Portsmouth CITY COUNCIL

NOTICE OF MEETING

CABINET MEMBER FOR HEALTH, WELLBEING & SOCIAL CARE

TUESDAY, 2 JULY 2019 AT 10AM

THE EXECUTIVE MEETING ROOM - THIRD FLOOR, THE GUILDHALL

Telephone enquiries to 023 9283 4060
Email: jane.didino@portsmouthcc.gov.uk

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

Membership

Cabinet Member for Heatlh, Wellbeing & Social Care
Councillor Matthew Winnington (Cabinet Member)

Group Spokespersons
Councillor Graham Heaney
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

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

A G E N D A

1 **Apologies for Absence.**

2 **Declarations of Members' Interests.**

3 **Public Health aspects of the Portsmouth Health and Care Operating Model** (Pages 5 - 8)

Purpose.
To provide an overview of progress, opportunities and next steps for public health functions within the emerging Health and Care Portsmouth operating model.

RECOMMENDED that the Cabinet Member for Health, Wellbeing & Social Care note the report.

4 Adoption of Residential Care and Ethical Care Charters by Portsmouth City Council (Pages 9 - 28)

Purpose.
The Ethical Care Charter was first proposed for adoption to the Council in July 2015 by Cllr Gerald Vernon-Jackson & Cllr Lynne Stagg. Since the Liberal Democrat administration of the Council commenced in May 2018, the commitment to implement the Ethical Care Charter became Council policy.

This report also has regard to the motion passed by full Council in March 2019 requesting that the Cabinet implement the Unison Ethical Care and Residential Care Charters and work with providers to pursue a shared objective of achieving the provisions of the Charters. This was after meetings between Unison and the Health, Wellbeing & Social Care Cabinet Member in Autumn 2018.

Links are provided to the Charters below:

http://www.savecarenow.org.uk/ethical-care-charter
http://www.savecarenow.org.uk/residential-care-charter

This report will set out the current practice in relation to the charters, any highlights areas for improvements as well as the plans to address these; as well as recommending that the Council works with providers to pursue the shared objective of achieving the provisions of the Charters.

RECOMMENDED that the Cabinet Member for Health, Wellbeing & Social Care agree to adopt the principles of the Ethical Care and Residential Care Charters within PCC Adult Social Care and requests officers engage with care providers in Portsmouth, to share the Charters and explore how providers can align with those principles across the Portsmouth care market.

5 Section 75 Agreement for Mental Health Services (Pages 29 - 32)

Purpose.
To seek approval of the Cabinet Member for Health, Wellbeing & Social Care to extend the section 75 agreement for the Integrated Adult Mental Health Service.

RECOMMENDED that the Cabinet Member for Health, Wellbeing & Social Care agree to the extension of the current AMH s75 agreement for a period of thee years until 1 July 2022.

Members of the public are permitted to use both audio visual recording devices and social media during this meeting, on the understanding that it neither disrupts the meeting nor 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.

Whilst every effort will be made to webcast this meeting, should technical or other difficulties occur, the meeting will continue without being webcast via the council's website.

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Portsmouth CITY COUNCIL

Title of meeting:	Cabinet Member for Health, Wellbeing & Social Care Decision Meeting
Subject:	Public Health aspects of the Portsmouth Health and Care Operating Model
Date of meeting:	2nd July 2019
Report by:	Director of Public Health
Wards affected:	All

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1. Requested by

1.1 Councillor Winnington, Cabinet Member for Health, Wellbeing and Social Care

2. Purpose

2.1 To provide an overview of progress, opportunities, and next steps for public health functions within the emerging Health and Care Portsmouth operating model.

3. Information Requested

3.1 Background

3.1.1 The agreed direction of a single operating model for Health and Care Portsmouth will form a unified leadership and delivery structure between Portsmouth City Council and NHS Portsmouth CCG, building upon current sound collaborative working.

3.1.2 The first phase of this arrangement includes the Director of Public Health becoming a joint role between Portsmouth City Council (PCC) and NHS Portsmouth Clinical Commissioning Group (PCCG), overseeing arrangements for statutory functions in respect to public health, as well as the commissioning and direct delivery of public health services.

Progress to date

3.2 Governance arrangements

3.2.1 In Autumn 2018, the Portsmouth Health and Wellbeing Board agreed proposals to revise its remit, enabling it to support the proposed Health and Care Portsmouth operating model. A subgroup of the Board, the Health and Care Portsmouth Commissioning Committee, met for the first time in April 2019 where priorities were considered including the need to use the Joint Strategic Needs Assessment to inform decision making.

3.2.2 These new arrangements will provide opportunities for improved co-ordination and collaboration of interdependent services as well as planning and decision making. This is of particular relevance to public health where there is natural alignment between responsibilities of PCC and PCCG.

