Portsmouth CITY COUNCIL

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NOTICE OF MEETING

HEALTH OVERVIEW & SCRUTINY PANEL

THURSDAY, 14 MARCH 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 Minutes of the Previous Meeting (Pages 3 - 8)

RECOMMENDED that the minutes of the meeting held on 31 January 2019 be agreed as a correct record.

2 Welcome and Apologies for Absence

3 Declarations of Members' Interests

4 **Local Dentists Committee update** (Pages 9 - 16)

Keith Percival, Honorary Secretary, Hampshire & Isle of Wight Local Dentists Committee will answer questions on the attached reports.

5 **Southern Health NHS Foundation Trust Organisational Restructure** (Pages 17 - 20)

To note a report on the organisational restructure of Southern Health NHS Foundation Trust.

6 **Hampshire & IoW Partnership Clinical Commissioning Group** (Pages 21 - 28)

Sara Tiller, Managing Director for NHS Fareham and Gosport and South Eastern Hampshire CCGs and Matthew Hall, Deputy COO, Solent NHS Trust, will present an updated report from the Hampshire & Isle of Wight Partnership Clinical Commissioning Group.

7 **Response to the Gosport Independent Panel Report into the War Memorial Hospital** (Pages 29 - 32)

Sara Tiller, Managing Director for NHS Fareham and Gosport and South Eastern Hampshire CCGs and Matthew Hall, Deputy COO, Solent NHS Trust, will provide a response to the Gosport Independent Panel Report into the Gosport War Memorial Hospital. The full Panel report can be found online here.

8 **Hampshire NHS Mental Health Trusts Service Redesign: Mental Health Crisis Provision and Oakdene Mental Health Rehabilitation Services** (Pages 33 - 56)

The Panel will consider the attached reports on the arrangements for assessing substantial change in NHS provision: Hampshire NHS Mental Health Trusts: Mental Health Crisis Provision and Oakdene Mental Health rehabilitation services.

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, 31 January 2019 at 1.30 pm in The Executive Meeting Room - Third Floor, The Guildhall

Present

Councillor Jennie Brent (Chair)
Councillor James Fleming
Councillor George Fielding
Councillor Leo Madden
Councillor Steve Wemyss
Councillor Philip Raffaelli, Gosport Borough Council

1. Welcome and Apologies for Absence

Apologies were received from Councillors Marge Harvey and Mike Read.

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.

RESOLVED: 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

The Panel received a report from Dr Jason Horsley. He said that it had been submitted at the request of the Panel, and that the challenge around representations meant that the data was not that clear.

Adrian Noble, Health Development Manager presented the report and highlighted the following areas:

- That substance misuse treatment covered a wide range of provision which included harm reduction initiatives such as needle exchange to reduce the spread of blood borne viruses and the prescribing of substitute medication such as methadone which was used for a period of time to achieve abstinence.

- There were a number of detoxification provisions which included residential rehabilitation, peer-led services, such as PUSHing Change, which provided advocates and mentors who were in stable recovery.

- There had been a reduction in clients over the last few years and during 2018 the Society of St. James (SSJ) had worked in partnership with the Council to undertake a systems thinking intervention looking at the Recovery Hub in order to expand capacity without additional funding. This 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 was the assessment process which was now offered five days per week on a drop in basis. There had been a marked improvement in the percentage of clients successfully completing for all categories, apart from opiate users.

- That the data was chaotic because there was a low number of representations. Data from Southampton was similar, and showed representations rates that were unstable.

In the ensuing discussion, the following points were made:

- That the contract with SSJ ran for three years, with the option of an additional two years that he was minded to utilise. There would be no uplift in the contract value, and additional costs would have to be factored in by SSJ.

- That the service was in competition with well organised criminal gangs and it was important to be able to act swiftly to support service users.

- That subutex, the drug used to treat opiate addiction, had increased in price by 500%, and that as the provider was absorbing this cost, it was likely that there would be a reduction in service.

- That the data was not allowed to be made public as there were national constraints through the National Drug Treatment Monitoring System (NDTMS) data was checked by the Office of National Statistics, and then returned to the Council within a year. The Council relied on the up to date service data that it had in order to provide forecasts.

- That the use of methadone varied for the user concerned. Long term chaotic users who required stability were provided the drug for longer. It also reduced the possibility of crime and death

- A Member suggested that the vanguard thinking process would be a useful way to address the interplay between the CCG and the Mental Health, Substance Misuse and Housing Services in order to allow for savings to be made.

- A Member was impressed by the way that the SSJ had improved, and welcomed the idea of the implementation of system integration with other partners in the field of mental health and addiction in order to ensure that those with these problems did not slip through the net on either side.

- Dr Horsley pointed out that psychiatric issues would be subject to the CCG's next five year plan. The system was currently in flux, and the CCG were being asked to make reductions in opportunity costs. A discussion was in hand with the CCG's COO concerning this.

The Chair thanked Dr Horsley and Mr Noble for their report.

5. Portsmouth Clinical Commissioning Group

The Panel noted an updated report from Innes Richens, Chief Operating Officer, Portsmouth CCG and Dr Elizabeth Fellows, Chair of the Board of the CCG. He highlighted that:

- the planning work to prepare for winter as a health and care system, involving all CCGs, provider Trusts and local authorities in the Portsmouth and south east Hampshire area, began earlier than in previous years and enabled a comprehensive plan with clear actions to be taken by all system partners. As a result, there were signs of improvement on last year during November, December and the early part of January.

- In the short term it was intended to 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. This would be achieved through increasing capacity in the community but with a longer term view to transform services through work to further integrate health and social care. The Portsmouth plan involved:

    - Increasing domiciliary care capacity.
    - Working with the Reablement Team and Community Units to deliver more capacity.
    - Increasing capacity to enable processes around continuing health care to be completed within the community.

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

- The CCG was working with city partners to prepare to pilot a long-term conditions ‘hub’ in Portsmouth in the spring which would initially involve two practices – Portsdown and East Shore – and was intended to provide support to defined groups of people who lived with diabetes and respiratory illness.

- The full report into the findings from Phase 2 of the Big Health Conversation engagement programme would be produced shortly.

- The Portsmouth, Fareham & Gosport and South Eastern Hampshire CCGs had agreed with Southern Health NHS Foundation Trust and Solent NHS Trust a fundamental change to the way mental health crisis services would be delivered across the Portsmouth & South East Hampshire locality. The new service would combine the Southern and Solent crisis teams into a single service model that improves responsiveness and consistency for adults.

In the ensuing discussion, the following points were raised:

- That the QA Hospital had received over a thousand more patients over the winter period than had been expected. The COO said that it was not clear why this had happened, but it was a reflection on the efficacy of the preplanning that the system had coped.

- That the IT services that were being put in place were compatible with the Gosport system.

- It was felt that as the changes to the mental health crisis services had been flagged up by the CCG as being fundamental, that it was quite possible that they fell under Section 244 of the NHS Act 2006, which placed a statutory duty on relevant NHS bodies to consult Local Authorities on any proposals for significant development or substantial variation in health services. At the time of the last meeting, no consultation with HOSP had been undertaken. It was made clear that whilst HOSP had not been consulted the changes, intended to be operational by the summer 2019, had been discussed with Healthwatch Portsmouth. It was agreed that the item would be brought forward to the next meeting.

6. Healthwatch Portsmouth

The Panel received a presentation from Siobhain McCurrach, Strategic Lead, Healthwatch Portsmouth on the last six month of activities of Healthwatch.

She highlighted the following areas that:

- There had been five new Board Members who had been recruited to the Board over the last few months.

- There had been a third walk through the QA and recommendations would be made to the hospital for improvements from the patient's perspective.

- Additional appointment slots had been made available at Lake Road Surgery.

- There was a rolling caseload of over forty advocacy cases supported by a senior advocate from residents who wanted to make a complaint about NHS services which were resulting in service improvements.

- They were working with other local Healthwatch Boards in order to set up linkages.

- A challenge had been made to the Southern Health Foundation NHS Trust as they had not included Healthwatch at a strategic level final review following feedback on the mental health crisis service plans.

In reply to a question concerning the views of the community, she said that whilst there did seem to be a preponderance of negative news from the community, Healthwatch did also receive positive feedback concerning local NHS provision, and that all responses were fed into a database in order to

allow it to extract information on a local postcode basis. She was not confident about the range of people who were being reached, and whilst tweets that had been sent out about CPR for infants school children had been retweeted six thousand times, Healthwatch would also go into GP surgeries to discuss issues with patients and staff.

The Chair thanked her for her presentation.

7. CQC update

The Panel noted the report from the CQC. In the absence of anyone from the CQC to present it, it was agreed that the report should be carried over to the next meeting. It was requested that the ratings for Portsmouth NHS Trust be bought up to date before the next meeting.

R$ESOLVED that the report be carried over to the meeting to be held on the 14 March.

