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Portsmouth CITY COUNCIL

NOTICE OF MEETING

HEALTH OVERVIEW & SCRUTINY PANEL

THURSDAY, 24 JUNE 2021 AT 1.30 PM

VIRTUAL REMOTE MEETING

Telephone enquiries to Lisa Gallacher Tel: 023 9283 4056
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Membership

Councillor Ian Holder (Chair)
Councillor Lee Mason (Vice-Chair)
Councillor Matthew Atkins
Councillor Judith Smyth
Councillor Rob Wood
Vacancy

Councillor Arthur Agate
Councillor Trevor Cartwright
Councillor Lynn Hook
Councillor Rosy Raines
Vacancy
Vacancy

Standing Deputies

Councillor Ryan Brent
Councillor Stuart Brown
Councillor Lee Hunt

Councillor Kirsty Mellor
Councillor Gemma New
Councillor Ian Bastable

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

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

A G E N D A

1 Welcome and Apologies for Absence

2 Declarations of Members' Interests

3 Minutes of the Previous Meeting - 18 March 2021 (Pages 3 - 10)

The minutes of the last meeting on 18 March 2021 are attached for approval.

4 Update from South Central Ambulance Service (Pages 11 - 16)

Tracy Redman, Head of Operations South East, will answer questions on the attached report.

5 Update from Adult Social Care (Pages 17 - 28)

Andy Biddle, Director of Adult Social Care, will answer questions on the attached report.

6 Care Quality Commission - update on Provider Collaboration Review (Pages 29 - 44)

Claire Oakley, Inspector will answer questions on the attached report.

7 Hampshire and Isle of Wight Integrated Care System update (Pages 45 - 48)

Richard Samuel, Director of Transition and Development will answer questions on the attached report.

8 Update from Solent NHS Trust (Pages 49 - 52)

Suzannah Rosenberg, Chief Operating Officer will answer questions on the attached report.

9 Guildhall Walk Healthcare Centre update (Pages 53 - 94)

Jo York, Managing Director Health and Care Portsmouth will answer questions on the attached report.

10 Health and Care Portsmouth/CCG update (Pages 95 - 102)

Jo York, Managing Director Health and Care Portsmouth will answer questions on the attached report.

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held remotely on Thursday 18 March 2021 at 1.30pm.

Present

Councillor David Fuller (Chair)
Lee Mason (Vice Chair) - left the meeting after item 6.
Graham Heaney (from 3pm)
Leo Madden
Steve Wemyss (from 3:35pm)
Tom Wood
Vivian Achwal, Winchester City Council
Arthur Agate, East Hampshire District Council
David Keast, Hampshire County Council
Philip Raffaelli, Gosport Borough Council

8. Welcome and Apologies for Absence (AI 1)

Apologies for absence were received from Councillor Trevor Cartwright and Councillor Graham Heaney had sent apologies as he would be arriving after 3pm.

9. Declarations of Members' Interests (AI 2)

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

10. Minutes of the Previous Meeting (AI 3)

The Sustainability & Transformation Partnership keep well collaborative document was published with the minutes.

An update on the Sustainability & Transformation Partnership's Apprenticeship Academy that was requested at the January meeting had been sent to the panel on 17 March.

RESOLVED that the minutes of the meeting held on 21 January 2021 be agreed as a correct record.

11. Portsmouth Clinical Commissioning Group - update (AI 4)

In response to questions, Jo York, Deputy Chief Health and Care Portsmouth NHS Portsmouth Clinical Commissioning Group (CCG) / Portsmouth City Council explained that:

The White paper is due to come into legislation from April 2022 if it passes smoothly through Parliament. The CCGs will cease to exist and the Integrated Care System will become the statutory body and take over their functions.

Portsmouth CCG is already part of the Hampshire Integrated Care System. The White Paper proposes that there will be more formalised partnership working and delegation of responsibilities and resources to local “Place based

partnerships" aligned to upper tier local authority boundaries. This builds on the existing partnerships already in place for Health and Care Portsmouth.

The CCG Board has delegated responsibilities to the Chief Executive of Portsmouth City Council to act as the Executive Lead for Health & Care Portsmouth to continue the integration between the local NHS and the Local Authority.

Portsmouth CCG will share an accountable officer with the Hampshire, Southampton & Isle of Wight CCG

Councillor David Fuller dropped out of the meeting so Councillor Lee Mason, Vice Chair took over as Chair.

The White Paper sets out very clearly that the commissioning functions will sit in the ICS and that there will be a strong place-based delegation. The integration of health and social care services is fundamental to the paper.

Councillor David Fuller re-joined the meeting.

Portsmouth already has a very strong integration of the Health & Care functions with joint roles and pooled funding arrangements

Portsmouth did not want to isolate itself from other areas. There is a very clear need to work together across the health and care boundaries and the boundaries of the hospital's footprint.

It will be a more complex environment as the situation moves forward.

The ICS will not be a one size fits all. Some functions will be carried out at a local level.

RESOLVED that the report be noted.

12. Portsmouth Hospitals NHS University Trust update. (AI 5)

Penny Emerit, Deputy Chief Executive and John Knighton, Medical Director from Portsmouth Hospitals' University NHS Trust explained that Covid 19 rates in rates in Portsmouth continues to decrease. It is currently 44 cases per 100,000 people. There are more than 100 patients in hospital with Covid 19. Portsmouth reached higher rates sooner than other parts of Hampshire and Isle of Wight area and therefore has a higher bed occupancy rate.

In response to questions from the panel, they explained that:

<u>Support for Staff</u>

Many staff have worked outside their normal roles and this can cause pressure. The focus is on supporting staff through this wave and afterwards in order to maintain all services and be ready for the next wave. An independent and anonymous staff wellbeing survey was commissioned to understand what additional support they would find valuable. Three thousand

members of staff responded and will receive individual reports based on their responses.

Staff absence was modelled initially for very high levels but the reality was that it was managed very well. Retention is a concern. Some staff are thinking of retiring early or looking at other career options.

In the ICU they were managing at three times the normal staff capacity. In the non-invasive ICU unit there were twice as many staff.

Vaccination Take Up.
All staff have been offered the vaccination and 88% have taken it up. It is important that this is increased as high as possible. A lot of work is going on to understand the concerns. Making the flu vaccination mandatory was discussed pre-pandemic and more recently the Covid 19 vaccination. As a county, there is no appetite for doing so.

Infection Rate.
The Covid 19 infection rate continues to be a concern. The community and hospital rates are related but independent. Once there the nosocomial infection those occurring in hospitals) rate is more than 20%, there will be a steep and parallel rise in the community. At its peak in the second week of February it was at 25% and peak occupancy was during the second week of January.

During the first wave the hospital was 50% empty so every case was isolated. Currently the hospital is at 95+% occupancy. Now that the hospital has rapid turnaround tests that have more than 89% accuracy rate, patients with a positive diagnosis can be separated into cohorts more securely.

Additional support comes from the Infection Prevention Team and intelligence cross infection specialists look at every possible opportunity to lower the risk including using PPE differently, reviewing the ventilation of wards and patients movement through the hospital. The monthly Infection Prevention Assurance Framework is monitored by the Board.

Consultations
During the first wave all face-to-face outpatient consultations were suspended nationwide and alternatives such as virtual or telephone consultation offered. Face-to-face appointments remain the preferred option wherever appropriate.

Post Covid and Long Covid Support
The Hampshire & Isle of Wight ICS funded the setting up of a multi-faceted rehabilitation service to treat people who after having Covid and also those who are suffering from Long Covid.

Lessons Learnt
Many lessons have been learnt regarding service transformation and staff adaptability. There will be a period of readjustment and learning.

Clinical leadership has been and will continue to be at the centre.

More work needs to be done with the community to encourage people to access community services rather than go to the Emergency Department.

Virtual appointments have proved very popular with patients and are very efficient. Virtual staff meetings have proved successful.

Cancer performance was maintained throughout the pandemic.

Resources had been prioritised for critical services.
The panel noted the good work that Mark Cubbon had carried out as Chief Executive and wished him well in his new position.

Members reminded PHT that any major changes to service provision must be shared with the HOSP and others at the earliest opportunity.

RESOLVED that the update be noted.

13. Guildhall Walk Healthcare Centre (AI 6)

The Chair informed members that on Tuesday the Full Council resolved that the matter contained in Public Question 2 *"Will the administration commit to opposing the closure of Guildhall Walk GP surgery and if necessary, pledge to work with the CCG, the patient participation group and others, to secure alternative provision as close as possible to the current surgery?"* be referred to HOSP for consideration. He noted that this item was already on the agenda and asked members to consider the Council's recommendation.

