Portsmouth CITY COUNCIL

Public Document Pack

NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

WEDNESDAY, 28 NOVEMBER 2018 AT 10.00 AM

THE EXECUTIVE MEETING ROOM - THIRD FLOOR, THE GUILDHALL

Telephone enquiries to Joanne Wildsmith, Democratic Services Tel: 9283 4057
Email: joanne.wildsmith@portsmouthcc.gov.uk

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

Health and Wellbeing Board Members
Councillors Matthew Winnington (Joint Chair), Gerald Vernon-Jackson CBE, Luke Stubbs, Rob Wood and Leo Madden
Innes Richens, Dr Jason Horsley, Mark Cubbon, Dr Linda Collie (Joint Chair), Ruth Williams, Dianne Sherlock, Sue Harriman, Alison Jeffery, Andy Silvester and Siobhain McCurrach

Dr Linda Collie (Joint Chair)
Plus one other PCCG Executive Member: Dr Elizabeth Fellows , Dr J. Lake, Dr A Eggins and Dr N Moore

Portsmouth Councillor Standing Deputies:

(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

Deputations by members of the public may be made on any item where a decision is going to be taken. The request should be made in writing to the contact officer (above) by 12 noon of the working day before the meeting, and must include the purpose of the deputation (for example, for or against the recommendations). Email requests are accepted.

A G E N D A

1 Apologies for absence

These include Diane Sherlock, Mark Cubbon and Councillor Luke Stubbs.

2 Declarations of Interest

3 Previous Minutes - 3 October 2018 and Matters Arising (Pages 5 - 10)

RECOMMENDED that the minutes of the Health and Wellbeing Board meeting held on 3 October 2018 be agreed as a correct record.

4 Portsmouth Safeguarding Children's Board - Annual Report 2017/18 (Pages 11 - 44)

The Portsmouth Safeguarding Children's Board (PSCB) Annual Report will be presented by the independent Chair Richard John.

RECOMMENDED that the content of PSCB annual report 2017/18 be noted.

5 Portsmouth Health & Care Operating Model (Pages 45 - 58)

Innes Richens, Chief Operating Officer, to present this CCG discussion paper.

The Health and Wellbeing Board is requested to support the RECOMMENDATIONS of:

- Establishment of a single operating model for Health & Care Portsmouth between PCC and CCG
- Establishment of a committee on behalf of PCC and PCCG for its commissioning of adult and children's health, social care and public health services
- Integration of PCCG and PCC functions into joint roles: Chief of Health & Care Portsmouth, Director of Children's' Services and Director of Public Health
- Review and reconfigure the structures and existing capacity under these roles to ensure capacity is available to deliver Health & Care Portsmouth whilst recognising the need to achieve running cost efficiencies
- A review of other enabling functions to assess the benefits of further integration to support delivery of the Health & Care Portsmouth operating model – specifically financial management, business intelligence, communications/engagement, community sector partnership development
- Direct the respective Accountable/Chief Executive Officers, working within their scheme of delegations and constitutional powers, to review the management and staffing structures currently in place in order to align this capacity with the new Health & Care Portsmouth operating model and for this to include cost-share arrangements.

6 Hampshire & Isle of Wight (HIOW) Sustainability Transformation Partnership (STP) System reform paper (Pages 59 - 106)

The Health and Well Being Board are asked by the STP to consider 'The System Reform Statutory Board Pack' (see attached documents). These will be presented by Sue Harriman (Chief Executive, Solent NHS Trust) and Innes Richens (Chief Operation Officer CCG and Director of Adult Social Care, PCC).

The system reform proposals have been developed by the Hampshire and Isle of Wight Sustainability and Transformation Partnership (STP) Executive Delivery Group (EDG).

The attached document summarises the proposals developed over the Summer for consideration by all NHS provider board, CCG Governing body and local government cabinets at their respective meetings over the autumn of 2018.

For ease of consideration the **recommendations** made throughout the document have been pulled out into the separate note for the Board's reference.

Whilst the general direction of travel is uncontentious and the recommendations, as written, provide for considerable flexibility, the Governing Board will wish to consider the most effective way to develop the approaches set out, ensuring that any potential duplication of effort or source of confusion between the various layers of operation is minimised.

Specific work will be undertaken to develop the individual recommendations in due course – and approvals sought from the appropriate Boards and organisations as and when appropriate.

7 Date of next meeting

The next HWB meeting is scheduled for 13th February 2019 at 10am.

NB - at the conclusion of this meeting (11.30am onwards) members of the HWB are invited to attend an informal session to discuss an action plan for tackling Childhood Obesity, to be led by Dr Jason Horsley in a separate venue.

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

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HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING of the Health and Wellbeing Board held on Wednesday, 3 October 2018 at 10.00 am in Conference Room A, Civic Offices, Portsmouth.

Present

Dr Linda Collie (in the Chair)
Councillor Matthew Winnington
Councillor Gerald Vernon-Jackson CBE
Councillor Luke Stubbs
Councillor Rob Wood
Councillor Leo Madden (non-voting)

Innes Richens
Sue Harriman
Alison Jeffery
Dr Nick Moore
Lois Howell (for M Cubbon)
Jackie Powell(for A Silvester)
Dominique Le Touze (for Dr Horsley)

Officers Present

Kelly Nash & Joanne Wildsmith

47. Apologies (AI 1)

Apologies for absence had been received from Mark Cubbon (represented by Lois Howell), Andy Silvester (represented by Jackie Powell), David Williams, Siobhan McCurrach and Dr Jason Horsley (represented by Dominque Le Touze).

48. Declarations (AI 2)

Councillor Rob Wood declared that his daughter works for Motiv8, which was a non-pecuniary interest for him.

49. Previous Minutes - 20 June 2018 (AI 3)

Matters Arising:

- minute 43 Joint health and wellbeing strategy monitoring framework -It was confirmed that alcohol and poisoning were both coded causes of self-harm hospital admissions for 10-24 year olds

- minute 45 Drug Related Harm - it was reported that the contract with the Society of St James had been reduced.

Accuracy:

- minute 44 Portsmouth Blueprint, 3rd line of page 4 should read "reduce the target further **down"**

RESOLVED with the above correction that the minutes be approved as a correct record.

50. Membership Update (AI 4)

It was noted that the new Healthwatch Portsmouth representative for HWB was Siobhain McCurrach.

51. Trafalgar Medial Group Practice and The Eastney Practice Merger (for info) (AI 5)

This information item was noted.

52. Blueprint for Health and Care in Portsmouth (information report) (AI 6)

Innes Richens had made a full presentation at the previous meeting, so this was a short update. In answer to a question on the SEND Hub Kelly Nash reported that the co-location of support services for families was being investigated.

53. Partnership Working (AI 7)

Innes Richens presented David Williams' report, explaining the background to moving to a new partnership arrangement which would also require an expanded membership to cover Health and Wellbeing, the Safer Portsmouth Partnership and the Childrens' Trust Board. It was envisaged that the new body would meet 3 times a year, but here could be conferences too on the themes of both "people" and "place". The structures of the 3 bodies would continue so that the sub committees would remain in place.

There would need to be a further paper on the revised terms of reference (due to be brought to the November HWB meeting) and this would need to go to PCC's Council for approval.

The following questions and comments arose:

- Whilst the body would evolve to include a wider membership, as the Health Wellbeing Board is a statutory body the revised terms of reference would require council approval
- The structures for each body's sub committees would remain in place
- The follow-up report on the structures would need to reflect the strategic level of joining up the 3 bodies and detail the statutory reporting requirements

- With only 3 meetings to deal with the business of 3 bodies would the agenda be manageable? Innes responded that the intention was for strategic priorities to receive full debate.

RESOLVED that the Health and Wellbeing Board agreed the proposals for a revision of partnership structures in Portsmouth, including revision to the remit of the Health and Wellbeing Board.

54. Director of Public Health's Annual Report 2017 (information report) (AI 8)

Dominique Le Touze presented Dr Jason Horsley's annual report as the Director of Public Health on the subject of childhood obesity, setting out a coordinated approach to tackle the issue in the city and which also reflected national concerns. The report set out the mapping of data in Portsmouth and work taking place to try to change behaviours on a small group and individual basis as well as focusing on wider determinants of food and exercise (to include how movement takes place around the city and designing a walking city).

The following comments and questions were raised:

- the need to understand what children think and how to influence their behaviours, also targeting the parents - it was reported that the 'You Say' survey was being used for feedback
- the difficulty in countering national external influences, such as food promotions
- learning lessons from elsewhere (the examples from Finland and Germany) and working with other departments to achieve the joint aims
- the two local case studies provided useful and positive stories
- the positive outcomes were noted, although one member was concerned about straying into "nanny state" territory
- it was noted that whilst this is an independent report by the DPH it should be taken forward for further joint working with other departments and organisations to sign up to; a joint plan arising from this would mean a co-produced solution

Dominique Le Touze responded that the preparation of this report was a statutory responsibility for the Director of Public Health, but stemming from it the joint action plan would be useful.

RESOLVED that as well as noting the publication of the Director of Public Health's annual report, the HWB members invited Dr Horsley to consult partners in bringing forward a broad plan of key issues, and this should be brought to the attention of PCC's Cabinet.

55. Adult Social Care Challenge (presentation item) (AI 9)

A presentation was made by Innes Riches as PCC Director of Adult Services, Angela Dryer (Assistant Director) and Richard Webb (Finance Manager) entitled 'Adult Services - Sustainability Strategy' - the presentation slides would be made available on the website as part of the record for the meeting. They set out the challenges locally in the context of national picture which included:

- Rate of admissions for people aged 65+ higher per 100,000 population than national and regional picture in 2016-17
- 71% of new service users aged 65+ who received a reablement service, went on to receive either a costed package of care or equipment /adaptation
- 61% of new service users aged 65+ who requested support were discharges from hospital
- Domiciliary care weekly average costs are rising, package volumes are increasing and people are receiving services for longer
- Overall cost basis at average package / placement levels present lower than national / regional but there are hidden costs in terms of numbers entering services, longer term use of resources, models of supported living, and increasing use of PCC bed base provision for short term use
- Draft accommodation strategy data analysis shows supply of residential and nursing home care exceeds demand and will continue to do so even with demographic changes
- The quality of residential and nursing homes in Portsmouth is a concern with a higher % of homes rated Inadequate or Requires Improvement by The Care Quality Commission regionally and nationally
- Work identified through various interventions has evidence of ineffective processes and systems, driving duplication and significant waste

PCC has been successful in supporting more people to live independently at home and in the community, but the main challenges remained quality of care (although CQC ratings were improving), affordability and the cost of the workforce at a time of budget overspending. Richard Webb explained the financial pressures (slide 4 showed a projected national gap between expenditure and funding of £9bn for local authorities by 2019/20[1]) and Older Persons Physical Disability (OPPD) client volume trends showing increased demands, especially in domiciliary care.

Angela Dryer reported on the 3 key drivers to address this problem:

- Enabling a higher proportion of people to help themselves earlier and empowering them to be more resilient and live independently

[1] University of Birmingham study May 2017

- Providing the right support for the right period of time, to ensure that people continue to be independent

- Providing care and support (including when we provide residential care) by working across the Local Authority, other public, private, voluntary, health and care economy organisations, to ensure quality and affordability

She stressed the importance of individuals' choice in making informed decisions affecting their later life. Affordability would also be aided by the use of technology, where appropriate. Care at home would also help to reduce hospital admissions.

Innes Richens concluded that the message was to be ambitious and brave in making improvements, seeking support and involvement when changing services.

The following issues arose from the presentation:

- The transition phase from child to young adult is not always addressed
- What use of technology was envisaged? This including sensor movement systems (such as 'Just Checking'), medicine management, possible systems like 'Alexa', tracking shoelaces (with consent), gas monitoring sensors etc. It was reported that the take-up of Telecare systems used by PCC depended on the availability of suitable responders, which may need further exploration regarding the use of trusted volunteers. The need to continue human support too was emphasised.

- The implications of and preparation for reduced access for EU workers earning under £30k to the care system - work was taking place with care associations on this and the impact would not be seen immediately

- A restorative approach across health and social care was evident for the whole family in supporting people to make their own choices

- Minimum wage implications for night staff in care homes and use of technology there - it was reported that sensor systems were used at night and a 12 week project analysis had taken place to look at the necessity of waking night staff to be based at residential homes, as well as considering the safety issues. Funding for the sleep-in staff was being investigated and further updates from government were awaited.

- The low take-up of direct payments was acknowledged, partly due to the tax and National Insurance implications and finding carers the people knew and trusted.

- The role of early intervention to help address the pressures on emergency care - PCC Adult Services had an Independence and Wellbeing team to coordinate groups for older persons to help enable

them to help themselves (such as cookery classes, healthy walks, allotments, 'Men in shed' schemes etc.). The Housing Service also involved at involvement in dementia friendly schemes.

56. Complex Needs (AI 10)

Dominque Le Touze, Public Health Consultant, presented the Director of Public Health's report.

In response to a question from Councillor Madden on the consultation process Kelly Nash reported that information from the rough sleeper strategy would be made available to him. She also explained the aim of gathering intelligence for commissioning purposes and to strive to unblock any barriers.

Councillor Winnington asked that members encourage as many people as possible to respond to the consultation.

RESOLVED that the Health and Wellbeing Board

(1) Endorsed the development of the "Team around the Establishment" model linked to homeless and supported housing services, and agreed to receive further progress reports;

(2) Endorsed the need to move forward with data-matching and case study exercise, to enable conversations with information governance officers of relevant organisations to move forward.

57. Dates of future meetings (AI 11)

The dates of the next meetings of 28th November and 13th February were noted, to commence at 10am.

It was suggested that an item on System Reform Plan be brought to one of these meetings.

The meeting concluded at 11.35 am.

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Dr Linda Collie
Chair

Annual Report 2017-18

Portsmouth Safeguarding Children Board

Safeguarding is everybody's responsibility

This report gives an overview of the work of the Portsmouth Safeguarding Children Board (PSCB) from April 2017 to March 2018; showing what our plans were, what we achieved and what further work needs to be done to strengthen safeguarding arrangements and promote the welfare of the children of Portsmouth.

The PSCB Independent Chair is required to produce an Annual Report which evaluates the partner progress against the Business Plan and to demonstrate that the statutory requirements of the Board have been met. You can read more about the PSCB and the business unit at our website: **www.portsmouthscb.org.uk/**

Foreword … from the PSCB Independent Chair, Dr Richard John

'This is my first report as the new chair of the Portsmouth Safeguarding Children Board (PSCB) having taken over from Reg Hooke on the 10th September 2017. I would like to take this opportunity to thank Reg for his hard work and commitment in working with our partners and community to keep children safe in Portsmouth.

The PSCB is a statutory partnership that works with agencies, including but not exclusively health, police, social care, education, probation and the voluntary sector to safeguard and promote the welfare of children in Portsmouth. The future arrangements of the PSCB are currently under review in line with the Children and Social Work Act 2017. This will ultimately present some challenges and changes, however, it is important to highlight that any changes will be made with the full consultation of our partners and the safety of children of Portsmouth will remain at the heart of any variation of local arrangements.

This report summaries a year's work and indicates opportunities, risks and our collective priorities. Listening to voice of the child and our community is key to us. Having listened to the views of one of our care leavers we have changed our website and invite you to visit our site. We have worked hard to promote and deliver a culture of restorative outcomes through training and workshops and continued to undertake a broad range of audits within our partnership organisations which have presented an excellent platform for identifying best practice for sharing and reflective learning.

Children in a modern society face a number of challenges and our priorities reflect this. I am proud to work with such committed and dedicated professionals who are resolute to keeping children safe in Portsmouth within a changing and complex environment.'

Portsmouth Safeguarding Children Board
Annual Report 2016-17

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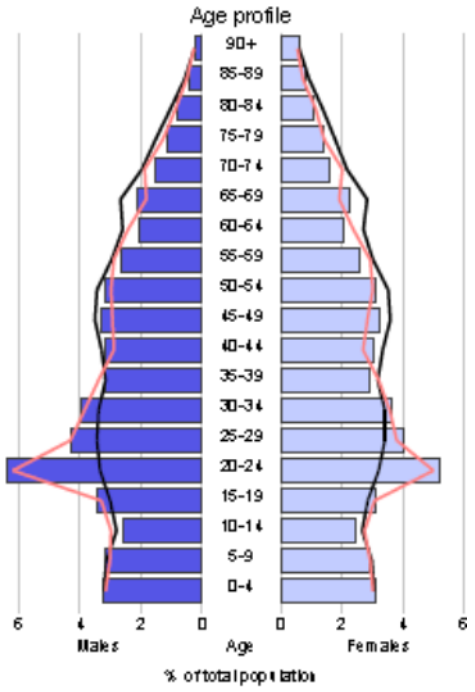
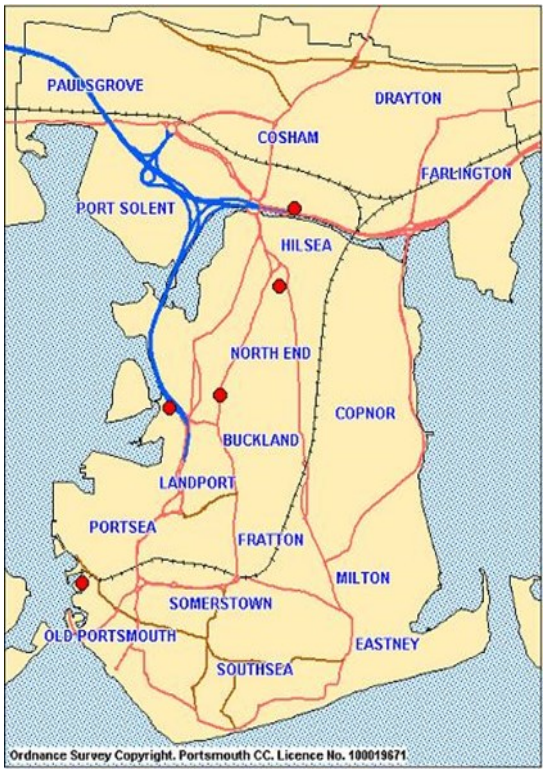
Introduction

The City of Portsmouth

Portsmouth is a port city situated on the southern coast of Hampshire. The city area spans just 15.5 square miles, with a population of approximately 209,000[1] it is recognised as being the most densely populated area in the United Kingdom outside of London.

Population by Age Group





The Children of Portsmouth

Approximately 43,990[2] children under the age of 18 years live in Portsmouth; this is 20.6% of the total population in the area. Portsmouth is one of the 20% most deprived local authority districts in England with 7,535 (20.3%) of children under the age of 16 years living in low income households.

Portsmouth has a relatively high proportion of Armed Forces personnel resident in the city, with 2.3% of the adult population compared to the England average of 0.3%.

Children and young people from minority ethnic groups account for 20.1% of all children living in the area, compared with 21.6% in the country as a whole. The largest minority ethnic groups of children and young people in the area are Mixed Ethnic Group: White and Asian (3.5%), Asian/Asian British: Bangladeshi (3.5%) and White: Other White (2.9%). After English, Bengali and Polish are the most common languages spoken in Portsmouth schools

In January 2018 there were 25,298 children on roll at schools in Portsmouth in years R to 11. Of these:

- 4,752, 18.8% were registered as being eligible for free school meals on census day[3].
- 4,262, 16.8% of pupils in Portsmouth did not have English as their first language. After English, Bengali and Polish were the most common languages spoken in Portsmouth schools
- 3.8% of Portsmouth pupils had a statement or Education, Health and Care Plan. This compares to a national average of 2.9% and an average of 3.0% across the south east region[4]

[1] Hampshire County Council: Small Area Population Forecast
[2] Public Health England: Public Health Outcomes
[3] Includes all pupils at state-maintained schools, free schools, city technology colleges, studio schools, direct grant nursery schools
[4] https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2018

The Board

Statutory Duties and Functions

The functions undertaken by the PSCB are set out in Chapter 3 of Working Together to Safeguard Children issued in March 2015. Regulation 5 of the LSCB Regulations 2006 sets out in detail the functions of an LSCB, the core objectives are set out as:

- to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established; and
- to ensure the effectiveness of what is done by each such person or body for that purpose.

What is the Portsmouth Safeguarding Children Board?

The Board is made up of representatives from local statutory and voluntary sector agencies that work with children and their parents or carers and 3 long-standing Lay Members. The Board is led by an Independent Chair whose role is to hold agencies to account.

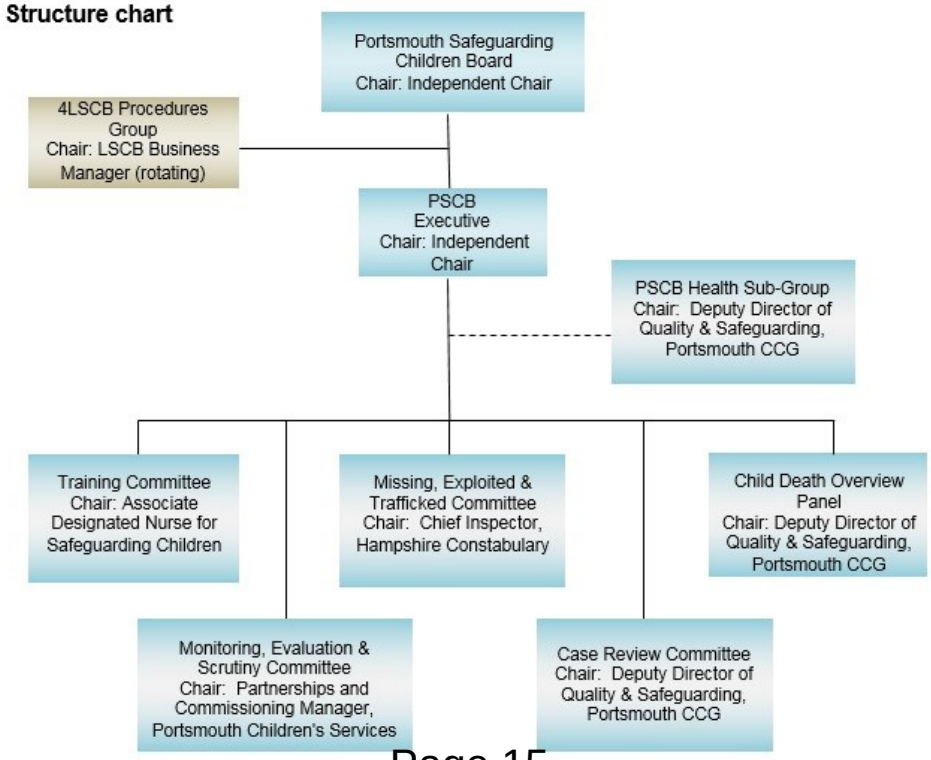
It is the responsibility of the Local Authority Chief Executive to appoint the Independent Chairperson (with the agreement of a panel including LSCB partners and Lay Members) and to hold the Chairperson to account for the effective working of the PSCB. In order to provide effective scrutiny, an LSCB should not be subordinate to, nor subsumed within, other local structures.

The Board agrees a Business Plan each year which ensures its functions are fully carried out and improvements can be progressed which arise from local and national learning. The main Board meets 4 times during the year with an additional development day in March to review the progress of the Business Plan over the previous year, and to agree the priorities for the forthcoming year.

A significant amount of the PSCB's work is undertaken by the Executive Group and Committees. These help to progress many of the detailed actions in the PSCB Business Plan

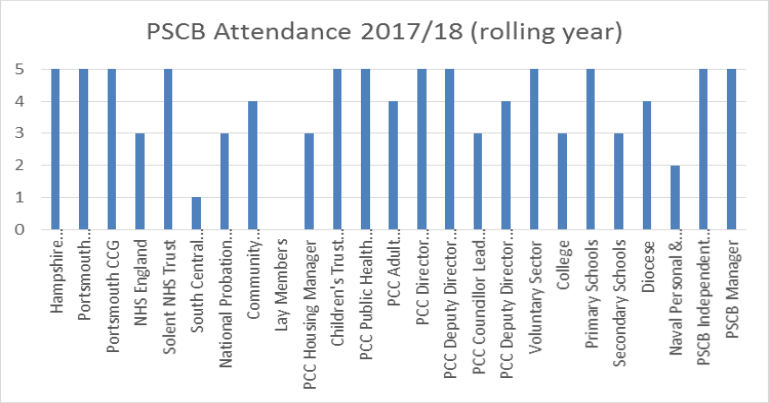
The Executive Group and the Committees are accountable to the Board and this is reflected in the terms of reference of each group. The Committee's Chairs are all Executive Committee members and report routinely at the main Board

Structure chart



Membership and Attendance

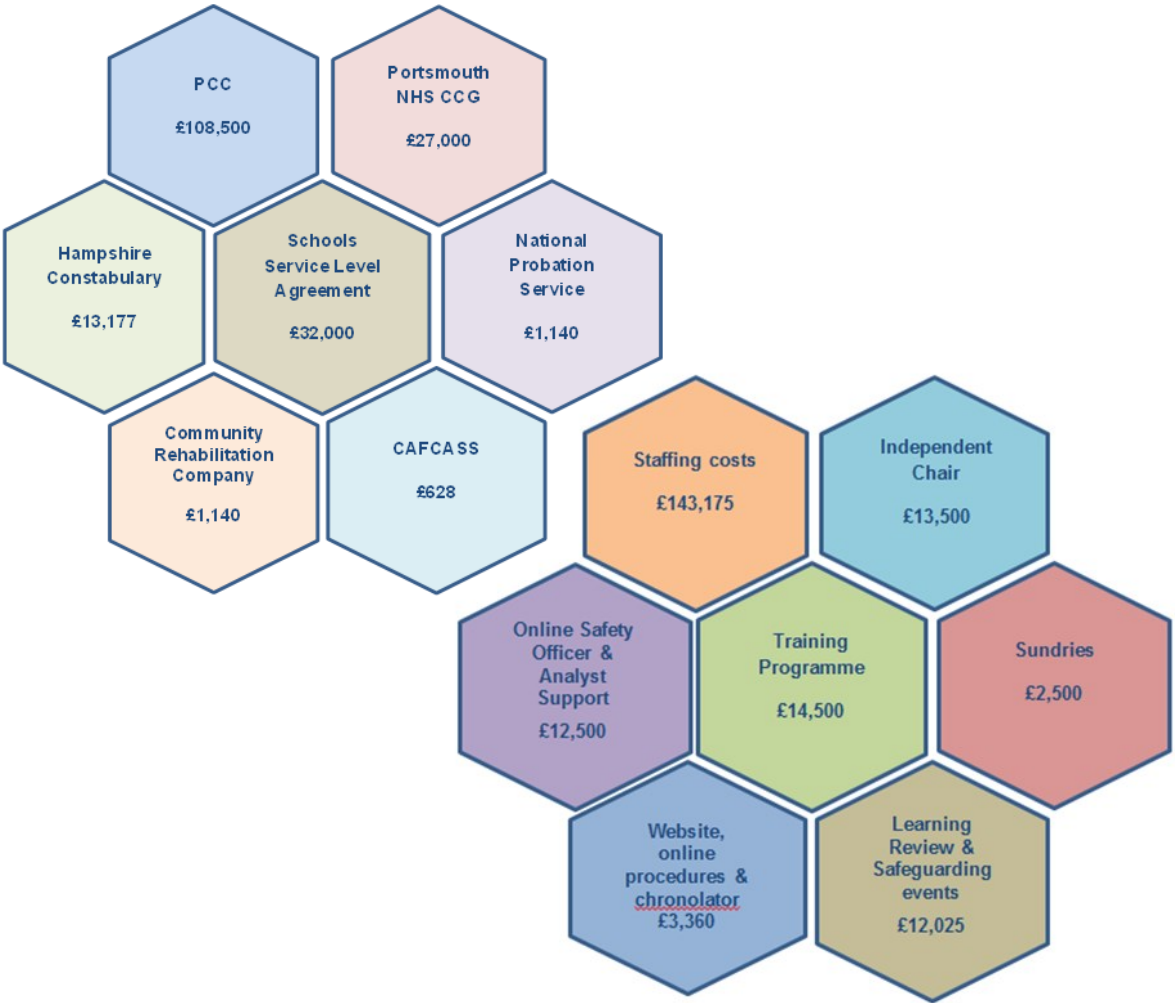
A list of the statutory and non-statutory Board members as at 31 March 2018 and their attendance is shown below. We are confident the Board is represented by the right local statutory and voluntary agencies who are engaged appropriately in the Committees.