8. DATE OF NEXT MEETING

The meeting ended at 3.10pm

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Councillor Jennie Brent
Chair

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H&IOW Local Dental Committee: Secretary's Report to the Portsmouth Health Overview and Scrutiny Panel

14th March 2019

INTRODUCTION

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

NHS England-South (Wessex):

- Recovered monies and non-recurring UDAs 2018/19 – It is difficult to accurately identify the likely amount of clawback 2018/19 but activity in Primary Care dental at month 6 showed an underperformance of £2.8m which is similar to 17/18. The current position is projected to be a significant recovery as a large corporate contract rebasing took place in 17/18 and the enacted contract reductions will influence 18/19. In 17/18 the final clawback was £8.4m. Mini procurement has usefully utilized £1.3m of the underspend and this forms part of the current break-even strategy where plans to reinvest in-year come to fruition rather than spending the entire dental services budget. The non-recurring initiative looks set to continue in the shorter term but there is a distinct possibility that in the near future over-performance will be limited to 102% or possibly 10% as a one-off uplift. The Policy Book only allows for one 10% uplift during the lifetime of a contract. The alternative would be a procurement exercise with mini-competitions. It is useful and convenient for NHS England to consider over-performance as a waiting list initiative. Those contractors who have geared up to accommodate high levels of over-performance will be at significant risk. We are concerned that nationally the £100-£120 million recovered monies will be stripped out of the dental budget and lost to other services. However, we have been assured by the Assistant Head of Finance that the Wessex Dental Budget will be protected. There is a move to increase the scrutiny of underperforming contracts (33%) that are expensive to manage and who are not interested in rebasing or prefer a temporary rebasing solution. The Area Team recently went through an external audit by Deloitte

and it was highlighted that greater scrutiny of contacts at the mid-year point was desirable. The Business Services Authority (BSA) will take over the responsibility for the management of the contract year end process and this will commence in Wessex from mid-year 2019. The LDC fears that when the BSA takes this over, any agreed over-performance will be incongruent with the BSA process and may well cease 2019/20. The centre for primary dental care contract management in Dorset remains in Southampton and not in the South West.

- Flexible Commissioning –This is already taking place in Wessex but we are aware that there is very little guidance being published centrally. Quite recently the concept was introduced to Local Dental Network (LDN) Chairs but there seems to be no enthusiasm to share this more widely. In Wessex we have piloted oral health services' activity in 4 areas: Under 5 toddler groups, homeless, care and nursing homes and diabetes (advice). There has been limited take-up by contractors in Wessex. These schemes are likely to be piloted for an extended length of time with the diabetes initiative re-modelled and with an evaluation of all four in future state. It is unclear whether or not over-performance is flexible commissioning.

- Dental electronic Referral Systems (DeRS)- The DeRS procurement has been awaiting approval from the Cabinet Office and this has been a very slow and laborious process. However, very recently we were informed that progress has now been made and the Business Case will be approved by mid-March and go out to tender in April. The contract will be awarded in September 2019 and there should be a start date in January 2020. This will eventually facilitate more efficient referrals within a number of dental specialities – Oral Surgery, Periodontics, Orthodontics and Advanced Restorative. The eventual introduction of tier 2 contracts and aligned educational support from Health Education England will be enabled by the captured data within the DeRS model with clinical audit helping commissioners to make procurement and activity related decisions.

- Orthodontic and CDS Procurement Wessex – The orthodontic procurement in the South is almost complete with all 4 batches in mobilization. The 2 lots more recently out to tender in Test Valley and the IOW have been evaluated and moderated with announcements made at the end of December. One other lot has gone back out to tender due to a challenge centred on an inaccuracy within the procurement documentation. The LDCs will expect to receive copies of the orthodontic (7+3) and taper (2+1) contracts. Clearly, there is a potential shortfall in the Isle of Wight and this was highlighted by the H&IOW LDC at the beginning of the procurement process. Since the last joint NHS England/LDC liaison meeting it has become clear that across the southern region a small number of successful corporate providers of orthodontic services are failing to comply with important parts of their tendered bids and especially around the provision of suitable premises and associated planning permission. However, more recently the two providers that were most seriously lagging behind have announced that they will be ready by the end of May 2019.The orthodontic procurement has been and continues to be very traumatic for incumbent providers and this has been a steep learning curve for all those participating in this exercise. The procurement process for the Community Dental Service (CDS) is much more complicated than the orthodontic one and awards of contracts are likely to be delayed for up to two years until 2021. The LDCs have flagged up that the Local Representative Committee represents CDS dentists as well as General Dental Practitioners (GDPs) and urged that an LDC representative attends the procurement stakeholder meetings.

- Cross Border referrals - This perennial problem may be solved in part once the DeRS is in place. Historically, the problem emanates from the patient's GP address but the LDCs are unsure why this problem persists. Primary Care Dental Services are not

commissioned by Sustainability and Transformation Partnership (STP) boundaries. NHS England-South (Wessex) have agreed to look into this concern and especially in relation to DeRS and report back.

- Practitioner Advice and Support Scheme (PASS) - Both LDCs in Wessex have excellent schemes in place to help dentists in difficulty with H&IOW LDC having just launched a new PASS which was presented to the NHS England-South(Wessex) performance team 22nd January 2019. Both schemes in Dorset and Hampshire are currently active.

- Low Unit of Dental Activity (UDA) rates – There have been lengthy discussions with NHS England based on the LDC's concerns that where the UDA rate was below the patient charge that this should be uplifted to a UDA rate that is service-sustainable and realistic to secure business continuity. The LDCs are aware that some providers cannot retain or recruit associates where their UDA rate makes them less competitive than other practices in Wessex and thereby endangers the viability of their contracted activity, potentially resulting in end of year under-performance, clawback and reduced patient care. Historically, contracts were awarded based on activity data from 2005/6 which over twelve years later is clearly not very relevant with the plethora of changes that contractors have seen in the interim. It seems that the Area Team will evaluate individual contracts when this problem is highlighted to them and refer to the process in the Policy Book relating to a safe and viable service. We are not confident that this is being taken seriously nor the disillusioned dental workforce's poor morale that is, in part, generating recruitment problems.

- Wessex Intermediate Minor Oral Surgery Services (IMOS/IOSS) – The current contracts (level 2 and 3a) finish in October 2020 and it is likely that these will be extended for twelve months with an option to extend a further twelve months.

- Secondary Care Orthodontic Services – Nationally, there is a shortage of Orthodontic Consultants and as a result Hampshire Hospitals NHS Foundation Trust (FT) have given six months' notice on the Winchester Secondary Care Orthodontic Services as this service is no longer sustainable. This notice compounds the problem surrounding the notice already given by Southampton University Hospitals NHS FT which will be enacted on the 31st March 2019. The H&IOW LDC is very concerned that we could lose both of these services.

- LDC Assistance – LDCs have been approached by the Wessex Area Team to consider putting on training events for GDPs to include practice business development and financial management. NHS England will provide funding for speakers, venues, refreshments and Continuing Professional Development (CPD) certification. The LDCs are pleased to offer their assistance in the interests of their constituents. The LDCs have been invited to individually contact their constituents who do not have an nhs.net account bearing in mind the forthcoming DeRS and the mandatory electronic submission of forms to the BSA in May 2019. The LDCs felt that this was an important task for them to help their constituents to recognize the associated urgency to comply with this change to a paperless system.

- Superannuation Concerns Personal Dental Services (PDS) – IMOS contracts are based on the NHS standard contract that does not attract superannuation and the LDCs once again revisited and highlighted this inequitable state of affairs. NHS England will look into this to see how superannuation could be part of future IMOS contracts when retendered.

- Individual Funding Requests (IFR) – The LDCs suggested that there was a need to produce a patient information sheet, explaining both the value and limitations of this

service. A leaflet could be easily distributed by dental practices to patients who might qualify for treatment under the IFR route.

- Restorative Needs Assessment **-** An LDN meeting was held on the 19th November to discuss David Cheshire's paper titled 'Assessment of Complex Restorative Dentistry Need, Demand and Capacity in Wessex'. The assessment paper will be published on the LDC website and it is planned to form a H&IOW LDC restorative sub–committee to review the recommendations and feedback to the LDN unless a Restorative Managed Clinical Network (MCN) is created in the shorter term.

- Patient Charge Revenue – This is likely to increase year on year with consequent reduced patient engagement with NHS dental care.

EU Exit Operational Guidance from the Department of Health and Social Care: This is published advice with regard to dental practice planning for Brexit and business continuity. The Chief Dental Officer has suggested that dental practices confer with NHS England dental leads and the LDN to firm up the local approach and protocols. The key information has been circulated by the Dental Contracts Team and is published on the LDC Website www.hiowldc.org

The key points are:

1. UK health providers should not stockpile additional medicines beyond their business as usual stocks.

2. There is no need for health and adult social care providers to stockpile additional medical devices and clinical consumables beyond business as usual stock levels. Officials in the Department will continually monitor the situation and if the situation changes, will provide further guidance.

NHS 10-Year Plan: There is no coherent strategy for dental services and the Starting Well initiative (13 English local authority areas) will not receive any new investment. Spend per head has dropped from £40.95 to £36.00 in the last 5 years and the plan does not address the current recruitment crisis. Dentistry has once more been treated as an afterthought and does not acknowledge the stresses and challenges facing the 24,000 dentists that provide NHS dental services.

Putting the Mouth in the Body: The CDO has stated that there is a growing body of evidence that supports the benefits and returns on investment to be derived from integrating oral health into the wider health, educational and social care agendas. This approach will help to address the enduring issues of health and oral health inequality. Areas of development include:

- Digital transformation and connectivity with the wider health and social care network.
- Increasing opportunities for developing clinical leadership and thereby innovative service provision to meet the needs of the population.
- Dental Contract Reform with prevention at the centre of service provision.
- Improved regional access and opportunities for workforce career development

Special Care Dentistry services are experiencing a significant increase in the number of referrals and this is being compounded by an ageing population.