A deputation against the closure of the centre by Mark Stubbings, PHL was read out. Councillor Cal Corkery also made a verbal deputation on this item. Deputations are not included in the minutes but can be watched here Health Overview & Scrutiny Panel, 18 March 2021 on Livestream.

In response to questions raised in the deputation, Jo York, Deputy Chief Health and Care Portsmouth NHS Portsmouth Clinical Commissioning Group / Portsmouth City Council and Simon Cooper, Director of Primary Care Portsmouth CCG informed the panel that

The CCG Primary Care Commissioning Committee had decided not to re-procure an AMPS contract currently held by PHL at the Guildhall Walk premises. The current provider would not necessarily have won that tender. The contract had already been extended for a year until September 2021and could not be extended again which meant the decision was either to go out to tender or not to reprocure.

The building is in poor condition and the landlord has decided to significantly increase the cost of the lease.

This is not a reduction of provision as there is adequate primary medical care capacity in the city. The University Practice is moving to a new larger premises in Commercial Road which will open during December 2021. Other

nearby practices also have capacity to take on new patients. A number of these are within half a mile.

There will be a well-managed dispersal of patients to receiving practices led by the CCG following patient choice.

When the CCG met with Councillor Corkery to discuss the situation, an Equality Impact Assessment had not been started this is now underway.

Since the pandemic started, much care has been provided differently including virtual and telephone consultations. This has been welcomed by most patients.

Prior to the pandemic, more outreach support was provided to rough sleepers and this has been increased during the pandemic. Traditionally they are reluctant to access health care facilities. The CCG will continue to work with PHL to understand their vulnerable patients. Work will also continue to identify the best ways to offer health care support to rough sleepers. Conversations are also being held with Brunel PCN who are working on increasing support for these residents.

Possible Alternative Locations.
A long-term conditions hub was (pre-pandemic) located at the Somerstown Hub. The Somerstown Hub already has a practice (Portsdown Medical Practice) within the space and a dental surgery run by Solent NHS Trust. There is insufficient space for the Guildhall Walk Healthcare Centre (GHWHC) to move into the Somerstown Hub.

Chaucer House would require a full fit-out with associated costs and the CCG does not have the capital funding to do this. It was also thought to have insufficient space to accommodate the GHWHC practice.

Safe space
This service had not operated since the start of the pandemic. Before the pandemic had started, the CCG and ambulance service had been discussing other venues as the current premise is no longer appropriate.

In response to questions from the panel, they explained that:

Capacity
The patient: GP ratio is not an accurate measure, because practices work in many different ways. Patients see different healthcare professionals not just GPs and so this is no longer a good guide to practice capacity. Patients also have very different healthcare needs.

The GHWHC has 8,400 patients. The new university surgery would accommodate an additional 6,000 patients comfortably. The Portsdown Medical Group Practice could accommodate up to 2,000. The Lighthouse Southsea Medical Centre could accommodate 800-1,000 extra patients. The Lake Road Practice with John Pounds Centre branch premises has capacity for a further 2,000.

Transfer Process

There is no active patient participation group for this practice. An email inbox has been set up for questions around the closure. There had been few: one patient asking for details of the transfer; one patient had submitted a complaint regarding another matter and one member of the public had written to express concern. A second letter is due to be sent to patients next week explaining the transfer process. Online engagement events will be held in April and patients will be invited to choose from a list of practices from which they can register according to their residential address. The transfer will be carried out in July/August. The practices will make sure that their new patients feel familiar with the services offered.

Decision

A lot of work has been carried out to ensure the viability of the GP practices in the city including sharing staff and services.

It was decided that a full reprocurement of the service would not be the best option for the patients at GHWHC. The minutes of the meeting where this decision was taken are not public as it was a contractual issue.

(Councillor Heaney joined the meeting).

PHL is a large organisation and is looking to recruit more GPs due to a recent turnover of staff. The CCG is working with them to understand the implications of the GHWHC closure on their staff. The CCG will continue to offer support to PHL staff.

Councillor Wemyss joined the meeting.

If the CCG had gone to a procurement process patients would have been required to move premises anyway.

Members reflected that it seemed as if the decision was made to run down the GHWHC when the walk-in service had been removed.

Members expressed their disappointment that they had not been consulted about this change of service before a decision had been taken so that they could determine if they consider the change to be a substantial variation of service and request further information. The panel noted that it had the right to refer any substantial variations to the Secretary of State if members did not consider them to be in the best interests of service users.

Jo York acknowledged that ideally the panel should have been informed in August/ September 2020. The pandemic had impacted the CCG's capacity to carry out forward planning. They would work more closely with the panel in future.

Actions

The panel requested that the following documents be shared with the panel:

- The Equality Impact Assessment concerning this decision.
- The Forward plan for all GP surgeries in the city be shared.

RESOLVED that in the event that the CCG confirms its decision to close the Guildhall Walk Healthcare Centre, the panel asks it to pledge to work with the Patient Partnership Group and others including the Health & Wellbeing Board to secure alternative provision as soon as possible to the current surgery and to bring a report to the HOSP prior to September 2021.

Councillor Lee Mason left the meeting.

14. Public Health update (AI 7).

RESOLVED that the update be noted.

15. Portsmouth Dental Data Update (AI 8).

The Chair reported that NHS England had not been able to send a representative to the meeting but would send respond to any questions sent to them.

RESOLVED that this update be noted.

The meeting ended at 4:10pm.

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Agenda Item 4

South Central Ambulance Service NHS
NHS Foundation Trust

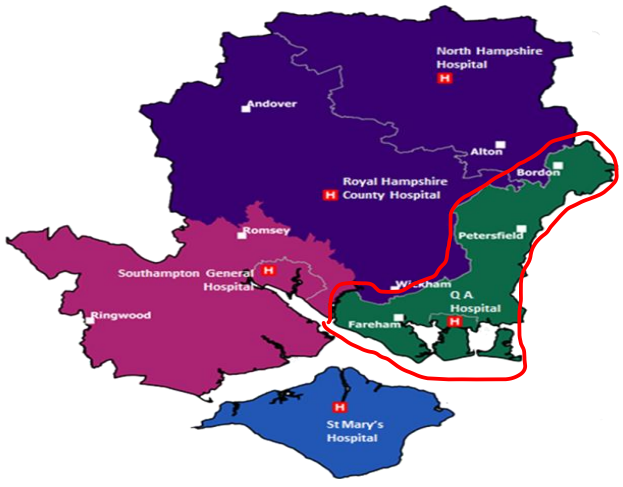
Title	Health Overview and Scrutiny Panel
Author	Tracy Redman - Head of Operations SE South Central Ambulance Service NHS Foundation Trust (SCAS)
Date	May 2021

Contents

Introduction / SCAS 999 South East

South Central Ambulance Service NHS Trust provides emergency, urgent and non-emergency healthcare services, along with commercial logistics services. The Trust delivers most of these services to the populations of the South Central region - Berkshire, Buckinghamshire, Oxfordshire and Hampshire - as well non-emergency Patient Transport Services in Surrey and Sussex. In Hampshire SCAS 999 operate in 3 'nodes'

SCAS 999 - South East Hampshire



Over 100k - 999 calls a year

Approx. 50k ambulance conveyances a year

Approx. 50k patients treated at home / signposted to other services

Circa 300 frontline operational team members

Up to 35 ambulances on duty at the busy times of day

One main hub site with satellites

Developments

COVID-19

On the 30th January 2020, the first phase of the NHS' preparation and response to COVID-19 was triggered with the declaration of a Level 4 National Incident.

This has seen significant challenge across the NHS including the Ambulance sector.

Some of these areas include changes to demand, clinical & operational practice, leadership, and the well-being of our staff.

- SCAS have adapted and learnt alongside colleagues from our partner organisations.
- Demand has been variable with peaks and troughs together with some changes in patient presentations.
- The delivery model has been flexible based on the demand and resources available.
- Clinical and operational practice has also had to adapt in line with national guidance to ensure that patients and staff remained as safe as possible. This has included the introduction of additional personal protective equipment for attendance at all patients along with further requirements for some types of patients.
- Enhanced leadership to support staff and challenging situations remain in place. In addition, SCAS enacted its internal command and control structure, which included links into to wider systems and partners command and control structures, both locally and nationally.
- The health and wellbeing of our staff remains a very high priority, with some COVID challenges including increased absence levels due to both illness (both physical and mental) and contact tracing as well as real concerns raised for family members.
- The staff vaccination programme has been delivered by both internal clinics, and with support from external clinics; all those staff who wanted a vaccine have had access to receive both doses.