3.3 Healthy Child Programme commissioning arrangements

3.3.1 Currently commissioning responsibility for the Healthy Child Programme is delegated to the Director of Children's and Families. This includes delivery of mandated public health functions within this programme. Under the new arrangements, NHS Portsmouth CCG children's functions will also be within the remit of the Director of Children's and Families.

3.3.2 Commissioning arrangements securing on-going provision of the Healthy Child Programme are currently being developed and will feed into the Health and Care Portsmouth Commissioning Committee, alongside wider 0-19 functions.

3.4 Enhancing information and intelligence functions

3.4.1 Strengthening information and intelligence functions will be a crucial enabler for informed decision making within the future operating model for Health and Care Portsmouth. The current small resource within Public Health works to comprehensively assess and understand population needs and assets within the local population.

3.4.2 A shared vision for Health and Care Portsmouth is to create capacity and capability to collate meaningful information, synthesise these data into intelligence and to present this as engaging and accessible products used to inform decision making.

3.4.3 Enhancing intelligence functions is underway. A restructure of the public health intelligence function has taken place through close working with current staff and Human Resources colleagues. Recruitment is in progress to provide a small amount of additional analytical capacity as well as a strategic lead for intelligence role. This strategic role will aim to work with colleagues across the local system to develop greater co-ordination of intelligence under the remit of Health and Care Portsmouth.

3.4.4 A benefit of strengthening intelligence functions will be to formulate a single picture of health and wellbeing needs and assets of the Portsmouth population. With increasing use of the Health and Care Portsmouth website, hosting the Joint Strategic Needs Assessment on this domain is an opportunity to explore for the future.

3.4.5 Once established, this function will need to develop its role and ways of working - guided by perspectives of a range of colleagues along the way. The intelligence function will need to inform commissioning and strategic decision making and make the link with wider determinants of health. This will need to be accompanied by a better understanding of available evidence about effectiveness of proposed interventions.

3.4.6 Portsmouth will benefit from some strands of intelligence work being progressed at Portsmouth and South East Hampshire Integrated Care Partnership level and at the Hampshire and Isle of Wight Integrated Care System level - particularly through the Population Health Management work programmes. The Director of Public Health is playing a key role in driving these programmes forward.

Further opportunities within public health related functions

3.5 Integration of planning, prioritisation and leadership of commissioned services

3.5.1 The Health and Care Portsmouth operating model aligns with delivery of the NHS Long Term Plan through delivering ‘triple integration’ of primary and specialist care, physical and mental health services, and health with social care.

3.5.2 Related to these aims, there are several interdependencies between services commissioned by Public Health and those commissioned by PCCG. Currently PCCG and PCC work collaboratively to mitigate any unintended consequences of decisions made within their respective, separate functions. There is appetite and opportunity under the single Health and Care Portsmouth model to deliver an integrated approach to care, overcoming current divisions in responsibilities for the benefit of local residents.

3.5.3 These areas include further integration of:

- *Public Health sexual health promotion, contraception, psychosexual counselling and sexually transmitted infection services alongside CCG termination of pregnancy and vasectomy services.* Services are delivered via a single point of access, however, there is opportunity to bring commissioning of these areas closer together. This would include relevant GP and community pharmacy locally commissioned services e.g. provision of long acting contraception (LARC) and emergency contraception. (HIV services are commissioned by NHS England Specialist Commissioning)

- *Public Health drug and alcohol services and preventative mental health planning (suicide prevention) alongside CCG adult mental health and hepatology services*

- *Further areas may include integrating health improvement* (weight management, smoking cessation services) and cardiovascular disease prevention (NHS HealthChecks) alongside maternity commissioning and diabetes prevention programmes enabling greater focus on reducing inequalities in outcomes

3.5.4 Beyond services directly commissioned or provided within its remit, Public Health is able to contribute to decisions about wider service planning and delivery. As well as planning needed at City level, announced by the NHS Long Term Plan, Primary Care Networks (groups of GP practices based on populations of 30,000 to 50,000), are expected to make decisions about how services are best configured for their population. This is an example of where intelligence and wider public health skills such as population needs assessment and appraising evidence may be useful resources to draw upon as Primary Care Networks develop.

3.5.5 It is useful to note that some areas of public health commissioning are NHS England responsibilities such as screening and immunisation programmes. Here, integration will enable greater co-ordination of local initiatives to understand variation in, and encourage, uptake.

3.5.6 There are opportunities to develop closer working arrangements in relation to specialist functions such as Emergency Planning, Resilience and Response, and in local health protection arrangements such as outbreak control.