Generally, referrals to secondary care are increasing with dentists fearful of litigation and increasing regulatory censure adding to the burden placed upon general dental practitioners.

K Percival
Hon Sec
H&IOW LDC

University of Portsmouth Dental Academy
Community Outreach Health Promotion Report
March 2019

1. Introduction

The University of Portsmouth Dental Academy (UPDA) is a partnership between the University of Portsmouth and Kings College London Dental Institute (KCLDI) which started in August, 2010. We train the entire dental team including the dental nurses, dental hygiene/therapists and dental students. We do this through Certificate, Diploma and a BSc in dental nursing, BSc in Dental hygiene/therapy programme, BSc in Dental Hygiene and are an outreach facility to KCLDI dental students.

This report records the activities undertaken by the students during the academic year starting

2. Details of the Dental Academy's Community Outreach Programme

The community outreach programme is manned by the Dental students (DS) and the Dental Hygiene and Therapy students (DHDT) who are accompanied by qualified staff members. The programme has expanded in the past few years and although manned by the students, is very staff intensive both in terms of planning, co-ordination and execution. Ms. Gemma Potts, is the Outreach Administration Officer in charge of organising the programme and its execution.

2.1 Primary Schools

A. Supervised tooth brushing programme 'Brush UP'

'Brush UP' is a very successful supervised tooth brushing programme which since inception has involved 13/14 schools in the area and gradually enrolled more nurseries.

The aims of the Brush UP programme are:

- To improve the oral health of children in Portsmouth.
- To offer oral health education to support families in self-management of oral health.
- To signpost children in need of treatment to local NHS dental services or their existing dentist.
- To encourage a positive relationship with dental services from a young age.

It targets the Reception class of each school. The total number of primary schools and nurseries enrolled on the programme since 2012 are enlisted in Table 1. There has been a steady increase in the nurseries enrolling in the programme while the schools dropping out.

Table 1: Total number of schools enrolled in the Brush UP since 2012-2013

	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019
Schools	14	14	13	13	11	9	9
Nurseries	0	3	2	2	1	2	5

The programme has been received very positively by most participating schools. The consent rates for the tooth brushing has always been over the average of 90% and of Fluoride varnish application above 85%.

(i) Total number of children benefiting since 2012 from the 'Brush UP' is given in Table 4

Table 4: Total number of children enrolled in the programme

	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019
Schools	992	900	879	816	636	622	TBC
Nurseries	0	105	107	75			

Registration with a dentist

An analysis of the data for the two years of 2016-2017 showed that only 75% of the children were registered with a dentist in 2016/17, which further decreased to 70% in 2017/18. Considering that the dental care for children is free, these figures show that 25-30 percent of children in Portsmouth area are not getting the dental care they deserve. The Brush UP programme may be their only contact with the dental care professionals making this programme very valuable.

(ii) Annual reviews to maintain the quality of tooth brushing

Performance against the tooth brushing standards is monitored annually by the students with a standardised observation form. They assess the standard of implementation and the effectiveness of the programme. The top three most impressive schools/nurseries are presented with a 'Brushing Excellence' Award and a Certificate and prize by the Dental Academy.

(iii) Health promotion resources

Initially, schools receive start up stock, consisting of toothbrushes, toothpastes, a tooth brushing song and the brush-buses. In line with current guidance, each school has their own toothbrush and toothpaste stock renewed every three months when requested through an online ordering form. Each school receives training and manuals for their teachers, while each child receives appropriate leaflets and information as mentioned in the previous reports.

B. Fluoride Varnish Programme

The 'Brush UP' fluoride varnish (FV) programme is another successful prevention programme which targets children in Year 'R'. There is strong

international evidence to show a significant reduction in dental decay in children who have fluoride varnish professionally applied two to four times a year. The Dental Academy will be providing 2 applications of FV per year to a child from October 2015.

The children who have consent are screened for dental decay and those who have disease are referred to their own dentists. Those without a dentist are invited to attend the Dental Academy for treatment. Fluoride varnish is applied to all those who have a consent by the dental students, dental hygiene and therapy students and Dental nurses on the Diploma HE in Dental nursing students assisted by trained dental nurses and tutors.

C. Oral health talks for year 1 and year 2.

Oral Health Talks for year 1 and Year 2 are offered when requested by the schools. This is carried out by the DCP students as a voluntary activity and is considered as a graduate employability skill.

2.2 The Dental Academy higher deprivation programmes

Young Adults/Hard to reach triage sessions until 2016 included Portsmouth probation services; The Foyer (homeless shelter for 16-25 year olds; Baytrees and Block C (Drug and Alcohol detoxification unit and recovery hub); After that the Probation service was stopped and screening has been taking place at the Yew House and Hope house both of which offer services to the hard to reach population.

The goals of the triage sessions are to:

- Increase access to preventative oral healthcare to young adults
- Provide individualised oral health education
- Identify people with urgent dental needs who do not have regular access to dental services and to assist those people in obtaining treatment
- To educate people about how to access dental health services
- To reduce the incidence of untreated dental caries and improve the oral health of the population of Portsmouth

As part of the level 6 Dental hygiene and dental therapy curriculum our students visit the following venues to deliver oral health education -

- Sure Start Centres
- The Foyer (homeless shelter 16-25)
- Baytrees (Drug and Alcohol detoxification unit)
- Shearwater (elderly care home - dementia)
- The Kestrel Centre

In the year March 2018 to February 2019, the UPDA has screened adults at four venues; Yew House, Hope House, ASDA Fratton car park and TESCO car park. This has been in collaboration with the charities involved in these centres and the supermarket. 76 patients were screened and 26 of these were offered appointments at the Dental Academy. Among them were 17 patients who had not visited a dentist for more than 5 years.

3. Evaluation and feedback from our service users and Community settings

Evaluation of all the settings is undertaken for service provision and improving care. This ensures that our protocols and the processes are robust.

4. Collaboration of community activity

In the year 2017 a pilot was undertaken where the NHS health check was combined with the oral health check and was offered by the Pharmacy students along with the Dental students as an example of inter-professional learning. The research linked to this project is yet to be published. The project however has highlighted that patients were attracted to enrol in the health check as they really wanted to resolve their dental problems. So, oral health checks can encourage more patients to engage with the general medical services.

5. Research in the community

The Dental Academy along with its research partners is undertaking research on several aspects of community care including assessing the beliefs of parents in schools regarding Brush up and oral health care, dietary plans in early settings, research on hard to reach group.

6. Conclusion

Dental Academy's community outreach programme has been providing good service to diverse groups in diverse setting. While we get very positive feedback from those with whom we work, it has been difficult to recruit new settings. The potential health gain to the service users is massive and life enhancing, irrespective of whether they are at the beginning or at the end of their life.

The community programme undoubtedly benefits the diverse groups of service users. In addition and more importantly, the student feedback confirms that community activity inculcates and embeds the core NHS principles of respect and dignity, compassion, improving lives, putting patients and communities before organisational boundaries and the principle that everyone counts.

The Dental Academy's priority for the coming year is to work with the Commissioners to convince more people of the effectiveness of the oral health programme. We are working closely with Public Health England, Dental Public Health and other stakeholders to gather evidence of the oral health needs in Portsmouth to support commissioners to commission services.

Report submitted on behalf of The University of Portsmouth Dental Academy By

Mrs. Latha Davda
Clinical Director
01 March 2019

Southern Health
NHS Foundation Trust

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An update on Southern Health's new operational organisational structure

Portsmouth HOSP

Dear Colleagues

In December, I sent you an options appraisal paper asking for feedback to help us to shape our new operational organisational structure. The purpose of the restructure will enable us to align our mental health and physical health services with the ultimate aim of delivering better, more joined-up and holistic care to people and communities across Hampshire.

Thank you for your feedback, I am now delighted to share Southern Health's new operational organisational structure. Please find a high level version of what our new operational organisational structure will look like attached.

I have outlined just some of the examples of how we have used the feedback received to shape our new operational organisational structure below:

- We have used the structure outlined in **option one** which was the option preferred by staff and stakeholders
- We have reduced the number of Directorates from six to five: Four integrated geographical Directorates (one of these is Southampton) aligned to the developing Integrated Care Partnerships across the county and one specialist Directorate
- Our physical specialist services (such as diabetes, MSK, tissue viability and heart failure) are now integrated within three geographical Directorates. We have changed the name of what was previously the Forensic Mental Health Directorate to Specialist Directorate
- Learning Disabilities, children's services and public health services (such as Quit4life) now also sit under the Specialist Directorate.

Alongside this, we conducted a consultation to make sure we have a strong senior operational leadership teams in place to help us deliver our new structure.

We are now recruiting to these roles and hope to have our new structure in place in the spring. Once in place, our new senior operational leadership teams we will be working alongside, you, our staff, and the people we support to look at how the new structure will be delivered across Hampshire.

It's important to note that while the new structure is being put in place, every effort is being made to ensure our services continue as usual so the people we support are not affected by these changes.