Integrated Urgent Care

SCAS continue to work closely with partner health and social care providers to ensure efficient and effective collaboration. SCAS frontline clinicians work closely with Community Teams as well with Primary Care, with a single point of access now in place to support this and enhance clinical decision making.

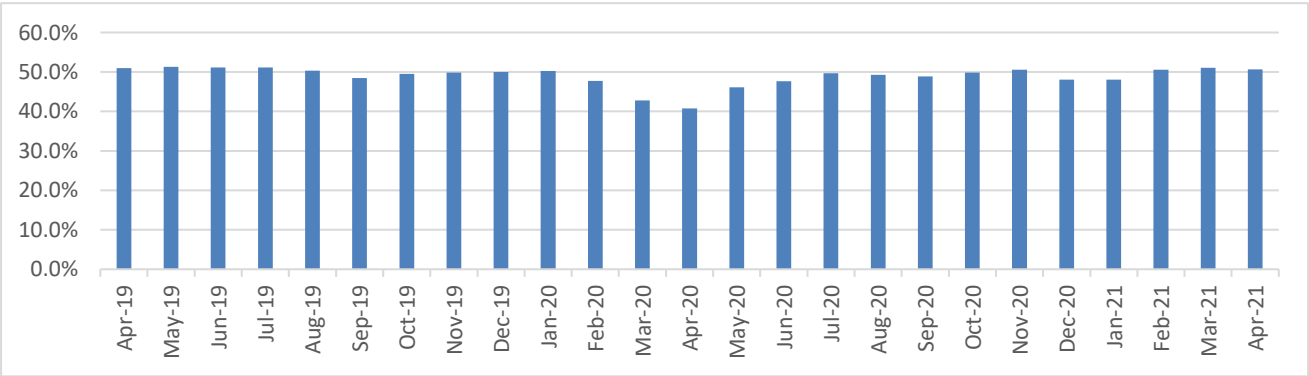
In addition, wider health and social care colleagues from Social Services, Mental Health and Maternity services are directly supporting SCAS and patients by being embedded in the SCAS Clinical Co-ordination Centre.

SCAS are integral to ongoing programmes of work to support patients being treated in their own home or at the most appropriate place. This includes SCAS clinicians managing conditions at home; either via the telephone or face to face and onward referrals to other health care professionals where required. This has been further enhanced with the development of SCAS connect which is a digital platform to support clinical decision making and patient signposting.

Further to this SCAS and primary care work in partnership to ensure when patients call for help they are assessed and directed to the most appropriate service from the outset.

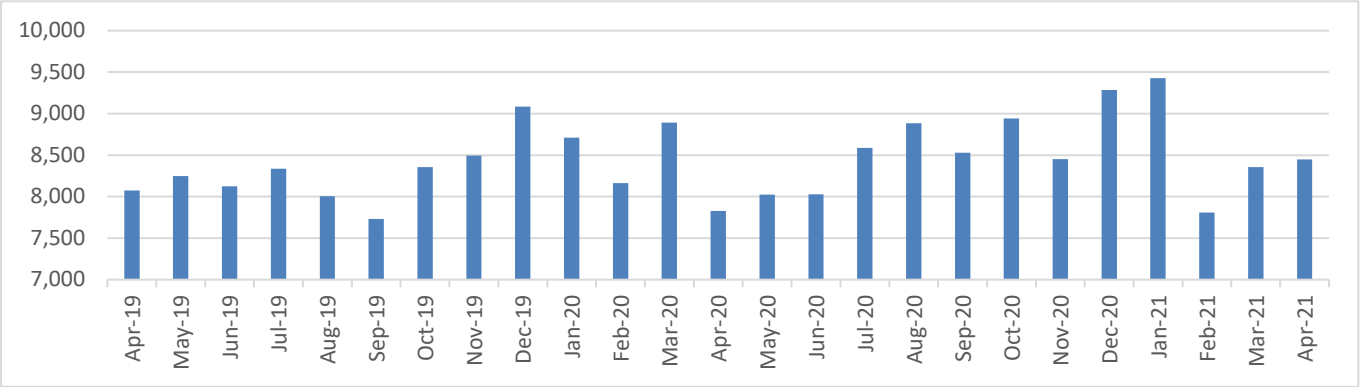
This approach not only ensure the patient appropriate and timely care, but it also support s the agenda of working towards keeping the Emergency Department (ED) for Emergencies.

As a result of these actions SCAS only convey approx. 50% of its demand to the ED dept – this has remained fairly stable throughout the past year.



999 Demand / Performance

Demand has been variable over the past year, which again has been reflected both locally and nationally with a clear uplift in recent weeks.



Performance by Category by area

Fareham & Gosport

Cat	National Standard	F&G Q4 19/20 Demand	Mean	90th	F&G Q4 20/21 Demand	Mean	90th	F&G Apr 21 Demand	Mean	90th
Cat 1	7 Mins (Mean); 15 Mins (90th)	539	0:06:25	0:10:53	589	0:05:54	0:10:01	192	0:05:42	0:11:03
Cat 2	18 Mins (Mean); 40 Mins (90th)	3,836	0:19:15	0:36:43	3,800	0:17:51	0:34:05	1,189	0:15:34	0:29:17
Cat 3	120 Mins (90th)	2,648	0:53:54	2:02:46	2,572	0:54:51	2:01:38	869	0:48:49	1:39:53
Cat 4	180 Mins (90th)	164	1:03:06	2:20:48	220	1:05:46	2:18:25	84	1:06:38	2:31:02

Additional performance information is provided (appendix 1) by postcode for F&G as requested at the previous HOSP meeting.

Portsmouth

Cat	National Standard	Ports Q4 19/20 Demand	Mean	90th	Ports Q4 20/21 Demand	Mean	90th	Ports Apr 21 Demand	Mean	90th
Cat 1	7 Mins (Mean); 15 Mins (90th)	735	0:05:36	0:09:55	882	0:04:57	0:08:29	271	0:04:52	0:08:21
Cat 2	18 Mins (Mean); 40 Mins (90th)	4,590	0:14:26	0:30:24	4,289	0:15:34	0:31:37	1,360	0:12:18	0:24:34
Cat 3	120 Mins (90th)	2,655	0:47:55	1:59:16	2,508	0:52:27	2:04:53	918	0:44:29	1:42:39
Cat 4	180 Mins (90th)	156	0:55:09	2:10:10	189	0:54:03	2:03:11	69	0:54:57	2:11:17

South Eastern Hampshire

Cat	National Standard	SEH Q4 19/20 Demand	Mean	90th	SEH Q4 20/21 Demand	Mean	90th	SEH Apr 21 Demand	Mean	90th
Cat 1	7 Mins (Mean); 15 Mins (90th)	532	0:07:40	0:13:24	500	0:06:53	0:12:25	212	0:06:50	0:12:41
Cat 2	18 Mins (Mean); 40 Mins (90th)	4,086	0:16:42	0:31:55	3,896	0:17:01	0:32:16	1,197	0:14:06	0:26:17
Cat 3	120 Mins (90th)	2,723	0:46:23	1:45:51	2,476	0:51:31	1:50:01	823	0:47:26	1:41:41
Cat 4	180 Mins (90th)	195	0:55:20	1:59:51	224	0:58:42	1:56:16	74	0:52:17	1:50:16

Challenges / Opportunities

Transformation Review

Following the delivery of our transformation programme, SCAS is now embarking upon a review to determine how successful the process was and what, if anything needs to change going forward. This will primarily include our staffing and deployment models.