Financial Arrangements

The Safeguarding Board is jointly financed by contributions from partner agencies, with the largest proportion coming from the local authority. The Board has again successfully managed a balanced budget, despite there being no change in member contributions for 5 years. All PSCB member organisations have an obligation to provide resources (finance and in kind) to enable the PSCB to be strong and effective

Income total = £183,585 + £60,163 (carry forward from 2016-17) = £243,748



The Business Plan

In April 2017 the PSCB published a new 2 year plan which set out the focus and planned ambitions of multi-agency safeguarding activity in Portsmouth, to ensure that **children and families in Portsmouth have access to the right support at the right time**.

The plan seeks to ensure that while the PSCB continues to oversee and drive improvements in its "core business" through which significant numbers of children are safeguarded, it also seeks to ensure that we maintain an overview of safeguarding issues which affect particular groups of vulnerable children and young people. We continue to learn more about the nature and scale of problems such as child sexual exploitation; radicalisation; the impact of living with domestic abuse etc., and the PSCB needs to ensure that multi-agency responses to these and other issues are child focused, informed by national and learning, and are proportionate and effective.

The PSCB Business Plan 2017-2019 is intentionally brief and focused on **strategic priorities** that form the basis of the work of the Board over this period**.** These priorities support the statutory functions of the PSCB and the partnership response to protecting vulnerable children and young people, preventing harm and promoting their welfare.

In developing our plan we took into account various strategies and the priorities of our partners to ensure that we have a holistic approach that adds value to safeguarding Portsmouth's children and young people. This plan is set in the context of other multi-agency plans held by Portsmouth's Childrens Trust, Portsmouth Safeguarding Adults Board and Safer Portsmouth Partnership.
The priorities were agreed based on the issues identified as having a significant impact on the safety and wellbeing of children in Portsmouth. These priorities are driven and informed by:

- Consultation with members of the PSCB about progress with existing priorities and developing areas of concern
- The statutory functions of the PSCB
- A review of the Business Plan for 2014/17
- Learning from the PSCB dataset, local and national case reviews, audits of practice reports to the PSCB and scrutiny of issues by the Board
- Discussion with groups of children and young people

Priorities for 2017-18 and how we delivered against them

1. Children Experiencing Neglect

The PSCB reviewed the findings of Ofsted's national thematic inspections of neglect and noted their finding that 'the local authorities providing the strongest evidence of the most comprehensive action to tackle neglect were more likely to have a neglect strategy and a systematic improvement programme addressing policy, thresholds for actions and professional practice'. As such the Board worked with its partner agencies to develop a multi-agency strategy for Portsmouth to coordinate and focus the work of partner agencies with families where neglect is an issue.
The objectives of this strategy are:

- To strengthen local responses in line with current national and local guidance, policies and good practice
- To ensure families receive a coordinated response from those who work with them and their children.
- To adapt, rather than duplicate, existing guidance, policies or procedures to tackle neglect.
- To raise awareness and improve the safeguarding duty of all relevant agencies with regards to neglect

Priorities for 2017-18 and how we delivered against them

We revised the neglect tools used by the workforce to ensure they were relevant for children at all developmental stages, and covered emerging issues such as childhood obesity being considered as neglect. The practice guidance that supports the identification and response to neglect was updated to include a guide to recognising the severity of neglect, to support the workforce in identifying the appropriate response as the right time for the child.

During Safeguarding Week in November 2017 three workshops were held to update the workforce on the neglect tools and practice guidance, covering how and when to use these and how they can support work with families where neglect is a feature. There was also a whole day conference that focused on 3 of the key issues identified by the workforce that they wanted more support and/or information about. These were:

- Working with resistant families and addressing disguised compliance
- The role of the Early Help & Prevention Service in address emerging issues of neglect
- The impact of diet and obesity on a child's well-being

The Board has worked with the Local Authority, Police and health agencies to agree a set of indicators to add to the existing dataset, to enable monitoring the impact the implementation of the strategy and revised tool has on outcomes for children. It is planned that during 2018-19 the Board will undertake an audit of the quality of Early Help Assessments to consider how well emerging indicators of neglect are being identified and responded to.

2. Missing, exploited and trafficked children

The PSCB have worked with the LSCBs in Hampshire, Southampton and the Isle of Wight to produce a pan-Hampshire Missing, Exploited and Trafficked (MET) Children Information Guide for the workforce. This builds on the previous MET Protocol and includes information on Child Sexual Exploitation; Children Missing from Home, Care and Education; and Trafficked Children; but now also covers Child Criminal Exploitation, County Lines and Internal Trafficking. It is a comprehensive multi-agency information and procedure document to direct practitioners working with children affected by these issues. By producing this as a pan-Hampshire document it ensures there is clear guidance for all those working in the local area, but also consistency of recognition, identification and response to MET children by those who work in our partner agencies that cover 2 or more of these LSCB areas.

To ensure there is a clear focus on the identified issues for children in Portsmouth, the PSCB MET Strategic Committee have reviewed the MET Strategy and set the 3 priority areas in Portsmouth:

1. Exploitation - CCE and threat/risk from county lines, including links to CSE
2. Unaccompanied asylum seeking children and trafficking (including internal trafficking); and
3. Risk of radicalisation - the links between this and other forms of exploitation

Within this, two key themes will focus the work in these areas:

i. Neglect and deprivation (Adverse Childhood Experiences); and
ii. The use of technology to facilitate exploitation and safeguarding in a cyber enabled society.

In December 2017 the pan-Hampshire LSCBs organised and delivered a pan-Hampshire conference introducing the emerging threat to children of their criminal exploitation by Organised Crime Gangs. This included lived experiences of gang members who were exploited as children and now work to divert children who are vulnerable to exploitation. It was attended by over 200 practitioners from across all sectors. This event was followed up by two workshops in Portsmouth attended by 210 practitioners in February 2018. These were organised by Active Communities Network and gave an update from Hampshire Constabulary on their operational activity to address CCE; and a presentation from the Boarders Project to give workers more information on the impact of CCE and how they can help young people involved in CCE.

Given the growing numbers of children being identified as having been trafficked, the PSCB commissioned Barnardo's who operate the Independent Child Trafficking Advocacy (ICTA) Service to offer workshops during 2018 to particularly raise awareness of internal trafficking and the ICTA Service. The first of these was held in February 2018 with a further 2 commissioned for later in the year.

Priorities for 2017-18 and how we delivered against them

The MET Strategic Committee also identified that children from ethnic minority communities were under-represented in those identified at risk of CSE. Therefore the PSCB commissioned the specialist BME worker with Barnardo's to deliver 2 sessions for practitioners specifically aimed at raising awareness of CSE within ethnic minority communities. These sessions will continue to be delivered over 2018.

In addition to these bespoke workshops, the PSCB continues to offer both a taught and an online course on Working with Exploited Children. This course has been reviewed and updated throughout the year to include information on criminal exploitation and county lines.

The MET Committee are working with services and agencies to ensure that relevant data is available to allow members to consider how effective the MET Strategy is. This has included identifying relevant data from education; working with Children & Families Service and Barnardo's to revise the information available from return interviews with missing children; and the Police MET and FIB Teams identifying what data and information can be shared on perpetrators and the prosecution of these.

A short-life task group was developed under the MET Strategy Group to look at the processes and procedures for supporting children in Portsmouth who had gone missing from home and were identified as being a 'medium risk'. This group was established following Hampshire Constabulary's decision that their MET Team would focus on the priority (high) risk children, it was agreed that a pathway for management of medium risk children needed to be developed. This group agreed that Neighbourhood Police Teams will take on oversight of these children and work with Locality Teams and other relevant professionals to respond appropriately to these children. This will allow more effective ownership within Neighbourhood Policing Teams, Locality Teams and Barnardo's to deliver joined up planning.

Given our emerging understanding of criminal exploitation of children, the MET Committee is engaged with a review of the Portsmouth CSE Risk Assessment Tool alongside pan-Hampshire colleagues and Barnardos. This group will use tools, data and profiles from across the teams to develop a mechanism for the assessment all types of child exploitation. This will be supported by academic oversight and include consideration of the impact of adverse childhood experiences and trauma

3. Children Affected by Domestic Abuse

The PSCB are represented on the Domestic Abuse Strategy Group and the Commissioning Group for Portsmouth by the PSCB Safeguarding Partnerships Manager, to ensure that there is a sharp focus kept on the impact of children caused by domestic abuse. During the year this has included highlighting concerns about the apparent drop in the number of referrals from health services to domestic abuse services and by the PSCB presenting a report to the Safer Portsmouth Partnership asking for their support to raise this issue. Solent NHS Trust and Portsmouth Hospitals Trust are putting action plans in place to ensure that Health Visitors and Midwifes are routinely asking whether domestic abuse has taken place; that appropriate risk assessments are completed; and referrals made to Domestic Abuse Services where appropriate.

The PSCB also requires assurance by the Safer Portsmouth Partnership of the effective delivery of the objectives within the Domestic Abuse Strategy in driving improvement to practice and outcomes. During 2017-18 a pilot was launched in the North Locality (funded by the Violence Against Women and Girls strategy) introducing a new model of intervention for parents whose children have a child protection plan where both parents are using unhealthy behaviours within their relationship and it is clear that the current victim and perpetrator intervention is not appropriate. This has strengthened the partnership between specialist DV provision and child protection processes and is designed to keep more children in the family home and in a safer environment.

The PSCB aims to raise professional awareness regarding the impact of domestic abuse on children to ensure they are appropriately identified, protected and supported. This is achieved by supporting multi-agency attendance on a specialist taught course delivered by the specialist Domestic Abuse Service. Both this specialist course and the PSCB Safeguarding Training give the same message about quality assessments to identify individual need resulting in bespoke plans to meet those needs. Within the PSCB Child Protection course domestic abuse case examples are embedded to support learning.

The PSCB has supported the pilot and subsequent introduction of Operation Encompass into Portsmouth. This scheme means that Hampshire Constabulary send a notification to the child's school when they have responded to a domestic abuse incident in their household the previous day. This allows the school an opportunity to provide immediate support as well as consider longer term needs for the child.

PSCB Safeguarding Training

During 2017-18 1,889 delegates have attended PSCB courses:

- **1,306** spaces were filled on the **multi-agency and eLearning modules**
- **583** delegates were taught in **single agency settings**

The attendance figure shows an overall 31% decrease from the previous year. Whilst there have been 911 fewer practitioners accessing the multi-agency taught and online courses, there has been a 12% increase in the number of practitioners receiving safeguarding training in a single agency setting.

Sector	Number of attendees
Armed Services	4
Early Years & Childcare	138
PCC Adult Social Care Services	1
PCC Community Safety	21
PCC Children & Family Services	85
PCC Early Help and Prevention	62
PCC Education Services	19
PCC Housing, Youth & Play Services	52
PCC Other (e.g. Business Support)	8
PCC Public Health	5
Hampshire Constabulary	2
Portsmouth Hospital Trust	11
Schools and Colleges	559
Solent NHS Trust	13
Sport & Culture	5
Voluntary & Community Sector	321

Course	Numbers attended
Basic	115
Early Help	84
Child Protection	92
Supervision	25
Managers	61
Designated Safeguarding Leads	30
CSE	81
Basic Inset Training in Schools	497
Bespoke/Single Agency	86
PSCB Briefings	95
E-learning	723
GRAND TOTAL	**1889**

Despite economic and workload pressures on services, the PSCB training programme has continued to be delivered by a team of professionals from its partner agencies, supported by the PSCB Training Manager and Administrator. This has meant that PSCB has had the capacity to offer the amount of courses to meet demand with no one waiting longer than 3 months (with priority given when needed) and no cancellation of courses.

In a time of significant change to the offer of services to children and families in the city, it has also been important to draw on local and up-to-date knowledge from the multi-agency training team to design and tailor courses to meet the training needs of frontline professionals. This multi-agency approach needs to continue to ensure best use of resources and ensure the availability of enough courses delivered in an appropriate timescale to keep the knowledge and skills of the workforce up to date.

Restorative Practice

Some of the reduction in numbers attending the Safeguarding Training Programme can be attributed to the introduction of a large scale programme of Restorative Practice Training that the PSCB Training Manager has supported. The Restorative Approach has been adopted in Portsmouth by all services working with children and families in the city. The Board is aware that practitioners only have so many days a year that they can attend training, and so by them attending the Restorative Approach training this may have impacted on their availability to attend Safeguarding Training.

PSCB has held 9 Restorative Practice courses, with approximately 91 staff from across services in the Local Authority having attended these. Of the 69 education settings in Portsmouth, 24 have so far received training in Restorative Practice, including:

Further Education College	1
Secondary Schools	5
Pupil Referral Unit	1
Primary Schools	17

Solent NHS Trust has trained 143 of their practitioners who work in Portsmouth, including:

Health Visitors	35
Community Health Nurses	9
School Nurses	13
Clinical Team Leaders	9
CAMHS Staff	34
Children's Therapy Services	34
Breastfeeding Support Workers	3
Family Nurse Practitioners	6

The PSCB Training Manager has been consulting with agencies and listening to feedback from practitioners to understand how we can improve attendance in 2018-19. Some of the changes that we will be making are:

- Publishing the dates of the courses - when the programme was originally introduced the dates were not advertised as it was felt important to ensure there was a good range of different agencies represented on the courses. However, practitioners have fed back that this makes it difficult to then accept the date offered, so we will now be publishing the dates of all courses in advance
- Simplifying the booking process - previously this has been a manual system where the applicant has had to identify the course, access the booking form from the website and then email their application to the PSCB Training Manager. During 2018-19 we will be moving to a web-based booking system, which will be a one-step process.
- Reviewing the course content - to ensure that both taught and online courses are relevant and up to date, and accurately reflects changes made to systems, processes and structures in Portsmouth. As well as reviewing what we have learnt over the last few years as to the challenges faced by children and families living in Portsmouth, and emerging concerns such as criminal exploitation etc. The review will also consider course length to consider how much time is required to disseminate the required and relevant information. Wherever possible taught courses will be no longer than 3 hours or 1 day, to lessen impact on time spent away from core business.
- Mapping course content against required professional standards for practitioners - to ensure that professionals in health, social care, education, early years etc. can more easily identify how the training offered by the PSCB maps against standards required by their relevant professional accreditation bodies.
- Introduce topic/issue based training into the programme - for those experienced practitioners who have completed all of the relevant core safeguarding training. To recognise the need for more advanced courses that focus on specific issues, such as Safeguarding Children with Disabilities, Working with Children Experiencing Neglect etc.

Joint PSCB & PSAB Safeguarding Improvement Board

During 2017-18 two inspection reports from the Care Quality Commission (CQC) were published regarding the quality of health provision in Portsmouth

- CQC Portsmouth Hospitals NHS Trust, Queen Alexandra Hospital Quality Report (publication date 24th August 2017).
- CQC Review of health services for Children Looked After and Safeguarding in Portsmouth (publication date 19th September 2017)

These reports both identified areas of good practice as well as some areas concern relating to safeguarding of children and adults in Portsmouth's health services. To ensure that both the PSCB and Portsmouth Safeguarding Adults Board had sufficient oversight of the improvement activity in partner agencies, whilst not overly burdening them with duplication of reporting; a Joint Safeguarding Improvement Board was convened to seek assurance that appropriate actions have been identified and undertaken to address the areas of concern. As many of the patients who will attend Portsmouth Hospitals Trust will live in Hampshire, the Safeguarding Improvement Board has also sought to work in partnership with the Hampshire Safeguarding Adults Board and the Hampshire Safeguarding Children Board.

This Board is jointly Chaired by the Independent Chairs of the PSCB and PSAB and the membership is made up of:

- Chief of Health & Care Portsmouth, NHS Portsmouth CCG/Portsmouth City Council
- Deputy Director of Quality and Safeguarding, NHS Portsmouth CCG
- Head of Safeguarding, Portsmouth Hospitals NHS Trust
- Associate Director of Quality and Governance, Portsmouth Hospitals NHS Trust
- Public Health Consultant, Public Health
- Director of Children's Services, Portsmouth City Council
- Head of Health & Wellbeing Partnerships, Healthwatch Portsmouth
- Associate Director Quality & Nursing, South Eastern Hampshire/Fareham and Gosport Hampshire CCG Partnership
- District Manager for Hampshire Children's Services, Hampshire County Council
- Chief Superintendent, Head of Prevention and Neighbourhood Command Hampshire Constabulary
- Board Manager, Portsmouth Safeguarding Adults Board
- Safeguarding Partnerships Manager, Portsmouth Safeguarding Children Board
- Strategic Partnerships Manager, Hampshire Safeguarding Children Board
- Strategic Partnerships Manager, Hampshire Safeguarding Adults Board

Portsmouth Hospitals Trust, Solent NHS Trust, Portsmouth Clinical Commissioning Group, Public Health and the Society of St James had all developed detailed action plans in response to the recommendations in these reports.

The objectives of the group are:

a. To ensure appropriate actions have been identified and undertaken to address the areas of concern

b. To provide a direct line of reporting and accountability for the actions / work streams being undertaken by providers

c. To provide an accessible escalation route to address any areas that may prevent or hinder the necessary actions being taken

d. To provide strategic support to providers as required.

This work is ongoing and aims to be completed by September 2018, at which point any actions still outstanding will be reviewed by the PSCB and PSAB respectively.

What our dataset tells us

There were 20,518 contacts to the Multi-Agency Safeguarding Hub for 10,905 children. The percentage of these that led to an assessment is good (96.7%), which indicates that the workforce has a better understanding of the thresholds for safeguarding.

However, the number of these assessments that led to the child being referred to Children and Family Services was up 12% on last year.

The number of children on a Child Protection Plan in March 2018 was 288, a 19% increase from the previous year, and the number of repeat Child Protection Plans also increased to 12%

The number of Children Looked After rose significantly during 2017-18, from 358 to 419. However, 100% of these children are in 'good' or 'outstanding' placements.

There has been a significant reduction in the number of children being reported missing 3 times in 90 day, down from 201 in 2016-17 to 144 in 2017-18. During the same period the number of children being identified as trafficked has increased by over 300% from just 12 to 50.

There have been no reported incidents of FGM or forced marriage during 2017-18.

It appears that there is greater awareness of the role of the Local Authority Designated Officer, with an increase of 32% in the number of allegations reported.

Indicator	Value	Increase from	Reduction from
Number of Looked After Children	419	17.03%	---
Number of children on a Child Protection Plan	288	19%	---
% of CP Plan due to neglect	68.94%	1.17%	---
% of CP Plan due to emotional abuse	25.26%	---	4.49%
% of CP Plan due to sexual abuse	0.68%	---	1.8%
% of CP Plan due to physical abuse	5.12%	5.12%	---
% of CP Plans where domestic abuse is present	35.07%	---	6.67%
Number of children who were Children in Need (rate per 10,000)	229	23.78%	---
Number of referrals to Children & Families Service	2,785	12.34%	---
Number of child deaths	10	---	9.09%
Number of children missing 3 times in 90 days	144	---	28.35%
Number of new referrals of CSE investigated by Police	83	---	9.78%
Number of victims of trafficking	50	316.66%	---
Number of children linked to high risk domestic incidents	862	121.5%	---
Number of Fixed Period School Exclusions	2,260	24.1%	---
% early years settings rated good or better	94%	---	4%
% of schools graded by Ofsted as outstanding or good	84.1%	3.5%	---

Over the year the Board's Monitoring, Evaluation and Scrutiny Committee (MESC) reviews this data that is provided on a quarterly basis and provide regular reports to the Board. These reports identify parts of the system that appear to be working well and those we want to keep an eye on. The report also identifies parts of the system that the Board needs to consider what improvements activity is required as they appear to indicate possible areas of concern.

What we have learned in 2017-18

All partners are effectively providing regular updates on the Recommendations made from the dataset.

When reviewing the data for 2017-18 the Board received the following messages:

Significant positives

- Child protection conference quoracy is improving as well as good participation by families and reports being received on time
- Allegation management continues to function well
- Good workforce development in place for all agencies
- Good multi-agency grip on CSE and missing children through Operational Group and data tracking
- Good take-up of PSCB training

However…

- Continued high pressure on the safeguarding system in terms of numbers
- Repeat child protection plans and plans lasting over two years are rising issues
- School exclusions are rising
- There appears to be a rise in trafficking (but as will be explained later in this report this may be due to the introduction of the Independent Child Trafficking Advocacy Team being introduced in Portsmouth)

Recommendations

- MESC to undertake multi-agency audit on repeat child protection plans (this audit is planned for quarter 3 of 2018-19)
- Police to report back to the Board on the reasons behind increase in numbers of children being trafficked (this is being considered by partners in the Missing, Exploited and Trafficked Strategic Group and a report will be presented to Board in February 2019)
- MET Committee to report back to the Board on why we continue to have low numbers of low and medium risk CSE assessments (the PSCB has written to all agencies to ask how many assessments they have completed that scored as low or medium, and what they have done as a result. To ascertain whether more assessments are being completed and then not submitted to the MET

What we have learned in 2017-18

Learning from PSCB Audits

The PSCB oversees a range of audit activity to understand the effectiveness of early help and safeguarding in the city. These include multi-agency audits, single agency audits and 'deeps dives' into specific topics.

During April 2017 to March 2018 the Board supported by its partner agencies completed 3 multi-agency audits, the findings of which were reported to the Board. Specific actions relating to cases were fed back to the relevant services and progress on the actions resulting from the recommendations in the audit reports were monitored by the Board's MESC.

Intra-Familial Child Sexual Abuse

This aim of this thematic learning review was to understand how effective multi-agency practice was in responding to a sample of four children where disclosures had been made that sexual abuse may be occurring within a family.

How we did this:

- We looked at cases that had been considered as a Section 47 Enquiry or at a Child Protection Conference where the child had disclosed that they had been sexually abused by a family member. Of these lists four cases were chosen to be considered within this audit.
- For two of these children the child protection process had concluded and so it was agreed that an audit based on agency records would be appropriate. A tool was devised that was sent to all agencies known to have worked with the child that asked them to describe their involvement; write a chronology of key events; and to evaluate the engagement with the child and their family.
- In the other two cases the child was either now being looked after or was on a Child Protection Plan. It was agreed that it would be more appropriate to invite the key practitioners who knew the child best to attend a reflective practice meeting.

What we found:

- Swift and appropriate responses to the allegations, both by family members and the workforce
- Having Children's Social Care structured into locality teams has helped build up the social history and genogram of the extended family that all live in the local area
- Social Worker demonstrated good practice in recalling the archived records in order to understand the historic working, issues and social history of the family
- Good robust Team Around the Family working ensured that all the agencies involved with family members shared the same awareness parent(s) ability or inability to be a protective factor
- There were lots of positive efforts to engage the child, both by the social workers and the schools
- Where there are large, complex families with multiple child protection concerns it would help to have a lead Social Worker reviewing all of the known information and considering where there are any contradictions/duplications in plans for children in the extended family
- Foster carers are trained to contact the social worker if the child in their care were to make a further disclosure. The Social Workers are then not always remembering to inform the police, who would then to decide whether this changes their prior decision not to pursue an allegation.
- National changes to the bail process means that when a suspect is released following arrest and pending investigation, cases need to be referred to a Superintendent who could apply bail conditions in exceptional cases where to not do so might leave the victim at risk. The Board will be reviewing this over the coming year to ensure it responds appropriately to challenge this process should there be concerns that this is not appropriately safeguarding children
- When the actions in the initial safety plan were complete the cases were quickly stepped down from Child in Need, keeping them open for longer would allow consideration about what work should be done with the child to address their sexually harmful behaviour.