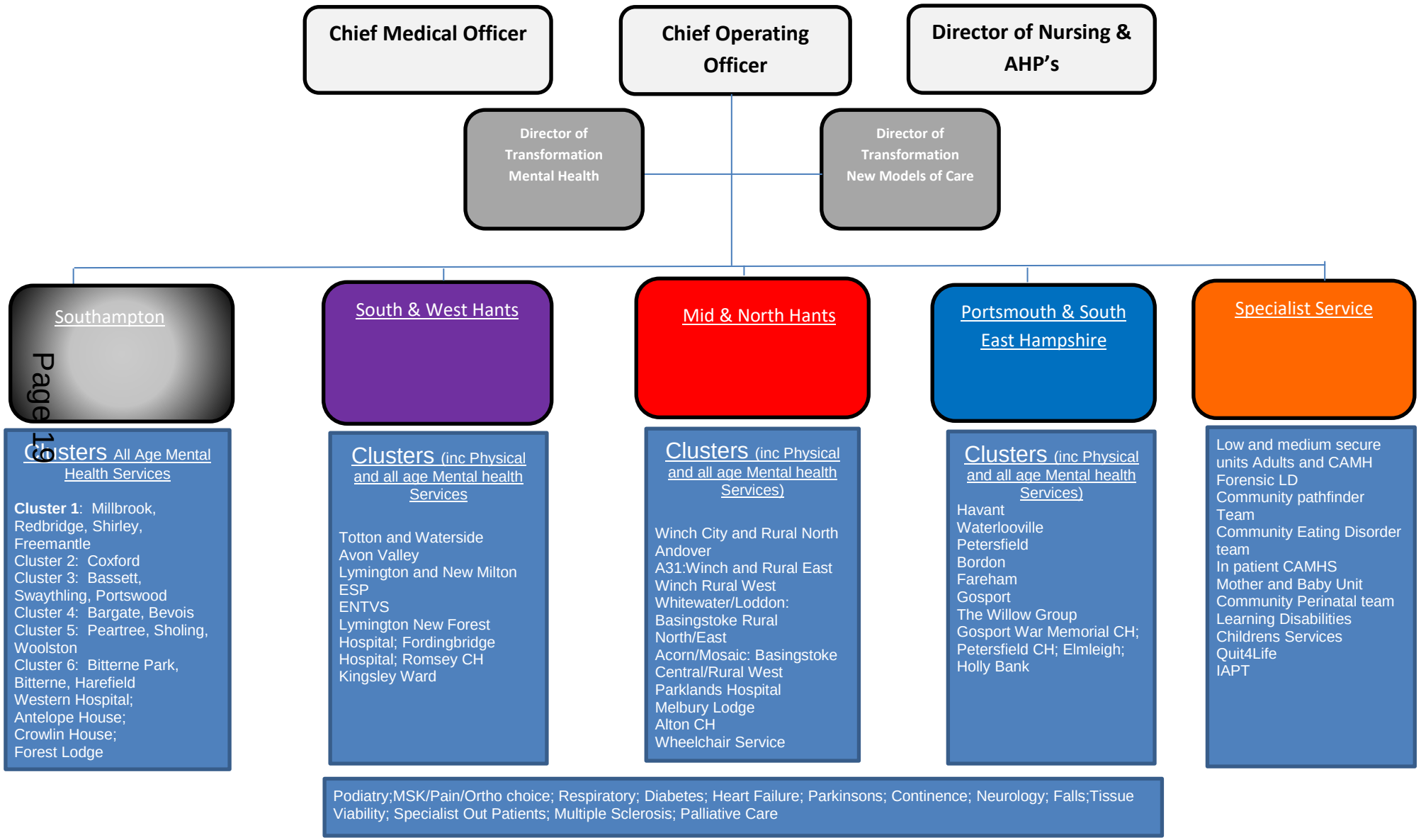
I would like to thank you for your co-operation and support with this process. As I highlighted in my previous correspondence, this is our most significant and ambitious shift in the shape of Southern Health to date and will no doubt improve the way provide health care, for the better, across Hampshire.

If you have any further questions, comments or concerns please contact Paul Draycott, Executive Director for Workforce, Organisational Development and Communications via email on paul.draycott@southernhealth.nhs.uk or by telephone on 023 8087 4661. Paul would also be happy to arrange a meeting if you would find this helpful.

Yours sincerely

Dr Nick Broughton
Chief Executive
Southern Health NHS Foundation Trust

Final SHFT Operational Organisation Structure (Five Divisions)



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NHS
Fareham and Gosport
and South Eastern Hampshire
Clinical Commissioning Groups

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Hampshire
PO17 6AR

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

4 March 2019

Dear Cllr Brent,

Hampshire Partnership of Clinical Commissioning Groups: Update for Portsmouth Health Overview and Scrutiny Panel

This letter is provided, as requested, to update you and the members of the Portsmouth Health Overview and Scrutiny Panel on the work of the Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups.

We have tried to address all the items you requested but would be happy to provide further clarification if it is required and we are always happy to facilitate direct discussions if there are particular issues which are of interest.

1 How the Partnership operates

The Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups (CCGs) serves an overall population of more than one million people and manages a budget of £1.4 billion. It comprises five clinical commissioning groups:

- Fareham and Gosport
- Isle of Wight
- North East Hampshire and Farnham
- North Hampshire
- South Eastern Hampshire

The clinical commissioning groups of Fareham and Gosport, North East Hampshire and Farnham, North Hampshire and South Eastern Hampshire established a formal partnership on April 1, 2017. The Isle of Wight CCG joined the Partnership in April 1, 2018. The CCGs in the Partnership have a single Chief Executive and executive team, with each area retaining a clinical chair and managing director.

The aim of the Partnership is to help accelerate improvements in patient care, be more effective and reduce duplication. By working together, we can share capacity and skills and operate with greater consistency with our partners for the benefit of patients. This also enables us to:

- ensure local people have access to timely and high quality care;
- work with patients and our health and care partners to integrate and improve services; and
- support and develop our clinicians and staff so they can deliver the best services and support for our communities.

Where it makes sense to do so, the Partnership will work at scale to 'fast-track' health improvements across a large area and implement them locally. By working at scale it ensures that we use our limited resources wisely, as well as learn from others who have already implemented an improved service/system.

However, our local communities remain our principal focus and so we will continue to work with our patients and partners in Fareham and Gosport and South Eastern Hampshire to design, develop and deliver services that our localities need. We will do this by ensuring that the objectives we set at a Partnership level form the basis for the priorities we identify in each local area.

Partnership Objectives	
Quality, performance and money	We will ensure that local people have consistent access to timely, high quality care, in line with the NHS constitution. We will improve efficiency and value for money so that we manage within the available budget.
Implementing models of care	We will achieve this by fully implementing models of care in all localities, working with patients and partners in order to improve outcomes and experience, and to make services sustainable.
People, systems and partnership	We will succeed by supporting the development of our workforce and member practices. We will reform the way we and the commissioning system work, planning and delivering care with our partners – locally, in integrated health and care systems, and at scale across the Partnership.

In Fareham and Gosport and South Eastern Hampshire we have identified a number of priorities to help us meet the objectives described above and these focus on the areas which we, and our partners, believe need most attention locally.

These priorities reflect the work we need to do to deal with the challenges that we are seeking to resolve around urgent and primary care and establish new ways of providing out of hospital care and support that will mean people spend less time in hospital settings.

They include ensuring effective system resilience by redesigning urgent care services, and looking at how we can redesign certain elective care pathways through our work with our local partners. We want to be able to offer more support for people closer to home through the development of primary and community care (as described by the NHS Long Term Plan) with the overall aim of reducing unnecessary admission to hospital and ensuring timely discharge.

We will also seek to improve the resilience of general practice, again through the development of primary care networks and our local GP alliance. And, of course, we will ensure we have robust plans in place to manage our financial position in accordance with the requirements set for us by NHS England.

How we fit with the Portsmouth and South East Hampshire Integrated Care Partnership

One of the benefits of working within the CCG Partnership is the opportunity it affords to operate at scale, while enabling each constituent member CCG to draw on wider support in working in its local area as and when it needs to.

Local leaders recognise that health and care services need to be planned and delivered at a number of different levels and both Fareham and Gosport and South Eastern Hampshire CCGs, whilst members of the broader CCG partnership, are committed to working as part of the more local Portsmouth and South East Hampshire integrated care partnership which will drive the transformation and change articulated in the NHS Long Term Plan.

This helps us to build on the close working relationship we have always had with Portsmouth CCG and our local provider trusts, and our intention is to continue, and further strengthen, these relationships as part of the integrated care partnership model.

It is evident, and beneficial, that the CCG Partnership and the Portsmouth and South East Hampshire Integrated Care Partnership share similar aims and objectives, placing an emphasis on care out of hospital, integrated approaches to urgent, primary, community and social care and the need to adopt common and coordinated approaches where it makes sense to do so.

The CCGs locally fully endorse this model and will play an active role in working with partners across Portsmouth and South East Hampshire to lead the transformation process and deliver improvement.

2 Performance and Finance

The Panel has requested information relating to financial and activity performance. The first meeting in public of the Hampshire and Isle of Wight Partnership of CCGs Board received a

report on the overall position regarding finance, performance and quality and this is available to view here:

https://www.farehamandgosportccg.nhs.uk/Downloads/Partnership%20board%20meeting/8.%20Quality%20Performance%20and%20Finance%20Report.pdf

In addition, details about the performance of the South Central Ambulance Service (SCAS) in relation to response times were requested. As this does not feature on the performance report presented to the Partnership Board, the latest information available, covering the Portsmouth and south east Hampshire area, is presented below.