3.5.7 Facilitating and enhancing joint working between wider PCC and PCCG functions to improve population health and wellbeing is a further opportunity. This may be in exploring how integration can deliver improvements for specific population groups such as healthcare provision for individuals who are homeless or in advocating for the determinants of health to be considered and embedded across relevant areas of PCCG work - for example in considering contributions to improving air quality, or in working collaboratively with colleagues in housing, leisure, communities, education, economic development, transport and planning.

3.6 Proposed next steps

3.6.1 Work towards creating an integrated Director of Public Health role between PCCG and PCC to support the Health and Care Portsmouth operating model

3.6.2 Review existing capacity delivering functions identified in section 4 and establish an operating model reporting to the Director of Public Health aligned to these roles and functions

3.6.3 Continue to strengthen intelligence functions including to further define how it intelligence can best support the Health and Care Portsmouth operating model

3.6.4 Explore potential for the Health and Care Portsmouth website to host the Joint Strategic Needs Assessment

3.6.5 Continue to support appropriate use of the public health grant for Health and Care Portsmouth activities to improve population health and wellbeing and reduce inequalities

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Signed by Dr Jason Horsley, Director of Public Health

Appendices:

None

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

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

Title of document	Location

Portsmouth CITY COUNCIL

Title of meeting:	Cabinet Member for Health, Wellbeing & Social Care
Date of meeting:	2 July 2019
Subject:	Adoption of Residential Care and Ethical Care Charters by Portsmouth City Council.
Report by:	Chief of Health & Care Portsmouth
Written by:	Assistant Director, Adult Social Care.
Wards affected:	All
Key decision:	No
Full Council decision:	No

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1. Purpose of report

The Ethical Care Charter was first proposed for adoption to the Council in July 2015 by Cllr Gerald Vernon-Jackson & Cllr Lynne Stagg. Since the Liberal Democrat administration of the Council commenced in May 2018, the commitment to implement the Ethical Care Charter became Council policy.

This report also has regard to the motion passed by full Council in March 2019 requesting that the Cabinet implement the Unison Ethical Care and Residential Care Charters and work with providers to pursue a shared objective of achieving the provisions of the Charters. This was after meetings between Unison and the Health, Wellbeing & Social Care Cabinet Member in Autumn 2018.
Links are provided to the Charters below:
http://www.savecarenow.org.uk/ethical-care-charter
http://www.savecarenow.org.uk/residential-care-charter

This report will set out the current practice in relation to the charters, any highlights areas for improvements as well as the plans to address these; as well as recommending that the Council works with providers to pursue the shared objective of achieving the provisions of the Charters.

1.1. Context

In order to provide a social care service that meets the needs of Portsmouth residents, meets the Council's statutory duties and manages the demands of increasing needs and costs, Adult Social Care (ASC) has been developing a service wide strategy covering changes in the way we work from 2018/19 to 2020/21. Implementing the ASC Strategy will achieve outcomes for residents and work toward financial balance. By 2022, our aim is that ASC in Portsmouth will be:

- Delivering services that have technology at the heart of the care and support offer;
- Working in way that recognises the strengths that people have, and have access to in their networks and communities - and draws on these to meet their needs;
- Working efficiently and responsively, using a reablement approach centred around the needs of the customers;
- Delivered through a market based on individual services to people that meet their needs and help them achieve the outcomes they want to achieve and keep them safe;
- Delivered, (where appropriate) through PCC residential services in one service area to enable quality and maximum effectiveness.

This strategy will enable ASC to be financially stable and sustainable.

1.2. These outcomes align to the priorities in the 'Blueprint for health & care in Portsmouth' published in 2015:

- Improve the range of services people can access to maintain their independence
- Give people more control, choice and flexibility over the support they receive
- Do away with multiple assessments and bring services together in the community
- Bring together services for children, adults and older people where there is a commonality of provision, including a family centred approach
- Create better resources and opportunities for vulnerable people and their carers.

1.3. ASC is an increasingly high profile area of local authority business. There is an acknowledgement at a national level that social care is under increasing pressure for a variety of reasons including an increasing demand to support people with more complex needs in their own homes. More broadly, the care market is also under pressure resulting from increasing costs of employment for providers of social care services that the council contracts with, due to rises in the National Living Wage and increases in 'auto-enrolment' pension contributions. For the NHS to be able to care for people's health, it is critical that social care is able to meet the needs of citizens.

2. The Charters

The following pages contain information relating to the Charters and the progress made by ASC in implementing the principles and the areas for improvement. This is then followed by a recommendation to the Cabinet Member for Health, Wellbeing & Social Care.