Learning from PSCB Audits

Recommendations:

- For the Board to scrutinise support and resources currently available across partner agencies for child demonstrating sexually harmful behaviour, to consider whether we have in Portsmouth a sufficient and up response to this issue.
- For Children & Families Service to develop guidance for Social Workers to help families plan for the longer term, rather than just supporting them to develop a safety plan to address the immediate presenting concerns
- For the Board to scrutinise the current advice and guidance available to supervisors to support professionals working with cases of child sexual abuse. To consider whether this is sufficiently robust enough for them to adequately support practitioners working with often difficult and complex cases.
- A multi-agency task and finish group to develop practice guidance on how we manage large and complex families. To consider how we could be smarter in putting our knowledge and analysis together to make sure we have all the necessary information and a coordinated approach.
- That health agencies present the pathway for medical support for victims of historic child sexual abuse, so the Board can be assured that there is appropriate support in terms of considering if there are any sexually transmitted diseases, injuries and/or pregnancies.
- Hampshire Constabulary to report back to Board how it can address the difficulty that arises when children's allegations cannot pursued due to there being insufficient evidence to bring a charge. In these instances the message the child hears is that they aren't being believed, so how can support be made available to help the child understand this decision.

What we are doing as a result

- The Designated Doctor for Portsmouth is working with Hampshire Constabulary and colleagues in the MASH to develop a protocol and easy to understand flow chart of how to refer a child who is suspected to have been sexually assaulted for a medical examination. To ensure this is well understood and embedded, the Designated Doctor will deliver a series of workshops to relevant staff on this protocol
- Portsmouth Children and Families Service is working closely with Portsmouth Abuse and Rape Counselling Service to commission appropriate specialist post abuse support for children who have experienced sexual abuse.

Learning from PSCB Audits

Quality of Reports Submitted to Child Protection Conferences

The purpose of the review was to repeat the audit completed in March 2016 to consider whether the quality of information supplied to child protection conferences had improved since the introduction of a Restorative Approach to these conferences

How we did this:

- We used the same audit tool as had been adopted in March 2016, with a few amendments to reflect recent changes in practice, to enable us to directly compare these findings to the earlier audit.
- 10 ICPCs held in July 2016 were selected, ensuring there was a representational selection from each of the three locality areas in Portsmouth. All the reports submitted to these ICPCs were then audited

What we found:

- Of the 52 reports audited 42.3% were considered to be of a good quality overall and 42.3% were considered to be adequate
- 15.4% of the reports were of an inadequate quality overall.
- There was no noticeable change in the overall quality of reports to Initial Child Protection Conference since the previous audit completed in March 2016.

Recommendations:

- For the Board to develop guidance and examples of good practice to share with agencies to improve the quality of reports to Initial CP Conferences
- The PSCB Chair will write to all partner agencies summarising the findings of this audit and to reinforce the expectation that:
    - the child's views and wishes are included in reports to ICPC (where children are pre-verbal or have limited communication skills, that an observation of their interactions with their parent/ carer are included); and
    - reports to ICPCs are shared with families prior to conference.
- For the CCG to undertake a separate audit of GP reports to CP Conferences, to explore the barriers to GPs providing reports and provide guidance to help them understand the importance of submitting a report.

What we are doing as a result

- The PSCB Training Manager is revising the Child Protection Training Course, to ensure the relevance of completing the reports to Child Protection Conferences is well understood and that participants understand what a 'good and robust' report would look like
- Once these recommendations are complete, the PSCB Monitoring, Evaluation and Scrutiny Committee will conduct a dip sample of reports submitted to 5-10 Initial Child Protection Conferences to consider the impact upon the quality of these reports.

Learning from PSCB Audits

Quality of Early Help Interventions

The purpose of the review was to consider whether early help assessments are being used appropriately to help clarify all of the issues being experienced by the family; and to coordinate the multi-agency response.

How we did this:

- Two cohorts of children were identified for whom we would expect to see a robust early help response to an emerging need. These were:
- Children aged 0-5 years who were not brought to medical appointments on 3 or more occasions; and
- Children aged 5-10 years with chronic absence from school with less than 50% attendance.
- Five cases from each cohort were sought.

What we found:

- In all of the cases reviewed there appeared to be robust application of the thresholds, and the cases had been appropriately stepped up to Child in Need/Child Protection or down to Early Help
- There was evidence that nurseries and pre-schools are not routinely invited to Team Around the Family meetings nor is the Early Help Assessment and plan sent to them
- There was a strong sense from the cases that whole family working is not embedded.
- GPs were not routinely aware of the concerns about the safety and welfare of the child, nor did they appear to have received a copy of the Early Help Assessment which would have helped inform them of the concerns.

Recommendations:

- Solent NHS Trust and Healthy Child programme commissioners to ensure that in the development of the ECHO service, there is robust and regular liaison between Health Visitors and the registered GP for children who are of concern. .
- A 'was not brought' policy should be introduced in Portsmouth to ensure there is a consistent and robust response to families where children are frequently not brought to medical appointments.
- The PSCB will write to all relevant agencies to ensure that the Lead Professional ensures a copy of the family's Early Help Assessment is sent to the appropriate nursery/pre-school (with consent).
- For Children and Families Service to ensure that engaging early years settings in early help processes is referenced in the processes for and/or role description for Family Lead Professionals. Additionally, the Think Family Mentors should remind those Lead Professionals they work with of the need to send the EHA and Plan to the early years setting as appropriate.
- For Children and Families Services to review their Step Down Protocol and process to ensure that Social Workers are routinely having conversations with the agency they identify as best placed to take on the lead professional role, to ensure they are best placed to take on this responsibility and have agreed to this before the case is transferred.

For Portsmouth Hospitals Trust to carry through on their commitment to identify a link Band 7 midwife for each of the city's 3 Multi-Agency Teams to ensure that there is early identification of pregnant women who will need additional support to safeguard and promote the welfare of their baby.

What we are doing as a result

- The PSCB will work with the Hampshire, Isle of Wight and Southampton LSCBs to develop a pan-Hampshire 'Was Not Brought' police for health agencies to ensure there is consistency of approach across the 4LSCB area
- Within the re-development of the PSCB website planned for quarter 1 of 2018-19, a dedicated Early Help section will be created. All of the relevant tools, assessments and practice guidance relating to early help will be located within this to make these resources easier to access for the workforce.

Partner Compliance with Statutory Safeguarding Requirements

Effective practice to safeguard children and young people is dependent on partners having appropriate policies, procedures and arrangements in place to support their staff. Section 11 of the Children Act 2004 and sections 175 and 157 of the Education Act 2002 set out the requirements for agencies and form the basis for regular self-auditing of compliance.

Working Together to Safeguard Children 2015 states that one of the key functions of a Local Safeguarding Children Board is *'the monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve'*.

Part of the way in which Portsmouth Safeguarding Children Board (PSCB) discharges this function is by carrying out Safeguarding and Early Help Compact Audit self-assessments. This audit is carried out in a two-year cycle with half of all agencies to whom the duty applies completing the audit each year.

This is the 6th year that Portsmouth Safeguarding Children Board chosen to combine various duties to test agencies compliance with safeguarding legislation. This Compact Audit allows us to make comparisons between health, education, early years and voluntary settings alongside those listed as statutory agencies in Working Together 2015. The enables our Board to consider the quality of the whole system in Portsmouth that children and families will engage with at all tiers of need, from universal services through early help settings and into those providing statutory child protection processes.

The PSCB Monitoring, Evaluation & Scrutiny Committee (MESC) reviewed the returns submitted in 2017-18 and it was noted that usually a random sample of 12 agencies will be chosen for a moderation visit each year. This is a measure to test the validity of the evidence against which they are self-assessing their grades for each standard. The PSCB Safeguarding Partnerships Manager attends each of these to allow for some continuity and is accompanied on each by a Board or Committee Member.

This year unfortunately only 1 provider visit was managed due to the increased administration time taken to collate and analyse the provider returns. The PSCB MESC agreed that this was a position that should not be replicated in future years and is developing an agreement that this work will be shared by members for the 2018-19 to ensure that the commitment to visit 10% of all providers submitting a return is completed.

However the MESC members were reassured that evidence from visits completed in previous years showed that providers were very objective in their self-assessment. In cases where grades were found to be inaccurate this was always due to the provider being cautious and under-scoring their processes, and that there was no evidence of over-inflation of grading. It is noted though, that in order to give full assurance to the Board of the effectiveness of safeguarding and early help processes in the city that these moderation visits must occur in future years.

<u>What we learnt</u>

114 agencies were sent the self-assessment tool to complete this year and we received 85 completed returns.

The return rate this year is very disappointing with only 75% of agencies sent the tool completing it, this compares to an average response rate of over 95% in the previous three years. It is unclear as to the causes for this as the same method to chase late return was used this year. However, 72% of those not responding were from the voluntary and community sector, so consideration should be given as to whether a shorter more applicable tool may improve this return rate in future years.

Overall MESC members were satisfied that these results demonstrated that services have a clear understanding of their responsibility to safeguard and promote the welfare of children. The feedback from many agencies is that they find the tool helpful as a self-assessment of their safeguarding processes. Schools have reported that they find it useful in preparing for Ofsted Inspections and in reporting to their governing bodies on their compliance with Keeping Safe in Education 2016. Many smaller voluntary organisations have actively requested to complete the tool to identify which areas they need more support and/or training.

Partner Compliance with Statutory Safeguarding Requirements

What was also particularly noticeable this year was that all agencies provided an appropriate description of the evidence they have to support their self-assessment. This varies from the policies and procedures they have in place, to a description of the training staff have received. This gave MESC members additional confidence that these grades are an accurate reflection of practice within these services.

The 3 standards where services felt they had the most improvements to make were:

- Safe Recruitment - Within this 12 services recognised that they needed to improve the training those staff involved in recruitment received. Half of the GP Practices also considered that they weren't sufficiently ensuring that any tempoary and agency staff were clearly informed of their responsibility to safeguard children.
- Equality of opportunity - it is interesting to note that of the 3 GP Practices, 10 early years settings, 14 schools completing this audit felt the need to complete an equality impact assessment when making changes to their service was not applicable to them. A further 6 services ignored this question completely and left their assessment blank. The high number of services not addressing this question will obviously skew the overall percentages. A similar finding was highlighted in the report summarising the findings from this audit completed in 2016-17. MESC will need to consider the implications of this for future audits as it was this one question in particular that affect the overall results.
- Disabled children - Interestingly all services who assessed whether they are proactive in identifying when it is working with a disabled child or their family graded themselves as outstanding or good. The questions within this standard that attracted the most assessments of 'requires improvement' or 'inadequate' were whether their staff:
  - ⇒ that work with disabled children: have been given specific training
  - ⇒ understand the relevant concerns to make a referral to Children's Services in a timely fashion
  - ⇒ receive training in communication skills and methods to work with disabled children and young people

This is the same situation as was found in the 2016-17 audit, so would demonstrate that this is a significant

Recommendations

1. Agencies that did not supply a return this year they will be included in the list asked to submit a return in 2018-19. Should they not submit a response, then a meeting between the PSCB Independent Chair and a senior manager within that service will be arranged.
2. As a matter of urgency the PSCB Independent Chair will write to all services in Portsmouth to ask them to detail what training is currently available to the workforce in relation to working with disabled children. The PSCB Training Committee will review these responses and present a report to Board with recommendations as to how current training provision in this area can be improved or whether additional training should be commissioned.
3. The PSCB Independent Chair will write to all services in Portsmouth to ask them to detail what training is currently available to the staff involved in the recruitment process. The PSCB Training Committee will review these responses and present a report to Board with recommendations as to how current training provision in this area can be improved or whether additional training should be commissioned.
4. For Portsmouth CCG to review their safeguarding training for GP Practices to ensure it emphasises the need to ensure any temporary and agency staff are clearly informed of their responsibility to safeguard children. Evidence of this should be provide to PSCB MESC by September 2018
5. Given the high number of nil returns from community and voluntary organisations; the PSCB Safeguarding Partnerships Manager will work with the Children and Young People's Alliance to develop a tool that is more relevant and easier to complete for this sector

Case Reviews

Local Safeguarding Children Boards are required to consider holding a Serious Case Review (SCR) when abuse or neglect is known or suspected to be a factor in a child's death or when a child has been seriously harmed and there are concerns about how professionals may have worked together.

Child E Serious Case Review

Child E was 18 days old when he died. It became apparent that his injuries were not consistent with the explanation given by his mother. Following criminal proceedings his mother has been found guilty of his murder.

The case was considered by the Portsmouth Safeguarding Children Board (PSCB) at its Case Review Committee on 22 January 2015 under Regulation 5 of the Local Safeguarding Children Board Regulations 2006. The committee found that this case met the criteria for a serious case review and agreed the commissioning arrangements in order to meet the requirements of such reviews as laid out in HM Government 'Working Together to Safeguard Children', 2013 (now 2015).

Working Together allows LSCBs to use any learning model consistent with the principles in the guidance, including systems based methodology. An Independent Social Work Consultant was commissioned as the lead reviewer to complete the work using a hybrid approach.

Whilst the Review was completed in 2015 publication was delayed until February 2018 due to criminal proceedings.

Safeguarding Concerns

- During her pregnancy with Child E, his mother (Mrs X) received no antenatal care and was, at least partly, in denial about her pregnancy
- Whereas Mrs X had been seeing her GP 2 to 3 times a month, during her pregnancy she had withdrawn from all medical appointments.
- Child E was born at home with the assistance of an ambulance crew, which had only been called when she had been in labour for 3 days and was in the final stages.
- Mrs X and Child E were taken to hospital following his birth and were there for 4 days. During this time a heated argument was witnessed between Mrs X and her partner Mr W. Maternity Services referred Mrs X and Child E to Children's Social Care and an assessment was started.
- Whilst in hospital Mrs X disclosed she experienced mental health issues and domestic abuse.

Findings

1. Better use of early help and intervention - Early signs of neglect were not shared between professionals because no use was made of the mechanism for doing so (i.e. Early Help Assessment).
2. The role of supervision for all agencies - The review highlights the necessity of good reflective supervision and management scrutiny in all agencies. This is particularly prevalent in families such as this where the issues are complex.
3. Assessment of the impact of specific parental issues (DA, alcohol misuse, parental mental health) - Information was held about both adults that was not widely shared and as a result the information was not considered in terms of the impact of their issues on their parenting capacity.
4. Exchange of information between agencies - In the referral and assessment process, the exchange of information between agencies is crucial. Poor exchange of information is likely to result in the wrong application of thresholds and subsequently flawed assessments. In this case the exchange of information between agencies was left wanting particularly in relation to the adults' respective histories.
5. Risks associated with concealed pregnancies - The risks associated with concealed pregnancies are well documented within literature. Within SCRs, families where concealed pregnancy is an issue form a small but significant number. Agencies need to have a shared understanding of these risks and their role in dealing with them.

The recommendations made to address these findings and the action taken thus far, can all be found in the Board's response to SCR Child E, on the SCR Page of the PSCB website. This page also includes the full SCR Child E Overview Report.

Case Reviews

During 2017-18 seven cases have been brought to the attention of the Case Review Committee for discussion. In these cases all agencies who knew the family were asked to provide a summary of their involvement.

A summary of the discussions of the cases are circulated to all participating agencies for dissemination to support learning and highlight good practice. In one case it was felt that although it did not meet the criteria for a SCR, there were sufficient concerns about the way that agencies had worked together that the PSCB have commissioned an Independent Consultant to complete a Learning Review

Child G

This Learning Review is being undertaken to consider the effectiveness of agency involvement with Child G and his family. Following his diagnosis of a life-limiting medical condition, there had been concerns that his mother had not been able to meet all of his care needs and that he experienced neglect; despite ongoing support and packages of care from health professionals and children's services. In particular the concerns focused on poor home conditions and Child G not being taken to his health appointments.

The case was referred to the Case Review Committee by Solent NHS Trust following a re-admission to hospital due to Child G being acutely unwell. Paediatricians considered his life to be in danger due to malnutrition, pressure ulcers and a high risk of aspiration.

The Case Review Committee considered this information and concluded that there was insufficient evidence to suggest that the deterioration in DH's health was linked to abuse rather than his life-limiting medical condition. However, the scoping exercise did highlight that there had been issues around the way agencies worked together, and differences in opinion as to how the suspected neglect was addressed.

So whilst the case does not meet the criteria for a Serious Case Review, it was agreed by the PSCB Independent Chair that a Learning Review should be commissioned to provide insights into the way these organisations had worked together to safeguard and protect the welfare of Child G. As set out in Working Together 2015, it was felt that this review would provide an opportunity for the services involved to identify opportunities to improve their practice, multi-agency working, engagement with resistant families and transition planning for children with life-limiting medical conditions. This review is due to present its final report to Board in October 2018

Multi-Agency Reflective Practice Meetings

In two of the cases (and one that was originally referred in 2016-17) it was recommended that a multi-agency reflective practice meeting be held.

Child CC

The referral was made to the Case Review Committee (CRC) in November 2016, regarding a child but the case also involved an adult at risk. The criteria for a Serious Case Review was not met but the CRC and the Portsmouth Safeguarding Adults Board (PSAB) Safeguarding Adults Review (SAR) sub-group, decided to proceed with a multi-agency reflective practice meeting. This would consider how agencies had worked together and what lessons could be learned to improve the outcomes in future situations.

CC is a teenage child who lives with her mother. In 2016 mother was found guilty of the coercive and controlling behaviour of her daughter following numerous reports to the police by CC to either report her mother missing or express concern for her welfare. These calls were usually the result of the mother leaving messages for her daughter that led her to believe her mother intended to harm herself.

Findings and Learning Points

- Tendency of services to focus on isolated incidents. Lack of seeing the bigger picture of the situation.
  - ⇒ The sum impact of events needs to be considered.
  - ⇒ Individual agencies to be assured that they understand how to identify and respond to the cumulative effect of individual incidents and escalate / refer accordingly.
- Both individuals seen by multiple agencies on multiple occasions i.e. lots of input but not coordinated as no individual / agency seemed to be taking the lead.
  - ⇒ To allow for more effective multi-agency working there needs to be an understanding of different agencies and individual roles, and in particular where responsibility of each starts and finishes
- The high intensity user group at the hospital agreed an approach to manage the mother's attendance at the Emergency Department, but didn't consider the impact this may have had on the child and other family members.
  - ⇒ Agencies to consider risk assessing the impact of withdrawing services to the individual on the wider family.

Child 1

Child 1's mother booked late for maternity care at 28 weeks gestation and disclosed having learning difficulties and epilepsy; mother's learning difficulties were not considered to be significant, and so no contact was made with the MASH. However when mother was admitted for induction of labour, the hospital midwife recognised quickly how significant mother's learning difficulties were and contacted out of hours MASH within 4 hours of admission.

Following his birth Child 1 was diagnosed with a cleft palate and he was transferred to the neonatal intensive care unit due to problems secondary to the cleft palate. On the neonatal ward it became apparent that his parents were struggling to meet their own needs. Child 1's feeding needs were complex and his parents were obviously finding these difficult to meet. A suitable placement was identified by Childrens Social Care for the family at a residential parent and baby placement in another local authority area. During the handover from the social worker to the placement staff upon arrival of Child 1 it became apparent that some of the medical equipment for feeding was missing (the syringes) and the placement did not have any they could use. Child 1 was taken to the local hospital and staff there became concerned that the placement's staff who had received training for feeding Child 1 did not seem sufficiently confident in using the nasal-gastric tube; and they were concerned that not a sufficient number of staff at the placement had received training to feed him competently.

Multi-Agency Reflective Practice Meetings

Learning identified:

- The health pathway for parents' with learning difficulties needs to be clarified for staff within Portsmouth Hospitals Trust and Solent NHS Trust - including the learning disabilities passport tool and guidance to staff about how to use it.
- All health practitioners who may come into contact with pregnant women must be aware of the 4LSCB Unborn/Newborn Baby Protocol. These staff should be aware of the appropriate safeguarding response when a woman is late booking her pregnancy. They must understand the risks associated with a late booking or concealed pregnancy and that this requires an urgent contact to the MASH.
- It is essential that when contacting the MASH regarding a safeguarding concern that the referrer is really clear as to how their concerns about the parent are (or may) potentially impact of the safety and well-being of the child. Staff must also be familiar with the Portsmouth Thresholds Document when completing an Inter-Agency Contact Form (IACF) and clearly indicate on this form the reason they feel it meets the threshold for a statutory response (tier 4) or a response form the targeted early help service (tier 3)
- When a professional decides that a contact should be made to the MASH, if they cannot complete this within a reasonable timescale they must discuss this with their manager and/or safeguarding lead.
- A checklist of all specialist equipment and care required to care for a child with additional needs should be routinely used at discharge meetings. To ensure all issues are properly considered, relevant plans put in place and that all required equipment is handed over.
- A process must be developed to ensure the qualifications, competency and procedures from provider settings are formally checked and verified, in relation to meeting the requirements of a child with identified additional medical and/or care needs.

Child 2

This case involves a 3 year old who now weighs 27.5kg (the weight of an eight year old). Child 2 was seen by a paediatrician in November 2017 but not brought to a follow-up apt in December 2017 and contact was made to the Portsmouth MASH.

The Reflective Practice Meeting for this case will be held in May 2018.

For 2 of the other cases that were not progressed to either a SCR, learning review or reflective practice meeting the following was agreed:

- A 19 year old care leaver who was discovered deceased in her supported housing with an aerosol canister in her hand. Had a history of substance misuse and recognised vulnerability factors and was open to Children's Services as a care leaver at the time of her death.
    - ⇒ a letter was sent to the independent chairs of both Safeguarding Boards recommending Children's Services and Solent NHS Trust review current transition arrangements and inform the Boards of the outcomes of this review and progress on any action plans. The aim being to ensure there are clear transition pathways and adequate safeguarding processes around when young people do not engage.
- TD aged 15, one of 3 siblings who was removed from home to care in 2012 as they were all experiencing chaotic care in the home environment with exposure to violence and neglect. All siblings are in separate care placements with complex individual needs. He was involved in an arson incident at some playing fields in Portsmouth and suffered burns resulting in him being hospitalised in intensive care. TD was discharged to a Children's Home. Previous to this incident TD had gone missing on 16 separate occasions.
    - ⇒ Recommendation made to the Board around developing a multi-agency process for dealing with extremely complex cases where a child is admitted to hospital, to ensure strategy meetings take place quickly so any risks can be identified and shared earlier on.
    - ⇒ The good practice within this case was also highlighted to the Board. As there was evidence of a robust multi-agency discharge planning meeting taking place at the hospital.

For the remaining two cases, it was felt that appropriate responses had been made in both and that there were no further recommendations required.

Child Death Overview Panel

The Child Death Overview Panel (CDOP) is the inter-agency forum that meets quarterly to review the deaths of all children normally resident in Portsmouth. It is a subcommittee of the Portsmouth Safeguarding Children Board (PSCB) and is therefore accountable to the PSCB Chair.

The purpose of the review is to determine whether a death was deemed preventable, that is one in which there are identified modifiable factors which may have contributed to the death. These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be prevented. If this is this case the panel must decide what, if any, actions could be taken to prevent such deaths in future.

The Portsmouth CDOP received 10 child death notifications during this reporting period of which 5 were reviewed. The reviews of the five remaining cases were delayed due to post mortem results and single agency reviews being finalised and these deaths will be reviewed when all relevant information is available. A total of 13 cases were reviewed by the panel over the last financial year but some of these deaths occurred in the preceding financial year. No themes or trends were identified from the deaths reviewed this year.

All cases (both expected and unexpected) discussed at panel were due to medical causes, perinatal/ neonatal events or known life limiting conditions. Boys' deaths accounted for a greater preponderance. None of the deaths reviewed had a Statutory Order in place at the time of the child's death or were subject to a child protection plan. None of the deaths included child asylum seekers and none of the children whose deaths were reviewed were within the 10% most deprived areas of England. All of the child deaths occurred in an acute hospital setting and the reviews were completed in less than six months since the child's death.

Last year the panel identified there was a requirement to provide refresher training on the Rapid Response process within Portsmouth. This was investigated by the panel and Hampshire Constabulary has recently trained emergency department staff at Queen Alexandra Hospital on the process. The aim is to roll this out further to partner agencies later in the year.

The panel previously identified the inconsistent quality of the returned 'Form B' from agencies. To ascertain the picture an audit took place during summer 2017 and the findings showed the forms audited contained a better than expected return rate. It was noted that some agencies have a tendency to attach documentation rather than input directly into the form. It would be preferable if all information is returned via one medium and this is being addressed accordingly by the panel.

Bereavement training for professionals supporting a family or sibling affected by the death of a child was considered by the Portsmouth CDOP to gain assurance that this was consistent and appropriate. Each panel member investigated the support provided to staff within their own agencies and the returned information was reviewed by the panel and it was deemed robust. Solent NHS also ran workshops for child practitioners to understand the impact of loss when experienced by children and young people and their families.

It was identified this year that it would be useful to capture the mother's BMI at 12 weeks gestation and to understand if there was any smoking in pregnancy. The Portsmouth Form B is to be amended to enable this information to be captured for future cases to help inform discussion at case reviews.

The Portsmouth CDOP felt it was important to highlight to the workforce that in the City the infant (aged 0 to 1 year) mortality rate remains consistently lower than the England average with recent figures for Portsmouth at 2.8 per 1,000 live births, (England average 3.9 per 1,000) with no deaths due to sudden infant death syndrome (SIDS). The child (aged 1 to 17 years) mortality rate is also lower than the rest of England at 6.6 per 100,000, compared with 11.9 per 100,000. This is despite the proportion of children under 16 living in low income families being 24.0%, which is higher than the England average of 20.1%. It's not clear why the infant and child mortality rates are lower in Portsmouth, but its seems that the hard work done by the local authority and public health, health visitor and school nursing teams, primary care, maternity and neonatal services and paediatrics must have a role to play in this.

