Portsmouth CITY COUNCIL

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NOTICE OF MEETING

HEALTH OVERVIEW & SCRUTINY PANEL

THURSDAY, 12 SEPTEMBER 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 Chris Attwell (Chair)
Councillor Gemma New (Vice-Chair)
Councillor Graham Heaney
Councillor Leo Madden
Councillor Hugh Mason
Councillor Steve Wemyss
Councillor Vivian Achwal
Councillor Arthur Agate
Councillor Trevor Cartwright
Councillor Philip Raffaelli
Councillor Rosy Raines
Vacancy

Standing Deputies

Councillor Geoff Fazackarley
Councillor Ben Dowling
Councillor Lee Mason
Councillor Robert New
Councillor Will Purvis
Councillor Luke Stubbs

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

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

A G E N D A

1 Welcome and Apologies for Absence

2 Declarations of Members' Interests

3 Minutes of the Previous Meetings - 13.06.2019 and 18.07.2019 (Pages 5 - 16)

4 CCG update - Enhanced Care Home Scheme

Jo York, Director of New Models of Care, will give a verbal update.

5 Portsmouth Hospitals Trust update (Pages 17 - 22)

Lois Howell, Director of Governance & Risk, and Mark Roland, Associate Medical Director, will answer questions on the attached report.

6 Solent NHS Trust - Jubilee House (Pages 23 - 32)

Sarah Austin, Chief Operating Officer, and Andrea Havey, Operations Director, will give a verbal update on developments since the previous meeting (original report attached).

7 Dental Services update (Pages 33 - 36)

Julia Booth, Acting Head of Primary Care (Hampshire, Isle of Wight and Dorset) at NHS England and NHS Improvement South East will answer questions on the attached report.

8 Southern Health NHS Foundation Trust update (Pages 37 - 46)

A representative from Southern Health NHS Foundation Trust will answer questions on the attached reports on acute in-patient mental health care.

9 Healthwatch Portsmouth update (Pages 47 - 52)

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

10 Care Quality Commission update (Pages 53 - 54)

Sarah Ivory-Donnelly, Hospitals Inspection Manager, will give an update on Care Quality Commission processes.

11 Podiatry Hub at St Mary's Campus (Pages 55 - 60)

Katie Arthur, Head of Operations, Primary Care Services, and David Noyes, Chief Operating Officer, will answer questions on the attached report.

12 Dates of future meetings

For information only:

Thursday 21 November at 1.30 pm
Thursday 30 January at 1.30 pm
Thursday 19 March at 1.30 pm

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

Date Not Specified

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HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held on Thursday, 13 June 2019 at 1.30pm in the Guildhall.

Present

Councillor Hugh Mason (Chair)
Marge Harvey
Leo Madden
Philip Raffaelli
Rosy Raines
Mike Read

19. Welcome and Apologies for Absence (AI 2)

Apologies were received from Councillors Chris Attwell, Trevor Cartwright, Graham Heaney and Gemma New. In the absence of the Chair and Vice-Chair a nomination was sought for a Chair. Councillor Madden proposed that Councillor Mason be the Chair; the proposal was seconded by Councillor Wemyss. Councillor Mason was duly appointed Chair.

20. Declarations of Members' Interests (AI 3)

No interests were declared.

21. Minutes of the Previous Meeting (AI 1)

RESOLVED that the minutes of the meeting held on 14 March 2019 agreed as a correct record.

Deputation

Jerry Brown, a member of the public, made a deputation on agenda item 10 (Sustainability Transformation Partnership), asking for more detailed reporting to show what extent the ten major deliverables had been met.

22. Portsmouth Hospitals' NHS Trust update - CQC report on Emergency Department (AI 4)

Lois Howell, Director of Governance & Risk, presented the report and in response to questions clarified the following points:

Although it was disappointing to see that some areas still require improvement there is a different approach and the culture in the Emergency Department (ED) is changing. Staff are encouraged to put themselves in patients' shoes and to take time out to see the experience, focusing on dignity and privacy, particularly at busy times. Staff were surveyed to find out what the barriers were to delivering care to the standard to which they had been trained.

The physical layout of the ED is poor and confusing but thanks to investment the trust is looking to develop it in the next couple of years. It is intended that residents can access necessary services in the locations they need and not come to the ED as a default. Therefore, the ED will have a different range of patients. There will be new qualifications, including physician associates, a

bigger staff complement and changes to health and social care pathways across the system. There will also be a revised approach to providing services for people with acute mental health problems.

With regard to concerns about leadership the trust needs to help partners solve problems and vice versa. Many improvements are within the trust's control. Leadership had changed significantly since 2016. Most directors had changed and staff feel able to approach the senior management team. However, leadership in the ED is another issue. A skills audit and individual training programmes have taken place. Leaders need to take a less operational view of the ED and step back.

A patient collaborative (a panel of patients, service users, carers and families who have expressed a wish to participate) will come from a wide range of people. The trust adopted a "sprint approach" to address issues incrementally with a change management model of plan - do - act - check to attempt to resolve issues. Staff or volunteers will be used to guide patients around the physical layout of the ED. Measures to prevent delays in ambulances handover are also in development. The panel requested a copy of the Urgent Care Recovery Plan that had been reported to the Trust Board.

The panel was concerned that the proposed psychiatric support might not have sufficient staff to be effective as these patients may need more security, attention and medication. Members were informed that it is more a pathway and holistic service than a physical location and will have specialists with the right knowledge and skills. Discussions are being held with NHS Solent NHS Trust and Southern Health.

Staffing will be checked on a shift by shift basis and, if necessary, shifts will be supplemented with other staff to mitigate risks, for example, having more support workers to replace a nurse. However, the recruitment strategy is only as good as the numbers who are appointed and there is a shortage of specialist staff. Creative approaches to recruitment are being taken, for example, creating an extended Nurse Associate role.

The staff passport had been very helpful.

The "sprint analysis" can ensure an environment that is "fit for purpose" by checking items such as curtains and screens are in place. Work will take place within the next three months so it is difficult to say how far it is working as the trust has not identified all the actions it has to do. Consistent use of safety measures can be measured by the safety checklist to show patients are safe, comfortable, warm and have enough to eat and drink. Compliance is 90 to 95% since the checklist was introduced in February 2019.

It is unsure whether all staff have specialist training in autism and learning disabilities but they all undertake safeguarding training on meeting the needs of vulnerable people.

RESOLVED that the report be noted and that updates be provided for the next meeting on:

1. **Report on psychiatric provision in the ED, specifically addressing the number of staff in the ED and ambulance staff trained in mental health and autism awareness, number of specialists and details of the patient pathway in place for patients presenting with mental health issues and autism and any improvements made or that will be made in the immediate future.**
2. **An update on how well the Urgent Care Recovery Plan is working.**
3. **Progress on the quality improvement "sprints."**
4. **How many staff the staff passport has helped.**

23. Public Health update (AI 5)

Dr Jason Horsley presented the Public Health update and Dr Adam Holland presented the Portsmouth Events Safety Advisory Group report on drug related harm at festivals. In response to questions they explained that:

There is uncertainty around funding and functions mandated by government as there has been no update.

With regard to violent crime it was noted the Glasgow experience, which started in 2009, did not deliver results overnight. Bigger social drivers have to be considered such as the social discourse around victims and perpetrators of violence; the latter are now viewed as young people with no significant life opportunities who potentially have a brighter future and a second chance. The connection between school exclusion rates and violence needs examining. Much needs to be done with youth work in Hampshire and the Isle of Wight; neglecting youth work has a significant price. Data sharing about vulnerable people can help, for example, data can be used to make a case for additional funding and there is joint working with police to do this.

Drug and alcohol services focus on the most serious users. The service cannot be extended until there is more funding; however, some funding has been secured for work with children affected by parental alcohol use.

Sexual health services are increasingly stretched and the rate of sexually transmitted diseases is increasing. It is hoped to maintain service levels but this cannot be guaranteed without funding. On the whole, commissioned services are working well and there are others Public Health would like to provide.

There is currently no joint working specifically regarding homelessness between the public health team and Hampshire County Council but there are teams within Portsmouth City Council who work jointly and there have been dramatic improvements in the last two years. The two cities of Portsmouth and Southampton have a very different homeless situation compared to the rest of Hampshire. Coastal cities have higher rates of homelessness. Public Health England has worked across Hampshire.

Portsmouth Events Safety Advisory Group

It was disappointing that drug testing (checking the contents of drugs brought to events by festival goers) could not take place at a recent festival due to the Home Office refusing permission but hopefully this is a temporary setback. Dr Holland spoke to The Loop (the charity who test drugs) and the National Police Chief Council has reported in favour of drug testing at festivals and are in discussions with the Home Office. The report has not been publicly released yet. Dr Holland clarified figures in the survey on page 10 of his report.

It is not possible to conclude whether or not drug checking could encourage drug taking – there is no evidence to suggest this is the case though. It is difficult to assess effectiveness of the policy as national trends in the circulation and types of drugs will change risk from year to year. Researchers would need a comparator between festivals. There would need to be two festivals, one with and one without checking, where drugs are being taken the same way, and so this level of evidence is unlikely to ever be achieved. However, the initiative needs to also be seen as a small part of the solution to a larger problem.

Despite the best efforts of abstinence education people take drugs; a recent survey showed 73% ecstasy users knew there were risks. If people provide drugs for testing at festivals they only need to give a small amount. It is important to engage with drug users and the initiative is an opportunity to do this.

The panel agreed the report was a good piece of work.

