Portsmouth CITY COUNCIL

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NOTICE OF MEETING

HEALTH OVERVIEW & SCRUTINY PANEL

THURSDAY, 31 JANUARY 2019 AT 1.30 PM

THE EXECUTIVE MEETING ROOM - THIRD FLOOR, THE GUILDHALL

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

Membership

Councillor Jennie Brent (Chair)
Councillor Gemma New (Vice-Chair)
Councillor James Fleming
Councillor George Fielding
Councillor Leo Madden
Councillor Steve Wemyss
Councillor Trevor Cartwright
Councillor Marge Harvey
Councillor Philip Raffaelli
Councillor Rosy Raines
Councillor Mike Read
Councillor Elaine Tickell

Standing Deputies

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

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

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

A G E N D A

1 Welcome and Apologies for Absence

2 Declarations of Members' Interests

3 Minutes of the Previous Meeting (Pages 3 - 8)

RECOMMENDED that the minutes of the meeting held on 22 November 2018 be agreed as a correct record.

4 Public Health Update on Performance in the Substance Misuse Services (Pages 9 - 28)

Dr Jason Horsley, Joint Director of Public Health for Southampton City Council and Portsmouth City Council will provide an update on the substance misuse service performance.

5 Portsmouth Clinical Commissioning Group (Pages 29 - 36)

Suzannah Rosenberg, Director of Quality and Commissioning, Portsmouth CCG will answer questions on the attached report.

6 Healthwatch Portsmouth (Pages 37 - 40)

Siobhain McCurrach, Strategic Lead, Healthwatch Portsmouth, will provide a presentation on the work of the organisation.

7 CQC update (Pages 41 - 52)

A representative of the Care Quality Commission (South Central Region) will answer questions on the attached report.

8 Date of Next Meeting

The next meeting will be on 14th March at 1.30pm.

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

HEALTH OVERVIEW & SCRUTINY PANEL

Minutes of the meeting of the Health Overview & Scrutiny Panel held on Thursday, 22 November 2018 at 1.30 pm at the Civic Offices, Portsmouth

Present

Councillors Jennie Brent (in the Chair)

George Fielding
Marge Harvey
Leo Madden
Philip Raffaelli
Rosy Raines
Mike Read
Steve Wemyss

1. Welcome and Apologies for Absence

The Chair welcomed Members to the meeting. She thanked Cllr Gary Hughes for his work on behalf of the Panel and welcomed Cllr Marge Harvey to the meeting.

Apologies were received from Cllrs Elaine Tickell and Michael Ford JP.

2. Declarations of Members' Interests

Cllr Steve Wemyss declared a non-pecuniary interest as he works for the Central and South West Commissioning Support Unit.

3. Minutes of the Previous Meeting

The Panel noted the minutes of the previous meeting.

The Chair reported that, as a matter arising from the minutes, the South Central Ambulance Service (SCAS) information on response times had been sent to the panel on 13 November. The Ambulance Response Programme Board had completed a Spring Review into the effectiveness of the new ambulance model and identified that the performance measures were accurately reflecting the correct response method to patients. During the review a consensus could not be reached on what the CAT 1 Transport target should be and this would continue to be reviewed in order to develop a robust target in the future. SCAS will continue to measure the CAT 1 Transport at 18 minutes as it felt that this was an appropriate target and was one of the time measures being considered by the ARP Board.

RESOLVED: that the minutes of the meeting held on 13 September 2018 be agreed as a correct record.

4. Director of Public Health

The Panel received a report from Dr Jason Horsley, Joint Director of Public Health for Southampton and Portsmouth City Councils. He said that the update was designed to cover the key areas of public health such as childhood obesity. He had included a presentation on sexual transmitted infections but, as this was a nationally focused document, he was aware that it did not address the contraception aspects of the Sexual Health Service.

In response to questions, the following matters were clarified:

- The final report on the Drug and Alcohol Service had yet to be received, and would be presented the following week. The vanguard process had been used as there was one overarching aim for the process, and the data that had been collected was useful at a national rather than a local level.

- Re-presentation data on service users was not reported as it was a national reporting scheme, but could be provided for the Panel if required. The drug and alcohol programme had been very successful, and the providers took a holistic approach, recognising that the clients were the most important part of the service. This meant that the reported figures were not as high as they could be, but that engaging clients provided the best way of enhancing their lives.

- The problem of dealing with childhood obesity was managing it after it was embedded, and the service was dealing with children who were already obese. The aim was to put resources into prevention of the condition, rather than reducing the prevalence of obesity. Portsmouth and South East Hampshire were intending to access funding from the Sustainable Transport Fund in order to improve sustainable transport options. Other councils had also added supplementary planning documentation around the provision of fast food outlets and the health impact that these have on children.

- In reply to a question, the Director confirmed that the budget was being spent every year, and as there had been a neutral settlement there would have to be cuts in service. It would not be possible to provide a pay rise. There were other pressures on Children's Services, such as housing, that had to be dealt within Public Health.

- The priorities for the service, operating with a smaller work force, was to get into the workstreams of other services in order to ensure there was an impact om how others operated their services. An example of this was that a member of staff was going to be embedded in both the Planning and Transportation services for a day a week to help address issues around fast food outlets and sustainable transport.

RESOLVED: That the report be noted.

5. Portsmouth Clinical Commissioning Group

The Chair recommended that, as there were no representatives from the Clinical Commissioning Group to present the report, it be deferred to the next meeting.

Concern was expressed by Members of the Panel that CCG representatives were not available to present the report.

RESOLVED: That the report be deferred to the meeting to be held on 31 January 2019

6. Hampshire & IoW system reform proposal

The Panel noted a report. Richard Samuel, Senior Responsible Officer for the STP presented the report. A great deal of work had been undertaken in the summer in anticipation of the launch of the NHS Long Term Plan on 3 December. During the ensuing discussion the following points were raised:

- All organisations were being asked to endorse the plan and highlight areas that they were considered about, areas for clarification and where more work was needed. At this juncture however, the panel was not being asked to ratify the documents.

- In reply to a question, he went on to say that within the summary of recommendations laid out on page 109 of the report, the task and finish groups had completed their work and had set out the role and functions of care systems across Hampshire and the Isle of Wight and had been led by local authorities and this work was being fed into how the care system would feed into the integrated care partnerships. The draft Terms of Reference for the Strategic Commissioning Board would be considered by all statutory commissioning organisations. Draft Memorandums of Understanding had been drafted for each integrated care partnership (ICP), and a meeting would be held on the 5 December to discuss how these would allow the ICPs to work together.

- It was anticipated that there would be more ability to flex control totals within ICPs and that the NHS Long Term Plan would set out further flexibilities in order to unlock flexibility and deployment of resources.

- The regulatory system had been formally brought together in a single structure over NHS England and NHS Improvement, in order to ensure that the problems associated with financial issues between the provider and commissioning sectors were overcome, and that system affordability was now paramount.

- As a result, in Portsmouth and the South East Hants, a £4m risk fund had been generated that had allowed for investment in out of hospital services prior to winter. It was hoped that the ten yea plan would reinforce this.

- It was important that, once the tools were in place to achieve the aspirations, a coherent business plan should be in place in order to deal with the £577m STP funding gap by 2020. A structured financial plan would help to provide confidence. It was noted that a transitional 2019-2020 one year plan was being generated, concurrently with a three to five sustainability plan, the latter by the summer of 2019.

RESOLVED: That the report be noted.

7. Portsmouth Hospitals' NHS Trust

The panel noted a report from Portsmouth Hospitals' NHS Trust.

The Delivery Director reported that plans for winter 2018 were well in hand and the intention was to reduce bed occupancy on the Queen Alexandra (QA) Hospital site. The plan was a whole system one which would reduce the number of patients waiting on site by providing 12 additional beds, discharging patients into a temporary location and crating more medical and fewer surgical beds. There would be a change in case mix with more outpatients and fewer inpatients. He expected that there would be pressured days, but he reassured the Panel that the hospital was better prepared than it had been for the previous winter. There was more capacity in the community and the trust had received a great deal of support from its system partners. The length of stay for patients was also being reduced by discharging patients earlier.

In the ensuing discussion, the following points were made:

- The selling of the cottage hospital had not made the situation at QA worse as patients needed to be at home and not in hospital. There had not been sufficient capacity in the cottage hospital and discharged patients were fully supported at home.

- Despite the national shortage of nurses, QA had recruited 66 new nurses at bands 3-5.

- The Home First Programme had been instigated in the last week. This was a programme designed to support patients at home, and would provide for a 100 more care hours a week in the community.

- The number of EU staff was considered as part of the risk register, but that the trust had not been asked to address this issue yet. 7% of the staff across the Isle of Wight and Hampshire were EU nationals.

RESOLVED: That the report be noted.

8. Southern Health

The Panel noted a report from Southern Health presented by the Interim Director for Mental Health and Learning Disabilities. The following issues were highlighted:

- Greater integration of both mental and physical services brought opportunities for the benefit of patients. Patients with severe mental health problems tended to have a shorter life expectancy as a result of physical health problems that were properly managed. People with long term physical health conditions were also more likely to experience mental health problems. Examples of more joined up care included the trust's diabetes service which provided direct care to the medium secure mental health unit.

- The trust was consulting on plans to create a new organisational structure which would further enable the joined up way of working. Services would be planned and managed based on local populations in order to ensure that the mental, physical and learning disability health needs were met for patients in each area. It was expected that the structure would be launched in the New Year.

- In reply to a query, the Interim Director said that whilst the autism diagnostic service lay within Learning Disability services, autism support was treated within a separate service.

- The Care Quality Commission (CQC) had published their report into the trust. Whilst the overall rating remained as 'requires improvement', the CQC found many signs of progress across the organisation. The inspection took place in June/July 2018. The trust's community services received a rating of 'good' overall and the inpatient services for people with a learning disability were rated as 'outstanding' overall.

- That the carer's support service was a needs led service in Solent, and supported people regardless of their age. It was a person centred

9. Dates of Future Meetings.

It was noted that the next meeting would be held on 31 January 2019.

The meeting concluded at 3.12 pm.

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Councillor Jennie Brent
Chair

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Portsmouth CITY COUNCIL

Title of meeting:	Health Overview and Scrutiny Panel
Subject:	Public Health update on performance in substance misuse services
Date of meeting:	31 January 2019
Report by:	Dr Jason Horsley, Director of Public Health
Wards affected:	All

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1. Requested by Health Overview and Scrutiny Panel

2. Purpose: To provide the panel with an update on substance misuse service performance.

3. Background

3.1 Substance misuse treatment services in Portsmouth are commissioned by Portsmouth City Council's Public Health service, as part of the Council's public health responsibilities. The lead provider of our community services is the Society of St. James (SSJ).

3.2 In addition to the health consequences of drug and alcohol misuse, there are significant social and economic costs, such as crime (acquisitive and violent), lost productivity, and higher children and adult social care costs. Often the cycle of addiction will be intergenerational, with children of substance misusing parents following a similar path.

3.3 Public Health England has undertaken analysis of the costs and benefits of drug treatment. They have found that the social return on investment for drug treatment was £4 for every £1 spent, and £3 for alcohol treatment[1].

3.4 Portsmouth City Council currently invests £3,009,100 per annum of the Public Health grant on drug and alcohol support and treatment provision. This is a significant reduction from 2012/13, when £4,829,889 was spent, although funding has increased slightly over the past year.

3.5 Substance misuse treatment covers a wide range of provision. This includes:

- harm reduction initiatives, such as needle exchange to reduce the spread of blood borne viruses
- prescribing of substitute medication, such as methadone
- Psycho-social interventions, such as groups therapy, 1 to 1 counselling
- Detoxification

[1] Public Health England, Guidance: Alcohol and drug prevention, treatment and recovery: why invest? February 2018, https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest

- Residential rehabilitation
- Peer-led services, such as PUSHing Change, which provides advocates and mentors who are in stable recovery.
- Education and volunteering opportunities, to develop skills and maintain recovery
- Other positive activities, such as Lottery funded sports activities delivered by Re:Fit (a joint project between SSJ and Pompey in the Community).