Patient care

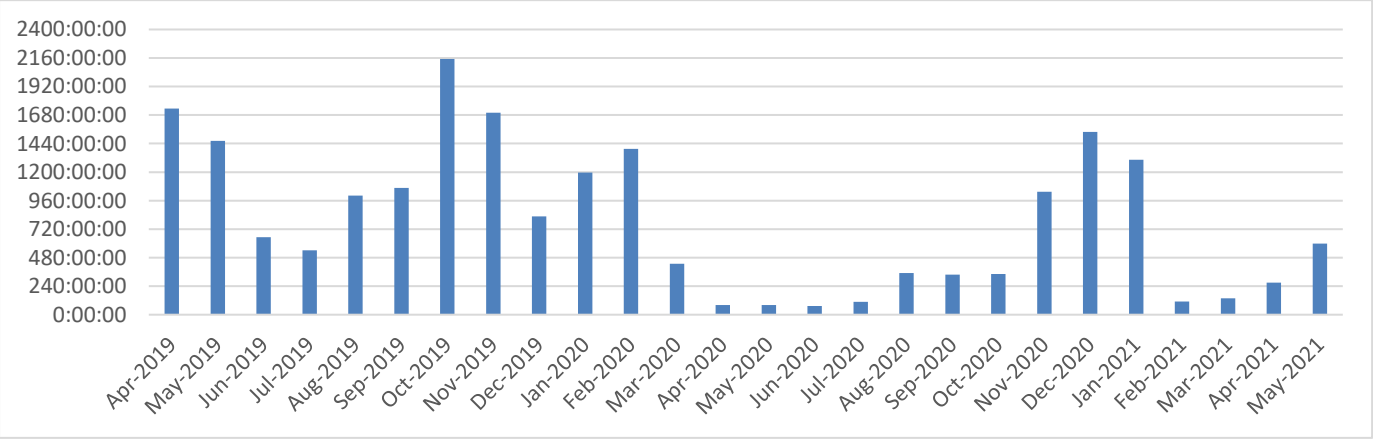
Whilst there were some improvements from COVID-19 for example a reduction in hospital handover delays and the development and rapid implementation of some urgent care pathways. The challenge is to harness this work and take it forward. This is a focus for the system as a whole to support the patients receiving the right care in the right place, first time.

Hospital/System resilience and capacity - Impact of Hospital Handover delays

Hospital handover delays do remain a challenge to the SCAS service delivery. Again, we have seen impact of COVID-19 actually reducing the delays, but we now see some difficulties re-emerging.

The delays are measured to a national standard of 15 minutes from the arrival at hospital to the handover of the patient. The time lost is where a patient is unable to be handed over within the 15 minutes. The result is that SCAS resources are tied up and unable to respond to other patients in the community during this time.

Hours lost at QA Hospital:



SCAS continue to work closely with NHSI/E, the CCGs, Portsmouth Hospitals and other health and social care providers to mitigate the effects of these delays on patient care, and the impact on staff.

Appendix 1

Fareham & Gosport performance Data by postcode April 2021

Cat	National Standard	PO12 Demand	Mean	90th	PO13 Demand	Mean	90th
Cat 1	7 Mins (Mean); 15 Mins (90th)	58	0:04:53	0:08:30	36	0:05:16	0:08:27
Cat 2	18 Mins (Mean); 40 Mins (90th)	337	0:17:21	0:31:29	232	0:16:31	0:31:22
Cat 3	120 Mins (90th)	253	0:52:27	1:47:51	161	0:43:41	1:14:53
Cat 4	180 Mins (90th)	22	1:34:14	3:04:59	14	1:20:28	2:34:01

Cat	National Standard	PO14 Demand	Mean	90th	PO15 Demand	Mean	90th
Cat 1	7 Mins (Mean); 15 Mins (90th)	27	0:05:48	0:12:11	17	0:07:04	0:11:52
Cat 2	18 Mins (Mean); 40 Mins (90th)	199	0:15:05	0:31:10	114	0:12:16	0:20:19
Cat 3	120 Mins (90th)	111	0:47:21	1:41:13	69	0:48:10	1:34:36
Cat 4	180 Mins (90th)	13	1:06:06	2:02:39	5	0:44:01	1:21:56

Cat	National Standard	PO 16 Demand	Mean	90th	PO17 Demand	Mean	90th
Cat 1	7 Mins (Mean); 15 Mins (90th)	30	0:04:47	0:09:27	0	-	-
Cat 2	18 Mins (Mean); 40 Mins (90th)	180	0:12:54	0:23:43	3	0:09:38	0:10:59
Cat 3	120 Mins (90th)	177	0:49:34	1:45:34	0	-	-
Cat 4	180 Mins (90th)	19	0:34:01	0:54:36	0	-	-

Cat	National Standard	SO31 Demand	Mean	90th
Cat 1	7 Mins (Mean); 15 Mins (90th)	24	0:08:24	0:14:13
Cat 2	18 Mins (Mean); 40 Mins (90th)	124	0:16:43	0:25:37
Cat 3	120 Mins (90th)	98	0:48:41	1:32:58
Cat 4	180 Mins (90th)	11	1:01:07	2:05:02

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Title of Meeting:	Health Overview and Scrutiny Panel
Date of Meeting:	24th June 2021
Subject:	Adult Social Care Update
Report By:	Andy Biddle, Director of Adult Social Care

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1. Purpose of Report

To update the Health Overview and Scrutiny Panel on the key issues for Adult Social Care, (ASC) in the period September 2020 to May 2021.

2. Recommendations

The Health Overview and Scrutiny Panel note the content of this report.

3. Overview

Portsmouth City Council Adult Social Care, (ASC) provides advice, information and support to adults aged 18 years and over who require assistance to live independently and to unpaid carers who look after someone who could not cope without their support including those looking after children with additional needs. This support may needed as the result of a disability or a short or long term mental or physical health condition. The aim is to encourage people to use their own strengths and community resources to have as much choice and control as possible over how their care and support needs are met. For some, the service will also help people find the short or longer term care and support arrangements that best suit them.

ASC's purpose is defined as:

- Help me when I need it to live the life I want to live

4. Priorities

4.1. The period that this report covers includes the second wave of COVID-19 infections and its impact on the NHS, the national 'lockdown' from late December 2020 and subsequent recovery plans.

4.2. The focus for ASC in this period was to;

- Maintain critical services to protect the most vulnerable and work with all partners in the health, voluntary and independent sectors to provide support and advice to people affected by COVID-19. Support the NHS in admission avoidance and discharge from hospital in a safe and timely way.

- Comply with all government legislation & guidance in response to COVID-19.
- Work toward restoration and recovery of normal services.

4.3. During 2020 and 2021, the Department for Health & Social Care, (DHSC) published varied guidance which Local Authorities were required to follow in discharging their Adult Social Care duties. Much of this guidance continues to be followed and includes:

- Infection prevention and control
- Hospital discharge requirements
- Personal Protective Equipment
- Social Care Action Plan
- Working in care homes
- Working in domiciliary care
- Providing unpaid care
- People supported through direct payments
- Care Home Support Plan
- Adult Social Care Winter Plan
- Designated Premises

5. Health & Care Portsmouth

Portsmouth City Council has a strong history of integrated working relationships with all NHS partners in the City, in particular with NHS Portsmouth Clinical Commissioning Group (PCCG). We continue to work together with Portsmouth Hospital University Trust, (PHU) Solent NHS Trust and voluntary and community sector colleagues in integrating the health and care approach in Portsmouth.

The recent white paper *'Integration and innovation: working together to improve health and social care for all*' set out the legislative and associated arrangements for the NHS from 1st April; 2022. This included reference to working with the Local Authority in an Integrated Care System, (ICS). Portsmouth partners continue to build arrangements and integration at a 'place level' as referenced in the white paper. We also work at the Portsmouth & South East Hampshire level as part of the Integrated Care Partnership, focussing on discharge and flow from Queen Alexandra hospital; place based care and the healthy communities programmes of work.

5.1. Themes

There have been some significant themes and responses required during the September 2020 to May 2021 period/ The report groups these into services, demand and recovery.

5.2. Provider Support

ASC continued to have a regular dialogue with care providers in Portsmouth throughout the period as part of a shared effort with NHS partners. The government's Adult Social Care Winter Plan was implemented, supporting providers with prevention and control of infection, technology and digital support, workforce and guidance. Support plans were required for all care homes around testing, vaccination and visiting, in conjunction with the government guidance.

The 'provider portal' on the PCC website containing guidance and local and national advice was supplemented by a direct mail newsletter and is due to move to a Microsoft Teams platform.

Whilst locally funded extra financial support for providers ceased during the period, ASC continues to provide support to day service providers, in acknowledgement of the impact of social distancing requirements on income. In total, from March 2020, up to March 2021, £3,076,326 of government funding and £1,327,000 of local Authority funding was directly distributed to the care sector in Portsmouth via the council. As of May 2021, a national workforce grant and infection control/rapid testing grant have also been distributed to the sector totalling £1,035,000.

In Portsmouth City Council care homes, there were further outbreaks of COVID-19 during the second wave, the impact of these on the health of residents appeared to have been lessened by the vaccination programme led by the NHS. This programme commenced in Portsmouth care homes from December 2020. ASC was also able to support staffing for an independent sector care home with a significant outbreak during this time.