	Oct 18	Nov 18	Dec 18
	Mins/secs	Mins/secs	Mins/secs
Category 1 – 7 minutes response time	6.53	6.56	6.55
Category 1 – 15 mins 90th percentile response time	12.45	12.49	12.26
Category 2 – 18 minutes mean response time	15.44	16.56	17.13
Category 2 – 40 minutes 90th percentile response time	31.10	34.06	34.54
Category 3 – 120 minutes 90th percentile response time	1hr 48.33	2hr 01.20	2hr 10.56
Category 4 – 180 minutes 90th percentile response time	2hr 37.46	2hr 50.28	2hr 56.59

Note:

- *Category 1 Life threatening injuries and illnesses*
- *Category 2 Emergency calls*
- *Category 3 Urgent calls*
- *Category 4 Less urgent calls*
- *Percentile targets = these calls will be responded to at least 9 out of 10 times before the required time period.*

Overall, ambulance response times have remained relatively stable over the past few months but the impact of winter on performance levels is always closely monitored and this will continue to be the case.

We are aware that SCAS' performance rates against the NHS111 calls answered within 60 second standard has been low, particularly in December 2018 when performance was 67% against a target of 95%. Performance in January improved significantly to 82.24% but is still some way short of the target. The Trust has produced a recovery action plan to meet the target by June 2019 following intervention from the CCGs.

3 Primary care update

The Panel requested an update on the situations relating to the Willow Group and Brockhurst Medical Centre practices in Gosport.

Willow Group: Panel members may be aware of the temporary suspension on GP registrations in Gosport which was introduced to help GP practices stabilise after more than 2,100 patients transferred between a number of the practices in the town, not just the Willow Group.

It is not unusual for GP practices to sometimes close their lists to help them safely manage their services. Practices across an area do not normally do this at the same time but in this instance Fareham and Gosport CCG supported the practices in Gosport to take this temporary measure to help manage their services over the busy winter period.

We know there have been concerns about the Willow Group, particularly about telephone access and availability of routine appointments. The Group is doing a number of things to improve the situation and we are seeing an increase in positive feedback from patients. The key areas are:

- Significantly investing in a new telephone system
- Appointing locum GPs which means more appointments are available
- Trying to actively recruit GPs
- Recruiting a number of other health professionals including pharmacists and a mental health worker, with plans to appoint a physiotherapist, to offer access to the most appropriate professional
- Working with Portsmouth University to support their training programme which will include hosting a trainee Physician's Assistant from September as well as providing training placements for GPs and nurses.

Whilst we are pleased that the practice is making these improvements we are also closely monitoring the situation by regularly meeting with clinical and managerial staff from the practice and seeking feedback from surrounding practices and local patient groups. The practice has also reassured us that their staffing situation is improving.

The registration suspension will remain in place until March 31st. All practices in Gosport offer patient online services, and eConsult. Therefore, where patients are struggling to get an appointment these might be other avenues to try.
Practices are also offering a range of appointment times for routine (pre-booked) and same-day appointments, in the evenings and at weekends.

Brockhurst Medical Centre: the situation with regard to the ongoing leasing arrangements for the Brockhurst Medical Centre is, we hope, nearing resolution. The local NHS is continuing to work with the District Valuer to speed up the process by which Brockhurst Medical Centre can secure its future by signing the lease on its building in Brockhurst Road.

The CCG, which reimburses all its practices for the cost of their rent, has a duty on it to ensure that the valuation put on the building is a fair one and represents value for money – not only to protect NHS funding but to safeguard the practice too.

We continue to support the practice with some complex legal issues regarding the lease and we remain fully committed to seeing this through to enable the practice to stay where it is in its preferred building of choice.

Emsworth Surgery: The GPs at Emsworth Surgery have been considering relocating to a new site to ensure long-term sustainability and to help meet the increasing health needs of a growing population.

An Outline Business Case has been submitted to NHS England and this recommends that the Emsworth Victoria Cottage Hospital be refurbished and becomes the new home for the GPs. The Westbourne branch surgery would be retained. The business case is now progressing through the required approvals process. It is not clear when it will be finally approved, but it is hoped that this will happen before the end of April 2019.

In parallel with the Outline Business Case, work has already started on preparing the Full Business Case. This requires preparing detailed designs for the refurbishment, producing a complete specification of the required work, obtaining tendered costs from contractors and securing full planning permission. Architects have already been appointed and are working closely with the GPs to ensure that the refurbishment meets their requirements and also adheres to strict NHS building standards and regulations.

While there remain several issues that need to be managed, it is hoped that the Full Business Case will be completed by mid-autumn. It will then need to be approved by the CCG and NHS England, with the aim that work on the refurbishment could commence towards the end of 2019 and complete by late 2020/early 2021. However, this timetable is only indicative and will become clearer once the Outline Business Case is formally approved by NHS England.

4 Ongoing updates to the Panel

The publication of the NHS Long Term Plan will naturally have an influence on how local health services are organised, commissioned and provided over the next few years. In keeping with this it will be important to ensure that we continue to engage people locally on long term plans for health services in this area and the steps we may need to take in the short term to ensure new ways of providing health and care services can be implemented appropriately.

As Panel Members will be aware, we have used our Big Health Conversation engagement programme across Portsmouth and South East Hampshire as a key means of supporting us to engage with people locally, working with Portsmouth CCG. This is an important element of our overall approach to engagement and we will continue to use this, alongside specific, service-related engagement activity where it is needed, to support our work.

We are well aware that this activity is something that needs to be shared with the Panel on a regular basis, to satisfy Members that we are meeting our statutory requirements to engage. As CCGs we feel it is vital that our patients, local residents and partners are able to share their views on the design, development and delivery of services and we employ a range of different approaches to try and encourage this. However, we are also mindful that the way

engagement is carried out in future may change, as we work as part of a more integrated partnership across Portsmouth and South East Hampshire, and so discussions about the most appropriate way to keep the Panel updated would be welcomed.

I trust that this update has been helpful.

Yours Sincerely

Sara Tiller
Managing Director South Eastern Hampshire and Fareham and Gosport CCGs
Hampshire and Isle of Wight Partnership of CCGs

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Response to the Gosport Independent Panel Report briefing

On behalf of: Hampshire and Isle of Wight Partnership of CCGs and NHS Portsmouth CCG

February 2019

1. Introduction

This report is intended to provide an update to the Portsmouth Health Overview and Scrutiny Panel on the work undertaken locally since the publication of the Gosport Independent Panel Report (June 2018) and subsequent Government response in the autumn.

It is evident that the Gosport Independent Panel Report is a challenging read and while there is no doubt that the NHS has changed over the last 20 years, it is imperative that we take this opportunity to review the actions that have been taken and ensure that improvements have been and, where necessary, continue to be made, and that these are embedded into the culture and the way we do things.

Part of this ongoing work is to ensure that actions included in the Government response to the Gosport Independent Panel report are carried out across the Hampshire and Isle of Wight Partnership of CCGs and Portsmouth CCG.

To support this, a Gosport Learning and Assurance Oversight Board, which includes representatives from the CCGs, NHS England, NHS Improvement, Healthwatch and clinical leads has been established.

The sections below provide information about the work undertaken to date in assessing how the CCGs relate to the key themes in the report, particularly where it is felt that there is room for improvement and how this is being taken forward.

2. Themes from Gosport Independent Panel Report (and other reviews)

The themes in the Report and other reviews were identified and grouped in the three domains of governance that are now established in the NHS – patient safety, clinical effectiveness and patient experience. They are described below as failures and the self-assessment process required evidence of assurance to demonstrate that these have been addressed.

- Patient Safety
    - Failure to maintain patient safety through poor medication prescribing and administration practice
    - Failure to work effectively in partnership including when carrying out investigations
- Clinical Effectiveness
    - Failure to have effective clinical oversight to identify and respond to poor clinical practice
    - Failure to provide exemplary care for older people
    - Failure to use information available or utilise high quality information
- Patient Experience

    - Failure to respond to, listen to and learn from the concerns raised by staff and families regarding the experiences of patients
    - Failure to provide appropriate end of life care.

To date no gaps requiring urgent action have been identified, and areas for improvement have been acknowledged, as well as some examples of excellent practice.

3. Self-assessment tool

A self-assessment tool was developed which also incorporated the findings of other reviews referred to in the Report. This was completed by CCGs to help identify any gaps or weak areas in relation to the themes and provide a focus for action.

The self-assessments did not identify any urgent actions but did identify areas for improvement and work plans are being developed to address these.

In addition each local care system (eg Portsmouth and south east Hampshire) across the Partnership is now in the process of completing an assessment which will inform their work plans to address any gaps or weaknesses identified.

4. Self-assessment findings

The result of the first stage of self-assessments has been completed and it is clear that there is a comprehensive programme of assurance already embedded, as well as several programmes of work underway. However, the following areas for further improvement were identified and programmes of work are now being established:

- Medication and Prescribing
    - Support move to electronic prescribing across the whole system
    - Ensure that reporting from the Controlled Drug network and the information that chief pharmacists have is used in local care systems
    - Develop locality / system means of monitoring medication prescribing and administration compliance
    - Support an audit programme specifically to build confidence and provide assurance
- Partnership working
    - Actively participate in the implementation of the safeguarding adults intercollegiate document
    - Improve documentation/records storage using the standards in the Data Security and Protection Toolkit to support improvements
    - Support the work of the Hampshire and Isle of Wight STP Quality Board to bring together the existing patient experience work programmes
- Clinical Oversight
    - Ensure that there is oversight of the standards of care provided by practice nurses and care home nurses, in the same way as NHS providers' nurses
    - Ensure clinical standards for new models of care are incorporated in the planning process
    - Work with others, such as NHS England and NHS Improvement to ensure that there is system wide visibility of clinical outcomes, for example dentist and optometrists
    - Develop locality / system means of monitoring clinical outcomes that includes all providers, NHS, private, and independent
- Quality of information
    - Ensure that within each local area there are robust systems for reviewing broader sources of information about the services provided/delivered

    - Ensure that information and data used is assessed for data quality
- Excellence in the care of older people
    - Actively support the Wessex Academic Health Science Network poly-pharmacy work and incorporate other allied health professionals in this
    - Develop capability and competence in staff in relation to the Mental Capacity Act and Mental Health Act
    - Building on the success of the frailty work, identify areas for further improvement in the elderly care pathway
- Listening to and learning from staff and patients' concerns
    - Fully implement 'freedom to speak up' guardians in CCGs and Primary Care
    - Reduce the number of complaints upheld by the Parliamentary Health Service Ombudsman (PHSO) through improving the quality of complaint investigation and engagement with families and complainants
    - Review actions, themes and learning from complaints within local systems
- End of Life Care
    - Test compliance with the analgesic ladder in local systems.

There are also examples of good practice identified through the self-assessment process and these include:

- The establishment of the frailty pathway across north and mid Hampshire
- The collaboration that is taking place in the Frimley system
- The work of the medicines management leads to support medicines safety
- The clinical reference group for end of life care services when clinicians have worked together to revise the guidance available for staff in relation to caring for patients at the end of their lives, incorporating best practice prescribing and drug administration.

5. Next steps

Work programmes for each area of improvement are now being developed and implemented. Progress on these is reported to the Gosport Oversight Board and further updates on its work can be provided to the Panel, as required.

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Arrangements for Assessing Substantial Change in NHS provision: Hampshire NHS Mental Health Trusts: Mental Health Crisis Provision and Oakdene Mental Health rehabilitation services

Purpose and Summary

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

2) It describes the actions and approach expected of relevant NHS bodies or relevant health service providers and Local Authorities with health scrutiny functions when proposals that may constitute substantial service change are being developed and outlines the principles that will underpin the discharge of each parties' role and responsibilities and, in particular the change in approach to delivering mental health services by bringing together two NHS mental health trusts in partnership to deliver a single service, outlined in Appendix 1. Appendix 2 outlines the service remodelling of the mental health rehabilitation services currently based at Oakdene Unit on The Limes at St James Hospital in order to provide community based intensive rehabilitation and an alternative model of inpatient support,

4) This framework was amended in 2013 following the publication of 'The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013'[1]. These regulations followed from changes made to local authority health scrutiny in the Health and Social Care Act 2012. Subsequent guidance has been produced by NHS England[2] and the Department of Health[3] on health scrutiny, and this framework has been consequentially updated.

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

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

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

7) Section 242 of the NHS Act places a statutory duty on the NHS to engage and involve the public and service users in:

- Planning the provision of services
- The development and consideration of proposals to change the provision of those services
- Decisions affecting the operation of services.

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

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

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

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

    It is therefore expected that the NHS body or relevant health service provider works closely with health scrutineers to ensure that timetables are reflective of the likely timescales required to provide evidence of the above considerations, which in turn will enable health scrutiny committees to come to a view on the proposals.

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

- How the proposed service change affects choice for patients, particularly with regard to quality and service improvement.

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

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

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

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

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

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

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

20) Although each issue will need to be considered on its merits the following information will help shape the views of health scrutiny committees regarding the proposal:
    1. The case of need and evidence base underpinning the change taking account of the health needs of local people and clinical best practice.
    2. The extent to which service users, the public and other key stakeholders, including GP commissioners, have contributed to developing the proposal. Regard must be given to the involvement of 'hard to reach groups' where this is appropriate, including the need for any impact assessment for vulnerable groups.
    3. The improvements to be achieved for service users and the additional choice this represents. This will include issues relating to service quality, accessibility and equity.
    4. The impact of the proposal on the wider community and other services. This may include issues such as economic impact, transport issues and regeneration as well as other service providers affected.
    5. The sustainability of the service(s) affected by proposals, and how this impacts on the wider NHS body or relevant health service provider.

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

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

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

24) If the health scrutiny committee affected by a proposal are not satisfied with the conduct or content of the consultation process, the reasons for not undertaking a consultation (this includes temporary urgent action) or that the proposal is in the interests of the health service in its area then the option exists for the matter to be referred to the Secretary of State. Referrals are not made lightly and should set out:

    - Valid and robust evidence to support the health scrutiny committee's position. This will include evidence that sustainability has been considered as part of the service change.

- Confirmation of the steps taken to secure local resolution of the matter, which may include informal discussions at NHS Commissioning Board Local Area Team level.

Guiding Principles

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

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

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

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

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

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

Appendix One – Framework for Assessing Change: Mental Health Crisis Response

Key questions to be addressed

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

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

Name of Responsible (lead) NHS or relevant health service provider: Solent NHS Trust & Southern Health NHS Foundation Trust

Name of lead CCG: Portsmouth CCG, in collaboration with Fareham & Gosport and South Eastern Hampshire CCGs.

Brief description of the proposal:
Leading representatives from Hampshire's two mental health trusts, two local authorities, commissioners and other partners have agreed to a change in their approach to improving the delivery of mental health services by bringing together two NHS mental health trusts in partnership to deliver a single service.

Southern Health NHS Foundation Trust and Solent NHS Trust have agreed to work in closer partnership, alongside local authority and voluntary sector colleagues, supported by commissioners. They recognise that a key theme of the co-production design process that took place in the Summer of 2018 was improving crisis response, so they have started by bringing the two crisis teams together into a single service model that improves responsiveness and consistency for adults of all ages.

Service Users and Carers said	The new service will
You want a timely response when you need it	Deliver a 24/7 needs led crisis service with response time standards
You want alternatives to admission	Offer home treatment as an alternative to admission Work with our partners to continue to develop community support, such as wellbeing centres and safe spaces
There shouldn't be a post code lottery	Aspire to have the same service for everyone living in Portsmouth and South East Hants
You should be able to self-define your crisis	Open the service to self-referral
Carers need support too	Open the service to carers to call
You want to talk to people who have lived experience and can give you hope	Work to increase peer support in the service
You want staff to listen and you want to be empowered to look after yourself	Support our staff to develop skills to help you achieve this
You want us to look after our staff	Design a programme of staff support and development

Why is this change being proposed?

This change has followed months of careful observations of how 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 compelling findings of this extensive work have been crucial in establishing the principles and priorities for change, and that much closer working is needed.

Many patients/service users, family members, carers, staff and partners have given their time and energy to talk about their views on current services, being honest about their experiences, and making suggestions for the future.

It is undisputed that the people delivering care, treatment and support within services are hardworking and compassionate, and they strive to provide quality care. However it is clear that the processes and systems they are working within are not always efficient, can provide challenges in meeting demand.

Description of Population affected:

Mental Health Crisis Services in Portsmouth & South Eastern Hampshire have traditionally only been accessible to people

already open to secondary care mental health services. This proposal seeks to extend the offer of Crisis Support and Home Treatment to a wider population of people, by allowing self-referral to the service when individuals self-define being in crisis. The service will also be newly available to carers.

Date by which final decision is expected to be taken: The project steering group has been meeting since September 2018 with a view to the new service going live from the summer 2019

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

Name of key stakeholders supporting the Proposal: Portsmouth CCG, Fareham & Gosport and South Eastern Hampshire CCGs, Solent NHS Trust, Southern Health NHS Foundation Trust, Solent Mind, Havant & East Hants Mind, Hampshire County Council, Portsmouth City Council.

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
Case for Change		
1) Is there clarity about the need for change? (e.g. key drivers, changing policy, workforce considerations, gaps in service, service improvement)	Yes	The proposals have been informed by months of careful observations of how 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. The compelling findings of this extensive work have been crucial in establishing the principles and priorities for change, and that much closer working is needed.
2) Has the impact of the change on service users, their carers and the public been assessed?	Yes	
3) Have local health needs and/or impact assessments been undertaken?	Yes	Quality, equality and data protection impact assessments have been undertaken for the project.
4) Do these take account of :		
a) Demographic considerations?	NA	No changes to this are being proposed
b) Changes in morbidity or incidence of a particular condition? Or a potential reductions in care needs (e.g due to screening programmes)?	NA	No changes to this are being proposed
c) Impact on vulnerable people and health equality considerations?	Yes	This has been considered in the Equalities Impact Assessment.
d) National outcomes and service	NA	There are no national outcomes or service specifications relating to

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
specifications?		Crisis provision.
e) National health or social care policies and documents (e.g. five year forward view)	Yes	The NHS Long Term Plan commits to ensuring that a 24/7 community-based mental health crisis response for adults and older adults is available across England by 2020/21. This proposal will meet this requirement well in advance of this date. The Mental Health Five Year Forward View states that by 2020/21, all areas will provide crisis resolution and home treatment teams (CRHTTs) that are resourced to operate in line with recognised best practice – delivering a 24/7 community-based crisis response and intensive home treatment as an alternative to acute in-patient admissions. Again, this proposal will deliver this at a local level in advance of this date.
f) Local health or social care strategies (e.g. health and wellbeing strategies, joint strategic needs assessments, etc)	Yes	The proposal supports delivery of the Health & Wellbeing Strategy, particularly the aim to "support social, emotional, mental and economic health" and the priorities to "promote positive mental wellbeing across Portsmouth" and "reduce the drivers for isolation and exclusion". It will do so by improving access to Mental Health services for people in Crisis and providing greater consistently in the support they receive.
5) Has the evidence base supporting the change proposed been defined? Is it clear what the benefits will be to service quality or the patient experience?	Yes	As outlined in the narrative sections above (description of the proposal and why the change is being proposed), the proposal is based on a compelling evidence base and over 150 hours of workshops and consultation. The benefits to service quality and patient experience are outlined in the table provided in the above section, and directly correlate to improvements identified in the workshops & consultation. The need to make changes to these areas have directly informed the actions committed to in this proposal.
6) Do the clinicians affected support	Yes	The clinicians affected by this proposal have been fully involved in the

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
the proposal?		workshops, consultation and co-production of the service transformation.
7) Is any aspect of the proposal contested by the clinicians affected?	No	
8) Is the proposal supported by the lead clinical commissioning group?	Yes	The CCG are fully committed to delivering this priority transformation project.
9) Will the proposal extend choice to the population affected?	Yes	The proposal will allow individuals to self-define when they are in crisis, and to self-refer into the Crisis Team, providing a greater choice of services to access (i.e. self-referral to the crisis team will remove the need to see a GP first) and ownership of their health condition.
10) Have arrangements been made to begin the assurance processes required by the NHS for substantial changes in service?	NA	The proposal does not constitute substantial change in service delivery. Existing levels of service will be enhanced for Portsmouth residents with a more robust out of hours staff deployment by combining two teams cross Portsmouth & SE Hampshire
Impact on Service Users		
11) How many people are likely to be affected by this change? Which areas are the affecting people from?	Yes	The Crisis Teams currently receive over 2,100 referrals each year across the Portsmouth and South East Hampshire area. They support around 450 early discharges from acute mental health wards each year and provide over 1,000 people with episodes of Home Treatment.
12) Will there be changes in access to services as a result of the changes proposed?	Yes	This change will affect all of the patients currently receiving services from Crisis Teams as well as individuals who may gain access to the service because of the changes being proposed - including carers and self-referrers.

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
13) Can these be defined in terms of		
a) waiting times?	Yes	The proposal will deliver 24/7 needs led crisis service with response time standards, in direct response to service user requests for a timely response.
b) transport (public and private)?	NA	
c) travel time?	NA	Transport and travel time will not be affected as the combined crisis service will continue to deliver services from local hubs within localities.
d) other? (please define)	Yes	Access will be improved to ensure there is no post-code lottery, aspiring to have the same service for everyone living in Portsmouth and South East Hants. Access will also be improved to enable self-referral and for carers to call the service.
14) Is any aspect of the proposal contested by people using the service?	No	People using the service have been fully involved in the workshops, consultation and co-production of this proposal.
Engagement and Involvement		
15) How have key stakeholders been involved in the development of the proposal?	Yes	The proposal has followed months of careful observations of how 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 compelling findings of this extensive work have been crucial in establishing the principles and priorities for change, and that much closer working is needed.
16) Is there demonstrable evidence regarding the involvement of		
a) Service users, their carers or families?	Yes	

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
b) Other service providers in the area affected?	Yes	
c) The relevant Local Healthwatch?	Yes	
d) Staff affected?	Yes	Additional engagement workshops were held with service front line staff to cascade information about the proposals and to identify their concerns, issues and ideas. 6 key themes were raised, which are now being addressed by the project operational group and task and finish groups.
e) Other interested parties? (please define)	NA	
17) Is the proposal supported by key stakeholders?	Yes	Proposals are supported by Southern Health NHS Foundation Trust, Solent NHS Trust, Portsmouth Clinical Commissioning Group, South Eastern Hampshire Clinical Commissioning Group, Fareham and Gosport Clinical Commissioning Group, Hampshire County Council and Portsmouth City Council - who all attended and contributed to the project development workshops.
18) Is there any aspect of the proposal that is contested by the key stakeholders? If so what action has been taken to resolve this?	No	
Options for change		
19) How have service users and key stakeholders informed the options identified to deliver the intended change?	Yes	As part of the redesign process.
20) Were the risks and benefits of the options assessed when developing the proposal?	Yes	The multi-agency steering group includes service user representatives and is meeting monthly to manage the risks as the project develops.

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
21) Have changes in technology or best practice been taken into account?	Yes	There is a Digital Enabling work stream which is part of the STP programme. They are looking at supporting inter-operability between the two trusts and opportunities for online consultations etc.
22) Has the impact of the proposal on other service providers, including the NHS, local authorities and the voluntary sector, been evaluated?	Yes	
23) Has the impact on the wider community affected been evaluated (e.g. transport, housing, environment)?	No	
24) Have the workforce implications associated with the proposal been assessed?	Yes	This project enables a more effective use of nursing & medical workforce across the two Trusts particularly during the overnight period which is always more difficult to staff.
25) Have the financial implications of the change been assessed in terms of: a) Capital & Revenue? b) Sustainability? c) Risks??	Yes	It is expected that this change will be delivered within existing budgets.
26) How will the change improve the health and well being of the population affected?		Improved access to crisis services so people can get the right care at the right time.

Appendix Two – Framework for Assessing Change: Mental Health Rehabilitation Services

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

Name of lead CCG: Portsmouth CCG

Brief description of the proposal:

It is proposed that mental health rehabilitation services currently based at Oakdene Unit on The Limes at St James Hospital are remodelled to provide community based intensive rehabilitation and an alternative model of inpatient support. The proposed model is being developed by Solent NHS Trust in partnership with the CCG and key stakeholders. These proposals will be subject to consultation with service users / patients and carer scrutiny.

Mental health rehabilitation services provide specialist care to people with complex problems who have not recovered adequately from an acute episode of illness to return home and be discharged into the care of GPs or Community Mental Health Teams. They aim to stabilise service users' symptoms, maximise social functioning and promote autonomy to facilitate successful community discharge.

Why is this change being proposed?

Portsmouth CCG undertook a review of the Oakdene based rehabilitation provision to understand its function within mental health pathways and to model it against recommended pathways from the Joint Commissioning Panel for Mental Health's *Guidance for commissioners of rehabilitation services for people with complex mental health 2016*.

The review was based on the results of a bed audit undertaken with the service on 29th September 2017, conversations with patients on the ward, analysis of contractual data and feedback from a variety of health and social care stakeholders. The review made a number of recommendations around future pathway development, and Solent NHS Trust and the CCG have reached a consensus that the provision does need to be remodelled to provide the most effective and cost efficient rehabilitation provision for Portsmouth patients.

Key findings from commissioners Oakdene Review:

- The unit provides an overflow/step-down function for the acute wards, while patients stabilise and recover, but before they are able to meaningfully engage with rehabilitation - this provision is at a higher cost than an acute bed and outside the scope of rehab provision.
- The unit delivers good outcomes for high dependency (high support) rehab, however the 14 bedded unit exceeds the number of these beds needed for Portsmouth patients, resulting in high cost beds being used ineffectively.

- The community rehabilitation function delivered in the unit would be better placed in a more domestic environment, linking patients with their community and social care, and allowing for more meaningful rehab occupational therapy programmes to be developed. There is also insufficient psychology input for the acuity of patients.
- The ward environment at The Limes is incompatible with community rehab provision.

Solent NHS Trust and Portsmouth CCG are now developing alternative models of service delivery, informed by the Oakdene review and best practice in other areas. A number of health trusts have implemented rehabilitation models which focus more heavily on providing support to people in the community and working more holistically with housing and voluntary sector providers to deliver long term outcomes.

Description of Population affected:

The population affected covers those individuals who would under the current configuration of service receive inpatient treatment at Oakdene unit. Oakdene is a 14 bedded unit, which over the course of 2016-17 treated 29 individual patients (26 of these being Portsmouth residents). This is a relatively small cohort of people who have complex needs.

The bed audit provides a snapshot of service user's needs - all patients had received treatment in the acute mental health ward before being admitted onto Oakdene, diagnoses include treatment resistant schizophrenia, paranoid schizophrenia, bipolar disorder, psychotic depression and multiple anxiety disorders, it is extremely common for patients to also have secondary mental health diagnoses, half of patients were currently detained under the Mental Health Act, or had been during their admission, on average, patients have been in contact with secondary Mental Health services for 21.5 years.

People in receipt of rehabilitation services are a low volume, high need, high cost group with complex problems that complicate their recovery. These include treatment resistance, which occurs in up to 30% of people with schizophrenia, cognitive impairment, pervasive negative symptoms, poor social functioning and challenging behaviours. The cost of services that provide for this group of patients is between 25 and 50% of the total national mental health budget in England.