RESOLVED that the update be noted and that the following information be brought to the next meeting:

1. **Public health indicators and long-term outcomes so the panel can see how they are being met.**
2. **List of all the locations of the community defibrillators.**
3. **The Police Chief Constable's report on drug-related harm at festivals to be sent to the panel as soon as it is published.**

24. Sustainability Transformation Programme update (AI 10)

The Chair agreed to bring forward agenda item 10. Richard Samuel, Senior Responsible Officer, and Sue Harriman, CEO Solent NHS, presented the report and in response to questions, explained that

The panel was grateful for the financial statement presented at the last meeting. However, they felt there was very little detail about how the aims can be tracked against KPIs as there is not enough data to give a view.

Richard Samuel apologised if there had been a misunderstanding about the depth and format of information that the panel wanted. He could bring a detailed synopsis of progress made on how the ten workstreams of the programme are being achieved. Plans and savings are indicated on receipt of £90 million of revenue to transform services and £192 million as capital generated over five years. The STP has secured £125 million capital over the

last two cycles of capital allocation. Around £190 million in cost reduction has been achieved over the last year, subject to audit. There is an anticipated cost reduction of £217 million with the caveat that the NHS long-term plan requires the STP to draw up a delivery plan by October or November 2019. The Panel also wanted to know how the £577 million savings could still be delivered between 2016 and now and for the next five years.

RESOLVED that the update be noted and that the following information be brought to the meeting on 21 November:
Detailed synopsis showing:

1. **The progress made with regard to the savings and the 10 workstreams.**
2. **Plans and anticipated savings predicted on receipt of the £90m.**
3. **The progress made from 2016 until the present day clearly shown against the performance indicators.**
4. **Details of how the £577m will be spent.**

25. Southern Health NHS Foundation Trust update (AI 6)

Nicky Adamson-Young (Divisional Director of Operations) presented the report (Dr Robin Harlow sent his apologies) and in response to questions explained that:

The diagram of the new structure and leadership teams contained personal information and was therefore was removed from the report. An amended version will be sent to the panel. Once the next level of the structure is finalised and roles have been filled a more detailed version will be sent, specifically showing the Portsmouth and South East Division structure. Specific KPIs will not be decided until the recruitment phase is completed. When the new structure is in place Southern Health will decide targets specific to each division and then report back to the Panel together with progress towards them.

The Core 24 framework is used for the mental health liaison services at QA Hospital to ensure the right level of expertise in the workforce.

Patients are involved at board level as they are employed as "experts by experience." A huge amount is being invested in quality improvement work based on the Northumberland Tyne & Wear improvement model. There is work with existing user representatives and there are also patient representatives at locality level.

The panel was interested in the ratio of referrals into mental health services from social care and housing that do not meet the relevant threshold for services.

There are 65 mental health beds outside the area and there is a currently a very detailed piece of work being undertaken to be signed off at board level to bring them back. It is recognised having beds outside the area is not suitable for patients nor their families. It is a challenging national issue.

RESOLVED that the report be noted and updates be provided to the panel including:

1. **Diagram of new structure and leadership teams.**
2. **Ratio of referrals to mental health services, including from social services and housing associations, that do not meet the relevant threshold for the service.**

26. Portsmouth Clinical Commissioning Group update (AI 7)

Innes Richens, Chief of Health & Care Portsmouth, introduced the report and in response to questions explained

Since the start of the centrally located 24/7 Primary Care Service in July 2019 there has been a 1% decrease in ED attendance, an encouraging sign that people can access the help they need elsewhere.

The number of care homes in the Care Home Team (provides integrated support) has increased from two to six. There is a 72% reduction in hospital admissions and the scheme is being rolled out to other homes. A high number of care home residents had often been admitted to hospital as the homes did not have expertise on the premises. The initiative helps residents stay in what is effectively their home. However, adding a new home to the scheme entails more staff, which is a limiting factor.

The physiotherapy triage service aims to put patients in touch with a physiotherapist directly the same day; so far the scheme has saved 3,000 GP appointments.

The Wellbeing House is being rebranded as Positive Minds and will help people with low level mental health needs and emotional distress. A location is being sought. It was noted mental health specialists do not always have access to mental health specialists in the community.

27. Adult Social Care update (AI 8)

Innes Richens, Chief of Health & Care Portsmouth, and Simon Nightingale, Head of Business Management & Partnerships, introduced the report on behalf of Andy Biddle (Deputy Director, Adult Social Care) and in response to questions clarified that:

The Adult Social Care (ASC) new record system, SystmOne, had started on 18 March and initial GPs' feedback had been positive as they could now see ASC involvement in patients' records (provided patients have given consent). Information from hospital records is not included but discussions are being held on how this could be done, particularly for ED records. The aim is to reduce the number of referrals between organisations. Information, particularly social care information, has to be treated carefully. However, very few people have objected to their information being shared.

With regard to the recently established ASC Strategy Board, portfolio holders and lay members hold the Chief of Health & Care to account. More details on how the board's priorities are going to be met can be provided, including more information on support for autism.

The wording in the first bullet point in paragraph 4.1.2 of the report could be changed to show that people are at the heart of the care and support offer rather than technology.

With regard to systems thinking, outcome measures are being developed to see if it is still delivering. There are currently three interventions: the sensory service; domiciliary care and integrated locality intervention. The new delivery model for domiciliary care aims to put people at the centre of care.

The panel congratulated ASC on the efficient way residents had been moved from Edinburgh House.

The number of applications for DoLS (Deprivation of Liberty Safeguards) authorisations had continued to rise due to court judgements and increased awareness in the NHS of DoLS and patients' rights. The Care Act imposed a duty on local authorities to carry out DoLS. The proposed Liberty Protection Safeguards give power back to other providers such as the NHS rather than the local authority. However, the greater the number of organisations involved the more there is a risk to consistency of application.

RESOLVED that the update be noted and that the following information be provided at the November meeting:

1. **Composition of the ASC Strategy Board.**
2. **Details as to how the ASC Board will meet their priorities and to how they have been met since 2015.**

Cllr Marge Harvey left the meeting at 15:40.

28. South Central Ambulance Service update (AI 9)

Tracy Redman, Head of Operations South East introduced the report and in response to questions clarified that:

The new rosters were intended to go live in September when there is a full complement of staff in place. The next stage will consider how to deploy ambulances and response cars.

Delays in making public data based on postcodes had been due to staff capacity issues.

Performance against targets may change if ambulance locations change; the majority of ambulances currently come out of in Cosham. There are standby points, for instance, at road sides, provided there are enough crews to put there.

It was acknowledged that responding to high priority calls means other calls may have to wait longer; queues at hospitals also cause delays in response times.

This Winter's figures are better than the previous year's. The service did a lot of pre-winter work which may have helped. As for the Spring figures being worse than Winter it may be because Winter came late.

All frontline operational staff receive mental health training but by the nature of the job they are not specialists. However, they need to be clear about capacity.

The panel agreed that the ambulance service would be first on the agenda the next time they attended.

RESOLVED that the update be noted and that the report to the January meeting include the reasons for the rise of lost hours due to hospital handover delays.

29. Care Quality Commission update (AI 11)

The panel was very disappointed to note that this was the third meeting the CQC had been unable to attend or send an update.

RESOLVED that a letter be written to the CQC expressing the panel's disappointment and requesting that a representative attend the next meeting to present an update.

The meeting ended at 3:50pm.

Signed

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Councillor
Chair

HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held on Thursday 18 July 2019 at 11.30am in the Guildhall.

Present

Councillor Chris Attwell (Chair)
Gemma New
Graham Heaney
Leo Madden
Vivian Achwal
Arthur Agate

28. Welcome and Apologies for Absence (AI 1)

Apologies had been received from Councillors Trevor Cartwright, Marge Harvey, Hugh Mason, Philip Raffaelli and Rosy Raines.

29. Declarations of Members' Interests (AI 2)

No declarations of interests were made.

30. Proposals for Jubliee House (AI 3)

Sarah Austin, Chief Operating Officer, Solent NHS Trust introduced the report that had been circulated with the agenda and asked the panel to note the following points:

The paper had been amended in light of feedback from the panel before being published.

Most patients are from Portsmouth and will move on to another service or go home.

The staff have a reputation for providing compassionate care. It is hoped that every member of staff will journey forward with us.

The building is not fit for purpose now because the way care is delivered has changed.

The panel has had the opportunity to visit Jubilee House.

The patients receive end of life care not hospice care.

There are three groups of patients each requiring a different approach:

- The first group receive end of life care. This has reduced to less than 20% as more patients chose to be at home.
- The second group comprises patients who move on to long term residential placements e.g. nursing or care homes which can provide more stimulation and whole person assessments.
- The third group comprises patients who move back home.

The proposed service at the new location would encourage rehabilitation with a gym and activities provided. Patients would be encouraged to move around the facility but observation would be easier.

Discussion had taken place informally with the panel before staff engagement commenced.

The detailed planning would not commence before approval had been given by the HOSP.

In response to questions, she explained that:
Jubilee House has not been used for respite care for a long time. Short term care home placements are used for respite. This provides an opportunity for thinking time for the patients and their families and for assessments to be carried out. This is particularly important for patients with dementia.

End of life care would still be provided for patients at the new Jubilee House if required. If patients have complex or distressing symptoms of end of life they would stay at the Rowans Hospice.

No patients would be moved from Jubilee House during their admission if there is no clinical need. The closure would be as natural as possible with beds not being filled.

Jubilee House is only suitable for patients with mild dementia. Those with more complex dementia needs are supported by the Limes.

The aim is to maintain the overall number of staff. However, a change of the skills mix would be required for the new model and so more registered staff would be recruited. The new Jubilee House would need 11 and Harry Sotnick House if used, 14. Other colleagues would be redeployed elsewhere.