3.6 The impact of reductions in funding has been mitigated to some extent by recommissioning the service to the voluntary sector, better use of buildings, an increase in peer-led support, a reduction in the use of inpatient detoxification and residential rehabilitation.

3.7 However there has obviously been a reduction in capacity and therefore less people accessing treatment. In 2013/14 there were 799 people accessing treatment for heroin addiction, in 2017/18 this had reduced to 692. The current projection, based on service data, is 728 opiate clients by the end of 2018/19. The biggest reduction had been amongst alcohol clients, which reduced from 775[2] in 2013/14 to 163 in 2017/18, although it is projected this will rise to over 220 clients by the end of 2018/19.

3.8 It is estimated that there are 3,295 alcohol dependent persons in the city. Each year we are providing treatment to approximately 7% of these. In contrast there are an estimated 1,427 opiate and crack cocaine users in the city, with approximately 51% receiving treatment.

3.9 A more detailed report on drug related harm was presented to the Health and Wellbeing Board in June 2018 which provides more background information. This is available on the Portsmouth City Council website[3].

4.0 Successful completions and representations

4.1 In addition to numbers in treatment, there are two measures of quality used to monitor the effectiveness of services. These are 'Successful completions' and 'Representations'. A successful completion is when someone leaves treatment drug/alcohol free or as an occasional user (but not using an opiate, prescribed or otherwise, or crack cocaine). A re-presentation is when someone re-presents to treatment within 6 months following a successful completion. This data is captured and reported through the National Drug Treatment Monitoring System (NDTMS).

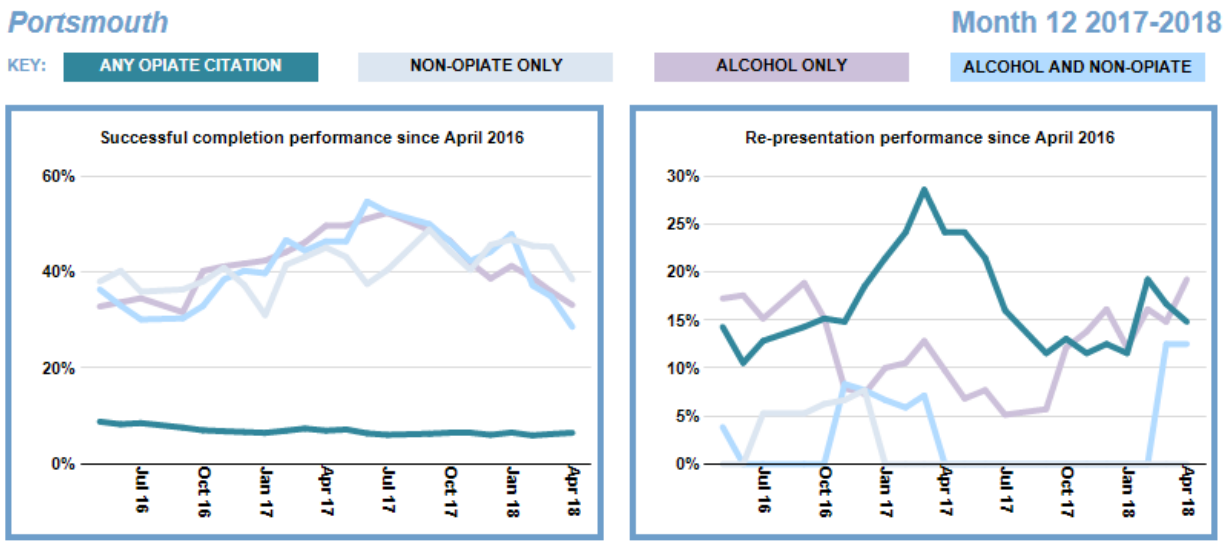
4.2 Due to restrictions on this sensitive (NDTMS) data, the most recent data we can publish is for the year 2017/18. The charts below show the Portsmouth and Southampton performance for these two measures. Whilst there is more stability in the successful completion data, the re-presentation data spikes up and down, this is primarily due to the low numbers, where a few people can make a significant change.

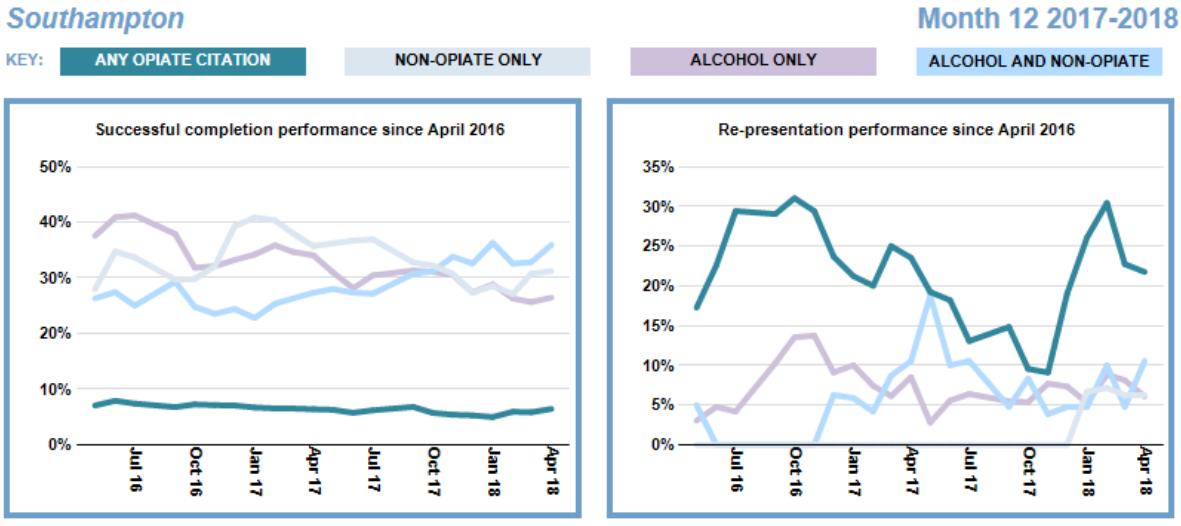
[2] This data for 2013/14 is not directly comparable with later years as the Alcohol Specialist Nurse Service (ASNS) at Queen Alexandra Hospital were reporting to the national data system, but ceased doing so in 2015. Approximately half this number could be attributed just to the ASNS.

[3] Portsmouth City Council. report to the Health & Wellbeing Board, Drug Related Harm, June 2018: https://democracy.portsmouth.gov.uk/documents/s19021/Drug%20related%20harm%20report.pdf

For example for the opiate representations over a rolling 12 months period, there were 4 representations out of 27 people completing.

4.3 Since March 2018 there has been a significant improvement in the percentage of clients successfully completing for all categories, except opiate users, this remains stable. For alcohol and other drugs, successful completions are now similar to the levels in April/July 2017. Re-presentations have also been on a downward trend, except for opiate users which is broadly stable.





4.4 The percentage of opiate users who successfully complete treatment drug free each year is relatively low; this is a national trend, which Portsmouth mirrors. Many people in drug treatment have had very many years of addiction and have a wide range of associated problems, such as mental and physical health issues, homelessness, no employment history and debt. They will often take many attempts to become drug free and this can take a number of years to achieve. However, whilst they are engaged in treatment, they are less likely to die of a drug related death and less likely to commit crime, and public safety is improved through a reduced risk of transmission of blood borne viruses.

4.5 Addiction is a relapsing condition. It is usual that service users will have a number of attempts to stop using drugs and alcohol before they finally achieve abstinence, similar to smokers that will make a number of quit attempt before succeeding. There can be any number of reasons why a relapse occurs and whilst the service can provide the user with all the psychological tools to prevent relapse, it is impossible to completely remove the risk. Conversely some drug or alcohol users will achieve abstinence when least expected.

5.0 Vanguard systems thinking intervention

5.1 During 2018 the Society of St. James (SSJ) worked in partnership with Portsmouth City Council to undertake a systems thinking intervention looking at the Recovery Hub, the main access point to treatment. The intervention found aspects of service delivery which could be changed or even stopped if it provided no direct benefit to the client's needs. An example is the assessment process. Before the intervention assessments were available on Tuesdays or Thursday for clients to drop-in. There was an initial triage assessment to identify need. If the client was suitable for treatment they would be allocated to a worker who would then invite them back again for a full assessment. If the client required a medical intervention, such as methadone prescribing, then they would be required to come back again to see the Doctor. This whole process could take weeks and the drop-out rate high with this chaotic client group. Through a change to the assessment process, the service is now able to offer 5 day per week drop-in access for assessment. A more client focused assessment is completed on the same day, by the worker who will become the key worker and if the Doctor is available the client could also receive a prescription on the same day.

5.2 Since the new way of working was adopted feedback from staff and service users has been positive. Numbers in treatment have also been increasing. Fuller details of this intervention have recently been reported to the Cabinet member for Health & Social care and this report is attached as Appendix 1.

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Signed by (Service Director)

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

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

Title of document	Location
Drug Related Harm. Report by the Director of Public Health to the Health and Wellbeing Board, June 2018.	https://democracy.portsmouth.gov.uk/documents/s19021/Drug%20related%20harm%20report.pdf

Appendices:

Appendix 1

Title of meeting:	Health, Wellbeing, and Social Care Portfolio Meeting
Subject:	Systems Intervention in Substance Misuse
Date of meeting:	January 29th, 2019
Report by:	Director of Public Health
Wards affected:	All

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4. Requested by - Director of Public Health

5. Purpose of report

To provide an overview of work completed over the last year aimed at improving substance misuse services provided from the *Recovery Hub* and the outcomes achieved to date.

6. Information Requested

a. Background

The Recovery Hub is operated by the Society of St James (SSJ), and is commissioned by PCC. The service provides access to a wide range of support for people experiencing problems with their substance use. The service is open access so appointments are not necessary - people can just come in and speak to a member of staff who will be able to help them access the support they need. The Recovery Hub can help clients to access a range services and sources of support, including:

- substitute prescribing services
- counselling
- community day rehab
- one-to-one support
- groups
- housing

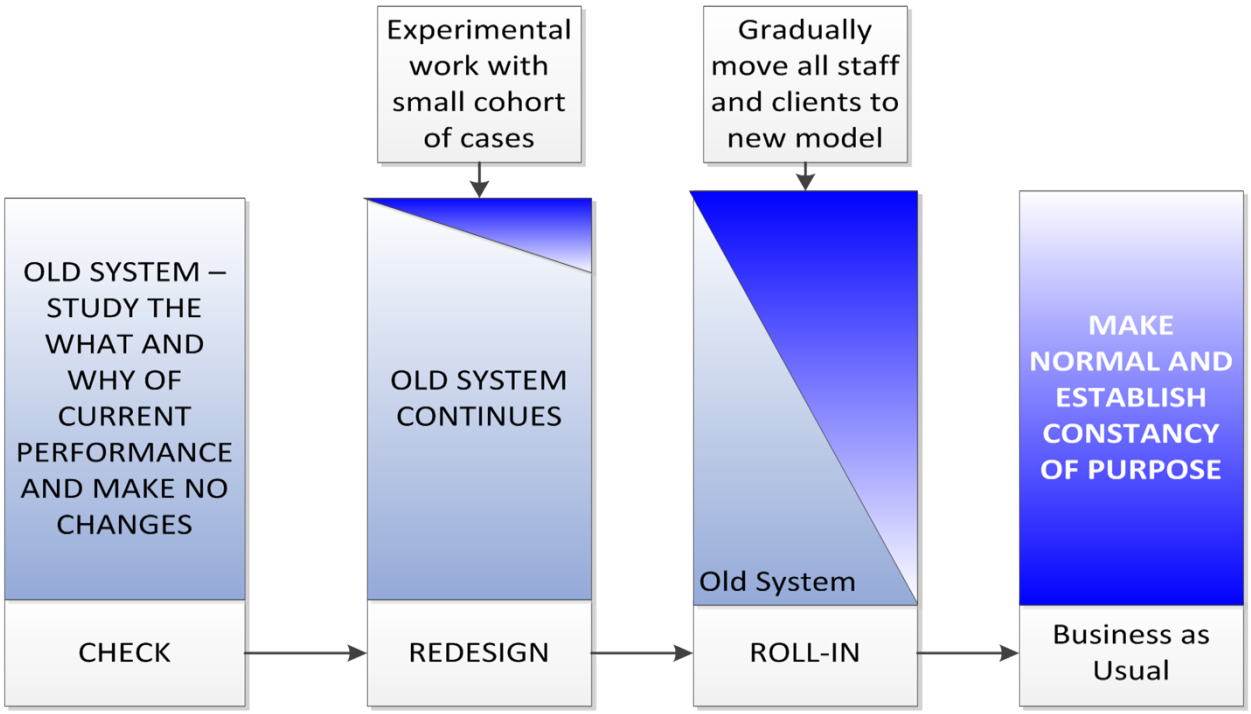
In the summer of 2017, after discussions between SSJ and PCC, it was agreed to run a systems thinking intervention to study the service and (possibly) to redesign the way that it worked from the client's point of view.