PCC care homes continue to offer placements for people unable to live independently. The Russets respite unit, (which offers breaks to families from their caring role) has offered a reduced service due to the need of social distancing and Infection Prevention & Control, (IPC) measures. The unit has still been able to offer support to people and their families where living arrangements have been under strain or broken down. It is hoped step 4 of the government road map, (at whatever date) will enable Russets to increase the respite offer.

5.3. Shielding and Vulnerable People

ASC continued to work with the HIVE, the CCG and local pharmacies to deliver medications to shielded patients. In cooperation with the HIVE, ASC developed and supported a network of Local Area Coordinators across the City providing volunteer support to those most in need.

5.4. Hospital Discharge

ASC continued to adhere to the guidance on Hospital discharge published in April 2020, (updated August 2020) during the pandemic and decreased the number of bed days lost, due to people awaiting discharge in Hospital. A senior lead was appointed for discharge, working on behalf of ASC and NHS Solent and they directed an integrated team to work with all those needing care and support to discharge from hospital.

The national 'Social Care Action Plan' required Local Authorities to put in place alternative accommodation and care for people, (needing a care home placement) discharged from hospital who were COVID-19 positive. In partnership with PCCG and funded via the NHS national discharge fund, ASC set up a unit at Harry Sotnick House to enable people to be discharged. Later during the second wave, ASC moved the 'Victory Unit' for rehabilitation to Harry Sotnick House and used the staffing to open the 'Southsea Unit'. This enabled more people to be discharged from hospital and offered a short stay, with reablement support, to make a decision about how ongoing care and support needs could be met. There are current discussions with PCCG colleagues around continued funding for this 'Discharge to Assess' facility.

The Hospital Social Work team, previously providing the social work input to support complex, safe and timely discharges from QA, also changed into a Discharge to Assess, (D2A) Team. Various models were tested with our NHS Solent colleagues taking more of a lead on discharges in line with the guidance.

The Team moved out of QA over a period of a few months and into the D2A role permanently from January 2021, leaving a small number of staff to continue working as part of the Discharge Hub. The D2A Team work across NHS Solent and PCC bedded units to provide timely Care Act assessments for people leaving hospital with complex needs whilst maintaining a 'home first' ethos. Staff have adapted well to the changes, and closer working with NHS colleagues has resulted in positive changes for the individuals needing to leave hospital and to the service in a rapidly changing and developing post-second wave response.

5.5. Continuing Health Care

The Continuing Health Care, (CHC) service, led by ASC on behalf of PCCG, was stepped down from March 2020 to the end of August 2020. Business as usual returned from 1st September 2020. There were a number of deferred assessments and outstanding CHC assessments that were required to be completed by the end of March 2021. This target was achieved and all

outstanding assessments were completed within this timeframe, providing a timely response to individuals and their families.

During the pandemic the CHC Social Workers have been used flexibly, supporting assessments other than CHC work in respect of the impact of the pandemic, including at one point supporting the in-house D2A unit. Whilst Solent NHS Trust are responsible for case managing those eligible for CHC in their own homes, due to the pressures experienced by the Community Nursing Team, the CHC Team supported with a number of community cases. The team's personal health budget Support Workers maintained regular contact with those receiving a personal health budget (people with a high level of support needs within the city) and assisted with any presenting issues. Two of the CHC nurses also volunteered to support the vaccination programme.

5.6. Work with People with a Learning Disability

In the initial stages of the crisis the Integrated Learning Disability Service (ILDS) developed and distributed easy read information about the changes in service provision, with information about how people could continue to access their support and developed social stories to help service users to understand what was happening. A system for ‘checking in’ on all service users was put in place. The service also ensured that service users had up to date 'hospital passports' should they find themselves in hospital. Day service provision continued throughout the pandemic, with a both a face to face and online offer. As the restrictions have eased most of people have now started to access the services in person.

The service has had a recent focus on ensuring that adults with a learning disability have been able to access vaccinations. This has included developing a virtual tour of vaccination sites so people can be more prepared, with a better sense of what to expect, having staff accompany people to the centres and in some cases providing vaccinations to people in their own homes. This combination of approaches has meant that at the time of writing 87% of those known to ILDS have received a vaccination. Some work is now underway to understand the impact of long COVID on adults with learning disabilities, and how we need to support them through the delivery of appropriate health and social care services to make a full recovery.

6.6 Carers Service

The Carers Service supports adult carers, usually via a Carers Assessment, to access breaks, information and advice, emotional support and help with emergency planning. The team continued to support carers remotely, and

when needed, in person throughout the pandemic. The Carers Centre building reopened to carers peer support groups on the 12th April.

During February and March the service worked with colleagues in Public Health, Primary Care and Corporate Communications to ensure eligible carers were able to be vaccinated. Carers were a challenging cohort to target due to there being no single dataset of carers.

The Carers Service is now working on a programme of group, peer and individual support to help carers recover from the impacts of the pandemic and to re-engage with social activities.

The Carer's Service Manager supports and informs regional and national policy work via the National Institute for Clinical Excellence, (NICE) and Association of Directors of Adult Social Services, (ADASS). They are a committee member on the recent Supporting Adult Carers NICE Guideline (Published January 2020) and Quality Standards (Published March 2021) and support the ongoing implementation of these documents including being a panellist on a SCIE webinar. The work of the South-East ADASS Carers Network is reflected in regular meetings with the Department for Health & Social Care, (DHSC) contributing to their understanding of how carers were experiencing the pandemic and how local services were responding.

Month	Professional referral	Self-referral	
Sept- 20	26	8	
Oct-20	19	8	
Nov-20	18	2	
Dec-20	25	12	
Jan-21	23	16	
Feb-21	36	25	*Comms on carer vaccines released
Mar-21	17	30	
Apr-21	26	11	
May-21	35	12	

6. Demand

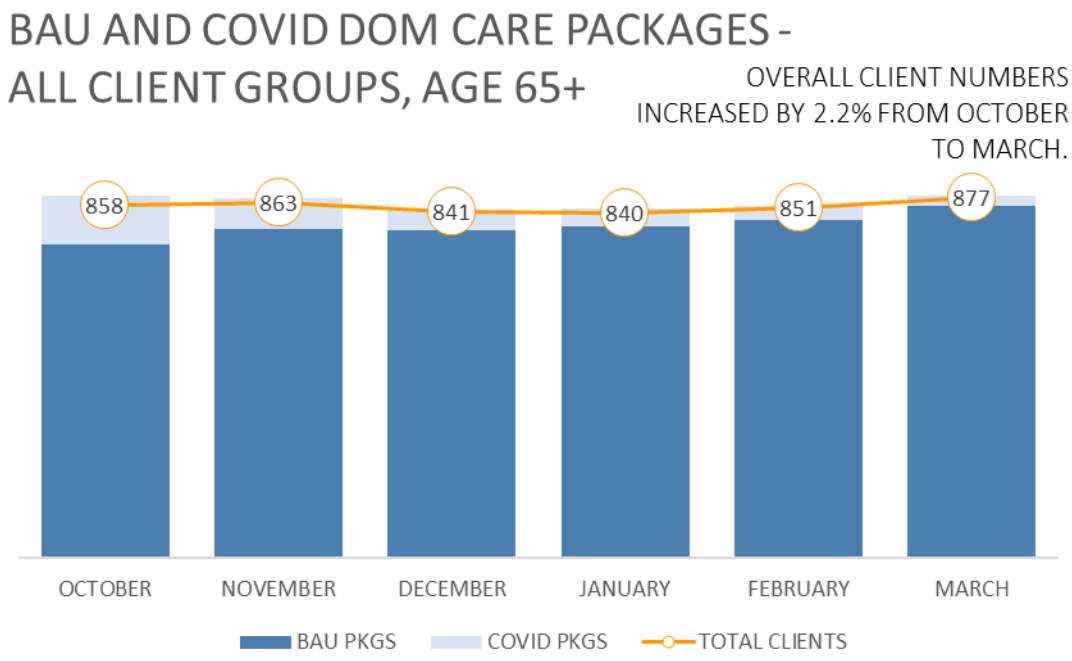
The figures below are snapshots of people with care and support needs with open care packages on the last day of the month.

6.1. Domiciliary Care - Age Group 65+

The domiciliary care packages over this time period were split between BAU (Business As Usual) domiciliary care and Covid funded domiciliary care. A

person may have received both and therefore the numbers for BAU and Covid will not add up to the total number count.