Portsmouth CITY COUNCIL

Comparison of UNISON Ethical Care Charter against Current Practice

Criteria	Current Practice	Gap/Impact
Stage One		
Commissioning of visits to be based on client need not minutes or tasks	Commissioning of care starts with an assessment of the customer's needs, goals and wishes. Once we know what support is required to support the person to be able to live the life they want, a discussion takes place regarding how the support could be delivered most appropriately - through existing circles of support, the voluntary sector or through a registered care provider. If a care provider is selected, the details of the customer and outcomes needing to be achieved / met and an indication of the time likely to be required are passed to the provider. The provider meets with the person to make their own assessment and the care plan will be finalised.	Most ASC domiciliary care is delivered based on time purchased. In order to move from 'time & task' to more personalised support, the 'systems thinking' intervention, (commissioned in 2018) is in the 'redesign' phase. This involves working with a cohort of people and, designing a prototype system which includes 1) Real-time digital care records available to the Care Coordinator, Social Worker, applicable family members, and anyone else who needs access. 2) Scheduling care based on the actual time needed by the client, rather than pre-planned multiples. 3) Increasing/decreasing the length of care call based on need. 4) Chargeable clients being billed on the basis of the actual minutes they received.

Criteria	Current Practice	Gap/Impact
		The aim of the intervention is to produce a service model that is more person-centred and offers the greatest value to the Council.
Time allocated will match need of clients. In general 15 minute visits will not be made	Social Care policy is not to commission care in multiples less than 30mins where personal care is required. Fifteen minute visits are generally 'pop-in' welfare checks. There are always exceptions to the rule but the guidance to staff commissioning services is that a fifteen minute visit is only acceptable if customer and provider agree the task can be managed within this timeframe.	The domiciliary care intervention will indicate the commissioning model for care and support which is likely to move away from blocks of time.
Homecare workers to be paid travel time, travel costs and other necessary expenses e.g. mobile phones	Adult Social Care has developed a cost matrix which sets a base line for the hourly rate set for home care. This included all associated costs including cost of regulation requirements, costs of travel and 'non-contact' time. Since then, the rate has increased annually, recognising the increasing provider costs. ASC contracts state that travel time must be included between care calls in accordance with national best practice and the requirements of the CQC and Inland Revenue.	
Visits to be scheduled so that workers are not forced to rush their time with clients or leave to get to next client on time	Our providers are required to meet the customers' needs in a dignified and caring manner. Customer complaints are monitored to address areas of concerns with providers and	The domiciliary care intervention will lead to more effective measurements being put in place which should provide clearer data on clients call times and whether carers' are completing calls to client

Criteria	Current Practice	Gap/Impact
	contracts officers consider performance with providers on a regular basis. Where demand is high and capacity low, there are times when providers will need to carry out proportionate visits to their customers with appropriate safeguards in place but customers are informed first and commissioners involved to support with additional requirements.	preferences. The use of an electronic monitoring would also assist. If these two measures can be used, PCC may be able to manage without additional staff resource.
Workers who are eligible get paid SSP	Our providers are required to comply with all statutory requirements in terms of employment. PCC employees will receive Occupational Sick pay, casuals and temps will receive SSP in accordance with whether they qualify dependent on earnings, length of service and National Insurance contributions.	
Stage 2		
Clients to be allocated same homecare worker wherever possible	Our providers are encouraged to facilitate this where possible but due to the working practices of individuals (part time, term time only, working at different times of the day, the amount of customers in one area, etc.) it is not always possible for the customers to have the same person each time. However, continuity of carer is a priority and when there are changes required, providers are required to advise their customers accordingly.	Providers have worked to maintain a regular number of carers in areas where this is possible. The domiciliary care intervention, (currently underway) is considering this aspect of care support. Further research around where this has been achieved and the measures that help this will be undertaken with providers.

Criteria	Current Practice	Gap/Impact
Zero hours contracts not to be used in place of permanent contracts	Regular work in the area with providers and their staff shows a mixed picture in that some staff opt for zero hour contracts rather than being obliged to accept them. Three of the four main providers expressed that their staff would prefer to be on fixed hour contracts as their hours can fluctuate from week to week. 1 provider stated that the carers' prefer the flexibility of zero hours' contracts. PCC do not use zero hours contracts, we use temps or casual staff in addition to permanent staff.	If PCC were to insist on minimum hour contracts it is likely that the flexibility of the service would reduce, the workforce would reduce through a decline in staff acceptance of the terms, an increase in 'downtime' (not value for money) and increased costs through having to pay more to attract a different workforce into health and care.
Providers to have a clear and accountable procedure for following up staff concerns about their clients wellbeing	For PCC managed care homes supervision arrangements, (both formal and informal) enable an opportunity to raise any concerns up to and including 'whistleblowing'. CQC inspection takes account of how staff are led in registered services and therefore assure appropriate mechanisms through inspection. In addition, the quality team support providers to consider compliance with good practice and standards. Where concerns amount to safeguarding, PCC requires all providers to adhere to the pan regional safeguarding policy as well as incorporating it within their own policies.	
All homecare workers to be regularly trained to the necessary	Training is a requirement of our contracts with providers.	