b. **Methodology**

This work was completed by a small team of staff from SSJ, supported by a PCC Interventionist. Interventions at PCC are based on the Vanguard Method for Systems Thinking, and are usually supported by the council's **Systems Development Service (SDS)**, which in turn is part of the Housing, Neighbourhood, and Building Services (HNB) Directorate.

The intervention approach uses action-based learning to enable management and staff to study and then (if required) radically transform and improve the services that they work in. An intervention, if followed to completion, is comprised of three phases:

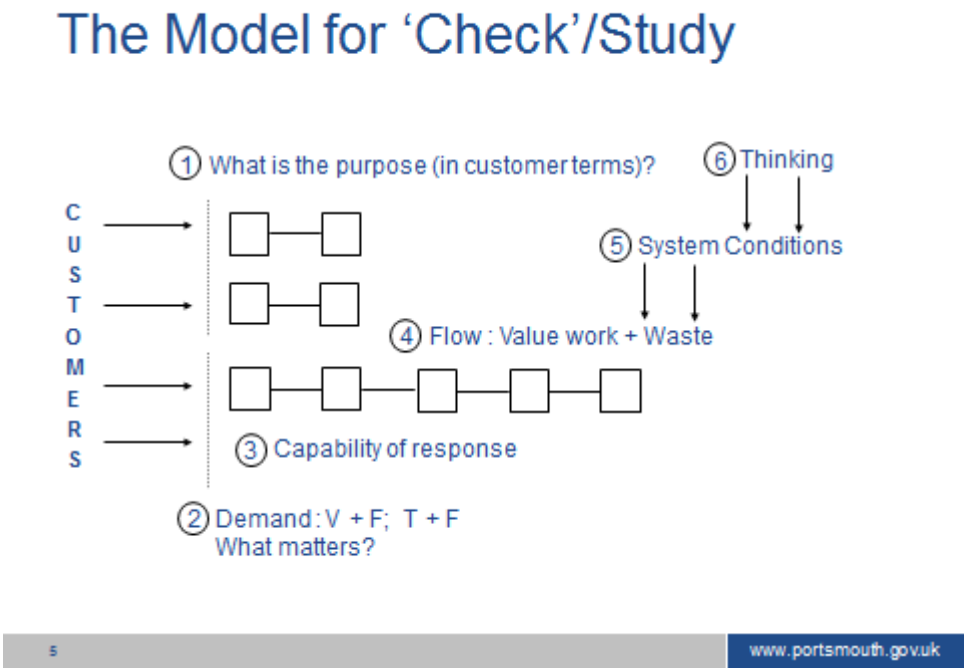
Check - Study the system
Redesign - Experiment with new approaches
Roll-In - Scale up and normalise the changes



Between each completed phase, the team completing the work present the findings to senior leaders, who review what has been learned and decide whether to proceed to the next phase of the intervention.

c. October 2017 - December 2017 - Studying the system ('Check')

The team spent time studying the existing system (from the customer's point of view) from October 2017. The purpose of the 'Check' phase is to gain knowledge about how any system currently operates, both in terms of 'what' the customer experience is like, and 'why' it is like that.



Purpose
The purpose of the service (from the customer's point of view) was defined as:

"Help me to make my life better"

This is aimed to recognise that the Recovery Hub supports a wide range of service users, who present at the service in a variety of situations and have their own view of what 'better' might look like for them.

Demand
The team moved on to studying demand. In an intervention, customer demand is divided into two categories:

Value Demand - Demand that the service exists to meet
Failure Demand - Demand that arises from a failure to do something; or a failure to do something right for the customer.

Demand was studied via live observation of customers contacting the service and asking for help. During the period of sampling, the team observed Value Demand at 81% and Failure Demand at 19%. In effect, this means that one in five of the contacts received by the service were the product of something either going wrong or simply not happening somewhere in the system, with the result that the customer re-contacted the service. Much of the failure demand came in the form of 'progress chasing'; that is, where a customer has requested a service and before they have received it have to re-contact in order to query what is happening. Failure demand is very common in public services that support vulnerable people and contributes to delays/higher waiting times and systems coming under capacity pressure (because the same underlying demand for help is 'received' by the service on multiple occasions.

Capability of Response
The team reviewed how capable the service was of responding to the demand it receives, and, crucially, how the service measured this. The team found that the existing datasets collected by the service were largely driven by the national agenda (i.e. for benchmarking and aggregation) and were of limited use in trying to understand the experience of customers at the local level. For example, the service had no reliable measure of how long it would typically take for a client to receive help after they had asked for it.

In order to gain at least some understanding of how long the service was taking to meet customer demand, the team completed a series of reviews of recently completed cases, deriving the data from them.

This showed:

- Contact to assessment (days) - Average 11 days/Upper control limit 26 days
- Providing a prescription (days) - Average 18 days/Upper control limit 78 days
- Appointments - 91% of all appointments at the request of the service, only 9% at the request of the client. Clients failed to attend 32% of the appointments booked

Flow of Work
The team studied the 'flow' of work through the system by looking at every step in every core process used by the service in response to receiving a demand from the customer. As with demand, this phase of study was completed via live observation of the work happening. Having observed and mapped a process, the team would then validate their findings with the staff who do the work, to ensure accuracy of understanding. Finally, the team categorised every step, as follows:

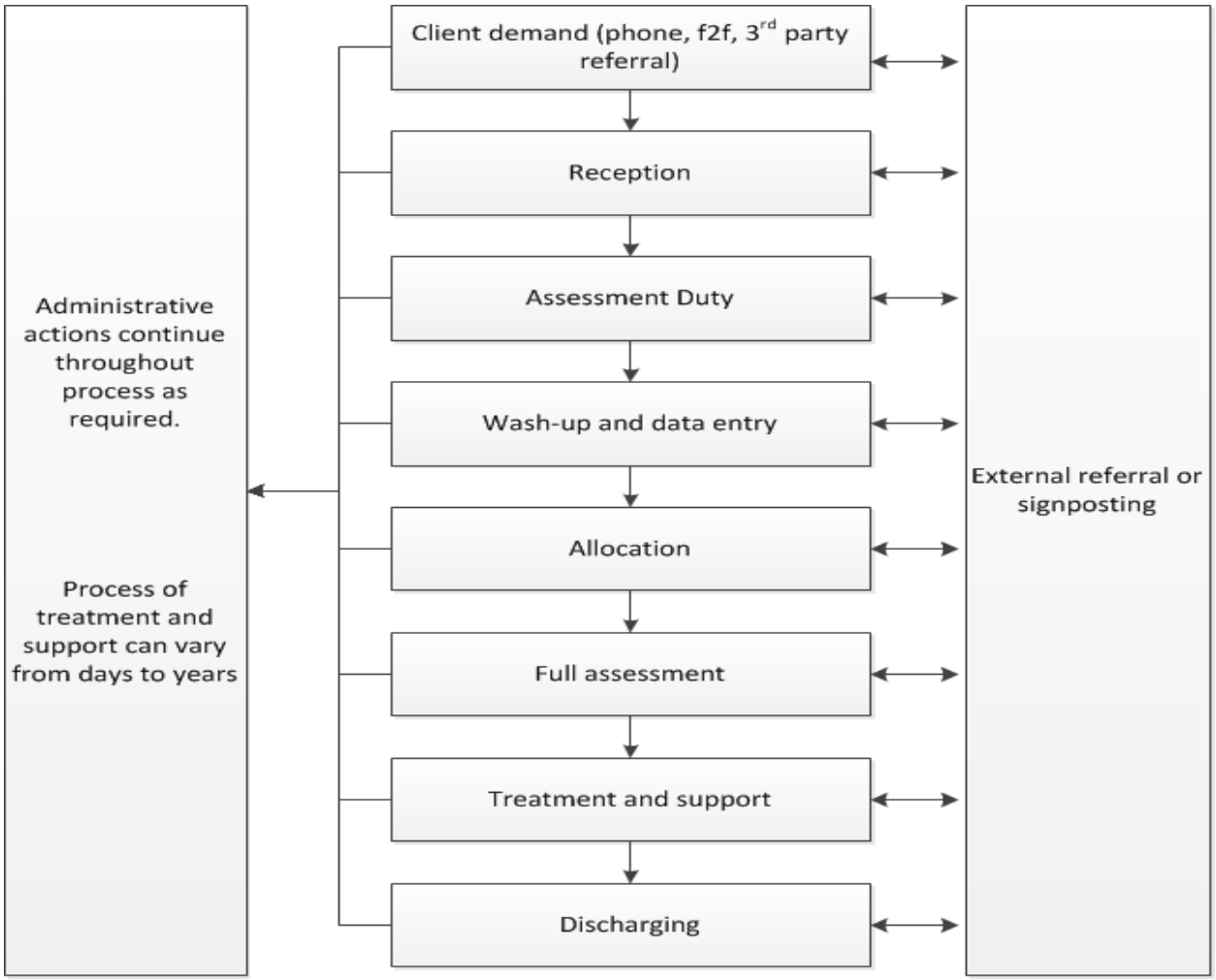
Value Work (directly delivers the agreed Purpose) - 24.8%
Type 1 Waste (can be removed without consequence) - 3.6%
Type 2 Waste (Designed in to the current process - not readily removable) - 63.8%
Type 3 Waste (the product of the law, regulation, or contractual issues) - 7.8%

This is a fairly typical finding for services of this type when we study them in this way.