The new Jubilee House building will be more modern. It is expected that running costs would be lower.

Solent NHS Trust spoke to Healthwatch Portsmouth after its informal meeting with the HOSP.

Feedback from staff and service users and carers has been taken into account when considering the new service.

The current Jubilee House site and land is owned by the trust. There would be an opportunity to dispose of the land ith a focus on social value. Her preference would be for another health care facility to open on this site but clearly that is a matter for the trust and the planning authorities. Discussions would take place with Health care partners, the Health Overview & Scrutiny Panel, Ward Councillors and Healthwatch Portsmouth.

It is anticipated that there would be fewer delays because the new site would have rooms and bays and so could be more flexible particularly with regard to the separation of men and women patients.

A number of performance indicators are currently used. It is important that the changes do not cause delays for patients leaving hospital or increase the number of people needing long term residential care. The length of stay at the new Jubilee House would be closely monitored.

She has been assured that there is adequate space close to Spinnaker Ward for the beds transferring. It is not possible to confirm that until the detailed plans are in place. Partition walls could be installed and windows moved if necessary.

Quality Impact Assessments would be carried out and all the normal building and regulatory standards would be adhered to.

It is important that new services are up and running before Winter in order to avoid any problems at QA Hospital and elsewhere.

If agreed by this panel, the proposals would be considered by the trust's Executive at the end of the following week.

Members noted that they were very happy with the report and the proposals.

Actions

- The panel's thanks to all the staff involved in the visits be passed on.
- A link to the trust's Executive report papers be sent to the panel.

RESOLVED that the panel is satisfied in principle with the plans brought before it and would welcome further details to be brought to this panel in September.

The meeting ended at 12.30pm.

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Councillor Chris Attwell
Chair

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Portsmouth Hospitals NHS Trust

Portsmouth City Council Health Overview and Scrutiny Panel
12th September 2019

Portsmouth Hospitals NHS Trust update

Portsmouth Hospitals NHS Trust (PHT) is providing updates to the Health Overview and Scrutiny Panel on the following issues of interest:

1. **Psychiatric provision in the Emergency Department**
   - Specifically addressing the number of Emergency Department (ED) staff trained in mental health and autism awareness and the number of specialists in the ED.
   - Information about the patient pathway in place for patients presenting with mental health issues and autism and any improvements made or that will be made in the immediate future.

2. **Urgent Care Recovery Plan**
   - An update on what has been put in place and how well this is working.

3. **Recruitment**
   - Update on recruitment drive, including the number of staff who have been helped by the staff passport.

4. **Sprints**
   - Update on Quality Improvement sprints and how these are working.

1. Psychiatric provision in the Emergency Department

Training on the Mental Capacity Act and Deprivation of Liberty Safeguards is included as part of the Trust's Essential Skills training for all patient-facing staff.

As of June 2019, 96.40% of staff had completed this training at level 1 and 81% had completed the more advanced level 2 programme.

The Emergency Department has Registered Mental Health nurses (RMN) Band 5 cover 24 hours a day, seven days a week.

Southern Health NHS Foundation Trust covers liaison psychiatry for adults and older adults based within the Mental Health Liaison Team in the Emergency Department and also offers cover for wards when needed.

Southern Health NHS Foundation Trust and Solent NHS Trust, supported by Portsmouth, Fareham and Gosport and South Eastern Hampshire Clinical Commissioning Groups, are committed to working together locality to improve mental health services. A number of Sustainability and Transformation Partnership (STP) bids were submitted and the bid for phase 1 has been agreed. This includes psychological services, to provide a robust children, adults and older adults liaison psychiatry service.

There is an aspiration at PHT to develop psychological support services under one umbrella, working closely together as required.

2. Urgent Care Recovery Plan

Providing timely emergency care to our patients is our absolute priority. Our Emergency Department (ED) has seen a significant increase in demand in recent years, which has meant some patients have waited longer than we would have liked. Our priority is always the care and safety of our patients, and everyone who arrives at the Emergency Department is assessed and prioritised according to clinical need. We are working with all of our health and care partners across Portsmouth and south east Hampshire to ensure we are able to meet the needs of patients in all areas of the system, and that we are seeing patients who attend ED as quickly as possible.

Further to this, our system-wide Urgent Care Recovery Plan has four key areas of focus:

1. Population Health
2. Emergency Department Processes
3. Bed Occupancy
4. Out of Hospital Services

There is considerable overlap between these areas and the summary provided below focuses on the work being done within PHT in relation to ED processes and bed occupancy.

ED Processes

An emergency care improvement group has been established with 10 key workstreams. These are:

1. 6As Audit (The 6As are contained within NHSI Guidance on admission avoidance and cover access to the following resources: Advice, Access to outpatient services, Ambulatory Emergency Care, Acute Frailty Unit, Acute Assessment Units and Admission to Specialty Ward Directly)
2. Recruitment and Retention
3. Cultural Change, Care and Compassion
4. Ambulance Handover and Pitstop processes
5. Ambulatory Care
6. Emergency Department Processes
7. Acute Medical Unit and short stay processes
8. Frailty
9. Minors
10. Urgent Care Centre Streaming Processes and Mental Health

The group meets weekly to drive forward our internal improvements:

- 3-5 additional majors spaces in ED - pilot mid-August removing all six trolleys from Majors B and replacing them with 12 chairs, resulting in six additional care spaces
- Recruitment of 3.7 FTE Consultants
- Recruitment of two middle grades on track
- Northumbria learning (PHT have been participating in a shared learning partnership with Northumbria Healthcare NHS Foundation Trust for over a year now with one of the areas of focus through this partnership being clinical leadership and culture in the Emergency Department)
- Primary Care Provision in ED - the Urgent Care Centre (UCC) is a focus for current adaptation and future modelling. A new model is due to be piloted in September, providing GP cover from 2pm to 9pm with “doubling up” between 4pm and 7pm. During the conclusion of the pilot the conversion rate of those successfully screened and avoided ED attendance or admission will be reviewed and a standard for success set
- Frailty Interface Team (FIT) and Frailty - work continues on improving the frailty pathways within the community and hospital in a whole system approach.

Bed Occupancy

- We are working to continuously improve and are focusing on reducing bed occupancy and improving flow throughout the hospital. This is key to further improving safety, patients care and outcomes, and means a better experience for patients and staff.

- A weekly group has been established to deliver improvements at ward level to increase timeliness of discharges for patients who have received all of the appropriate acute care they need and are ready to be discharged. The group is also working to ensure discharge prescriptions are completed in a timely fashion to help reduce delays, and driving accuracy and ownership of estimated discharge dates across all major bed holding specialities.

- The Quality Improvement Team has “buddied” with wards who are participating in a Ward Collaborative to use improvement techniques from a range of tools designed to identify common blockers and barriers to timely discharge.

- A Long Length of Stay project has instigated a “Wednesday Walkabout” to discuss the most complex, long stay patients with ward teams directly and work to progress supported discharge where appropriate.

- We are confident that by implementing this plan we can significantly improve urgent care pathways.

- Our Emergency Care Transformation Programme is also well underway, and will include redevelopment of the Emergency Department. This will also help to improve patient flow and deliver a better experience for patients and staff.

3. **Recruitment**

Recruitment

We have seen a significant improvement in Nursing and Midwifery vacancies including Band 5 Registered Nursing vacancies and recruitment drives are ongoing. Overall, Nursing and Midwifery vacancies have reduced by 30% in the past year. Band 5 Registered Nurse vacancies have reduced by 42% in the same period.

- In August we welcomed 29 international nurses to the Trust and we are expecting to welcome 32 in September. This is in addition to the 30 newly qualified nurses joining us between now and the end of October. We plan to greet a further 70 international nurses before Christmas which is a challenging target, but we are positive in our approach and are confident in achieving this. The additional nurses we have recruited will add greater stability to many teams and departments, but ultimately, this allows us to provide greater continuity of care to our patients.

- The Objective Structured Clinical Exam (OSCE) is a practical examination made up of six stations designed to test knowledge and understanding of assessing, planning, implementing and evaluating care as well as testing clinical skills. The experience nurses have in the first few weeks of joining PHT plays a key role in their future success at OSCE and many teams work together to give a warm welcome. The Practice Based Learning team delivers an OSCE Preparation Programme and pastoral support which in partnership with the nurses, who have demonstrated a strong commitment to preparation and practice, has seen achievement of a 100% pass rate.

Staff Passport

- Passporting is the agreement between NHS organisations that allows staff who have completed Statutory and Mandatory Training (Essential Skills) elsewhere to bring that training record with them into a new role, and therefore not have to repeat the training as part of their induction to the new organisation. The training has to have been aligned to the Skills for Health Core Skills Training Framework to be eligible and there has to be a minimum of 12 weeks left before a refresher is due. In total 31 staff have been able to passport in one or more subject since February 2019.

4. Sprints

Improvements made in our unscheduled care processes in the last year are already benefiting patients and staff. This is attributable to the incredible hard work and dedication of the whole PHT team.

Part of the activity undertaken was the launch of an intensive programme which focused on how to make departmental improvements each and every day, focusing on a range of topics.

In 2019 the Trust is running a “Always Improving – Unscheduled Care” intensive improvement initiative. As part of this it held an eight-week “Sprint,” with the aim of identifying key internal projects across the Trust.