Criteria	Current Practice	Gap/Impact
standard to provide good service at no cost to themselves and within work time.	Training is expected to be provided and paid for by providers within work time through the funding level set within our hourly rate. Some training is made available to the wider sector through PCC.	
Homecare workers will be given the opportunity to regularly meet co-workers to share best practice and limit their isolation.	Supervision is a requirement of the regulator and many providers provide this both as 121 to discuss specific cases or as group supervision.	
Stage 3		
All homecare workers to be paid at least the Living Wage or where outsourced the provider is required to pay this and funded to pay it.	The rate set by Social Care in conjunction with providers is based upon the NLW and there is a requirement to pay NLW to employees. Many providers may pay higher than this in order to attract and retain staff. All eligible PCC staff, irrespective of age are paid £9.00 an hour, this includes casual staff and agency staff contracted to PCC.	
All homecare workers to be covered by an occupational sick pay scheme so they are not pressurised to work when ill in order to protect the welfare of vulnerable client	Providers have policies and procedures in place regarding managing sickness which protects them and their customers. The details regarding pay, other than statutory requirements, have not been ascertained, however from speaking with a number of providers, our understanding is that if a valid	

Criteria	Current Practice	Gap/Impact
	sick note is provided then the workers are paid in full. Permanent PCC staff receive occupational sick pay in accordance with the NJC terms and conditions of employment.	

Comparison of UNISON Residential Care Charter against current practice

Criteria	Current Practice	Gap/Impact
Protecting and Supporting Residents		
Employers will maintain adequate staffing ratios that enable quality care to be delivered. This must be care that extends beyond basic tasks and includes a social dimension.	This is current custom and practice which falls within regulatory scrutiny, which is the responsibility of the Care Quality Commission. Adult Social Care is notified where care falls below standard by CQC and act upon this information. ASC and the Clinical Commissioning Group have commissioned a quality team working within Portsmouth. The team's general role is to work with care home providers and support them to provide appropriate care and support. Within PCC owned and managed care homes, the 'turn around team' was commissioned in 2018 to work with managers to implement better practice standards and staffing was reviewed to ensure adequate staffing ratios.	

Criteria	Current Practice	Gap/Impact
Care workers, residents and families must be given information about how to raise concerns and protection if they decide it is necessary Employers will have clear and accountable procedures to follow up any concerns raised	Within PCC owned and managed care homes, staff are able to raise concerns through the supervision, (formal and informal) process with line managers. Residents can raise any concerns through the keyworker mechanism in place and families and visiting professionals are able to raise any concerns through staff on duty or discussions with the Unit Manager. A governance framework is followed regarding concerns via safeguarding / CQC / PCC complaints team. This will be the same within non-PCC managed homes and will be scrutinised by CQC. The ASC/CCG quality team regularly review these arrangements with providers they work with.	
Care home providers will ensure all residents have ready access to any NHS services required	There are good relationships with NHS services and staff within the city, appropriate referrals are made as per PCC guidance for PCC managed homes The 'care home team' commissioned through Solent NHS Trust work with care home providers in Portsmouth and act as a gateway to ensure that residents have access to NHS services.	

Criteria	Current Practice	Gap/Impact
Providers will carry out thorough risk assessments to ensure the safety of residents and care workers	All points in the protecting and supporting residents section are adhered to with clear guidance and procedures.	
Employers will provide care workers with safe equipment	All points in the protecting and supporting residents section are adhered to with clear guidance and procedures.	
Care workers will be given time to provide regular activities and effective forms of therapy for residents	Care workers are expected to be given time to meet the needs of the residents based upon their care plans.	
Training and support for employees		
All care workers - including bank and relief staff will be regularly trained to meet the needs of all residents as set out in their care plans.	This is a current expectation. The nominated individual in any organisation is responsible for ensuring that staff are trained to expectations and requirements as per the regulations.	
Training requirements will be met. Training must be met and carried out in work time, so cover staff must be arranged	Comprehensive induction and training is provided to in-house residential staff. Mixture of standard and/or bespoke off-site, in-house, e-learning and DVD training is used. Training is made available through the Local Authority to non-PCC managed care homes and will be monitored via regulation inspection.	
DVD and e-learning will be used to complement high quality and face to face training.	As above	
Decent Pay for Quality Work		

Criteria	Current Practice	Gap/Impact
All residential care workers will be paid at least the Foundation living wage	There is a requirement to pay the National Living Wage. All eligible PCC staff, irrespective of age are paid £9.00 an hour, this includes casual staff and agency staff contracted to PCC.	
Councils which outsource employees on or above the Living wage should ensure that the new providers are required to maintain pay levels throughout the contract.	This would be covered under Regulation 13 of the TUPE Regulations as part of any TUPE transfer and is incorporated into PCC Procurement processes.	
Councils which outsource employees on or above the Living wage should ensure that the new providers are required to maintain pay levels throughout the contract.	This would be covered under Regulation 13 of the TUPE Regulations as part of any TUPE transfer and is incorporated into PCC Procurement processes.	
Extra payment will be made for working un-social hours, including weekends and Bank Holidays	As care is a 24/7, 365 days per year business there are less enhancements required for working outside of traditional office hours. Where such payments are necessary to attract staff to shifts are generally special holidays such as Easter and Christmas. PCC staff receive a shift allowance of either 7% 17% or 33% dependent on hours or days/nights worked following LPR.	