System Conditions
In addition to understanding *how* the work happens, the team also sought to understand *why* each element of the existing system was designed in the way it was. This is done by analysing and understanding the choices that underlie each element of each process and describing how these impact on the customer experience. The key system conditions impacting the Recovery Hub's processes were:

Fragmentation – leading to a ‘stop-start’ customer journey.
Authority levels – management process controls creating delays
Process design – necessitating duplication and rework

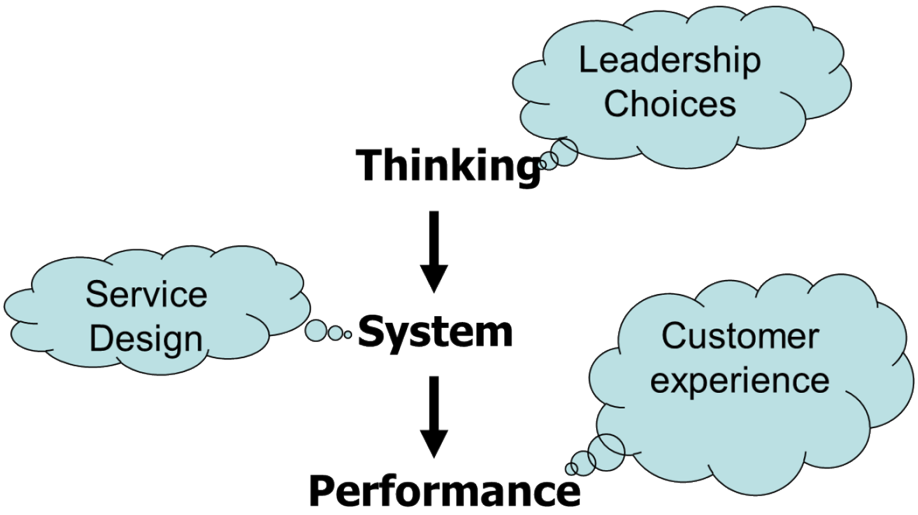
At a high level, the process was fragmented *by design* into a discrete sequence of separate activities:



Although many more system conditions were identified (IT, legislation, targets), the three listed above were the most impactful in terms of their influence on the customer experience. Crucially for this work, they were also largely within the control of the service to change, by making different choices.

Thinking

System conditions like those identified above are neither natural nor inevitable. Invariably, they are the product of leadership choices aimed at achieving certain aims (eg - economy efficiency, process control, legislative compliance, etc). The process of Check enables leaders and staff to have clarity about the effect of those choices on service design, and ultimately the customer experience, and to therefore understand whether those choices have had unintended consequences. For example, the decision to have a two-stage assessment process was designed to 'filter out' clients that were unsuitable for the service. In practice, this approach meant that most clients had a fragmented experience of the service, because they had to attend the Recovery Hub at least twice in order to receive any support.



The 'thinking' in any system is studied by interviewing staff, managers, and other stakeholders to gain multiple different perspectives on the design of the system. In this context, the key finding was that people at all levels felt a tension between the needs of direct service delivery to clients and the need to respond to national and/or contractual requirements.

At an operational level, there were two key elements of the process, imposed by choices about service design that caused the 'stop-start' dynamic of the service, namely:

'Assessment Days' - Although the Recovery Hub is open to the public from Monday to Friday, the system as we found it in 2017 would only generally provide assessments to 'new' clients on Tuesday and Thursday each week. While this enabled the service to concentrate on casework with existing clients on other days, it meant that anyone presenting to the service on Monday, Wednesday, or Friday would invariably be told to come back on another day.

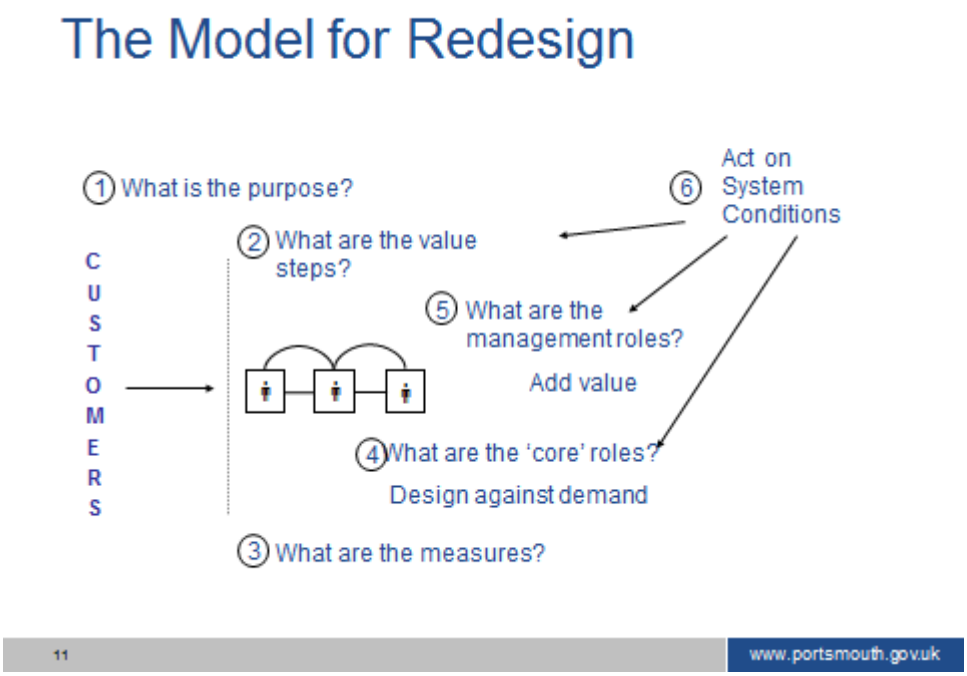
Pre- and full assessment - At their initial presentation with the service, clients would receive a 'pre-assessment' - essentially a screening process that enabled the service to gather basic information about the client and their needs. After the pre-assessment, the client would leave, and later the same day their case would be allocated to a Recovery Worker. The Recovery Worker would contact the client (generally on a subsequent day) and invite them to come back again for their 'full' assessment, after which services and/or support could be arranged.

Taken together, these elements of the system's design meant that a client could have to visit the service three times in order to get to the point where services were offered. If the client needed an appointment with the service's doctor (eg for substitute prescribing), this would also be arranged for a later date, therefore requiring a *fourth* visit to the service.

The team presented the findings from 'Check' to senior leaders at the end of November 2017. The leaders agreed that there was scope to improve the service, and it was agreed to proceed with a Redesign in the New Year.

d. January 2018 - April 2018 - Redesigning the system

The team reconvened in late-January 2018 to begin the process of Redesign. This involves taking live casework in a 'controlled environment' in order to learn how to deliver a 'perfect' process with 'clean flow'.



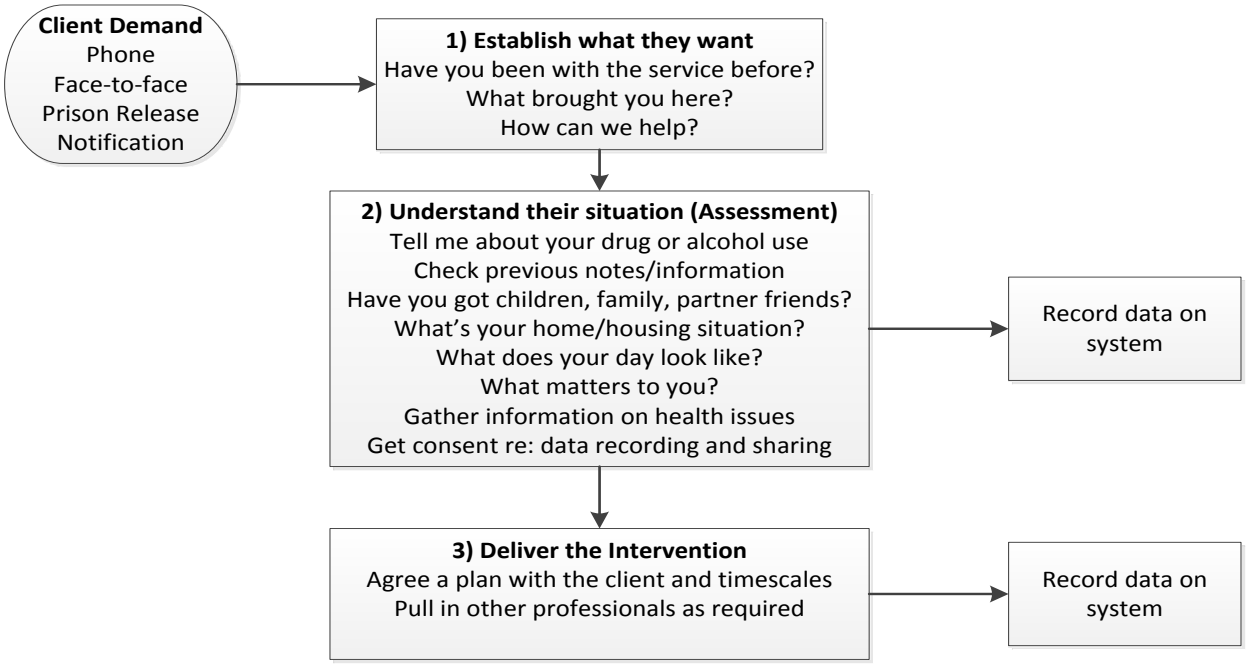
In practice, this means designing a prototype process for the purpose of experimentation with live case work. Prior to beginning this, the team seek to remove the system conditions identified in 'Check' or at least mitigate their impact. When completing the work, the team follow a series of principles that enable them to move towards a new design logic for the service. These are:

1) Customer sets the nominal value - It is the customer who defines the work to be done, how, when, and with what qualities. In the context of services for vulnerable people, professionals may still need to exercise professional judgement about what is in the best interests of the client, but the starting point is always what *they* hope to get from the service.
2) Only do the value work - Wherever possible, all 'waste work' is removed from the experimental process to maximise the capacity to do work that directly benefits the customer.
3) Work flows 100% clean - The team remove all unnecessary hand-offs from the process and minimise delays and fragmentation.
4) Single Piece flow - Again, wherever possible, upon receiving a demand, workers complete all of the necessary tasks to deliver what is required in a single set of continuous actions until either the work is complete, the client asks the worker to stop, or the worker hits a practical barrier that requires the work to be 'parked'.
5) Pull not push - Clients are enabled to 'pull' value from the system, which in turn responds readily when they place a demand. The system does not 'push' unnecessary and unwanted processes and procedures onto the client.
6) Best resource at the front end - The team try to ensure that the person who is best placed to support a client (in terms of skills and knowledge) is available at the front

of the system to respond to a demand immediately, again in order to minimise hand-offs.

It should be noted that these are *principles,* not *rules.* They guide the Redesign process, but are not rigidly adhered to where to do so would be counter-productive or impractical.

When the experiment began, the team devised the process shown below, based on three high-level 'Value Steps':



From February, the team supported 20 newly-presenting clients, providing a single holistic assessment of need at the point of contact, and then putting in place the services to meet the need, basing their decisions on the PLAN framework:

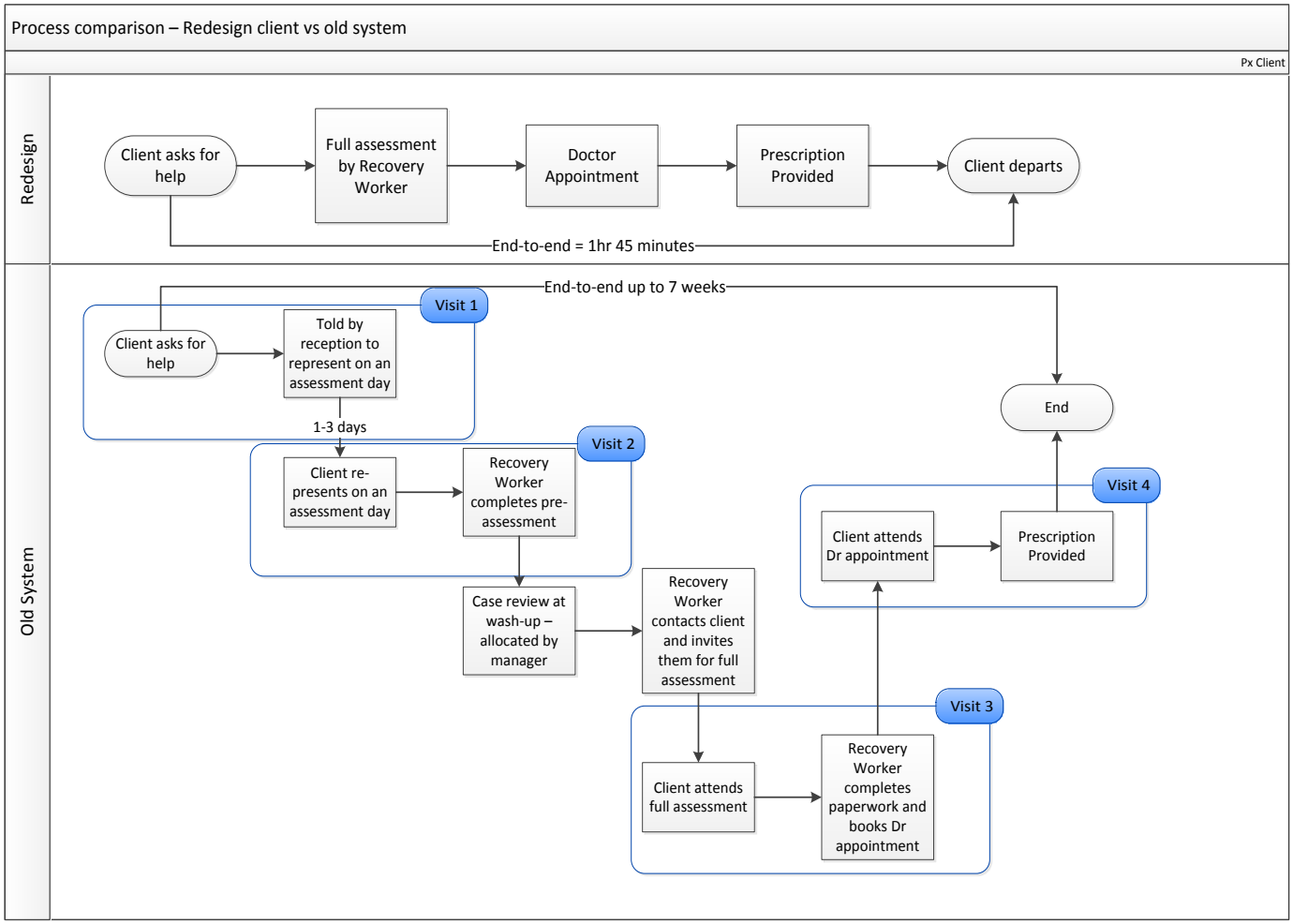
Proportionate - What is a proportionate response to the situation?
Legal - What does the law say we should or should not do?
Accountable - Can I account for my actions (or inaction)?
Necessary - What is it necessary to do or not do in this situation?

In supporting this small cohort of clients in Redesign, the team learned the following:

- A single assessment, at the point of contact, was effective in encouraging clients to engage with the service;
- A narrative-based assessment, replacing the 'tick box' form, was also effective in enabling Recovery Workers to have a more 'human' conversation with each client; and,
- Where possible and appropriate, providing clients with the opportunity to see a doctor immediately after their assessment was welcomed by clients in enabling their needs to be met more quickly.

The diagram below illustrates the contrast between the 'old' system that the team found during 'Check' and the experimental model used during Redesign. The old system would routinely require the client to visit the service 3-4 times and would take up to seven weeks

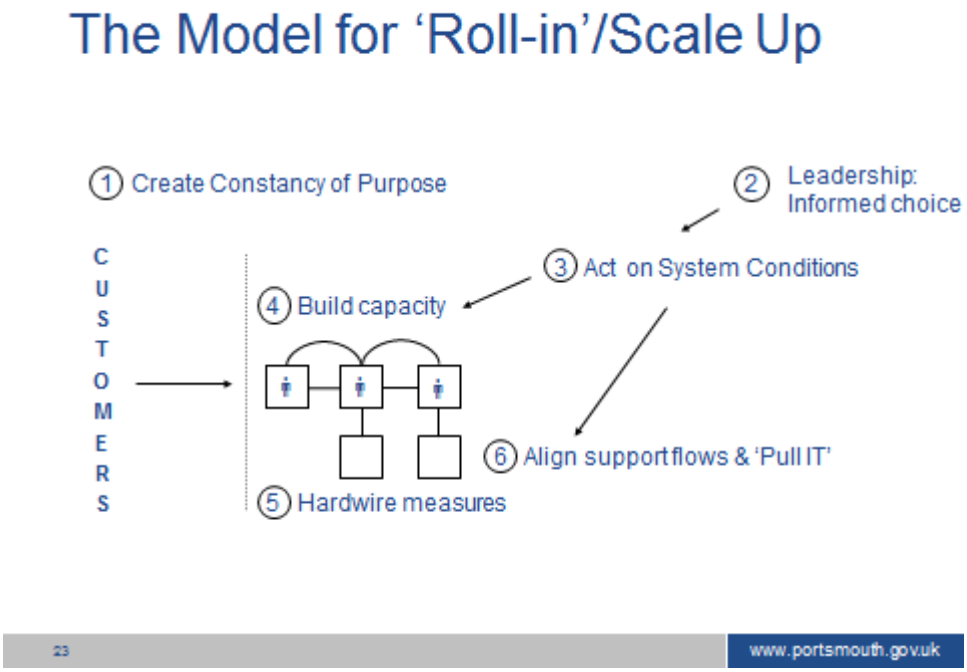
to (in this case) supply the client with a prescription. In Redesign, the team learned that the 'perfect' flow for a similar case would involve all of the work being done in a single visit to the Recovery Hub, with an end-to-end time of 1 hour 45 minutes. Clearly, this would not always be possible, but it did demonstrate what *could* be achieved if the system had no artificial barriers or delays within it.



The team presented detailed findings from the Redesign phase to senior leaders in April 2018. It was agreed that the team could move on to the third phase - 'Roll-In'.

e. June 2018 - November 2018 - Scaling up the new system

Having devised a new process using action-based learning, the team set about the process of 'Roll-In' - gradually transferring all Recovery Workers (and the clients that they support) to the new approach.



Primarily, this is achieved via one-to-one training and coaching with each individual member of staff, personalised around their learning style. The team followed the 'EDIP' model in completing this work, as follows:

Explain - Team member explains the new way of working and the learning that underpins it, to the member of staff being trained.

Demonstrate - Team member takes a new case and shows their colleague how to complete the new process, while continuing to explain the differences with the 'old' system of work.

Imitate - The person being trained then takes their first case using the new approach, supported (in person) by their coach/mentor. After the live work is completed, the coach will ask the member of staff to reflect on 'how it went' and how the principles that underpin the new system have been applied. This step is repeated until coach and member of staff are both confident that the learning has been sufficient.

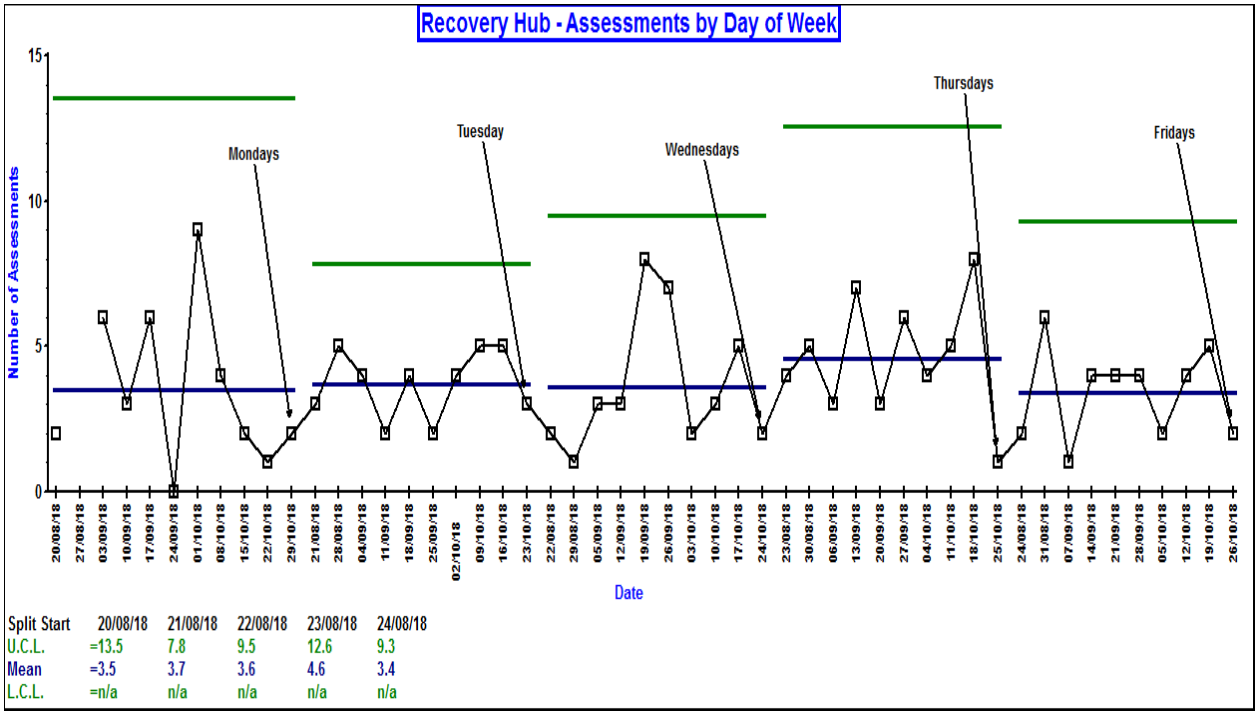
Practice - Once the worker has achieved competence in the new process, they carry on taking all new work using the new approach, following the value steps identified in 3.4 above. They will continue to reflect on the work as they complete it in discussions with their coach, until both agree that it is appropriate for their ongoing learning to be dealt with by their regular line manager.

Because of the nature of the work at SSJ, staff having part-time hours, and 'assessment days' (ie - days when new clients would come in) being only two days a week, the process of completing EDIP with all staff was time-consuming for all concerned.

Broadening access

As noted above, the 'old' system had been designed to only provide drop-in assessments on Tuesdays and Thursdays. Clients who presented at the service or phoned in on other days of the week were advised to attend on those days to seek help. By August 2018, enough of the Recovery Workers were working to the new approach (ie had completed 'EDIP') to enable the service to expand access. From late-August 2018, the service moved to offering assessments five days a week. Because of uncertainty about the likely impact, this was not proactively marketed externally at the time. Internally, the service re-profiled the staffing available to run its 'duty' function, to ensure that staff would be available to meet the anticipated demand.

Perhaps surprisingly, demand (as measured by requests for assessment) 'flattened out' relatively quickly, and by late-October, although Thursday remained the busiest day of the week, most of the rest of the week was roughly at the same level, as shown in the chart below:



As a result, the service has been able to considerably broaden access for clients within its existing resources and is better-placed to provide the initial assessment at the time that is most convenient to the client.