	BAU DOM CARE PKG		COVID FUNDED DOM CARE PKG		TOTAL CLIENTS AND COSTS	
	CLIENT COUNT	WEEKLY COST	CLIENT COUNT	WEEKLY COST	CLIENT COUNT	WEEKLY COST
OCTOBER	763	£ 163,204.02	118	£ 22,397.90	858	£ 185,601.92
NOVEMBER	801	£ 170,830.95	73	£ 17,225.50	863	£ 188,056.45
DECEMBER	796	£ 171,354.38	49	£ 15,793.75	841	£ 187,148.13
JANUARY	806	£ 175,845.49	42	£ 11,116.69	840	£ 186,962.18
FEBRUARY	821	£ 176,650.46	35	£ 12,346.06	851	£ 188,996.52
MARCH	856	£ 184,328.52	25	£ 10,084.89	877	£ 194,413.41



Looking at cost bands:

All domiciliary care packages across ASC (excl Continuing Health Care).

<u>All client groups</u>, includes Covid funded clients.

Predicted weekly cost, care package open at the end of the month.
The table above shows the number of clients in each domiciliary care cost band at the end of the month.

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	SINCE OCTOBER
£0-50	127	126	123	113	115	125	-1.6%
£050-200	525	534	524	522	530	541	3.0%
£200-300	163	164	145	154	151	160	-1.8%
£300-400	69	61	57	60	63	77	11.6%
£400-500	72	70	68	71	76	74	2.8%
£500+	102	112	118	118	112	110	7.8%
TOTAL	**1058**	**1067**	**1035**	**1038**	**1047**	**1087**	2.7%
CHANGE OVER PREVIOUS MNTH		0.9%	-3.0%	0.3%	0.9%	3.8%	

In summary, there was a considerable demand for funded support related to COVID-19 during the time period and we saw a general increase in need, people being more unwell or having more significant deterioration in their ability to manage their own daily living and needing more help.

6.2. Residential Care

Residential (and nursing) care figures need to be viewed within the context of the pandemic. Neither have recovered from the initial drop in April 2020, with additional drops in January 2021. Residential placements are currently 5.6% down on October 2020, and nursing numbers are 1.4% up, but both are still 10% down on February 2020 (the last 'normal' month).

	RES	NUR
Oct-20	342	148
Nov-20	352	150
Dec-20	345	154
Jan-21	332	148
Feb-21	325	149
Mar-21	323	150
% CHANGE	-5.6%	1.4%

6.3. Deprivation of Liberty Safeguards (DoLS)

During the pandemic mental capacity and best interest assessments were undertaken virtually, with face to face visits undertaken in exceptional circumstances. Short authorisations were agreed in some circumstances recognising that virtual assessments, although necessary, were not ideal for everyone. As restrictions ease face to face assessments are resuming and we are working closely with our care homes to manage this safely.

For the first time in some years, the number of applications for Deprivation of Liberty Safeguards, (DoLS) authorisations declined:

- 786 (2014/15)
- 1473 (2016/17)
- 1695 (2017/18)
- 1787 (2018/19)
- 1917 (2019/20)
- 1083 (2020/21)

This is likely to be skewed by temporary arrangements that continued in the second national lockdown.

The Department of Health & Social Care, (DHSC) had intended that the 'Liberty Protection Safeguards' (LPS) would replace the current system of DoLS by October 2020. However, the DHSC have announced a further delay to the implementation of LPS until April 2022 at the earliest. ASC began scoping work looking at the impact of the changes and will review this work during the next 12 months, it is anticipated that this will be likely to need specific project management and a dedicated training resource.

Across the South East, Councils are working in partnership to arrange a legal briefing to include LPS leads across adults and children's services. We have also agreed a scoping tool which will help us all to understand likely demand. This will support our action planning and in particular what our workforce development requirements will be.

6.4. Mental Health Act Assessments

During the initial lockdown period referrals to the service dropped from usual levels but as soon as these restrictions began to be lifted the referral rates returned to normal levels and the service continues to be busy.

During the pandemic, the service has continued to undertake assessments and provide external scrutiny to the care and support arrangements made for adults who are unable to consent to those arrangements. Assessments have all been completed in person.

In the early stages of the pandemic it was felt that assessments could be completed remotely. A subsequent legal challenge ruled that virtual assessments were not acceptable. In Portsmouth we had undertaken 4 assessments in this way. We reassessed in person those that were still detained and wrote to those that were living in the community, explaining the ruling in Court and advising them of their rights should they wish to complain. No complaints were received.

6.5. Adult Safeguarding

The referral rate into the safeguarding team has been variable with no particular pattern of concerns. The team were initially quiet in the early part of the pandemic but referral rates have now increased to pre-COVID-19 levels. The team has seen a 25% increase in concerns raised by the police which is challenging to manage. A triage system is in place to manage the increased workload to the team, but some work is taking longer to assess.

The team continue to run fortnightly clinics offering advice and support to colleagues undertaking safeguarding enquiries and planning is underway to recommence targeted training sessions. Face to face visits are becoming more frequent and social workers are now able to visit care homes to discuss safeguarding concerns in person.

The team has continued to work closely with housing colleagues and the third sector to support them to reduce risk and signpost to the relevant services.

6.6. Complaints

The complaints team received 43 complaints for the period of 01/09/2020 - 18/05/2021. In addition, the service also received 4 councillor enquires, 6 customer contacts and 5 possible complaints. This is in line with what we usually see throughout the year.

The service also received 37 compliments compared to 18 compliments received for the same period the previous year.

The majority of complaints received have been related to communication with employees. This is a recurring theme when looking at annual complaints data. However, the service also received three complaints about missing property at Harry Sotnick House, which were upheld. As a result of these complaints the property list form within the home has been changed and a more robust procedure has been implemented. A photo is now taken of any valuables and is attached to the form.

The complaints team has been working remotely during the pandemic and continue to do so. Virtual meetings rather than face to face meetings with complainants have been in place which has worked well.

6.7. Recovery

During the second wave of COVID-19, ASC had to stand down some face to face services such as our community connectors and social groups, day services also reduced numbers in attendance from January 2021. However, by February 2021 we were able to start these services back up in conjunction with government guidance around limited gatherings and COVD safe environments.

ASC led for the Council on the Zero Waste vaccination scheme supporting 1st vaccinations for Council staff, schools, early years, the University of Portsmouth and voluntary sector providers.

ASC are currently drafting a sustainable care strategy in conjunction with the sector to acknowledge the oversupply of care home places in Portsmouth and the decrease in placements as a result of the pandemic and the discharge to assess arrangements implemented for those coming out of hospital.

Ministry for Housing, Communities & Local Government funding has been secured through a bid made by colleagues in housing to employ a social worker for three years. This post has now been appointed to and is an opportunity to work collaboratively across services to support rough sleepers and those experiencing homelessness to access the support they need to address their often complex and multiple needs.

The service is in the process of refreshing the ASC Strategy during May/June 2021, recommencing programmes of work that were ceased to focus efforts on the pandemic. The medium term financial strategy to achieve financial balance by 2023 by focussing on reablement and recovery has also been refreshed. Priorities over the next six months include:

- Increased co-production to shape provision.
- Support and influence building capacity in communities.
- Focus on the prevention agenda, social prescribing and independence & wellbeing to avoid hospital admission & using discharge to assess to avoid multiple admissions
- Introducing carer's champions across the Council
- Preparing for the first national inspection of ASC
- Developing data and performance reporting
- Developing transition for young people with care and support needs
- Developing extra care housing for people with dementia
- Continuing the work with our local NHS partners in developing working at place level in the ICS.

7. Summary

Whilst it is not possible to cover all of the work undertaken across adult social care in response to the second wave of the pandemic, nor all of the priorities for the coming year, this report highlights some of the main themes and priorities. The response to the pandemic would not have been as strong without the integrated approach that we have established through Health & Care Portsmouth. As the ICS begins to take shape, ASC is part of the focus on place based working, built on the strong foundations of integrating health and care for the citizens of Portsmouth.

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Provider collaboration review: Urgent and emergency care

Categories: Public

This report about urgent and emergency care (UEC) in England is the second of our provider collaboration reviews [https://www.cqc.org.uk/publications/themes-care/provider-collaboration-reviews].

These reviews aim to show the best of innovation across systems under pressure, and to drive system, regional and national learning and improvement.

We looked at urgent and emergency care in eight areas of England in October 2020. Urgent and emergency care covers a wide range of services that people turn to when they need immediate help, including NHS 111, GP out-of-hours services, urgent treatment centres, urgent dental services, accident and emergency, ambulance services and pharmacies.