The Portsmouth CDOP reviewed local safe sleeping messages and colleagues within Public Health confirmed messages are regularly disseminated via various methods including articles within regular publications that are sent directly to homes and schools within the city. Whilst Portsmouth has not had any deaths related to sleeping practices during 2017/18 we recognise that our population is at increased risk due to the levels of deprivation in the city and will be supporting the work carried out across the 4CDOP area.

Multi-Agency Safeguarding Hub

The Portsmouth Multi-Agency Safeguarding Hub (MASH) was established in November 2015. It is the multi-agency front door that manages child safeguarding concerns and determines an appropriate response. The PSCB Threshold Document is used as guidance for the management of all contacts through the MASH

Multi-agency membership:

- Children's Social Care = 1 Service Leader, 2.5 Team Leaders, 0.5 Team Leader with MH specialism, 5.5 Social Workers, 1 Business Support Team Leader and 5 Business Support staff
- Police = 1 Detective Inspector, 2 Sergeants and 7 Community Safety Administrators
- Health = 1 Health Navigator - Specialist Safeguarding Nurse and 1 Health Visitor
- Education = 1 Pastoral Support Worker
- Other = 0.5 Probation Worker, 2 Independent Domestic Violence Adviser, 1 Youth Worker, 3 Think Family Mentors, 1 Early Help Practitioner and 1.5 Early Help Business Support staff
- Adult Social care (affiliated) = 1 Team Manager, 1 Assistant Team Manager and 3 Social Workers

The development of Targeted Early Help Teams led to a targeted Tier 3 service within Portsmouth from July 2017. Access to this service is either via a contact to the MASH or step down from Children's Services. Threshold is assessed on contacts and all contacts meeting threshold for Tier 3 are directed for allocation to the relevant Locality Targeted Hubs.

The Adult MASH continues to sit alongside the children's MASH. Whilst they are not integrated this affords very positive links and some good joined up working opportunities.

The MASH process continues to allow for a senior social worker to oversee the allocation of all work and to endorse the recommendations from the multi-agency team for response.

Between April 2017 and March 2018 contact numbers averaged 919 per month, a decrease on last years' average of 1006. This resulted in a decrease to the total number of contacts into the MASH, from 12,076 for 2016/17 to 11,025 for 17/18.

MASH Contacts	16/17	17/18
Initial Decision MASH	2484(21%)	2951(27%)
Initial Decision MASH S47	807(6.5%)	468(4%)
Initial Decision MASH Early Help	2726(22.5%)	2384(22%)
Initial Decision Remain with Universal Services	6059(50%)	5222(47%)
Total MASH Contacts	**12,076**	**11,025**

When a contact is received by the MASH an initial decision is made by a senior social worker in accordance with the information provided and the PSCB thresholds for services document. This reduction in contacts suggests an increased understanding of threshold across the children's workforce in Portsmouth.

Where the information indicates that threshold may be met for a tier 3 or 4 service the contact is passed through the MASH team so that known, relevant information by each agency can be shared. This full information affords for robust decision making, so that the right children receive the right service.

Where the initial decision indicates that the threshold for a S47 enquiry is met, a multi-agency strategy meeting will be convened. This provides an alternative arena for information sharing, but again affords for robust decision making.

Where the MASH determines a contact meets the threshold for Tier 3 assessment and intervention these are passed to the recently developed Targeted Early Help Team for action. If the contact meets the threshold for a Tier 2 intervention these are coordinated by the Think Family Mentors who are now based within MASH Early Help.

Multi-Agency Safeguarding Hub

There has been an increase in referrals to Tier 4 in 17/18 from 16/17.

	2016/17	2017/18
Referral to Social Care - Tier 4	2059 (17%)	2217 (20%)
Targeted Early Help - Tier 3	N/A	897 (18%)
Think Family Mentors - Tier 2	359 (3%)	929 (8.5%)

There have been 3 multi-agency audits completed during 2017-18. On each occasion 30 contacts were considered by Senior Managers from Children's Services, Health and Police.

These audits evidence threshold being applied appropriately, there is good multi-agency working and information sharing. Work is carried out in a timely way. The ongoing area for improvement is that the issue of consent is explicitly recorded in all cases. The audits do evidence a good improvement in this.

The City's Prevent offer remains situated in the MASH, the chair of Channel Panel is the Senior Manager responsible for Adult MASH and Service Leader for the Children's MASH is taking on deputy chair role. Both the chair and deputy chair are National peer reviewers for the Prevent programme.

Early Help and Prevention

In Portsmouth, Early Help and Prevention is about enabling every parent to provide a positive and supportive environment for their children to grow up in.

Some families may have needs which will require additional support - early help - to enable them to reach their full potential. At different times families may present with different levels of need, which might require limited support or more intensive support depending on need.

With the introduction of multi-agency co-located teams in three localities across the city - the north, centre and south - the early help offer to children and families has been strengthened. Through the Stronger Futures Strategy, led through the Children's Trust, agencies working with children and families have agreed:

To adopt a restorative approach

To utilise specialist/expert knowledge through a team around the worker model, rather than referring families on to one service after another.

To intervene for only as long as is necessary for families to effect positive change that can be sustained for their stronger future.

To develop the volunteer offer to families with children and young people 0-19 years through the Family hubs

The aim of our early help offer in Portsmouth is to provide support to help families find their own sustainable solutions. Once improvement is made services will reduce or end so as to not create dependence.

We have developed a simple outcome-focused framework to determine the effectiveness of our early help work.

Improved health, safety and education

Secure accommodation and employment

Reduced instance of crime, anti-social behaviour and domestic abuse

Key to our approach is to utilise a range of interventions from universal services, volunteering, restorative practice and targeted family support. The Early Help offer in Portsmouth is integrated with Health Visitors, School Nurses and Family Nurses working alongside the 5-19 Early Help team provided by Portsmouth City Council Portsmouth

The integrated 0-19 early help team are also responsible for the co-ordinating the behaviour management offer which is available City wide and delivering the Young Carers service and the 4U project which helps young people with LGBTQ matters.

Children in need (including children subject to protection plans) and looked after children

As at March 2018 Children's Social Care were working with 872 Children in Need; 286 Children subject of Child Protection Planning and 415 Looked After Children (which included 72 Unaccompanied Asylum Seeking Children).

The locality based teams are working well across children's social care, police neighbourhood teams, community health workers and the newly established targeted early help teams. However, between April 2017 and 2018 2742 referrals were made to children's social care - an increase of 10.9 per cent.

The quality assurance framework for children's social care was refreshed this year and a robust program of live auditing (auditing alongside the social work practitioner) was introduced. A total of 144 cases were audited between April 2017 and March 2018, with 74% graded good. An external auditor has been commissioned to reassess 20% audited cases and this has demonstrated that the service is clear what good practice looks like.

Social work assessments continue to be timely and a range of practice tools are now being used to assist children and families understanding what harm a child is experiencing or at risk of suffering- and then what needs to change to increase safety. This is supporting the implementation of restorative principles in practice.

Child protection conferences are now underpinned by restorative principles - with children and families being at the centre of the process. The number of children made subject to protection plans increased as we introduced this new way of working but as the conference chairs have become more proficient in facilitating the new approach the numbers are starting to fall and this should be evident in a clear reduction in the number of children subject to protection plans next year. As at the end March 2018 there were 196 plans recorded under the neglect category; 73 under emotional abuse; 15 under physical abuse and 2 under sexual abuse.

Children's Social Care have continued to work closely with the police driving activity to support children going missing from home and care, being exploited or trafficked at risk of exploitation or trafficking. At any one time there are about 11 children in the city considered at high risk of CSE and 23 children at medium risk. However there is more work to do across the children's workforce to identify more young people who are at low risk so as to offer keep safe work at the earliest opportunity.

Domestic abuse remains a significant issue for the city, with 5,500 recorded instances. Approximately 70% child protection conferences have domestic abuse as a feature and almost 50% children who come into the care of the local authority do so as a result of domestic abuse.

Children's Social Care has continued to facilitate participation events for children, carers and staff so as to promote their involvement in the designing and delivery of services. During 2017/18 the number of children aged 5 or older participating in child protection conferences increased to 74%. Further participation of looked after children in their reviews has remained high at 93%. In the annual participation survey, completed February 2018, 100% children in care who took part, reported that they felt safe and well cared for and 90% of children reported feeling well supported by their social worker. This reflects an increasingly stable and competent workforce.

In Portsmouth we have seen a steady rise in the number of unaccompanied minors coming into the city through the Port. Between April 2017 and March 2018 85 unaccompanied minors came into the city, a rise of 118% from the preceding year, which had seen a rise of 30% on the year before.

As a result of the rise in both the generic population of children coming into care and the unaccompanied minors Children's social care continue to seek local foster carers and our local Foster-Portsmouth campaign continues to be successful. Despite the significant rise in care numbers, the proportion of children placed more than 20 miles away remains low - at 14%.

A lot of attention has been afforded to placement stability and examining the reasons behind placement disruptions. A high proportion of children in care only experience 3 placements, but there are a small number of children who have experienced significant disruption. Robust focus by the independent reviewing service is now afforded to children whose placements are fragile and next year we will implement a new trauma informed model of care to promote increased stability.

Private Fostering

A privately fostered child is defined as ‘a child who is under the age of 16 (18 if disabled) and who is cared for, and provided with accommodation, by someone other than:

- the parent
- a person who is not the parent but who has parental responsibility, or
- a close relative defined in this context as a brother, sister, aunt, uncle, grandparent or step-parent.

A child who is looked after in their own home by an adult is not considered to be privately fostered. Children who are privately fostered are amongst the most vulnerable and the Local Authority must be notified of these arrangements.

Information collected locally mirrors the national situation in relation to low notifications and reports rarely coming from parents. Portsmouth have invested in a full time Private Fostering Social Worker to coordinate activity and increase the marketing "reach".

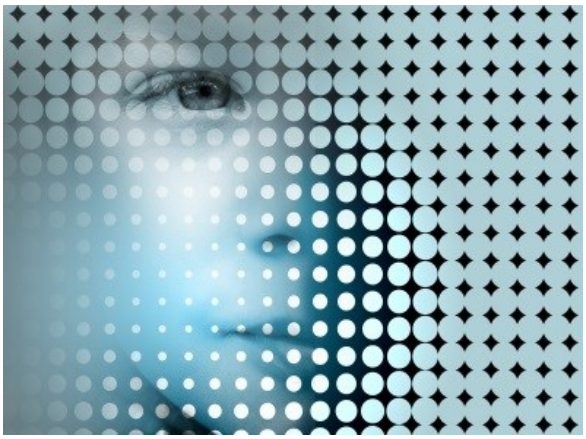
There were 30 young people subject to private fostering arrangements between 1st April 2017 and 31st March 2018, increased from 25 in 2016-17 and 11 in 2015-16.

23 of these were new notifications. At the end of March 2018 there were 5 open private fostering cases. Of the current Private Fostering Arrangements 5 people with parental responsibility made a financial contribution to the placement.

In all cases the child was visited within 7 working days of receipt of notification of the arrangement and additionally throughout the year on a six monthly basis, and an annual review was required in only one case.

The notifications were received from a variety of sources, 1 from a language school, 3 from Private Foster Carers, 1 from parents, 1 from MASH, 11 from the Locality Teams, 1 from a school, 2 from a guardianship agency for students from abroad, 1 from Heathrow airport and 1 from Portsmouth City Council housing.

Children who offend or are at risk of offending



The Portsmouth Youth Offending Team (PYOT) Partnership Management Board oversees youth justice services for the Portsmouth City Council (PCC) area comprising the local Youth Offending Team (YOT), Junior Attendance Centre (JAC) and Appropriate Adult (AA) services contracted out to The Appropriate Adult Service (TAAS). Broader preventative functions in the PCC area are served via Early Help and Prevention services and the voluntary sector.

Portsmouth Youth Offending Team is a multi-disciplinary team working with children who have committed offences aged 10 to 17 (and in exceptional cases, aged 18). In 2017/18, it was aligned with Portsmouth City Council's Harm and Exploitation services, recognising the vulnerability experienced by children who offend, as well as the risks they may pose to others. It remains co-located with Children and Families teams, including the MASH, South Locality and Through Care, and maintains good links in terms of safeguarding.

Caseload levels from 2016/17 have been maintained- marking an increase from previous years but stabilising to a degree. Work has been completed to understand this, with a view to reducing the number of children who are known to the team via delivery effective interventions and joint working with partners.

The Joint Decision Making Panel (also known as Triage) continues to meet on a weekly basis; making recommendations for outcomes in response to offending by children based on holistic assessment. Since December 2017, a representative of Early Help has also attended to inform discussion and contribute to decisions made. The YOT have also continued to access consultation and clinical supervision via the Hampshire and IOW Forensic CAMHS Service.

Overall, PYOT works towards 3 national Key Performance Indicators- Reducing First Time Entrants, Reoffending and Use of Custody. At year end 2017/18, the number of first time entrants had reduced to 67 in 2017 from 90 in 2016 and a previous a high of 117 in 2014. Reoffending data showed fluctuation and a slight reduction from a previous high in July 2011-June 2012. The number of custodial sentences imposed had increased in from 8 in 2016/17 to 12 in 2017/18, but an overall reduction since a high of 24 in 2011/12. Work is ongoing to understand these trends, and achieve further reduction, included specific sets of analysis planned to take place during 2018/19.

The key outcomes sought by PYOT in the coming year, as set out in its Annual Strategic Youth Justice Plan, are:

- Portsmouth Youth Justice services are offered innovatively, within resource available, across the partnership
- A culture of performance and accountability is embedded within PYOT
- Reduction in First Time Entrants
- Reduction in Reoffending
- Reduction in Use of Custody

Allegations against adults working with children

The Local Authority Designated Officer (LADO) is responsible for managing and overseeing allegations made against adults working or volunteering with children. Working Together to Safeguard Children (2018) and Keeping Children Safe in Education (2017) set out the framework for how the LADO role is delivered and the policy document is available on the PSCB website.

Notifications need to be made to the LADO within one working day of a manager becoming aware of an allegation or concern of a safeguarding nature regarding a person working or volunteering with children.

This framework for managing allegations should be used in respect of all cases in which it is alleged that a person who works with children has:

- behaved in a way that has harmed a child, or may have harmed a child;
- possibly committed a criminal offence against or related to a child; or
- behaved towards a child or children in a way that indicates s/he would pose a risk of harm to children.

The number of notifications to the LADO during 2017-2018 has increased by 32% from the previous year with 238 notifications being received. These were in relation to staff working in the following agencies:

Children's Social Care	20
Schools	87
Further Education	2
Early Years	25
Faith Groups	3
Police	1
Health	12
Foster Carers	39
Childminders	1
Adults	1
Other PCC Departments	2
Public Services	2
Charity	19
Sports	10
Commercial	12
Other	2
Total	**238**

The most significant increase has been in notifications regarding staff and volunteers in Childrens Social Care, Early Years, Further Education, foster care, charities, sports and commercial organisations.

The data for CSC staff has been impacted by multiple allegations from one young person against several staff in one residential children's home. These allegations were all found to be false, unfounded, or did not meet LADO criteria.

Notifications relating to health workers and school staff have also increased.

These increases are likely to be linked to safeguarding education, awareness raising and an increased awareness of the LADO role and requirement to notify.

Where decreases have been noted these relate to small numbers of staff and small decreases from last year's figures.

A strategy discussion or meeting, chaired by the LADO, between the LADO and key agencies happens in 100% of cases within 2 working days from the notification being received. This ensures an action plan is in place to ensure that no child or children are left in a position where they are at risk of harm. Where initial strategy meetings were required this was achieved within 2 working days in 71% of cases. A designated minute taker is present at the meeting and minutes are sent out within 5 working days.

Allegations against adults working with children

The outcomes of the allegations in the 238 cases were:

Substantiated	15	6.3%
Unsubstantiated	23	9.7%
Malicious	2	0.8%
Unfounded	6	2.5%
False	23	9.7%
Advice only	65	27.3%
Did not reached criteria	59	24.7%
Transferred to another Local Authority	25	10.5%
On-going	20	8.4%

Keeping Children Safe in Education (2017) states that 90% of cases should be resolved within 3 months. In the twelve month period 79% of cases were resolved within 3 months. It is further guidance that 80% of cases should be resolved within one month; this was achieved in 69% of cases.

Further detail and information is available within the Management of Allegations Annual Report which will be presented to the PSCB on 31st October 2018.

Notification forms can be found on the PSCB website. If you wish to discuss a matter with the LADO, they can be contacted on 0239882500 or email LADO@portsmouthcc.gcsx.gov.uk

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Health & Care Portsmouth – Integrated Working Next Steps

1. Introduction and outline

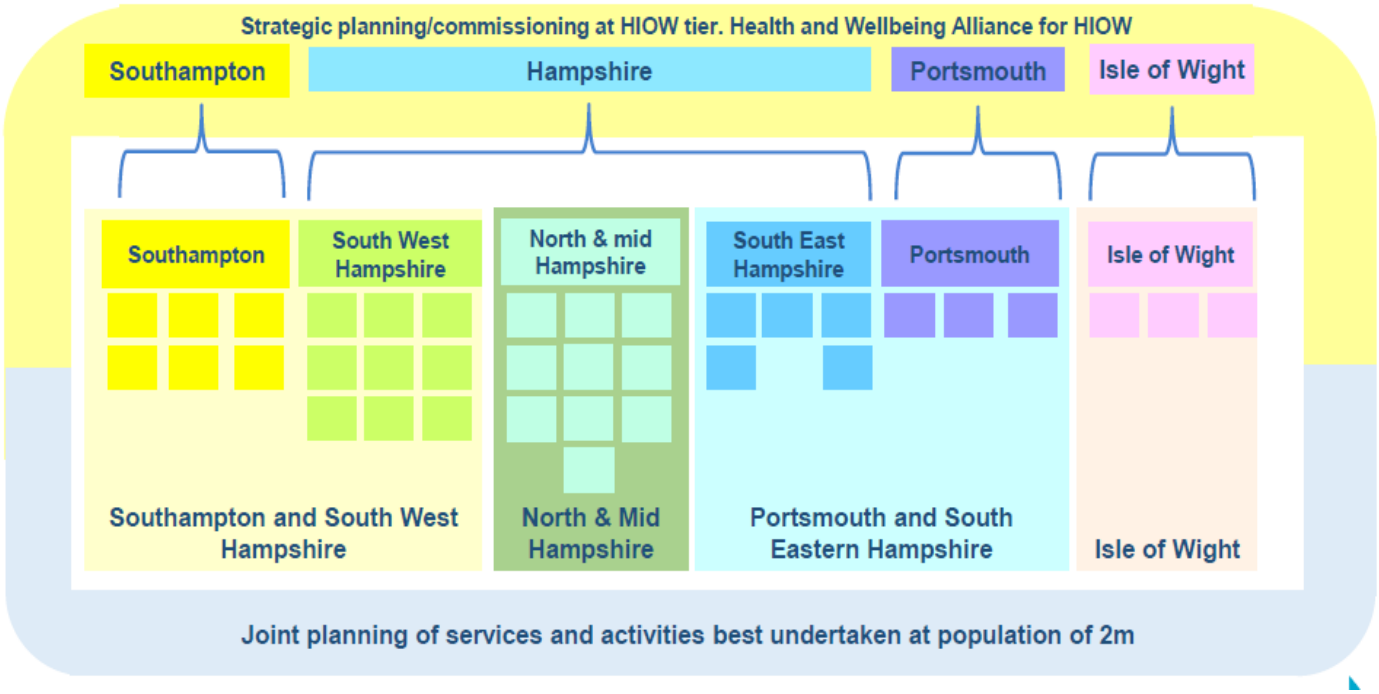
Portsmouth City Council (PCC) and NHS Portsmouth Clinical Commissioning Group (PCCG) have a long history of successful integrated working across health and care for the City. This is demonstrated through its single vision and blueprint of 'Health & Care Portsmouth' (HCP) and is underpinned by shared teams and posts as well as pooled funds utilising legislative measures such as section 75 and section 113 agreements.

This paper reviews the operating model in place between the two organisations in the context of the broader Hampshire and Isle of Wight Health & Care system reform programme and the desire to have a strong care system for the City and makes recommendations for the next steps for consideration by our Health and Well Being Board and the Governing Board of PCCG.

2. Direction of travel – operating at four different levels

Both organisations have a clear focus on improving the health and life experiences of the people of Portsmouth City whilst recognising that in order to do this they will continue to work as part of wider care partnerships and systems.

The Hampshire and Isle of Wight Sustainability & Transformation Programme (STP) – a collaboration between health and care partners - envisages providers, commissioners and Local Authorities working with residents and the voluntary and community sector at four levels which can be illustrated as:



The emerging purpose and description for each of the four levels can be articulated as:

Clusters Natural communities of 20-200,000 people	• The foundations of the reformed system • Strengthening primary care • Delivering integrated mental and physical health, care and wider services to cluster populations • City wide approach to clusters, aligned to 'natural communities' for appropriate services and care • Proactively managing the population health needs
Place based planning Aligned to existing Health and Well-Being (local authority) footprints	• Integrate local authority and NHS planning and delivery • Aligned to Health and Well-Being (local authority) footprints • Health & Local Authority aligned commissioning resource & agreed local leadership/management models. • Basis of the Joint Strategic Needs Assessment (JSNA), means through which Health and Well-Being Boards exert tangible influence on the direction of health and care services for the population through health and commissioning and wider determinants of health • Direct and drive Cluster development, ensure consistency of practice, reduce unwarranted variation
Integrated Care Partnership Based on c600k populations served by acute partners	• Support the vertical alignment of care enabling the optimisation of acute physical and mental health services • Design and implement optimal care pathways • Support improved operational, quality and financial delivery
Hampshire and Isle of Wight System 2 million population	• System strategy and planning • Implementing strategic change across multiple integrated care partnership footprints/places • Alignment of strategic health and Local Authority commissioning • Provider alliances (acute physical and mental health) • Oversight of performance and single system interface with regulators

There is a strong history of working within Portsmouth at a neighbourhood or 'cluster' level, recognising that this is where residents often access the majority of their health, care and community support. Many of the city's health & care services are configured to deliver within three localities within the city, supporting strong connections with other local services. In this respect, the direction emerging from the Sustainability & Transformation Programme aligns well with the approach in Portsmouth and, as such, PCCG and PCC are able to engage and operate at all of these levels. PCCG and PCC have an ambition to do so with a single voice for the City by establishing a single operating model across the two organisations.

3. Our current arrangements

PCC and PCCG deliver many of its health and care planning, prioritisation and commissioning responsibilities in an integrated manner through a range of mechanisms including:

- Portsmouth Health and Well-being Board providing politically accountable, multi-agency strategic governance

- A single vision and blueprint for 'Health & Care Portsmouth' with an underpinning executive and work programmes
- Health & Care Portsmouth Executive Group, providing senior officer input across NHS, public health, adults and children's services and community safety
- Integrated commissioning team (Health & Care Portsmouth Commissioning Services (HCPCS)) with shared people, single planning and programmes and pooled resources
- An integrated Better Care Fund (BCF) and programme which pools resources far beyond the minimum national requirement
- A Better Care Fund and Health & Care Portsmouth Commissioning Service partnership management group to oversee the above
- A single shared continuing health care team for adults with shared people, one process and pooled resources with an overarching partnership management group
- Delivery of a number of enabling and supporting functions by PCC to PCCG including: HR, workforce, learning & development, health and safety, landlord and facilities, complaints, freedom of information and engagement activities
- Integrated executive leadership through the appointment of a shared Chief of Health & Care Portsmouth who oversees the care systems working for the City and manages adult social care alongside PCCG commissioning responsibilities

All these arrangements are underpinned by Section 75, Section 113 agreements and other appropriate governance. In addition PCC is integrated with Solent NHS Trust in the provision of a number of shared community services and teams, such as adult mental health and learning disabilities

PCC also provides some services to other Local Authority partners including Gosport and the Isle of Wight, and has some shared arrangements with Southampton City Council and Hampshire County Council.

PCCG works in a commissioning partnership with NHS Fareham and Gosport CCG and NHS South Eastern Hampshire CCG focused predominately on shared approaches to the hospital interface. This is part of the Integrated Care Partnership (ICP) for Portsmouth and South East Hampshire (PSEH) which includes other NHS providers delivering health services for people in that geography. Both Portsmouth City Council and Hampshire County Council are members of this Integrated Care Partnership. The three CCGs also share shared teams for the delivery of performance, planning, finance, communications and Emergency Planning Response & Resilience (EPRR) functions.

Across the Hampshire & Isle of Wight region all NHS and Local Authority partners are considering how their operating model will need to change to further promote integrated delivery of services for their residents. Integrated ways of working between Portsmouth City Council and the NHS are well advanced in Portsmouth and this places the city in a good position to continue to deliver improvements for residents and also be an active partner in shaping these wider regional reforms.

4. Our key priorities as a City

Our Health and Well Being Board has developed and adopted a **blueprint for Health & Care**. This has been developed with our NHS partners and Portsmouth City Council. The blueprint vision is for everyone to live healthy, safe and independent lives with the right support for individual needs provided in the right place and at the right time. This means empowering individuals and communities to maintain good health and prevent ill health. It means a shift from acute care to community care. It means a radical improvement in early intervention and prevention. And it means joining up the planning, commissioning, delivery and management of services.

The blueprint aims to remove issues caused by working as separate organisations and to join up services around the care of individuals. This will include bringing together the statutory functions of the different organisations, and the commissioning of health and social care. The result will be joined up services integrated around the care of the person.