Date by which final decision is expected to be taken: April 2019

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

Name of key stakeholders supporting the Proposal: Portsmouth CCG and the Solent NHS Trust

Solent & the CCG plan to fully engage Portsmouth City Council including Adult Social Care and Housing departments, and to undertake a consultation on changes with patients, carers and broader mental health patient groups.

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
Case for Change 27) Is there clarity about the need for change? (e.g. key drivers, changing policy, workforce considerations, gaps in service, service improvement)	Yes	The CCG & Solent NHS Trust are fully agreed that there is a clear case for change based upon: - The need to change service provision to meet national guidance around rehabilitation pathways. - Gaps in service provision - a lack of community based rehabilitation options. - Local commitments to move care closer to home and reduce the need for institutional care. - Confidence that services could meet patient needs through a more effective and cost efficient model, by closing the high cost Oakdene unit and reinvesting in community based provision. - Improving services into recovery focussed models offering peer support and better access to evidence based treatments and therapies.
28) Has the impact of the change on service users, their carers and the public been assessed?	Ongoing	The service change seeks to improve the care, treatment and experiences of service users and their carers by providing more evidence based therapies and treatments closer to home and reducing the need for institutional care. Mental Health professionals including consultants, psychiatrists, psychologists, nurses, occupational therapists and social workers have fully considered the impact on patients in designing new models of provision. Patient and carer groups will be fully consulted on the impact of proposed changes.
29) Have local health needs and/or impact assessments been undertaken? 30) Do these take account of :	Ongoing	Quality, equality and data protection impact assessments will be completed once a preferred model has been agreed with stakeholders and the results of patient consultation have been taken into account.

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
a) Demographic considerations?	Ongoing	Impact assessments will seek to take account of each of these elements
b) Changes in morbidity or incidence of a particular condition? Or a potential reductions in care needs (e.g. due to screening programmes)?	Ongoing	
c) Impact on vulnerable people and health equality considerations?	Ongoing	This will be addressed in the Equalities Impact Assessment
d) National outcomes and service specifications?	Yes	The proposal is based on the Joint Commissioning Panel for Mental Health's guidance and best practice in other areas (including the nationally promoted Sheffield Model). No national service specifications or rehab specific NICE guidance currently exist.
e) National health or social care policies and documents (e.g. five year forward view)	Yes	National policy focusses on reducing out of area placements, which can be in part caused by a lack of suitable rehab provision. There is no specific mention of rehab services in the NHS Long Term Plan & Five year Forward View for Mental Health.
f) Local health or social care strategies (e.g. health and wellbeing strategies, joint	Yes	The proposal supports delivery of the Health & Wellbeing Strategy, particularly the aim to "support social, emotional, mental and economic health" and the priorities to "promote positive mental wellbeing across Portsmouth" and "reduce the drivers for isolation and exclusion". It will do so by improving the calibre of Mental Health rehabilitation services available to better support people in the community.
g) strategic needs assessments, etc)	NA	
31) Has the evidence base supporting	Yes	The evidence base provided in the CCG's review of Oakdene Unit and

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
the change proposed been defined? Is it clear what the benefits will be to service quality or the patient experience?		case for change has been endorsed by Solent NHS Trust. There is clear consensus on the benefits this will provide to service quality and patient experience. This will be fully articulated when designing the new service model and be informed by past patient experiences.
32) Do the clinicians affected support the proposal?	Yes	Clinicians have been engaged in developing the case for change, partaking in an initial bed audit, and have been instrumental in designing rehab models for future service provision.
33) Is any aspect of the proposal contested by the clinicians affected?	No	Consultation is still ongoing whilst the redesigned model is finalised and enters public consultation.
34) Is the proposal supported by the lead clinical commissioning group?	Yes	Proposals were endorsed by the CCG's Clinical Strategy Committee on the 2nd January 2019.
35) Will the proposal extend choice to the population affected?	Yes	The proposal will increase the range of rehabilitation services available to individuals - this will be as clinically appropriate and may not be directly open to patient choice, but patient preferences and prior care plans can be taken into consideration.
36) Have arrangements been made to begin the assurance processes required by the NHS for substantial changes in service?	Yes	NHS England assurance processes are ongoing.
Impact on Service Users		
37) How many people are likely to be affected by this change? Which areas are the affecting people from?	Yes	Oakdene unit has capacity to treat 14 patients at any one time. The proposed new rehabilitation model may increase the number of people who are able to receive support as it is looking to deliver a more cost effective service. This proposal has scope to affect people from across the entire geography of Portsmouth.
38) Will there be changes in access to	Yes	

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
services as a result of the changes proposed?		
39) Can these be defined in terms of		
a) waiting times?	No	Services will be accessible from patients in the community and delivered within their own homes as appropriate, rather than solely available as inpatient provision. For some patients this will eliminate the need for transport and travel times.
b) transport (public and private)?	Yes	
c) travel time?	Yes	Access will be improved for patient's family and friends as they will be able to visit and support loved ones from within that individuals own homes, and no longer need to travel to the St James hospital site to meet in the Family Room.
d) other? (please define)	Yes	
40) Is any aspect of the proposal contested by people using the service?	TBC	This is as yet unknown - patient and carer consultation and engagement will be undertaken in the new year.
Engagement and Involvement		
41) How have key stakeholders been involved in the development of the proposal?	Ongoing	This paper is being presented to HOSC at an early stage of development, with engagement and patient involvement still being undertaken. Engagement with housing providers is ongoing to ensure accommodation is available to support the community offer. Adult Social Care are aware of plans and involved in the design of proposals.
42) Is there demonstrable evidence regarding the involvement of		
a) Service users, their carers or families?	Ongoing	Service user feedback formed part of the initial review of Oakdene unit, which led to the development of this proposal. Plans for a broader consultation with current Oakdene patients, former patients, and wider Mental Health service users are in place and will inform the final service design.

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
b) Other service providers in the area affected?	Ongoing	Engagement with housing providers is ongoing to ensure accommodation is available to support the community offer. Adult Social Care are aware of plans and involved in the design of proposals.
c) The relevant Local Healthwatch?	Yes	Engagement processes are underway - the Chairperson of Healthwatch has been informally briefed, and the proposal will be considered by the full Healthwatch board.
d) Staff affected?	Ongoing	Staff have been fully engaged in the developed of the proposal via a number of design workshops. They will be subject to a formal consultation.
e) Other interested parties? (please define)	Ongoing	
43) Is the proposal supported by key stakeholders?	Yes	The CCG fully supports the proposal, which forms part of a four year plan agreed with Solent NHS Trust. Secondary Care Mental Health services and Adult Social Care are supportive, having been engaged throughout the design process.
44) Is there any aspect of the proposal that is contested by the key stakeholders? If so what action has been taken to resolve this?	No	No aspects of contention have been raised to date, but engagement and consultation is still ongoing.
Options for change		
45) How have service users and key stakeholders informed the options identified to deliver the intended	Ongoing	The views of patients and stakeholders informed the Oakdene Review and case for change, their input continues throughout the design of the final delivery model.

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
change?		
46) Were the risks and benefits of the options assessed when developing the proposal?	Yes	Risks and benefits were considered at a preliminary design meeting, continue to inform the final design model and are reviewed regularly at project meetings.
47) Have changes in technology or best practice been taken into account?	Yes	Best practice has been considered in reconfiguring services and the need to develop more community based rehabilitation provision. New models delivered in Sheffield, Humber, Bristol, Lambeth and Derbyshire have been shared and considered to inform a new Portsmouth model. Updated national guidance has also provided the foundation for reviewing and redesigning services - notably the Joint Commissioning Panel for Mental Health's Guidance for commissioners of rehabilitation services for people with complex mental health.
48) Has the impact of the proposal on other service providers, including the NHS, local authorities and the voluntary sector, been evaluated?	Ongoing	This proposal has potential impacts on social care, housing and voluntary sector provision as people will be supported to live in the community rather than an inpatient setting. This may result in an increased demand on social housing and supported accommodation - the impact of which are currently being considered, modelled and engaged on. Market development may be required depending on the design model. The new model will work with provision across the Portsmouth and South East Hampshire Local Care Partnership
49) Has the impact on the wider community affected been evaluated (e.g. transport, housing, environment)?	Ongoing	See above.
50) Have the workforce implications	Ongoing	Solent NHS Trust have considered workforce implications and will assess these throughout the design of a new model. Any staff affected

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
associated with the proposal been assessed?		will be subject to full consultation and redeployment within the trust.
51) Have the financial implications of the change been assessed in terms of: a) Capital & Revenue? b) Sustainability? c) Risks??	Yes - ongoing	Solent NHS Trust will fund the new model within the current financial envelope for the Oakdene Unit. It is likely this will be achieved by closing the ward and reinvesting in rehabilitation provision and releasing some savings. Full financial modelling is ongoing, and dependent on the final design model.
52) How will the change improve the health and wellbeing of the population affected?	Yes	Successful rehabilitation enables people to maximise their potential and live as independently as possible. It gives people the knowledge, skills and empowerment to manage their mental health condition and also physical health and wellbeing. The proposals seek to provide more meaningful rehabilitation to people within their community, more fully ensuring they are able to live as independently as possible, and removing the current gap between inpatient and community provision.

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