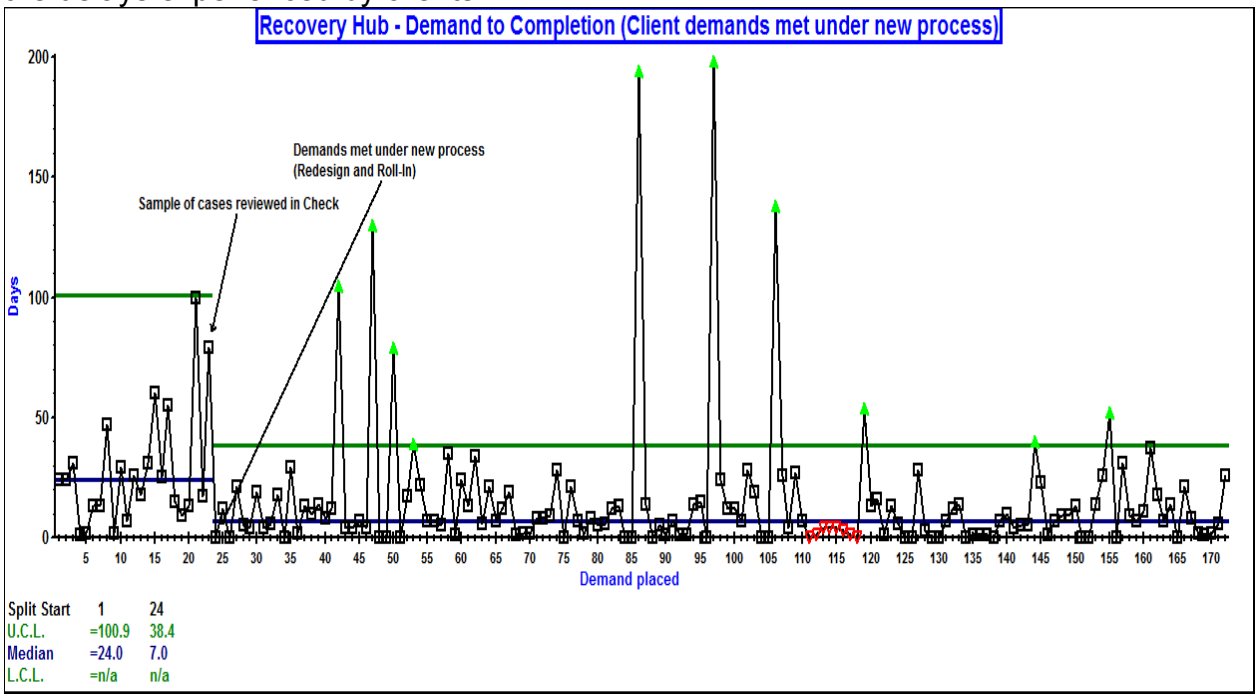
Improving capability of response

A key element of the Redesign was to attempt to simultaneously improve how readily the service could respond to customer demand as well as enabling Recovery Workers to personalise the approach to the unique circumstances of each individual client.

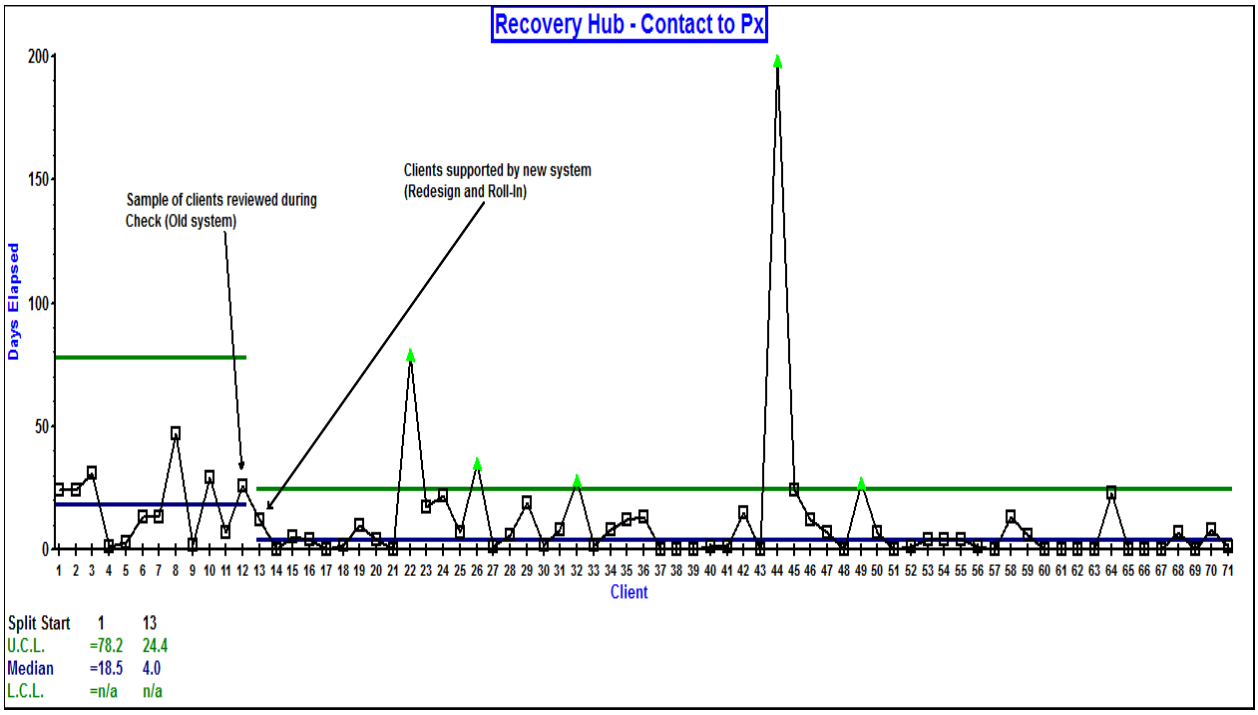
When the team studied the system in 'Check', they found that the fragmented process created considerable delays for the client. As shown in the diagram at 3.4 above, a typical client would need to attend the Recovery Hub 3-4 times over a period of time in order to get access to (for example) a prescription. The team attempted to overcome this by

enabling Recovery Workers to complete assessments at the point of contact and then to begin to work on 'Delivering the Intervention' (the third Value Step) immediately after the assessment, wherever possible.

This has been effective to date, with clients receiving the services/support they asked for considerably more quickly in the 'new' system. The chart below shows cases sampled from the 'old' system on the left hand side of the split, with the 'new' system on the right. To date, the median time taken to complete the work on behalf of clients and get access to services for them has fallen from 24 days to seven days. Clearly, as shown on the chart, there are still factors that can delay the completion of work - referrals to services outside of SSJ's control are still subject to whatever wait times prevail at the time, while some clients still take time to fully engage with the service, which can create delays. Nevertheless, the data collected to date shows that removing fragmentation from the system has enabled Recovery Workers to at least 'get things started' more quickly, which in turn has reduced the delays experienced by clients.



Similarly, the time clients wait to get a prescription has also reduced, and largely for the same reasons (the data in this chart is a subset of the one above). In this case, the waiting time for a prescription has come down from a median of 18 days to a median of four



Institutional Action-Based Learning
The key to sustaining and improving upon the progress that the service has made to date will be for the service to continue to make change based on learning, with the primary role of management becoming to continuously act on improving the system, for the benefit of clients.

This will include:

- Understanding of variation via appropriate use of measures
- Monitoring failure demand and acting to design it out wherever possible
- Engaging staff in understanding obstacles and acting to remove them.

The service has adopted these disciplines into its business-as-usual approach to management. This work has already identified further scope to improve the system in areas that were not part of the original scope of the intervention. In the coming months, the service will look to first understand, and then improve:

- Interface with pharmacies in the city (ie for prescriptions)
- Doctor availability
- Referral processes to other services
- Links to the criminal justice system
- Admin support and processes within the service

The service has achieved a great deal in radically redesigning its operating model:

Clients can now ask for help on five days of the week, rather than just two;
Clients receive an assessment from a Recovery Worker at the point of contact, and wherever possible the worker will start to put services and support in place immediately after the assessment;

Clients will generally be supported by one named worker, enabling them to build a supportive relationship; and, the assessment process itself is now narrative-based and personalised around client needs and circumstances, rather than being a standardised 'tick box' exercise.

To date, the changes made have been highly effective - the service is measurably more responsive to client need and feedback from clients is very positive. However, it is impossible to accurately state the *long term* benefits to clients at this stage. Because this work is still very new, we will need to consider the impact on the wider system in due course.

……
Signed by (Director)

Appendices:

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

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

Title of document	**Location**
Check Presentation	PCC Internal Network
Redesign Presentation	PCC Internal Network
Roll-In Presentation	PCC Internal Network

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NHS
Portsmouth
Clinical Commissioning Group

Cllr J. Brent NHS Portsmouth CCG Headquarters
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1 Guildhall Square
(Civic Offices)
Portsmouth
Hampshire
PO1 2GJ
Tel: 023 9289 9500

21st January 2019

Chair
Portsmouth Health Overview & Scrutiny Panel
Member Services
Civic Offices
Portsmouth PO1 2AL

Dear Cllr Brent,

Update for Portsmouth Health Overview and Scrutiny Panel

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

I recognise that this letter should have been considered at your November meeting but no one from the CCG was able to attend the meeting. I am sorry that this situation arose and I am grateful that you are able to consider this letter at your January meeting instead. With that in mind I have provided a few updates to the original letter to reflect developments over the past couple of months.

Our website – www.portsmouthccg.nhs.uk – provides some further details about what we do if members are interested, but of course we are always happy to facilitate direct discussions if there are particular issues which are of interest to the Panel.

1 Preparing for winter

Health and care organisations across the Portsmouth and South East Hampshire system are currently working closely together to manage demand pressures for urgent care services as we enter the main winter, and cold weather, period.

The planning work we undertook to prepare for winter as a health and care system (involving all CCGs, provider Trusts and local authorities working in the Portsmouth and south east Hampshire area), as well as within the city, began much earlier than in previous years and this has enabled us to develop and agree a comprehensive plan with clear actions identified to be taken by all system partners working collaboratively.

As a result, there have been encouraging signs of improvement on last year during November, December and the early part of January, although clearly we have a long way to go in terms of bringing our performance levels fully up to the standard required of us nationally and that patients, locally, should expect. Obviously the unstinting and collective efforts of our health and care staff has been a major factor in this improved position and we are, as always, very grateful to them for the contribution they have made.

The plan has a number of objectives which cover specific service delivery areas and include actions to address the issues that caused particular difficulty last year: capacity, discharge plans, four-hour wait performance and ambulance handover delays, as well as seeking to reduce the risks posed by flu for both our staff and our local communities.

All NHS and care organisations have a role to play in the delivery of the winter plan, which is managed directly by system leaders and the A&E delivery board.

A key aim within the plan is to reduce the capacity gap in acute hospital bed provision from its peak last year of 144 beds. The plan identifies it should be possible to release 90 beds, through improving the way complex discharges are achieved, in both the Portsmouth and Hampshire systems.

The specific Portsmouth element of this plan is required to release 23 acute beds, and reduce the number of medically fit for discharge (MFFD) patients waiting from the weekly baseline position of 49 per week, down to a target of 30 per week.

In the short term we will do this through increasing capacity in the community but with a longer term view to transform services through work to further integrate health and social care. In summary the Portsmouth plan involves:

- **Increasing domiciliary care capacity:** extend an existing, short term capacity boost for a further six months (2 locum social workers, 350 hours of additional domiciliary care); re-focusing Solent NHS Trust end of life care support services to increase productivity and extend referral pathways; and provide further additional capacity (another 600 hours of additional domiciliary care.)
- **Working with the Reablement Team and Community Units to deliver more capacity** with a greater focus on a more dynamic 'in-reach' service, where team members can actively 'pull' patients out of short-stay wards at QA Hospital and into community services without waiting for notification; and
- **Increasing capacity to enable processes around continuing health care to be completed within the community,** once optimisation of the person's re-enablement and rehabilitation has been reached in a community setting rather than in an acute hospital.

Portsmouth City Council is playing an active role in helping to develop and finalise the winter plan and the total investment to deliver the Portsmouth-specific improvements is around £1.25m, split equally between the CCG and the Council.

The Council's financial contribution comes at a time when adult social care is already overspending by £3.1m on its budget for this year, driven by a number of issues including an increase in the cost of community care packages directly related to more complex need, the flexibility required around purchasing residential placements at times of peak pressure and increasing staffing in Council residential homes in order to respond to CQC concerns. All of these contribute directly to delivering capacity in the city to both facilitate discharge from hospital and to avoid admission.

The Council is to receive around £890,000 (a share of a national total of £240m of additional, non-recurrent funding announced by the Department of Health and Social Care in October) and this funding will be directed towards offsetting the costs identified above, which is in line with the conditions for use of the funding set out by the Department.

Clearly we are keen to ensure that the encouraging early signs of progress with the plan continue, but the challenge posed by winter remains significant for this area. It therefore remains imperative that organisations across the system continue to work together to deliver the plan, as well as an associated communications programme with the public, which has also been developed to support this.