Criteria	Current Practice	Gap/Impact
	The majority of providers pay an enhanced weekend rate, 1.5 time at bank holidays and 2 time Christmas and New Year.	
Pay for Sleep ins must be at a level to ensure that the average hourly rate does not drop below the Living Wage	PCC legal services have been advising contract and commissioning staff on this matter for some time. Whilst we are committed to ensure the NLW is paid to staff, what constitutes working hours and non-working hours in regards to sleep-in is still under review. Varied judgements have emerged following a Department for Work & Pensions case in 2017, however, the current situation is that an hourly rate is not required. Any sleep in amounts paid to PCC permanent employees, are paid at the minimum rate of £9.00 per hour.	
Holiday periods must be paid as if at work	Pay arrangements and complying with statutory duties are the responsibility of the provider. Permanent PCC employees receive their normal pay during holiday periods.	
All care workers must be paid occupational sick pay	Permanent employees are paid occupational sick pay. Casuals or temp staff would be paid in accordance with their eligibility for SSP.	
Employers will pay for DBS checks	PCC complete and pay for DBS checks for PCC staff.	Residential Care providers in the city pay for this.

3. Recommendation

The Cabinet Member for Health, Wellbeing & Social Care agrees to adopt the principles of the Ethical Care and Residential Care Charters within PCC Adult Social Care and requests officers engage with care providers in Portsmouth, to share the Charters and explore how providers can align with those principles across the Portsmouth care market.

4. Equality impact assessment

A preliminary EIA has been completed and a full EIA is not required as the decision will have no negative impact on the protected characteristics.

8. Legal implications

8.1 Whilst the specific adoption of the Charters is not a mandatory requirement for the Council, these represent UNISON's recommendations for best practice in the field of social care in the interests of social care clients and care workers.

9. Finance comments

9.1. The table on the previous pages sets out the progress made by Adult Social Care (ASC) in implementing the principles of the Unison Ethical Care and Residential Care Charters.

9.2. As highlighted within the table, current practice within ASC is closely aligned with the principles of both charters. The aim of the current domiciliary intervention is to produce a service model that is more person-centred and moves away from the current models of care allocated in blocks of time. Further financial analysis is required following the outcome and recommendations from this intervention.

9.3. The recommendations within the report also seek that officers engage with care providers in Portsmouth, to share the Charters and explore how providers can align with those principles. As independent organisations, the decision to align to the principles of the charters will be for each of the providers to consider; therefore there is no direct financial implication for the City Council.

Signed by:

Appendices: None

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

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

Title of document	Location

The recommendation(s) set out above were approved/ approved as amended/ deferred/ rejected by …… on ……

……
Signed by:

NHS
Portsmouth
Clinical Commissioning Group

Portsmouth
CITY COUNCIL

Equality Impact Assessment

Preliminary assessment form 2018

www.portsmouthccg.nhs.uk www.portsmouth.gov.uk

The preliminary impact assessment is a quick and easy screening process. It should:

- identify those policies, projects, services, functions or strategies which require a full EIA by looking at:
  - negative, positive or no impact on any of the equality groups
  - How are going to mitigate or remove any potential negative impacts
  - opportunity to promote equality for the equality groups
  - data / feedback
- prioritise if and when a full EIA should be completed
- justify reasons for why a full EIA is not going to be completed

Directorate: Adult social care

Service, function: Adult social care

Title of policy, service, function, project or strategy (new or old) :

Ethical & Residential Care Charters

Type of policy, service, function, project or strategy:

- ☐ Existing
- ★ New / proposed
- ☐ Changed

Q1 - What is the aim of your policy, service, function, project or strategy?

Unison's charters are designed to establish a minimum baseline for the safety, quality and dignity of care by ensuring employment conditions for care staff. By doing this, Unison is hoping to ensure the recruitment and retention of a more stable workforce through more sustainable pay, conditions and training levels.

Q2 - Who is this policy, service, function, project or strategy going to benefit or have a detrimental effect on and how?

Designed to benefit workers in the care sector.

Q3 - Thinking about each group below, does, or could the policy, service, function, project or strategy have a negative impact on members of the equality groups below?