The blueprint sets out how we aspire for things to change in the future including:

- **To increase the care provided in the community, with a clear focus on early intervention and prevention**, and reducing the pressure on costly urgent and emergency care
- **Combined health and care teams will be created based in seven day a week 'community hubs' across the city.** The hub based teams will offer a broad range of services from primary and hospital care, to social care, wellbeing, mental health, occupational therapy, and rehabilitation and reablement
- A **single point of access will be created for health and social care in Portsmouth** so individuals, and their families and carers, find it easier to get the information and advice they need to make choices about the services they use and to manage their own care
- Better prevention and early intervention will enable **hospital care to be more focused on planned treatment** and, where urgent care is needed, choices will be simplified
- **Social care will continue to develop** so that people's social care needs are met in the community wherever possible
- Work to establish **multi-agency teams for children and families** will continue and will be incorporated, in time, into community hubs
- Future models of health and social care will be developed by **'growing our own' workforces, so health and social care staff have the skills to support new ways of providing services in the future**
- Making more effective use of buildings will build capacity for community based organisations and activities
- A coordinated information system will mean individuals have a single care record that can be accessed by them, and by those providing their care

5. Building a stronger voice and approach for our City

PCC and PCCG have a strong appetite to advance integration plans and to build on existing integrated working in the city. Both organisations, through these arrangements, aim to strengthen leadership for health & care in Portsmouth, make best use of our combined resources (people and money), reduce waste by avoiding duplication of management and achieve a better focus on health & care outcomes for people in the city.

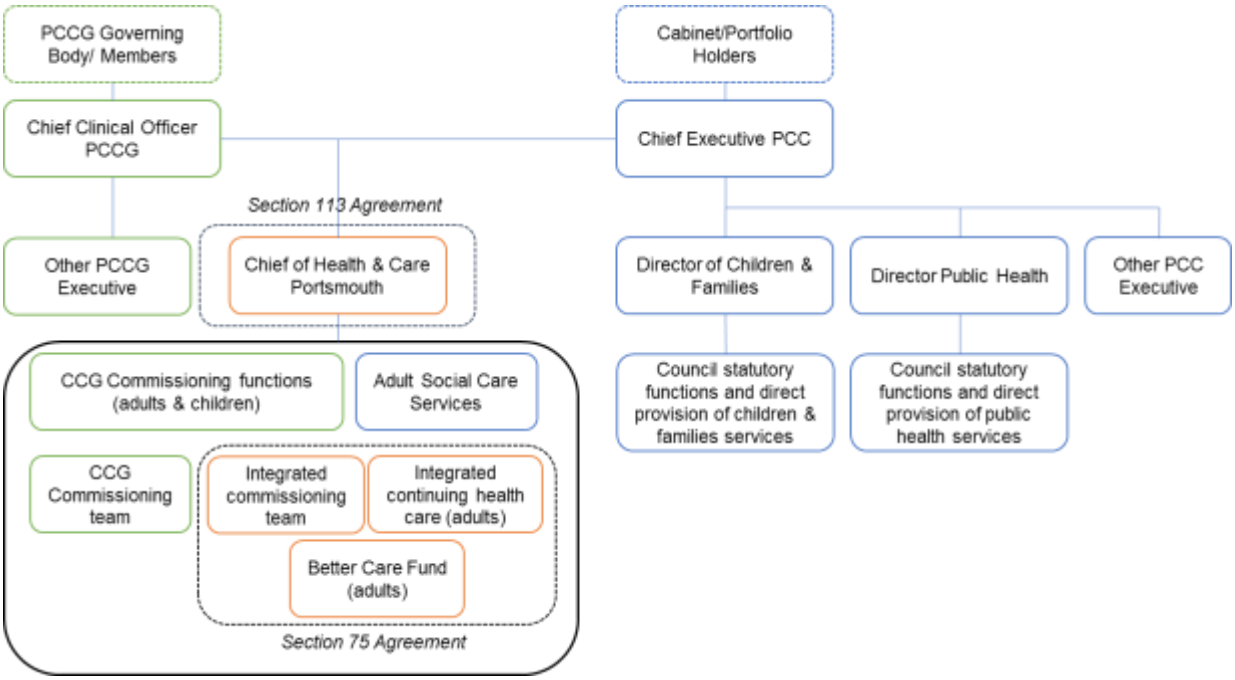
Strengthening arrangements for Health & Care Portsmouth will allow the city to work effectively as a partner in the Portsmouth and South East Hampshire Integrated Care Partnership. From a Hampshire & Isle of Wight Sustainability & Transformation Programme perspective, Health & Care Portsmouth will thus encompass the functions of both 'clusters' and 'placed based planning' (these are defined in Section 2 of this paper) and will enable a single voice for Portsmouth within all tiers of Sustainability & Transformation Programme and Integrated Care Partnership planning and delivery.

	Role of 'Health & Care Portsmouth'
Strategy & planning	• Place based planning driven by population needs assessment • Integrated Local Authority and NHS planning and delivery • Single strategy and plan for the City – Health & Care Portsmouth
Care redesign	• Developing new models of care across health, social care and public health • Delivery of new models of care with providers including integrated primary and community care teams in place across health and care • Programme management with providers to enable delivery of care redesign strategies
Workforce development	• Developing the right workforce with the right roles including new/extended roles, innovative workforce solutions to address city workforce challenges and to meet the needs of the blueprint including a focus on pathways to qualifications and multi-agency working • 'Organisational' development to cluster and other new ways of working
Accountability & performance management	• Oversight of delivery of the blueprint for Health & Care Portsmouth including clusters/new models of care • Delivery (and recovery) of constitutional standards/city agreed outcomes and driving improvement and reducing unwarranted variations in the City • A single approach to performance management
Managing collective resources	• Aligning health, care and other sector resources to focus on delivering improved outcomes building on existing integrated working arrangements • Pooled/delegated funds for range of health and care services – adults, children, public health • Directing resources to priorities and to address risks and perverse incentives • Shared support services
Leadership & governance	• A single coherent entity (Health & Care Portsmouth) bringing together agreed PCCG and PCC functions • Care professionals leading service integration and improvement • Working in collaboration with partners to further improve wellbeing, independence and social connectivity through the wider determinants of health including public health, housing, employment, leisure and environment • Further integration of governance with an Integrated Commissioning Committee bringing together PCC Elected members with PCCG Governing Board at a strategic level acting as the single decision making committee for commissioning in the City • A united voice/representation in the integrated care partnership and Hampshire and Isle of Wight wider system arrangements

6. The Current Operating Model

The current operating model for Health & Care Portsmouth is given below. This has been built over a period of years and on the basis of partnering and collaboration between the local NHS and Portsmouth City Council.

It utilises current legislation to ensure the statutory functions of the CCG and the Council are delivered in a way that is compliant with the law but also goes further making use of shared roles, resource and aligned budgets (e.g. Better Care Fund) to align decisions on health & care for people in Portsmouth.



7. Changes to our operating model

In considering what measures need to be taken on the next steps of our integration journey several aspects have been taken into account:

- Review and learning from our own experiences of integration – and a desire to take this forward in specific areas and to bring children's and public health integration work within a common governance arrangement with work on adult services
- A need to specifically address senior executive capacity across PCCG and PCC in order to ensure appropriate discharge of statutory duties such as the Director of Adult Social Services (DASS) and Director of Childrens' Services (DCS) functions and to ensure maximum value and reduced duplication from greater integrated working
- Learning and experience from elsewhere – both local partners (e.g. Southampton) and further afield
- The work undertaken as part of the Hampshire and Isle of Wight Sustainability & Transformation Programme and the Portsmouth and South East Hampshire Integrated Care Partnership

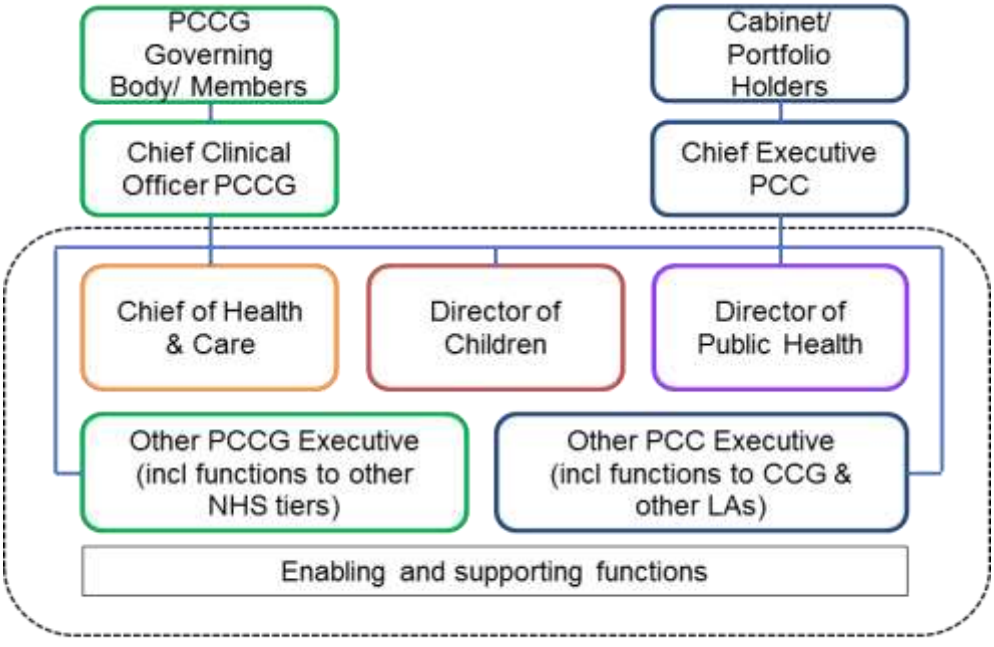
- Ensuring arrangements align with emerging partnership arrangements resulting from public sector reform now and into the future.

In summary, the proposals are:

- Incorporate defined PCCG functions for children services within the existing Director for Children's' Services in PCC, mirroring the integrated role for adults already established within the Chief of Health & Care Portsmouth in PCCG
- Integrate defined Public Health and PCCG commissioning functions within a single role or roles (utilising existing roles)
- To strengthen support to the Chief of Health & Care Portsmouth in the discharge of their statutory Director of Adult Social Services (DASS) functions - create a dedicated Director of Adults Services role, from an existing post within Adult Social Care, reporting to the Chief of Health & Care Portsmouth. This will ensure sufficient leadership capacity for adult social care transformation in the City and for engagement in other tiers (in particular the local Integrated Care Partnership)
- Review existing PCC and PCCG capacity currently reporting to the Chief of Health & Care Portsmouth, Director of Children's' Services and Director of Public Health and align roles and portfolios to this integrated Health & Care Portsmouth executive

Such a move to an integrated executive team for the shared health and care responsibilities of PCC and PCCG would underpin a strong health & care system for the City. This could look like:

Proposed Health & Care Portsmouth Operating Model



Integrated resource under a Section 75 or 113 agreement

This operating structure will also enable all health & care leaders and representatives from the City, including the two Accountable Officers for PCCG and PCC, to act as the 'voice of the City' in other system settings including the Integrated Care Partnership and the proposed strategic commissioner arrangements across Hampshire and Isle of Wight.

Chief of Health & Care Portsmouth:

Integration via the Chief of Health & Care Portsmouth role and team is advanced. This role leads the PCCGs strategic commissioning functions, directs the integrated arrangements for Health & Care Portsmouth for PCC and PCCG, and holds the statutory responsibility for Adult Social Care for PCC. This will role will be retained.

The development of a 3-year plan for improvement and delivery of adult social care services for Portsmouth requires a clear and dedicated leadership role with sufficient capacity to manage the change and delivery of operational adult social care services. A Director of Adults Services role will be created from an existing senior management role within PCC Adults and the supporting senior management team reconfigured to align portfolios to the strategic priorities of the 3-year plan. This role will be an integral part of the Health & Care Portsmouth leadership, reporting to the Chief of Health & Care Portsmouth as well as being a visible and active part of the emerging Portsmouth and South East Hampshire Integrated Care Partnership.

Portfolios and capacity within existing Director roles in the CCG are currently being reviewed to identify opportunities for these roles to incorporate responsibilities from both the CCG and PCC.

Consideration needs to be given to ensuring a balance of portfolios whilst also integrating management arrangements across health and care beyond the Chief/Director level – for example exploring a single approach to quality across health and care. Consideration also needs to be given to the current age related separation of certain functions such as those for safeguarding, mental health and vulnerable adult services.

Each of the Directors within the Health & Care Portsmouth operating model would also have a specific lead role for the City in the Integrated Care Partnership and Sustainability and Transformation Programme, and in some cases, lead programmes for the ICP (e.g. Mental Health). All team members in the Health & Care Portsmouth team would be part of the Section 75 agreement (or other arrangement to be agreed) for the City.

Currently PCC and PCCG have a single ‘integrated commissioning team’, line managed by the PCCG’s Director for Quality & Commissioning and formalised via a Section 75 agreement for pooled staffing; this team is known as the Health & Care Portsmouth Commissioning Service. The team delivers key functions including managing large scale service change across organisational boundaries, engaging and working with residents and front-line professionals to identify improvements and efficiencies. This skill set will continue to be required across the whole Health & Care Portsmouth programme of work. If agreed in principle by both the PCCG and Portsmouth City Council, further work will be conducted to establish how resources can be aligned (budgets and people) in order to reduce duplication and strengthen a single approach to planning, prioritisation, service improvement and resource allocation for those services in scope.

Children & Families:

There is an appetite to integrate the city's approach to health and care for children & families services to reflect the operating model already in place between PCCG and PCC for adults' services.

Based on scoping work undertaken between PCCG and PCC, there are a number of PCCG and PCC functions and services that could form part of an integrated Health & Care Portsmouth approach under the single leadership and direction of the Director of Children & Families, PCC.

Services or functions that are proposed to be in scope for a unified approach are given below.

PCC and CCG children & families functions proposed to be within scope

Portsmouth City Council	NHS Portsmouth CCG
• All Children's social care and early help services (all services within the Children and Families service) • All SEN and Inclusion services including behaviour and attendance, PSHE and Post 16 young people's support services • Ethnic Minority Advisory Service • Out of city care and education placements • Public Health nursing services (health visiting, school nursing and Family Nurse Partnership service)	• Children & Adolescent Mental Health Services including Tier 2 provision (currently commissioned from the 3rd sector) and neurodiversity provision • Childrens' Therapies (physio, occupational therapy, speech and language, podiatry) • Children's Community Nursing • Continence • Special school nursing • Continuing Care for children • Community Paediatric Medical Services • Community Eating Disorders • Inpatient Eating Disorders • Unplanned acute care (emergency paediatrics) • Planned acute care • Maternity • Wheelchairs provision for children (subject to current procurement commitments)

The following PCC services or functions are currently considered to be out of scope of these proposed integration arrangements:

- School place planning; school admissions
- School improvement

If agreed in principle by both PCCG and PCC, further work will be conducted to establish how resources can be aligned (budgets and people) in order to reduce duplication and strengthen a single approach to planning, prioritisation, service improvement and resource allocation for those services in scope. As part of this, consideration will be given to the relationship between this integrated Director of Children & Families role and other PCCG responsibilities including NHS planning and performance, quality assurance and financial management. This would include considering utilisation of current legislation to secure good, legal governance (for example use of Section 75 or Section 113 powers).

Public Health:

There is an opportunity to consider integration of planning, prioritisation and leadership of Public Health commissioning with NHS commissioning. There are several interdependencies between the services commissioned by Public Health and those commissioned by the CCG. Currently PCCG and PCC work collaboratively to mitigate any unintended consequences of decisions made within their respective, separate functions. There is appetite currently to establish a single approach to NHS and Public Health commissioning for services where these interdependencies are strongest and where, from a resident's perspective, the current division of planning limits the provision of a single integrated approach to care.

Using as a starting point the 2011 Department of Health guidance on Local Authority Public Health commissioning responsibilities the following areas are where Public Health and PCCG commissioning have a clear impact on each other and could form the basis of a single integrated operating model between PCCG and PCC:

Portsmouth City Council	**NHS Portsmouth CCG**
Alcohol and drug misuse services Preventative mental health services (suicide prevention)	Adult mental health Hepatology services
Sexual health services/promotion	Termination of pregnancies, vasectomies and overlap with GP Locally Commissioned Services (e.g. provision of long acting contraception or LARC) (HIV services are commissioned by NHS England Specialist Commissioning)
Public Health Children programme (currently delegated to the Director of Children & Families, PCC)	CCG Children's & families services (noting proposal is to delegate these functions to the Director of Children & Families, PCC)

There are further opportunities to consider whether other interdependent PCCG and PCC public health functions could be brought together under this single operating model once established. This includes obesity services and aspects of prevention programme work (such as smoking and maternity or healthchecks and diabetes + hypertension services).

If agreed in principle by both PCCG and PCC, further work will be conducted to establish how resources can be aligned (budgets and people) in order to reduce duplication and strengthen a single approach to planning, prioritisation, service improvement and resource allocation for those services in scope. This would include considering utilisation of current legislation to secure good, legal governance (for example use of Section 75 or Section 113 powers).

Enabling Functions:

We will continue to explore the opportunities presented by integrating further other functions of PCCG and PCC in support of our strategies and plans. In particular the following functions will be reviewed:

Financial planning and management: local government and NHS financial responsibilities, constraints and regimes vary considerably. Recognising that statutory and democratic responsibilities for budgets will remain unchanged in this operating model, there are benefits in bringing together aspects of our financial management arrangements to align with the Health & Care Portsmouth single operating model and it is proposed to scope the potential to develop a singular approach to strategic financial planning to underpin Health & Care Portsmouth.

Use of data and intelligence to improve the health & care offer: There is a need to strengthen the intelligence functions to allow better assessment of local need to inform commissioning decisions. This function should include where possible other sources of data that are relevant to commissioning services, including information about wider determinants of health that may be relevant to services that are provided under the banner of improving health. This would need to be accompanied by a better understanding of the available evidence about the effectiveness of proposed interventions.

This needs to be integrated with developing intelligence offers at a Sustainability and Transformation Programme and Portsmouth and South East Hampshire Integrated Care Partnership level, to ensure that needs across the Hampshire and Isle of Wight system are considered in resource allocation and also to ensure that health inequalities are considered in commissioning processes. Integrating our skills on the collection and presentation of data locally would have benefits in more informed commissioning and service design.

Performance management, planning and business/governance services in support of the Health & Care Portsmouth Executive and its programme of work must be explored to find the most effective operating models.

Communications and engagement: there are already good collaborative working arrangements between PCCG, NHS partners and PCC for the delivery of communications and engagement functions where there are shared business; building on these arrangements, there will be benefit to assessing what options are available within these existing resources to better align communications & engagement capacity with the single operating model.

There are a number of opportunities to focus on the **wider determinants of health** through collaborative working with housing, leisure, education and also bringing together resources in areas such as community engagement. Establishing a clearer leadership for Health & Care Portsmouth enables further cross-departmental working as well as further integration between health & care and all PCC functions.

There are opportunities to develop joint working arrangements in relation to **specialist functions** such as Business Continuity Planning, Emergency Planning & Resilience Response, estates and capital planning.

Financial Impact:

As far as possible these changes need to be achieved within existing available resources. The proposals currently focus on utilising existing roles within both PCC and PCCG to consolidate functions, reduce duplication and form a single Health & Care Portsmouth leadership. If the proposed model is supported in principle by both PCCG and PCC, it is recommended that the respective Accountable/Chief Executive Officers, working within their scheme of delegations and constitutional powers, review the management and staffing structures currently in place in order to align this capacity with the new Health & Care Portsmouth operating model. This will include reviewing current cost-share arrangements in place between PCCG and PCC for joint roles to ensure they reflect the new operating model.

8. Changes to our Governance

PCCG and PCC already have a range of Section 75 agreements and Section 113 agreements to underpin its joint working arrangements supported by individual partnership management groups. These would need to be refreshed to fit the broader approach described in above.

Our **Health and Well Being Board** at its October meeting agreed proposals for a revision of partnership structure in Portsmouth which included revisions to the remit of the Health and Well Being Board. The Health and Well Being Board provides a statutory body which can be developed to provide the necessary decision-making, governance and accountability to deliver this integrated approach, and meet the aspirations of both PCCG and PCC to streamline the current partnership boards operating across the city.

It is proposed that Portsmouth develop an **formal committee or sub-committee (or similar)** which would be able to make joint decisions on behalf of PCC and PCCG for its commissioning of adult and children's health, social care and public health services in conformity with the policy set by the Health and Well Being Board. National evidence shows how having a unified approach to health and care planning and funding (commissioning) provides greater opportunity to improve outcomes for our residents. Such a committee would have delegated powers from PCC/Cabinet and PCCG Governing Board to mirror the scope of the expanded section 75/113 agreements described earlier plus other existing partnership agreements/shared funding arrangements. This committee would bring together many of the functions of the existing partnership management groups as well as potentially taking on delegated authority for some of the responsibilities currently within the remit of the Health and Well Being Board.

9. Relationship with other tiers of planning

The proposals outlined above would move the City to a unified approach and voice across health and care for the City. It would also provide a direct alignment to policy on children's services, housing, community safety and other aspects of city management that have a direct impact on the determinants of health and care. This would allow us to take an integrated City perspective in our working relationships with the Portsmouth and South East Hampshire Integrated Care Partnership. In addition the integrated health and care approach described would enable clear City executive leadership in each of the partnership programmes to ensure alignment between the partnership strategies and the work of Health & Care Portsmouth.

10. Conclusion and Recommendations

Portsmouth is well placed to increase the pace and depth of its integrated commissioning arrangements which can work as a single entity in other layers of planning and delivery of health & care. Portsmouth has a strong track record of building on its asset of co-terminosity and history of integrated working. Through these arrangements it is believed that together PCC and PCCG will be able to push further and faster its delivery of its blueprint for Health & Care Portsmouth and improve the health and care experience of the residents of the City.

PCC and PCCG are asked to support the recommendations of this paper:

- Establishment of a single operating model for Health & Care Portsmouth between PCC and CCG
- Establishment of a committee on behalf of PCC and PCCG for its commissioning of adult and children's health, social care and public health services
- Integration of PCCG and PCC functions into joint roles: Chief of Health & Care Portsmouth, Director of Children's' Services and Director of Public Health
- Review and reconfigure the structures and existing capacity under these roles to ensure capacity is available to deliver Health & Care Portsmouth whilst recognising the need to achieve running cost efficiencies
- A review of other enabling functions to assess the benefits of further integration to support delivery of the Health & Care Portsmouth operating model – specifically financial management, business intelligence, communications/engagement, community sector partnership development
- Direct the respective Accountable/Chief Executive Officers, working within their scheme of delegations and constitutional powers, review the management and staffing structures currently in place in order to align this capacity with the new Health & Care Portsmouth operating model and for this to include cost-share arrangements

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Hampshire & Isle of Wight (HOIW) Sustainability and Transformation Partnership (STP) System Reform Proposals

1 Introduction

The Health and Well Being Board are asked by the STP to consider 'The System Reform Statutory Board Pack' (see attached).

The system reform proposals have been developed by the Hampshire and Isle of Wight Sustainability and Transformation Partnership (STP) Executive Delivery Group (EDG).

The attached document summarises the proposals developed over the Summer for consideration by all NHS provider board, CCG Governing body and local government cabinets at their respective meetings over the autumn of 2018.

For ease of consideration the recommendations made throughout the document have been pulled out into this separate note for the Boards reference.

Whilst the general direction of travel is uncontentious and the recommendations, as written, provide for considerable flexibility, the Governing Board will wish to consider the most effective way to develop the approaches set out, ensuring that any potential duplication of effort or source of confusion between the various layers of operation is minimised.

Specific work will be undertaken to develop the individual recommendations in due course – and approvals sought from Boards and organisations as and when appropriate.

2 Summary of Recommendations:

The following statements / considerations are directly lifted from the 'The System Reform Statutory Board Pack' and should be considered with document as reference.

As stated on slide 24, the Board is asked to endorse:

1. The developing role of clusters as outlined on the previous slide (slide 23)
2. The recommendation that partners across Health & Wellbeing Board (HWB) footprints and integrated care partnerships work together to define the resources required for cluster operation – a critical first step is establishing professional and operational leadership to drive cluster development
3. the proposed next steps for the cluster task and finish group which are summarised as follows:
   a) Quantify the impact/expected outcomes of cluster teams (already in progress in most areas): defining outcome metrics for individual clusters and a small set of common metrics across whole HIOW
   b) Describe the support requirements and responsibilities to accelerate full cluster implementation
   c) Describe the proposed interplay between clusters and other components of the Integrated Care System (ICS), including governance and participation arrangements for clusters as part of HWB footprints and integrated care partnership structures
   d) Strengthen primary and social care involvement in this work at a Hampshire and Isle of Wight level (membership of the task and finish has already been extended to reflect this)

As stated on slide 27, the Board is asked to endorse the following recommendations from the Executive Delivery Group (EDG), informed by the task and finish group work to date:

1. The emerging ‘restatement’ of the function of partnership working on a HWB footprint as described on the previous slide
2. The proposed next steps for a task and finish group by the end of September, which are to:
   a) define the common functions of the role of HWB footprints in an integrated care system
   b) clarify the relationship between this and the other component parts of the proposed Hampshire and Isle of Wight Integrated care system
   c) set out a mechanism for achieving ‘active and effective democratic engagement at all levels’ across the Hampshire and Isle of Wight integrated care system (including the role of HWB)

Leads from the other Hampshire and Isle of Wight task and finish groups on integrated care partnerships, strategic commissioning and clusters will be involved in developing this thinking.

As stated on slide 33, the Board is asked to work with geographically aligned partners within the identified four Integrated Care Partnership (ICP) footprints to:

1. Discuss and agree the remit and focus of the ICP;
2. By October 2018 prepare a Memorandum of Understanding [MoU] that sets out the remit, focus and the leadership / governance / decision making arrangements of the ICP and how the local Health and Wellbeing Boards (Care systems) and the ICP interface with one another - the balance and focus of each;
3. Set out the key milestones for the ICP for April 2019 and April 2020.

As stated on slide 39, the Board is asked to: endorse the recommendations of the EDG, informed by the work of the strategic commissioning task and finish group, that:

1. The strategic commissioning task and finish group further develop the proposal with an aim to establish a strategic commissioning function by October 2018, initially through a joint committee which will have delegated authority to make binding decisions in relation to its in-scope functions and responsibilities.
2. That a new task and finish group is convened including providers, commissioners, local authorities, and NHS England and NHS Improvement, to work together and take responsibility for the development of the next phase of the work to build the strategic planning, transformation, resource allocation and assurance function for HIOW, constructing ICS governance that supports our approach.