Local areas and organisations covered

The local areas or specific organisations covered in our reviews are:

Cheshire and Merseyside Health and Care Partnership
Hampshire and the Isle of Wight
Cornwall and the Isles of Scilly
Northamptonshire Health and Care Partnership
Herefordshire and Worcestershire
East London Health and Care Partnership
Suffolk and North East Essex
West Yorkshire and Harrogate.

Some of these areas are integrated care systems (ICSs) and some are sustainability and transformation partnerships (STPs).

We wanted to know whether people were getting the right care at the right time and in the right place, and how collaboration across local areas had made a difference. Much of the joined-up work is usually behind the scenes from the patient's perspective, but we have seen in the past how good collaboration is often evident in the better examples of care we find.

This report shares the overall learning from the review, which falls broadly into the following themes:

1. Ensuring access

Urgent and emergency services collaborated in a variety of ways to maintain access to services, although access to the right UEC care was sometimes difficult for people.
The pandemic served as a catalyst for change – pathways were often evolved at pace with positive impact.

2. Tackling inequalities

There was variation between local systems in the level of focus and action on health inequalities, linked to pre-COVID oversight and planning maturity around population needs.
The pandemic exposed where some systems lacked the full understanding of inequalities across their population groups.

3. Governance and shared planning

Governance varied across systems, but with a number of common priorities.
The extent to which data was shared across the system significantly affected oversight, assurance and decision-making.
Support for adult social care varied. Some providers felt well supported by system partners, but many others felt uninformed and not supported. Some providers said they were not always included in planning or decision-making.
Good existing relationships across a system set the foundation for the effectiveness of collaboration and shared planning.

4. Safety and staff skills

Providers created new collaborative relationships, sometimes sharing staff or helping ensure services were adequately staffed.
Staff have been flexible and risen to many challenges. But exhaustion and burnout were concerns everywhere, especially with the impact of winter.
We saw little evidence of widespread shared strategies, at a whole-system level, for managing anticipated increased demand for UEC services this winter. Systems didn't always feel it was in their remit to plan for system-wide staffing.

5. Use of technology

Technology increased and changed the way people were encouraged to access UEC, although some systems were more advanced than others in their approaches to equality of access.
Many people benefitted from the quick responses of primary care to offer virtual access. Rapid technology advancements were seen to significantly improve transfers of care.
Where electronic patient records were shared across all sectors, we heard of a positive and timely impact for people accessing care.

We have previously shared learning examples from the areas that we covered [https://www.cqc.org.uk/publications/themed-work/collaboration-urgent-emergency-care], and links to these examples are also shown in the relevant sections below.

We also share some learning in respect of three areas of focus:

Safeguarding
Children and young people
Medicines optimisation

Looking forward to next winter and beyond, the main challenges we have identified for systems are:

Develop and build on relationships: provider and system leaders must collaborate and work together to meet the needs of their local populations. Our work shows that it is crucial to establish good and meaningful relationships across local areas and systems.
Share important information: urgent and emergency care services will be able to help people most in need of care if lasting solutions for information sharing are achieved.
Understand staffing: to ensure the right numbers of people and skills, workforce strategies should cover a local system or area, not just localised services.
Understand inequality: leaders need to work hard to understand the inequalities that exist in their areas and further develop strategies to address them
Embrace technology: rapid advancement of new ways of working have shown that in many cases there is an opportunity to improve people's access to care and their experience.

Ensuring access

Key learning

Urgent and emergency services collaborated in a variety of ways to maintain access to services, although access to the right UEC care was sometimes difficult for people.
The pandemic served as a catalyst for change – pathways were often evolved at pace with positive impact.

There were many initiatives to try to help people to access care [https://www.cqc.org.uk/publications/themes-care/collaboration-urgent-emergency-care#right-time]: new phonelines for triage (keeping people safe but away from emergency departments, if possible); remote care provision, including 24/7 mental health crisis lines; new physical services included 'hot hubs', plus taxi services to get people to hot hubs; urgent dental hubs; and enhanced mental health crisis support, including crisis houses and cafes.

NHS 111 was at the centre of much collaboration, assessing urgency and directing people to the right service or pathway.

Some providers have been proactive in considering the needs of certain population groups, such as older people or people with certain health conditions. Mental health services were available in some areas, but some people struggled to get urgent mental health treatment, and in many areas UEC faced challenges in meeting the emotional needs of children and young people.

Access to the right UEC care was sometimes difficult for people. Some people could not arrange urgent GP, dental and mental health appointments due to service closures. This, coupled with reduced capacity in some services that remained open, had a knock-on effect on other UEC services and people seeking urgent care. NHS 111 sometimes struggled to point people to services because of unplanned service closures, which put extra strain on emergency services.

Community mental health services were affected and dental services that were open struggled with demand – some emergency departments helped people who could not see a dentist.

Providers and system partners faced challenges in communicating that UEC services were available, and had to strike a balance between encouraging people to seek help if needed while concerned about potentially being overwhelmed. To get the message across, services tried social media, radio and television, bus stop posters and contact through professionals such as social workers or district nurses.

Changing pathways

There was collaboration among UEC services to separate people with coronavirus and those without the virus. At the height of the first wave, services tried to avoid hospital admissions and keep people away from hospital emergency departments.

Changes meant people were directed elsewhere – urgent care and treatment happened in different ways and in different places. Telephone and online systems were established or used more often – and we were told about the challenge of directing a person safely by phone or online; without seeing someone face to face, it was not always clear how unwell they might be.

We heard how some primary and community care services decided that treatment in people's homes was a better option than the risk of an urgent care site, but not everyone could be cared for at home.

Other changes in services included some outpatient departments' services being moved to a different hospital or site. This helped make way for different patient pathways – there were codes for pathways and sites, such as 'hot' or 'cold' sites, or 'red' or 'green' pathways, determining the movement of COVID or non-COVID patients. Some hospitals were designated non-COVID only, known as a cold site.

Specialist UEC care pathways were devised to bypass hospital A&E departments. This allowed people direct admission into hospital wards or to other services that they needed. People could access a range of specialisms including mental health care, frailty, palliative and end-of-life care, children's services, gynaecology, urology, ophthalmology, and ear, nose and throat care.

Although we heard about problems for people trying to access mental health care, some acute and mental health trusts worked together to prevent people with urgent mental health needs being admitted to acute hospitals.

Hospitals worked with GPs, NHS 111 and ambulance services to try to direct people to the right places; there were adult social care and health care services that tried to reduce COVID risks and the need for UEC services through enhanced support and training in care homes; and we heard about some good cross-sector communications and information sharing that enabled better outcomes for people. The introduction of Think 111 First in some areas – enabling direct access for some appointments with GPs and EDs – was coordinated at system-level.

Providers, particularly GPs, and other organisations such as local authorities and the voluntary sector, contacted vulnerable and shielding people to offer advice and guidance and to check on their welfare.

Tackling inequalities

Key learning

There was variation between local systems in the level of focus and action on health inequalities, linked to pre-COVID oversight and planning maturity around population needs.
The pandemic exposed where some systems lacked the full understanding of inequalities across their population groups.

In our reviews, we wanted to know about strategies and plans for tackling health inequalities [https://www.cqc.org.uk/publications/themes-care/collaboration-urgent-emergency-care#tackling-inequalities].

The pandemic exposed health inequalities that were not well known before, and it provided the momentum to tackle long-standing inequalities. Work to understand and tackle health inequalities had focused on economic disparities, while the pandemic highlighted the need to address other factors, particularly ethnicity.

Some providers tried to work with communities and sought the views of specific population groups to improve their awareness of health inequalities and consider how to tackle them. We heard about listening events and the involvement of people using services in wider learning activities, but this did not happen everywhere - in some places there was a lack of public involvement.

Collaboration with the voluntary sector and community engagement supported providers to understand and meet the needs of different groups. Engaging directly with communities, especially using 'community connectors', was particularly important in sharing information and guidance. Community connectors will be different people in different places, but they are usually people who are well-known within their communities – for example, a leader within a local religious community, or someone else with a known reach or influence within a specific population group.

Communication about COVID-19 was provided in different languages and we heard about specially created easy-to-read information for people with a learning disability. However, we saw there were barriers for certain groups of people in some places, including those with different languages. Some people did not get the information they needed about how to access services.

There were some initiatives to provide accommodation and health and care services for the homeless and, in some systems, this work provided learning that could also help meet the needs of homeless people in the future.