Group	Negative	Positive / no impact	Unclear
Age	☐	★	☐
Disability	☐	★	☐
Race	☐	★	☐
Sex	☐	★	☐
Gender reassignment	☐	★	☐
Sexual orientation	☐	★	☐
Religion or belief	☐	★	☐
Pregnancy and maternity	☐	★	☐
Marriage & civil partnership	☐	★	☐
Other excluded groups	☐	★	☐

Note: Other excluded groups examples includes,Homeless, rough sleeper and unpaid carers. Many forms of exclusion are linked to financial disadvantage. How will this change affect people on low incomes, in financial crisis or living in areas of greater deprivation?

If the answer is "negative" or "unclear" consider doing a full EIA

If there are any potential negative impacts on any of the protected characteristics, What have you put in place to mitigate or remove the negative impacts/barriers?

N/A

Q4 - Does, or could the policy, service, function, project or strategy help to promote equality for members of the equality groups? e.g. A new service has been created for people with a disability to help them gain employment this would mean that this helps promote equality for the protected characteristic of disability only.

Group	Yes	No	Unclear
Age	★		
Disability	★		
Race	★		
Sex	★		
Gender reassignment	★		
Sexual orientation	★		
Religion or belief	★		
Pregnancy or maternity	★		
Marriage & civil partnership	★		
Other excluded groups	★		

If the answer is "no" or "unclear" consider doing a full EIA

Q5 - Do you have any feedback data from the equality groups that influences, affects or shapes this policy, service, function, project or strategy?
Please add in the text boxes below what feedback / meetings you have attended for each specific protected characteristic

Group	Positive or negative feedback
Age	
Disability	

Race	
Sex	
Gender reassignment	
Sexual orientation	
Religion or belief	
Pregnancy and maternity	
Marriage & civil partnership	
Other excluded groups	

Q6 - Using the assessments in questions 3, 4 and 5 should a full assessment be carried out on this policy, service, function or strategy?

☐ yes ★ No

PCC staff-If you have to complete a full EIA please contact the Equalities and diversity team if you require help Tel: 023 9283 4789 or email:equalities@portsmouthcc.gov.uk

CCG staff-If you have to complete a full EIA please email: sehccg.equalityanddiveristy@nhs.net if you require help

Q7 - How have you come to this decision? Summarise your findings and conclusion below

The purpose of the Ethical Care and Residential Care Charters is to establish a minimum baseline for the safety, quality and dignity of care by ensuring employment conditions for care staff. By doing this, Unison is hoping to ensure the recruitment and retention of a more stable workforce through more sustainable pay, conditions and training levels.
It is anticipated that thsi will benefit all those who access care services.

Q8 - Who was involved in the EIA?

This EIA has been approved by: Andy Biddle

Contact number: 8697

Date: 24/05/2019

PCC staff-Please email a copy of your completed EIA to the Equality and diversity team. We will contact you with any comments or queries about your preliminary EIA.
Telephone: 023 9283 4789, Email: equalities@portsmouthcc.gov.uk

CCG staff-Please email a copy of your completed EIA to the Equality lead who will contact you with any comments or queries about your preliminary . Email: sehccg.equalityanddiversity@nhs.net

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Portsmouth CITY COUNCIL

Title of meeting:	Cabinet Member for Health, Wellbeing and Social Care
Date of meeting:	2 July 2019
Subject:	Adult Mental Health Section 75 Extension
Report by:	Head of Safeguarding, Mental Health and Learning Disability
Wards affected:	All
Key decision:	No
Full Council decision:	No

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1. Purpose of report

1.1 To seek approval of the Cabinet Member for Health, Wellbeing and Social Care to extend the section 75 agreement for the Integrated Adult Mental Health Service (AMH)

2. Recommendations

2.1 The Cabinet member agrees to the extension of the current AMH s75 Agreement for a period of three years, until 1st July 2022.

3. Background

3.1 The AMH social work element of the integrated mental health service operates under a Section 75 arrangement with Solent NHS Trust as the lead provider, delivering the requirements set out in the Care Act 2014 to people in Portsmouth whose primary needs are linked to their mental health. Solent NHS Trust have direct line management responsibility for PCC staff, and staff are co-located with their NHS colleagues and based at St Mary's Hospital in Portsmouth.

3.2 The service is provided to anyone over 18. The transition protocol is currently being re-written in conjunction with children's social care colleagues and the 'milestones' for when the AMH service begins to engage with young people, (before their 18th Birthday) will be part of this protocol.

3.3 The service provides support to around 120 people from the perspective of social care funding.

3.4 The AMH service will link to the Wellbeing Hub and potentially use the Hub as a point of contact once the Hub has an established base. The Head of Service for Mental Health, Safeguarding and Learning Disability services is linked to the Well-being Hub development.