Staff of all grades and disciplines, including trainees in all specialties and non-clinical staff, were invited to join and play a part in helping to improve the quality and safety of care provided. The Sprints comprised five teams, focusing on a number of workstreams:

- ED Process (Ambulance Handover)
- Utilisation of Frailty Assessment Unit
- Ambulatory pathways
- Emergency Department/Acute Medical Unit interface
- Ward processes

The key outputs from the sprints were as follows:

- Allocated time and space has allowed improvement work to be undertaken and teams valued this
- Individual group support from sprint team has allowed for Quality Improvement (QI) methodologies to be coached
- Improved patient safety from three ED process sprint outcomes (new Immediate Care Needs proforma/admin process/patient at handover)
- Improved patient experience from change in handover process
- Improvements within the ED admin team have been identified and actioned through sprints
- Dialogue around progressing and enhancing the role of the Frailty Assessment Unit
- A new scoring tool has been developed to make discharges more accurate within the ED and this learning is being shared with other wards
- Work from sprints will continue to embed and sustain positive changes
- Learning for Sprint leads and QI team around methodology, communication and delivery

ENDS

Proposed relocation of the Jubilee House Intermediate Care Service

Summary

Solent NHS Trust has adopted a new practitioner model, ensuring that our care is completely patient focused. We are working increasingly with strategic partners, including Portsmouth City Council, to provide an integrated, responsive service that provides the highest possible quality of care for all patients and residents across Portsmouth and surrounding areas.

Together, Solent NHS Trust and Portsmouth City Council are working collaboratively to achieve the best outcomes for patients and staff across both organisations.

This document provides an outline of developments that are being proposed to improve the quality of services offered to a patient group that are currently supported whilst at Jubilee House in Cosham, Portsmouth.

The following information provides context, notes reflecting the learning from user engagement and additional issues that have combined to create a need for change. This, and additional information, is also being provided for all employees involved as part of an engagement process. The proposed changes include the relocation of services and therefore of the employees.

As an organisation, Solent NHS Trust continually looks at ways we can improve patient care and are working towards practitioner led clinical services within the city.

Introduction

Jubilee House is a community inpatient facility, with 25 beds, managed by Solent NHS Trust, in Cosham, Portsmouth. Originally built over one hundred years ago as a farm building on the Wymering manor estate, it has undergone a number of building alterations and changes to its purpose.

Jubilee House has been used, and highly valued, as accommodation for patients receiving end of life care, with patients in the main benefitting from the privacy of single rooms.

In line with the NHS Long Term Plan and feedback from service users and relatives, end of life care is now commonly provided in patients own homes, enabling people to die at home with dignity. In addition, there is community nurse support and residential care homes that offer long term accommodation.

These are appropriate alternatives to inpatient or community hospital wards, and so the provision of end of life care at Jubilee House has reduced and now typically accounts for less than 20% of admissions.

Over time, it has become apparent that the current building is no longer fit-for-purpose. To ensure we can continue to deliver the very best possible care to our service users, we have considered alternative accommodation for the unit.

The following options appraisal would provide the maximum benefit to service users and staff. If approved, the relocation would be scheduled to commence from the end of 2019, following a significant engagement and communication phase and support from key stakeholders.

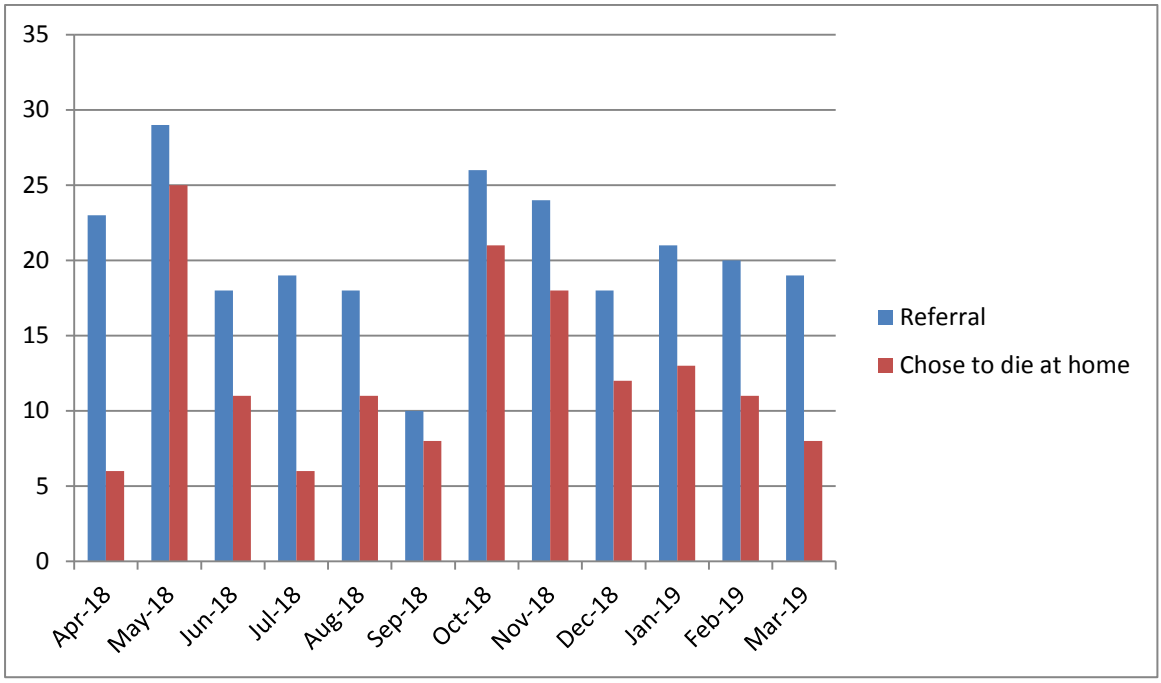
Case for change

In May 2017, Solent NHS Trust piloted an End of life community provision, in order to increase the choices for local people. This provision increased the number of people who could be supported to receive end of life care at home through the creation of an integrated nursing and domiciliary care service.

In 2018 this provision was mainstreamed and now offers up to 11 home care spaces a day for local residents. The service is frequently at capacity and this has reduced the demand on Jubilee House.

Instead, Jubilee House accommodates patients requiring rehabilitation and medical input to facilitate further recovery and those requiring Continuing Healthcare (CHC) assessment or the planning of long term care packages. In addition, some patients are admitted (from secondary care hospital beds) to receive care whilst waiting for longer term packages of community based care to be established (referred to as 'bridging'). The patient group now commonly includes people with dementia and those with a higher level of need requiring full active management, including the potential for resuscitation.

The below graph shows the number of referrals v the number of people/ families who chose to die at home.



The nature of the current need for inpatient community beds

There is a need to provide inpatient community beds for patients in three groups:

1. People with a low to medium level of medical need that require support with rehabilitation and re-ablement or, in some complex cases, people requiring end of life care. These patients may need a community bed to prevent admission to a secondary care hospital bed, or to enable timely discharge from the hospital.
2. People in secondary care hospital beds that will be supported with a package of care in the community, but for whom this is not currently available. Community beds are required for these patients to provide 'bridging'; i.e. to enable discharge from an acute hospital whilst awaiting or planning the package of care or future placement.
3. People who have been discharged from Acute care, who require a Continuing Healthcare assessment to determine what the most appropriate placement and/or services are.

Effective use of the Jubilee House service would be to designate it as a low-medium acuity intermediate care service, accepting Portsmouth patients described as group 1 (above).

Continuing Healthcare assessment and accommodation to provide 'bridging' are more appropriately facilitated in a care home setting where a less medical, home-like environment is more suitable and beneficial to patients' well-being.

Therefore, the most appropriate reorganisation would facilitate:

1. A new, modern Jubilee House unit lead by an advanced practitioner providing day-to-day full time patient support, with rehabilitation facilities and with an environment more in keeping with a medium acuity intermediate care service.
2. Beds, for patients requiring a Continuing Healthcare assessment, to be moved directly to an appropriate care home or other environments with domiciliary support.
3. Patients requiring end of life care to be managed based on clinical need; as inpatients at Jubilee House, in care home environments or supported with domiciliary care.

Risks for continuing to run the Jubilee House unit out of current premises

There is awareness that:

- Jubilee House has a u-shaped design with a dining room and dedicated off-corridor bathrooms, resulting in considerable walking distances for patients and employees.
- Nursing administration areas are a small enclosed office off the main corridor and space on the first floor, with neither allowing direct observation of the rooms. The absence of a central nurses' station, hinders active ward management and increases risk.
- Storage areas are similarly enclosed in dedicated areas away from the living space.
- The patient group typically requires physiotherapy and/or occupational therapy support as part of rehabilitation and this is hindered by the absence of suitable facilities (e.g. there is no gym or appropriate therapy spaces).
- The building is out of date does not provide the caring environment we would aspire to.
- Jubilee House is also disadvantaged by poor connectivity; the city's community healthcare services, social care services and primary care services all use a shared electronic clinical record which can be difficult to access.

Service User engagement, involvement in developing proposals and potential impact

A co-production approach has been used when considering the ways in which the provision of intermediate care at Jubilee House could be enhanced. This has involved numerous meetings with relatives who have experienced services at

Jubilee House for CHC assessment, end of life care and 'bridging' admissions for those awaiting a package of care elsewhere.

Some of those involved were identified as a result of their use of the complaints process, but others were also directly approached to gain feedback from their recent experience of Jubilee House.

The opinion of service users has enabled a more comprehensive understanding of the needs and wishes of patients and their families.

Engagement with relatives has highlighted concern regarding:

- the detrimental effects of single rooms that provide limited stimulation to patients with dementia
- the need for both continuity and speciality in decision making over patients with more complex medical needs and/or those moving into end of life care
- The need for more advanced nursing practices, including parenteral (intravenous) nutritional support.

The proposal of a new Jubilee House service

The availability of a purpose built unit and the opening of a modern, purpose built care home in Portsmouth present significant opportunities for addressing patient needs as described above.

It is therefore proposed that we facilitate:

1. The use of a further 12 beds, to enable Continuing Healthcare assessments and ‘bridging’ to be facilitated for Portsmouth patients, at Harry Sotnick House in central Portsmouth.

2. The relocation of the low acuity rehabilitation and re-ablement patients within the Jubilee House service, potentially to a new unit at the recently refurbished St Mary's Hospital. This unit would retain the Jubilee House name and be support 10 beds, providing a modern intermediate care facility with appropriate space for rehabilitation, supporting people with a low to medium level of medical need.

As neither Harry Sotnick House, nor the proposed new location for the Jubilee House service, would require significant building works, a phased development could be facilitated by the end of 2019.

There is a need to complete an engagement process with existing employees and to undertake appropriate workforce planning and training. The employee resource will be strengthened by the addition specialist practitioners in leadership roles.

Recruitment to add the specialist support from senior practitioners is already on-going, as there has been a commitment to facilitate this to enhance the intermediate care services provided by the existing partnership of Portsmouth City Council and Solent NHS Trust.

The proposal would end the use of the current Jubilee House building in Medina Road, Cosham. This site need could be repurposed ideally for other health or social care developments as appropriate.

The proposals respond to feedback from engagement with patients, relatives, service employees and partner organisations.

The proposed reconfiguration of the current Jubilee House services will deliver an improved quality of service by deploying existing staff resources more efficiently and into accommodation that is suited to its purpose. As such, the proposal does not represent a reduction in the services being offered nor is there any reduction in the staffing cost of service delivery, although capital and non-pay costs will reduce.

Benefits of the proposal

Creation of an integrated team at Harry Sotnick House will allow for the effective cross fertilisation of ideas amongst health and social care professionals to improve patient care.

Other considerations

Waiting times

We will be able to take an increased number of female patients so waiting times will be reduced for this group. An improved environment will mean that new patients can be admitted in a timelier manner. In our current ward the lack of de-escalation space means that admissions have to be carefully planned and often delayed until previous patient is settled.

Travel time

Travel time for Portsmouth patients and their families should not be affected by these moves. Public transport connections to all sites are good and on street parking is available.

Environment, including housing

The facilities recommended will have modern infrastructure, reducing energy waste. Due to the arrangement of modern waste management facilities at these sites, recycling rates should significantly increase.

Catchment area

The services that Jubilee House provide are predominantly commissioned by Portsmouth Clinical Commissioning groups (CCGs).

Finance

We are currently working with Portsmouth City Council colleagues to ascertain the precise professional skills and staffing numbers required but accept that the patient numbers will remain as they are or increase. Based on this, we do not expect cost savings to staffing across the city.

	Current Staff in Post	Jubilee in Spinnaker	Harry Sotnick House	Recruitment	Redeployment	Total
Registered	19.36	11.25	14	-5.9	0	19.36
Unregistered	17.14	8.61	0	0	8.53	17.14
Total	**36.5**	**19.86**	**14**	**-5.89**	**8.53**	**36.5**

Communication and engagement

We have developed a communications and engagement plan, in conjunction with our strategic partners at Portsmouth City Council. The main aim of this plan is to ensure we:

- Communicate and engage effectively with Service users and their families and carers, to ensure we capture their concerns and inform them of the potential of this project.

- Communicate and engage effectively with our people, to ensure we remove concerns around the proposed changes and inform them of the potential benefits for service users and for them, working as part of an integrated team.
- Communicate with key stakeholders in advance of any changes, ensuring a clear and transparent decision making process that will lead to improved conditions and outcomes for our service users and our people.

Key stakeholders:

Patients and families

Through the complaints process and face to face dialogue, the concerns raised by service users and their families have created a detailed picture of the experience of staying at Jubilee House. This feedback has directly informed the proposals in this document. Following any approval for these proposals, the intention is to engage with service users and their families, to reduce anxiety and to show we are listening to their concerns by offering a solution.

Staff/clinicians

Our people are our biggest asset. To ensure that they are able to deliver the best care and work in a healthy environment, we have taken on board their thoughts. Following any acceptance of the proposals in this document, we will consult effectively and engage with our teams to ensure the best possible outcomes for them.

Portsmouth Hospital Trust

As a key partner and stakeholder, we are engaged with Portsmouth Hospital trust and will continue to be so, ensuing that our proposal supports a system wide approach to care for Portsmouth residents.

Healthwatch (Portsmouth; Southampton and Hampshire)

Should these proposals be accepted, we will share this information with Healthwatch Portsmouth at the earliest opportunity to ensure that we have their oversight and views on any changes.

HOSP (Portsmouth)

We would provide regular updates to HOSP on any service move or change and the outcomes for service users and our people.

Other communications channels

We will also share information around the proposal through a range of channels including:

- Press releases and briefing to local media
- Uploaded information on Solent NHS Trust and Portsmouth City Council's websites.
- Letters to GPs and other health and social care partners.
- Regulators

Conclusion

The driving force of this proposal is the great care of patients.

The proposed reorganisation of community beds presents an opportunity to improve the quality of care for patients, whilst reducing risk, by transferring the Jubilee House services to a new in-patient facility and a care home environment with dedicated accommodation for those requiring Continuing Healthcare Assessment or awaiting the provision of longer term packages of care.

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Update for Portsmouth Health Overview and Scrutiny Panel (HOSP)

on NHS dental services

Background regarding the commissioning of general dental services

NHS England holds contracts with dental care providers on behalf of the NHS, as part of its responsibilities for the commissioning and oversight of all NHS dental services (including general dental services, specialist community dental services and secondary care (hospital) dental services). General dental services and specialist community dental services are commissioned in line with national regulations, with dental providers commissioned to deliver care and treatment as measured by units of dental activity.

Decision by Colosseum Dental Group to cease providing NHS dental services at three Portsmouth dental practices

The Colosseum Dental Group informed NHS England that they wished to give notice on the contracts under which they provided NHS general dental services at the following three dental practices in the Portsmouth area, with effect from 31 July 2019:

- Portsea Dental Clinic, John Pounds Centre, 23 Queen Street, Portsmouth, PO1 3HN
- Paulsgrove Dental Clinic,Paulsgrove & Wymering Healthy Living Centre, 219-225 Allaway Avenue, Portsmouth, PO6 4HG
- Southsea Dental Clinic, 96 Victoria Road North, Southsea, PO5 1QE

The services Colosseum was commissioned to provide at the three practices accounted for around 10 per cent of the NHS dental provision commissioned within the local area, with 22 other dental practices also providing NHS services to patients.

Colosseum was contractually obligated to continue delivering care for NHS patients at the practices until 31July. While we understand Colosseum was experiencing staffing challenges, it is disappointing that the provider did not act in the best interests of their patients by ceasing to provide services at the three practices ahead of their contractual obligations ending on 31 July. NHS England took formal action as a result of this breach of their contracts to deliver NHS care. Breach notices were issued to Colosseum, who will need to declare this should they decide to bid for contracts to provide any NHS dental services in the future. All payments made to Colosseum for any NHS services they have not delivered will also be recovered.

As mentioned above, we understand Colosseum were experiencing some staffing and recruitment challenges. The national Interim NHS People Plan published in June 2019 recognises that dental workforce challenges are not unique to the Portsmouth area and commits to addressing this, in order to ensure the dental workforce can meet patient needs.

Action taken by NHS England to maintain the capacity of NHS dental services in Portsmouth

In response to Colosseum's decision to close the three dental clinics, our immediate priority has been to maintain the capacity of local NHS dental services in the interim period, whilst a

procurement process is undertaken to commission new long-term NHS dental services to serve patients in Portsmouth and to put in place the contractual arrangements to support this.

NHS England is legally required to undertake such a procurement process to award any new long-term contracts for the provision of NHS dental services.

We have therefore been working with other existing local dental practices, so that we can support them to provide more appointments for NHS patients in the interim period, where individual practices are able to do so. We asked all other dental practices in the area to indicate whether they would be in a position to deliver additional NHS care, so that we could fund them to provide this.

We have finalised an agreement with the Bupa Dental Care practice in Cosham to provide additional appointments for NHS patients. The Bupa practice, located at 90 Northern Road, Cosham, PO6 3ER, is just over a mile from the Paulsgrove dental practice that had been run by Colosseum.

The University of Portsmouth Dental Academy in the south of the city, which is located less than a mile from one of the other former Colosseum practices, has also agreed to deliver a significant amount of general dental care to NHS patients, as part of a temporary contract. The existing contract we hold with the Dental Academy, which is part of the University of Portsmouth, is to support the training and education of the dental workforce and to provide a dental service to people who would not necessarily have access to a dentist. This includes working in partnership with community-based organisations that support homeless people, young people, older people, offenders on probation and other groups, as well as working with local children's centres to support better oral care for young children. The additional temporary contract the Dental Academy will hold to provide general dental services to more NHS patients requires them to recruit new staff in order to deliver this service. We are continuing to work with the Academy so that they can establish this service as quickly as possible.

We are also working with a third dental care provider who has indicated a willingness to provide additional dental treatment to NHS patients at one, or even two of, their dental surgery sites. We hope to have confirmation about these arrangements shortly.

These interim arrangements will overlap with the commencement of new long-term NHS dental services within the City.

We have written to patients who previously used the three Colosseum dental practices that have now closed, confirming how they can find details of other local dental practices at the point they need NHS dental care.

Patients who are in pain and in need of urgent dental treatment can continue to access this in the same way by calling the NHS 111 service. They will then be referred to a local dental practice to receive any urgent treatment, as needed.

The process to procure long-term dental services

The procurement process to put in place long-term contractual arrangements for new NHS dental services in Portsmouth is now underway. A refreshed service needs assessment has been completed to inform the procurement plans.

As part of the procurement process it is important for us to take time to engage with the market, as well as local people, to ensure the services procured are sustainable and meet the needs of the population. We will be putting in place a survey so that patients and the public can let us have their views on dental services. This will run for four weeks and we will work with system partners (including the clinical commissioning group, Healthwatch and the local authority) to request that they help to promote the survey through their communications channels and networks). Any assistance Portsmouth City Council can give in regards to this would be appreciated. The survey will be available online on the NHS England website and will also be available in easy-read format. There will be a phone number for people to call if they would prefer to talk to someone. These arrangements will be in place shortly. We are grateful for the support of a representative from Healthwatch Portsmouth, who is a member of the project group that is managing the procurement.

We will ensure the Health Overview and Scrutiny Panel (HOSP) is kept updated as the process progresses and will be contacting the Panel shortly to seek feedback to inform the recommissioning of these services, in addition to seeking views from other local stakeholders.

Julia Booth
Acting Head of Primary Care (Hampshire, Isle of Wight and Dorset)
NHS England and NHS Improvement – South East

30 August 2019

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Southern Health
NHS Foundation Trust

07 2019
Communications and Engagement Team

Briefing note:

Providing acute inpatient mental health care within Hampshire

Overview

Out of area (OOA) bed placements, and the reality of sending patients miles away from their family and friends, is serious issue affecting almost every mental health provider across the country. However, Southern Health NHS Foundation Trust was recently highlighted as having more OOA bed placements than some other trusts and we are keen to address this.

This paper outlines the plans we are putting in place to tackle the OOA bed issue within our adult mental health services – which, most importantly, will benefit future patients who need an inpatient stay. It will ensure a more effective use of the Trust's resources, as the costs of OOA beds are currently a significant burden on the Trust's finances.

Background

What is an out of area placement?

An 'out of area placement' for acute mental health inpatient care happens when a person with assessed acute mental health needs who requires adult inpatient care, is admitted to a unit that does not form part of the usual local network of funded services. This maybe an inpatient unit that does not usually admit people living in the catchment of the person's local community mental health service and where the person cannot be visited regularly by their care co-ordinator to ensure continuity of care and effective discharge planning.

Southern Health has a contractual responsibility to provide inpatient care when patient need exceeds what can be supported in the community. Unfortunately, demand for inpatient care has exceeded Southern Health's bed capacity since May 2016 and the underlying root cause of the situation is complex, with no single solution to fix the problem.

What are the challenges to reducing OOA bed placements?

Reducing the number of OOA bed placements is not a simple task and it is complicated by a number of factors.

These challenges include:

- An increase in the number and acuity of the patients we see in Hampshire, with 57.3% of admissions being detained under the Mental Health Act, compared to 45.5% in 2016/17.
- Fewer acute beds in Hampshire than the national average (14 per 100,000 compared to 19 per 100,000) - national benchmarking would suggest we have 40 too few beds compared to similar populations.
- Longer average lengths of stay in Hampshire (44 days compared to the national average of 32) - with 39% of beds occupied by patients who have been in them more than 100 days.

- A perceived lack of investment in alternatives to inpatient care - such as community mental health services, home treatment and crisis response.

Although these issues are key to ensuring a stable bed position in the longer term, this paper focuses on the management of flow across our patient pathways as an immediate action to effect change fast.

What is the current process for bed management?

Southern Health's Adult Mental Health services are divided into four geographical areas/divisions – North and Mid Hampshire, South West Hampshire, East Hampshire and Southampton. Currently, mental health beds and patient flow are managed by the Trust's Acute Care Support Team (and not by individual divisions). This is a **centralised bed management model** which unfortunately has not proved successful enough in managing the resource. There have also been local operational concerns regarding the sustainability of the model in the longer term.

These concerns include difficulty in managing planned admissions locally; continuity of care; and differing thresholds for admission, discharge and potential risk across divisions. By using this centralised bed management system, we have found there are a number of factors that can cause an increase in a patient's length of stay (when compared to beds being managed more locally by areas/divisions):

- Admission/gatekeeping is less robust when making the decision to admit a patient to shared bed stock. Incentives to intensively treat a patient in their own home and effectively manage risks, compared to admitting to another division's bed are lacking (particularly out of hours).
- Once admitted, there is little incentive for the patient's home area/division to prioritise early discharge or repatriate the patient when they are 'safe' in a bed and staff are stretched. Travelling and lack of familiarity with other teams further impact on the ability of one division to in-reach to another.
- When a local Acute Mental Health Team (AMHT) is looking for a bed for their patient they can more easily identify a local patient on their ward to home treat, than a patient from another area/division. A 'one in, one out' model between an AMHT and a local ward works well, where locational relationships are strong.
- The inpatient team does not have the benefit of 'knowing' the patient as well as patients from their own area/division and may take some time to make themselves familiar with the case and start an effective treatment plan. Prior knowledge as well as community in-reach and information sharing make timely and effective treatment more likely.
- The responsible clinician will be less likely to consider leave for a patient who is from another division and this can impact on recovery. Reasons include: logistical transport issues, difficulty getting the patient back for early review, lack of relationship with the AMHT that will be reviewing the patient whilst on leave, difficulties getting prescriptions issued/delivered and also a concern that if a patient needs to be recalled the bed won't have been protected and will have been given to someone else.
- Discharge planning can be difficult and untimely, as a safe discharge will often involve direct communication with the AMHT/Community Mental Health Team who will be following the patient up. Organising this in a timely fashion when clinicians are far away is difficult, so significant delays are frequent. Added complications include social care packages that need to be coordinated by teams remotely, who have no relationship with the inpatient team.

In essence, all areas/divisions report that not having 'ownership' of their beds, in respect of planning admissions and discharges is the single biggest barrier to the maintenance of patient flow through the inpatient services. The Divisional Bed Model is proposed in order to address these issues (see below).

What have we been doing to improve the situation up until now?

Before outlining the planned new way of managing mental health beds, it is important to understand all the work already taking place to try and address the unacceptable rise in OOA bed placements.

The Trust has been investing significant efforts into reducing OOA bed placements and developed a seven point 'Right Care, Right Place' plan to run alongside the current centralised bed management model. The seven point plan is:

(1) To embed the principles of effective patient flow and supporting resource
(2) To improve the culture in which beds are managed
(3) To fully develop and implement the Emotionally Unstable Personality Disorder Clinical Pathway
(4) To develop and embed system-wide resilience and escalation
(5) To develop accommodation solutions to admission prevention and early discharge
(6) To improve access to longer-term placement, including the rehabilitation pathway
(7) To review the system-wide capacity and demand

We did this by taking part in a number of multi-agency meetings to help us understand the local system, work with our partners and find solutions. These include:

- Local meetings in all areas with Hampshire County Council; unblocking issues and delays to discharge
- Weekly Stranded Patient Meetings with HCC, Southampton City Council and local commissioners
- Strategy meetings between HCC and Southern Health senior managers
- Meetings with different housing providers to investigate housing options
- Weekly meetings with local authority colleagues to look at any delays in the transfer of care
- Monthly mental health directors meetings – where it was agreed that OOA placements were a system-wide, multi-organisational priority and an ECR programme board was established.

We have also been applying the Quality Improvement methodology to the flow of acute patients through Southampton, working with all local partners, with a view to potentially standardising the approach across the Trust. We are also working with Hampshire County Council to apply the QI methodology to our social care flow, ensuring that patients who are discharged and need Social Care input do not fall through the gaps and end up back in the system.

In addition, we have been working to provide more support to people before they get to the point of crisis/admission, e.g.

- Opening a community based Crisis Lounge in Southampton
- Placing mental health nurses in the NHS111 call centre to offer support and triage, freeing up teams to support more patients
- Working with commissioners to bid for transformation funds to support crisis services, alternatives to admission and improved psychiatric liaison in our acute hospitals
- Setting up a Psychiatric Intensive Care Unit working group.

As is clear, much work has been undertaken to address the issue of OOA bed placement but it has not been significantly impactful, which is why we are now proposing to make swift changes internally to how we manage the process.

Proposed Changes

We are proposing to align bed allocation to areas/divisions, moving away from the current centralised bed management model. This new way of working is called the Divisional Bed Model and has the support of our commissioners.

It is a system which has had success in the past, and which we can learn from. In 2014/15, a similar area model system saw the use of out of area beds drop rapidly for the Trust - and the position was sustained through the following financial year. Whilst the model worked well, some areas were subsidising others and a perverse

incentive developed, where the more successful an area was, the higher the volume of referrals, discharges and leave that had to be managed by staff, with a negative impact on them.

Through a period of significant organisational change, plus several changes in senior leadership and the temporary closure of Hamtun Ward (on the grounds of safety) and Kingsley Ward (for a significant refurbishment), the model eroded until we ended in our current position. However, with the Mental Health and Learning Disability Division now replaced by Integrated Locality Divisions, the Trust is in a position to once again adopt a local bed management model to allow divisions to have more control of clinical pathways and improve overall patient experience.

Scope

Currently the scope of the Divisional Bed Model includes Adult Acute and PICU wards across North and Mid Hampshire, South West Hampshire, Southampton and South East Hampshire. Older People's Dementia and Functional beds will potentially come into scope following this first phase.

The Detail

Beds available will be ring-fenced for each division for their sole use. Each division will not have assumed use of acute beds outside of their division (with the exception of when bed allocation exceeds resource available within a division).

By 'owning' the beds, each division will be better placed to identify individuals likely to require admission earlier and be confident that if admission is required a bed will remain available (without other divisions filling it). By having this control over the acute resource, each division will also be in a position manage the whole pathway (community and acute inpatient), rather than the current situation where care is fragmented.

The key principles include:

1. The management of the commissioned bed stock lies with each division.
2. The divisions are able to offer beds to the system to offset any overspill from other divisions, but they are also able to decline on the basis of demand, acuity and staffing levels.
3. Referrals for a bed from another division should go from one Acute Mental Health Team to another, as gate keepers. Therefore, the current centralised Acute Care Support Team will no longer be required – and resources will instead transfer into AMHTs to allow local services to extend the bed management role out of hours, reducing the pressure on on-call services.

In order to establish the number of acute beds to each Division, the total numbers of beds were allocated against the weighted population. For the duration of the trial period beds have been allocated as follows.

- Southampton has the sole use of Saxon and Trinity wards. The wards are based at Antelope House and each ward has 18 beds.
- South East will have use of Elmleigh and the three purchased beds in Solent. Elmleigh is an Acute hospital in Havant which has 34 beds. The Solent beds are in the Portsmouth area.
- North Hampshire will have use of Hawthorns 2. These 23 beds are based in Parklands Hospital, Basingstoke
- South West and Mid Hampshire will have access to Kingsley Ward and the ten contracted beds at Marchwood Priory. Kingsley ward is a 25 bedded unit in Winchester, and Marchwood provides 10 additional beds between Totton and Hythe.

Timing, oversight and evaluation

The proposal will initially run for six months, from 8 July 2019, with a three-month review at the end of September. All key stakeholders including commissioners will provide ongoing oversight during this period. In order to evaluate the outcome of the 6 month trial we will look at the number of patients being sent outside of the Southern Health footprint, the number of miles patients have had to travel to access inpatient care, length of stay and number of admissions.

Next Steps

In order for the new Divisional Bed Model to work as effectively as possible, we will be implementing some associated changes - working up plans and liaising closely in partnership with our staff and commissioners and in consultation with our local scrutiny committees. This will include agreeing some changes to the configuration of mental health beds across Southern Health.

For example, whilst we will retain the six contracted beds with Solent NHS Foundation Trust to mitigate any initial risks in the new model, Southern Health plans to cease the contract for 10 beds at Marchwood Priory when no longer required.

In order to give the new model the best chance of success from the outset, it is planned that patients currently in out of area beds will not be repatriated to Hampshire but instead will remain in their current unit until discharged back to our local community services. Whilst clearly not an ideal course of action and not a decision that was taken lightly, it was deemed absolutely essential for divisions to have the necessary time to firmly establish the new bed model within their teams.

We also recognise that during the trial period the situation may arise where a patient is placed out of area whilst a bed is available in Hampshire. However, on balance the benefits of working to the Divisional model during this period, to test if over the short to medium term it can dramatically reduce the number of people overall being placed out of area, is a calculated risk.

There will always be individual circumstances that are considered and made an exception to this rule and we have protocols in place should these situations arise. This short term impact on some of our inpatients should result in a longer term benefit for the majority of our patients going forward.

In summary

Whilst the current centralised bed management system initially makes sense when looking at economies of scale, in reality it generates perverse incentive, longer bed stays, is inefficient, and relies on the premise that there is consistency across all teams and pathways, which is not always the case.

Most importantly, we continue to use an excess numbers of out of area beds at significant financial risk, caring for people away from their local communities, and failing to provide continuity through the clinical pathway.

At present, if a division is struggling with bed management, it impacts on the system as a whole. However if divisions are able to retain management of their own bed stock, the Trust can focus its support, resource and interventions trying to find local solutions to local pressures, rather than engaging in system wide change (which has a negative impact on other divisions).

Ultimately we believe the new bed model will reduce the number of patients treated out of area, away from their local communities. It will also significantly improve the Trust's financial position.

Any questions?

If you have any questions, please contact the communications team on 02380874666 or email communications@southernhealth.nhs.uk

Ends

Southern Health
NHS Foundation Trust

Ref: NB/hr/401468

5 August 2019

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Dear Colleague

Improving acute inpatient mental health care within Hampshire

I wanted to write to you about changes we are making to improve access to acute mental health care for people in Hampshire, alongside our partners across the health and care system.

As you will be aware, demand for mental health inpatient care is outstripping capacity across the NHS nationally. Locally, this means that at any one time there are dozens of Hampshire residents receiving care miles from their homes, loved ones and support networks. This has a detrimental effect on our patients, and is also very costly to find and fund 'out of area' placements when our own beds are full.

Clearly, this situation is entirely unacceptable and requires urgent and ongoing action. As a local provider of mental health services, improving access to care closer to home is one of our most pressing priorities. It is also a priority for the Hampshire and Isle of Wight Sustainability and Transformation Partnership (STP).

The root causes of the problem are many and complex:

- An increase in demand for acute mental health care (more patients, greater acuity, longer stays)
- Limited investment in mental health services - especially community-based crisis care/prevention
- Historical reductions in acute mental health beds - Hampshire is below the national average for population size (14 beds, compared to 19 beds, per 100,000)
- Limited alternatives to admission, such as crisis lounges and day treatment models
- Challenges associated with timely discharge from hospital to the community (e.g. availability of housing or supported accommodation)
- Systems and processes, which have limited our staff's ability to deliver the best care.

Unfortunately, there are no simple fixes, and the solution lies across multiple areas of work. In response, we have undertaken a number of initiatives, including:

- Establishing a Crisis Lounge in Southampton and Day Treatment Programme in Fareham and Gosport, to provide alternatives to hospital admission

- Placing mental health nurses in the NHS 111 call centre to triage and provide appropriate care and response to anyone in Hampshire and the Isle of Wight - 24 hours a day, 7 days a week
- Working with Solent NHS Trust to develop an improved community crisis care response in Portsmouth and South East Hampshire
- Working with local authorities and housing providers to unblock issues regarding delays to discharge and to also introduce alternative accommodation for people in crisis
- Making use of local private sector beds and those of partner NHS trusts
- Appointing staff with lived experience of mental health problems to ensure we are listening to, and learning from, people using our services.

We have also placed bids to access additional national funding to develop better crisis care and mental health in-reach in local acute hospitals (e.g. improved psychiatric liaison in A&E departments).

Divisional Bed Model

Most recently, we have made some internal changes to how our Trust manages adult mental health beds. We have moved from a centralised model to a new 'divisional bed model' aligned to our four geographical divisions - North and Mid Hampshire, South West Hampshire, East Hampshire and Southampton. This is to ensure all aspects of a patient's care, from the community to hospital, is managed by local care teams, reducing the fragmentation of care and enabling closer working between community and hospital teams. This model has been used before successfully – and has reduced the need for local people to receive care outside Hampshire.

In order to enable this new model to work, we have taken the difficult decision to focus on current patients in Hampshire rather than the repatriation of patients currently out of area. It also means that in some circumstances, in the short term, it will be necessary for some local patients to receive care out of area rather than impacting on another division's bed management. However we are confident that, in time, this new approach will result in fewer out of area placements and better access to the most appropriate care for people.

An Increase in Beds

Despite all these initiatives, we acknowledge that we currently do not have sufficient beds in Hampshire to meet demand. That is why we are now proposing to change the location of some of our mental health beds and open additional ones. These plans will help the new divisional approach to bed management work effectively, as well as moving us towards a needs-led, rather than age-led, approach to mental health inpatient care.

The proposals involve:

- Moving the Crisis Lounge, currently at Southampton's Antelope House (in part of the unit called Abbey Ward), into a community setting in the city - something patients have told us they'd prefer.
- Moving Berrywood Ward from the Western Hospital in Southampton into Abbey Ward. This would then become a 13-14-bed specialist mental health ward for patients with frailty.

- Moving Stefano Olivieri Ward from Melbury Lodge in Winchester into the 18-bed space vacated by Berrywood Ward at Western Hospital, following a full refurbishment.
- Using the space vacated by the Stefano Olivieri Ward in Winchester to create 12-14 new beds for adult patients with acute mental health needs. (This substantial increase in adult mental health beds would result in one or two fewer beds overall for older people's mental health, where capacity currently exists).

Please note that we are in the early stages of these proposals and some of the detail is subject to change. We are committed to involving our staff, patients and wider stakeholders in these planned changes in the coming months, so they feel fully informed and able to support the proposals. Needless to say, we would carry out any agreed changes with sensitivity and the minimum of disruption to patients.

If you would like further detail, or have any questions about this work, please do not hesitate to get in touch. We would also be delighted to arrange a visit to any of our services, should you find that helpful. My contact details are below.

Yours sincerely,

Dr Nick Broughton FRCPsych
Chief Executive Officer

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Agenda Item 9

healthwatch Portsmouth

2019 – Spring and Summer activity

- Re-start of Healthwatch Portsmouth Service
  - re-engaging staff with new host organisation, Help and Care
  - publicising our re-start in new location with new contact details
  - re-engaging with Healthwatch Portsmouth volunteers
  - registering of our volunteers with new host organisation
- Re-start of Independent Health Complaints Advocacy Service
  - inc. seeking permission from clients, previously supported by the service while hosted by Learning Links, for the new host organisation to hold their personal details, in accordance with General Data Protection Regulations
- Healthwatch Portsmouth Annual Report 2018-19 : highlights include:
  - we spoke with 530 people at our stalls at 30 community events
  - 4,443 people accessed our information and advice online
  - We visited 13 health and care facilities across the city
  - We increased (by 97%) to 1,329,859 our online reach via our website and social media

Community Engagement work

- Stalls at 30 community or health service events
- Involvement in health service plan discussions:
  - Dental services in Portsmouth – sudden closure of 3 surgeries
  - Dental services Re-procurement process for Alton, Tadley, Portsmouth
  - Special Care Dentistry (adults), Paediatric Dental Service
  - HIOW Voices – we have been trying to find out how to become involved on the new online feedback forum
  - Raised concerns about disabled parking, access to/signage at St Mary's
  - Changes to the services offered at Jubilee House
  - Podiatry service review
  - Provision of Support for Adult Carers (NICE)
  - Healthwatch comments and recommendations made during our 'Third Walk Thru' at QA Hospital

Plans for September - March

- Remainder of Healthwatch community research with patients in GP surgeries to find out awareness of Enhanced Access Service at Lake Road
- Patient Led Assessment of the Care Environment visits to QA Hospital, St Mary's Hospital, St Mary's Treatment Centre, Spire Portsmouth
- Testing of the new Urgent and Emergency Care Standards at QA Hospital, part of national pilot programme
- Volunteer refresher training on Enter and View
- Fourth Walk Thru of Emergency Department at QA Hospital in spring '20
- Issues raised with service managers in connection to advocacy service work to support clients wishing to complain about NHS service they received

Thank you for listening, any questions

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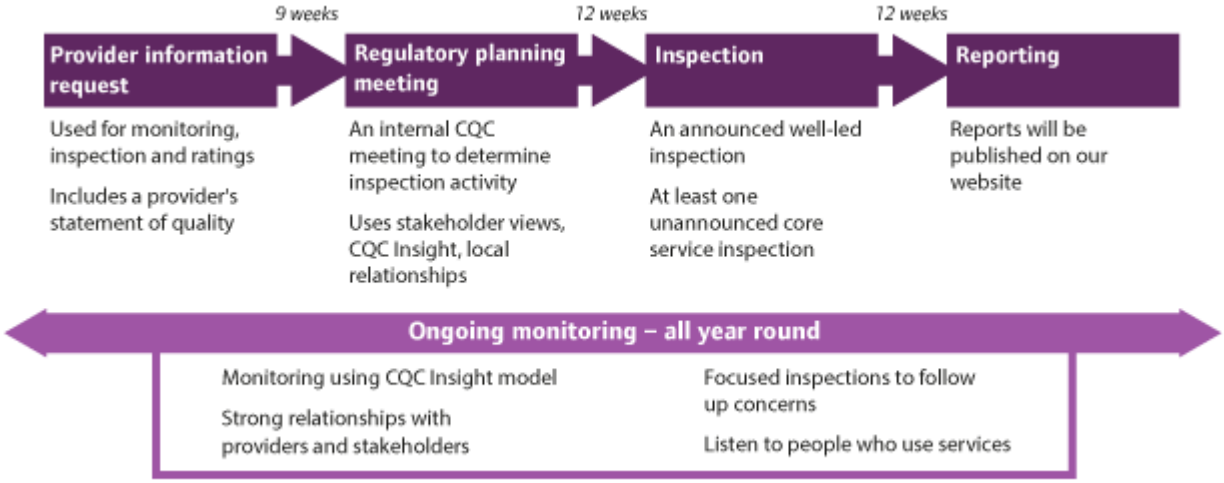
This diagram below shows how our ongoing monitoring and inspections work for NHS trusts.



Last updated:
05 April 2019

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Proposed St Mary's Community Health Campus Podiatry Hub

Summary

Solent NHS Trust believes that high quality care, delivered in the right environment, is of the utmost importance.

This paper seeks to outline a proposal for consolidating a number of podiatry delivery sites within Portsmouth, into a single location at St Mary's Community Health Campus (CHC) in Portsmouth which brings with it benefits for patients and employees.

A number of changes are being made to the NHS footprint in Portsmouth, not least the decision by NHS Property Services to sell areas of the St James' Hospital site, including the Turner Centre, where Solent currently provides a substantial Podiatry clinic.

In addition to this, Solent was the beneficiary of a £10.3M award by the Sustainability Transformation Partnership (STP) to redevelop and refurbish Block B and Block C on the St Mary's Community Health Campus, along with infrastructure works at the St James' site.
With the substantial reinvestment into our estate, Solent is presented with the unique opportunity to re-shape the delivery of key services to the benefit of its patients.

This document provides an outline of the proposed creation of a centralised specialist Podiatry Hub. The Hub design would see all five locations currently operational, brought into one hub on the main St Mary's CHC site.

Introduction

The Solent NHS Trust Podiatry Team currently provides services to people living in Portsmouth from five sites within the city:

- Cosham Health Centre
- Eastney Health Centre
- Lake Road Health Centre
- The Turner Centre, St James' Hospital (given notice by the owners, NHS Property Services, to leave the building by October 2019)
- Paulsgrove Healthy Living Centre

People who use the service include those with moderate and high risk diabetes patients and high risk non-diabetes patients e.g. vascular patients.

For patients who are house or bed bound the service provides home visits, along with the support of community nursing, who provide the majority of their care.

The service also offers nail surgery for patients 10 years of age and over and assessment and a treatment plan for patients with foot deformity and/or pain from the age of 10 to 17.

The STP funding for the Phase 2 investment affords the Trust the unique opportunity to develop a 14 chair clinical site for the delivery of our specialist Podiatry service, with significant positive implications for service users and employees.

This would mean relocating the clinics, outlined above, to the new St. Mary's CHC Hub. The relocations would begin from the end of October 2019.

Case for change

Patients seen by the service can have complex needs and require easily accessible, fit for purpose, clinical environments in which to be seen. Providing accessible care to patients, and an excellent environment in which people work, is really important to the delivery of excellent podiatry care and to attract Podiatry professionals.

The current buildings, in which Podiatry services are provided, are out of date, not fit for purpose and do not provide a suitable training environment for the creation of a future workforce.

In addition, the service faces the challenge to increase capacity, provide safe, timely and effective care for patients, in line with NICE Clinical Guideline (NG19) for the management and prevention of foot problems for patients with diabetes.

The service has already attempted to make changes to improve by developing an action plan and, where possible, implementing multi-chair clinics to support employees. These changes, however, are a temporary measure.

Benefits of the proposal to create a centralised Podiatry Hub

Due to the recent £8.3m investment into Block B at St Mary's Community Health campus, the Trust is now able to provide its own purpose built rooms, offering a safe, clean and modern environment for patients and employees.

The creation of a 'one-stop shop', with up to 14 chairs in use at any one time, with varied mixed skill onsite, offers a number of opportunities, including:

- Reduced number of cancelled appointments and an opportunity to review moving to extended opening hours to suit patient needs.

- Multi-disciplinary (MDT) clinics, working alongside colleagues and services, such as Diabetes and Vascular services.
- Direct access to medications that Podiatrists can prescribe through Patient Group Directions (PGDs), on site X-rays for timely management of infection.
- Appropriately trained clinicians, with a diverted prescribing budget, will have the opportunity to prescribe antibiotics, reducing the burden on GP prescribing and reducing the risk of hospital admissions and amputations from infection.
- Improved links and referrals to related services including: Vascular, Diabetes, Dermatology and Phlebotomy.
- Utilising our Apprenticeship programme, to bring in new people to the field.

The Trust believes that by reviewing the skills mix, including investing in Band 3s, there is an opportunity to create a healthy and sustained recruitment and retention drive, which could run counter to the national picture through the use of apprenticeships.

In addition, by employing a mixed skill and specialist treatment option all on one site, Solent will create a Specialist Podiatry 'one-stop shop' that will enable patients to be seen for a multitude of injuries and issues, such as musculoskeletal, wound care and nail surgery. This would reduce travel time and appointment waiting times for patients.

Employee annual leave and sickness cover would be firmly in place, ensuring service continuity.

There would be no risk to employees through lone worker arrangements and there are many wellbeing factors, including a newly refurbished public and employee restaurant, which offers healthy and affordable meals.

Communication and engagement

A thorough communications and engagement programme is planned.

The main aim of this plan is to ensure we:

- Communicate and engage effectively with all patients, their families and carers, to ensure we capture their concerns and inform them of the potential of this project.
- Communicate and engage effectively with our people, to ensure we remove concerns around the proposed changes and inform them of the potential benefits for service users and for them, working as part of a larger team, in one location.

- Communicate with key stakeholders in advance of any changes and throughout the process, ensuring a clear and transparent process that will lead to improved conditions and outcomes for our service users and our people.

Key stakeholders:

Commissioners

Solent NHS Trust will be asking Portsmouth CCG for assistance with the move of these services to the new centralised hub

Patients and families

Following any approval for this proposal, the intention is to engage with service users and their families, to reduce anxiety and to show we are listening to their concerns by offering solutions, where possible. The major concerns for our patients will be changing the location and therefore the familiarity and a potential increase in transport costs and parking charges.

Both of these concerns, along with any other concerns, will be addressed directly, to reassure and inform.

Employee/clinicians

Our people are our biggest asset. To ensure that they are able to deliver the best care and work in a healthy environment, we have taken on board their thoughts. Following any acceptance of the proposals in this document, we will consult effectively and engage with our teams to ensure the best possible outcomes for them.

It is anticipated that the creation of the Hub would be the best possible outcome for our people, as it will reduce work based stress and increase support, in a modern and effective clinical environment.

HOSP (Portsmouth)

We would provide regular updates to HOSP on any service move or change and the outcomes for service users and our people.

Healthwatch (Portsmouth; Southampton and Hampshire)

We will share these proposals with Healthwatch Portsmouth and ask for their input into the proposals and to our communication and engagement plans.

Other communications channels

We will also share information around the proposed changes through a range of channels including:

- Press releases and briefings to local media
- Solent NHS Trust and Portsmouth City Council's websites.
- Letters to GPs and other health and social care partners.

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