(A summary of the recommendations being asked for endorsement by the Board are found in slides 41 and 42)

NHS
Hampshire and Isle of Wight
Sustainability and Transformation Partnership

Hampshire and Isle of Wight System reform proposal

Statutory body pack

August 2018

MOVING FORWARD TOGETHER

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Introduction and context

Purpose of this document

This document summarises the system reform proposal as developed to date through the work of the Hampshire and Isle of Wight Sustainability and Transformation Partnership's (STP) Executive Delivery Group (EDG) and informed by the broader health and care system leadership.

It forms the basis for NHS provider board, CCG governing body and local government cabinet consideration at their respective meetings in autumn 2018.

Context

The health and care system across Hampshire and the Isle of Wight has been working together to develop a response to the national ambition to improve the integration of health and care for the benefit of local people.

As the Care Quality Commission put it in its 2016/17 State of Care report:

"People should be able to expect good, safe care when they need it, regardless of how this care is delivered... It's clear that where care providers, professionals and local stakeholders have been able to do this – where they have stopped thinking in terms of 'health care' and 'social care' (or specialties within these) and instead focused their combined efforts around the needs of people – there is improvement in the quality of care that people receive. To deliver good, safe care that is sustainable into the future, providers will have to think beyond their traditional boundaries to reflect the experience of the people they support."

National context

The most recent mandate given by the Government to NHS England includes increasing integration with social care so that care is more joined up to meet physical health, mental health and social care needs. More recently, the House of Commons Health and Social Care Committee has expressed its support for improving integration of care, highlighting its potential to improve patient experience.

NHS England's policy goals in relation to this area have been clear for some time. NHS England's ambition to transform the delivery of care in this spirit was first described in 2014's Five Year Forward View (FYFV):

"The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three"

Case for change

What do our citizens and our staff tell us?

Our citizens have been consistent in telling us that…

- they want **better and more convenient access** to support to help them to live well for longer. We have diverse communities across Hampshire and the Isle of Wight and people want support better suited to their needs;
- **they value and have confidence in General Practice and the wider primary and community team,** but there is a bewildering array of teams who do not appear to communicate with each other. **People often have to repeat their story** multiple times, making accessing care a frustrating experience. So they want all of the clinicians and care workers involved in their care to know their care plan, to work together and to communicate with one another. Many people also want greater control of their care, from better access to their records through to personalised budgets;
- when they have an urgent care need, **rapid access to the right clinical advice and support** is the most important factor to them. They want the health and care system to make sure they know how to rapidly access a complicated and sometimes confusing system;
- when they are managing a long term physical and/or mental health condition they typically want continuity of relationship with a trusted clinician to support them; they want better support to understand and manage their condition; and they want to ensure that when they travel for specialist advice and support, then the journey is worthwhile. Currently **40% of people** whom have a long term condition tell us they **don't feel supported** to manage their condition.
- they are more **willing to travel a little further for specialist care** if the services they access will give them better outcomes. People also add however, that there is nowhere like home and that they would rather be there, than a hospital bed. Unfortunately a quarter of people in hospital still do not feel involved in decisions about getting them home.

Our workforce are telling us that:

- they are **under more pressure than ever** before. They often feel that there is not enough time in the day, with too many targets to reach and administrative tasks to perform, both of which take time away from patients;
- services are running on such **low staff numbers** that any unplanned sick leave or annual leave has a significant effect. Despite significant efforts of some providers, we continue to exceed our planned expenditure on agency and locum spend;
- care professionals want a means by which to **share information** with other professionals within the system. There is often a poor interface between primary, secondary and community care with time wasted trying to contact other care services;
- whilst it doesn't feel this way in general practice, and in the community and hospital services, our workforce has actually increased over the last few years. However so too has the number of people leaving within two years;
- many frontline staff have spent large parts of their professional careers **trying to integrate care for patients,** often working around policies that construct rather than remove barriers to integrated care at local level;
- they want **better career options** along with opportunities to improve their skills and expertise.

What does the data tell us?

We need to strengthen our approach to prevention, early intervention and supported self-management…

- We have a national reputation for developing innovative models of prevention, case finding and early intervention and supported self-management. However, we have not systematically implemented these innovative models. For example, within three years, 330 heart attacks and 490 strokes could be averted with improved detection and treatment of hypertension and atrial fibrillation. This represents a cost saving of up to £2.5m for heart attacks and £6.7m for strokes through optimal anti-hypertensive treatment of diagnosed hypertensives.
- For cancer services, for example, we have made real progress in improving the early diagnosis of cancers over the past 4 years, and are now are one of the best performing systems in the country. But we still only **diagnose just over half of cancers at stage 1 and 2**.
- The **life expectancy of people with serious mental illness is 15-20 years less** than the average life expectancy in Hampshire and the Isle of Wight, with two thirds of these deaths due to avoidable causes. And yet the number of health checks for people with severe mental illness in HIOW is below the national average.
- We are making improvements, but we are **not yet closing the inequalities gap -** the life expectancy gap (and disability-free years gap) across HIOW is not closing.

The complexity and fragmentation of our current system (including siloed budgets and payment systems) is currently holding back a system focus on this agenda.

We have a significant opportunity to improve discharge and flow across Hampshire and the Isle of Wight…

- Our citizens continue to **stay in hospital for a long time** even though many are medically fit to leave. As we know the longer people stay in hospital, the more likely they are to develop complications and reduced independence; and it is also expensive to keep someone in hospital unnecessarily.
- Our flow and discharge is noted as being in the **lowest performance quartile in the country**
- We continue to be the **second poorest performing system in the country** with regards to **delayed transfers of care**.
- **We are the second poorest performer** nationally with regards to **CHC assessments in the community**.
- Recent data positions us as having one of the greatest opportunities nationally to reduce **excess bed days** and super-stranded patients.
- There has been a relentless focus on improving discharge and flow across all of our systems and yet despite this the number of delayed transfers of care per 100,000 population remains at the same rate it did two years ago*

This data would indicate that continuing to operate as we have done in the past will not yield a different outcome. We need to reform the system in a way that best allows us to tackle the challenges we face.

* with the exception of the Isle of Wight which now operates with three times fewer delays as other HIOW systems.

What do we know about new models of care?

The past four years have seen significant progress in developing 'new care models' which are founded on integration between partners and a systematic focus on the whole population's needs. Nationally we have seen both Multispecialty Community Provider and the Integrated Primary and Acute Care Systems develop. More recently the Next Steps on the Five Year Forward View further articulated the ambition ***'to make the biggest national move to integrated care of any major western country'.***

Within our patch we are reporting very tangible benefits for our citizens as a result of health and care partners working together / integrating more effectively than we have seen before. In the most developed systems we are seeing:

- **1% reduced emergency admissions** compared to an average of 3.5% growth nationally;
- New models of care are successfully managing and treating people more effectively in the community **reducing potentially "avoidable" emergency admissions by 10%** on last year;
- **4% reduction in GP referrals** on last year;
- **Reduction in the number of people experiencing mental health crisis** / emergency admission to acute mental health beds as a result of enhanced support in the community
- **A&E attendances are holding at the same level** as last year compared to demographically similar systems which have increased activity on last year;
- Citizens engaging with integrated care teams are reporting **significant improvements in health status, personal wellbeing, experience and health confidence;**
- **Staff satisfaction rates significantly improving** where they are operating in integrated care teams.

These achievements are both important for citizens, staff and for the financial health of the system. We know that new models of care work, however, our integrated primary and community teams are at different stages of development and so too are their interfaces with local health and wellbeing footprints and the acute physical and mental health system.

Finance and efficiency

Increasing value for money

The current funding and budget systems make it hard to reallocate resources to where they are needed most. This can also be prohibitive to collaborative working between partner organisations. Frustratingly for all, the current payment systems can be unhelpful – rewarding activity rather than outcomes.

Our financial position is unsustainable. Hampshire and Isle of Wight NHS has forecast a 'do nothing' gap of £577million gap by 2020/21 (23% of our £2.5bn allocation) and in addition to this, the pressures in social care and local government more broadly are unprecedented. Whilst the required level of efficiency has been delivered to date we require a step change in productivity and cost reduction to ensure we meet our financial targets.

In many organisations too much resource and energy is focused on seeking to suppress expenditure in providers or generate additional income from commissioners, rather than work in partnership to focus on cost reduction, quality improvement and living within the system's finite resources. **We will require different approaches**, including **collaboration**, e.g. pathology, pharmacy distribution centres; scale, eg: collective procurement; **back-office optimisation**, eg: HR, finance; **greater partnerships**, eg: increasing retention of our workforce, reducing bank and agency costs; and **reduced unwarranted variation** in practice.

If we are to make the transformational changes required to improve outcomes, experience, satisfaction, quality, performance, financial sustainability and address our workforce challenges **we must radically enhance our functionality, removing obstacles to enable far greater collaboration and integration**. These radical changes will become a reality only if there is a collective commitment from all partners to transform and implement a new way of working.

Reducing complexity

- We have **21 NHS and local authority statutory partners** as signatories to our transformation partnership **and three non-statutory partners** (with leadership responsibilities around workforce, innovation and research).
- We have **grown our workforce by 4.5%** over the past three years. Too much of this growth has, however, been in non-clinical roles. One of the key drivers for this is the continuing burden of reporting, assurance and inter-organisational contract management.
- **We are a complex system.** Whilst there has been collaboration between provider, commissioner and regulatory partners, our system reform work over the past six months has demonstrated significantly greater opportunity to reduce system complexity; reduce the burden of assurance and reporting and ensure all partners collaborate towards clearer strategic goals;
- NHS England and NHS Improvement are currently undergoing a national and regional integration programme. The expectation is that locally the Hampshire and Isle of Wight system will develop **simpler but more effective self-regulation and assurance models** that will allow NHSE/I to work more strategically with the system.

The system reform programme is a means by which we can reduce this complexity and develop strong self-regulation and assurance models.

The proposed system

Our vision

"Our vision is to support citizens to lead healthier lives, by promoting wellbeing in addition to treating illness, and supporting people to take responsibility for their own health and care. We will ensure that our citizens have access to high quality consistent care 24/7, as close to home as possible.

Our vision – tomorrow's system

We are taking action to prevent ill-health and promote self care...

- Empowering citizens, patients, service users and communities
- Harnessing technology more effectively to support wellbeing

We are strengthening local primary and community care...

- Developing integrated health and social care teams designed to support the needs of the local communities they serve
- Ensuring a strong and appropriately resourced primary care workforce
- Providing care in the right place at the right time by reducing over-reliance on hospitals and care homes
- Using technology to revolutionise people's experiences and outcomes;

We are improving services for people who need specialist care...

- Identifying, understanding and reducing unwarranted variation in outcomes, clinical quality, efficiency;
- Through consolidating more specialised care on fewer sites;

We will make intelligent use of data and information to empower citizens, patients, service users and support our workforce to be more efficient and effective in delivering high-quality care

Integrated care systems

The HIOW Executive Delivery Group (EDG) – representing the HIOW health and care system – recommend that to deliver our vision for health and care, we need to reform our system to ensure 'form follows function', signalling a shift from the separation of provision and commissioning to integrated planning and delivery. Nationally there is a similar realisation, which has led to the national guidance on Integrated Care Systems.

What is an integrated care system (ICS)?

NHS England defines ICS as those systems in which:

"Commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations".

What will an integrated care system do?

National guidance sets a number of expectations for ICS:

- ICS are expected to produce together a credible plan that delivers a single system control total, resolving any disputes themselves.
- ICS will assure and track progress against organisation-level plans within their system, ensuring that they underpin delivery of agreed system objectives.
- [ICS] will be given the flexibility, on a net neutral basis, and in agreement with NHS regulators, to vary individual control totals during the planning process and agree in-year offsets in one organisation against financial under-performance in another.
- NHS England (NHSE) and NHS Improvement (NHSI) will focus on the assurance of system plans for ICS rather than organisation-level plans.

There is an expectation that, over time, ICSs will replace STPs.

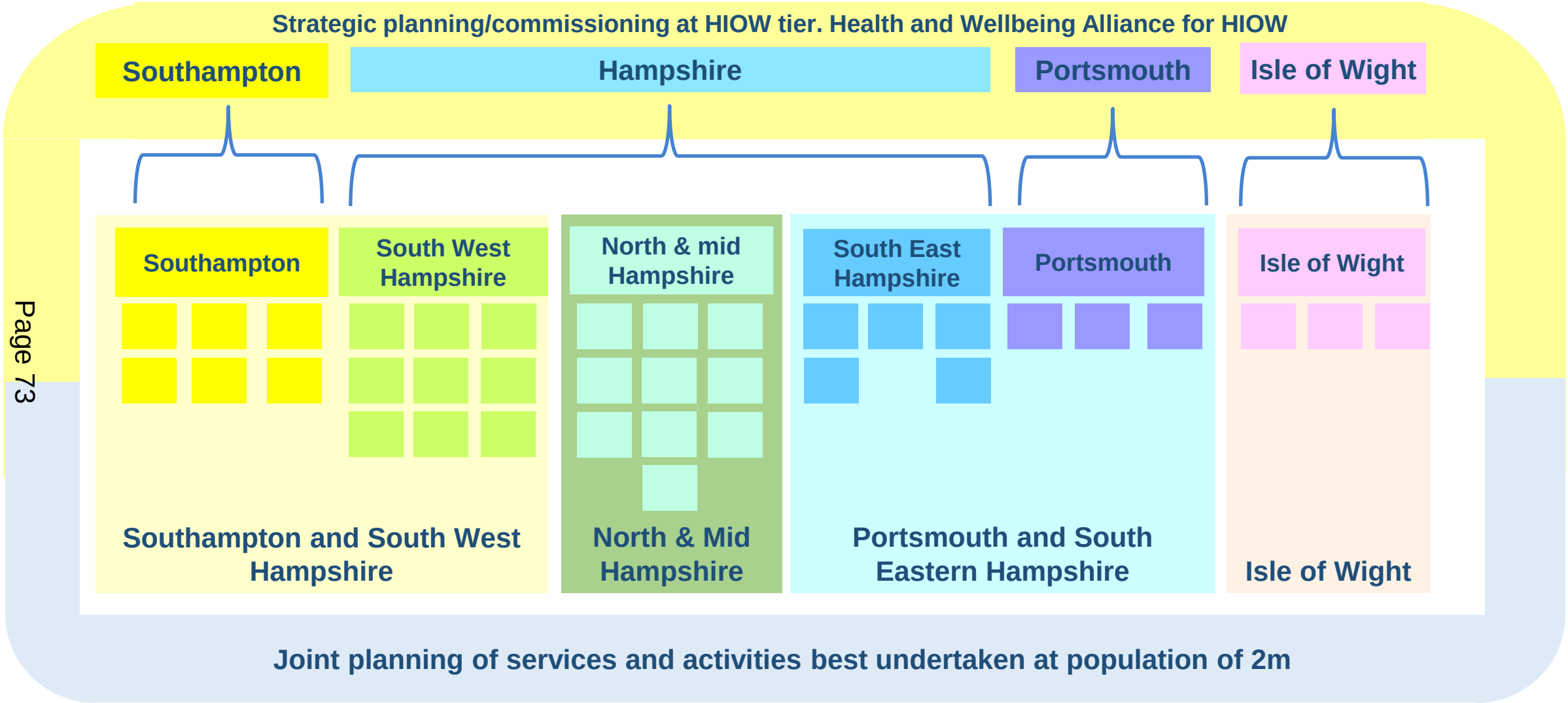
Benefits of ICS – the national view

- Creating more robust cross-organisational arrangements to tackle the systemic challenges facing the health and care;
- Supporting population health management approaches that facilitate the integration of services focused on populations that are at risk of developing acute illness and hospitalisation;
- Delivering more care through re-designed community-based and home-based services, including in partnership with social care, the voluntary and community sector; and
- Allowing systems to take collective responsibility for financial and operational performance and health outcomes.

Local alignment

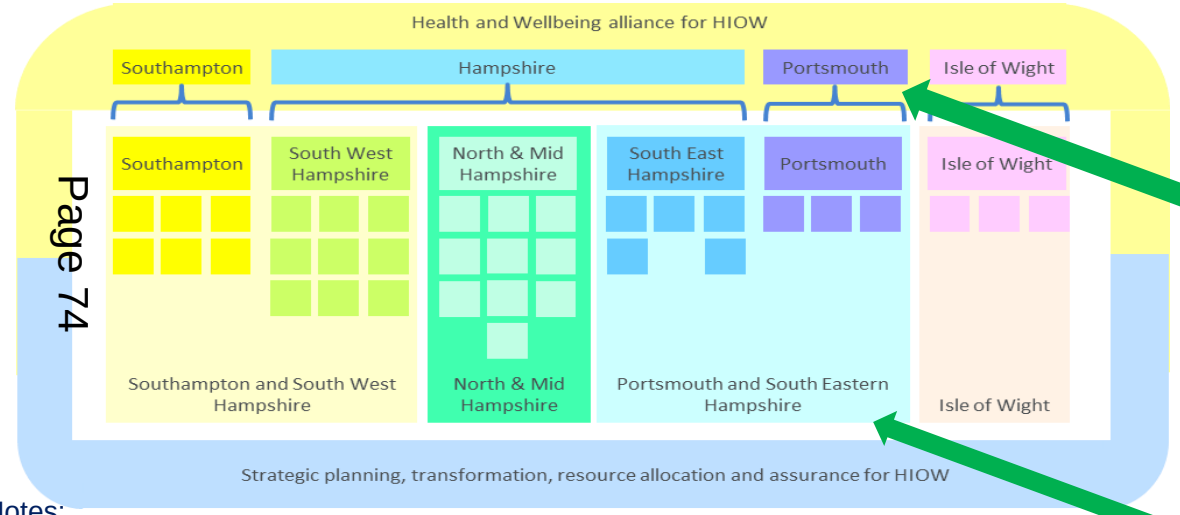
The EDG tasked a sub-set of its members, supported by others, to form a series of task and finish groups to develop the key elements of a proposal for moving the HIOW system towards ICS ("the system reform programme").

How could HIOW look in the future?



The proposed HIOW integrated care system:
A whole system planning, delivering and transforming in collaboration

The proposed reformed system envisages providers, commissioners and local authorities working in ever closer collaboration with each other and with citizens and voluntary sector organisations to address the case for change, empowering and supporting citizens to best manage their own health and wellbeing and frontline teams to provide and sustain the best possible services and care.



Component	Purpose and description
Accelerated implementation of 36 clusters Natural communities of 20-100,000 people	• The foundations of the reformed system • Strengthening primary care • Delivering integrated mental and physical health, care and wider services to cluster population • 36 clusters, aligned to 'natural communities'. • Proactively managing the population health needs
Ongoing development of place based planning Existing Health & Wellbeing Board footprints	• Integrated local authority & NHS planning • Aligned to HWB (local authority) footprints • Health & LA aligned commissioning resource & agreed leadership/management models • Basis of the JSNA, means through which HWB exert tangible influence on the direction of health and care services for the population through health and care commissioning and wider determinants of health
Simplified structure of 4 integrated care partnerships populations of c600k served by acute partners	• Support the vertical alignment of care enabling the optimisation of acute physical & mental health services • Design and implement optimal care pathways • Support improved operational, quality and financial delivery
HIOW integrated care system Drawing together the above component parts, delivering some functions at a scale of 2 million population	• System strategy and planning • Implementing strategic change across multiple integrated care partnership footprints/places • Alignment of strategic health and LA commissioning • Provider alliances (acute physical & mental health) • Oversight of performance and single system interface with regulators

Notes:

1. The term 'cluster' is used for consistency to describe the foundation of the system where general practices with statutory and voluntary community health and care services work together in 20-100k populations to meet the needs of local residents. A variety of terms are currently used to describe this including localities, extended primary care teams, natural communities of care, neighbourhood teams.
2. Where HWB and integrated care partnerships are coterminous, activities are undertaken together. In areas where integrated care partnerships span more than one HWB footprint, the partners will work together to determine the most appropriate allocation of responsibilities between HWB area and the integrated care partnership to achieve the shared objectives.
3. The Hampshire HWB area also includes North East Hampshire, which is also part of the Frimley Integrated Care System and therefore omitted from the figure above

Conditions for integration

The development of an ICS for Hampshire and Isle of Wight has been based upon a variety of national guidance and evidence from around the country about best practice approaches. We have studied the work ongoing in Surrey Heartlands Dorset, Manchester and South Yorkshire and Bassetlaw and learnt from their experiences.

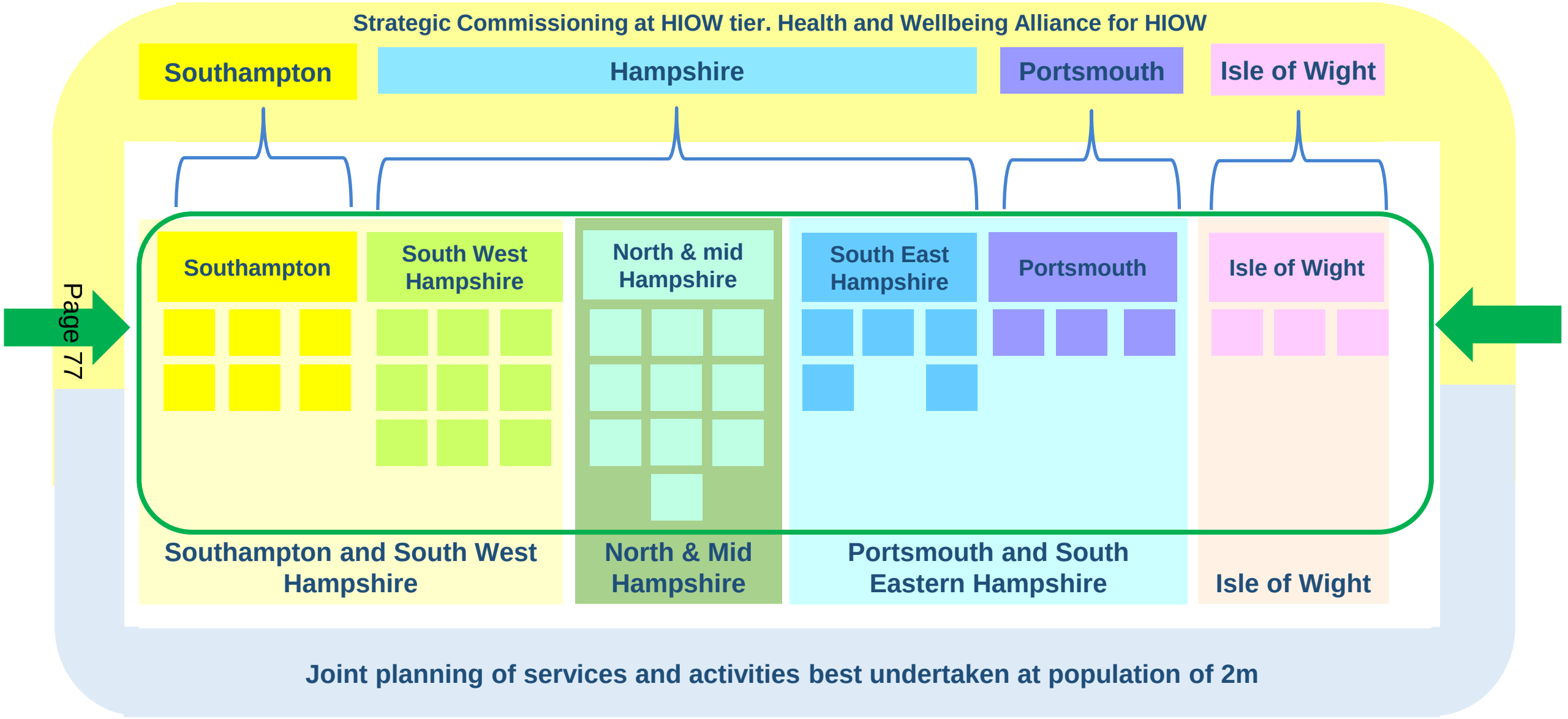
The work of the Kings Fund on integration is also helpful in setting out conditions which support greater integration. Their assessment is that current and future ICS must address the following development needs if they are to succeed in transforming health and care, building on new care models and related initiatives:

- Developing trust and relationships among and between leadership teams
- Establishing governance arrangement to support system working
- Committing to a shared vision and plans for implementing the vision
- Identifying people with the right skills and experience to do the work
- Communicating and engaging with partner organisations, staff and the public
- Aligning commissioning behind the plans of the system
- Working towards single regulatory oversight
- Planning for a system control total and financial risk sharing.

The work involved in addressing these needs is time consuming and cannot be rushed: ‘progress occurs at the speed of trust’, **collaborative rather than heroic leadership holds the key to progress.**

Components of the system

Clusters - integrated primary and community care teams



Clusters - integrated primary and community care teams

Clusters will be the bedrock of the reformed delivery system. The key purpose of our wider system reform arrangements is to support empowered clusters.

Role and benefits of clusters:

- Clusters will see health and care professionals, GPs, the voluntary sector and the community working as one team to support the health and care needs of their local community. They will focus on helping people to manage long term conditions and improve access to information about healthier lifestyles and improving/maintaining wellbeing.

- Evidence shows that the most successful work of this type will reduce the overall number of people who need to be cared for in hospital and improve the health and wellbeing of communities. Clusters will shift the pattern of care and services to be more preventative, proactive and local for people of all ages

Impact of clusters for people

- ✓ People are supported to stay well and take greater responsibility for their own health and wellbeing
- ✓ People can easily access support and advice that is timely, delivered close to home and with the right professional to meet their needs
- ✓ People with chronic or complex illness receive care that is consistent, joined up and centred around their needs and wishes, with fewer hand-offs and reduced duplication
- ✓ People are only in hospital for the acute phase of their illness and injury and are supported to regain/retain independence in their usual place of residence
- ✓ People have greater choice and control over decisions that affect their own health and wellbeing

Impact of clusters for HIOW system

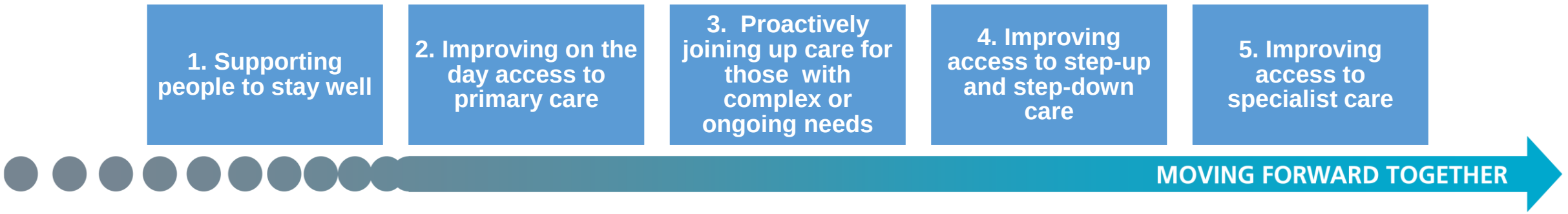
- ✓ Increased capacity in primary and community care to manage local health and care needs
- ✓ Reduction in rate of acute mental and physical acute non-elective activity growth and demand for urgent care services
- ✓ Optimised resource utilisation as a result of better managed chronic conditions and reduction in preventable conditions
- ✓ Reduction in variation in access and outcomes
- ✓ Fewer permanent admissions to residential and nursing care
- ✓ Primary care is sustainable and supported leading to improving GP recruitment and retention rates
- ✓ Attract and retain right workforce in all sectors with particular emphasis on those sectors in greater need such as mental health
- ✓ More efficient bed use and fewer delayed transfers of care

Characteristics of clusters

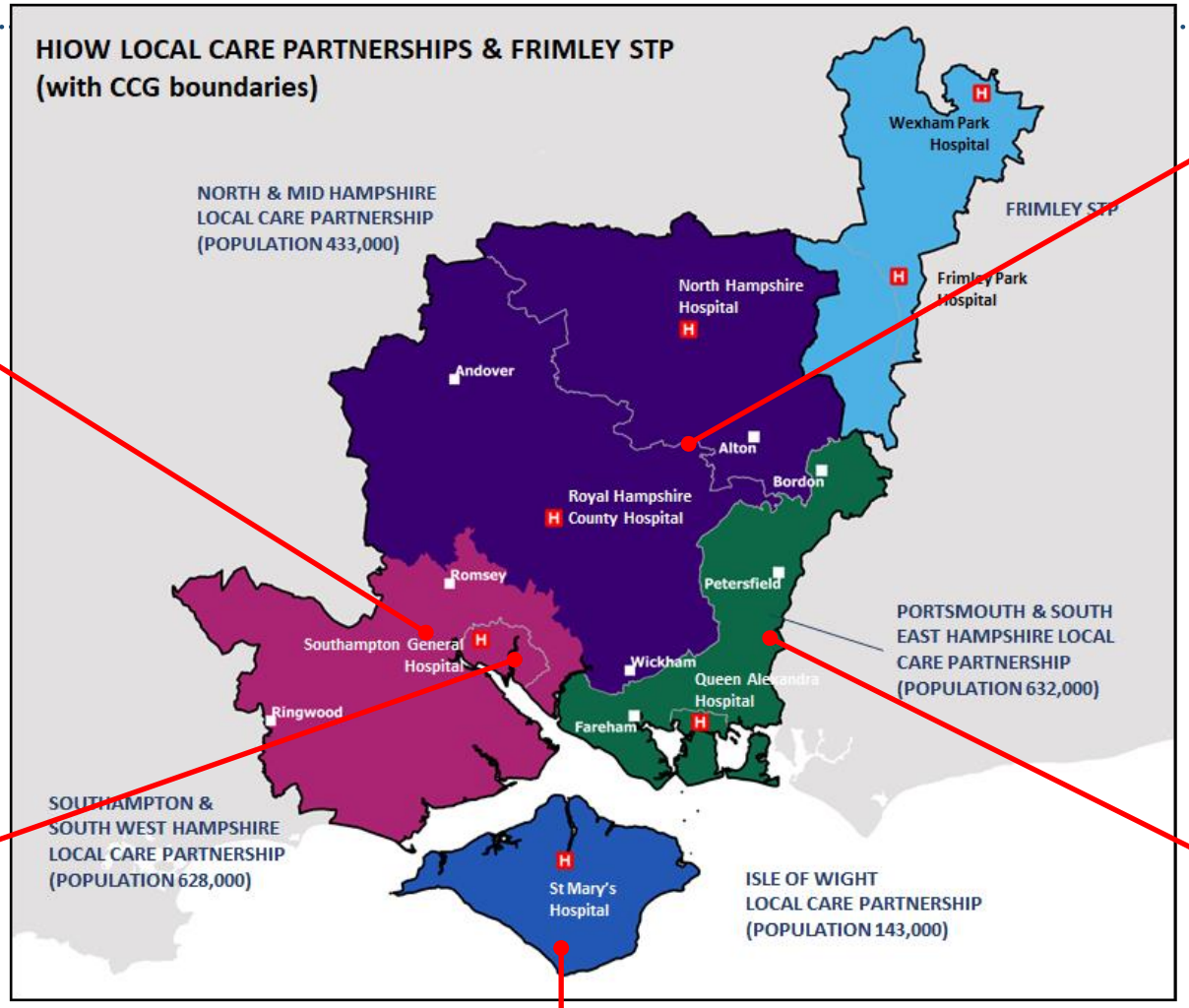
Clusters will vary based on the needs of the communities they serve, but will be built on a common foundation and share common characteristics:

- Clusters will be empowered to innovate in order to best serve their populations. In order to facilitate this, they will work to a specification which is outcome-based, but which is common across HIOW. Developing this specification will be an early priority.
- Cluster footprints align to 'natural communities of care.' Areas must be meaningful to those they serve, as they provide the basis for community-focussed services. Clusters' population range provides flexibility in cluster boundaries to ensure they align with both natural communities and GP registered lists.
- Clusters will include a range of mental and physical health, care and wider services in one place. Multi-professional working will be supported by multi-agency information sharing and, wherever possible, physical co-location.
- Co-ordinate services and teams from across organisations through alignment arrangements (MOU, alliance contract or joint venture) – allowing professionals to maintain their current employment status.
- Multi-professional (including clinical) leadership. Each cluster will have a named lead, and will be supported by a professional managerial team, who will be responsible and accountable for the performance of cluster services and the management of an indicative cluster budget. Clusters will manage their performance based on agreed datasets.
- GP federations will be vital in facilitating clinical leadership in clusters, as well as in leading the transformation of primary care, which will be vital to clusters' capability.
- Clusters will identify, understand and reduce unwarranted variation between their practices. Colleagues and systems across the footprint of HWB and integrated care partnerships will support clusters in this, as well as identifying unwarranted variation between clusters (see below).
- Clusters and acute physical and mental health providers will work together in integrated care partnerships, to ensure alignment of pathways and integrate services to optimise the health and care support they provide, responsive to the populations they serve.

The 5 core functions of a cluster:



36 clusters across HIOW (as at August 2018)



South West Hampshire

1. Eastleigh
2. Eastleigh Southern Parishes
3. Chandler's Ford
4. North Baddesley
5. Avon Valley
6. New Milton
7. Lymington
8. Totton
9. Waterside

Southampton

1. Cluster 1
2. Cluster 2
3. Cluster 3
4. Cluster 4
5. Cluster 5
6. Cluster 6

North and Mid Hampshire 20

1. Mosaic
2. Whitewater Loddon
3. Acorn
4. A31
5. Rural West
6. Andover
7. Winchester City
8. Winchester Rural North
9. Winchester Rural East
10. Winchester Rural South

Isle of Wight

1. North and East
2. West and Central
3. South Wight

Portsmouth and South East Hampshire

1. East Hampshire
2. Waterlooville
3. Havant
4. Fareham
5. Gosport

1. Portsmouth North
2. Portsmouth Central
3. Portsmouth South

Balancing autonomy and standardisation in clusters

A key test of this proposal overall is that cluster governance must accelerate and facilitate, rather than impede, local change and improvement. Therefore clusters will be encouraged to innovate and improve services for their citizens.

This innovation will be facilitated by both their contract /incentive structure and support from HWB and integrated care partnerships (see next slides).

HWB and partnerships will support clusters in identifying and reducing unwarranted variation, including striking the right balance between standardisation / consistency and local flexibility (ie. standardising only where this adds value).

Standardisation may apply across a HWB or partnership footprint, or more widely, as appropriate. We would expect some pathways, services, systems and processes to be standardised across HWB or partnership footprints, some to be standardised across the whole of HIOW. Elements not standardised will allow each cluster to take the approach which works best for them, but with encouragement and support to consider what other clusters are doing and the potential to spread best practice where it adds value (or reduces duplication of effort) to do so.

As part of this freedom to innovate, we recognise that clusters will continue to evolve. The current structure of clusters across HIOW (see next slide) may therefore change as clusters become established and take on an increasing role in service delivery.

Operationalising clusters is a key priority. This will include developing an outcomes-based cluster specification and providing management and development resources to clusters from CCGs

Accelerating the implementation of clusters

Every part of the HIOW system has confirmed the development of integrated cluster teams as a key priority for 2018/19, and every area has a change programme in place to deliver this.

- The 36 cluster teams across HIOW are at variable stages of development and maturity.
- The most established teams, formed under Better Care and Vanguard programmes, offer a wealth of evidence and learning about what works; however we are yet to effectively capitalise on this across HIOW.
- There are currently different names for cluster teams in each care system, reflective of evolutionary local plans.
- However, there are high levels of congruence in the overall description of the function and form of these teams across the system.

Therefore, the ambition for cluster development for 2018/19 is to:

- Accelerate and embed the infrastructure for all 36 cluster teams by March 2019
- Evidence impact on patient outcomes, primary care capacity, hospital admissions and system flow

Current thinking about the development of the clusters by March 2019 and March 2020 is described on the following page.

The developing role of clusters

	October 2018 – March 2019	By April 2020
Strategy and Planning	• Cluster priorities identified and delivery plan in place • Cluster level population data available and used to support priority setting and planning	• Longer-term cluster objectives being shaped, informed by data • Mechanism in place for co-production of plans and services with local people
Care Redesign	• Practices working together to improve access and resilience • Core cluster team membership defined • Integrated primary and community care teams in place with joint assessment and planning processes • Prototypes in place for highest risk groups • Gap analysis undertaken, end state defined for key functions	• Components of delivery model in place for each of key functions (minimum 50% completion) • Active signposting to community assets in place • Shift of specialist resources into cluster teams • Integrated teams fully functioning and include social care
Workforce development	• Cluster workforce plan defined with targeted action to support recruitment/retention of key roles • Cluster level OD/team development plan in place	• Development of new/extended roles in cluster teams to meet local need • Beginning to share workforce and skills within clusters
Accountability & performance management	• Information sharing agreements in place between all partners • Plan for shared care record confirmed • Cluster responsibilities documented via MOU/alliance agreement	• Data used to drive improvement and reduction in variation within and between clusters • Shared care record (health) in place • Cluster monitoring impact on key outcomes
Managing collective resources	• Cluster assets mapped to inform future planning (estate, back office, people, funding) • Resources identified to enable/support cluster plan delivery (eg change management) • Cluster level dashboard including outcomes in place	• Shift of specialist resources into cluster teams • Clusters have sight of resource use and can pilot new incentive schemes • Cluster level plan to optimise use of assets and early components in place
Leadership & governance	• Dedicated professional and operational leadership in place in each cluster • Governance arrangements in place in each cluster, eg cluster board • Cluster partners identified and engaged in the development and delivery of the cluster plan • Cluster engaged in integrated care partnership decision making	• Cluster leadership embedded with defined responsibilities for co-ordination of cluster responsibilities • Mechanism in place to share learning between clusters • Practices have defined how they wish to work together going forward • Cluster is full decision making member of integrated care partnership

Statutory bodies are asked to:

Endorse:

1. **The developing role of clusters as outlined on the previous slide**
2. **The recommendation that partners across HWB footprints and integrated care partnerships work together to define the resources required for cluster operation – a critical first step is establishing professional and operational leadership to drive cluster development**
3. **the proposed next steps for the cluster task and finish group which are summarised as follows:**

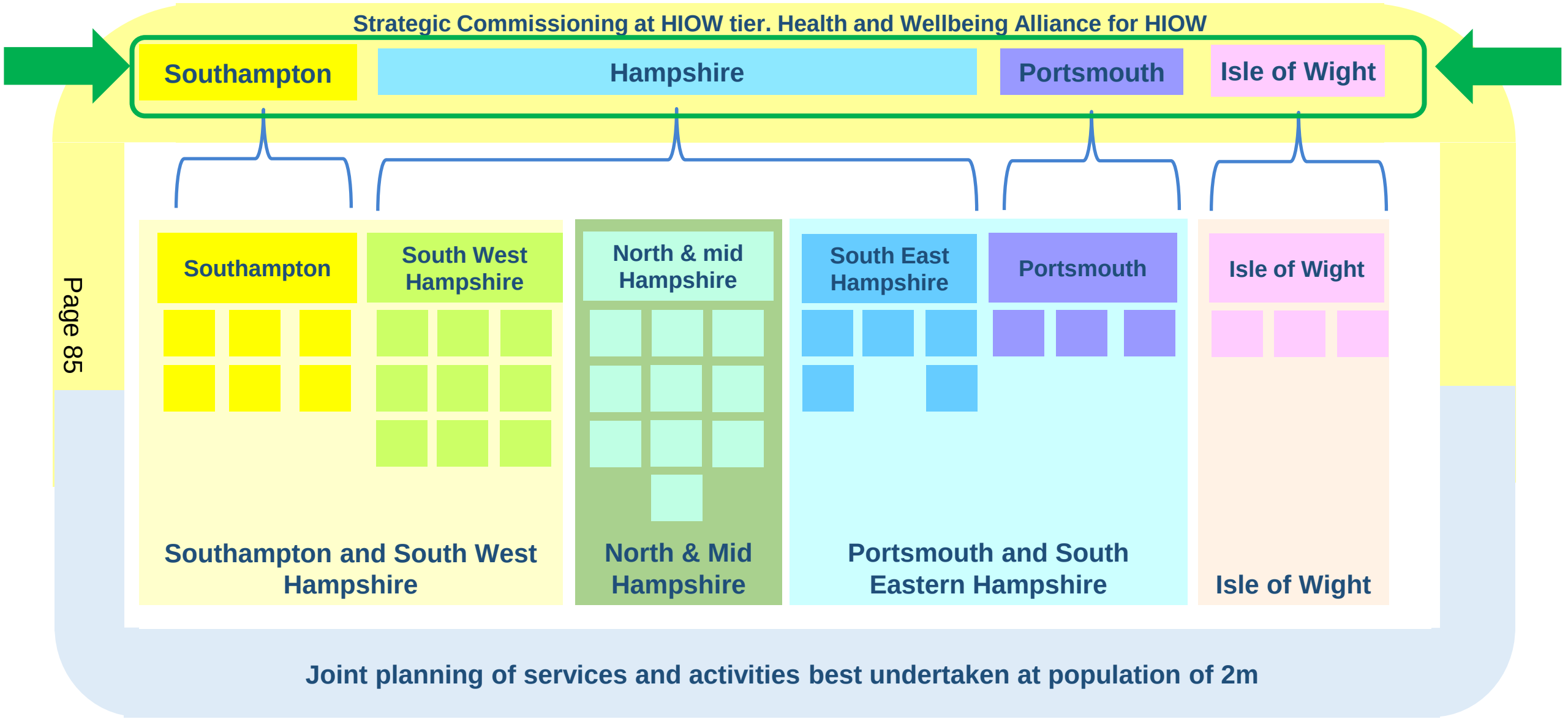
    a. Quantify the impact/expected outcomes of cluster teams (already in progress in most areas): defining outcome metrics for individual clusters and a small set of common metrics across whole HIOW

    b. Describe the support requirements and responsibilities to accelerate full cluster implementation

    c. Describe the proposed interplay between clusters and other components of the ICS, including governance and participation arrangements for clusters as part of HWB footprints and integrated care partnership structures

    d. Strengthen primary and social care involvement in this work at a Hampshire and Isle of Wight level (membership of the task and finish has already been extended to reflect this)

Integrated planning for a place: Health and Wellbeing Board footprints



Restating the function of Health and Wellbeing Board footprints within an integrated care system

Local government partners have convened to start work on restating the critical function of integrated health and care planning and delivery on a Health & Wellbeing Board (HWB) footprint.

An early draft definition of the function is summarised below:

HWB footprints will continue to be **the focus for place-based planning** (undertaking population needs assessment) and for aligning health, care and other sector resources to focus on delivering the improved outcomes for local people, building on the long-established integrated working arrangements, e.g. Better Care Fund, Section 75 arrangements, etc. Working in collaboration, partners will maximise the potential to further improve wellbeing, independence and social connectivity through the wider determinants of health including public health, housing, employment, leisure and environment.

The statutory role of the HWB with their political and clinical leadership, means that they should be central to the governance of health and care planning for a 'place'. The sustainability of the health and care system depends on public and political acceptability and support – as well as the right systems of design and delivery. So the active and effective democratic engagement at all levels (cluster through to whole HIOW) is vital. Strong and equitable relationships between NHS and local government will provide the necessary collective energy and focus required for system change. Furthermore, cross sectoral partnerships of public, private and voluntary and community organisations have important roles in all components of the system.

Much of our prevention and health improvement activities will continue to be designed and delivered in HWB footprints. We will use our ability to align / pool monies between NHS and local government partners to ensure that a clear focus for each HWB footprint is the resourcing of our 36 clusters (integrated primary and community care teams).

Our HWBs are based on local authority footprints. We will continue to integrate our CCG and LA teams focused on place-based health and care planning on these HWB footprints, reducing complexity and duplication. We will also be deploying some of our health (CCG) and care staff directly to support the operationalisation of our 36 clusters.

All four LAs have committed to meet with health provider and commissioner colleagues during August/September as a task and finish group to further develop the above definition and proposed next steps (see more detailed recommendation on the next page).

Statutory bodies are asked to:

Endorse the following recommendations from the EDG, informed by the task and finish group work to date:

1. **The emerging 'restatement' of the function of partnership working on a HWB footprint as described on the previous slide**

2. **The proposed next steps for a task and finish group by the end of September, which are to:**

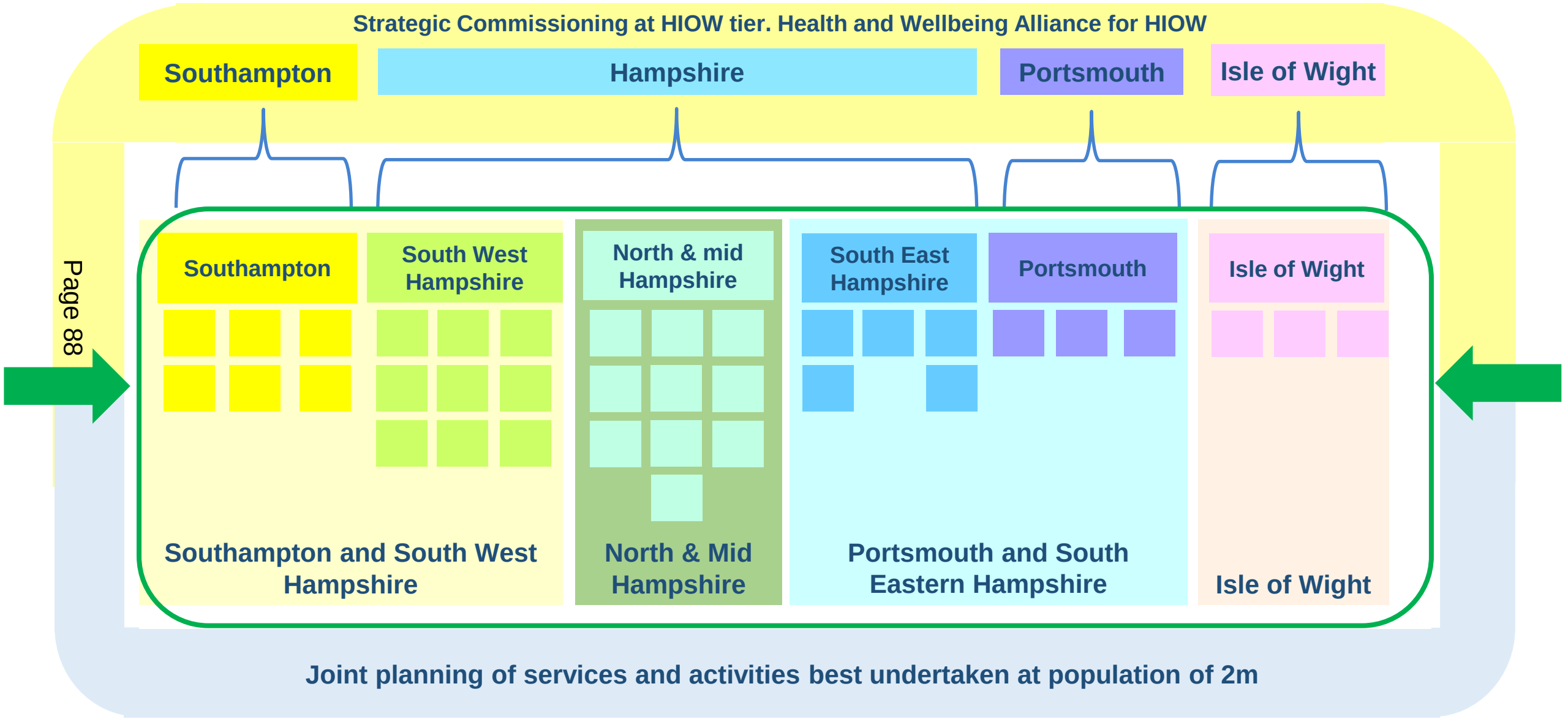
a. define the common functions of the role of HWB footprints in an integrated care system

b. clarify the relationship between this and the other component parts of the proposed Hampshire and Isle of Wight Integrated care system

c. set out a mechanism for achieving 'active and effective democratic engagement at all levels' across the Hampshire and Isle of Wight integrated care system (including the role of HWB)

Leads from the other Hampshire and Isle of Wight task and finish groups on integrated care partnerships, strategic commissioning and clusters will be involved in developing this thinking.

Integrated care partnerships



Integrated care partnerships

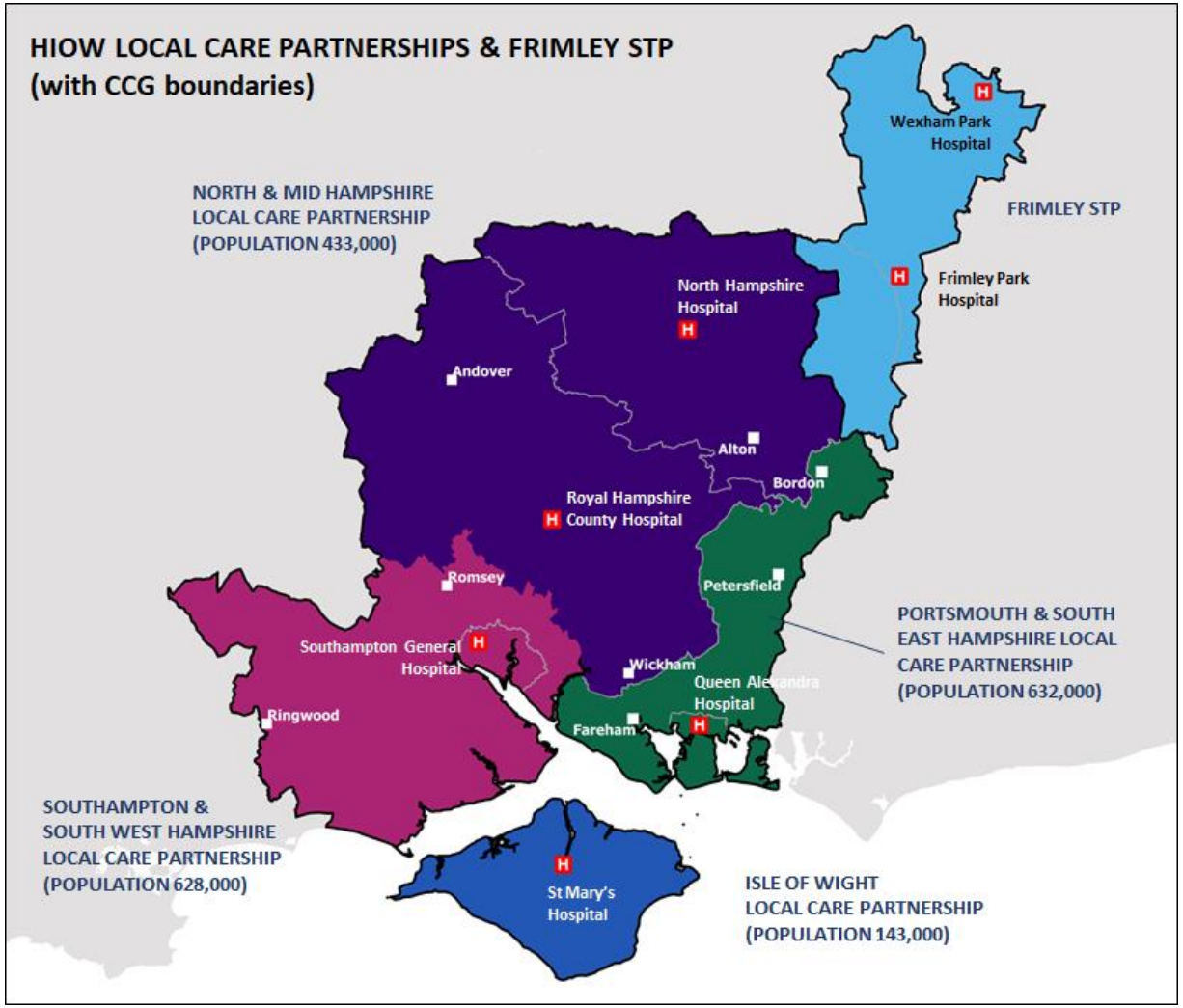
Integrated care partnerships are where we align the work of the local clusters, community services, acute and specialised physical and mental health services, for the benefit of the local population.

Providers of mental and physical health and care services including general practice, NHS commissioners, local authorities and voluntary sector organisations come together in geographies based on the local catchments of acute hospitals to benefit their local population.

The term ‘integrated care partnership’ [ICP] is being used to describe the collaboration of partners on these geographies.

The ICPs across HIOW will reflect local needs and will differ in the extent of their focus and work programme. For some, the focus may be predominately on improving operational ED performance. In others there is already an intent to work together on a more comprehensive basis with established governance structures to deliver agreed improvement programmes.

The balance and focus of the planning and delivery that takes place in HWB footprints and integrated care partnerships will vary in each part of HIOW.



What could integrated care partnerships look like? 30

The nature of Integrated Care Partnerships [ICPs] will vary according to local circumstances, challenges and opportunities. For some the arrangements will mirror current state. For others their development is such that by **April 2020, integrated care partnerships could be working together to:**

- implement a integrated care partnership delivery plan which sets out the collective priorities of the integrated care partnership, over the medium term (3-5 years) and in the short term (1-2 years) [noting that as previously alluded to, the balance and focus of planning and delivery that takes place in integrated care partnerships is likely to vary in each part of HIOW]
- design and implement optimal care pathways, and to identify, understand and reduce unwarranted clinical, operational and service variation
- make the best use of the collective resources of the integrated care partnership, including workforce, financial resources and estate, maximising system wide efficiencies and encouraging resources to flow to address the key risks facing the partnership
- support the ongoing development of the integrated care partnership:
    - progressively building the capabilities to manage the health of the population, to keep people well and to reduce avoidable demand
    - supporting the ongoing development of clusters, as the bedrock of the local health and care system
    - in some areas, potentially managing the transition to evolved organisational form arrangements that enable members of the integrated care partnership to sustainably meet the population needs

An integrated care partnership board could lead the partnership, providing strong system leadership, actively breaking down barriers that hinder progress in the delivery of integrated care, building trust and acting together to deliver improvements for citizens, for the system as a whole and through which partners hold each other to account for delivery of the shared priorities.

In integrated care partnerships, NHS providers including primary care, commissioners and local authorities work to overcome the barriers to collaboration associated with the separation of provision and commissioning. Whilst recognising the important individual statutory responsibilities of each partner, it is envisaged that:

- CCGs will deploy their people and resources to work collaboratively with other CCGs in the integrated care partnership, focussed on implementation of the integrated care partnership delivery plan – improving services, improving operational performance and delivering cost reduction.
- NHS providers will work together to make strategic and operational decisions that are in the best interest of the integrated care partnership.
- Where possible, in order to reduce duplication and bureaucracy, CCGs, NHS providers and if relevant local authorities, will seek opportunities to optimise corporate support services and infrastructure such as finance, quality, communications and governance teams.

Current thinking about the development of integrated care partnerships by March 2019 and March 2020 is described on a subsequent slide.

ICPs: an example of a different approach

We anticipate seeing:

- CCGs deploying their people and resources to work collaboratively with other CCGs in the local care system and with providers
- Providers making decisions and delivering care together – provider alliances
- CCGs, NHS providers and potentially local authorities sharing corporate support services and infrastructure?
- Over the next 18 months, working through together the impact on financial flows, contractual models and organisational forms (drawing national models such as the ICP contract consultation)

Enabling us to have:

- Better grip on improving the money, performance and quality
- Integrated care partnerships supporting clusters to develop and thrive
- Whole system implementation of improved care pathways, and reduction in unwarranted clinical, operational and service variation
- Collective support for all services in the integrated care partnership to meet operational performance and quality standards
- Reduced transaction costs

The ICP Task and Finish Group has been developing a vision of how the future might look. Each ICP will develop proposals that reflect their local context, challenges and opportunities

A potential timeline for the development of ICPs

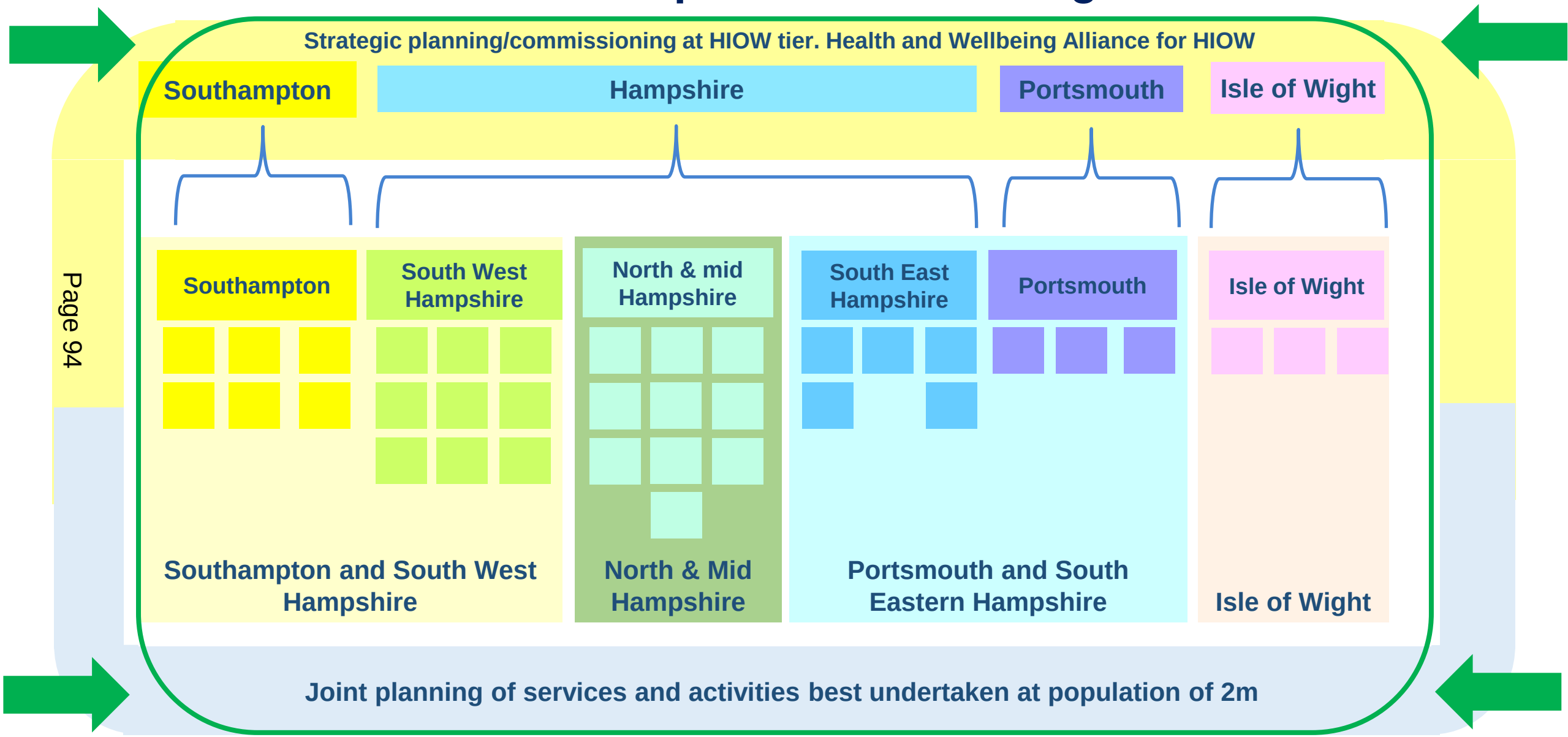
	October 2018 – March 2019	By April 2020
Strategy and Planning	• Develop and agree plan to make optimal use of acute and specialised physical and mental health services • Aligning the work of clusters at HWB footprint with community and acute physical and mental health services	• Agreed single strategy and operational plan for the integrated care partnership describing collective priorities and how those priorities will be delivered • Planning undertaken jointly by CCGs, providers and LAs
Care Redesign	• Implementing Urgent & Emergency Care priorities for the integrated care partnership • Developing optimal care pathways across the integrated care partnership • Agreed plan to support the development of clusters • Engaging staff and local communities in redesign	• 100% of clusters thriving, with lower mental and physical acute care demand as integrated teams support people to stay well at home • Managing a comprehensive programme of service improvement to address the integrated care partnership priorities • Population groups with high service utilisation or unmet need identified and action agreed
Workforce development	• Understanding the workforce issues for the integrated care partnership	• Securing the right workforce, in the right place with the right skills in the integrated care partnership, and ensuring the wellbeing of staff
Accountability & performance management	• Working together to monitor and improve delivery of constitutional standards	• Instigating clinically led quality improvement • Extensive use of data to drive improvement • Oversight of delivery in clusters • Leading recovery of standards without outside intervention
Managing collective resources	• Understand current resource use in the integrated care partnership • Working together to make the best use of the collective resources (workforce, estate, financial) in the integrated care partnership • Test new approaches to manage funding flows (e.g. DTOC) • Maximising system wide efficiencies	• Managing the collective resources of the integrated care partnership • Capable of taking on a delegated budget • Directing resources to address the key integrated care partnership risks • Shared corporate support services • Shared medium term financial plan including efficiencies
Leadership & governance	• Understanding the context, ambitions and challenges of each member of the integrated care partnership, building trust, acting together • Governance structure in place to enable collaboration • Cluster leaders engaged in integrated care partnership planning and decision making • Members of the integrated care partnership working together to agree any changes required to organisational structures	• Joint provider, CCG and LA leadership to enable planning and delivery in the integrated care partnership • Care professionals leading service integration • Governance mechanisms in place to enable decisions to be made in the best interests of the system and residents • Implementing agreed changes to organisational structures to better enable delivery in the integrated care partnership

Statutory bodies are asked to:

Work with geographically aligned partners within the identified four ICP footprints to:

1. Discuss and agree the remit and focus of the ICP;
2. By October 2018 prepare a Memorandum of Understanding [MoU] that sets out the remit, focus and the leadership / governance / decision making arrangements of the ICP and how the local Health and Wellbeing Boards (Care systems) and the ICP interface with one another - the balance and focus of each;
3. Set out the key milestones for the ICP for April 2019 and April 2020.

Strategic planning, transformation, resource allocation and assurance at the scale of Hampshire & Isle of Wight



Strategic planning, transformation, resource allocation and assurance at the scale of Hampshire & Isle of Wight

In order to support and add value to the work of clusters, HWB footprints and integrated care partnerships, it is envisaged that providers, commissioners and local authorities will work together to undertake strategic planning, transformation, resource allocation and oversight activities at HIOW level.

This could be achieved, by April 2020, through a single entity for HIOW which, in its mature form, would develop strategy, set priorities and provide strategic leadership and direction to the HIOW integrated care system.

The strategic planning and transformation function in the HIOW integrated care system would:

- include the input and expertise of providers, CCGs and local authorities
- programme manage the implementation of HIOW level transformational change (change that spans more than one integrated care partnership or which is most appropriately managed at HIOW system level)
- proactively support the development of integrated care partnerships
- manage the specialised commissioning budget for HIOW
- align the resources coming into HIOW from a wide variety of sources around the delivery of the agreed strategic priorities, in order to increase the impact for populations
- act as the assurance body for HIOW, providing oversight of operational, quality and financial performance, and enabling the HIOW integrated care system to take action to improve performance without the need for outside intervention.

Whilst recognising the important role of external regulation, it is anticipated that the integrated care system will increasingly develop the capacity and capability to role-model ‘self-regulation’ – where robust processes are in place to ensure that action is taken to identify issues and improve performance without the need for outside intervention.

Creating this strategic planning and transformation function for the HIOW, which involves providers, CCGs and local authorities, is an opportunity to bring together in one place a number of functions including: those CCG functions best undertaken at HIOW level, STP functions, functions currently undertaken by the Director of Commissioning Operations, NHS England/NHS Improvement regulatory functions, specialised services commissioning and potentially other NHS England direct commissioning activities; HIOW clinical networks.

Current thinking about the transition towards this new way of working, by March 2019 and March 2020, is described on a subsequent page.

The characteristics of the HIOW integrated care system

It is proposed that, based upon national ICS, national guidance and evidence of best practice, an entity operating at the scale of HIOW could display the following characteristics:

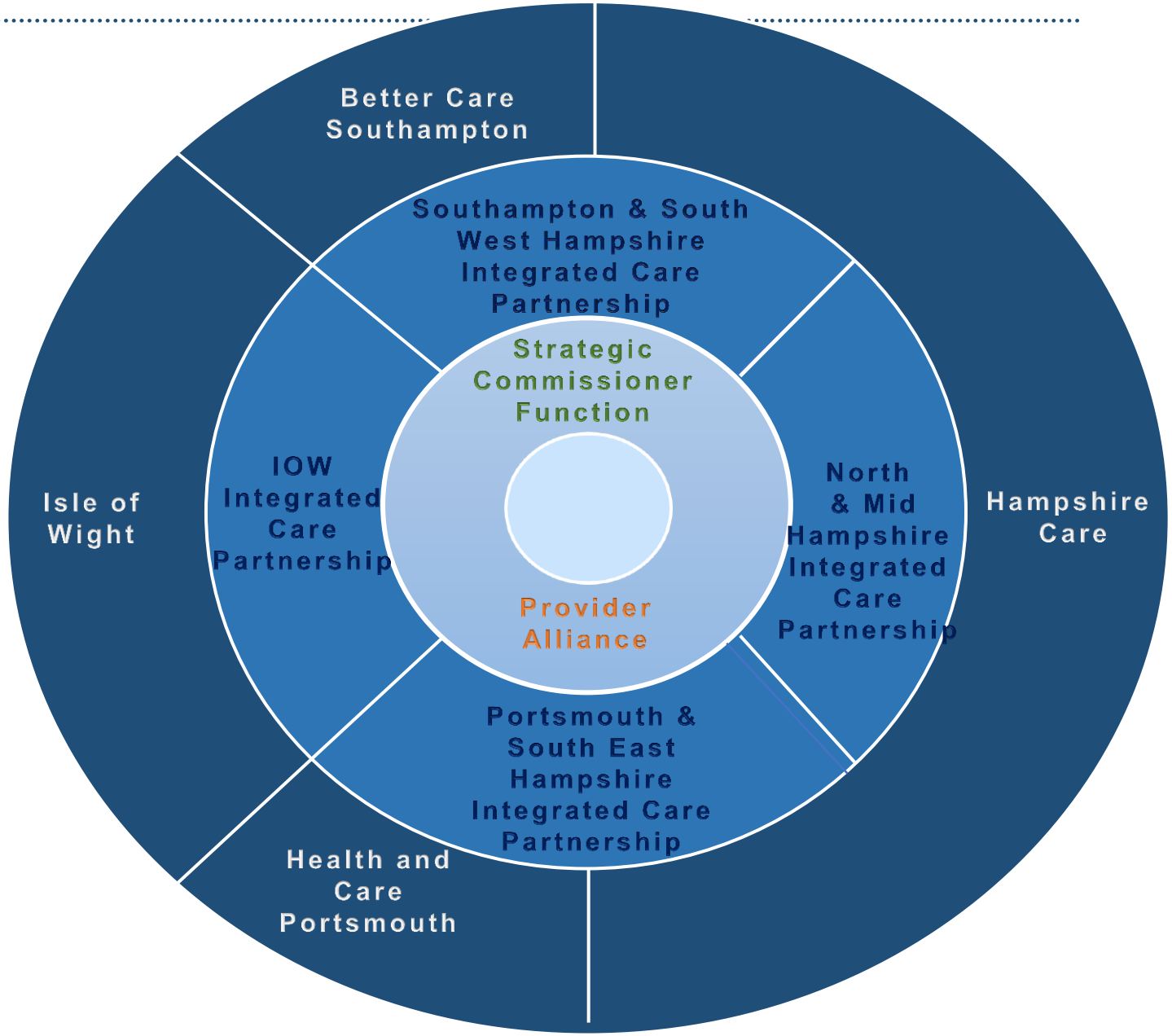
Subsidiarity: only undertaking functions that for reasons of cost or complexity need to be undertaken at the scale of 2m+ population. Unnecessary complexity and bureaucracy are stripped out with 80% of the transformation process led by local place-based teams;

Inclusive: national models / guidance show that prospective ICSare founded on partnership; for HIOW this would draw together:

- A newly established strategic commissioning function
- the four HWB footprints
- the four integrated care partnerships
- provider alliance

Founded on self-regulation: all components of reformed systems have effective self-regulation and enable a model of collective assurance at the scale of the ICS. This allows NHS England and NHS Improvement to deploy resource into the ICS and have a single touch point on delivery to the newly reformed regional and national infrastructure;

Politically-led: prospective ICS all demonstrate strong political leadership and close connection with Health and Wellbeing Strategies and Boards.



Strategic planning/commissioning at the scale of HIOW

As an immediate next step in the transition to this future system model, it is proposed that HIOW CCGs and local authorities establish a strategic planning/commissioning function during Q3 2018/19.

By working together at HIOW level, CCGs and local authorities expect to be able to reduce fragmentation and bring the following immediate benefits:

- stronger alignment of health and local authority commissioning
- the development & agreement of consistent whole system strategic priorities for HIOW
- improved and simplified commissioning decision-making for HIOW wide issues.

The functions of the strategic planning/commissioning function in its initial form would include:

- Setting consistent commissioning strategy and strategic priorities for HIOW
- Managing whole system resilience at HIOW level
- Management and deployment of supra-allocation resources (including capital)
- Demand and capacity planning and commissioning decisions about the future configuration of acute physical and mental health services for the 2 million population of HIOW
- Oversight of NHS constitutional standards, financial performance and quality improvement – with work to be done to ensure this activity isn't duplicated elsewhere
- Work with specialised commissioners, understanding current activity flows and costs, inputting to and aligning decision making
- It is also proposed that the strategic planning/commissioning function incorporates the transformation programme function of the HIOW Sustainability and Transformation Partnership.

Proposed governance:

- Established through a joint committee, in the first instance, during Q3 2018/19
- Members include CCGs, NHS England (specialist commissioning and Regional Director of Commissioning) and local authorities
- Joint committee will have delegated authority to make binding decisions in relation to the in-scope functions and responsibilities
- Expect by April 2019 the governance and organisational arrangements evolve further

The strategic planning/commissioning function is a mechanism through which commissioners can pool skills, expertise, resources and accountability to deliver transformation at HIOW level. There is a strong desire to create a new way of working, rather than add layers to existing ways of working.

The developing functions at a scale of HIOW

	October 2018 – March 2019	By April 2020
Strategy and Planning	• Clear commissioning priorities agreed for HIOW • HIOW system strategy and priorities being refreshed/updated • Demand and capacity planning for HIOW acute services • Agree aligned planning process for 2019/20-2020/21	• CCGs, providers & LAs setting shared strategy & priorities for HIOW with aligned health & LA planning processes • Fully own a single HIOW system operating plan that brings together plans of constituent parts of the system
Care Redesign	• Decisions being made about future configuration of acute physical health and mental health crisis and acute care • Leadership of plans to improve urgent care for HIOW, including oversight of delivery of the Integrated Urgent Care Plan • Decisions about community services provision for Hampshire	• Well developed plans being enacted to support the development of integrated care partnerships • Programme managing the implementation of HIOW level strategic change programme • Leading on implementation of acute service and estate reconfiguration
Workforce development	• Understanding the workforce issues for the system • Influencing the addressing of key workforce issues	• Strategic workforce plan in place and being implemented • Influencing future workforce supply and training requirements
Accountability & performance management	• Oversight of HIOW winter resilience and preparedness • Oversight of delivery of integrated urgent care plan • Acting as interface with assurance bodies for HIOW	• Collective oversight of quality, operational performance and money • Acting as the assurance body for HIOW – supporting the system to take action to improve performance and address challenges without the ned for outside intervention
Managing collective resources	• Agree system wide capital and estate priorities and sign off wave 4 capital allocations • Develop understanding of whole system financial plans and financial risks • Plan for aligned management of specialised commissioning	• Take accountability for a HIOW system control total • Managing collective finances & risk openly and as a system • Aligning resources flowing into HIOW to achieve priorities • Support integrated care partnerships to take delegated budget • Managing the specialised commissioning budget
Leadership & governance	• CCGs operating with a single decision making committee for HIOW level commissioning business • All STP partners involved in the design of the future HIOW level system strategic planning, implementation and assurance function • STP partners providing leadership to strategic change programmes	• A single coherent entity in place that brings together HIOW level CCG functions, STP and NHSE/I functions • Strategic alignment of providers, commissioners and local authorities around the system strategy and priorities • Clear clinical leadership for the system and input from HWB footprints and integrated care partnerships in decision making

Statutory bodies are asked to:

Endorse the recommendations of the EDG, informed by the work of the strategic commissioning task and finish group, that:

1. The strategic commissioning task and finish group further develop the proposal with an aim to establish a strategic commissioning function by October 2018, initially through a joint committee which will have delegated authority to make binding decisions in relation to its in-scope functions and responsibilities.

2. That a new task and finish group is convened including providers, commissioners, local authorities, and NHS England and NHS Improvement, to work together and take responsibility for the development of the next phase of the work to build the strategic planning, transformation, resource allocation and assurance function for HIOW, constructing ICS governance that supports our approach.

Summary of recommendations

In summary, the governing bodies and boards of statutory organisations are asked to endorse the following recommendations from the EDG, informed by task and finish group work to date:

Clusters

1. **The developing role of clusters as outlined earlier**
2. **The recommendation that partners across HWB footprints and integrated care partnerships work together to define the resources required for cluster operation – a critical first step is establishing professional and operational leadership to drive cluster development**
3. **The proposed next steps for the cluster task and finish group which are summarised as follows:**
   a. Quantify the impact/expected outcomes of cluster teams (already in progress in most areas): defining outcome metrics for individual clusters and a small set of common metrics across whole HIOW
   b. Describe the support requirements and responsibilities to accelerate full cluster implementation
   c. Describe the proposed interplay between clusters and other components of the ICS, including governance and participation arrangements for clusters as part of HWB footprints and integrated care partnership structures
   d. Strengthen primary and social care involvement in this work at a Hampshire and Isle of Wight level (membership of the task and finish has already been extended to reflect this)

Health and Wellbeing Board Footprints

1. **The emerging 'restatement' of the function of partnership working on a HWB footprint as described earlier in the document**
2. **The proposed next steps for the task and finish group by the end of September, which are to:**
   a. define the common functions of the role of HWB footprints in an integrated care system
   b. clarify the relationship between this and the other component parts of the proposed Hampshire and Isle of Wight Integrated care system
   c. set out a mechanism for achieving 'active and effective democratic engagement at all levels' across the Hampshire and Isle of Wight integrated care system (including the role of HWB)

Integrated care partnerships

Work with geographically aligned partners within the identified four ICP footprints to:

1. Discuss and agree the remit and focus of the ICP;
2. By October 2018 prepare a Memorandum of Understanding [MoU] that sets out the remit, focus and the leadership / governance / decision making arrangements of the ICP and how the local Health and Wellbeing Boards (Care systems) and the ICP interface with one another - the balance and focus of each;
3. Set out the key milestones for the ICP for April 2019 and April 2020.

Strategic commissioning

1. The strategic commissioning task and finish group further develop the proposal with an aim to establish a strategic commissioning function by October 2018, initially through a joint committee which will have delegated authority to make binding decisions in relation to its in-scope functions and responsibilities.
2. That a new task and finish group is convened including providers, commissioners, local authorities, and NHS England and NHS Improvement, to work together and take responsibility for the development of the next phase of the work to build the strategic planning, transformation, resource allocation and assurance function for HIOW, constructing ICS governance that supports our approach.

Next steps

System reform programme next steps

A number of recommendations have been set out linked to each component of the proposed ICS. In addition to those associated with the specific components of the proposal, there are a number of overarching 'implementation programme deliverables', some of which will result as a coming together of the outputs from the various task and finish groups. These include:

- System reform implementation programme plan
- Structure and leadership plan – transitionary and end state
- Development and implementation of a communications and engagement plan
- Request for support (endorsement , agreement in principle, technical and financial) from NHS England , NHS Improvement and other arms length bodies such as the Local Government Association, NHS Leadership Academy, Health Education England
- Proposals to replace STP infrastructure (inc. Chair & SRO) to align with future form
- Organisational change plan and talent management plan
- HIOW ICS Chair and relevant leadership appointments
- Indicative budgets and financial framework for all components of the ICS
- Three year financial plans

It is recommended that a working group is formed, reporting to the EDG, to support the development of the above. Members of EDG are asked to nominate a representative to represent the interests of their part of the system.

Glossary

Glossary of terms

Clusters - also referred to locally and nationally as neighbourhoods, localities, primary care networks. Multi-disciplinary teams delivering integrated health, care and wider services to cluster populations based on natural communities of 20-100,000 people.

Health and Wellbeing Board (HWB) footprints – also known as care systems and are based on local authority footprints. The basis of the joint strategic needs assessment (JSNA), means through which HWB exert tangible influence on the direction of health and care services for the population through health and care commissioning and wider determinants of health. Locally the HWB footprints come under the guise of Better Care Southampton, Health and Care Portsmouth, Hampshire Care and the Isle of Wight Care Board.

Integrated care partnerships – also know as local care partnerships and are based on acute (physical) hospital footprints. Integrating care delivered in clusters with broader community and acute physical and mental health services; optimising the utilisation of acute services; designing and implementing optimal care pathways.

Integrated care system - the Hampshire and Isle of Wight health and care system, serving a population of 2 million citizens.

NHS England defines ICS as those systems in which:

“Commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations”.