3.5 Under the partnership agreement PCC contract with Solent NHS Trust for an agreed staffing establishment and associated costs with clear outcomes. Solent NHS Trust have the delegated responsibility, as the lead provider for delivery of the social work element of AMH services. Quarterly meetings of the Partnership Management Group are held to monitor the effectiveness of the arrangements.

3.6 The current agreement, which commenced November 2013, was set to run for three years and expired in 2016. For 16/17 and for 17/18 it was agreed the current arrangements would be extended for those years. The current agreement was extended for a further year in June 2018. It is recognised that the agreement does not reflect the changes brought in with the Care Act 2014 and that it needs to be rewritten. This process is underway and will clearly articulate the requirements of the Care Act. Performance indicators and outcome measures have been refreshed and PCC is in the process of confirming the resource that will be provided to Solent NHS to deliver the service. It is anticipated that the refreshed S75 agreement will be in place by the end of July 2019. If the three year extension is granted, the refreshed agreement would be signed off across the two services, without needing to return for Cabinet Member approval.

3.4 The s75 partnership agreement is overseen and monitored by Adult Social Care, through Partnership Management Group meetings.

4. Governance/Audit

4.1 The PCC Head of Service for Mental Health, Safeguarding and Learning Disability Services meets monthly with the Solent Operations Director for Mental Health to review tactical issues within the service.

A PCC employed lead for Adult Social Care and Transformation works within mental health services in Portsmouth and is accountable for the operational effectiveness and quality of the service.

A Partnership Management Group is established between Solent NHS Trust and PCC, chaired by the Chief Operating Officer for Solent NHS Trust and oversees the strategic direction of the service.

4.2 Portsmouth has recently been part of a thematic review of the social work role in mental health in the South East, carried out as part of the Sector Led Improvement work of the Association of Directors of Adult Social Services. Feedback from the review included the observation that Portsmouth has a strong alliance across the ASC Lead, the Social Work Lead (also the transformation lead in the Joint Commissioning Unit) and a Social Work clinical manager, enabling reach across different levels and strategic and operational remits. The review also focused on Portsmouth's success in embedding a systemic focus on improving well-being in teams through supervision. Portsmouth was commended for considerable evidence of positive experiences of multi-disciplinary team work with strong professional leadership infrastructure and representation of Social Work in the

NHS workforce. Portsmouth's practice in retaining an AMHP, (Approved Mental Health Professional) hub was seen as assisting well-being and identity.

4.3 A review of the management of Adult Mental Health was undertaken as a part of the 2017/18 audit plan. Three high and one low risk exception was raised as a result of testing with a limited assurance opinion. A follow up audit was carried out as part of the 2018/2019 Audit Plan to ensure the agreed actions to the exceptions raised during the initial review have been implemented. A follow up audit in 2018/19 showed one high, (S.75 arrangements) and one low risk exception, with an overall rating of reasonable assurance.

4.4 Two of the primary objectives in Mental Health services for ASC are to decrease the number of people in residential care and support more people to return to live in the community and manage within the resources allocated to the service. From a starting position of £350,000 overspend in 2014, the budget stood at £27,580 in March 2019. Those people in residential care has decreased in the last year by circa 10%.

4.5 Having an integrated service, made up of a range of professionals across different disciplines, sitting under one line management structure allows for coordinated multi-agency planning to meet the needs of people with mental health difficulties.

4.6 The extension of the existing s75 agreement will ensure continuity of service delivery, acknowledging that some amendments are required to ensure it complies with the requirements of the Care Act 2014.

5. Equality impact assessment

5.1 An assessment is not required as the decision will have no negative impact on the protected characteristics. This is an extension of an already existing service for people whose primary need is linked to their mental health.

6. Legal implications

6.1 Section 75 of the NHS Act 2006 allows local authorities and NHS bodies to enter into partnership arrangements to provide a joined service and pool resources, if such arrangements are likely to lead to an improvement in the way their functions are exercised.

6.2 The arrangements permissible between the Council and NHS bodies under section 75 include the provision as well as the commissioning of integrated services.

6.3 As part of the arrangement, to enable Solent NHS Trust to provide the integrated services, PCC staff are made available to the Trust under section 113 of the Local Government Act 1972. These arrangements will continue during the extended term of the s75 Agreement.

6.4 The provisions of the original section 75 Agreement for AMH enable the parties to extend its duration by agreement between them and also to agree any varied or updated terms and conditions that may be required.

7. Finance comments

7.1 There are no additional financial implications arising from the recommendation contained within this report, as it seeks to continue the existing arrangements, as set out within the s.75 agreement.

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Signed by:

Appendices: None

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

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

Title of document	Location

The recommendation(s) set out above were approved/ approved as amended/ deferred/ rejected by …… on ……

……
Signed by: