **Community Alcohol Partnership** The Fratton and Milton Community Alcohol Partnership is moving into the evaluation stage			
Work with the South Central Ambulance Service and police to improve quality of data collection regarding alcohol related crime and safety issues	*Rob Anderson-Weaver / Alan Knobel*	**By end Q3**	SCAS have provided data for PH regarding On-sales and NTE, the relationship is being developed through project work at the 'Safe Space' site which is staffed and ran by SCAS Police data has been slow in coming when requested if at all. **Q4 Update**: In collaboration with the CCG and SCAS an end of year report on Safe Space has been created using the data provided from the service, this report provides an overview of the frequency, trends and type of presentations generated by the Night Time Economy in the Guildhall and City Centre.	Y		A good example of collaborative working to monitor and evaluate activity which we want to do more of in terms of building capacity across the organisation and within public health.

Public Health Projects						
Project	**Target Date**	**Key progress and issues arising**	**On track - time (RAG rating)**	**On track - budget (RAG rating)**	**On track - outcomes (RAG rating)**	**Key project risks**
See above for time and outcomes RAG ratings. Budget ratings available in quarterly reporting.						

Public Health - Risk Register								
Risk owner	**Risk Area**	**Where risk identified**	**Risk Likelihood**	**Risk impact**	**Current Risk Status**	**Potential outcomes**	**Mitigation/commentary**	**Type of Risk**
DPH	Insufficient focus on system prevention and early intervention in system-wide plans	System wide working with partners	Low	Moderate	Low	Failure to reduce demand on services	Working with partners to ensure the Portsmouth Health and Care Programme is sufficiently focused on prevention and early intervention	Failure to achieve objectives
DPH	Reduction in funding in services, including for vulnerable people eg. drug and alcohol services, oral health, healthy child programme	Commissioned services	High	Moderate	High	Population health outcomes decline	Managed through service redesign, retender of services and performance management of providers, where possible.	Failure to achieve objectives

Briefing Paper – National Breast Screening Serious Incident, May 2018

1. Purpose

1.1 The purpose of this paper is to provide members of the four Hampshire and Isle of Wight (HIOW) Scrutiny Committees with an overview of the national breast screening serious incident and management response. It also aims to provide elected members and local authority public health teams with information that will enable them to respond appropriately to queries from members of the public and signpost them to relevant sources of support.

2. Contents

2.1 The briefing paper includes:

- a description of the cause of the national serious incident which relates to the way in which women were invited for screening
- a description of the national response to manage the women who have been affected by this incident
- an explanation of the technical 'fix' for the invitation system that has been put in place to prevent reoccurrence
- an overview of the number of women in the Hampshire and Isle of Wight population who been affected
- an update on local management arrangements to recall and support the women affected by the incident
- contact details for further professional, public and media queries
- four appendix documents which provide further information for those who may be unfamiliar with the breast screening programme. These include an explanation of the screening process and the role of the National Screening Committee in deciding whether a screening programme should be developed; the breast screening pathway; and an overview of local breast screening service provision and delivery in Hampshire and the Isle of Wight.

3. The problem

3.1 On 2 May 2018, the Secretary of State reported to the House of Commons that a serious incident had occurred in the national Breast Screening Programme. A large number of women had not received their final invitation for a screen when they were aged between 68 and 70 years. An independent review has been set up by the Secretary of State.

3.2 The issue was identified in January 2018 whilst data from the age extension trial (AgeX) was being reviewed. Public Health England (PHE) identified that the AgeX trial algorithm could incorrectly randomise women out of the trial before they had reached their 71st birthday. A similar issue was occurring in some local programmes due to incorrect specification of batches and the failsafe criteria resulting in some local services not inviting all of the eligible women in the three years before their 71st birthday.

4. The national response

4.1 Public Health England is leading the management of the incident. A multi-agency incident team at a national level has been established to manage the incident which includes NHS England, NHS Digital, NHS Improvement, Department of Health and Social Care and a representative from the provider teams. Richard Gleave, Chief Operating Officer and Deputy Chief Executive of Public Health England is the chair of the multiagency group

4.2 An expert clinical advisory group has been providing support since the issue was identified.

4.3 Public Health England, together with NHS Digital, has led on the implementation of a ‘fix’ to the IT system; the patient notification; provision of helpline support for the women affected by this incident affected women and developing the mechanism for assessment of harm to the women concerned.

4.4 NHS England and NHS Improvement are leading on 'service response' aspects within the management of the incident. This means making sure that breast screening capacity is made available for women affected by the incident who want to be screened and ensuring capacity for subsequent diagnostic and treatment services is made available. This needs to be done in a timely way without impacting on the routine screening service for women aged 50-70 years.
The Helpline: A national telephone helpline (0800 169 2692) has been set up. It provides initial advice and support to women and to relatives, including those of women who have died. It directs callers to a range of support services when needed including taking details from women who want a screening appointment, specialist cancer clinical advice from local breast care services, Breast Care UK, Macmillan and from PHE clinical staff. After the initial peaks of calls, response times are now good and performance is being closely monitored.

4.5 **Patient recall:** On the advice of the Clinical Advisory Group, patients have been divided into two categories – those aged under 72 years on the 1 April 2018 and those aged 72 years and over. Those aged under 72 years have been sent a letter from Public Health England explaining that they will be sent a screening invitation. Those aged 72 years or over are being sent a letter asking them to contact the national helpline if they would like to self refer for a screening appointment. Around 200,000 letters will be sent out in total and all letters will have been sent out by the end of May 2018. Patients can expect to have been screened by the end of October 2018.

4.6 **Patient numbers:** Public Health England (nationally) is working to provide an accurate estimate of the numbers affected by the incident and the footprint on which this should be shared. This should be available by June 2018.

4.7 **Assessment of Harm:** Public Health England has designed an individual clinical review process which will link to duty of candour and the arrangements for compensation that the Secretary of State highlighted. The process and timescale will be shared with local Directors of Public Health, when known.

4.8 **Co-ordination of response:** All organisations are working closely together. The incident response is being managed nationally as a multi-agency group chaired by Public Health England. There are mechanisms for local questions to be raised nationally through a national contact point and via daily regional teleconferences. Providers have weekly teleconferences with local commissioners who are working to support them in finding the additional capacity needed. Answers to questions and decision outcomes / developments are being cascaded down to commissioners and providers via the regional teleconferences and via an operational bulletin update including 'frequently asked questions' which is cascaded directly on a weekly basis.

4.9 **Additional capacity:** NHS England and NHS Improvement are working closely with providers to secure additional breast screening capacity where feasible in addition to maintaining the routine service. There is a national shortage of specific staff groups which may limit the additional capacity available. All providers are required to maintain national standards, processes and accreditation in the delivery of the additional capacity. Securing additional capacity is being handled carefully as breast screening is a system not a test and appropriate governance and failsafe systems will be required to ensure it works effectively across the pathway.

5. The 'fix'

5.1 Public Health England has carried out a thorough investigation of the whole breast screening system and a detailed analysis of the data from 2009 to March 2018.

5.2 The starting date of 2009 is the point at which all breast screening services in England had completed the age extension to invite women aged 50-70.

5.3 In the 2013/14 national service specification, it was clarified that 70 meant up to the woman's 71st birthday.

5.4 A number of IT improvements and changes to processes across all services have now been made nationally to the screening invitation system to 'fix' the issue. These include:

- An interim fix to the Age X algorithm to prevent women from being placed in the control arm of the trial before they reach their 71st birthday. This was implemented by NHS Digital to the national breast screening system on the 9th May 2018. A permanent fix will be put in place by September.

- A manual failsafe check to identify women who were given a particular code in the AgeX trial from 1 April 2018 to 9 May 2018 to ensure appropriate action can be taken.

- Breast screening services have been reminded of the importance of using monthly failsafes for women aged 70 years and 11 months and this is being audited monthly by Public Health England's Screening Quality Assurance Service.

6. Hampshire and Isle of Wight women

As Public Health England are still finalising the numbers involved (see above), local figures are provisional and not yet in the public domain. Working estimates, for the purposes of planning the additional capacity, suggest around 9,000 women from Hampshire and the Isle of Wight are included in the incident. The number is also approximate because the figures are provided by programmes and do not neatly match to local authority areas. Details of the programmes and sites for screening and included in Appendix D.

7. Hampshire and Isle of Wight arrangements

7.1 NHS England (Wessex) is the commissioner of the breast screening programme at a local level. Commissioning is led by the Public Health Commissioning Team, headed by the Head of Public Health Commissioning, with an embedded specialist Public Health England Screening and Immunisation Team which is led by a Consultant in Public Health.

7.2 The Public Health Commissioning Team is a small team which is responsible for commissioning a wide range of screening and immunisations for the Wessex population. The breast screening incident local management response is being treated as a priority by the team and other priorities may need to be delayed or deferred as a result.

7.3 Providers in Hampshire and the Isle of Wight are currently working up capacity plans to offer screening appointments to all of the women affected by the incident in the local area. All but one have sufficient additional capacity in place to offer screening appointments to the under 72 year olds before the end of July.

7.4 Commissioners are working closely with the provider in Portsmouth to secure additional capacity / staff for the women (of all ages) affected by the incident. Additional capacity is being managed strategically at a regional and national level by NHS England and NHS Improvement.

7.5 At this stage, Hampshire and Isle of Wight providers are unable to confirm whether all of the patients in the 72 and over group will be screened by October but they are working hard to achieve this. Situation reports are made daily and show a steady increase in capacity. A further assessment will be made in mid / late June, following a number of anticipated developments over the coming weeks. These developments include:

- providers receiving the detailed patient lists from Public Health England which will enable them to verify whether available screening appointments are located where the women can access them. (Please see appendix D)
- clarification of the additional funding that has been identified and whether it is possible to lift national caps on agency costs to allow for additional staff to be employed
- clarification of additional staffing / service provision

7.6 Commissioners are working closely with all providers to minimise impact on the routine breast screening programme for 50-70 year olds. However, there are severe and long term, national staffing shortages within some of the roles required for breast screening so resources may need to be prioritised.

8. Contact details

8.1 It would be helpful if queries could be directed to the relevant contact points as set out below.

- Enquiries from members of the public should be referred to the national Public Health England telephone helpline which is 0800 169 2692.

- Enquiries from the media should be referred to Public Health England Press Office on 020 7654 8400 in hours. 0208 200 4400 Out of hours.

- Local authority queries and concerns should be conveyed via the Directors of Public Health to PHE Centre Directors who will forward them to national team, or to the local Screening and Immunisation Lead.

9. Appendices

9.1 For those who are less familiar with the breast screening programme, four appendices have been included to provide background information.

- Appendix A outlines the role of the National Screening Committee in deciding whether there should be a screening programme for a particular condition.

- Appendix B outlines what NHS population screening is, how it works and its strengths and limitations. It also outlines key stages in a screening pathway.

- Appendix C outlines the specific screening pathway for the breast screening programme.

- Appendix D outlines the commissioning and delivery arrangements for the breast screening programme in Hampshire and the Isle of Wight.

Report submitted by:
Clare Simpson, Consultant in Public Health – Screening and Immunisation Lead
NHS England (Wessex)
18 May 2018

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Appendix A -National Screening Committee

This summary outlines the role and governance of the National Screening Committee. This is an independent committee made up of experts who review evidence and advise on whether a population screening programme meets agreed criteria including clinical and cost effectiveness.

National Screening Committee

The UK National Screening Committee (UK NSC) is an independent committee that advises ministers and the NHS in the UK (England, Scotland, Wales and Northern Ireland) about all aspects of population screening and support implementation of screening programmes.

The NSC:

- advises ministers on the case for introducing new screening programmes and continuing, modifying or withdrawing existing screening programmes
- supports implementation of screening programmes by developing high level standards
- maintains oversight of the evidence relating to balance of good and harm and overall cost effectiveness of existing programmes
- works with partners to keep abreast of scientific developments in screening, screening policy in other countries and emerging technologies
- is accountable to the 4 Chief Medical Officers in the UK

Meetings are held 3 times per year to review current decisions and make recommendations on screening programmes. Draft minutes are available online approximately 6 weeks after each meeting

Evidence review process

The NSC follows a detailed process to assess the evidence for screening against its criteria for appraising the viability, effectiveness and appropriateness of a screening programme.

The NSC makes a recommendation for over 100 diseases / conditions as to whether a population screening is

- recommended
- non recommended

The evidence informing these decisions is updated on a regular basis. As a minimum, each decision is reviewed every 3 years and more frequently if significant evidence has been published since the last review.

Scope of screening programmes

For the NSC to consider a population screening programme:

- the target population to be screened should be sufficiently large to enable safe, clinically and cost effective screening
- the cohort to be offered screening are apparently well ie do not have symptoms of the disease / condition
- there is an effective means of identifying and contacting the whole cohort to be offered screening
- the population can be proactively approached to ensure that those offered screening would be properly informed of the potential benefits and risks in order to make an informed choice
- the primary purpose of screening should be to offer benefit to the person being screening.

Criteria for screening programmes

The evidence for each condition is reviewed against criteria which cover key issues relating to the condition, the test, the treatment and the effectiveness of a screening programme.

Further information

- Role, membership and a link to minutes of the UK NSC www.gov.uk/government/groups/uk-national-screening-committee-uk-nsc
- UK NSC evidence review process www.gov.uk/government/publications/uk-nsc-evidence-review-process
- UK NSC evidence review criteria www.gov.uk/government/publications/evidence-review-criteria-national-screening-programmes
- A complete list of UK NSC recommendations www.screening.nhs.uk/policydb.php

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Appendix B: Screening – what it can and can't do

This summary outlines what NHS population screening is, how it works and its strengths and limitations. It also outlines key stages in a screening pathway.

Screening

Screening is the process of identifying healthy people who may be at increased risk of a disease or condition. The screening provider then offers information, further tests and treatment. This is to reduce associated risk or complications.

Screening process

- Identify the eligible cohort
- Invite for screening (also known as call/ recall)
- Screening test
- If the test finds the person does not have the condition, a result is sent to individual and they are invited for screening again after a set interval. This person is at low risk of having the condition.
- If the test finds that the person does have the condition, a further investigation is offered. This person is at higher risk of having the condition. They may need further diagnostic tests and treatment. When treatment is concluded, they are usually invited for screening again after a set interval.

Informed choice

To be effective and cost effective, screening programmes need a certain number of people to have the screening test. This is usually expressed as a percentage of the eligible population. It is based on the evidence of clinical and cost effectiveness and is different for each screening programme.

It is important that individuals have the information they need to make an informed choice about whether to have screening. Health professionals have to ensure that individuals receive:

- Guidance to make informed choices
- Support throughout the screening process

In cancer screening, approximately 5% of the eligible cohort makes an informed choice not to have screening. This should be respected. However if screening programme coverage rates are less than 95%, this means that there are people who would have screening but are not having it for other reasons such as access issues, which could be addressed.

Realistic expectations

The public (and health professionals) need to have realistic expectations of what a screening programme does.

Screening can:

- Save lives
- Improve the quality of life by identifying risk early
- Reduce the risk of developing a serious condition or its complications

Screening does not guarantee protection. A 'normal' or 'negative' result means that the individual is at low risk from having the condition. It does not prevent them from developing the condition at a later date.

In any screening programme there are always false negative and false positive results. Some people will be wrongly reported as having the condition (false positive) or wrongly reported as not having the condition (false negative). This is because the tests are not perfect.

Key terms

- **Prevalence**: the number of individuals in a population with the target condition
- **Sensitivity**: the ability of a screening test to identify and **refer on** the people who **DO** have the condition
- **Specificity**: the ability of a screening test to identify and **not** refer on those who **DO NOT** have the condition
- **False positives**: these are the individuals who were referred on but do not have the condition
- **False negatives**: these are the individuals who were not referred on but do have the condition

Further information

- NHS Screening Programmes explained www.gov.uk/topic/population-screening-programmes
- Making sense of screening leaflet. Useful for addressing misconceptions and weighing up harms and benefits. www.senseaboutscience.org.resources.php/7/making-sense-of-screening
- Health knowledge interactive learning module. Useful if you want to gain an in depth understanding of screening. www.healthknowledge.org.uk/interactive-learning/screening

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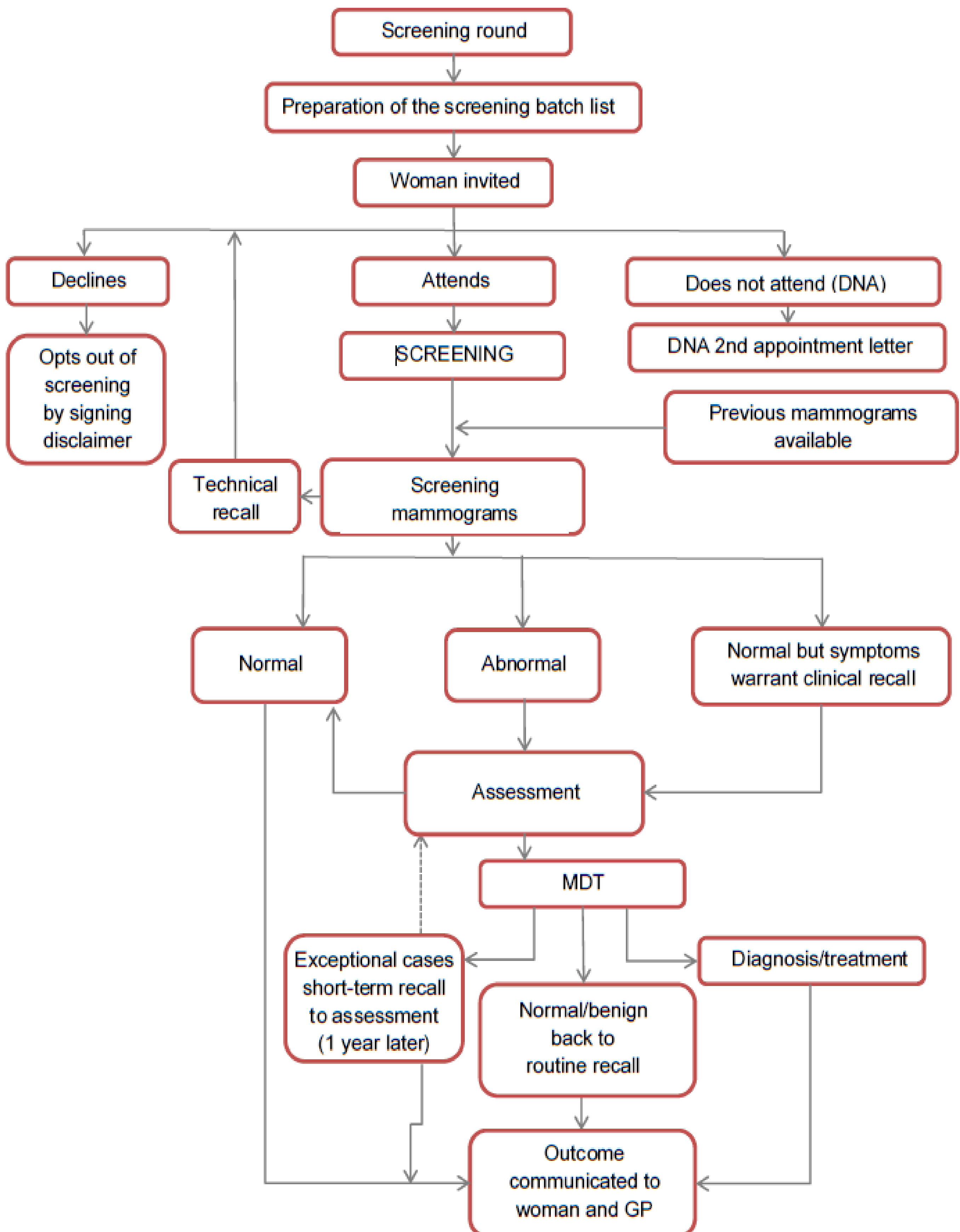
Appendix C: Breast Screening Care Pathway



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Appendix D: Breast screening in Hampshire, Isle of Wight (HIOW)

This summary outlines the local delivery of the national breast screening programme. The breast screening programme is commissioned locally by NHS England Wessex, Public Health Commissioning Team.

Purpose

Screening is the process of identifying healthy people who may be at increased risk of a disease or condition. The breast screening programme aims to find breast cancers early. The screening provider then offers information, diagnostic tests and treatment.

Prevalence of breast cancer

About 1 in 8 women in the UK are diagnosed with breast cancer during their lifetime.

Risk of developing breast cancer

The causes of breast cancer are not completely understood but there are some known risks that increase the chances of developing breast cancer. These are age, family history, previous breast cancer or benign cell changes; dense breasts; exposure to oestrogen and linked to this being overweight / obese; alcohol consumption; hormone replacement therapy; use of the contraceptive pill and exposure to radiation through medical procedures.

Effectiveness

All screening programmes have benefits and risks. They aim to reduce the risk of a person developing a condition or disease but are not perfect. Screening is different to a diagnosis.

At a population level, the breast screening programme is both clinically and cost effective and designed to do more good than harm. The National Screening Committee reviews the evidence to ensure this is the case, before agreeing to a screening programme and continues to review on an ongoing basis.

A group of national experts reviewed the evidence and concluded that screening saves about 1 life from breast cancer for every 200 women screened in the UK. This adds up to 1,300 saved lives per year. For more information please see Breast Cancer Screening on the NHS Choices website.

Benefits and risks of breast screening

At an individual level, women are asked to make an informed choice as to whether they wish to proceed with screening. Information is provided to help them to decide.

Eligible population

Screening is routinely offered to women in England, who are registered with a GP practice, aged 50 to 70 years. Women are first invited for screening between their 50th and 53rd birthday. Women can self-refer for screening after 70 years.

Screening interval

Breast screening in England is offered every 3 years. The screening interval is based on evidence and balances the need to find as many cancers as possible without undertaking unnecessary screening.

Service delivery – breast screening programmes

Breast screening in Hampshire and the Isle of Wight is delivered by 4 breast screening programmes based on patient flows and historical commissioning areas.

- Southampton and Salisbury programme which includes populations from Southampton, Hampshire and Wiltshire.
- Isle of Wight programme
- North and Mid Hampshire programme
- Surrey programme which includes populations from Surrey / Sussex and North East Hampshire.

Service delivery – venues

The Isle of Wight delivers all breast screening at St Mary's Hospital.

All of the other breast screening programmes in HIOW deliver screening at fixed sites (all year) and mobile vans (once or more every 3 years). Fixed sites include:

- St Mary's Hospital, IOW
- Royal Hampshire County Hospital, Winchester
- Queen Alexander Hospital, Portsmouth
- Princess Anne Hospital, Southampton
- Jarvis Breast Centre, Guildford

The mobile vans are similar to the size of an articulated lorry. They are moved to a new site and remain there for several weeks or months before being moved onto another site.

Invitations to women are grouped so that all the women in a local area are invited around the same time. The services have to plan carefully to make sure that the mobile van is in each area long enough to see all the women whilst ensuring they have moved onto the next location in time for when the next group of women are due to be screened.

Mobile screening sites

The mobile vans visit the following sites at least once (and sometimes more) in a three year cycle:

- Farnborough
- Basingstoke and North Hampshire Hospital
- Andover War memorial Hospital
- Fleming Park Leisure Centre, Eastleigh
- Bishops Waltham Village Hall
- Tesco Winnall, Winchester
- Bordon
- Asda, Fareham
- Locksheath Shopping Centre
- Sainsbury, Farlington
- Tesco, Petersfield
- Asda, Fratton, Portsmouth
- Ringwood Leisure Centre
- Bitterne
- Hythe
- Crosfield Hall, Romsey
- Sway Surgery
- Blackthorn Health Centre, Southampton
- Fordingbridge Drill Hall
  Lyndhurst Council Offices
- Salisbury Central Car Park
- Amesbury Health Centre

Independent Breast Screening Review

Background

On 2 May 2018 the Secretary of State for Health and Social Care reported to Parliament a serious failure in the national breast screening programme in England. He announced an independent review into the circumstances of the failure, and has appointed independent chairs to lead the review.

Co-chairs: Lynda Thomas, Chief Executive of MacMillan Cancer Support and Professor Martin Gore, Consultant Medical Oncologist and Professor of Cancer Medicine at the Royal Marsden.
Vice Chair: Peter Wyman, Chair of the Care Quality Commission.

Terms of reference

1. To investigate and report on the circumstances of the breast screening failure, including:

   - The reason/s why certain cohorts of women were not called for a final screen;
   - Establishing the timeline of relevant events from 2009 to 2018 of the Age X trial and the national programme, including their administration and governance;
   - Identifying why the problems were not detected earlier, including whether there were missed opportunities to identify and rectify the failure earlier;
   - Assessing the governance, assurance and accountability processes;
   - The clinical implications for the affected population as a whole; and
   - How the issue came to light, and the handling and escalation progress in 2018.

2. To make any appropriate recommendations based on the findings of point 1 both on breast screening, and any wider organisational or other issues that arise to ensure that such failures are not repeated.

3. To make any recommendations for any further reviews/analysis/investigation of the breast (and potentially other) screening programmes based on information gathered during this review.

4. To report by November 2018.

5. Secretariat to be provided by DHSC.

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Table 1

ONS code for countries	Country name	Number of letters sent as part of the PNE
E92000001	England	195,568
N92000002	Northern Ireland	72
S92000003	Scotland	530
W92000004	Wales	94
Total	**United Kingdom**	**196,264**

Table 2

ONS code for parliamentary consituencies	Parliamentary constituency name	Number of letters sent as part of the PNE
E14000530	Aldershot	376
E14000531	Aldridge-Brownhills	262
E14000532	Altrincham and Sale West	344
E14000533	Amber Valley	460
E14000534	Arundel and South Downs	690
E14000535	Ashfield	405
E14000536	Ashford	507
E14000537	Ashton-under-Lyne	387
E14000538	Aylesbury	241
E14000539	Banbury	173
E14000540	Barking	247
E14000541	Barnsley Central	417
E14000542	Barnsley East	454
E14000543	Barrow and Furness	248
E14000544	Basildon and Billericay	661
E14000545	Basingstoke	345
E14000546	Bassetlaw	333
E14000547	Bath	339
E14000548	Batley and Spen	551
E14000549	Battersea	235
E14000550	Beaconsfield	302
E14000551	Beckenham	271
E14000552	Bedford	401
E14000553	Bermondsey and Old Southwark	169
E14000554	Berwick-upon-Tweed	283
E14000555	Bethnal Green and Bow	161
E14000556	Beverley and Holderness	510
E14000557	Bexhill and Battle	435
E14000558	Bexleyheath and Crayford	403
E14000559	Birkenhead	260

E14000560	Birmingham, Edgbaston	293
E14000561	Birmingham, Erdington	225
E14000562	Birmingham, Hall Green	224
E14000563	Birmingham, Hodge Hill	180
E14000564	Birmingham, Ladywood	133
E14000565	Birmingham, Northfield	295
E14000566	Birmingham, Perry Barr	160
E14000567	Birmingham, Selly Oak	263
E14000568	Birmingham, Yardley	254
E14000569	Bishop Auckland	277
E14000570	Blackburn	369
E14000571	Blackley and Broughton	211
E14000572	Blackpool North and Cleveleys	285
E14000573	Blackpool South	193
E14000574	Blaydon	263
E14000575	Blyth Valley	509
E14000576	Bognor Regis and Littlehampton	843
E14000577	Bolsover	355
E14000578	Bolton North East	341
E14000579	Bolton South East	275
E14000580	Bolton West	341
E14000581	Bootle	311
E14000582	Boston and Skegness	282
E14000583	Bosworth	368
E14000584	Bournemouth East	285
E14000585	Bournemouth West	317
E14000586	Bracknell	217
E14000587	Bradford East	265
E14000588	Bradford South	273
E14000589	Bradford West	160
E14000590	Braintree	395
E14000591	Brent Central	182
E14000592	Brent North	228
E14000593	Brentford and Isleworth	258
E14000594	Brentwood and Ongar	408
E14000595	Bridgwater and West Somerset	255
E14000596	Brigg and Goole	412
E14000597	Brighton, Kemptown	323
E14000598	Brighton, Pavilion	132
E14000599	Bristol East	443
E14000600	Bristol North West	221
E14000601	Bristol South	298

E14000602	Bristol West	169
E14000603	Broadland	628
E14000604	Bromley and Chislehurst	256
E14000605	Bromsgrove	491
E14000606	Broxbourne	440
E14000607	Broxtowe	351
E14000608	Buckingham	345
E14000609	Burnley	283
E14000610	Burton	480
E14000611	Bury North	431
E14000612	Bury South	194
E14000613	Bury St Edmunds	699
E14000614	Calder Valley	403
E14000615	Camberwell and Peckham	176
E14000616	Camborne and Redruth	299
E14000617	Cambridge	242
E14000618	Cannock Chase	400
E14000619	Canterbury	520
E14000620	Carlisle	658
E14000621	Carshalton and Wallington	313
E14000622	Castle Point	491
E14000623	Central Devon	524
E14000624	Central Suffolk and North Ipswich	637
E14000625	Charnwood	256
E14000626	Chatham and Aylesford	208
E14000627	Cheadle	598
E14000628	Chelmsford	392
E14000629	Chelsea and Fulham	256
E14000630	Cheltenham	306
E14000631	Chesham and Amersham	209
E14000632	Chesterfield	360
E14000633	Chichester	701
E14000634	Chingford and Woodford Green	303
E14000635	Chippenham	439
E14000636	Chipping Barnet	224
E14000637	Chorley	582
E14000638	Christchurch	468
E14000639	Cities of London and Westminster	205
E14000640	City of Chester	426
E14000641	City of Durham	497
E14000642	Clacton	504

E14000643	Cleethorpes	346
E14000644	Colchester	504
E14000645	Colne Valley	432
E14000646	Congleton	475
E14000647	Copeland	641
E14000648	Corby	270
E14000649	Coventry North East	282
E14000650	Coventry North West	422
E14000651	Coventry South	295
E14000652	Crawley	393
E14000653	Crewe and Nantwich	361
E14000654	Croydon Central	516
E14000655	Croydon North	413
E14000656	Croydon South	600
E14000657	Dagenham and Rainham	379
E14000658	Darlington	257
E14000659	Dartford	351
E14000660	Daventry	319
E14000661	Denton and Reddish	375
E14000662	Derby North	445
E14000663	Derby South	348
E14000664	Derbyshire Dales	528
E14000665	Devizes	492
E14000666	Dewsbury	570
E14000667	Don Valley	257
E14000668	Doncaster Central	408
E14000669	Doncaster North	328
E14000670	Dover	473
E14000671	Dudley North	381
E14000672	Dudley South	290
E14000673	Dulwich and West Norwood	129
E14000674	Ealing Central and Acton	292
E14000675	Ealing North	244
E14000676	Ealing, Southall	236
E14000677	Easington	274
E14000678	East Devon	722
E14000679	East Ham	351
E14000680	East Hampshire	456
E14000681	East Surrey	371
E14000682	East Worthing and Shoreham	697
E14000683	East Yorkshire	384
E14000684	Eastbourne	405
E14000685	Eastleigh	418

E14000686	Eddisbury	427
E14000687	Edmonton	228
E14000688	Ellesmere Port and Neston	272
E14000689	Elmet and Rothwell	219
E14000690	Eltham	256
E14000691	Enfield North	102
E14000692	Enfield, Southgate	205
E14000693	Epping Forest	350
E14000694	Epsom and Ewell	302
E14000695	Erewash	518
E14000696	Erith and Thamesmead	249
E14000697	Esher and Walton	259
E14000698	Exeter	580
E14000699	Fareham	406
E14000700	Faversham and Mid Kent	289
E14000701	Feltham and Heston	283
E14000702	Filton and Bradley Stoke	260
E14000703	Finchley and Golders Green	335
E14000704	Folkestone and Hythe	519
E14000705	Forest of Dean	289
E14000706	Fylde	300
E14000707	Gainsborough	358
E14000708	Garston and Halewood	575
E14000709	Gateshead	393
E14000710	Gedling	276
E14000711	Gillingham and Rainham	350
E14000712	Gloucester	379
E14000713	Gosport	591
E14000714	Grantham and Stamford	601
E14000715	Gravesham	374
E14000716	Great Grimsby	221
E14000717	Great Yarmouth	1,091
E14000718	Greenwich and Woolwich	229
E14000719	Guildford	446
E14000720	Hackney North and Stoke Newington	338
E14000721	Hackney South and Shoreditch	258
E14000722	Halesowen and Rowley Regis	296
E14000723	Halifax	457
E14000724	Haltemprice and Howden	351
E14000725	Halton	317
E14000726	Hammersmith	221

E14000727	Hampstead and Kilburn	345
E14000728	Harborough	429
E14000729	Harlow	342
E14000730	Harrogate and Knaresborough	320
E14000731	Harrow East	217
E14000732	Harrow West	162
E14000733	Hartlepool	224
E14000734	Harwich and North Essex	394
E14000735	Hastings and Rye	297
E14000736	Havant	348
E14000737	Hayes and Harlington	247
E14000738	Hazel Grove	237
E14000739	Hemel Hempstead	312
E14000740	Hemsworth	285
E14000741	Hendon	192
E14000742	Henley	546
E14000743	Hereford and South Herefordshire	398
E14000744	Hertford and Stortford	300
E14000745	Hertsmere	275
E14000746	Hexham	324
E14000747	Heywood and Middleton	303
E14000748	High Peak	260
E14000749	Hitchin and Harpenden	290
E14000750	Holborn and St Pancras	428
E14000751	Hornchurch and Upminster	423
E14000752	Hornsey and Wood Green	308
E14000753	Horsham	542
E14000754	Houghton and Sunderland South	128
E14000755	Hove	112
E14000756	Huddersfield	268
E14000757	Huntingdon	387
E14000758	Hyndburn	323
E14000759	Ilford North	235
E14000760	Ilford South	301
E14000761	Ipswich	551
E14000762	Isle of Wight	593
E14000763	Islington North	234
E14000764	Islington South and Finsbury	237
E14000765	Jarrow	715
E14000766	Keighley	436
E14000767	Kenilworth and Southam	303

E14000768	Kensington	241
E14000769	Kettering	193
E14000770	Kingston and Surbiton	459
E14000771	Kingston upon Hull East	241
E14000772	Kingston upon Hull North	220
E14000773	Kingston upon Hull West and Hessle	268
E14000774	Kingswood	385
E14000775	Knowsley	426
E14000776	Lancaster and Fleetwood	545
E14000777	Leeds Central	181
E14000778	Leeds East	264
E14000779	Leeds North East	228
E14000780	Leeds North West	227
E14000781	Leeds West	175
E14000782	Leicester East	399
E14000783	Leicester South	272
E14000784	Leicester West	274
E14000785	Leigh	595
E14000786	Lewes	277
E14000787	Lewisham East	181
E14000788	Lewisham West and Penge	238
E14000789	Lewisham, Deptford	196
E14000790	Leyton and Wanstead	323
E14000791	Lichfield	851
E14000792	Lincoln	180
E14000793	Liverpool, Riverside	327
E14000794	Liverpool, Walton	357
E14000795	Liverpool, Wavertree	334
E14000796	Liverpool, West Derby	356
E14000797	Loughborough	339
E14000798	Louth and Horncastle	374
E14000799	Ludlow	405
E14000800	Luton North	292
E14000801	Luton South	178
E14000802	Macclesfield	410
E14000803	Maidenhead	242
E14000804	Maidstone and The Weald	422
E14000805	Makerfield	304
E14000806	Maldon	406
E14000807	Manchester Central	156
E14000808	Manchester, Gorton	195
E14000809	Manchester, Withington	181

E14000810	Mansfield	370
E14000811	Meon Valley	437
E14000812	Meriden	382
E14000813	Mid Bedfordshire	421
E14000814	Mid Derbyshire	438
E14000815	Mid Dorset and North Poole	415
E14000816	Mid Norfolk	444
E14000817	Mid Sussex	660
E14000818	Mid Worcestershire	580
E14000819	Middlesbrough	218
E14000820	Middlesbrough South and East Cleveland	234
E14000821	Milton Keynes North	264
E14000822	Milton Keynes South	349
E14000823	Mitcham and Morden	384
E14000824	Mole Valley	468
E14000825	Morecambe and Lunesdale	363
E14000826	Morley and Outwood	389
E14000827	New Forest East	395
E14000828	New Forest West	796
E14000829	Newark	433
E14000830	Newbury	243
E14000831	Newcastle upon Tyne Central	259
E14000832	Newcastle upon Tyne East	201
E14000833	Newcastle upon Tyne North	453
E14000834	Newcastle-under-Lyme	288
E14000835	Newton Abbot	314
E14000836	Normanton, Pontefract and Castleford	296
E14000837	North Cornwall	309
E14000838	North Devon	599
E14000839	North Dorset	348
E14000840	North Durham	356
E14000841	North East Bedfordshire	389
E14000842	North East Cambridgeshire	776
E14000843	North East Derbyshire	297
E14000844	North East Hampshire	259
E14000845	North East Hertfordshire	355
E14000846	North East Somerset	318
E14000847	North Herefordshire	638

E14000848	North Norfolk	658
E14000849	North Shropshire	693
E14000850	North Somerset	376
E14000851	North Swindon	363
E14000852	North Thanet	772
E14000853	North Tyneside	478
E14000854	North Warwickshire	290
E14000855	North West Cambridgeshire	556
E14000856	North West Durham	440
E14000857	North West Hampshire	495
E14000858	North West Leicestershire	195
E14000859	North West Norfolk	503
E14000860	North Wiltshire	405
E14000861	Northampton North	316
E14000862	Northampton South	298
E14000863	Norwich North	384
E14000864	Norwich South	450
E14000865	Nottingham East	170
E14000866	Nottingham North	239
E14000867	Nottingham South	197
E14000868	Nuneaton	225
E14000869	Old Bexley and Sidcup	471
E14000870	Oldham East and Saddleworth	346
E14000871	Oldham West and Royton	268
E14000872	Orpington	449
E14000873	Oxford East	210
E14000874	Oxford West and Abingdon	301
E14000875	Pendle	268
E14000876	Penistone and Stocksbridge	342
E14000877	Penrith and The Border	720
E14000878	Peterborough	538
E14000879	Plymouth, Moor View	522
E14000880	Plymouth, Sutton and Devonport	352
E14000881	Poole	448
E14000882	Poplar and Limehouse	202
E14000883	Portsmouth North	385
E14000884	Portsmouth South	381
E14000885	Preston	146
E14000886	Pudsey	183
E14000887	Putney	303
E14000888	Rayleigh and Wickford	657

E14000889	Reading East	243
E14000890	Reading West	271
E14000891	Redcar	309
E14000892	Redditch	330
E14000893	Reigate	393
E14000894	Ribble Valley	425
E14000895	Richmond (Yorks)	281
E14000896	Richmond Park	467
E14000897	Rochdale	317
E14000898	Rochester and Strood	427
E14000899	Rochford and Southend East	450
E14000900	Romford	427
E14000901	Romsey and Southampton North	279
E14000902	Rossendale and Darwen	450
E14000903	Rother Valley	453
E14000904	Rotherham	333
E14000905	Rugby	263
E14000906	Ruislip, Northwood and Pinner	378
E14000907	Runnymede and Weybridge	263
E14000908	Rushcliffe	252
E14000909	Rutland and Melton	336
E14000910	Saffron Walden	479
E14000911	Salford and Eccles	249
E14000912	Salisbury	542
E14000913	Scarborough and Whitby	357
E14000914	Scunthorpe	265
E14000915	Sedgefield	314
E14000916	Sefton Central	444
E14000917	Selby and Ainsty	313
E14000918	Sevenoaks	409
E14000919	Sheffield Central	187
E14000920	Sheffield South East	355
E14000921	Sheffield, Brightside and Hillsborough	335
E14000922	Sheffield, Hallam	351
E14000923	Sheffield, Heeley	300
E14000924	Sherwood	433
E14000925	Shipley	418
E14000926	Shrewsbury and Atcham	455
E14000927	Sittingbourne and Sheppey	532
E14000928	Skipton and Ripon	421

E14000929	Sleaford and North Hykeham	374
E14000930	Slough	283
E14000931	Solihull	342
E14000932	Somerton and Frome	444
E14000933	South Basildon and East Thurrock	638
E14000934	South Cambridgeshire	429
E14000935	South Derbyshire	407
E14000936	South Dorset	425
E14000937	South East Cambridgeshire	554
E14000938	South East Cornwall	448
E14000939	South Holland and The Deepings	303
E14000940	South Leicestershire	364
E14000941	South Norfolk	470
E14000942	South Northamptonshire	320
E14000943	South Ribble	521
E14000944	South Shields	1,119
E14000945	South Staffordshire	586
E14000946	South Suffolk	597
E14000947	South Swindon	311
E14000948	South Thanet	440
E14000949	South West Bedfordshire	310
E14000950	South West Devon	252
E14000951	South West Hertfordshire	373
E14000952	South West Norfolk	543
E14000953	South West Surrey	285
E14000954	South West Wiltshire	365
E14000955	Southampton, Itchen	252
E14000956	Southampton, Test	283
E14000957	Southend West	488
E14000958	Southport	289
E14000959	Spelthorne	415
E14000960	St Albans	332
E14000961	St Austell and Newquay	639
E14000962	St Helens North	292
E14000963	St Helens South and Whiston	337
E14000964	St Ives	446
E14000965	Stafford	380
E14000966	Staffordshire Moorlands	327
E14000967	Stalybridge and Hyde	302
E14000968	Stevenage	247
E14000969	Stockport	302

E14000970	Stockton North	320
E14000971	Stockton South	400
E14000972	Stoke-on-Trent Central	233
E14000973	Stoke-on-Trent North	240
E14000974	Stoke-on-Trent South	261
E14000975	Stone	519
E14000976	Stourbridge	328
E14000977	Stratford-on-Avon	511
E14000978	Streatham	196
E14000979	Stretford and Urmston	139
E14000980	Stroud	350
E14000981	Suffolk Coastal	840
E14000982	Sunderland Central	135
E14000983	Surrey Heath	248
E14000984	Sutton and Cheam	314
E14000985	Sutton Coldfield	356
E14000986	Tamworth	502
E14000987	Tatton	419
E14000988	Taunton Deane	538
E14000989	Telford	518
E14000990	Tewkesbury	521
E14000991	The Cotswolds	400
E14000992	The Wrekin	542
E14000993	Thirsk and Malton	344
E14000994	Thornbury and Yate	406
E14000995	Thurrock	331
E14000996	Tiverton and Honiton	505
E14000997	Tonbridge and Malling	380
E14000998	Tooting	219
E14000999	Torbay	360
E14001000	Torridge and West Devon	590
E14001001	Totnes	468
E14001002	Tottenham	202
E14001003	Truro and Falmouth	352
E14001004	Tunbridge Wells	466
E14001005	Twickenham	401
E14001006	Tynemouth	372
E14001007	Uxbridge and South Ruislip	214
E14001008	Vauxhall	182
E14001009	Wakefield	156
E14001010	Wallasey	507
E14001011	Walsall North	267
E14001012	Walsall South	316
E14001013	Walthamstow	347

E14001014	Wansbeck	362
E14001015	Wantage	294
E14001016	Warley	156
E14001017	Warrington North	290
E14001018	Warrington South	401
E14001019	Warwick and Leamington	349
E14001020	Washington and Sunderland West	110
E14001021	Watford	301
E14001022	Waveney	711
E14001023	Wealden	320
E14001024	Weaver Vale	390
E14001025	Wellingborough	472
E14001026	Wells	433
E14001027	Welwyn Hatfield	501
E14001028	Wentworth and Dearne	297
E14001029	West Bromwich East	140
E14001030	West Bromwich West	180
E14001031	West Dorset	610
E14001032	West Ham	415
E14001033	West Lancashire	382
E14001034	West Suffolk	377
E14001035	West Worcestershire	679
E14001036	Westminster North	253
E14001037	Westmorland and Lonsdale	475
E14001038	Weston-Super-Mare	701
E14001039	Wigan	342
E14001040	Wimbledon	342
E14001041	Winchester	460
E14001042	Windsor	243
E14001043	Wirral South	575
E14001044	Wirral West	411
E14001045	Witham	426
E14001046	Witney	292
E14001047	Woking	202
E14001048	Wokingham	479
E14001049	Wolverhampton North East	302
E14001050	Wolverhampton South East	243
E14001051	Wolverhampton South West	319
E14001052	Worcester	405
E14001053	Workington	569
E14001054	Worsley and Eccles South	359

E14001055	Worthing West	804
E14001056	Wycombe	310
E14001057	Wyre and Preston North	358
E14001058	Wyre Forest	516
E14001059	Wythenshawe and Sale East	233
E14001060	Yeovil	456
E14001061	York Central	185
E14001062	York Outer	295
W07000063	Montgomeryshire	6
W07000068	Brecon and Radnorshire	1
(Unknown)	(Unknown)	4
Total	**England**	**195,568**

NB: For four (4) women, the NHS GP register holds incomplete postcode data, so it is uncertain in which constituency these women reside.

Hampshire and Isle of Wight
Sustainability and Transformation Partnership

Agenda Item 6

Portsmouth HOSP queries, May 2018

MOVING FORWARD TOGETHER

Contents

- Introduction

HOSP query responses:

- Financial performance
- STP deliverables
- Structure and governance (and Partnership operating structure)
- STP role in implementation of new vascular service model
- List of appendices
- Contact details

MOVING FORWARD TOGETHER

Introduction

At it's meeting in March 2018, the HOSP raised a number of queries during and subsequent to a presentation from the Hampshire and Isle of Wight Sustainability and Transformation Partnership (see **Appendix A** for the March STP presentation).

As described during the presentation, and as context for these queries, it is important to note that the Hampshire and Isle of Wight Sustainability and Transformation Partnership is a group of 24 statutory health and care organisations who have determined to work together to deliver better health and care and better outcomes for local people. We do this in a number of ways:

- create environments in which partners can come together to strengthen trust and reduce the complexity of current health and care systems
- collectively agree a 'case for change' and, with engagement with local people, transformation priorities
- agree on how we will work together to deliver these transformation priorities, with a few being delivered at the scale of Hampshire and the Isle of Wight

Financial performance

The evidence of financial delivery across the STP is in each organisations' financial position, remembering that a significant proportion will relate to provider cost improvement programmes (CIP) and other 'routine' savings schemes e.g. Continuing Health Care (CHC), prescribing and so on.

The organisations across the HIOW STP are forecasting by the end of the 2017/18 financial year delivery of over £164m of efficiency savings. This is around 73% of the £209m target the organisations set themselves to deliver their overall control totals as set by the regulators of NHS Improvement and NHS England.

The STP is working with regulators around control totals for 2018/19 and deliverability of those. The savings delivered in 2017/18 are in line with the initial HIOW STP financial plan. Some of the challenges faced by the health economy are likely to mean it is a number of years before surpluses are consistently achieved across all the organisations. However we continue to focus on schemes that will reduce the overall cost to the system.

The current level of savings required for HIOW STP is 2018/19 is £222m, 35% greater than delivered in 2017/18. This is an average ask of 4.5% in the commissioning sector and 4.3% in the provider sector. A further £51m of savings would have to be achieved to achieve the control totals of HIOW. For 2018/19 final plan submissions have not as yet been made. However we expect 2-3 of the 13 NHS organisations to signal difficulty in achieving their control totals; this is currently subject to further discussion.

At month 11 of 2017/18, 3 of the NHS providers are forecasting non-delivery of their control totals, whilst 3 where forecasting delivery. For CCGs at month 11, 3 are forecasting achievement of their control totals and 4 are not. The final year end positions are being finalised, however this is unlikely to change the overall position.

If the HIOW organisations had delivered against control totals in 17/18, this would have been a better position than committed to in the STP – the STP planned to get to breakeven in 17/18, but control totals were set independently of the STP plan and increased the challenge to £50m surplus. Control totals are set by the regulators. It is also important to note that, for 2018/19, providers' control totals are not reset to take into account final performance in 2017/18.

The STP highlighted a savings requirement of £577m over 4 years (from 2017/18 – 2020/21). This is circa £144m a year, which is broadly in line with what has been delivered so far. The difference being the STP assumed additional funding to support the delivery of the plan of circa £50m a year, in line with indicative funding. However, the funding we have received from regulators has instead been added onto the control totals, rather than closing a gap. We also assumed capital funding of over £170m in 2017/18-2018/19 to further support transformation. Very little of this has been secured at this point.

The ambition is to release greater savings in 2018/19 than in 2017/18, improving on the £164m of savings delivered in 2017/18, which, it should be noted, is a significant amount and in excess of the initial STP financial plan. Organisations across the HIOW STP now share far more detailed financial information than ever before, to ensure they can work effectively together to reduce the costs of the system.

We are reviewing a number of areas to identify further efficiencies, including back office consolidation as part of the national 'Carter Programme', looking at pathology consolidation, radically changing approaches to workforce such as bank and agency usage, reviewing clinical variation through national programmes entitled 'Right Care' and 'Get It Right First Time', plus other national programmes of work to identify unwarranted variation. Through using such opportunities the aim for 2018/19 is to deliver greater levels of efficiency, improving the financial sustainability of the system.

2017/18 financial positions are being finalised and audited. The overall position of the HIOW STP organisations and plans for 2018/19 will be available in due course.

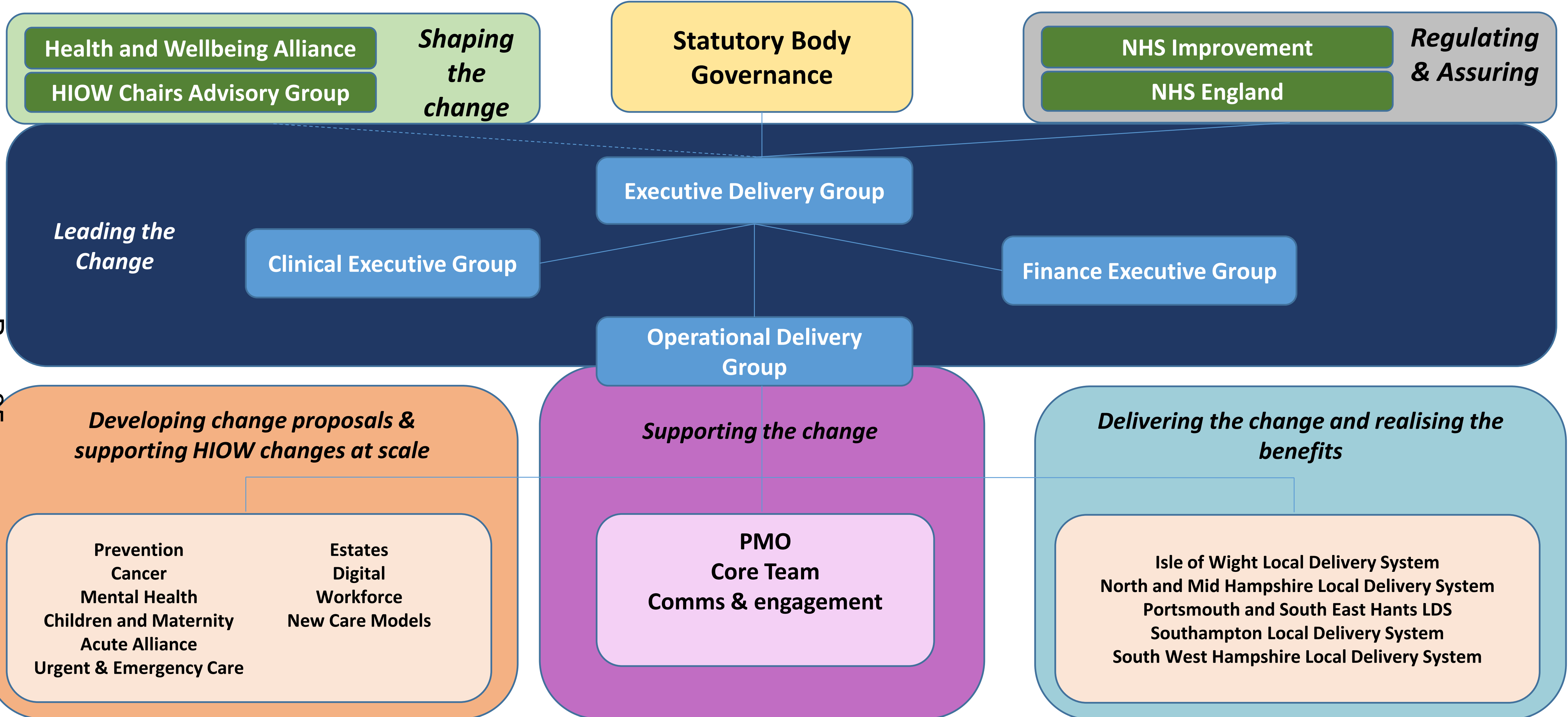
STP deliverables

- The STP has established a model of 5 local delivery systems who have come together to act as the means of delivery of the majority of transformation actions. Only those programmes best transacted at a 2 million population are undertaken at a whole HIOW level.
- Our priority actions as set out in the STP delivery plan in 2016, remain and are incorporated in local delivery system and organisational level plans. These include:
  - A radical upgrade in prevention and early intervention and self care
  - Accelerated introduction of new care models serving each community
  - Ensuring provision of sustainable acute services
  - Improving quality capacity and access to mental health services
- Key milestones for HIOW implementation plans are tracked through programme boards and risks escalated through relevant governance routes including local delivery system boards, HIOW executive delivery group, HIOW Directors of Finance group, etc (see example highlight reports attached **Appendix B, C and D**). Local delivery including KPIs and benefits realisation are monitored and managed within local organisations and local delivery systems.
- The STP work programme and progress is subject to assurance on a quarterly basis by NHS England and NHS Improvement.

Structure & Governance

- The Partnership is not a statutory body / constituted in law. It has been established under the policy direction of the NHS Five Year Forward View: Next Steps
- In 2017/18 local organisations have determined that they do not wish to establish governance structures that delegate responsibilities or powers to the Partnership. In this respect all decisions of the STP are consensual and statutory bodies retain full accountability for decisions. There is, however, an operating structure established by the Partnership and set out in a collectively developed Compact. The current operating structure is summarised on the following slide.
- To further complement and oversee the Executive Level infrastructure, as per the recommendation from the SCIE-PPL project in 2017, a HIOW HWB Alliance has been constituted as a meeting 'in common' between the four Health and Wellbeing Boards. The Alliance provides shared local authority/NHS oversight arrangements. The membership comprises the four upper tier local authorities Health and Wellbeing Chairs, five representatives from CCGs (one representative from IOW CCG, Southampton City CCG, Portsmouth CCGs and two from Hampshire representing the South West and North and Mid Hampshire local system perspective) - the CCG Chairs plus the STP Independent Chair and Senior Responsible Officer in attendance. See attached **Appendix E** for further details.
- The Partnership has recently embarked on a system design programme that will seek to revisit the governance arrangements of the Partnership and to locally design the future health system architecture. This is likely to reach initial conclusions in May 2018, at which point proposals regarding the future architecture will be further debated and refined through broader discussions with health and care system leadership including local authority partners.

Partnership Operating Structure



MOVING FORWARD TOGETHER

The STP role in the implementation of a new vascular service model

The Wessex Vascular Steering Group, led by NHS England, concluded its work in May 2017.

At that point the service model had been collectively agreed for South East Hampshire.

NHS England determined that it had reached a natural point of transition and that the implementation of the proposals was best taken forward by the Hampshire and Isle of Wight STP.

The STP's Solent Acute Alliance took on the majority of this work, refining the detailed clinical pathways, with the complex financial and activity alignments led by the STP Finance Team.

The Solent Acute Alliance supported by a range of colleagues from the broader STP, provided clinical leadership and ownership as well as technical finance expertise to ensure the overarching principles of the transfer of some surgical patients could be safely, sustainably and affordably delivered for the population of Hampshire and Isle of Wight.

Through networking arrangements for vascular surgery, provider and commissioner partners within the STP have developed, commissioned and delivered improved care pathways for patients to reduce the length of hospital stays and the need for radical surgery such as amputation.

A letter from NHS England is attached at **Appendix F** referring to the STP role in the implementation of the new service model.

Appendices

Appendix A: Portsmouth HOSP presentation March 2018

Example highlight reports:

Appendix B: STP prevention at scale highlight report

Appendix C: Solent Acute Alliance highlight report

Appendix D: STP digital programme highlight report

Appendix E: HIOW Alliance proposal

Appendix F: NHS England letter reference vascular service model

MOVING FORWARD TOGETHER

Contact us

The following organisations are supporting the delivery of sustainability and transformation programmes of work in Hampshire and the Isle of Wight:

NHS Fareham and Gosport Clinical Commissioning Group
NHS Isle of Wight Clinical Commissioning Group
NHS North Hampshire Clinical Commissioning Group
NHS North East Hampshire and Farnham Clinical Commissioning Group
NHS Portsmouth Clinical Commissioning Group
NHS South Eastern Hampshire Clinical Commissioning Group
NHS Southampton City Clinical Commissioning Group
NHS West Hampshire Clinical Commissioning Group
Hampshire County Council
Isle of Wight Council
Portsmouth City Council
Southampton City Council
NHS England
NHS Improvement
NHS South Central and West Commissioning Support Unit

Hampshire and Isle of Wight GP surgeries
Hampshire Hospitals NHS Foundation Trust
Isle of Wight NHS Trust
Portsmouth Hospitals NHS Trust
Solent NHS Trust
South Central Ambulance Service NHS Foundation Trust
Southern Health NHS Foundation Trust
University Hospital Southampton NHS Foundation Trust
Wessex Academic Health Science Network
Wessex Clinical Networks
Wessex Clinical Senate
Wessex Local Medical Committees
Health Education Wessex
Local voluntary and community organisations
Hospital and community trusts in neighbouring areas

For more information on any of the details within this document or to get involved in our work please email **SEHCCG.HIOW-STP@nhs.net**

MOVING FORWARD TOGETHER

Hampshire and Isle of Wight
Sustainability and Transformation Partnership

2017/2018 Delivery

MOVING FORWARD TOGETHER

Introduction

- The Hampshire and Isle of Wight Sustainability and Transformation Partnership [the Partnership] is a group of 24 statutory health and care organisations who have determined to work together to deliver better health and care and better outcomes for local people. We do this in a number of ways:
    - create environments in which partners can come together to strengthen trust and reduce the complexity of current health and care systems
    - collectively agree a 'case for change' and, with engagement with local people, transformation priorities
    - agree on how we will work together to deliver these transformation priorities, with a few being delivered at the scale of Hampshire and the Isle of Wight

Structure & Governance

- The Partnership is not a statutory body / constituted in law. It has been established under the policy direction of the NHS Five Year Forward View: Next Steps

- In 2017/18 local organisations have determined that they do not wish to establish governance structures that delegate responsibilities or powers to the Partnership. In this respect all decisions of the Partnership are consensual and statutory bodies retain full accountability for decisions.

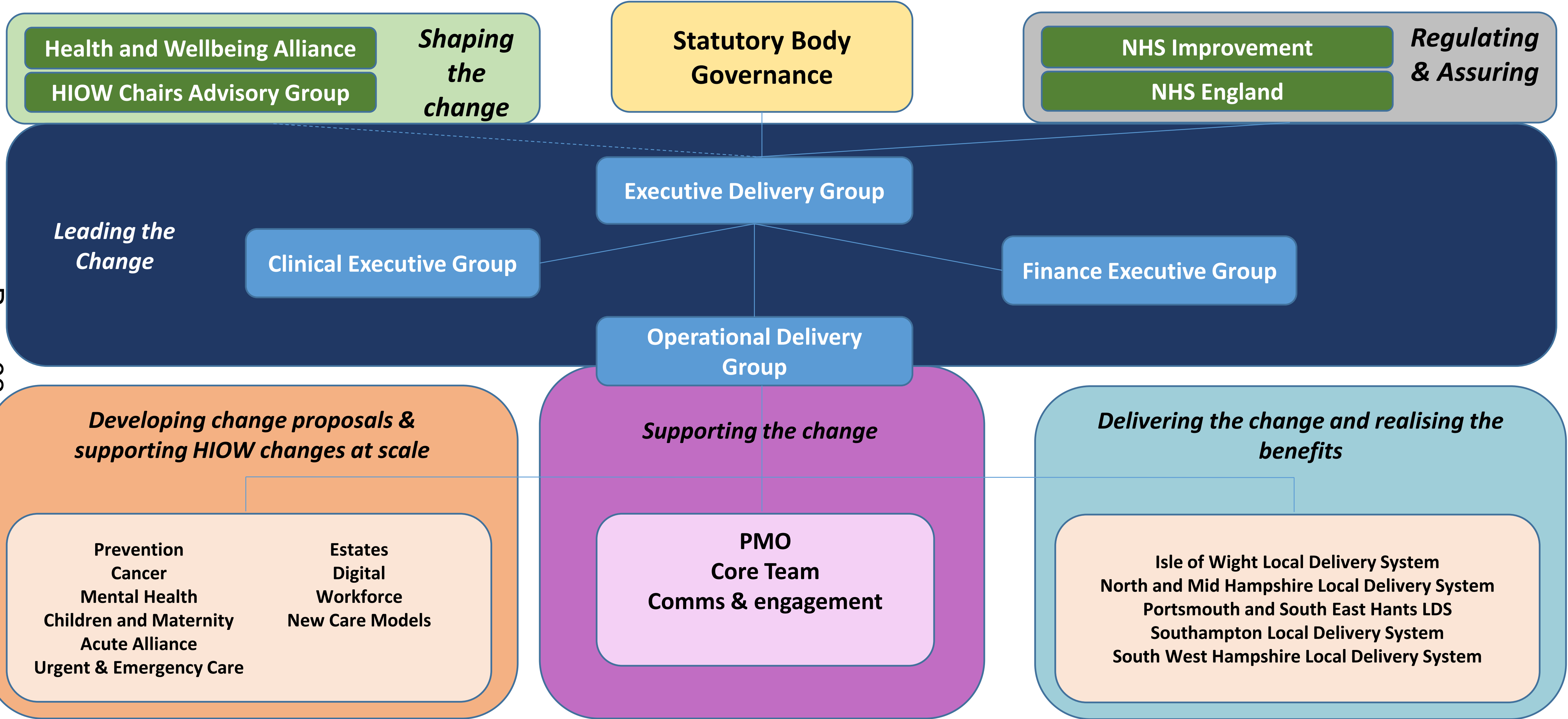
- There is, however, an operating structure established by the Partnership and set out in a collectively developed Compact.

- The Partnership has recently embarked on a system design programme that will seek to revisit the governance arrangements of the Partnership and to locally design the future health system architecture. This is likely to reach initial conclusions in May 2018

- The local Partnership is not subject to judicial review

MOVING FORWARD TOGETHER

Partnership Operating Structure



Leadership and Accountability

- the Partnership have established a model of 5 Local Delivery Systems who have come together to act as the means of delivery of the majority of transformation actions
- Only those programmes best transacted at a 2 million population are undertaken at a whole partnership level
- work programme and progress is subject to assurance on a quarterly basis by NHS England and NHS Improvement.
- An MOU sets out the respective responsibility of regulators and the Partnership core team
- In 2017/18 NHS England contributed £300,000 to support Partnership working. This was complemented by a number of partners contributing £40,000 each. For context, the annual NHS allocation for Hampshire and Isle of Wight is £2.5bn
- Using this resource, a small core team was established for 18 months to support the Partnership's activities

Delivery 2017/18

All of the achievements and aspirations detailed within this document would not be possible without the NHS and local authorities working in partnership. Working together as organisations and with local people, we are improving the health and wellbeing of the population of Hampshire and Isle of Wight.

Key delivery progress will be set out against our priority actions:

- Radical upgrade in prevention and early intervention and self care
- Accelerated introduction of new care models serving each community
- Ensure provision of sustainable acute services
- Improve quality capacity and access to mental health services

MOVING FORWARD TOGETHER

Financial Performance

- There is a difference between the requirement of individual statutory organisations to deliver regulator-set and assured control totals and the Partnership Programme to address an anticipated financial gap of £577m by 2021 in a ‘do nothing’ scenario.

- The Partnership originally set itself a whole system 2017/18 saving plan of £186m. The actual forecasted cost reduction in 17/18 is £164m.

- Anticipated in-year savings have been delivered in a number of areas including mental health, prevention, estates, medicines optimisation and the Solent Acute Alliance.

- Partnership savings anticipated in discharge and flow and provider cost improvement have not been fully achieved

- Whilst there is a gap in cost reduction (0.8% of turnover) the deficit financial position for the whole Partnership footprint is anticipated to be greater because of non-receipt of £40m of planned-for national transformation revenue and unanticipated additional costs incurred in delivery, notably in workforce costs.

MOVING FORWARD TOGETHER

Prevention, Early Intervention and Self Care

Expected impacts and benefits for patients, communities and services

- ✓ Improving Health and Wellbeing, with more people able to manage their own health conditions reducing the need and demand for health services
- ✓ More people supported to give up smoking, achieve a healthy weight and drink sensibly (reducing lifestyle related diseases)
- ✓ Efficiencies of £10m by 2020/21

Delivery at Scale in 2017/18

- 2,000 people supported on the Diabetes Prevention Programme across Hampshire and the Isle of Wight.
- 100 GP Practices now providing e-consult with over 1m local people now able to use the service
- In-house Hospital Stop smoking advisors appointed to UHS and HHFT increased referrals and rate to 32%
- Promotion of digital appointments for sexual health screening has resulted in a 30% increase in uptake and reduced service costs.
- Deployed signposting and care navigation roles in GP practices
- Training primary and community teams in health coaching and patient activation techniques
- A cancer prevention programme has been implemented improvInger access to screening opportunities
- Better Births programme has created My Birthplace app to empower mothers

Plans for 2018/19

- We will embed smoking cessation into all care processes and as a result witness an increase in the number of people who stop smoking. In order to deliver this, all trusts will develop a robust plan with support from the Commissioning for Quality and Innovation scheme.
- We will continue to roll out the National Diabetes Prevention Programme with 2500 new residents accessing the programme by end of 2018/19.
- All NHS organisations to have a MECC training plan agreed by their Board. Implementation of the plan will have started.
- We will continue to work on increasing the uptake of cancer screening with a particular focus in the early part of the year on cervical screening. Later in the year we will turn our attention to breast and bowel cancer.
- Establish the HIOW Personalised Health Record
- Establish 111 Online by July 2018
- Establish Integrated urgent Care by November 2018

MOVING FORWARD TOGETHER

New Care Models

Expected impacts and benefits for patients, communities and services

- ✓ Improved outcomes for people with long term conditions/multiple co-morbidities
- ✓ Reduced A&E attendances/hospital admissions for frail older people and people with chronic conditions
- ✓ More people maintaining independent home living
- ✓ Sustainable General Practice offering extended access
- ✓ Efficiencies of £46m by 2020/21

Achievements to date

- Secured £1 million investment to support better compliance with national treatment standards for people with diabetes.
- Three quarters of the Hampshire and Isle of Wight population now have access to evening and weekend GP appointments.
- Investment in Online consultations have freed up in the region of 500 GP appointments per week.
- Invested in the training and appointment of GP nurse practitioners, Physician Assistants, Nurse Mentors and clinical pharmacists linked to practices
- People can now more easily access a range of health and wellbeing services in a single location as part of integrated hubs that have been developed in Lymington, Farnham, Yateley, Gosport and Fareham. GPs, community nurses, physiotherapists, mental health practitioners, care navigators, pharmacists and hospital specialists are working together in the hub to support people to stay well, to provide the right support when needed and to better manage any long term illness.

Plans for 2018/19

- To ensure 100% of the Hampshire and Isle of Wight population has access to evening and weekend GP appointments
- To open more hubs across Hampshire and the Isle of Wight to improve access to support and care for local people. There will be 15 area health hubs in total by 2020.
- To further establish care teams in each local area to include staff from primary, community and social care as well as hospital specialists to support people in their local communities. Care might be provided in local hubs, in residential or care homes or in people's own homes.
- We intend to work with Health Education England and the Local Medical Committee to develop strong plans to support and retain the GP and nursing workforce, develop new roles as part of local care teams, and recruit high quality staff to the area
- Focused work with GPs, community teams, voluntary organisations and hospital specialists to improve support and care for people with long-term conditions, including access to education and support that improves people's confidence to manage their own health.

Sustainable Acute Services: *IOW / N&M Hants*

Expected impacts and benefits for patients, communities and services

- ✓ Conclude the process of developing options for acute services configuration for the population of Isle of Wight
- ✓ Conclude the process of developing options for acute services configuration for the population of North and Mid Hampshire

Achievements to date

- 1 February 2018: preferred option agreed for the future of acute services for the population of the Isle of Wight, following significant partnership work between NHS and Local Government partners
- 30 November 2017 North and West Hampshire CCGs agreed to the continued development of plans for more joined up local health services both in and out of hospital and the development of proposals for the centralisation of services within the current Hampshire Hospitals' footprint (Andover, Winchester and Basingstoke), This will include exploring any necessary capital development to support relocation of services. Other options, including a standalone critical treatment hospital will not be progressed at this time as part of the programme.

Plans for 2018/19

- IOW: Detailed work, led by the clinical teams and enabled by the Solent Acute Alliance, will refine the preferred option and quantify the future changes in capacity and demand brought about by the proposals. The ambition is to move towards a Stage 2 review and submission to the NHS England Finance and Investment Committee in the winter of 2018.
- N&M Hampshire: Detailed plans for strengthened integrated primary and community services for the local population will be presented to the two CCG Governing Bodies and the Trust Board in April. The ambition is to move towards a Stage 2 review and submission to the NHS England Finance and Investment Committee in the winter of 2018.

Sustainable High Quality Acute Services: *Cancer*

Expected impacts and benefits for patients, communities and services

- ✓ Improvements in the prevention and early detection of cancer ,
- ✓ Patient treatment and their experience of that treatment will be as good as it can be.
- ✓ People will be supported to live with and beyond their cancer diagnosis.

Achievements to date

- We have invested £1 million in a programme to help people on the road to recovery as soon as they receive a cancer diagnosis, rather than waiting for them to undergo treatment. This new scheme connects research teams with clinicians and patients and is trialling various techniques to quickly developing the most effective approach to support cancer recovery.
- We have received additional funding of £146,000 to increase the number of people who start their cancer treatment with 62 days of being referred for diagnosis by their GP. This money has been used to improve access to diagnostic services such as scans.
- Approximately 2000 cancer patients have now received assessments aimed at supporting both their physical and mental needs following their diagnosis.
- Following treatment for breast, colorectal and prostate cancer, patients at University Hospital Southampton are now able to control their own follow up care, supported by training and open access to clinical support when required. Patients are no longer required to attend frequent follow up appointments, but instead can contact a specialist when they need to. In most cases this is a significant reduction in the number of hospital appointments and in all cases health outcomes and patient experience have been as good or better.

Plans for 2018/19

- We will further increase the number of people who live for over a year following a cancer diagnosis.
- By the end of 2018/19 we will double the number of people receiving a physical and mental health assessment, post cancer diagnosis.
- We will implement the new model of follow up care piloted at University Hospital Southampton, across all hospitals in Hampshire and the Isle of Wight.
- We will focus on increasing the number of people who are diagnosed at the early stage of their cancer and hence improve their chances of survival. We will do this by supporting staff and patients to recognise the signs and symptoms of cancer.
- We will ensure that more than 85% of people who are diagnosed with cancer start their treatment within 62 days of being referred by their GP.

MOVING FORWARD TOGETHER

Sustainable Acute Services: *Solent Alliance*

Expected impacts and benefits for patients, communities and services

- ✓ All patients able to consistently access the safest acute services offering the best clinical outcomes, seven days a week and delivery of the national access targets for the Southern Hampshire and Isle of Wight population
- ✓ Reduced variation and duplication in acute service provision
- ✓ Efficiencies of £165m by 2020/21

Achievements to date

- In April 2017 and following consultation with local people, vascular services (which care for people with problems with their veins or arteries) were reconfigured.
- The Acute Alliance has brought teams together to share best practice across specialties such as gastroenterology and emergency medicine to ensure local people receive the best quality care no matter where they live.
- Following clinical and service user discussion, proposals are ready for implementation regarding the future configuration of spinal surgical services
- A Pathology consortia has been established to reduce costs and improve quality and resilience of pathology services
- By summer 2018, services to support patients experiencing kidney failure, known as renal services, will be joined up across the area ensuring that there is less variation and everyone receives the same high quality care.
- MSK Service review completed.

Plans for 2018/19

- From early 2018 and following input from local people, the configuration of the service which provides spinal surgery will be agreed. The aim of reviewing spinal services is to improve access for local people to this high quality specialist service.
- In consultation with local people, NHS organisations and clinical teams, we will agree the configuration of hospital services on the Isle of Wight.
- To undertake service reviews in plastics (surgery for the skin) and radiology.
- Implement findings of the MSK review.
- Isle of Wight Trust and University Hospital Southampton pathology departments are now working together to jointly procure a pathology equipment service. By working together costs to the local NHS are reduced.

MOVING FORWARD TOGETHER

Improved Quality and Access to Mental Health

Expected impacts and benefits for patients, communities and services

- ✓ All people in Hampshire and Isle of Wight will have early diagnoses to enable access to evidence based care, improved outcomes and reduced premature mortality
- ✓ Enhanced community care and improved response for people with a mental health crisis. Reduced out-of-area placements for patients requiring inpatient care
- ✓ Efficiencies of £28m by 2020/21

Achievements to date

- Tangible improvements have been achieved in ensuring people experiencing a mental health crisis, receive the appropriate care. This has significantly reduced the number of people detained under section136 of the Mental Health Act decreased in Hampshire.
- The Hampshire community eating disorder service for 0-18 year olds is now operational
- Specialist community perinatal services (which support women who suffer from mental illness during and one year after their pregnancy) are now in place across Hampshire and the Isle of Wight.
- All-age mental health liaison teams are now in place in all Hampshire and Isle of Wight hospitals supporting patients with both physical and mental health needs.
- Southampton hosted the first STP wide health and housing summit in the country. This programme highlights the links between housing and mental health and is an excellent example of the new approaches we are taking.
- Ours is one of only eight STP areas nationally to be successful in gaining Building Health Partnerships programme support and funding, the only one in the country with a focus on mental health.

Plans for 2018/19

- In March 2018, following engagement with staff and patients and their families, a preferred configuration of services to support those with more severe mental illness will be selected and subsequently implemented.
- We will work to reduce the number of people with severe mental illness who are being cared for outside of Hampshire and the Isle of Wight, ensuring they can be cared for in a place as close to their home as possible.
- We will work with local people and staff to understand their views on how we should configure mental health services which support people during a crisis.
- We will continue to work together with housing teams to help build stronger, mentally healthier communities
- We will continue to work on a Hampshire and Isle of Wight wide programme to double access to Individual Placement and Support. This scheme enables people with severe mental illness to find and retain employment.

MOVING FORWARD TOGETHER

Children and maternity

Expected impacts and benefits for patients, communities and services

- ✓ The children and young people of Hampshire and the Isle of Wight will be supported to have the best start in life, having the access they need to high quality physical and mental health care.
- ✓ Children and young people with severe mental illness will be cared for closer to their home receiving a diagnosis quicker and receive the care they need.
- ✓ Parents and carers will be supported to manage the mental and physical health of their child.

Achievements to date

- £500,000 in additional funding was received to support improvements in the services to support children and adolescents with severe mental illness.
- £190,000 additional funding received to establish children's connecting care urgent hubs throughout the area. These hubs are operational in Chandler's Ford, Eastleigh and Southampton with further hubs opening in Basingstoke, New Milton, Portsmouth and South East Hampshire . The hubs will support families by improving access to advice and support to manage childhood illness.
- We have undertaken substantial engagement with parents and schools to understand how we best support children who have either autism or attention deficit hyperactivity disorder (ADHD). Their feedback will help us to design services which are responsive to the needs of local children ensuring they are supported both at home and school.
- The Hampshire Parent and Carer Network is now supporting people during the interim period whilst they await a diagnosis for their child.

Plans for 2018/19

- To employ staff at the NHS111 call handling centre who have expertise in children's health.
- To reduce the amount of time children wait for an autism or ADHD diagnosis.
- To use the children's connecting care hubs to support families and to reduce the need for children to be admitted to hospital by 10%.
- To reduce the number of Hampshire and Isle of Wight children and young people with severe mental illness who are being cared for outside the county.
- Caring for children with severe mental health illness closer to their homes will also free up additional resources which can be used to support a wider group of children and young people with mental illness at home, and avoid the need for admissions to hospital.

Enabling Plans: Digital

Expected impacts and benefits for patients, communities and services

- ✓ An integrated care record for all GP registered citizens in Hampshire and Isle of Wight
- ✓ Flexible IT systems enabling care professionals to work from any location, with access to citizens health and care records
- ✓ Citizens able to manage their health and care plans – for example managing appointments, updating details, logging symptoms
- ✓ Real time information to support clinical decision making

Achievements to date

- We are in the process of installing Wi-Fi and flexible IT systems throughout GP practices, enabling care professionals to work from any location, with access to people's health and care records.
- 80% of practices in Hampshire and the Isle of Wight are now using electronic prescribing. This system makes it possible for prescriptions to be sent electronically to the pharmacy or dispenser of your choice, saving local people time by avoiding unnecessary trips to their GP.
- Two of our main hospitals have attracted additional funding totalling £15 million, having been identified as delivering exceptional care, efficiently, through the use of world-class digital technology and information.
- The Care and Health Information Exchange (CHIE, formally the Hampshire Health Record) will provide information to support clinical decision making. It ensures that staff throughout the health and care system can instantly access a patient's medical record during an appointment. This system will cover the whole of Hampshire and the Isle of Wight by Spring 2018.

Plans for 2018/19

- To develop and implement personal health records, which will allow local people to manage all their health appointments, update their personal details and log symptoms. This will provide people with greater control over their health.
- To implement IT systems which allow urgent and emergency service staff across the area to book appointments directly with other services. For example, enabling an NHS 111 call handler to directly book an appointment with an emergency dentist.

Enabling Plans: Estates

Expected impacts and benefits for patients, communities and services

- ✓ Improved collaboration and co-ordination of Hampshire and Isle of Wight estates expertise and information will mean that we can improve our planning capability at partnership and local level
- ✓ Providing estate that can be used flexibly and enable new ways of working
- ✓ Reducing demand for estate will generate efficiencies and savings through reduced running costs and release of land for other purposes
- ✓ Improving the condition and maintenance of our estate will mean that citizens can access services in fit for purpose facilities across Hampshire and Isle of Wight
- ✓ Release surplus land for housing and reducing operating costs in our buildings across Hampshire and Isle of Wight

Achievements to date

- We have created a single estates information system across Hampshire and Isle of Wight which enables joint planning across organisations for the benefit of staff and patients.
- We have agreed a consistent classification of the estate to assist health and care teams in sourcing high quality sites in the right location thereby improving access to services for local people.
- In each local area action plans and forums have been developed to better understand the condition of our buildings including GP practices, to increase the utilisation of the best estate and to produce development plans for sub-standard estate. This will increase both efficiency and quality, while releasing redundant estate for other purposes.
- A Hampshire and Isle of Wight Capital Panel has been established to review and prioritise bids for additional funding into the area. This increases openness and transparency, makes best use of a limited funding pot and puts us in a strong position to gain national support and funding to deliver improved facilities and services.

Plans for 2018/19

- We intend to work with the national lead for Strategic Health Asset Planning and Evaluation to improve both the accuracy of our estates database as well as the systems which evaluate the best use of a building or space. This work will support the local care system to develop new ways of working and identify opportunities to offer health and care appointments at a variety of locations closer to people’s homes.
- Continuing to increase utilisation of our best buildings, improve the overall quality of our buildings, whilst reducing the cost of running them including reducing charges for empty unused space.
- We are one of six national Strategic Estate Planning pilots to develop a case for additional estates expertise. This will put us in a strong position to deliver plans quickly and on a wide scale, so that patients will start to see positive benefits sooner.

MOVING FORWARD TOGETHER

Enabling Plans: Workforce

Expected impacts and benefits for patients, communities and services

- ✓ A flexible workforce shared across geographical and organisational boundaries, working in new ways with extended skills to deliver the workforce transformation that underpins the STP core programmes
- ✓ Health and care roles that attract local people, to strengthen community based workforce
- ✓ Significant reduction in the use of temporary and agency workers
- ✓ Increasing the time our staff spend making the best use of their skills/experience
- ✓ No overall growth in the workforce over the next five years

Achievements to date

- Working in partnership with Health Education England we have established a team who will lead a system-wide workforce plan ensuring we consider every aspect of the care needed by individuals, rather than planning purely from an organisational perspective.
- Across Hampshire and the Isle of Wight we have established key strategic groups focusing on collaborative working across three specific areas :-
  - Temporary staffing – with the aim of working together to explore the best and most cost effective options for the use of temporary staff, reducing competitiveness within the system and ensuring we do not increase costs;
  - Recruitment and retention – developing an area-wide strategy for attracting and retaining staff; working together to develop new opportunities and creative solutions to retain and attract high quality employees into the area;
  - Statutory and mandatory training/pre-employment checks – developing ways by which staff can change jobs within the local system without the need to recomplete their mandatory training (for example, information governance and equality training). This will remove the need for staff to be rechecked and retrained which causes additional cost, supports quicker start-dates, reduces the need to use temporary/agency staff, leaving staff with more time to spend with patients.

Plans for 2018/19

- We will have one workforce plan for the Hampshire and Isle of Wight health and social care system for the next three years showing where we need new roles, people to work differently as well as finding solutions to where we don't have enough capacity for core roles.
- We plan to go live with portable statutory and mandatory training and pre-employment checks across all NHS organisations in the area, with the aspiration to include social care employers, where feasible.
- We will implement our plans to retain as many staff within the area as possible and make Hampshire and the Isle of Wight a great place to work. Plans include schemes such as creative rotational nursing roles. This will attract new staff and different talents into the area and offer staff a wider set of career opportunities.
- We will develop shared recruitment campaigns so that we look at the staffing needs of the whole system and also make best use of our recruitment teams.

Contact us

The following organisations are supporting the delivery of sustainability and transformation programmes of work in Hampshire and the Isle of Wight:

NHS Fareham and Gosport Clinical Commissioning Group
NHS Isle of Wight Clinical Commissioning Group
NHS North Hampshire Clinical Commissioning Group
NHS North East Hampshire and Farnham Clinical Commissioning Group
NHS Portsmouth Clinical Commissioning Group
NHS South Eastern Hampshire Clinical Commissioning Group
NHS Southampton City Clinical Commissioning Group
NHS West Hampshire Clinical Commissioning Group
Hampshire County Council
Isle of Wight Council
Portsmouth City Council
Southampton City Council
NHS England
NHS Improvement
NHS South Central and West Commissioning Support Unit

Hampshire and Isle of Wight GP surgeries
Hampshire Hospitals NHS Foundation Trust
Isle of Wight NHS Trust
Portsmouth Hospitals NHS Trust
Solent NHS Trust
South Central Ambulance Service NHS Foundation Trust
Southern Health NHS Foundation Trust
University Hospital Southampton NHS Foundation Trust
Wessex Academic Health Science Network
Wessex Clinical Networks
Wessex Clinical Senate
Wessex Local Medical Committees
Health Education Wessex
Local voluntary and community organisations
Hospital and community trusts in neighbouring areas

For more information on any of the details within this document or to get involved in our work please email **SEHCCG.HIOW-STP@nhs.net**

High-Level Summary

Key activities completed this reporting period

All acute trusts have agreed to setting CQUIN targets and are committed to implementation of CQUIN for 2018/19.

MECC strategic plan for NHS. Driving forward with Comms strategy to increase and improve engagement with system partners in order to implement projects.

Key Indicator dashboard across all projects has been developed for internal monitoring and for engagement with LDSs. Data is benchmarked against targets and national performance to show areas of improvement required and show where positive outcomes have been achieved. Dashboard is being presented at LDS boards, prevention boards and being used to assess delivery against targets to drive improvements in performance.

Key activities for next reporting period

Support acute trusts to implement risky behaviours CQUIN and provide baseline data, gain commitment to place smoking advisors within each acute trust to support referrals to stop smoking services.

Pursue opportunity to present new projects requiring funding (LARC and Alcohol) with HIOW Commisioning Board and Partnership Boards. This will ensure the required funding and commitment is obtained to enable these project to embed within the NHS and delivery NHS savings.

Agree year 2 DPP delivery plan to address current provider issues. Resolve issues with current provider in collaboration with national NDPP contract managers.

Decisions, support or discussions required by ODG, if appropriate

Availabiliy of funding to support equitable delivery across HIOW - Smoking, Alcohol, LARC. Please see 2018/19 planning document for details. Guidance required on how to secure potential funds.

MECC Steering Group is being establish, representation is required from NHS system leaders and NHS Workforce leads. Input also needed from MECC strategy lead from within HHFT to develop trust-specifc plans and representation on MECC steering group.

Decisions, support or discussions required by EDG, if appropriate

Top Programme Risks for EDG attention - all other risks should be outlined in the 'Risk Register' sheet

High-Level Description & Summary	Gaps in controls	Actions	Liklihood (1-5)	Severity / Impact (1-5)	Risk Score DO NOT TOUCH (auto-calculated)	Project related? If so, which?
There is a potential risk to the delivery of programmes across the area due to capacity of frontline services.	Funding for prevention services	Escalation to ODG.	2	4	A	
There is risk that Alcohol CQUINs will not be fully implemented within each acute Trust due to limited resources.	NHS staff capacity	Escalation to ODG. Work with Workforce programme to identify opportunities, engagement with Acute trusts.	1	4	A	Smokefree for Surgery
There is risk that Smoking CQUINs will not be fully implemented within each acute Trust due to limited resources.	NHS staff capacity	Escalation to ODG. Work with Workforce programme to identify opportunities, engagement with Acute trusts.	1	4	A	Alcohol
There is risk that stop smoking and alcohol services on the IOW will not be able to respond to increases in referrals expected following implementation of the CQUIN due to financial restrictions for commissioned services.	IOW financial issues.	Escalation to ODG. Explore potential additional STP funding to support footprint-wide STP delivery. Identification of alternative implementation plan for at-risk areas and level of investment resources required.	5	4	R	Smokefree for Surgery and Alcohol
Limited capacity of STP board members to undertake the level of engagement needed to fully embed all prevention areas into LDS plans and other STP Work streams.	Staff capacity.	Working to review programme priorities, need to further engage NHS organsations to support delivery of prevention programme through coordinated communications. STP Prevention Programme refined to concentrate on projects that will deliver savings within the life of the STP.	2	4	A	
Repuational risk for local system due to insufficient capacity of NDPP provider to meet demand of referrals from primary care meaning that patients are waiting to be contacted/access courses. Raised as ugent issue to national NDPP coordination team.	Contract management done nationally by NHSE, rather than locally	Requested urgent recovery plan from provider, flagged as red risk in monthly NDPP report to NHSE	5	3	AR	NDPP

Risk Score

RISK SCORING MATRIX

	LIKELIHOOD				
	1	2	3	4	5
SEVERITY	Rare	Unlikely	Possible	Likely	Almost Certain
5 = Catastrophic	5	10	15	20	25
4 = Major	4	8	12	16	20
3 = Moderate	3	6	9	12	15
2 = Minor	2	4	6	8	10
1 = Negligible	1	2	3	4	5

Process:

- Risk Severity Number = ... (Part 1)
- Likelihood Number = ... (Part 2)
- **Part1 x Part 2 = RRN = ...(Part 3)**

(This is your Risk Rating number)

Compare Risk Rating Number with table:

1-3 Low Risk

4-6 Moderate Risk

8-12 Significant Risk

15-25 High (extreme) Risk

Programme Report

By Project

Project	Current Project Stage	Status	Comments
Smokefree for Surgery and Focussed stop smoking services	Delivering	Green =	Y2 delivery plan on track, with some concerns over capacity in IOW to respond to increased referrals to smoking services. All acute trusts have agreed to impmentation of CQUIN and will set targets following baseline data collected in Q1. **Next steps**: Support hospitals to have referral pathways in place so that people who need support to quit smoking have access to services, including provision of Stop Smoking advisors on-site. Ongoing support for CQUIN and monitoring and encouraging referrals to specialst services and resulting successfull quits.
Cancer - Screening	Delivering	Green =	Cervical Screening Coverage improvement plan in implementation which has sustained uptake rates amongst national downturn. However project is reaching it's limit for potential increases and narrowing the gap between best and worst performing CCGs. Systematic barriers to access still exist which is beyond control of this project. **Next steps:** Develop and implement improvement and communications plans for breast screening ready for implementation from April 2018 onwards. Revise plans for promotion of FIT bowel screening, an improved bowel screening method that will increase uptake, in line with national implementation schedule.
Sexual Health	Delivering	Blue =	Savings delivered through reduction in spend on LA budgets. Phase 2 - new project see below.
Healthy Conversations Training (including Making Every Contact Count)	Delivering	Green =	Terms of Reference for MECC steering group drafted with memebership of steering group being confirmed. Training package for "MECC Lite", a 2 hour version of MECC for Healthcare workers has been finalised, ready for rollout. **Next steps**: Establish steering group members, including MECC leads for each NHS trust. Support MECC leads to develop and implement Trust strategies. Offer first cohort of MECC Trainers training in MECC Lite to increase uptake within NHS Trusts, starting with IOW. Training in MECC for frontline staff will enable each contact to increase motivation for behaviour change and signpost to specialist services if required.
Diabetes - NDPP	Delivering	Red =	Referrals continue to increase although remain below target. Provider unable to meet demand due to lack of capacity of health educators. Urgent issues arising from lack of data following provider IT system migration problems. This has been raised with the national NDPP team, who contract manage our local provider. **Next steps:** Work with provider as they implement recovery plan. Liaise with NHSE on local action. Resolve urgent issues on performance and data currently effecting delivery of project.
Alcohol interventions	Planning	Green =	Project proposal discussed at Prevention Board **Next steps:** Proposals for service to be commissed by NHS to be taken to HIOW Commissioning Board and Partnership Boards, enabling service to be embedded, owned and supported by NHS.
LARC	Planning	Amber =	Project presented at Prevention Board. **Next steps:** Review financial benefit calculations with CCGs and present proposals for investment to NHS. Investment is required from CCGs to enable more GPs to offer LARC within primary care with the aim of preventing unwanted pregnancies and reducing associated maternity and termination of pregnancy costs.

By LDS - Confidence in alignment of LDS & Programme in delivering programme activity and achieving objectives

LDS	Status	Comments (if required)

By Principle - see 'Principles Guidance' sheet

Principle	Status

South West Hants	Amber	NDPP currently below referral projections. LDS leads working with LDSs to develop prevention plans.
North & Mid Hants	Amber	NDPP currently below projections. LDS leads working with LDSs to develop prevention plans. First lock-in session with LDS attended and feedback to be integrated in Comms and engagement plan.
Southampton	Green	Clear actions for LDSs identified through stocktake for priority projects. Regular updates with been provided through LDS lead with further 'Lock-in' session requested for Prevention Workstream.
Portsmouth & South East Hants	Green	Clear actions for LDSs identified through stocktake for priority projects.
Isle of Wight	Amber	NDPP, MECC and Cancer Screening on track. There are current capacity issues affecting the implementation of Smoking projects within acute trust and commissioned lifestyle services, highlighted as risks. Procurement and digital options in development..
Frimley (if relevant)	Green	Clear actions for LDSs identified through stocktake for priority projects.

Programme management	Green
Benefits management	Amber
Financial management	Amber
Programme delivery (Milestones)	Amber
Stakeholder engagement	Green
Risk & issue management	Green
Quality (including QIA's, if required)	Amber

Programme Benefits & Performance Management

Programme Performance & Benefit KPIs

KPI Name	KPI Description	Baseline	Target	Current	Status this Period	Comments
Under development will complete once plan completed						

HAMPSHIRE & IOW STP PROGRAMME HIGHLIGHT REPORT

*Please consult Programme SRO before submitting to PMO

Programme:	Solent Acute Alliance	**Programme SRO:**	David French	**Programe Director:**	Tristan Chapman
Programme Stage:	Delivering	**Report Date:**	23.04.18		

Programme Rating

Current Programme Rating:	Amber	**Previous Programme Rating:**	N/A	**Change:**	N/A

High-Level Summary

Key activities completed this reporting period

MSK
In October 2017, the SAA was asked to support GE Finnamore undertake a review of MSK services in Hampshire and the Isle of Wight. The review was completed in March 2018, with a recommended focus on hips and knees, joint injections, and outsourcing to the private sector recognised as key areas of further work. The SRO of the SAA Steering Group has written to the SRO of the STP recommending a system approach to undertake the next phase of work, which should focus on the areas recommended in the GE Finnamore report. It is now the responsibility of the STP EDG and Clinical Reference Group to look at this report and recommend next steps.

S6 Pathology Network
One Dorset progressing with LIMS procurement. Network supporting process.
MSC agreeing consortiums. Process in progress.
Reconfiguration group agreeing high level architecture for review. Development of enabling working groups set up to support the reconfiguration work.

Pharmacy
Procurement and Distribution: Financial and outline case developed with PHT and Akeso. Reviewed by PHT senior management mid April.
Aspectics: Product standardisation exercise complete. Reporting back to Pharmacy Board 24th April with findings and recommendations.

Solent Acute Alliance PMO
Adverts are out for SAA Programme Director, Programme Manager and Project Manager role, closing on Thursday 19th April. There will therefore be significant capacity shortfalls in the short to medium term to recruit posts.

Isle of Wight ASR
The Isle of Wight ASR is looking at all acute services on the island with a view to focusing on sustainability of island services. In February, an Options Appraisal paper with recommendations was endorsed by the IOW Local Care Board. The IOW ASR PMO are now working with the SAA on three priority project areas - Workforce and Pathway Resilience, Urgent Care Transfers and Stabilisation, and Digital Maturity. Medical Directors have met in the last period around the Workforce and Pathway Resilience work.

Decisions, support or discussions required by ODG, if appropriate

Key activities for next reporting period

MSK
STP EDG and Clinical Reference Group to consider GE report, and recommend next steps.

S6 Pathology Network
Strategic outline case required by NHSI by 31st July.
Expert project management being sourced to support the Reconfiguration work.

Pharmacy
Procurement and Distribution: Financial and outline case to be distributed to other trusts for check and challenge.
Aspectics: Closure docuementation.

Solent Acute Alliance PMO
Update on PMO staffing and governance.

Isle of Wight ASR
Approval of PIDs for three identified work programmes.

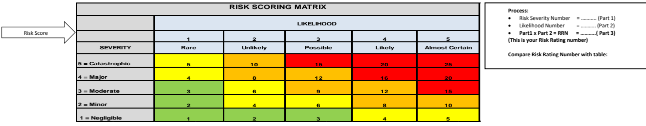
Decisions, support or discussions required by EDG, if appropriate

MSK Project needs review by EDG and Clinical Reference Group

Top Programme Risks for EDG attention - all other risks should be outlined in the 'Risk Register' sheet

High-Level Description & Summary	Gaps in controls	Actions	Liklihood (1-5)	Severity / Impact (1-5)	Risk Score DO NOT TOUCH (auto-calculated)	Project related? If so, which?
SAA Programme Director, Programme Lead and Project Manager leaving. This will create a high degree of uncertainty for existing projects, and the onward working of the SAA PMO.		Preparation in place for recruitment of new Programme Director. Programme Director working with Directors of Strategy to develop PMO structure.	5	4	R	

Risk Score



RISK SCORING MATRIX					
	LIKELIHOOD				
	1	2	3	4	5
SEVERITY	Rare	Unlikely	Possible	Likely	Almost Certain
5 = Catastrophic	5	10	15	20	25
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1 = Negligible	1	2	3	4	5

Process:
- Risk Severity Number = ... (Part 1)
- Likelihood Number = ... (Part 2)
- **Part1 x Part 2 = RRN = ...(Part 3)**

(This is your Risk Rating number)

Compare Risk Rating Number with table:

Programme Report

By Project

Project	Current Project Stage	Status	Comments
Clinical service review	Planning	Amber	
Pharmacy collaboration	Planning	Green	
Pathology	Planning	Green	Three programme workstreams agreed.
Theatre capacity	Monitoring	Green	
Spinal/Orthopaedics Transfer	Planning	Amber	Spinal and Orthopaedics transfer uncoupled. Still awaiting financial agreement between UHS and commissioners for cost of spinal transfer.
Isle of Wight ASR	Planning	Amber	
Radiology	Starting up	Red	SAA Working Group convened, but meeting constantly being rearranged due to attendees having other commitments.
MSK	Delivering	Green	Phase 1 complete.

There are more rows available if you require more. Find these by unhiding rows.

By LDS - Confidence in alignment of LDS & Programme in delivering programme activity and achieving objectives

LDS	Status	Comments (if required)
South West Hants		
North & Mid Hants		
Southampton		
Portsmouth & South East Hants		
Isle of Wight		
Frimley (if relevant)		

By Principle - see 'Principles Guidance' sheet

Principle	Status
Programme management	Red
Benefits management	Amber
Financial management	Amber
Programme delivery (Milestones)	Amber
Stakeholder engagement	Amber
Risk & issue management	Amber
Quality (including QIA's, if required)	Amber

Programme Benefits & Performance Management

Programme Performance & Benefit KPIs

KPI Name	KPI Description	Baseline	Target	Current	Status this Period	Comments

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Hampshire and Isle of Wight
Sustainability and Transformation Partnership

HIOW STP Digital Programme

Exec Update – April 2018 (Following HIOW Digital Transformation Board 23/4/18)

1. Investment

2.1 Our joint Expression of Interest bid to become a **Local Health and Care Record exemplar (LHCRE) was submitted on 25th April**. We are expecting to hear the results in mid-May. The bid team wish to express their thanks to everyone who has contributed.

2.2 An end of year 17/18 ETTF report was presented to the board and is available here: https://future.nhs.uk/connect.ti/Hiow/viewdocument?DOCID=36419333&done=DOCCreated1&FID=11344688

2.4 Representatives from the Solent Acute Alliance briefed the board on the two capital digital bids (Maternity PHR and Digital Outpatients) that had passed the next stage of approvals and they were now developing business cases. The board agreed there needed to be a close alignment between these projects and the STPs PHR strategy.

2. Projects Updates (Monthly Highlight Reports available on Kahootz)

Project	Update	Status
Care and Health Information Exchange (CHIE)	• CHIE V3 Upgrade –Amber Status. Go-live now planned for mid-June. Testing going well. Comms to stakeholders and users has started. Dress rehearsal for V3 upgrade in planning. • Extending CHIE to IOW – All 16 practices are now feeding data into CHIE. SSO integration between eCareLogic (IOW Acute Trust EPR) and CHIE tested successfully but wont go-live until V3 deployed. Agreed plan to incorporate Acute data into CHIE. • Dynamic Care Plans – Amber status. Dependent on V3 upgrade. Specification has been agreed. Work on primary care element started. Remaining procurement process started. • A CCN to extend the Graphnet contract for 1 year until Mar 19 has been signed off. • Plans are starting to be developed for a procurement following the extension i.e. for post April 19. A procurement strategy is being developed and will be presented at the May Digital Board before seeking approval to proceed at the Commissioning Board in June. • To accompany these plans a paper describing a set of options to manage the potential Conflict of Interest with members of the CSU, who currently support the management of CHIE, will also be presented to the Commissioning Board.	Amber
Wi-Fi	• 150/258 sites completed successfully • Pan organisational authentication solution (Govroam) has been procured • Patient Portal (landing page) IG assurance still being processed. • Technical group to be establish to agree to Govroam implementation.	Green
E-Consult (Online Triage And Consultation Tool)	• Currently 109 practices across HIOW live. • Further Go-Live completed 4 or 5 practices in the last month. • Workshops for each CCG being arranged to share best practice supporting practices embedding processes etc. • Ahmad Chughtai (NEH&F CCG) presented a benefits evaluation which is available in Kahootz.	Green
Personal Health Record (PHR)	• A small working-group has been to review detail of PA report and agree how to proceed. This has been delayed due to the LHCRE submission. The group will meet again in May and a paper will be developed for the May Digital Board.	Amber
E-Prescribing and Medicines Reconciliation	• No further progress will be made until funding identified and resources allocated	NA
Digital Communication	• Small pilot project is being setup to test Medxnote to support communication	Amber

	within a MDT in Southampton.	
Urgent & Emergency Care	• System decision confirmed for UTC's at GWMH and St Mary's (Ports) to utilise Adastra for 111 booking into UTC. • ePS Adastra module ordered for GWMH. Pending for St Mary's (Ports) • Risk escalated to NHSE for LNFH delivery due to issues confirming compatible UTC booking system in delivery timeframe. • Configuration quotes requested from Advanced for SCAS and UTC integration.	Amber
Optimising Intelligence Capability	• 3 workshops have been run to discuss and agree the information governance arrangements required to enable data flows to support a variety of 'secondary' uses of patient data. A report with a set of recommendations is being written up and will be presented to the Digital Board. • McKinsey have been appointed to help us develop an Intelligence and Analytics Strategy [I&AS] for HIOW. A series of interviews and workshops will be held over the coming months. A task and finish project group will be established to oversee the work and LDS representatives will be invited to join this.	Amber

Additional Priority Projects and Initiatives

Project	Update and Status
E-Referrals	• Acute providers have now enabled all their first outpatient consultant services onto ERS (with exception of Ophthalmology and Paediatrics at IOWT) • Paper Switch Off planning is underway with providers, CCGs and the Wessex LMC to agree dates from which paper referrals will be returned. • Acute providers had a CQUIN target to achieve Appointment Slot Issues (ASIs) to under 4% by March. HIOW providers ASI's currently range from 10-50%. • CCG ERS utilisation ranges from 37% to 89%.
Child Health Information Services	• A solution has been developed to automatically transfer child immunisations from GP Systems via CHIE into Southern Health's RiO application, which is used by the Child Health Information Service. The solution not only improves accuracy but also completeness of records by highlighting children that are not known to RiO and therefore not known to a health visitor or school nurse. • All 102 EMIS practices data feeds have been live since September 2017. Feeds from TPP SystmOne practices are ready to be implemented pending testing; but there is an issue with mapping of SystmOne immunisation codes which is being investigated. • The final stage of the project will be to backload immunisations to ensure that the records are as accurate and complete as possible. • The extract process from CHIE which has been established to support this initiative could also be used in future where there is a requirement to utilise the data in CHIE.
HSCN	• Procurement underway via mini competition from the CCS National Framework for HSCN) • Risk – Awaiting confirmation of national funding for HSCN connections to understand if any local investment will be required.
111 Online	• NHS England is pushing localities to adopt NHS Pathways solution for 111 Online. • Ahmad Chughtai is establishing a project group to take this forward. A recommendation for how HIOW should approach is being developed and will be presented to the Digital Board and then the Commissioning Board.

Questions and queries please contact andy.eyles@nhs.net (HIOW STP Digital Programme Director)

Project	Description
Care and Health Information Exchange (CHIE) (Project formally - Patient Data Sharing Initiative)	This project will deliver major enhancement to HIOW's interoperability capabilities. The evolution of the HHR into CHIE will enable support for mobile working and real-time information sharing. An integration engine and master patient index will provide the backbone of integration across care settings and integrated care plans functionality.
Wi-Fi	This project will ensure there is Wi-Fi coverage across all primary, secondary and social care sites in HIOW. The solution would enable any user to connect securely to their own network and systems from any site. The solution would also ensure Wi-Fi is available to patients across the footprint.
E-Consult (Online Triage And Consultation Tool)	This project will see the full roll-out of e-consultation solutions to all GP Practices in the HIOW footprint. This will build on the success of the roll-out in south Hampshire which is helping to reduce the need for face-to-face consultations.
PHR (Personal Health Record)	This project will deliver a single platform that provides patient facing portals and apps with a main route in to the HIOW health and care system. The platform will enable patients to view their records and pathways in the shared record, access self-help information, manage their appointments, provide pre-assessment data, order repeat prescriptions and ultimately contribute to their care management alongside health and care professionals.
E-Prescribing and Medicines Reconciliation	There is a requirement for a fully integrated end to end Medicine Management system reaching across different care settings. This comprises EPMA in hospitals including closed loop prescribing for safety, transfer of known meds (meds reconciliation), standards for coding (DM+D). This information will be available in all settings at any time combined with any hospital admission information.
Digital Communication	This project will deliver technology that makes use of new and current technologies to enable professionals to communicate securely across care setting. The project will provide a platform for video chat, telepresence and instant messaging capabilities.
Urgent & Emergency Care (Project formally Co-ordination Centre Infrastructure)	This project will design and coordinate the delivery of the technical infrastructure and capabilities to support the Urgent and Emergency Care (UEC) programme.
Optimising Intelligence Capability	This H&IOW wide user-led initiative aims to enhance insights and enable behavioural change by tackling real challenges across the system. Adopting population health management models and moving upstream to a stronger role in prevention will enable us to predict health risks for particular populations.

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HAMPSHIRE AND ISLE OF WIGHT HEALTH AND CARE SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP

PROPOSAL TO ESTABLISH A HAMPSHIRE AND THE ISLE OF WIGHT HEALTH AND WELLBEING ALLIANCE

1. PURPOSE OF PAPER

This paper and associated annexes are intended to support the development of a shared local authority and NHS 'strategy and oversight' capability for the collective programme of sustaining and transforming health and care across Hampshire and the Isle of Wight. The proposed arrangements would have a clear remit and scope for shaping and overseeing the delivery of the Hampshire and Isle of Wight Sustainability and Transformation partnership [STP].

2. SHARED LOCAL AUTHORITY – NHS OVERSIGHT ARRANGEMENT

In 2015/16 local authority and health partners across Hampshire and the Isle of Wight jointly commissioned SCIE-PPL to explore how all parties could collaborate to tackle the common challenges faced by health and care at a scale of Hampshire and the Isle of Wight. Building on the recommendations of the SCIE-PPL 'HIOW Future Health and Care Economy' report, and version 6 of the discussion paper 'Developing governance arrangements for the STP', annex one sets out draft outline Terms of Reference for a collective meeting of the four statutory Health and Wellbeing Boards within the Hampshire and Isle of Wight area. For the purposes of this paper, the proposed group is referred to as 'the Alliance'.

Priority areas of focus

Whilst the focus and working arrangements of the Alliance will be determined at the inaugural meeting, the local authority / health executive have identified the following potential areas of focus for 2017/18:

- build a collective understanding and ownership of the strategic 'case for change' and review and approve the STP Annual Delivery Plan
- support the development of a Hampshire and Isle of Wight system capacity and demand model for health and care
- take an overview and shape the transformation programme for those clinical services deemed to be best planned and delivered at the scale of Hampshire and the Isle of Wight, notably the future of critical treatment services for people with physical and mental health care needs
- shape the health and care workforce education and training priorities for Hampshire and the Isle of Wight, ensuring action is taken to tackle the areas of greatest challenge

- have oversight and shape the strategic digital and customer insight transformation programme for health and care in Hampshire and the Isle of Wight

- shape the evolving commissioning and delivery arrangements across Hampshire and the Isle of Wight.

3. CONSTITUTIONAL STATUS

At this stage it is envisioned that the Alliance would be constituted as a meeting 'in common' between the four Health and Wellbeing Boards. The SCIE-PPL project identified the opportunity and the benefits of the Alliance to be established as a formal joint sub-committee under legislation governing Health and Wellbeing Boards. However, in discussion with the four local authorities this approach is considered, at this stage, to be premature.

Limitations on role and function

It is recognised by all parties that the existing formal and statutory arrangements for local authority and NHS governance of local services remain the primary source of decision making and budget allocation, in accordance with the STP framework. However, it is proposed that the Alliance would provide a forum for statutory local authority and NHS bodies to ensure coherence and capacity to deliver on issues and targets which apply to the wider Hampshire and Isle of Wight area.

The Alliance would not be able to take legally binding decisions on health matters, nor would the Alliance be able to act as an Accountable Body because it would not be a legal entity in its own right, nor would it have constituted powers to manage health budgets. The Alliance could not provide audit and assurance for financial and contractual decisions relating to the STP or any other form of pooled funding.

4. MEMBERSHIP

The STP governance discussion paper proposed eight board members. In the interest of efficient and effective working, and in light of existing, robust local arrangements, this paper further supports the view that membership of the Alliance should be kept tight and proposes that the membership should comprise of ten people:

- four upper tier local authorities Health and Wellbeing Chairs
- five representatives from CCGs (one representative from IOW CCG, Southampton City CCG, Portsmouth CCGs and two from Hampshire representing the South West and North and Mid Hampshire local system perspective). Whilst it is envisaged that CCG Chairs will be in attendance, it may be that a decision is taken to have a lay or non-executive member represent the NHS at the Alliance meeting.
- STP Independent chair attends the Alliance meeting.

In attendance would be the Hampshire and Isle of Wight STP Senior Responsible Officer and the Alliance Secretariat. These arrangements would ensure a balance of local authority and NHS support in the first instance, which is bound to evolve as the Alliance develops. It is envisaged that as health and care commissioning and delivery arrangements evolve then this membership may similarly evolve.

The rules pertaining to political proportionality would not apply to the Alliance, but the working group could consider applying a rule to determine that a certain percentage of members are elected representatives.

Chairing arrangements should follow decisions about membership. Initially it is proposed that one of the Health and Wellbeing Board Chairs chair the inaugural meeting where the ongoing chairing arrangements will be agreed. The SCIE-PPL paper suggested that the Alliance may wish to consider the value of having an independent chair potentially for an initial period. This will be a decision, along with final agreement of the membership, will be made during the first meeting of the Alliance.

5. SUPPORT ARRANGEMENTS

It is proposed that the STP Programme Management Office provides support in the form of a secretariat, agenda management and venue support for the Alliance in its first 12 months of operation.

6. RELATIONSHIP WITH EXECUTIVE DELIVERY GROUP

Subject to a discussion and agreement at the first meeting of the Alliance, it is envisaged that the STP Executive Delivery Group [EDG] (which has responsibility for the planning and delivery of the sustainability and transformation programme) has a reporting / accounting line through to the Alliance with regards to the annual Delivery Plan, and on programmes of work agreed by the Alliance as being ‘in scope’.

7. NEXT STEPS

Following agreement by the Hampshire and Isle of Wight Shadow Executive Delivery Board on Friday 23 June 2017, it is proposed that an inaugural meeting of the Alliance is held on 14th September 2017 under the initial Chairmanship of Cllr Dave Shields of Southampton Health and Wellbeing Board.

ANNEX ONE: DRAFT HAMPSHIRE AND ISLE OF WIGHT HEALTH AND CARE ALLIANCE TERMS OF REFERENCE

1. Status and name

1.1 The group is constituted as a meeting in common of the four Hampshire and Isle of Wight Health and Wellbeing Boards.

- Hampshire Health and Wellbeing Board
- Southampton Health and Wellbeing Board
- Portsmouth Health and Wellbeing Board
- Isle of Wight Health and Wellbeing Board

1.2 The working title of the group is the Hampshire and Isle of Wight Health and Care Alliance. This may be changed at any time. In these draft outline Terms of Reference, the group will be referenced as the Alliance.

2. The Hampshire and Isle of Wight Health and Care Alliance

2.1 Purpose

The Alliance is responsible for providing strategic oversight and shaping the collective programme of sustaining and transforming health and care across Hampshire and the Isle of Wight. In fulfilling this role, the Alliance will take on responsibility for aligning where, beneficial, health and wellbeing programmes where there is a mutual dependency across Hampshire, Southampton, Portsmouth and the Isle of Wight.

2.2 The Alliance's strategic operating principles

- Decisions will be made at the most appropriate level.
- CCGs and local authorities will retain their statutory functions and their existing accountabilities for current funding flows.
- Clear agreement will be in place between CCGs and local authorities to underpin governance arrangements.
- All partners to be enabled to shape the future of HIOW health and care together.
- Decisions on local health matters to be transparent and made with local democratic input.
- Decisions about health and care matters to be taken as soon as possible.

2.3 Geographic areas of operation

The Alliance covers the geographic areas covered by the administrative areas of:

- Hampshire County Council
- Southampton City Council
- Portsmouth City Council
- Isle of Wight Council

3. **Composition**

3.1 The Alliance includes within its membership ordinary membership with full voting rights:

- One elected Member who has been appointed Chair, and one representative of a Clinical Commissioning Group who has been appointed Vice Chair, for each of:
  - Southampton Health and Wellbeing Board
  - Portsmouth Health and Wellbeing Board
  - Isle of Wight Health and Wellbeing Board
- One elected Member who has been appointed Chair and two CCG representatives from the Hampshire Health and Wellbeing Board (one from SW Hampshire and one from North and Mid Hampshire delivery systems)
- STP Independent Chair

Total ordinary membership is ten.

3.2 The Alliance will endeavour to make decisions by unanimous consensus across partners.

3.3 As existing members of constituent Health and Wellbeing Boards, members of the Alliance already comply with respective authority codes of conduct which manage pecuniary and conflicts of interest. Some reports to respective authority Full Councils may need to grant dispensations to some members to enable the management of potential conflicts of interest.

4. **Term of office**

Each member of the Alliance shall continue to be a member for as long as they are a member of their respective Health and Wellbeing Board.

5. **Chairing arrangement and quorum**

5.1 The Alliance will appoint an elected Member to Chair the Alliance and a CCG representative as Vice Chair. The Chair and Vice Chair of the Alliance will be appointed by the Alliance for a term of one year each, to be renewed annually by constituent member organisations. It is suggested that the Chair and Vice Chair come from different organisations and are rotated on an annual basis.
OR
The Alliance will appoint an independent Chair. The Vice Chair shall be appointed from the Alliance.

5.2 In the event that neither Chair nor Vice-chair is present but the meeting is quorate, the voting members present at the meeting shall choose a chair from amongst their number for that meeting.

5.3 It is important that sufficient members are present at all meetings so that decisions can be made and business transacted. The quorum for the Alliance will comprise four ordinary voting members and must include at least one ordinary Health and Wellbeing Board Chair and one ordinary member representative of a CCG. If a meeting has fewer members than this figure it will be deemed inquorate –matters may be discussed but no decisions taken.

6. Appointment of substitute members

6.1 **Allocation**

As well as allocating seats on the Alliance, the Health and Wellbeing Boards will, at an appropriate meeting each year (according to each Council's procedures), appoint a designated Substitute Member for each member of the Alliance. CCG members will be ratified by constituent Councils as per existing statutory arrangements for Health and Wellbeing Board membership.

6.2 **Powers and duties**

Substitute Members will have all the powers and duties of any member of the Alliance but will not be able to exercise any special powers or duties exercisable by the person they are substituting.

6.3 **Substitution**

Substitute members may attend meetings in that capacity only:

- to take the place of the ordinary member for whom they are the designated substitute
- where the ordinary member will be absent for the whole of the meeting
- after notifying the Chair five working days before the meeting of the intended substitution.

7. Sub-Committees

The Alliance may appoint one or more sub-committees of the Alliance to advise the Alliance with respect to any matter relating to the discharge of its functions.

8. Role and function

The role of the Alliance will be:

- For the purpose of advancing the health and wellbeing of the people of Hampshire and the Isle of Wight.
- To ensure respective strategic plans are complementary and coherent
- To aid efficiency across the health and care system and create capacity
- Consider the impact on residents and communities of decisions being made.
- To encourage collaboration and integration with the four Health and Wellbeing Boards, patient advocacy groups and health and care providers.
- To enable a collective response, particularly to national or regional issues.
- Hold a strategic overview of the operation of, the challenges and opportunities within the health and care economy of Hampshire and the Isle of Wight, and across the four HIOW JSNAs and the four HIOW JHWSs.

9. Meetings

9.1 The Alliance shall meet quarterly.

9.2 Meetings shall be held in one place/rotation of location.

10. Status of Reports

Meetings of the Alliance shall be open to the press and public and the agenda, reports and minutes will be available for inspection at [whose?] offices and on the [whose?] website at least

five working days in advance of each meeting. This excludes items of business containing confidential information or information that is exempt from publication in accordance with Part 5A and Schedule 12A to the Local Government Act 1972 as amended.

11. Support to the Alliance

The Alliance may be allocated a level of support from one or more organisations sharing the following:

- Democratic or secretariat support, programme management, STP manager
- Legal advice
- Financial management advice

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NHS England

Richard Samuel
Senior Responsible Officer
Hampshire and Isle of Wight STP

NHS England South
4th Floor
South Plaza
Marlborough Street
Bristol
BS1 3NX

11th May 2018

Dear Richard,

Vascular Transfer from Portsmouth Hospitals to University Hospital Southampton

I am writing to express my gratitude for the support of Hampshire and Isle of Wight STP, and in particular Steve Bolam, for the help and support provided to achieving a successful transfer of the vascular service from Portsmouth Hospital to University Hospital Southampton. The STP support enabled all parties to align the contracts and financial flows to the new clinical model jointly agreed by all parties across the STP.

Yours sincerely

Geoff Shone

Head of Financial Management – Specialised Commissioning South

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NHS
Portsmouth
Clinical Commissioning Group

Report To: HOSP

Report By: Tina Scarborough, Deputy Director Quality and Safeguarding, NHS Portsmouth Clinical Commissioning Group

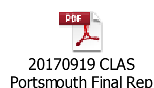
Report Date: 31 May 2018

Report Title: Progress Report following CQC's Children Looked After and Safeguarding (CLAS) Review in Portsmouth

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 final report was published on 19 September 2017



Response

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 (PSCB) at an extraordinary meeting on 03 October 2017. Comments from this were incorporated into the action plans prior to submission to the CQC.

In response to this report and CQC Portsmouth Hospitals NHS Trust Quality Report (publication date 24th August 2017) Portsmouth Safeguarding Adult Board (PSAB)and PSCB developed the joint Safeguarding Improvement Board which met for the first time in November 2017. The aim of the group is to ensure that the areas of concern relating to safeguarding identified in the reports have been addressed appropriately. The group will be a joint task and finish sub-group of the PSAB and PSCB working in partnership with the Hampshire Safeguarding Adults Board (HSAB) and the Hampshire Safeguarding Children Board (HSCB).

In addition, in response to the Wood Report and subsequent Children and Social Work Act 2017 PSCB developed a PSCB Health Sub-Group to enable health representatives, including,

Clinical Commissioning Groups (CCGs), Public Health and the NHS provider Trusts, Primary Care, Independent Hospitals and Agencies to meet together in order to fulfil their responsibilities to keep children safe across Portsmouth. One of the key functions of this group is to co-ordinate progress in Health on behalf of PSCB actions in relation to inspections, case reviews and audits.

The CQC CLAS Action Plan and Child related actions from the PHT CQC report are monitored and scrutinised by the PSCB Health Sub-Group. The chair of the Health Sub-Group then reports to the Improvement Board by exception progress and any action that are not progressing.

Action Plan Progress

There has been good progress made by all agencies involved with the action plan.

CQC Action Plan
010618.xlsx

Below is a progress report on those actions that are not yet complete.

Portsmouth CCG
Recommendation 2.1: Good progress has been made. Training has been delivered to GP practices. ICT solutions are being sought. Progress made with all GP practices now moving to the same electronic system (shared with Solent NHS Trust). To ensure that learning has been embedded a GP audit tool is currently being designed.

Recommendation 2.2
Good progress was made initially with updated Job descriptions however this has now stalled and is awaiting a response from Solent NHS Trust. Due to rapidly rising numbers of Looked After Children the CCG agreed a temporary cessation of the Designated Dr function to free up paediatrician time to deliver Initial Health Assessments to children. Solent NHS Trust agreed to review the service and provide a plan for how the service can be delivered going forward. The CCG are awaiting a response from Solent NHS Trust this has been escalated and is on the CCG risk register. To mitigate the risk the Designated Nurse has taken on some of the function and increased her LAC hours from 1 day per week to 1.5 days per week.

Portsmouth Hospitals Trust (PHT)
PHT had a significant number of actions for the CQC inspection and good progress has been made.

Recommendation 1.1
A new comprehensive risk assessment tool has been developed and is being piloted. Some minor changes will be made following the pilot and the tool has been shared for comment.

The revised tool will be launched in June 2018. The Improvement board have agreed a proposed new action to undertake an audit of the new tool in October 2018 to ensure that the tool is embedded into practice.

Recommendation 1.3
Work has progressed on changing the paediatric mandatory screening tool to rationalise/enhance the electronic risk assessment but this has stalled due to further IT upgrades or changes not planned until later in the year. There is a comprehensive risk assessment in place but staff find it difficult to use due to it's complexity and time restraints in an ED Department. The Improvement Board has recommended that PHT undertake a risk assessment in respect of the delay in completing this action which will be completed by the end of June 2018.

Recommendation 1.2, 1.4, 1.6, 1.9, 1.11, 3.1, 3.3
The actions to these recommendations have been completed but a new action has been added to ensure that the changes made have been embedded in to practice.

Recommendations 1.5
Good progress has been made and most of the action is complete. Work is underway to ensure that this has been embedded into practice. PHT are monitoring engagement with the Local Authority (LA) and will escalate findings to the relevant LA.

Recommendation 1.7
Most actions to this recommendation have been completed. The findings from Aug'17 CQC inspection report, Sept'17 CQC CLAS review report, Nov'17 External peer review report, Nov'17 Hampshire CCG's paediatric clinical visit report and the Jan'18 Hampshire CCG's maternity deep dive have all been amalgamated into an overarching action plan. A benchmarking report is in progress. A new action has been added to ensure that the changes made have been embedded in to practice.

Recommendation 1.8
The Maternity Service has secured funding approval from the Trust for a new IT system that will address this issue. In the short term the Maternity Service is looking at how record keeping arrangements can be improved to mitigate the risk until the new IT system is in place.

Recommendation 3.2
Paediatric risk assessment has been developed and is out to comment currently. This will then be trialled. PHT are adapting a National document regarding environmental risk assessment so that it will work locally. This will also be trialled and then embedded into practice by the end of July. CAMH Services have now agreed that their clinicians 'will write

the plan in the patients notes initially and a typed plan will follow. This is now being monitored by PHT to ensure compliance.

Recommendation 3.5
Business case submitted 02/03/18 to NHS England for a generic safeguarding role in ED. Partial funding was secured from NHS E. Further work is now required to progress a business case within PHT.

Solent NHS Trust
Recommendation 4.3
This action is complete apart from completion of an audit to ensure that practice is embedded. The audit report is expected in Quarter 2.

Recommendation 4.4
This action is complete apart from completion of an audit to ensure that practice is embedded. The audit report is expected in Quarter 2.

Recommendation 4.5
The BAAF form now includes consent and is now being used. The impact should be seen in Quarter 1 and 2.

Recommendation 4.6
The approval of the SOP was delayed but has now been progressed. The SOP is now being implemented and impact will be assessed during quarter 2.

Recommendation 4.7
Progress on this action has been made and once there is evidence of sustained improvement the action will be closed.

Society of St James
Recommendation 5.1
The action is complete but awaiting outcome of the latest audit

Recommendation 5.2
Good progress has been made but has been delayed due to availability of PSCB training due to capacity. The PSCB trainer post has been recruited to and the new trainer is now in post which will resolve this issue.

Public Health
All recommendations are complete.

Conclusion and recommendations for HOSP

It is clear that Health Services across Portsmouth are actively engaged in the safeguarding agenda. The Health and Care landscape is changing rapidly and there are increasingly limited

resources to deliver the service despite this all the agencies involved have made good progress on the CQC recommendations to improve services for the cities children.

There have been challenges especially due to the significant rise the city has seen in Unaccompanied Asylum Seeking Minors. This situation is not expected to change and is outside of the control and influence of the city's health services.

The Action plans are being scrutinised robustly by a number of bodies including the PSCB Health Sub-Group, the Joint PSCB and PSAB Safeguarding Improvement Board, Portsmouth CCG and CQC. As a result it is recommended that this no longer needs to be monitored by HOSP as well. If progress falters the PSCB/PSAB Improvement Board will refer back to HOSP.

Tina Scarborough, Deputy Director Quality and Safeguarding
NHS Portsmouth Clinical Commissioning Group
04 June 2018

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Care Quality Commission

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

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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.

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

Portsmouth Hospitals NHS Trust - Maternity Service Action Plan

***** WORKING DOCUMENT *****

Last updated: 01/06/18

Number	Recommendations	Actions	Assigned to	Completion Due	Progress	Comments / Evidence	RAG
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.	Named Midwife for Safeguarding Children (Sharon Ward)	~~Mar 31 2018~~ Jun 30 2018	05/01/18 First draft has been out for comments in safeguarding children team and returned to SMSC for extensive changes. 09/01/18 NMSC & SMSC met and produced second draft. Meeting scheduled for 30/01/18 to finalise second draft. 16/04/18 Tool finalised, 6 week pilot commenced whereby CORAL team will complete at booking, 31/40 and postnatal. Review meeting 29/05/18 with CORAL team for feedback. 17/05/18 Tool sent out to PSCB Health Sub Group members for comments / feedback. 17/05/18 Tool sent out to Named Midwives network for comments / feedback.		
		1.1.1a Snapshot audit to be undertaken three months after launch to gain assurance that the tool / process has been embedded into practice and that this has resulted in the anticipated improvements in practice.	Named Midwife for Safeguarding Children (Sharon Ward)	Oct 31 2018	17/05/18 New action added.		

		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.	Named Midwife for Safeguarding Children (Sharon Ward)	~~Mar 31 2018~~ Jun 30 2018	04/12/17 Meeting held with Hidden Violence Team Manager (PCC) and various PHT colleagues. Agreement reached that we will work together to develop a shortened DA risk assessment tool for use by midwives. EIP to support maternity (at no cost) with the delivery of DA training in 2018 - 2019 training year. 21/12/17 Hampshire's draft shortened DA questions & pathway emailed to meeting attendees for comments / feedback. 11/01/18 - 17/01/18 Various internal & external email correspondence re. review of Hampshire work and ratification for use in Portsmouth.31/01/18 Email from Designated Nurse Safeguarding Children advising that version 7 being taken to health sub group 05/02/18 and will then be taken to LSCB's for ratification. 07/03/18 Email sent requesting update on 4LSCB board date. 22/03/18 Hampshire DVA pathway discussed at PSCB Health Subgroup, feedback to be sent to 4LSCB re. Portsmouth referral route. Final pathway being presented to HSCB executive 16/05/18 for approval and Portsmouth DA Steering Group at the end of May.		
		1.1.2a Snapshot audit to be undertaken three months after launch to gain assurance that the tool / process has been embedded into practice and that this has resulted in the anticipated improvements in practice.	Named Midwife for Safeguarding Children	Sep 30 2018	17/05/18 New action added.		

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.	Named Midwife for Safeguarding Children (Sharon Ward)	Jun 30 2018	1.1.3 05/01/18 Decision made to include the 4 questions in the maternity booking notes rather than in the safeguarding risk assessment. CSE will be listed as a risk factor in the risk assessment. 05/01/18 Email sent to Sharon Hackett requesting questions be included in version 1 of the new notes. 26/02/18 Update from Director of Maternity that the request has been made to the Trust for payment of the new notes printing costs and she is involved in supporting this process. 16/04/18 funding issue has been resolved. Maternity service expects printing to commence in next two weeks. Due to delays a further batch of old notes had to be ordered, this stock will be used before new notes are launched to avoid wastage. 08/05/18 Update from PM - order has been placed, awaiting receipt of printed 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.	~~Senior Midwifery Manager Community & Public Health~~ Named Midwife for Safeguarding Children (Sharon Ward) & Specialist Midwife for Safeguarding Children (Vicky Brown)	COMPLETED	1.1.4 28/11/17 Clinical audit request form submitted to the clinical audit department. 21/12/17 Support secured from Mandi Warren with data collection needed which will be provided second week of January 2018. 21/12/17 Proof audit proforma / questionnaire tested and amendments requested. 10/01/18 NMSC & SMSC met, collated data and agreed plan regarding practicalities of undertaking actual audit. 18/01/18 Update from SMSC, audit of records progressing well, aiming to have completed this aspect in next two weeks. 28/02/18 Draft audit report emailed internally for comments by 09/03/18. 09/04/18 Audit report finalised and emailed to Designated Doctors and Named Nurses HCCG and PCCG. Senior Midwifery Manager for community services to work with CCG's and primary care to take forwards recommendations.	

		1.1.4a Audit action plan to be developed and progress/impact monitored via the Trust's Safeguarding Committee. Follow up audit to be included within the action plan.	Senior Midwifery Manager for Community & Public Health (Rebecca Church)	Jun 30 2018	17/05/18 New action added & email to RC requesting action plan.		
		1.1.5 Mechanism for monitoring this aspect of practice (see recommendation) to be built into the Safeguarding Service annual rolling audit programme / tool currently being developed.	Named Midwife for Safeguarding Children	Jun 30 2018	17/05/18 New action added.		
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.	Clinical Lead for Midwifery Practice Education	COMPLETED	11/10/17 Maternity mandatory training 2015/2016 included a 1 hour mental health training session. Maternity mandatory training 2017/2018 includes a mental health simulated training scenario. Vulnerable families team midwives received mental health training 17/07/17. 05/01/18 Evidence received from Angie West. 93.6% of all midwives attended MH training in 2015/2016. We are on track to achieve 40% this year 2017/2018.		
		1.4.2 Mental health training to be incorporated into maternity mandatory training plan for inclusion in training days at least every 3 years.	Clinical Lead for Midwifery Practice Education	COMPLETED	05/01/18 Email sent to Angie West requesting evidence of planning. MH training has been planned in for the coming years mandatory midwifery training and was delivered in two of the preceding three years.		

		1.4.3 Awareness of the Learning Disability passport to be raised within the maternity service.	Clinical Lead for Midwifery Practice Education	COMPLETED	Emails have been sent to staff and this has been discussed at the twice daily safety huddles. A LD resource folder has been produced on the maternity server and hard copies produced for the maternity wards. Maternity mandatory training 2018/2019 includes a one hour LD session.		
		1.4.4 Mechanism for monitoring this aspect of practice (see recommendation) to be built into the Safeguarding Service annual rolling audit programme / tool currently being developed.	Named Midwife for Safeguarding Children	Jun 30 2018	17/05/18 New action added.		
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.	Named Midwife for Safeguarding Children	COMPLETED	18/01/18 In light of agreements reached with the local authorities (see 1.5.2 below) the alerts system will no longer be needed. We are aiming to discontinue this from 01/04/18. New action (1.5.3 below) relating to the associated practicalities).		

	Safeguarding 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.	Named Midwife for Safeguarding Children	COMPLETED	13/12/17 Confirmation received from HSCB's strategic partnerships manager that the assistant director of CSC in Hampshire assured her that her social workers will comply with the 4LSCB guidance and lead on pre and post birth plans. 08/01/18 NMSC second meeting with PCC Head Assessment & Intervention who agreed in principle that their social workers will lead on pre and post birth plans. 17/01/18 nmsc met with Fareham & Gosport CSC managers. 24/01/18 Proposal discussed at Havant CSC managers meeting. 12/02/18 NMSC met with PCC Head Assessment & Intervention and agreement reached for PCC social workers to lead on and distribute pre and post birth plans for all unborn babies open to them with immediate effect. 21/02/18 NMSC discussion with HCC District Service Manager for Havant and agreement reached for HCC social workers in Havant / Fareham & Gosport to lead on and distribute pre and post birth plans for all unborn babies open to them with immediate effect.		

		1.5.3 New processes to be developed and implemented within maternity services to ensure pre and post birth plans are received, are accessible to all staff and staff know which tasks to perform as standard.	Named Midwife for Safeguarding Children	~~Mar 31 2018~~ Aug 31 2018	Agreement with PCC and HCC that if a pre and post birth plan has not been received by 34 weeks of pregnancy, PHT's safeguarding children team will phone social workers to remind them. Maternity alerts will continue to be produced until 01/04/18 as a safety net to allow time for the new process to embed with social workers. Meeting scheduled for 08/03/18 with maternity safeguarding email inbox administrators to talk through their role in new processes. 17/05/18 After allowing time for new process to embed in social work practice it is anecdotally reported that pre and post birth plans are not being received reliably and it is not safe to withdraw the maternity safeguarding alerts at this point in time. Data to be gathered at which point further discussions will need to take place with PCC and HCC.		
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.	1.7.5 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.	~~Named Midwife for Safeguarding Children (Sharon Ward)~~ Deputy Head of Midwifery (Pat Mooney) & Clinical Lead Midwife & Maternity DA Lead (Debbie L Hill)	~~Mar 31 2018~~ Jun 30 2018	14/12/17 Email to Abbie Aplin advising of my intention to delegate action to DLH as unable to progress it. Email from Abbie Aplin confirming Pat Mooney to ensure action moved forwards. 19/12/17 Email to DLH. 08/01/18 Confirmation from DLH that she is taking action forwards. 09/01/18 NMSC met with Director of Maternity and Deputy Head of Midwifery. DHoM confirmed planning to utilise scanning appointment underway. 07/03/18 Email sent requesting update. 17/05/18 Update from DHoM, discussions ongoing to identify a workable solution to practical challenges associated with undertaking this screening in the maternity outpatient department setting.		

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.	~~Named Midwife for Safeguarding Children (Sharon Ward)~~ Senior Midwifery Manager Clinical Effectiveness, Quality & Safety (Sharon Hackett)	COMPLETED	03/11/17 Action re-allocated to SMMCEQ&S. 10/01/18 Mapping exercise undertaken by NMSC, SMSC & DHoM.		
		1.8.2 Task and finish group to implement a maternity wide change of record keeping arrangements.	~~Named Midwife for Safeguarding Children (Sharon Ward)~~ Senior Midwifery Manager Clinical Effectiveness, Quality & Safety (Sharon Hackett)	~~Mar 31 2018~~ Aug 31 2018	03/11/17 Action needing re-allocation, email sent to Sharon Hackett advising that now tasked to her. 21/11/17 Conversation with SH ensuring she was aware of actions being allocated to her, original email forwarded. 05/01/18 Email sent to SH requesting update. 09/01/18 Discussed with Abbie Aplin & Pat Mooney. PM to support SH with progressing this action. 26/02/18 Informed by Director of Maternity that an extension has been agreed to August 31 2018 by the Improvement Board. 09/04/18 Email from SH to stakeholders setting out initial proposal and plan to arrange a meeting to move forwards.		

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.	1.9.1 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 (Sharon Ward) & Specialist Midwife for Safeguarding Children (Victoria Brown)	COMPLETED	04/12/2017 NMSC delivered training session to 16 maternity clinical leads on quality assurance of CP conference reports and referrals. 21/12/17 CP conference reports quality assurance checklist finalised. 02/01/18 New process launched, email sent to all staff, request made for inclusion in twice daily safety huddles. Checklist, guidance and exemplars uploaded onto the maternity K drive. 03/01/18 SMSC tasked with arranging and delivering second training session before clinical leads meeting in February or March 2018. 08/01/18 DoM attended the clinical leads away day and reiterated expectations in relation to quality assurance of referrals and reports.		
		1.9.2 Snapshot audit to be undertaken to gain assurance that the tool / process has been embedded into practice and that this has resulted in the anticipated improvements in practice.	Named Midwife for Safeguarding Children (Sharon Ward)	Aug 31 2018	17/05/18 New action added.		
		1.9.3 Mechanism for monitoring this aspect of practice (see recommendation) to be built into the Safeguarding Service annual rolling audit programme / tool currently being developed.	Named Midwife for Safeguarding Children (Sharon Ward)	Jun 30 2018	17/05/18 New action added.		
1.10	Ensure that newly qualified midwives demonstrate competency in child protection practice as part of their preceptorship.	1.10.1 Competency document to be produced	Clinical Lead for Midwifery Practice Education (Angie West)	COMPLETED	31/10/17 First draft received for comments. 20/11/17 Comments sent. 10/01/18 Document finalised.		

		1.10.2 Competency document to be ratified and included in the existing preceptorship programme for newly qualified midwives.	Clinical Lead for Midwifery Practice Education (Angie West)	Mar 31 2018	05/01/18 Email to Angie West requesting update on progress on submission of competency to learning & Development for ratification. 10/01/18 Final competency submitted to learning & development for ratification. 07/03/18 Email sent requesting update. 20/03/18 Email received confirming that the competency document has been ratified and are now included in preceptorship competency packs for all newly qualified midwives. 17/05/18 All NQM's are required to achieve all of the competencies within their preceptorship programme and must evidence this before they can progress from Band 5 to Band 6. A midwife cannot remain at Band 5 and any midwife who does not achieve all required competencies (after additional time and support is provided) would be performance managed.		
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.	3.1.1 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	10/01/18 Commissioning arrangements in relation to the support offered to maternity services from the the onsite mental health liaison team have been strengthened. Emails sent to consultant psychiatrist in onsite mental health liaison team 05/01/18 and 18/01/18 requesting a copy of the commissioning contract. 17/05/18 Extract of contract sourced by AF and shared with AA and AM for clarification.		

		3.1.2 Snapshot audit to be undertaken to gain assurance that the new arrangements have resulted in the anticipated improvements in practice and patient care.	Senior Midwifery Manager Community & Public Health (Rebecca Church) and Specialist Perinatal Mental Health Midwife (Anna May)	Aug 31 2018	17/05/2018 New action added & email sent to BC and AM requesting audit.		

Severely delayed, difficulty completing	(red)
Underway, due to be completed within timescales	(amber)
Completed	(green)

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CQC Action Plan - Review of Health Services for Children Looked After & Safeguarding in Portsmouth
Portsmouth Hospitals NHS Trust - Paediatric & ED Service Action Plan
*** WORKING DOCUMENT ***

Last Updated: 01/06/18

Number	Recommendations	Actions	Assigned to	Completion Due	Progress	Comments / Evidence	RAG
1.2	Improve the identification, assessment and recording of risk to children of adults who attend ED with concerning behaviours.	1.2.1 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 (Matt Chandy) & Named Doctor for Safeguarding Children (Simon Birch)	COMPLETED	Lead consultant identified and an IT administrator to co-ordinate changes. The decision has been made to add a question in the mandatory screening tool that specifically asks about dependants living in the home. (Adults & children). To include prompts for referrals. Elliot Wilkinson - ED consultant currently scoping current data recorded on OCEANO. To ensure a succinct mandatory screening. What is essential/non-essential? 22/01/18 EW informed NNSC that background work on the IT system (ECDS) is going live this week which is the foundation for the risk assessment element. Six weeks of IT support has been secured. 13/02/18 Confirmation received that OCEANO has been updated to include flags for violence, mental health and alcohol admission saying 'If there are children at home, please consider safeguarding concerns'.		
		1.2.2 Snapshot audit to be undertaken three months after launch to gain assurance that the IT system changes have resulted in the anticipated improvements in practice.	Emergency Department Consultant and OCEANO lead (Matt Chandy) & Named Doctor for Safeguarding Children (Simon Birch)	Aug 31 2018	17/05/18 New action added and emailed to MC / SB.		
		1.2.3 Mechanism for monitoring this aspect of practice (see recommendation) to be built into the Safeguarding Service annual rolling audit programme / tool currently being developed.	Named Midwife for Safeguarding Children (Sharon Ward)	Jun 30 2018	17/05/18 New action added.		

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.	1.3.1 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 (Matt Chandy) & Named Doctor for Safeguarding Children (Simon Birch)	~~Mar 31 2018~~ Jun 30 2018 - Revised date TBC	Lead consultant identified and an IT administrator co-ordinating changes. Elliot Wilkinson currently scoping current data recorded on OCEANO. To ensure a succinct mandatory screening. What is essential/non-essential? 22/01/18 EW informed NNSC that background work on the IT system (ECDS) is going live this week which is the foundation for the risk assessment element. Six weeks of IT support has been secured. 07/03/18 Email sent requesting update. 07/03/18 Email received advising that work has progressed on changing the paediatric mandatory screening tool to rationalise / enhance but this has stalled due to lack of IT time and further upgrades /changes not planned until late in the year. 23/03/18 Email received advising that meeting to finalise timeframe and planned modifications 04/04/18. 17/05/18 Email sent requesting update and revised completion date.		
		1.3.2 Snapshot audit to be undertaken three months after launch to gain assurance that the IT system changes have resulted in the anticipated improvements in practice.	Emergency Department Consultant and OCEANO lead (Matt Chandy) & Named Doctor for Safeguarding Children (Simon Birch)	TBC - depends on completion of 1.2.1	17/05/18 New action added and emailed to MC / SB.		
		1.3.3 Mechanism for monitoring this aspect of practice (see recommendation) to be built into the Safeguarding Service annual rolling audit programme / tool currently being developed.	Named Midwife for Safeguarding Children (Sharon Ward)	Jun 30 2018	17/05/18 New action added.		

		1.3.4 Work to be undertaken to ensure that staff in the Paediatric ED are following the 4LSCB Bruising Protocol (BP) and that any barriers to this are understood and addressed.	Named Doctor for Safeguarding Children (Simon Birch)	COMPLETED	18/05/18 New action added as per PSAB/PSCB Improvement Board: The BP was covered in the Trusts generic safeguarding training and in the bespoke updates delivered to areas that work with children throughout 2017/2018. In the summer of 2017 the Trusts Medical Director issued a directive to all medical staff that the BP should be followed without exception. PHT/Solent audit of the clinical management of immobile children presented to ED with a bruise or suspected bruise (undertaken August - October 2016) identified areas of the bruising protocol that were presenting barriers to compliance. In the summer/autumn of 2017 the NDSC participated in the 4LSCB review of the BP which has resulted in version 5 being ratified in February 2018 with numerous changes that address barriers identified from the PHT/Solent audit. Paediatric ED and the Paediatric Unit now stock the BP leaflet for staff to give to parents. In March 2018 50 laminated bruising in immobile children posters were distributed to key areas within the Trust and these are prominently displayed in the key areas. In April 2018 the HSCB 'Spotlight on... the bruising protocol' was widely cascaded across the Trust. The BP is included within the Trusts 'Essential Skills Handbook for All Staff' for April 2018 - March 2019' which is mandatory training for all staff. The Designated Doctor for Safeguarding Children for Portsmouth has delivered 4 BP training sessions to PHT staff in April and May 2018. The Trust is hosting one of the HSCB BP training sessions this year 29/06/18.		
		1.3.5 Snapshot audit to be undertaken to gain assurance that the bruising protocol is now being followed by all practitioners.	Named Doctor for Safeguarding Children (Simon Birch)	Aug 31 2018	18/05/18 New action added and emailed to SB.		
	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.	1.6.1 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.	~~ED Matron (Mike Goodfellow)~~ Consultant Adult & Paediatric Emergency Medicine (Matt Chandy)	COMPLETED	17/01/18 Update: Matt Chandy is now leading on this action and has tasked to Dr Neil Garrett who has started this piece of work.Email sent 01/03/18 requesting update. 02/03/18 Email update received from MC, he will chase up audit progress with NG. 06/04/18 Email received with audit report and actions planned including reaudit.		