2 NHS long term plan

Panel members will be aware of the publication nationally, on 7th January, of the NHS Long Term Plan which focuses on making the NHS fit for the future and getting the most value for patients out of every pound of taxpayers' investment.

The plan contains a broad range of aims and intentions for the NHS over the next ten years including setting out direction for the future configuration of the NHS, including CCGs.

It highlights both the need to work as part of a broader Integrated Care System (ICS) and the increased emphasis on integrated working with local authorities working singularly across health and social care.

We will need to work through this and any subsequent guidance to understand the implications for Portsmouth and the wider system in which we operate but we see our Blueprint and operating model for Health and Care Portsmouth as central to our local delivery of the aims of the NHS long term plan and we will continue in their development and implementation.

3 Pilot 'hub' for supporting people with long-term conditions

The CCG is working with city partners to prepare to pilot a long-term conditions 'hub' in Portsmouth in the spring.

The hub will initially involve two practices – Portsdown and East Shore – and is intended to provide support to specific, defined groups of people who are living with diabetes and respiratory illness. The location of the hub has not yet been finalised.

The key objectives of this new approach are: to combine both clinical and wellbeing support, to recognise the importance of maintaining good emotional health for those living with long term illness; to deliver greater consistency in the quality of care through standardised pathways and comprehensive care planning; to promote empowerment of patients, and proactive healthcare, and also to involve the voluntary sector in delivering holistic support.

The CCG is working with the two practices, NHS providers and other stakeholders to complete the business plan for the pilot scheme. Staff from the practices will 'rotate' into the hub, and be supported by specialist staff from provider Trusts.

There have been several pieces of public engagement looking at the support of people living with long-term conditions in recent years, which are informing the development of this initiative. To supplement this, an initial discussion about this project has taken place with one of the relevant Patient Participation Groups (PPGs), and more such discussions will follow.

One area to be covered will be how the CCG can work with others to assess patient experience of the trial service, alongside empirical data.

A more extensive briefing can be provided to the Panel at a later date, if desired.

4 Your Big Health Conversation update

We now have the 'topline' analysis from Phase 2 of our Big Health Conversation engagement programme.

The Panel will recall that following Phase 1 (gathering people's views on the changes and challenges facing the local NHS via an online survey), we wanted Phase 2 to have more of an emphasis on focus groups and discussions with a range of different patients' groups. We were particularly keen to ask patients with first-hand experience of services their views on possible future developments around the services they used. Discussions focused on four main areas:

- Community-based mental health care
- Living with long-term illnesses
- Living with frailty
- Using same-day services

In all we heard from patients and carers from over 20 group discussions, with attendance ranging from 5/6 people to 15 upwards. These were structured conversations – setting out the issues faced today in delivering services effectively, and sketching an outline picture of how services could change in future to try to maintain the best possible outcomes for people.

We are currently developing the full report into our findings from Phase 2 but some of the recurring themes we have heard so far include:

Mental health: some inflexibility around the way services are delivered which could lead to people not being able to access the exact support they need; too much reliance on pills or counselling as a solution, with apparently insufficient options in between; concerns about the NHS being able to offer strong support for people in crisis or needing low-intensity talking therapy, but again, not really offering enough between those two points.

Long term illnesses: speaking to people living with one or (usually) several long term illnesses brought common themes to the fore that included a strong sense, still, of people feeling as if they are dealing with services which operate in 'silos' – having to tell their story over and over again, leading to a sense of frustration around duplication and inefficiency.

All of the things that most people might notice – hard to get through on the phone, long waiting times – also really mount up and multiply in terms of inconvenience when you have multiple health problems. There were differing views on who service users want to lead or coordinate their care between their local surgery and specialists, with specialist nurses, in particular, being very highly thought of.

Frailty: with frailty there was a clear sense that carers need support – and don't always receive it currently, which, in some cases, leads to them feeling as if they are not always included or involved. Some of the other themes, not surprisingly, echoed the findings with other discussions, around the need for greater joined up working, not just responding to emergencies and the need to have enough staff in the community to provide sufficient help and support.

Interestingly, several people referred to loneliness and isolation – that being frail was more than a physical state, it was often a social state as well, and a damaging one at that. Normally people prioritise continuity of care – but for some people it is actually better if a very frail patient sees lots of different staff, because it can help to reduce loneliness.

Same-day services: the feedback here was slightly more diverse, possibly to be expected given the topic. Despite the changes to opening hours in recent years, there is still a perception for many that the NHS has not changed to reflect modern life. People still feel that GP surgeries and other same-day services have traditional, limited opening hours. That said, many people are not attached to the idea that they "must" see a doctor. But the more often people need help, the more they value continuity.

When talking about any sort of 'hub' type arrangement for urgent care, some people quickly query the travel distance which is still a key concern for some.

There were also a number of general concerns expressed about whether the local NHS has the money or the staff it really needs to deliver plans around urgent care, however positive these plans are.

There is, and will be, much to digest from all the feedback we have received and, when it is completed, we will be making the full report publicly available and will share it with Panel

members. It will also be shared with all of the groups of people who were so generous in giving up their time to talk about their experiences, and their thoughts.

The findings are also already informing work which is beginning to get underway now – including some of the developments we have included in this update, such as the long term conditions hub and mental health crisis services.

There is also likely to be a Phase 3 – taking what we have learned, and then moving into much more specific issues, looking in more detail about where services could be located, and how they could work.

5 Mental health crisis services

Portsmouth, Fareham & Gosport and South Eastern Hampshire CCGs have agreed with Southern Health NHS Foundation Trust and Solent NHS Trust a fundamental change to the way mental health crisis services will be delivered across the Portsmouth & South East Hampshire locality.

This has followed several months of careful observation around the way teams are currently working, examination of processes and records, and over 150 hours of workshops and consultation involving hundreds of patients/service users, carers and staff discussing how services should look in the future and particularly how people would access community mental health services.

The new service will combine the Southern and Solent crisis teams into a single service model that improves responsiveness and consistency for adults of all ages.

The service will be operational by summer 2019 and will deliver benefits for people living in Portsmouth such as:

- 24/7 needs led crisis service with response time standards
- Self-referral to support self-determination of crisis
- Support for carers
- Peer support to promote hope and recovery
- A supported workforce with the right skills to deliver person centred support and empower self-care

6 SystmOne - all Portsmouth practices now using the same IT package

Over the summer we were able to announce that all GP surgeries in Portsmouth now use the same IT system – paving the way for patients to get more joined-up, efficient care.

All GP practices in the city are now using the SystmOne product software which means they share a standard clinical system for everything from storing patient records to booking appointments.

The community and mental health teams run by Solent NHS Trust also now use that same system, and adult social care staff are expected to follow suit by the end of March.

The IT overhaul has direct implications for the quality of care that frontline teams can give to their patients, and should also reduce the frustrations of patients who have regularly had to explain their whole medical history every time they see a new doctor or nurse.

In the past, city residents using the out-of-hours service would be seen or spoken to by a clinician who could not see their notes. Now they can immediately access the patient's full record, no matter which practice they are registered with. That means better care, and a lower chance of the patient being referred back to their GP surgery.

GPs can now easily access records kept by other healthcare professionals, such as community nurses, to see – for example – whether their patients are waiting for test results, or have other appointments pending. In turn, community-based teams can also easily view a wider range of information about their patients. In the past, frontline staff could not easily access patient data which was held by other parts of the NHS.

Getting all of our practices onto the same patient record system is a huge step forward, and will really open the door so that we can press ahead with joining up services for patients.

Health staff will be able to make decisions about someone's care knowing that they are seeing the whole picture of that person's health, and can rely on using real-time, accurate, and comprehensive information.

7 Gosport War Memorial Hospital

The panel requested an update on the response to the publication of the Gosport Independent Panel report. This update is provided on behalf of the Hampshire and Isle of Wight CCG Partnership (Fareham and Gosport CCG, South Eastern Hampshire CCG, Isle of Wight CCG, North Hampshire CCG and North East Hampshire and Farnham CCG) as Gosport War Memorial Hospital is situated in the area covered by Fareham and Gosport CCG.

Locally, the Hampshire and Isle of Wight Partnership of CCGs has established its programme of work in response the Panel Report. The CCG Partnership has – following a Conflicts of Interest process – designated its Executive Director for Quality and Nursing, Emma Boswell, to take responsibility for leading this work.

A Governance Review Group has been established which has reviewed the report, and set the scope of the work programme. A Gosport Learning and Assurance Board is being established – working with local and regional NHS partners, and safeguarding boards – to oversee the agreed responses to the findings of the Independent Panel. NHS Portsmouth CCG is liaising with the CCG Partnership to ensure that all parts of the local health system are working in a co-ordinated way.

Nationally, the government response has now been made (November 2018). This response Is being reviewed by the CCG Partnership and other NHS bodies – including NHS Portsmouth CCG – and, where applicable, will incorporated into the programme of work relating to the events in Gosport.

We will continue to liaise with the CCG Partnership to ensure that all parts of the local health system are working in a co-ordinated way on any issues that arise from the Panel report. Further updates about Gosport will be provided in future through the update from the Hampshire Partnership.

8 Listening to our patients

We have provided an update on the Big Health Conversation elsewhere in this letter but there are many other ways in which the CCG, and the local NHS, interacts with local patients and partners.

Our 'Listening to Our Patients' document supplements our annual report and is published to outline how the CCG engages with its local community and how it acts on the feedback it receives. The document is available here and covers the period April 2017 – March 2018.

Yours sincerely

Innes Richens
Chief of Health and Care Portsmouth

healthwatch Portsmouth

What is Healthwatch Portsmouth?

- Healthwatch is the **local**, **public led**, **independent** group that makes sure people's voices are heard in decisions about health and social care services.
- We act as a local **champion** to help people speak up about the services they receive.
- We put local people at the heart of all services and make sure their voices are always heard.

2018 – Autumn and Winter Highlights

- Board member recruitment
- Third Walk-through of QA Hospital's urgent care pathway, report and recommendations in progress
- Community Research planned with patients registered in GP surgeries to find out their awareness of and use extra GP appt slots at Lake Road
- Rolling caseload of over 40 separate cases supported by senior advocate to support Portsmouth residents wishing to make a complaint about an NHS service received are resulting in service improvements
- Series of evaluations of our service: for advocacy service clients; our volunteers; member and stakeholders: so far so good with feedback
- Strategic level discussions on PCC's information service directory
- Attended (re-started) Learning Disability Partnership Board meeting

Community Engagement work

- Stalls and talks to wide range of community groups
- Worked with other local Healthwatch to identify our concerns on lack of patient and public engagement to develop Sustainability and Transformation Partnership plans for service transformation in their area

- Patient engagement best practice recommendations taken seriously by commissioners, used in consultation on future perinatal service, Long Term Conditions Hub
- From our community research conducted in GP surgeries (late summer) our recommendations for improved communication between surgeries and their patients on reasons for and potential benefits of a merger was taken up by CCG for future best practice

Outcomes and impact of our involvement

- Informed Solent NHS Trust Estates Manager ref re-introduction of bus service for St Mary's Hospital will help patients more easily access site
- Further to clarifying to HOSP we had not been involved in discussions and agreed proposed PHT patient engagement plans for re-location of spinal service we met with Trust senior managers and discussed content of patient leaflet
- Challenge to Southern Health Foundation Trust on not being included in strategic level final review following feedback we sought on mental health Crisis Service plans for Portsmouth residents resulted in a strategic level discussion and scrutiny on Crisis Service plans with local provider Trust

Outcomes and impact of our involvement

- From contributions made from 'the patient perspective' and offered through Portsmouth Hospital's Trust Patient Family Carer Collaborative:
  - update to the Trust's Duty of Candour template letter included 6 out of the 9 changes we had recommended
  - refreshed 'Getting Involved' patient involvement approach included 8 out of 10 recommendations we had made, based on feedback we have received

Thank you for listening, any questions

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www.healthwatchportsmouth.co.uk

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CareQuality Commission

CQC South Central Region Acute Hospitals.

Presenter CQC representatives

Event Health Overview and Scrutiny Panel meeting

Date 31 January 2019

1

Our purpose and role

CareQuality Commission

- We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve

- Register
- Monitor and inspect
- Use legal powers
- Speak independently
- Encourage improvement

- People have a right to expect safe, good care from their health and social care services

2

Our current model of regulation

CareQuality Commission

Register	Monitor, inspect and rate	Enforce	Independent voice
We **register** those who apply to CQC to provide health and adult social care services	We **monitor** services, carry out expert **inspections**, and judge each service, usually to give an overall **rating**, and conduct **thematic reviews**	Where we find poor care, we ask providers to improve and can **enforce** this if necessary	We provide an **independent voice** on the state of health and adult social care in England on issues that matter to the public, providers and stakeholders

3

Our 5 key questions

Are services...

Safe? Effective? Caring? Responsive to people's needs? Well-led?

#CareExpectations

4

Regulation to inspire improvement

What we do:

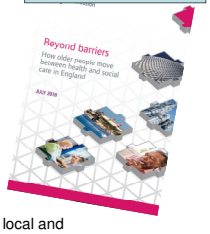
- Set clear expectations
- Monitor and inspect
- Publish and rate
- Celebrate success
- Tackle failure
- Signpost help
- Influence debate
- Work in partnership

5

Beyond Barriers: What did we find?

Can be used as one slide in a wider slide deck

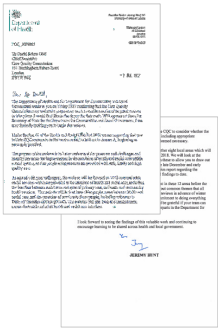
- A system designed in 1948 can no longer effectively meet 2018 needs
- Living longer – but with more complex health problems
- Increasingly, our care must be delivered by more than one person or organisation
- In 2018, we expect care to be personalised to people's individual circumstances
- A fragmented health and care system designed in 1948 can not meet the needs of today's population or operating environment
- We must remove the barriers to collaboration at a local and national level and create an environment that drives people and organisations to work together



6

Why did we carry out these reviews?

- Secretaries of State asked CQC to undertake a programme of targeted reviews in local authority areas
- Reviews sat outside CQC's usual legal powers (under Section 48 of the Health and Social Care Act)



7

How did this fit with our usual work?

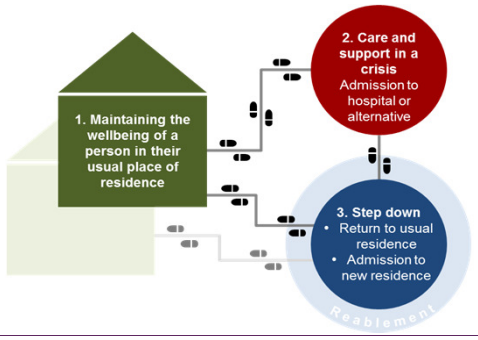
Reviewing local systems reflected key findings of recent reports including:

- State of Care 2016 & 2017
- Integrated care for older people

Also built on our previous programme of 'place reviews':

- 2015/16 - North Lincolnshire, Tameside, Salford
- 2016/17 – Cornwall, London Borough of Sutton

What did we look for in our reviews?



9

A system designed in 1948 can no longer effectively meet 2018 needs

- Living longer – but with more complex health problems
- Increasingly, our care must be delivered by more than one person or organisation
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10

What we found 1/2

- People experience the best care when people and organisations work together to overcome a fragmented system
- Dedicated staff regularly going beyond the call of duty
- There were examples of good practice in every local system we looked at
- Where local leaders share a clear vision, it provides a shared purpose for people and organisations across the local health and social care system
- But in a fragmented health and social care system there are barriers to collaboration at a local and national level

11

What we found 2/2

Funding: Health and social care organisations are limited in how far they can pool resources and use their budgets flexibly across prevention, social care and healthcare

Managing performance: Organisations are held to account for their own performance, not the performance of the system as a whole

Workforce: Services do not always have the right staff, in the right place, at the right time – the health workforce and social care workforce are seen as separate entities

Oversight: Regulation usually looks at quality of care in individual providers, rather than across a system as a whole

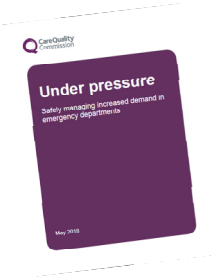
12

Recommendations to local and national leaders, and government

1. An agreed joint plan that sets out how older people are to be supported and helped which in turn, guides joint commissioning decisions over a multi-year period
2. A single framework for measuring the performance of how agencies collectively deliver improved outcomes for older people
3. The development of joint workforce plans with more flexible and collaborative approaches to staff recruitment, retention and development
4. New legislation to allow CQC to regulate systems and hold them to account for how they work together to support and care for older people

13

Under pressure



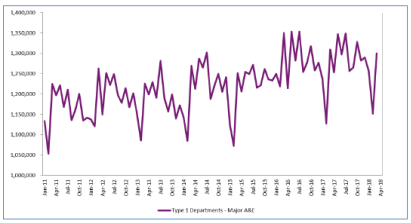
- Report published in May 2018
- To better understand the issues faced by emergency departments, and identify areas of risk
- We worked with over 70 frontline clinicians to identify best practice to make sure patients are kept safe
- A new way of working to prompt new ways of thinking

- Demand is leading to steadily increasing pressure on EDs
- Staff have generally maintained safety by going to extraordinary lengths
- Inspections have found much good practice, but some unsatisfactory care
- New ways of collaborating needed to keep people well, reduce attendances and reduce admissions
- Clinical staff have provided us with their insights into steps that can be taken to improve care
- Hospital cannot work alone the pressure is a symptom of much wider system capacity problem
- A whole system approach is needed now to change the situation before next winter

Demand

- Demand on health and social care services is leading to increasing pressure on emergency departments

Figure 1 – Total monthly attendances to emergency departments (type 1)[5]

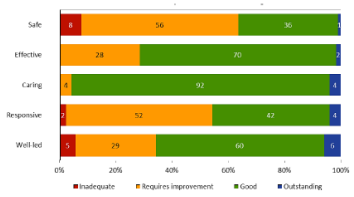


Source: NHS England

Variation

- Our inspections have found evidence of good practice and improvements but too much variation in planning for and managing increased patient attendances

Figure 2 – NHS acute hospital A&E ratings by key question[6]



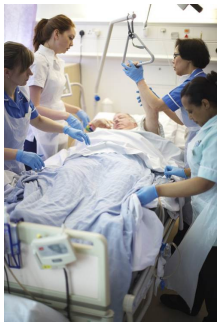
Source: CQC ratings data, April 2018

Eight issues

1. **Ambulance arrivals** – delays in patient handovers from ambulance into hospital.
2. **First clinical assessment** – delays in early assessment of patients.
3. **Deterioration** – monitoring of patients and identification of people at risk of deterioration.
4. **Escalation** – strategies for managing surges in demand.
5. **Specialist referrals** – delays in referrals and the working relationships between the emergency department and specialty teams.
6. **Use of inappropriate physical spaces** – this includes, for example, corridors for the care and treatment of patients.
7. **Staffing** – the wellbeing of staff and staff shortages.
8. **Patient outcomes** – the importance of all services monitoring the outcomes of their treatment and taking action if they are not within the expected range.

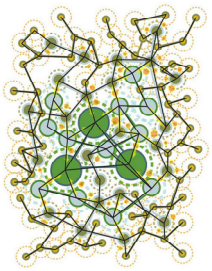
Collaboration and planning

- It is clear, what used to work doesn't work anymore
- New ways of collaborating and planning for surges in demand need to happen *now* to ensure that next winter is different



It's a system issue

- However, hospitals cannot work alone
- Longer term, transformation is needed across the health and care system as whole
- Problems in urgent and emergency care are symptomatic of a wider capacity problem in the health and social care system
- This will only increase unless there is a whole system approach to planning for, and managing heightened demand



These challenges are not insurmountable

- A multidisciplinary group worked with frequent users of their ED for a number of reasons such as violence and aggression (800 per year).
- The team is made up of;
  - Matron, consultant, psychiatry liaison nurse, homeless health team, drug and alcohol nurse and primary care
  - Regular input from police, ambulance and other specialities
- Support plans are made for individuals and people are signposted to other services to support them.
- **The group has shown a reduction in ED attendances and admissions of 80% from these frequent users.**

Bristol Royal Infirmary – High Impact User Group

Portsmouth Hospitals NHS Trust.

Services inspected during Comprehensive Inspection April 2018.

- Medicine
- Outpatients
- Diagnostic Imaging
- Maternity
- Children and Young People
- Critical Care
- End of Life Care

Portsmouth Hospitals NHS Trust.

Further Well Led inspection conducted 9-10 May 2018. We also inspected a further two services

- Surgery
- Urgent and Emergency Care.

What we found

- Our overall rating of the Trust stayed the same as our last comprehensive inspection in 2015. We rated the Trust as requires improvement.

Individual service ratings

Critical care..	Outstanding
Outpatients	Good
Urgent and Emergency	Requires improvement
Maternity	Requires Improvement
Medical Care	Requires improvement
Diagnostic imaging	Good
Surgery	Requires improvement
Children and Young people	Good
End of life care	Good.

Ratings table

20180628 Ratings table PHT.pdf

Thank you

Safe?
Effective?
Caring?
Responsive?
Well-led?

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26

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Ratings tables

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔🡐	🡅	🡅🡅	🡇	🡇🡇
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➔🡐 Jun 2015	Requires improvement 🡇 Jun 2015	Requires improvement 🡇🡇 Jun 2015	Requires improvement ➔🡐 Jun 2015	Requires improvement ➔🡐 Jun 2015	Requires improvement ➔🡐 Jun 2015

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for Portsmouth Hospitals NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↑ Feb 2017	Requires improvement ↓ Feb 2017	Requires improvement ↓ Feb 2017	Inadequate ↓ Feb 2017	Requires improvement →← Feb 2017	Requires improvement →← Feb 2017
Medical care (including older people's care)	Requires improvement →← Jun 2015	Requires improvement ↓ Jun 2015	Requires improvement ↓ Jun 2015	Requires improvement →← Jun 2015	Requires improvement ↓ Jun 2015	Requires improvement →← Jun 2015
Surgery	Requires improvement →← Jun 2015	Requires improvement ↓ Jun 2015	Good ↑ Jun 2015	Good ↑ Jun 2015	Requires improvement →← Jun 2015	Requires improvement →← Jun 2015
Critical care	Outstanding →← Jun 2015	Outstanding →← Jun 2015	Outstanding →← Jun 2015	Outstanding ↑ Jun 2015	Outstanding →← Jun 2015	Outstanding →← Jun 2015
Maternity	Requires improvement ↓ Jun 2015	Requires improvement ↓ Jun 2015	Good ↓ Jun 2015	Requires improvement ↓ Jun 2015	Requires improvement ↓ Jun 2015	Requires improvement ↓ Jun 2015
Services for children and young people	Requires improvement ↓ Jun 2015	Good →← Jun 2015	Outstanding →← Jun 2015	Good ↑ Jun 2015	Good →← Jun 2015	Good →← Jun 2015
End of life care	Good ↑ Jun 2015	Good ↑ Jun 2015	Good →← Jun 2015	Good →← Jun 2015	Good →← Jun 2015	Good ↑ Jun 2015
Outpatients	Good →← Jun 2015	N/A	Good →← Jun 2015	Good →← Jun 2015	Requires improvement ↓ Jun 2015	Good →← Jun 2015
Diagnostic imaging	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.