1.6		1.6.1a Action plan to be added to the Safeguarding Service combined audit action plan and monitored via the Trust's Safeguarding Committee. Action plan includes repeat audit.	Named Midwife for Safeguarding Children (Sharon Ward)	Jun 31 2018	17/05/18 New action added.		
		1.6.2 Awareness to be raised within the Emergency Department of the need to take care when inputting data onto OCEANO.	ED Matron (Mike Goodfellow)	COMPLETED	No update available re. Awareness raising. 01/03/18 Email sent requesting update. 02/03/18 Email update received from MC, care in relation to data input is included in all junior doctor induction sessions. **COMPLETED**		
		1.6.3 Mechanism for monitoring this aspect of practice (see recommendation) to be built into the Safeguarding Service annual rolling audit programme / tool currently being developed.	Named Midwife for Safeguarding Children (Sharon Ward)	Jun 30 2018	17/05/18 New action added.		
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.	1.7.6 Safeguarding children supervision arrangements in ED to be improved and clearly recorded.	Named Nurse for Safeguarding Children (Diane Urquhart)	COMPLETED	31/07/17 Weekly supervision put in place for ED Safeguarding Operational Lead. 27/02/18 NMSC attended first meeting of LSCB health supervision task & finish group. Aim to develop supervision standards for health that outline what good looks like in specific areas such as ED. ED Safeguarding Operational Lead for Nursing booked to attend LSCB safeguarding supervision training 13/03/18. 14/04/18 PHT review (audit) of safeguarding supervision compliance completed and report shared with relevant Heads of Nursing. 17/05/18 ED SOL attended PSCB safeguarding supervision in April 2018 and is providing responsive supervision to ED staff.	Links directly to 1.11	
		1.7.7 Snapshot audit to be undertaken to determine whether the new safeguarding supervision arrangements in ED have resulted in the anticipated improvement.	Named Nurse for Safeguarding Children (Diane Urquhart)	Aug 31 2018	1.7.7 New action added and emailed to DU.		

	Objective	Action	Lead	Date	Update		RAG
	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.	Paediatric Senior Sister ~~(Tracey Thomas)~~ (Jessica Porter)	Jul 31 2018	Draft risk assessment has been produced. 07/03/18 Email sent requesting update. 17/05/18 Email sent requesting update. 31/05/18 Verbal update - a risk assessment form has been produced and has been sent out to the paediatric consultant body for comments. Paediatric Senior Sister (TT) to email to safeguarding service for comments. 31/05/18 Maternity RA shared with Paediatric team for reference.		
		3.2.1a Snapshot audit to be undertaken three months after launch to gain assurance that the tool / process has been embedded into practice and that this has resulted in the anticipated improvements in practice.	Paediatric Senior Sister (Jessica Porter)	TBC - depends on completion of 3.2.1	17/05/18 New action added and emailed to JP.		
		3.2.2 Paediatric service documentation to be updated to include an environmental risk assessment for this group of children.	Paediatric Senior Sister ~~(Tracey Thomas)~~ (Jessica Porter)	Jul 31 2018	Scoping of appropriate tools is underway. Best practice being benchmarked against other Trusts. Draft copy underway. Plan to complete 19.01.18. 07/03/18 Email sent requesting update. 17/05/18 Email sent requesting update. 31/05/18 Verbal update - A number of documents have been obtained including a national document provided by the Association of Chief Children's Nurses. These are being adapted for use in PHT's Paediatric Unit.		
		3.2.2a Snapshot audit to be undertaken three months after launch to gain assurance that the tool / process has been embedded into practice and that this has resulted in the anticipated improvements in practice.	Paediatric Senior Sister (Jessica Porter)	TBC - depends on completion of 3.2.1	17/05/18 New action added and emailed to JP.		

3.2		3.2.3 Paediatric 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.	Paediatric Practice Educator (Sally Gray)	~~Mar 31 2018~~ Revised date TBC	No update available. 07/03/18 Email sent requesting update. 14/03/18 Email sent requesting update. 14/03/18 Email received with evidence of future plans in place with regards to MH training & details of all compliant staff as of September 2017. 20/03/17 Email sent requesting revised completion date.		
		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.	Paediatric Practice Educator (Sally Gray)	COMPLETED	All in progress. 07/03/18 Email sent requesting update. 14/03/18 Email sent requesting update. 14/03/18 Email received with evidence of future plans in place for MH within Paediatric Service rolling programme of mandatory training.		
		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.	Paediatric Matron (Katrina Adams)	~~Mar 31 2018~~ ~~Apr 30 2018~~ ~~Jul 31 2018~~	All in progress but sits outside PHT. 07/03/18 Email sent requesting update. 17/05/18 Email sent requesting update. 18/05/18 Email received, all staff have been reminded to request. Email sent suggesting discussion with partner agencies. 31/05/18 Verbal update - Paediatric Matron has had conversations with CAMHS and escalated to the Clinical Director for Paediatrics (HB) 21/05/18. There is also a piece of work underway on the CAMHS inpatient proforma. 31/05/18 CAMHS team leader email to HB confirms their clinicians 'will write the plan in the patients notes - it maybe that the pro-forma assessment paperwork is sent separately following typing'. Response/confirmation awaited from CAMHS clinician more familiar with the DSH assessment process.		
		3.2.5a Snapshot audit to be undertaken three months after launch to gain assurance that revised arrangements have been embedded into practice and that this has resulted in the anticipated improvements in practice.	Paediatric Matron (Katrina Adams)	TBC - Depends on completion of 3.2.5	17/05/18 New action added and emailed to KA.		

		3.2.6 Mechanism for monitoring this aspect of practice (see recommendation) to be built into the Safeguarding Service annual rolling audit programme / tool currently being developed.	Named Midwife for Safeguarding Children (Sharon Ward)	Jun 30 2018	17/05/18 New action added.		
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.	3.3.1 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 (Lesley Coles) and ED HoN (Rosemary Brownbridge)	Completed	11/10/17 SOP has been developed, ratified and launched within ED. Compliance will now be monitored via audit. 23/11/17 SoP updated following a SIRI panel where a decision has been made not to put 16 to 18 yrs old on Adult Obs bay. These YP now go to AMU or Paediatric Unit. Consultant to Consultant decision.		
		3.3.2 Snapshot audit to be undertaken to gain assurance that revised arrangements have been embedded into practice and that this has resulted in the anticipated improvements in practice and patient care.	W&C Head of Nursing (Lesley Coles) and Rosemary Brownbridge	Aug 31 2018	17/05/18 New action added and emailed to LC/RB.		
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.	Named Nurse for Safeguarding Children (Diane Urquhart) and Head of Nursing Emergency Medicine (Rosemarie Brownbridge)	COMPLETED	3.5.1 05/01/2018 further JD received from other Trusts. Outside of Wessex region. Current information to be discussed with new SG leads and used as part of review of establishment of SG teams.		
		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 (Diane Urquhart) and Head of Nursing Emergency Medicine (Rosemarie Brownbridge)	~~Mar 31 2018~~ Oct 31 2018	Business case submitted 02/03/18 to NHS England for a generic safeguarding role in ED. 22/03/18 Partial funding secured from NHS E, plans to be reviewed in light of this. 17/05/18 ED SOL is currently allocated 2 days per week for Safeguarding role and is undertaking some paediatric liaison functions but these are limited.		

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Underway, due to be completed	
Completed	

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

Portsmouth Hospitals NHS Trust - Safeguarding Service Action Plan

***** WORKING DOCUMENT *****

Last Updated: 01/06/18

Number	Recommendations	Actions	Assigned to	Completion Due	Progress	Comments / Evidence	RAG
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.	Associate Director of Nursing (Alison Fitzsimons) supported by the Director of Nursing (Theresa Murphy) & Head of Safeguarding (Sarah Thompson)	~~Timeline starting 20/09/17~~ ~~Mar 31 2018~~ Jul 31 2018	Findings from Aug'17 CQC inspection report, Sept'17 CQC CLAS review report, Nov'17 External peer review report, Nov'17 Hampshire CCG's paediatric clinical visit report and the Jan'18 Hampshire CCG's maternity deep dive have all been amalgamated into an overarching action plan. The Head of Safeguarding will produce a thematic analysis of the 86 individual recommendations by Mar 31 2018. 05/04/18 HoS & NMSC visited the Safeguarding Service at Frimley Health Foundation Trust as part of a peer benchmarking exercise. 17/05/18 Benchmarking report in progress.		
		1.7.2 Terms of reference for the Safeguarding Committee to be reviewed.	Associate Director of Nursing (Alison Fitzsimons) supported by the Director of Nursing (Theresa Murphy) & Head of Safeguarding (Sarah Thompson)	COMPLETED	Decision taken at Dec'17 Safeguarding Committee that TOR would be reviewed after new Head of Safeguarding has attended the Jan'18 committee meeting and is in a position to contribute her expertise and view. 17/05/18 ToR were discussed at Safeguarding Committee 06/04/18 and have now be finalised.		
		1.7.3 Appoint a Head of Safeguarding (Adults and Children) at an 8C, new strategic level post.	Associate Director of Nursing (Alison Fitzsimons) supported by the Director of Nursing (Theresa Murphy)	COMPLETED	New Head of Safeguarding Sarah Thompson commenced in post 2nd January 2018.		
		1.7.4 Workload of Safeguarding Children Team to be reviewed	Head of Safeguarding (Sarah Thompson)	COMPLETED	12/12/17 Named professionals meeting held - completed scoping of SCT workload / activity. 16/01/18 Named professionals meeting with Head of Safeguarding - completed analysis of SCT workload / activity and identified work that needs to stop. 17/05/18 The changes planned in respect of team activity have been achieved incrementally. The child and adult safeguarding teams have now begun the process of integration.		
		1.7.4a Snapshot audit to be undertaken to measure the impact of the changes made to the teams activity on overall workload and wellbeing.	Head of Safeguarding (Sarah Thompson)	Aug 31 2018	17/05/18 New action added & emailed to ST.		

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.	1.11.1 Safeguarding children supervision arrangements to be ~~audited~~ reviewed against PHT supervision policy and local safeguarding children board standards.	~~Named Nurse &~~ Named Midwife for Safeguarding Children (Sharon Ward) & Head of Safeguarding (Sarah Thompson)	COMPLETED	Review underway and will be utilised by the HoS who will produce a supervision strategy. 27/02/18 NMSC attended first meeting of LSCB health supervision task & finish group. Aim to develop supervision standards for health that outline what good looks like in specific areas such as ED. 05/03/18 HoS met with maternity band 7 clinical lead midwives to discuss the supervision trajectory within maternity services (see briefing and project plan with Director of Maternity and Midwifery). This will involve the supervision of 273 staff with a ratio of 1:17. This will consist of group supervision quarterly with a dedicated two hour session monthly as part of the mandatory training programme. A reciprocal arrangement has been agreed whereby the safeguarding service will co-facilitate the PSCB multi-agency safeguarding supervision training module in June 2018 and in return will have priority for seven training places for PHT staff. ED Safeguarding Operational Lead for Nursing booked to attend LSCB safeguarding supervision training 13/03/18. 14/04/18 PHT review (audit) of safeguarding supervision compliance completed and report shared with relevant Heads of Nursing.	Links to 1.7.6	
		1.11.2 Supervision Audit action plan to be developed and progress/impact monitored via the Trust's Safeguarding Committee.	Named Midwife for Safeguarding Children (Sharon Ward) & Head of Safeguarding (Sarah Thompson)	May 31 2018	17/05/18 New action added.		
		1.11.3 Mechanism for monitoring this aspect of practice (see recommendation) to be built into the Safeguarding Service annual rolling audit programme / tool currently being developed.	Named Midwife for Safeguarding Children (Sharon Ward) & Head of Safeguarding (Sarah Thompson)	Jun 30 2018	17/05/18 New action added.		

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 (DI Urquhart) &~~ Named Midwife for Safeguarding Children (Sharon Ward) ~~and Adult Safeguarding Lead (Collette Puntis)~~	COMPLETED	20/12/17 Meeting held. Apologies sent by Portsmouth CCG, Solent NHS and PHT adult safeguarding team. Future plans to merge MARAC into MASH arrangements discussed. Current MARAC arrangements for health clarified and gaps identified. Solutions have significant resource implications for agencies. Agreement that Deputy Director of Quality & Safeguarding at Portsmouth CCG to be asked to take lead on this action. 18/01/18 Email to DDQ&S. 15/02/18 Discussed with Head of Safeguarding who will discuss with DDQ&S. 07/03/18 Email to HoS sharing action to date so she can discuss with DDQ& S at PCCG. 17/05/18 No further action for PHT at this time, we will contribute (upon request) to work relating to the roll out of the new MARAC/MASH approach in Portsmouth.		

Severely delayed, difficulty completing	
Underway, due to be completed within	
Completed	

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CQC Action Plan - Review of Health Services for Children Looked After & Safeguarding in Portsmouth							
Solent NHS Trust - updated 220518							
Number	**Recommendations**	**Actions**	**Assigned To**	**Completion Due Date**	**Progress**	**Comments/Evidence**	**RAG**
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 Child	10.9.17 CLOSED	This is covered in all safeguarding training. It is also discussed as part of supervision. It is also promoted when responding to requests from professionals for advice and support. The protocols available to staff through the Trust intranet.	Complete and closed	
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 2017 CLOSED	The Team have worked with IT to adapt the risk assessment tool and to add additional fields, the team use the 'spotting the signs' The Service continue to work with the EPR provider for the additional functionality that is required to improve the RAT tool. They are waiting for a list of new updates that are about to be released to their test site before being deployed to live site. Monthly audits continue of RATS that have/have not been completed and Portsmouth continue to sit at 98.5%. Those not completing have discussions with Managers at 1:1 meetings.	**22nd May 2018** It is suggested that this action can no be closed. The service is showing consistently high levels of compliance with completion of the risk assessment tool. There are changes being made nationally to the tool and the service are expecting an option to be added so that frequent attenders are identified which will prompt a review. this will be available following the next system upgrade.	

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	30.09.18	This action is completed. The training has been provided and it is planned to carry out an audit to demonstrate application in practice. This audit will be completed in Q1 2018/19 and report available in Q2. SystmOne now incorporates recording that CSE has been considered.	It is suggested that once the audit in Q1 has been completed and results indicate improvement this will be closed as then considered business as usual. **22nd May 2018** There is no change from the update above. the audit is currently being completed and results will be shared in Q2 and following this a decision taken as to whether this action can be closed	
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	30.09.18	Alerts are being added to the system to identify when there are LAC in the house, or when the patient has been a LAC. This will continue to be monitored and an audit to be completed in Q1 2018/19.	This will be updated following the Q1 audit and considered for closure pending outcome. **22nd May 2018** There is no change from the update above. the audit is currently being completed and results will be shared in Q2 and following this a decision taken as to whether this action can be closed	
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	A proposal for a joint admin BAAF. A form has been adapted and now includes consent form . From 1st April the service will not accept any referrals without a BAAF A Form. Both of these actions are expected to have a positive impact on the appointing process ensure those new into care are seen in a more timely manner.	**22nd May 2018** The admin staff member has joined the team and the BAAF form is now being used for initial and review assessments. The impact should start to be realised after Q1 and so an update will be provided in Q2.	

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	30.09.18	As above it is expected that the joint admin role will support the improved communication between Social Care and LAC. The CLA nurses are now caseholding. The SOP is in development with the relevant team and it is hoped will be completed by April 2018 following internal approval processes	**22nd May 2018** The approval of the SOP to support this work has been delayed and is going to the service line governance meeting in May 2018. It will be implemented following this and impact will be assessed during Q2	
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	30.09.18	The service have been working to improve SDQ's but currently have a low response rate, currently 38%. The named Nurse for LAC is working with virtual schools who currently achieve 100% response rate to identify if the LAC team can utilise this information. The team have developed a letter which they will be sending to GP's inviting them to provide information to support the assessment. Work has been done within the team to improve the quality of health care plans and a system of peer review is to be undertaken bi-monthly and an audit will be completed in 2018/19. The SOP is currently going through local approval processes and is hoped to be signed off on 7/2/18	**22nd May 2018** The standard letter is now going to the GPs and the team are seeing a rise in the completion of SDQs. Once the SOP has been implemented and the improvement is sustained then it is proposed that this action can be closed in Q2	

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	A Anderson	An external consultant has undertaken a review of the corporate safeguarding team capacity. The report has been presented to the Chief Nurse on 24th January and its recommendations are currently being considered.	**22nd May 2018** The additional band 6 adult safeguarding facilitators have been successfully recruited to and one staff members starts on 1st June and the second on 22nd June. It has been necessary to go back out to advert for the Head of safeguarding and the response has been positive and it is hoped to hold interviews in June 2018	
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	CLOSED	The team have worked with the IG manager and it is agreed that the minutes of CP meetings can be uploaded onto the electronic patient system. The issue however of deleting the information after 2 years has yet to be resolved and national level advice is being sought currently. The audit was completed in Q2 2017/18 and found 100% compliance. The inclusion of alerts in mental health has been implemented in AHM services and the audit will be due to be completed in Q1 2018/19	It has been agreed that the minutes can be removed from SystmOne after the required period . However the Designated Nurses are seeking national advice regarding best practice. **22nd May 2018** The national guidance has not been received and so it is proposed to close this action and to follow the guidance issued by the Trust IG manager	

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 CLOSED	The alert system is on the notes and staff are aware, the team now have specific code for LAC. Southampton and Portsmouth staff can now upload the referral to the system but work is continuing to enable the same practice for those working in Hampshire. Again continue to work with the provider of EPR so that records that have been marked as vulnerable are more readily identifiable at all stages of booking. This means that a wider selection of staff will be able to identify vulnerable staff and provide them with support. New version of flow chart has been circulated to staff with updated details.	This is completed and suggest it should be closed.	
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 CLOSED	The intercollegiate guidance has been reviewed in the context of AMH staff and it has been agreed by the Named Nurse, safeguarding children and the professional lead, AMH that all nursing staff Band 6 and above will receive level 3 safeguarding children training	Matrix has been completed and staff are working through training currently. **22nd May 2018** Compliance is monitored monthly and so it is suggested as the matrix review has been completed this action can be closed	
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	30.09.18	Please see 4.3 above as this is a duplicate of that action	As per 4.3	

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

Portsmouth Clinical Commissioning Group PCCG - updated 210518

Number	Recommendations	Actions	Assigned To	Completion Due Date	Progress	Comments/Evidence	RAG
	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.	Sarah Shore, Associate Designated Nurse	COMPLETED	**10.11.17** Dates arranged. Also planned presentation at TARGET (Training for GPs) in January. Incorporated in Level 2 and level 3 training **03.01.18** CSE Training provided to majority of School Nurses 07.09.17 & to CAMHS 11.09.17 Training Community Paediatricians and LAC Nurses - 28.02.18 03.01.18 Emailed GP Surgeries who did not take up initial CSE training, offering to attend surgery and train staff. **190318 -** 24th March 2018 delivering training to GP Surgery. Plan to deliver training in TARGET on 25.04.18.		

2.1		2. Explore IT solutions to ensure that Primary Care use the shortened tool for all under 18 year olds requesting sexual health or contraceptive advice.	Sarah Shore, Associate Designated Nurse	31.01.18 Request extension on completion date to 31.08.18	**10.11.17** Temporary solution implemented by adding shortened tool to Systemone under sexual health, Contraception, mental health pathways. The tool can currently be bypassed but this action makes them more obvious to GPs whilst we explore other options. **190318** Awaiting response from IT to see if this can be made mandatory for all contraception requests for children aged 13-17. **21.05.18** Work on this is continuing. Currently working to transfer the last GP practice in Portsmouth on to System one.		
		3. Monitor number of referrals from health agencies to MASH related to concerns regarding CSE.	Sarah Shore, Associate Designated Nurse	30.06.18	**10.11.17** Initial stats requested and being collated by MASH Nurse. This will given a benchmark of current referral rate. **190318** This is being reported into the MET Strategic Group and will be monitored there. Also reporting to NHSE on a quarterly basis		
		4. Audit GP awareness of CSE and local tools.	Sarah Shore, Associate Designated Nurse	30.07.18	**10.11.17** Not yet started as requires previous steps to be embedded first. **190318** - No change. Audit to be undertaken in Jun 18. 21.05.18 Audit tool is under development		

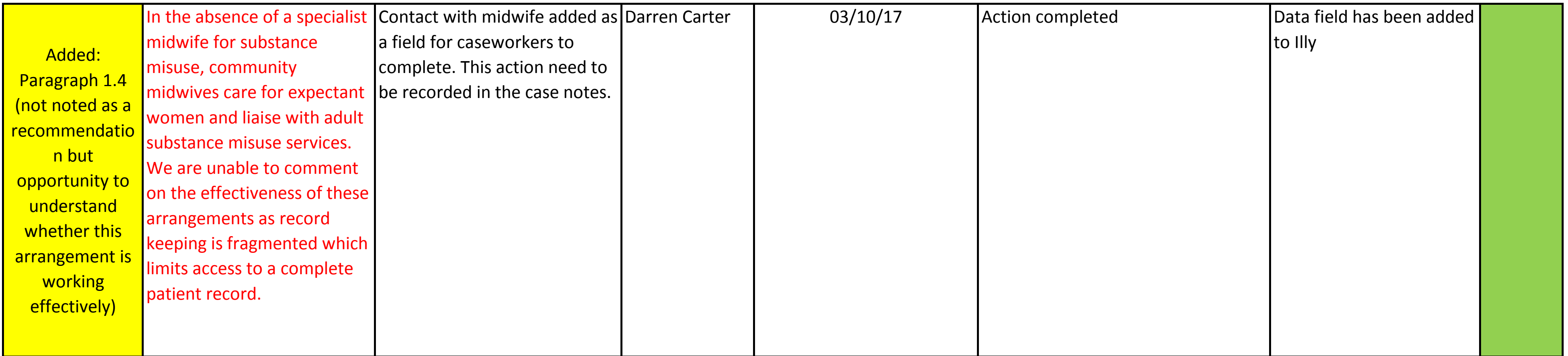
2.2	Ensure the arrangements and job descriptions for the designated and named doctor for LAC are compliant with the intercollegiate guidance and that there are clear accountability arrangements for the strategic and operational responsibilities for each postholder.	1. Meet with Solent NHS Trust to explore options.	Tina Scarborough Deputy Director Safeguarding and Quality	COMPLETED	**10.11.17** Initial Exploratory meeting held. Further meeting to be convened once JD updated. **19.03.18** JD updated in line with the Intercollegiate document. Follow up meeting held on **12.12.17.** Agreed that due to increasing work load caused by increase in UASM that the designated Dr hours would temporarily be used to deliver the IHA's and the Designated post would not be filled. Solent to develop a business case to present to the CCG for more funding. Currently awaiting business case to be presented to CCG. This is currently on the CCG risk register. **21.05.18** CCG have formally written to Solent NHS Trust requesting update by 31.05.18. If no resolution PCCG to take forward under contract processes.		
		2. Review and update Job Descriptions.	Tina Scarborough Deputy Director Safeguarding and Quality	COMPLETED	**10.11.17** DRAFT JD circulated to key individuals for comment. **12.12.17** JD agreed		
		3. Separate Roles and functions of the Named and designated LAC Posts.	Tina Scarborough Deputy Director Safeguarding and Quality	31.12.17 Extension requested to 30 June 2018	**19.03.18** Awaiting business case from Solent NHS Trust to be submitted. **21.05.18** CCG have formally written to Solent NHS Trust requesting update by 31.05.18. If no resolution PCCG to take forward under contract processes.	CCG have escalated this to contract team	

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.	**10.11.17** Portsmouth CCG and health partners are engaged with the MARAC steering groups to progress this work **19.03.18** MARAC Working Group met on 09.03.18 Health services are engaged in this work. IT systems being explored at present. ASC will be using system 1 shortly. All GP practices have now agreed to use System1. work being undertaken to implement System 1 into one GP practice. Solent NHS Trust provide representation on MARAC (Safeguarding and AMH). This will continue. Information is entered into System one and GPs can then access that information directly.		

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

Society of St James - updated 010618

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	31-Mar-18	6th Sept 2017- 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. May 2018- Audits completed and most recent sample audit showed 90% compliant. Where there were gaps, action plans are in place with Recovery Workers and this is being monitored ongoing in supervision.	Next sample audit to be completed Aug/Sept 2018	Ongoing
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	31-Mar-18	6th Sept 2017 - 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. Actions have been set in supervision for all staff to book on PSCB website. Completion of training is being monitored during supervision.	All staff are booked in with training and this is captured by the training tool 'My Learning Cloud'. Training is ongoing. PSCB have been short staffed and acknowledge that training is not as readily available as it has been previously.	Ongoing



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	03/10/17	Action completed	Data field has been added to Illy	

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

Public Health - updated 190318

Number	Recommendations	Actions	Assigned To	Completion Due Date	Progress	Comments/Evidence	RAG
Paragraph 1.8	Linked community midwives or school nurses are not routinely part of joint meetings for vulnerable families. This limits opportunity to share information between disciplines and jointly consider risks, agree any resultant actions and plans to support ongoing care.		Debbie Price	14/09/17	Action completed 1. Complete 2. To be discussed on 25th October 2017		
Paragraph 1.12	We were assured that if a 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 this, it is too early to measure whether it meets needs.	Kate Slater	30-Sep-17	GL, substance misuse worker has already started to develop guidance. This will need to be part of a broader substance misuse strategy. Meeting arranged with Early Help and GL on 31/8/17 to agree pathway and discussion to follow with Claire Currie PH consultant. Director of Childrens, Families and Education and Director of Public Health (and others) met on 21st August to discuss substance misuse provision for young people in the city. Discussions on-going.	Recent article in community care re team around the worker model: http://www.communitycare.co.uk/2017/08/10/building-team-around-social-worker-council-reducing-demand-supporting-staff/	Action completed. Pathway established. Mapping process underway to establish any gaps in provision.	

Paragraph 2.6	LSCB escalation processes, where there are areas of professional disagreement, are not always fully complied with by school nurses.	Lucy Rylatt	14-Sep-17	Escalation process shared with Teams 29/8/17	Attached link to procedure for reference: http://www.proceduresonline.com/4lscb/portsmouth/p_conflict_res.html?zoom_highlight=escalation+process	Action completed	
Paragraph 2.15	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.	Kate Slater	End of September 2017	YOT substance misuse worker in liaison with the adult substance misuse service to develop and agree a transition pathway.	Transition pathway in place and available to adult and Early Help teams	Action completed	
Paragraph 3.17	Home educated children and young people do not benefit from access to the school nursing service. Practitioners are not able to identify this population and this limits the provision of their service.	Julia Katherine	End of September 2017	Meetings have taken place with JK Head of Inclusion and support and CC Public Health Consultant to agree wording to promote access to the school nursing service via letters sent from the local authority to parents of children in Portsmouth City where notice has been give to be electively home educated. Action completed.		Action Completed	

Paragraph 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. Number of cases within school nursing and FNP where the opportunity to identify and assess CSE risk had been missed.	Sarah Newman	27-Oct-17		link to the document: Helping school nurses tackle child sexual exploitation https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/512907/2903823_PHE_Child_Sexual_Exploitation_Accessible_FINAL.pdf link to the recent PHE document to leading a system-wide approach https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/629315/PHE_child_exploitation_report.pdf	In progress. Initial training complete. Solent setting up more sessions to continue learning.	

Paragraph 5.1.14	The need to carry out safeguarding work within the current resources has affected the capacity of the service to deliver other mandated 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	Kate Slater	Jan-18	Discussions taking place within the SN service and with commissioners to change the model and resources for SN to enable drop-ins to start from January 2018 once recruitment is complete		In progress	
Shared actions with public health and other agencies							
Recommendation 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 Named Nurse for Safeguarding Children and ED Matron.	Mar 31 2018			See PHT	

Recommendation 4.3	Improve the identification, assessment and recording of risk around CSE within the 0-19 service.	Sarah Newman	27-Oct-17			Request has been submitted to allow recording of CSE on CAPITA. This will take 4 weeks to be completed. Solent records in the body of the records and audit process has been introduced for public health nursing services.	

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

Purpose and Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Guiding Principles

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

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

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

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

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

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

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

Appendix One – Framework for Assessing Change

Key questions to be addressed

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

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

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

Name of lead CCG:
Portsmouth CCG
Fareham and Gosport CCG
South East Hampshire CCG
Specialised Services NHS England

Brief description of the proposal:

It is proposed that the elective spinal surgical service at Portsmouth Hospitals NHS Trust (PHT) is moved to the Wessex Regional Spinal Unit at University Hospital Southampton NHS Foundation Trust (UHSFT).
The scope of the change proposal is for all elective work currently undertaken at PHT for patients suffering from spinal conditions. The proposal includes outpatient and inpatient work.

Complex spinal surgical work is already undertaken at UHSFT as is paediatric and trauma surgery for spinal conditions.

The number of potentially affected patients is 204 from across the catchment area for the Trust. Of this number of patients approximately 176 are from Portsmouth, Fareham and Gosport and South Eastern Hampshire CCG areas

Why is this change being proposed?

PHT currently has an unsustainable spinal surgical service with only one substantive consultant (0.85 PAs) now delivering the service. In 2010 the Spinal Taskforce produced a paper entitled, 'Organising Quality and Effective Spinal Services for Patients. A report for local health communities'. This stated "Single-handed spinal surgeons should not be working in isolation. Wherever possible, spinal surgeons should work in teams within organisations, ideally with more than one surgeon in each site."

Over the past three years the Trust has tried to recruit to the service unsuccessfully. This has resulted in lengthy waits for patients and so, two years ago the commissioners, working with the Trust agreed that PHT would accept only 'red flag' referrals from GPs and a small number of consultant to consultant referrals.

By only having one consultant available there is no consistency of medical cover available and the potential risks to quality and safety of care are higher with a service operated by a single clinician. There is also an impact on governance arrangements which provide quality assurance for the service as a whole as these may potentially be less rigorous in a service operated with one consultant.

Over the past two years the Trust has been working with Portsmouth, Fareham & Gosport and South Eastern Hampshire Clinical Care Commissioning Groups (PSEH), NHSE Specialised Services Wessex and University Hospital Southampton NHS Foundation Trust to seek a sustainable solution for the local population. The proposed transfer would also see the consolidation the existing Wessex Regional Spinal service, which has strong governance as well as both clinical and management leadership.

Whilst the CCGs are supportive of the proposal it will need to be considered by their Governing Bodies. When considering the proposal the CCGs will expect to see details of the views of clinicians, key stakeholders and local

people and how these have been taken into account.

Description of Population affected: PHT catchment area

The proposal involves the centralisation of the PHT surgical spinal service to University Hospital Southampton NHS Foundation Trust (UHSFT), which also currently provides the Wessex Regional Spines service. UHSFT already undertake the emergency and complex elective pathways so this proposal seeks to centralise the remaining non-complex elective pathway. The number of patients affected is limited to a small number of patients who require this type of surgery (204) as outlined in the table below.

	Activity 16/17	Activity 17/18	Activity 18/19
3 CCGs	163	174	176
Non Contract Activity	1	2	-
Other CCG's	18	17	24
Other Local Area Team	2	3	2
Wessex Area Team Specialised	1	1	2
TOTAL	185	197	204

Date by which final decision is expected to be taken:
The proposal has been put together jointly with the two Trusts, the three CCGs and NHS England Specialised Services Wessex and has also had strong involvement and input from the Solent Acute Alliance Board. Following engagement and involvement to consider the views of patients affected, the proposal will need to be considered by the Boards of the CCGs and both University Hospital Southampton NHS Foundation Trust and Portsmouth Hospitals NHS Trust for a final decision to be taken. It is anticipated that subject to formal agreement the transfer of the elective spinal service could take place in October 2018.

Confirmation of health scrutiny committee contacted:
Portsmouth Health Overview and Scrutiny Panel

Name of key stakeholders supporting the Proposal:

Commissioners
UHS
PHT Medical staff
Nursing staff
Governance personnel

Date:01/06/18

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
Case for Change 1) Is there clarity about the need for change? (e.g. key drivers, changing policy, workforce considerations, gaps in service, service improvement)	Yes	The spinal service provided at Portsmouth Hospitals NHS Trust is currently unsustainable because of workforce constraints. In 2010 the Spinal Taskforce produced a paper entitled, 'Organising Quality and Effective Spinal Services for Patients. A report for local health communities'. This stated "Single-handed spinal surgeons should not be working in isolation. Wherever possible, spinal surgeons should work in teams within organisations, ideally with more than one surgeon in each site." In addition, continuing to operate the service as it is currently provided will have an impact on the quality, safety and governance of the service provided. By only having one consultant available there is no consistency of medical cover available and the potential risks to quality of care are higher with a service operated by a single clinician. There is also an impact on governance arrangements which provide quality assurance for the service as a whole as these may potentially be less rigorous in a service operated with one consultant.
2) Has the impact of the change on service users, their carers and the public been assessed?	Yes	It is recognised that there will be an impact on service users as a result of the need to travel to Southampton for spinal surgery to be carried out. However the quality and safety of our patients has been the primary focus of this proposal. It is also anticipated that the small number of patients requiring post operative care will be repatriated to Portsmouth.

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
3) Have local health needs and/or impact assessments been undertaken? 4) Do these take account of : a) Demographic considerations? b) Changes in morbidity or incidence of a particular condition? Or a potential reductions in care needs (e.g due to screening programmes)? c) Impact on vulnerable people and health equality considerations?	Not at this stage	
d) National outcomes and service specifications? e) National health or social care policies and documents (e.g. five year forward view) f) Local health or social care strategies (e.g. health and	Yes	The proposals take account of the service specification for spinal services produced by the Spinal Taskforce. This document entitled, 'Organising Quality and Effective Spinal Services for Patients. A report for local health communities by the Spinal Taskforce' is attached to this paper as background.

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
wellbeing strategies, joint strategic needs assessments, etc)		
5) Has the evidence base supporting the change proposed been defined? Is it clear what the benefits will be to service quality or the patient experience?	Yes	Centralising spinal services in this way is the national direction of travel for specialist services and has been proven to improve clinical outcomes. It also allows the clinical on call rota to be strengthened and has benefits for operational management and clinical governance.
6) Do the clinicians affected support the proposal?	Yes	The orthopaedic clinicians support the fact that this is the best option to maintain a quality service for patients.
7) Is any aspect of the proposal contested by the clinicians affected?	No	
8) Is the proposal supported by the lead clinical commissioning group?	Yes	Yes, the proposal has been developed with Portsmouth, Fareham and Gosport and South East Hampshire CCGs and NHSE Specialised Services Wessex
9) Will the proposal extend choice to the population affected?	No	
10) Have arrangements been made to begin the assurance processes required by the NHS for substantial changes in service?	Yes	Given that the proposal affects a relatively small number of patients we have focused our plans for engagement on seeking the views of this specific patient group. Broadly speaking the proposals will impact on two groups of patients; those with chronic back pain and those who have had a disc displacement and require surgery. As a result we have

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
		made contact with the following groups and secured an initial meeting to discuss the proposals in detail and seek feedback. This meeting will be held on 12 June 2018: • National Ankylosing Spondylitis Society • National Osteoporosis Society • Partners friend through pain • National Rheumatoid Arthritis Society • Arthritis Care QA We have also sought to engage with the wider community through Locality Patients Groups and CCG Community Engagement Committees whose members include a range of community representatives. We also engage with our communities on an ongoing basis and know that travel and availability of car parking can be a concern. However we are also aware that people are prepared to travel if it means they are going to receive the best clinical outcome and they are able to be repatriated to their local hospital where possible. We are also aware that concern may be raised about the impact of the proposed change on other services provided by the Trust and will be reassuring local people that we are not currently anticipating that there will be any impact.
Impact on Service Users 11) How many people are likely to be affected by this change? Which areas are the affecting people		There are approximately 204 patients affected from the population served by the Queen Alexandra Hospital. With 176 of these from the

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
from?		local CCGs
12) Will there be changes in access to services as a result of the changes proposed?		Patients affected will be required to travel to Southampton hospital for their spinal surgery. This will inevitably result in a small increase in travel time for some patients.
13) Can these be defined in terms of a) waiting times? b) transport (public and private)? c) travel time? d) other? (please define)		
14) Is any aspect of the proposal contested by people using the service?		At this time there has been no formal or informal engagement with service users, however we are aware from our previous engagement work on similar issues that whilst additional travel may be a concern for some, patients are prepared to travel where it means they will have access to the best quality care.
Engagement and Involvement		
15) How have key stakeholders been involved in the development of the proposal?		Those clinicians affected by the proposed changes (both at PHT and UHSFT) have been involved in the discussions and development of the proposals.

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
16) Is there demonstrable evidence regarding the involvement of a) Service users, their carers or families? b) Other service providers in the area affected? c) The relevant Local Healthwatch? d) Staff affected? e) Other interested parties? (please define)		As stated above, we have plans to seek the views of patient groups about the proposal to consider their feedback and alleviate any concerns. Informal discussions have been held with Healthwatch Portsmouth and a description of the engagement activity outlined which they were content with. A full three month consultation will be undertaken with the spinal surgeon affected by the proposal as per the Trust's HR policy.
17) Is the proposal supported by key stakeholders?		Yes, the proposal is supported by clinicians and commissioners.
18) Is there any aspect of the proposal that is contested by the key stakeholders? If so what action has been taken to resolve this?		Key stakeholders are supportive of the proposal but we will review it in light of feedback received from the patient groups.

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
Options for change		
19) How have service users and key stakeholders informed the options identified to deliver the intended change?		An options appraisal was carried out with commissioners once it was realised that the service was no longer sustainable in its current form. The option to recruit additional consultants at Portsmouth was not considered realistic. In addition the caseload of patients was not sufficient to warrant an additional increase. The option to keep the outpatient activity at Portsmouth was also considered, however splitting the pathway in this way was considered to be a potential risk to quality and safety as well as potentially causing confusion for patients. Instead it was felt the proposed option was the best outcome for quality and safety combined with allowing those patients to be repatriated back to Portsmouth for ongoing required where necessary.
20) Were the risks and benefits of the options assessed when developing the proposal?	NA	
21) Have changes in technology or best practice been taken into account?	NA	
22) Has the impact of the proposal on other service providers, including the NHS, local authorities and the voluntary sector, been evaluated?	Y	
23) Has the impact on the wider community affected been evaluated (e.g. transport, housing, environment)?	Y	
24) Have the workforce implications associated with the proposal been assessed?		The proposal has come about because of concerns relating to the workforce and the current sustainability of the service. The proposal is intended to resolve these concerns.

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
25) Have the financial implications of the change been assessed in terms of: a) Capital & Revenue? b) Sustainability? c) Risks?? 26) How will the change improve the health and well being of the population affected?	NA	A full financial assessment of the proposal has been undertaken and included as part of the business case discussed and agreed with commissioners.

Organising Quality and Effective Spinal Services for Patients

A report for local health communities by the Spinal Taskforce

March 2010

Version 1

DH Gateway Ref. 13885

Update to this report

This document currently refers to a number of 18 Weeks weblinks that will shortly become out of date. At some point in 2010, all content on the 18 Weeks website will be transferred to the DH website (or other suitable home) and the 18 Weeks website will be closed.

Once the relevant content, referred to in this report, has migrated, this report will be updated with the new links as Version 2 and republished on the DH website.

Organising quality and effective spinal services for patients

Foreword

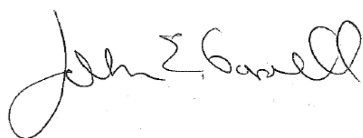
This report is intended to assist the NHS in developing and delivering effective spinal services, creating a set of productive services that deliver quality, timely and clinically appropriate care that meets patients' needs and expectations.

The report was commissioned in response to the national work on delivering 18 week pathways (for all patients who wish to be treated within 18 weeks and for whom it is clinically appropriate). In many Strategic Health Authorities (SHAs), providers were particularly struggling to deliver 18 week pathways for patients requiring spinal surgery. 'Top tips' aimed at organisations providing spinal services, giving operational advice on managing patients and organising service provision were therefore prepared and published in 2008. In preparing the 'top tips', it became clear that some wider issues around the organisation of spinal services also needed to be addressed, to ensure that the right range of services are available for patients and that these services are aligned in a way that is clinically safe and ensures rapid access, both for elective and emergency conditions. Closely aligned to this, the service would also benefit from support and guidance around implementing current National Institute for Clinical Excellence (NICE) Guidelines on spinal conditions including back pain and metastatic spinal cord compression.

The Department of Health (DH) therefore asked the Spinal Taskforce (membership detailed in **Appendix 1**) that developed the 'top tips' to also produce this short, but concise report for local health communities, including SHAs, PCTs, service managers and clinicians. This document will be particularly useful for those planning the delivery of spinal services for a wide population.

The document describes the main types of patients being referred to spinal services and gives advice on how to organise services to meet the needs of these groups, paying particular attention to the quality, clinical outcomes and cost-effectiveness of the services provided. It suggests the creation of a clinical network to offer advice on developing the right services for the local population.

I very much hope that the recommendations in this guidance will help them to address the challenges being faced in their local area.



Mr John Carvell
Consultant Spinal Surgeon and BMA representative
Chair of the Spinal Taskforce

Organising quality and effective spinal services for patients

Introduction

As part of the national work on delivering 18 week pathways (for all patients who wish to be treated within 18 weeks and for whom it is clinically appropriate), it emerged that, in many Strategic Health Authorities (SHAs), providers were particularly struggling to deliver 18 week pathways for patients requiring spinal surgery, with waits continuing to be longer than average waits across the country. The Department of Health (DH) (in collaboration with the relevant specialist associations and professional bodies) prepared a set of **'top tips' aimed at organisations providing spinal services** (see **Appendix 2**), giving operational advice on managing patients and organising service provision. In preparing this, it became clear that some wider issues around the organisation of spinal services also need to be addressed, to ensure that the right range of services are available for patients and that these services are aligned in a way that is clinically safe and ensures rapid access, both for elective and emergency conditions. This report addresses these concerns.

It looks at the effective organisation of spinal services for a wide population to support those planning and commissioning services across an SHA, PCTs and clinical and managerial teams within provider units. The document describes the main types of patients being referred for spinal treatment and advises on how to organise services to meet the needs of these groups, paying particular attention to quality, clinical outcomes and cost-effectiveness.

This report is intended to assist the NHS with the development and delivery of effective spinal services, that deliver quality, timely and clinically appropriate care, which meet patients' needs and expectations. It will also help **support the implementation of specific NICE guidelines on lower back pain and cancer of the spine.** As with guidance such as that issued by NICE, it is important to note that this document does not over-ride the individual responsibility of health care professionals to make decisions appropriate to the circumstances of the individual patient.

Patients requiring spinal services

Key to the organisation of safe and effective spinal services is an understanding of the type of patients presenting with spinal complaints and the services they require. Essentially, services should be arranged so that elective patients receive very early and robust triage and are then promptly referred to the most appropriate area for their condition. This will ensure that any 'red flags' are acted upon swiftly, but also ensure that patients with less clinically urgent needs receive care that is appropriate for their condition, thus preventing a decline into long-term chronic pain. Patients presenting as emergencies require emergency services that are able to promptly assess and investigate their condition, backed by appropriate in-patient provision. Broadly, patients requiring access to spinal services fall into the following main categories:

i. Non-specific low back pain

The largest group of patients will be those with **'non-specific low back pain'.** The vast majority of these patients, when presenting early in primary care, will benefit from simple structured education and reassurance based on the following well recognised national and international guidelines:

- **NICE Clinical Guideline CG88 - Early management of persistent non-specific low back pain**[1]
- The 18 week commissioning back pain pathway[2]
- Welsh government/health advice on backpain[3]

To help implement the suggestions in this report, and the clinical guidelines from NICE, there should be a focus on self-management of pain by providing patients with information about their condition, advising early mobilisation, and providing reassurance that most episodes will improve spontaneously[4].

When symptoms persist for **longer than six weeks**, or are recurrent, patients should undergo bio-psychosocial assessment, with confirmation of the diagnosis. A choice of the core therapies recommended in the NICE "low back pain guidelines" should be offered; exercise therapy, (preferably in groups) manual therapy, or acupuncture. Medication should be reviewed by their GP with advice from a pain specialist if necessary, especially if strong opioids are to be considered.

The Musculoskeletal Framework[5] recommends that the NHS work with employers to encourage good occupational health in the wider community, resulting in a reduction in sickness absence, particularly relating to those with previous sick leave and older workers.
Optimally, patients who have failed to respond to one or more of these less intensive treatments should undergo a further bio-psychosocial assessment, and, where there are

[1] www.nice.org.uk/CG88
[2] www.18weeks.nhs.uk/Content.aspx?path=/achieve-and-sustain/Specialty-focussed-areas/Orthopaedics/pathways
[3] www.welshbacks.com
[4] The Back Book ISBN 0-11-702949-1
[5] Department of Health, A joint responsibility: doing it differently – the musculoskeletal services framework, 12 July 2006 (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4138413)

significant 'yellow flags'[6] for chronicity and disability. They should have access to a Combined Physical and Psychological Programme (CPP), in line with the NICE guidelines. (See **Appendix 3** for a detailed description of a CPP programme). Patients with on-going pain and related disability for **more than a year** should be referred to a pain specialist where they can be offered a range of treatments, medication review and various specialised interventions - refer to the 18 week chronic pain pathway[7] for guidance on the patient pathway for those with chronic pain.

Surgery (spinal fusion) should only be considered for the small number of patients who have completed an optimal course of care, including a CPP programme. If after this their back pain is still severe, they should consider surgery.

In a large spinal service in the North East, only 4% of patients triaged as non-specific low back pain patients were re-referred to any service in secondary care within two years. An audit of these patients in primary care revealed substantial return to work, significant reduction in consultations with the general practitioner and substantial reduction in prescription / over the counter medication.

A second unit has recorded that, from initial GP referral, 30% of patients will be discharged without reaching an outpatient appointment (instead, receiving treatment in primary care settings). Of the remaining patients, around 60% could be managed by specially trained practitioners in primary care where their patient history, examination and special investigations have shown that surgery would be inappropriate. Only 4-5% of GP spinal referrals will normally need surgery.

ii. Radicular pain

The next largest group are those patients with **radicular pain**, (i.e., pain in the leg plus neurological symptoms and signs). These fall mainly into two groups:

- acute radicular compression by a prolapsed intervertebral disc
- spinal stenosis

MRI scanning is normally obtained for these patients and this can be requested by the triage and treatment practitioner who should receive training in interpretation of scans and have access to the reporting consultant radiologist. Referring practitioners should have access to pain management, orthopaedic, imaging, psychology services and consultant surgeons.

Research shows that surgical management of disc prolapse accelerates recovery and that the benefit, disability, and improvements to quality of life in the early stages are statistically and clinically significant. It is thus important that a triage system deals with acute nerve root compression rapidly. Patients require skilled advice on the relative merits of operative and non-operative care, and this should be **delivered within eight weeks** from onset of the pain. Many patients' symptoms resolve spontaneously but others suffer considerably. Patients' individual circumstances and clinical progress are very important in this decision making process.

[6] New Zealand yellow flags: www.nzgg.org.nz/guidelines
[7] www.18weeks.nhs.uk/Content.aspx?path=/achieve-and-sustain/Specialty-focussed-areas/Cross-specialty

Patients with intervertebral disc prolapse for whom surgery is not initially indicated may benefit from interlaminar epidural steroid or nerve root injection. Pain clinics may accept patients from a trusted referring source with consistent findings on an MRI scan without an intervening assessment appointment (which saves a lot of time), while in some centres root blocks are performed by radiologists, surgeons, and/or GPwSIs as part of the pathway for back pain and radicular symptoms. Pain clinics will also be able to provide appropriate pain management.

Patients with spinal stenosis also require skilled advice on the relative merits of operative and non-operative care, and patients who may benefit from surgery should be referred for a surgical opinion promptly.

iii. Potentially serious pathology

The most clinically serious (but also the smallest) group of spinal patients are those with **potentially serious pathology**. Cauda Equina Syndrome (CES), cancer of the spine (especially metastatic disease), fragility (osteoporotic) fractures, and infection are the principal pathologies under consideration. These patients need to be identified swiftly (using the red flags, as there is international recognition for these). CES is an emergency and requires access to 24 hour MR imaging (A recent BMJ Paper on CES provides additional information on managing this condition[8]). Detailed guidance on the management of spinal metastases has recently been issued by NICE:

- **NICE Clinical Guideline 75 - Metastatic spinal cord compression:** Diagnosis and management of patients at risk of or with metastatic spinal cord compression (Nov 2008)[9]

iv. Spinal deformity

The fourth group comprises the **spinal deformity** patients (adults and children). This group includes patients with scoliosis and kyphosis who require coordinated diagnostic and therapeutic support services, both for children and adults with scoliosis. It is essential that scoliosis services are made available for the population, as demand for these services is growing significantly and is likely to continue to increase in the coming years, particularly for adult spinal deformity. The DH has recently produced 'top tips' for the effective organisation of scoliosis services and these are shown in **Appendix 4**. The National Definition Set for these patients can also be found in **Appendix 5**.

v. Spinal trauma

The creation of regional trauma networks will provide the NHS with a framework measurement against which services can secure improvements in survival and better outcomes and care for patients suffering life threatening and major complex injuries, including those sustaining **spinal trauma**. These networks are currently under development

[8] 'Cauda Equina syndrome' Lavy C, James A, Wilson-MacDonald J, Fairbank J.. BMJ 2009; 338:936: www.bmj.com/cgi/content/extract/338/mar31_1/b936
[9] http://guidance.nice.org.uk/CG75

and will be dependent on provision of services locally. Patients with spinal cord injury need very careful management, with particular attention to prevention of avoidable life threatening complications. At present, local provision for patients with a spinal cord injury varies. When the trauma networks are established, every hospital receiving trauma should have a defined relationship with the appropriate spinal cord injury centre to provide advice, outreach care and education in the needs and immediate management of these vulnerable patients. Those with a spinal cord injury should be admitted to a spinal treatment centre within 24 hrs or as soon as possible.

vi. Other spinal pathologies

Lastly, there will be a small group of patients with **other spinal pathologies** who require specific pathways of treatment. These include congenital and acquired spinal stenosis, spondylolisthesis, and instability, inflammatory spondylitis with/without deformity, rheumatoid arthritis and metabolic disorders. These patients should be referred to a centre for spinal services and may require a multi-disciplinary approach.

Services required to meet the needs of these patients

Fundamental to providing the best quality services and experience for patients is to not only ensure that the right services are available for all categories of patients, but also that there are robust systems in place at all primary access points to ensure effective triage, in particular, to identify the first three categories of patients.

In order to meet the needs of all these groups of patients, it is suggested that local spinal service teams (clinicians and managers) work alongside their lead commissioners to create a clinical network for the provision of spinal services. This needs to go beyond the management of degenerative conditions and include a focus on cancer, trauma and deformity.

The clinical network will be able to advise on developing and delivering a cohesive set of services that includes all Trusts providing either neurosurgery or orthopaedics (or both). For the network to operate effectively, clinicians and managers should work together to enable understanding of the breadth of facilities and support required to provide a comprehensive spinal surgical service, including proper investment in the elements of a multi-disciplinary team, networks and infrastructure. To support this, it would be helpful to identify a clinical lead and it is suggested that this clinician co-chairs the network meetings. Given the significance of rapid triage (as set out above) and the need to ensure appropriate management of emergencies, it is important that all Trusts providing orthopaedic or neurosurgical services participate in the network, even those not providing spinal surgery, to ensure that elective patients are appropriately triaged and referred to the right services within the network and that spinal emergencies are adequately assessed and managed. Tasks that the clinical network may wish to consider include the following:

1. **Identify (and designate) a lead centre (or centres) for the provision of specialist spinal surgery to the local population**. Care for patients requiring specialist spinal surgery is low volume and high cost, and thus should be concentrated in specialist centres, although it is recognised that other centres in the area may also offer some of these services and facilities. The specialist centre/s should:

    - Provide an emergency rota for trauma and access to emergency and urgent spine services, for example for spinal cord compression;

    - Have MRI available 24/7 supported by good tele-radiology links with other centres;

    - Implement the guidelines and recommendations from the Spinal Specialised Services National Definition Set[10], (These can be found in **Appendix 5**) which identifies:

      Six areas of complex spinal surgery:

      i. Deformity (i.e. structural scoliosis, kyphosis, vertebral anomalies and severe spondylolisthesis)
      ii. Reconstruction (tumour, infection and spinal fracture)

[10] Specialised Services National Definition Set: 6 specialised spinal services (all ages), 8th February 2007

iii. Primary cervical, primary thoracic and primary anterior lumbar surgery
iv. Revision surgery
v. Intervention for complex back pain services
vi. Palliative or curative spinal oncology surgery

- Comply with the NICE guidelines on spinal metastases, including access to specialist input on chemotherapy or radiotherapy from oncologists and radiotherapists to support patients with metastatic disease and have access to specialist advice from a sarcoma unit (see paragraph 15 above);

- Have access to expertise in infectious disease management (including microbiology services) to support the treatment of infections;

- Offer specialised services for paediatrics (if providing children's spinal surgery), such as specialist paediatric nursing, anaesthesia, intensive care and rehabilitation, including resources for anaesthesia for MRI and CT scanning in small children;

- Deliver specialist services for scoliosis patients, including a Child Development Centre for paediatric patients (if providing children's spinal surgery), appropriate imaging and spinal cord monitoring for surgery in line with the Spinal Surgery National Definition Set (SSNDS). (The SSNDS for both adults and children can be found in **Appendix 5** and cover both scoliosis and spinal cord injury services);

- Provide a comprehensive service for patients with spinal cord injuries in line with the SSNDS, above. This should include assessment by a multi-disciplinary team, including spinal surgeons and specialists in spinal cord injury rehabilitation;

- Provide vertebroplasty/kyphoplasty and related procedures for patients with painful benign (osteoporotic) and malignant spinal fractures where indicated, including input from specialists in bone metabolism;

- Create links with other providers within their area, providing outreach and specialist advice and expertise as required.

2. **Agree which services should be provided only by the specialist centre/s** (technically complex spinal surgery and/or high risk of major complications) and which should be provided by non-specialist surgical services (routine procedures with low risk of major complications). **Appendix 6** summarises the national consensus on specialist and non-specialist surgery but this may be subject to local variation, based on clinical practice within the local area.

3. **Ensure all organisations providing spinal surgery have links with the lead centre/s, with clear clinical governance links across providers.** Single-handed spinal surgeons should not be working in isolation. Wherever possible, spinal surgeons should work in teams within organisations, ideally with more than one surgeon in each site. They should be working as part of a clinical network and the network will have responsibility for

governance arrangements to support these practitioners (both clinically and operationally) and for succession planning. The network will promote:

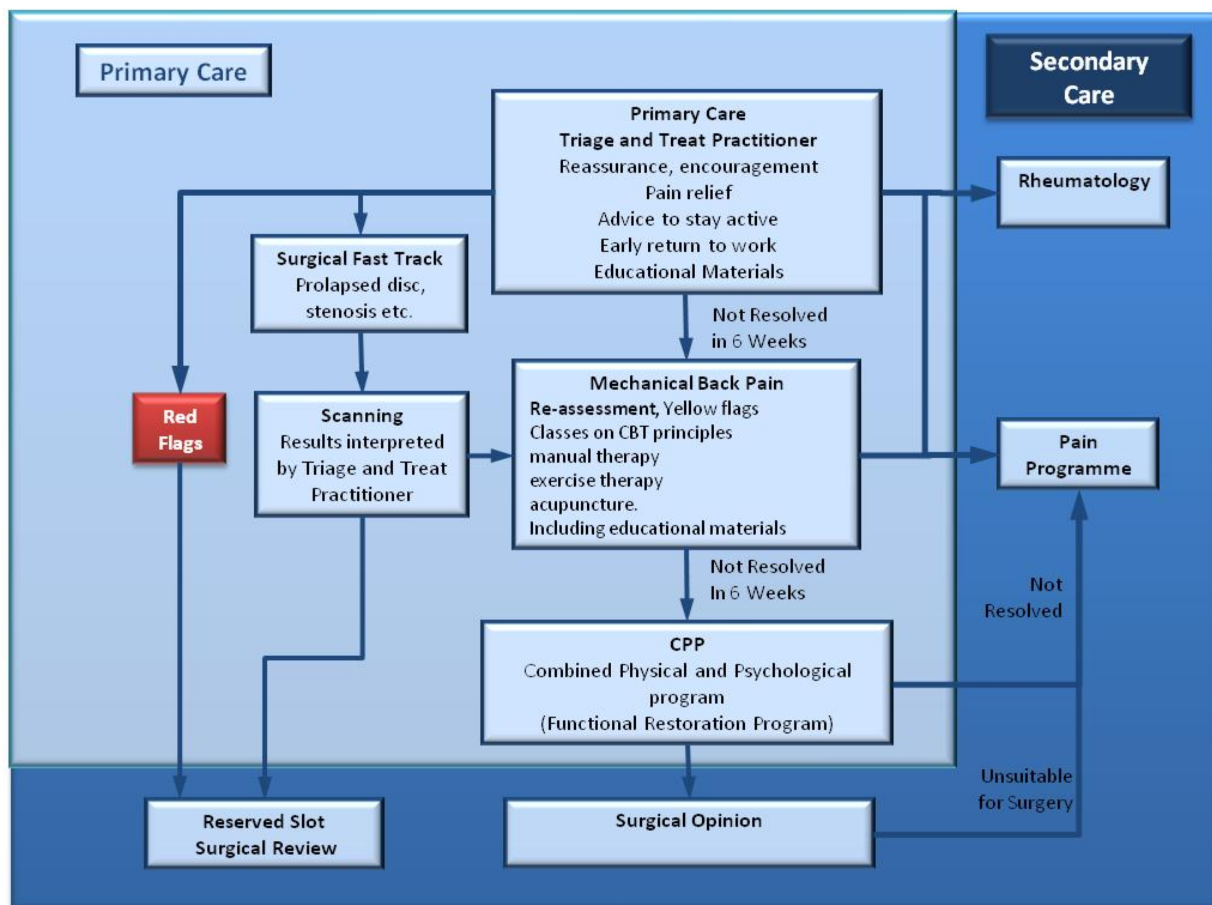
- Common network-wide audited standards of provision of medical, nursing, imaging and operative facilities;
- The development of in-house medical and nursing expertise for all hospitals in the area with an emergency department in the assessment and management of the unstable spine and the neurologically threatened or compromised patient.

4. **Effective triage is essential to deliver the pathways of care for elective spinal conditions efficiently and expeditiously, allowing fast tracking of patients to appropriate treatments.** In order to deliver effective triage, the network should consider developing the role of local 'triage and treat practitioners' (for example a nurse practitioner or extended scope physiotherapist) who are highly trained in triage and assessment and also trained in indications for MRI and interpretation, together with the skills to deliver educational material effectively. An example job description for a physiotherapy consultant and nurse specialist in spinal pain can be found in **Appendix 7**. The practitioners refer for diagnostics, therapies, surgery and CPP. The relationship of these practitioners with other specialists is crucial and close working will allow fast track appointments with surgeons, pain specialists, rheumatologists and others. Joint audit and governance arrangements are required and, in order to monitor practice, should include the specialist teams.

5. **Review the guidelines and recommendations contained with the Musculoskeletal Framework and implement as appropriate.** Specifically, the network should plan for a cohesive set of spinal services that triages patients at the point of referral and ensures that those with low back pain are seen by appropriate practitioners, freeing spinal surgeons to treat those patients requiring specialist surgery, integrating and co-ordinating care across organisational boundaries. NHS Quality Improvement Scotland (QIS) provides very useful information on the organisation of services for patients with acute low back pain[11].

[11] www.nhshealthquality.org

Organisational chart for Lower Back Pain services



6. **Ensure all hospitals receiving trauma have on site expertise in the assessment and management of acute spinal conditions both in the emergency department and on the inpatient ward.** They should also have 24/7 access to CT scanning, seven-day per week access to MRI, together with a defined written protocol to access 24/7 MRI scanning and have an established tele-radiology connection to a spinal centre. They should have the expertise to manage patients with acute spinal conditions either who are not fit for transfer or who have conditions appropriate for treatment in a non-specialist centre.

7. **Carry out a needs assessment for the population, mapping resources and their uses by people with spinal conditions,** including the NHS and other services outside hospital, hospital-based elective and emergency services, and use of diagnostics to understand the treatment that is required, highlighting any gaps in provision. This will inform the structure of the spinal network and align services with providers. As part of this, commissioners will wish to understand the demand for each procedure and the capacity required to meet this. An information pack is provided with this guidance giving activity information for each SHA and a suggested list of issues that commissioners and the clinical network may wish to consider in relation to current spinal activity (as defined in the information pack). The resource mapping should also include a review of the number of spinal surgeons (both orthopaedic and neurosurgeons) working in the service. Condition specific pathways and standards should be defined, for example time to surgery for intervertebral disc prolapse.

8. **Consider issues around training and education and consider how clinicians can best share training and education, audit and governance between primary and secondary care across the pathway and across organisations.** Issues that the network may wish to cover include:
   - The time available for shared clinical training and audit;
   - The assessment of spinal surgeons as defined by competence (rather than numbers of procedures undertaken alone);
   - Arrangements for post-CCT training (for example spinal fellowships and overseas postings). Two years fellowship training at post–CCT level is recommended by spinal societies;
   - The costs associated with speciality spinal training pre and post CCT (for example, courses on fresh cadaveric material are extremely expensive);
   - Mentorship of newly appointed consultants and provision of support from senior colleagues when first undertaking more complex procedures.

Concluding remarks

This report on improving the quality and effectiveness of spinal services has been developed by a clinical reference group at the request of the NHS as waiting times for spinal surgery continue to be longer than average waits across the country.

Adopting the good practice set out in this guide will assist NHS teams in organising, developing and ensuring the delivery of safe, effective and quality spinal services that meet with NICE clinical guidelines. This would create a set of services that deliver timely, clinically appropriate and cost-effective care that meets patients' needs, improves the overall quality of care they receive and enhances their general experience of the healthcare system in this area.

In order to deliver this model of high-standard and high-quality care/service for patients, it is recommended that a clinical network be established to advise on developing the right framework of services for the local population.

It is hoped that the recommendations made in this report will help local health communities organise and deliver the best quality and most effective spinal services for patients.

Appendix 1

Membership of the Spinal Taskforce & Acknowledgements

The Spinal Taskforce was formed in 2008 with representation from all the key stakeholders

Member	Designation
Mr John Carvell - Chair	Consultant Spinal Surgeon and British Medical Association (BMA)
Caroline Dove	NHS Elect
Piers Young	DH Musculoskeletal Team
Professor Charles Greenough	Professor in Spinal Surgery and NICE panels on MSCC and back pain
Mr Nigel Henderson	Consultant Spinal Surgeon, British Association of Spinal Surgeons (BASS) and Specialist Advisory Committee (SAC)
Mr Alistair Stirling	Consultant Spinal Surgeon, advisor on training and education - Royal College of Surgeons (RCS), British Orthopaedic Association (BOA)
Elaine Buchanan	Consultant Physiotherapist and NICE panels on MSCC and back pain
Dr Joan Hester	Consultant Anaesthetist and British Pain Society (BPS)
Dr Andrew Jackson	GP and Royal College of General Practitioners (RCGP)
Mr Jeremy Fairbank	Professor in Spinal Surgery and British Scoliosis Society (BSS)
Dr Geoff Hide	Consultant Radiologist and British Society of Skeletal Radiologists (BSSR)
Mr Tim Pigott	Consultant Neurosurgeon and Society of British Neuro-logical Surgeons (SBNS)
Susie Durrell	Consultant Physiotherapist
Maxine Foster	DH Workforce Team

For Appendices 2-7 please refer to supplementary documents:

Appendix 2	**Top tips for delivering 18 weeks for all spinal surgery**
Appendix 3	**Definition of a Combined Physical and Psychological programme (CPP) Programme in NICE Guidelines on Low Back Pain**
Appendix 4	**Top tips for the effective organisation of scoliosis services**
Appendix 5	**Spinal Specialised Services National Definition Set for both adults (part a) and children (part b)**
Appendix 6	**Summary of the national consensus on specialist and non-specialist surgery**
Appendix 7	**Example job description for a physiotherapy consultant (part a) and specialist nurse in spinal pain (part b)**

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Portsmouth
Clinical Commissioning Group
CCG Headquarters
4th Floor
1 Guildhall Square
Portsmouth PO1 2GJ
Tel: 023 9289 9500

5th June 2018

Cllr L. Madden
Chair
Portsmouth Health Overview & Scrutiny Panel
Member Services
Civic Offices
Portsmouth PO1 2AL

Dear Cllr Madden,

Update for Portsmouth Health Overview and Scrutiny Panel

This letter is intended to update you and the members of the Portsmouth Health Overview and Scrutiny Panel on some of work the Clinical Commissioning Group has been involved with over the past few months.

This formal update is in addition to the regular informal meetings with your panel colleagues which CCG colleagues and I attend, and which I hope continue to be useful for all concerned. Our website – www.portsmouthccg.nhs.uk – may provide some further details about what we do if members are interested, but of course we are always happy to facilitate direct discussions if there are particular issues which are of interest to the panel.

NHS 70th anniversary

The NHS is turning 70 on 5 July 2018, offering a perfect opportunity to celebrate the achievements of one of the nation's most loved institutions, to talk about the wide array of opportunities being created by advances in science, technology and information, and to thank NHS staff in all our organisations who are always there to greet, advise and care for us.

Local NHS organisations will be marking this anniversary over the coming month or so, helping us to reflect our pride in the NHS throughout the city.

As we all know, the NHS has delivered huge medical advances and improvements to public health, meaning we can all expect to live longer lives. It is thanks to the NHS that we have all but eradicated diseases such as polio and diphtheria, and pioneered new treatments like the world's first liver, heart and lung transplant.

None of this would be possible without the skill, dedication and compassion of NHS staff, as well as the many volunteers, charities and communities that support the service.

The history of the NHS is one of evolution, of responding to the changing needs of the nation. Today's NHS is rising to the challenge of a growing and ageing population, which means pressures on the service are greater than they have ever been. As the NHS turns 70, we are developing plans to address these pressures and make sure the NHS is fit for the future, such as our Health and Care Portsmouth blueprint.

Our key priorities locally reflect those nationally – the need to make it easier to see a GP, to improve cancer diagnosis and provide swift treatment, and making sure that mental health services and urgent and emergency care are available, and effective, whenever they're needed.

We can all play a role in supporting the NHS in this special birthday year. This could be by volunteering, raising money for local NHS charities, or even just taking steps to look after our own health and use services wisely.

2 Annual report

The CCG's annual report will be published in June. The report will provide a commentary on some of our main achievements over the past year, will consider our performance against important national and constitutional targets and reflect on our financial position for the year 2017/18. There are some positive stories to tell within a year of change and challenge and we will ensure that the report is made available to Panel members once it is published.

3 Health and Care Portsmouth

Panel members will be familiar, from previous discussions, that there are some big challenges facing NHS and care providers that can only be tackled by everybody working together.

We know that demand is increasing, but resources are limited. GPs, community, hospital and social care services are all under increasing pressure, whilst all are having difficulty with recruitment and retention of sufficient GP, nursing and therapy staff. This means that we need to meet these challenges by changing the way we work to ensure that clinical staff time is deployed as effectively as possible.

The Health and Care Portsmouth blueprint document set out the context for this and a plan for more effective joint working in future when it was published in 2015. Out of this came seven commitments to support the implementation of this ambitious programme.

Building on the effective working relationships that have been established over recent years, the Portsmouth Primary Care Alliance (PPCA – an alliance of all the GP practices in the city), Solent NHS Trust, NHS Portsmouth CCG and Portsmouth City Council (PCC) committed to work together to meet the challenges facing health and care services in the city.

Organisations were given encouragement, through the NHS Five Year Forward View, to develop an approach by which we can deliver stronger, more robust services through an ambitious integration of primary, community and social care and even some hospital services across the city.

This is, in essence, what sits behind the development of a multi-specialty community provider. Under this new care model outlined in the NHS five year forward view, GPs practices come together in networks or federations and collaborate with other health and social care professionals to provide more integrated services outside of hospitals. This might include GPs working with some specialists currently working in acute hospitals, as well as nurses, community health services and social workers.

These new models of care begin to dissolve the traditional boundaries between the delivery of these services as part of an agreed process of change. For us locally it is also something that can be developed in tandem with, and to meet the aims set out in, the Health and Care Portsmouth blueprint.

Developing a new type of integrated provider, combining primary, community and social care, also enables us to use resources more effectively and harness new ways of working, including making best use of digital technology, with the aim, as described above, of delivering stronger, more robust services that enable us to deliver the vision of the Health and Care Portsmouth blueprint.

It is vital that we address issues around increasing workload and reducing workforce and we can only really do that by doing things differently: proactive management of demand, especially from our older population and people with long term conditions such as diabetes and COPD. By changing the way we work, we will be able to reduce the reliance on secondary care. This may mean that we also have to rethink how some of the resources available to us (such as money, staff and buildings) are used, but in a way that makes sense.

Patients will benefit too, becoming more engaged, willing and able to manage aspects of their conditions themselves, with the support of an extended primary care team, personalising their care to meet their needs.

The four partners in the programme, the CCG, the Council, Solent NHS Trust and the PPCA have been working as a partnership to begin to deliver change through the MCP approach, acknowledging that other partners, including Portsmouth Hospitals NHS Trust amongst others, will have a role to play as the process unfolds.

The CCG's Governing Board recently received an update on progress over the past year against the seven Health and Care Portsmouth commitments – available here: http://www.portsmouthccg.nhs.uk/Downloads/Board/Gov%20Board%20Papers/2018/March%202018/AI09%20HCP%20Update%20_%20CCG%20Presentation.pdf.

4 Integrated Primary Care Service

One part of the move towards a more integrated system of primary care will come into effect in July.

From the beginning of that month, a new Integrated Primary Care Service (IPCS) will be introduced, meaning that a single provider (the Portsmouth Primary Care Alliance, the local federation of city GPs), will deliver three primary care components to supplement the 'core' in-hours primary care provision: out of hours; Extended Access, and the Acute Visiting Service.

This new approach takes advantage of the fact that the contracts for the home visiting, and the out of hours services, both expire in the coming months, Therefore, there is an opportunity to test out and develop new ways of delivering integrated primary care before the potential award of a longer term contracts such as the Multi-speciality Community Provider (MCP), in line with the NHS Five Year Forward View.

The new, integrated service will use a single IT system across all three elements, bringing benefits both to patients – who will be seen by clinicians who are able to see their records – and also to clinical staff – who will be able to make better-informed decisions about their patients. The change means that the out of hours GP service (providing booked appointments) will move from Queen Alexandra Hospital to the Lake Road Surgery. The 'walk in' Urgent Care Centre will continue to provide GP-led care at QA. More details about the change are provided in a briefing paper, which accompanies this letter.

5 Your Big Health Conversation

The second phase of the CCG's *Your Big Health Conversation* engagement programme is underway – building on the initial work last year which gathered feedback about a range of 'big picture' potential issues such as seven-day services, centralisation of specialist services, and concentrating more resources in community-based settings.
The latest phase is largely concerned with gathering feedback from face-to-face engagement sessions with patient groups, to inform the development of new models of care, especially outside major hospitals.

The work is going on throughout Portsmouth as part of the Health and Care Portsmouth programme, but will across be undertaken in surrounding CCG areas.

The CCG's Communications and Engagement team is organising a series of meetings to explore people's views on care in four specific areas – mental health, same-day access, frailty, and supporting those with multiple long-term conditions.

These areas were chosen because they affect a large number of people, and because changes to way these services are delivered in future are highly likely. In essence, the task is to set out the general direction of travel towards community-based, integrated care, and to seek in-depth feedback relating to what people is most important in terms of ensuring a good patient experience, what people's concerns are, and whether the local NHS needs to consider anything else as it develops its plans.

The meetings will continue taking place into the summer, and feedback from these discussions will be published and will be of significant help to us in planning the way care is delivered in future.

6 Gosport War Memorial Hospital/Gosport Independent Panel

The Gosport Independent Panel will publish its report about the historic concerns at Gosport War Memorial Hospital on 20 June. This will include a meeting with families of some of those patients whose deaths gave cause for concern at Portsmouth Cathedral on the morning of the 20th.

The national Panel was set up in 2014 and is chaired by Bishop James Jones, who also chaired the Hillsborough Independent Panel.

It was established to review documentary evidence across a range of organisations concerning initial care and subsequent deaths of older people at Gosport War Memorial Hospital from the 1980s through to the early 2000s.

Its terms of reference are here: https://gosportpanel.independent.gov.uk/terms-of-reference/ but, in essence, these were to: obtain, analyse, examine and oversee the maximum possible disclosure of all public documentation.

The report will provide an overview of information received and illustrate how the information disclosed adds to the public understanding of these events and their aftermath.

We are not expecting to see the report ahead of its publication but we do anticipate significant interest in this nationally and locally. We will provide further updates to the Panel once we know the findings of the report and the impact the report's publication has on the NHS locally, and nationally.

Yours sincerely

Dr Linda Collie
Clinical Leader and Chief Clinical Officer
NHS Portsmouth Clinical Commissioning Group

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NHS
Portsmouth
Clinical Commissioning Group

Integrated primary care service

Briefing for Health Overview and Scutiny Panel

Introduction

Access to primary care in Portsmouth, as with many areas across the country, is known to have been a challenge for some time.

The challenge is twofold – local residents seeking to access the services find them to be fragmented or hard to access, and the organisations providing the service experience difficulties in recruiting the required number of suitably skilled staff, and delivering timely care to patients.

A new approach is considered necessary to meet the needs of patients – where there is extensive engagement evidence to show that people find the urgent service 'offer' to be confusing and over-complicated – and to establish a more robust service model which can be delivered sustainably.

The proposal

NHS Portsmouth CCG is seeking to develop an integrated 24/7 primary care service through the provision of three interconnected services – out of hours, the Extended Access Service which was first introduced in 2017, and the Acute Visiting Service (AVS). This integrated service would be delivered by a single provider, rather than the split model which is currently in operation – the Portsmouth Primary Care Alliance of GPs delivering the AVS and Extended Access Service, and PHL delivering out of hours GP cover.

Using a single provider, the intention is to move towards a unified, streamlined Urgent Care pathway for out of hospital care, consolidating both the in-hours and out of hours provision of Primary Care.

The change is timely, because the contracts for both the AVS, and the out of hours provision, expire in the coming months. Therefore, there is an opportunity to test out and develop new ways of delivering integrated primary care before the potential award of a longer term contracts such as the Multi-speciality Community Provider (MCP), in line with the NHS Five Year Forward View.

Integrated primary care – how it will work

During traditional 'in-hours' periods patients will continue to access primary care services as normal, via their GP surgery. That remains as the foundation of local primary care, but the new service will include three important – and integrated – enhancements referred to above.

Firstly, during those traditional core hours (Monday-Friday, 8am – 6.30pm), the Acute Visiting Service (AVS) will operate, visiting patients in their homes to increase GP capacity, help to manage

the 'flow' of patients to acute hospitals, and reduce demands on the ambulance service. The AVS capacity will be able to flex, to meet demand. The service will be referred into by the patient's practice.

Secondly, the 'Enhanced Access' service will effectively extend the core hours of primary care well beyond the traditional times. Offering both routine and urgent appointments, the service can be booked into via a patient's surgery, or can be accessed outside normal in-hours either by the patient calling their surgery, or calling NHS 111. Patients will be triaged over the phone, and referred appropriately. The routine element of this service will run from 6.30pm – 8pm on weekdays, and 8am – 8pm on Saturdays. The urgent element of the service is operational from 6.30pm – 10pm on weekdays, and 8am – 10pm on Saturdays, Sundays and bank holidays.

Thirdly, for the (now shorter) remaining out of hours periods, the integrated service will be accessed via NHS 111. The service will include an overnight visiting service for this overnight period, when demands are lower.

Advantages of the new service

The proposed new service has a range of advantages over the current, more fragmented provision.

A fundamental improvement is that the integrated service will use SystmOne, the same IT system for recording and storing patient information that is now being used by GP practices across the city, and also by Solent NHS Trust, which provides community-based NHS services in Portsmouth. (The current out-of-hours service based at Queen Alexandra Hospital does not use this system, which has an impact both on the experience of the patient, and the ability of the clinician to deliver the best service.)

With a shared IT system, patients will benefit from being seen by clinical staff who can see their medical record – this not only improves the experience for the patient by avoiding the need to repeat their medical history unnecessarily, it also potentially shortens triage and appointments, and will reduce the need for people to be referred back to their own surgery. Clinicians will be more able, and more confident, to make informed decisions – a better, and safer, service staffed by clinicians who work in and know the Portsmouth system.

With greater provision of both routine and urgent appointments, the 24/7 integrated service – with evening and weekend availability, and direct telephone access - will mean that access to primary care is improved. That improved access during out of hours periods should also result in a smoothing out of peaks and troughs in demand throughout the week – for example, reducing some of the predictable demand for Monday morning appointments at GP surgeries.

The 'base' for the new out-of-hours service – a new location is required to benefit from using the SystmOne software – will be the GP surgery on Lake Road, rather than at Queen Alexandra Hospital, as is the case now. As well as the significant advantages delivered by a shared IT system (see above), this will also make the service more geographically convenient for the majority of the city population – approximately 77% of city residents using out-of-hours facilities at Queen Alexandra Hospital live in postcode areas PO1-PO5.

Engagement – what we know

There has been extensive engagement with local people regarding urgent and same-day care in recent years.
The proposal for an integrated primary care system has been developed in the light of a significant amount of intelligence about people's preferences and attitudes. Some of the key themes that the CCG has heard repeatedly in recent years are that Portsmouth residents…

…want the NHS to deliver a system which means they "tell their story only once". An integrated system using a single IT system is a major advance, meaning that clinicians do not have to start from 'square one' when they meet a patient.

…feel that the current system of urgent and same-day care is complex, and confusing. This change does not, in itself, address that issue in its entirety but it represents a move towards simplicity and stripping out complexity in the system.

…feel it is difficult to get an appointment at a GP surgery, which in turn can prompt people to use A&E instead. This service addresses that directly, by seeking to use the available workforce more efficiently, thus increasing the availability of GPs and other medical staff.

Next steps

The service is gearing up to 'go live' on 1 July.

The CCG is working with the Portsmouth Primary Care Alliance to develop a robust communications plan related to the introduction of this new, integrated service, with a view to both promoting awareness of the service and particularly the availability of appointments outside traditional working hours. The activity is likely to include, but not be limited to:

- Proactive promotion via the news media
- Information made available on CCG website
- Information prepared and disseminated for GP practice websites, including Q&A
- Briefing materials for frontline GP practice staff
- Posters for patient areas
- Social media activity

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healthwatch
Portsmouth

Healthwatch Portsmouth

Report to Health Overview and Scrutiny Panel

- Brief presentation on our activities April ‘17 - March ‘18
- But firstly, what do we do ?!

healthwatch helps people get the best out of their local health and social care services; whether it’s improving them today or helping to shape them for tomorrow.

Healthwatch Portsmouth
- what do we do?

- ✓ We **provide** people with information, advice and support about local health and social care services.
- ✓ We gather views and experiences from people on the way services are provided.
- ✓ We influence local services based on
  - the evidence we gather
  - through our position on the Health and Wellbeing Board
- ✓ We work with other Healthwatch organisations to build a national picture of people's views on health and social care services.
- ✓ We support and guide people wishing to make a complaint about NHS care.
- ✓ Local people run our organisation and get involved to improve services.

Healthwatch Portsmouth
- what we have been up to?

- Providing information and advice on access to services at Citizens Advice Portsmouth, talks, stalls, libraries, service directory, telephone support signposting

- Encouraging the community to engage with consultations – Pharmaceutical Needs Assessment, Portsmouth Clinical Commissioning Group's Big Conversation Phase 2, Healthwatch Hampshire's Maternity Matters, Adult Mental Health Crisis Service, eye services in Portsmouth, Healthwatch England Strategy 2018 - 23, Health and Wellbeing Board, Suicide Preventation Action plan, working with CCG to develop workable system for review of impact on patients following GP surgery mergers to see if benefits suggested have been realised, PHT Strategic plan 2018 - 2023

- Development of public engagement activities in relation to the Sustainability and Transformation Partnership to encourage local communities to have their say in the development of local health and care services in Portsmouth.

Healthwatch Portsmouth
- what we have been up to

We have a presence in the community:

- to gather feedback in hospital foyers, at community fairs, carers events, health information events in shopping centres, at Portsmouth City-wide Patient Participation Group, at Portsmouth Autism Community Forum.

- by receiving face to face feedback from the community we can provide intelligence to Healthwatch England combined with the themes we input onto our national feedback database.

We listen to issues raised and provide feedback to the scrutiny committees:

- strategic overview groups at Portsmouth Clinical Commissioning Group, Portsmouth City Council, Portsmouth Hospitals Trust, Solent NHS Trust,
- patient engagement forums, a mental health forum for Portsmouth and South East Hampshire, Healthwatch Portsmouth Board, carers groups.

- We make comments in the media, using patient feedback messages.

- We have increased our online traffic on our website and social media.

What have we been up to?
statutory functions: Enter and View Visit
Conducting independent surveys

Healthwatch Portsmouth volunteers and staff conducted 7 Enter and View visits to care homes to inform the Enhanced Health in Care Homes pilot project being developed by Portsmouth Clinical Commissioning Group. We also conducted an Enter and View visit with trained Healthwatch Portsmouth volunteers to a learning disability supported living service.

Healthwatch Portsmouth conducted community research

- on the identification of carers in GP surgeries
- 'mystery shopper' analysis of Portsmouth care home websites to find out how easy it is to find key information when wanting to choose a care home

- independent survey on person-centred care planning and personal budgets

Healthwatch Portsmouth supported University of Portsmouth student research:

- the transition of young people from CAMHS to adult mental health
- issues facing people with co-morbidities (poor mental health, diabetes)

What have we been up to
Scrutiny of progress made

Healthwatch Portsmouth were invited to attend progress board meetings at Portsmouth Hospitals Trust regarding the Care Quality Commission's required service improvements relating to safeguarding of adults and children.

We were invited to become Involved in Solent NHS Trust's Quality Improvement Project to consider how to improve their NHS complaint Local Resolution Meetings.

Our volunteers undertook Patient Lead Assessment of the Care Environment (PLACE) Assessments to QA Hospital, Spire Portsmouth, St Mary's Health Campus and St Mary's Treatment Centre.

Scrutiny of Portsmouth Clinical Commissioning Group proposed health care scenarios in order to provide initial feedback on service planning ideas.
QA Hospital Urgent Care Patient Discharge survey to look at issues affecting patients on discharge from hospital.

More scrutiny and governance activities

Healthwatch Portsmouth Board elections conducted for Board Members
Staff training organised on health and Safety, volunteer support & supervision

Preparation to be compliant with General Data Protection Regulations

Regular reporting to Portsmouth City Council (PCC), Learning Links Executive Team, responding to feedback from health providers regarding our processes.

A compassionate service in the independent NHS Complaints Advocacy Service was introduced for a volunteer to support the advocate on home visits to clients seeking compassionate support in which to express their complaint.

We reviewed our volunteering activities and set up a series of monthly drop-in meetings for our volunteers to plan for activities in the year, access information on health and social care developments and provide feedback.

We attend Health and Wellbeing Board meetings, Adult Safeguarding Board, quarterly meetings with the head of Adult Social Care and Portsmouth CCG, the Carers Executive Strategy Group, PCC/Care Quality Commission bi-monthly liaison meetings, Portsmouth CCG Primary Care Commissioning Committee, NHS England Quality Surveillance Group.

Key outcomes from our work

Through the independent NHS Complaints Advocacy Service:

- Parliamentary Health Service Ombudsman has upheld a complaint relating to a Trust's non-adherence to national guidance issued 2010 on neo-natal care.

- Healthcare Trusts writing to complainants to indicate how and where they are making changes to the way in which services are provided.
- Clients feel confident to discuss and resolve issues themselves directly.

Healthwatch Portsmouth :

- Co-produced with Portsmouth Clinical Commissioning Group patient health outcomes which will form part of their commissioning of a future Multi-speciality Community Provider contract.
- We encouraged Portsmouth City Council (PCC)to run a patient survey in advance of the Pharmaceutical Needs Assessment consultation to gain wider feedback.
- Portsmouth Hospital Trust delivered a comprehensive training programme to all participants in preparation for the Patient Led Assessment of the Care Environment (PLACE) visits to hospital wards after feedback from our volunteers
- PCC altered Health and Wellbeing Strategy to include a jargon buster explainer and a Frequently Asked Questions sheet.

Contact:

Siobhain McCurrach, Project Manager
(02393 977 079)
Siobhain.mccurrach@learninglinks.co.uk

Any questions?

www.healthwatchportsmouth.co.uk