We found variation between systems in the level of focus and action on health inequalities. Some systems had strategies and action plans in place. In some, the pandemic has heightened the need for learning and improvement. Work is ongoing to understand the impact of COVID-19 on different population groups, with some systems more advanced than others. The use of data appeared to be limited and an area for development and improvement.

Several systems reported that the fast pace of change due to COVID-19 meant equality impact assessments had not been completed early in the pandemic but were happening as part of reviews and lessons learned.

Some places had captured people's recent experiences of care to inform planning, including local Healthwatch projects in West Yorkshire and Harrogate and Suffolk and North East Essex.

Experiences of Health & Care in Bradford during the first phase of COVID-19 (Healthwatch Bradford & District) [https://www.healthwatchbradford.co.uk/report/2020-10-23/experiences-health-care-bradford-during-first-phase-covid-19]

There was a lack of evidence on equality outcomes specifically, although several prevention programmes and initiatives were highlighted. These were focused on older adults, people with a learning disability and others at greater risk of poor health outcomes.

In some, providers described approaches to understand and monitor inequalities, exploring the needs of different groups of people and the impact of the pandemic. There were processes to collect and analyse population-level data to identify where gaps in provision might be. However, in others, understanding of health inequalities was limited or there was a lack of data on demographics, particularly ethnicity.

Some providers had little to say about how they were tackling health inequalities. We were told that it was unnecessary because they tailored their care for individuals. Some systems had identified the needs of disadvantaged groups but had not put measures in place to address them.

We asked about cross-system approaches to tackling barriers for people from Black and minority ethnic groups. Some providers told us how they ensured the safety of Black and minority ethnic staff, but there was little about action to improve access to care and outcomes for patients. Some said this was not a priority because there were smaller populations of Black and minority ethnic people. This meant systems did not pay enough attention to the disproportionate effect of the pandemic or the needs of Black and minority ethnic people in their response. Some systems recognised this. This was a factor for systems in areas where visible ethnic minority populations were smaller and perhaps more isolated.

Governance and shared planning

Key learning

Governance varied across systems, but with a number of common priorities.
The extent to which data was shared across the system significantly affected oversight, assurance and decision-making.
Support for adult social care varied. Some providers felt well supported by system partners, but many others felt uninformed and not supported. Some providers said they were not always included in planning or decision-making.
Good existing relationships across a system set the foundation for the effectiveness of collaboration and shared planning.

Across our reviews, there was evidence of effective governance structures, with a developed understanding of roles and accountabilities. While there was variety across systems, with a wide range of overlapping structures, there were some common key priorities:

monitoring UEC demand and capacity in a consistent way
coordinating planning and sharing learning
protecting core UEC services, through optimisation of pathways, supporting preventative services and community services to reduce use of UEC services, and increasing capacity through commissioning
ensuring adequate numbers of skilled staff across the system.

Collaboration across urgent and emergency care has happened at multiple levels and there was not a one-size-fits-all approach. There were various arrangements for the planning and delivery of the UEC pathways across systems [https://www.cqc.org.uk/publications/themes-care/collaboration-urgent-emergency-care#governance] and we saw examples that went beyond system boundaries.

Priorities were often reflected in the winter planning done between services locally, and to a lesser extent at an ICS/STP level. There was a desire for operations to be managed at place level as much as possible. We saw that providers collaborated at multiple levels, with place-based partnerships leading on operational delivery of services.

Providers reported that they made their own plans and risk assessments and we saw that providers adopted their own 'command and control' hierarchies for escalation of concerns – and shared this planning with other providers across the system. This encouraged responsive decision-making. The structures usually had foundations in pre-existing relationships and arrangements and were in terms of 'gold', 'silver' and 'bronze' command layers.

We saw systems monitoring to identify which services were in high demand, identify pressures on the workforce, and determine escalation points. There were examples of modelling being used at a systems level, using historical and live data to forecast future demand and capacity, and to explore different scenarios for planning. We saw many examples of ongoing monitoring from CCGs, looking at population groups, changes to bed capacity, workforce numbers, evaluation of pathways, and monitoring of compliance with changing national guidance.

However, evidence about how well systems' data were communicated was mixed. Some providers commented on the usefulness of shared dashboards, record systems and updates, though for other providers there was little evidence that these had informed decision-making.

Working together

There was system-wide collaboration and planning at STP and ICS levels – this was for planning of urgent care pathways and service delivery, oversight of capacity and demand, workforce solutions, and commissioning.

There was collaboration between the NHS and independent sector. For example, we were told about examples where cancer care was moved to some independent hospitals, and providers looked at different ways to try to ensure people were assessed. Some unusual environments were used for care services, including sports clubs, and in some places, people were assessed in their cars.

There was extra support for social care providers in some places, to ensure residents got appropriate urgent care. Clinicians were aligned with care homes, sometimes through a primary care network. Equipment was provided to support remote consultations.

There was also some poor collaboration. Many adult social care providers felt uninformed, not supported or included by GPs and NHS trusts, particularly around coordination of the discharge of people from hospitals to care homes or into people's own homes.

Some adult social care providers told us that no measures were in place to ensure support from UEC providers for vulnerable people. Sometimes, support for people shielding was led by the adult social care service where people lived. Some home care services relied on NHS 111, while some care homes were supported by a GP and could also get rapid response via a special designated 111 service.

Relationships set the foundation

Looking ahead to next winter, strong leadership and a determination for local collaboration is essential. Provider and system leaders have a duty to collaborate to meet the needs of local people.

We found that pre-established relationships and ways of working set the foundation for how systems and place-based collaboration worked during COVID-19. For many systems, UEC partnerships and networks were mature even before the pandemic and there was an advantage in areas where working relationships were already in a good position. Relationships have since strengthened and systems were keen to maintain collaborations.

For systems with distinct place-based approaches to UEC, collaboration continued to be predominantly place-based. For example, in Hampshire and the Isle of Wight, we found four independent systems that came together. The separation appeared to stem from a history of working independently, with separate funding and information technology arrangements.

Barriers were put aside

Across our reviews, we were consistently told that previous barriers to collaboration were put aside during COVID-19, particularly around sharing information, resources, and staff redeployment. We heard this included a shift of focus from financial consequences and individual provider needs, to what was right for the patient. It was described as a liberation, placing people at the heart of decision-making, removing barriers and bureaucracy where possible to be more responsive.

Funding certainty was another lever for collaboration. While this had been consistently cited as a barrier to collaboration, changes were accelerated in response to COVID and financial decisions had not been the main driver in determining provision of care.

We heard that organisations worked together when money was 'off the table'. Interviews also highlighted the importance of joint commissioning between health and social care, providing synergy across whole systems. There were some examples of mutual aid agreements in place at both NHS trust and CCG level. However, we heard of uncertainty about future funding and there were concerns about the impact of this on future collaboration.

Adult social care and system planning

We heard how some smaller adult social care providers were not always involved in planning. In several systems, providers said they were not involved in decision-making. While this review has described positive examples of collaboration between health and social care – in care homes and home care agencies – we also heard about other problems for social care providers, including:

Not having a strong voice in planning and decision-making.
Absence of social care leaders in place/systems UEC programme boards.
Limited national guidance and support from the system early in the pandemic, creating pressure on providers to source PPE (later improved with access to NHS portals).
Hospital discharge processes into care homes: due to a lack of testing there was pressure to accept people into care homes. There was a suggestion that this had since improved, with patients only being discharged following a negative test result.

Role of the voluntary sector

The voluntary sector and community health services have played an important role in collaboration with UEC. Most systems we reviewed gave examples, including:

- identifying vulnerable groups and building community resilience
- reaching people in need before they entered crisis care pathways
- providing nursing treatment to prevent routine hospital admission
- supporting patients around their discharge from hospital.

We saw limited evidence about the involvement of voluntary and community services in UEC planning, although we know that system leaderships wanted to ensure that voluntary and community services had equal footing in discussions. They were described as "just as important as statutory services". It was less clear how these services were represented in meetings and decision-making processes.

During the pandemic, some systems lost the capacity that these services would normally bring.

Digital governance

Across the systems we reviewed, digital governance was mostly overseen by a board to ensure safety through digital services.

We were told that quality, risk and data impact assessments were implemented to ensure digital information governance processes were followed. However, some concerns about digital governance were raised when we talked to providers about urgent and emergency care. Confidentiality issues were raised about storage of patient information and information given through remote care. Examples included people being asked sensitive questions in public places, or people being visible in the background of video consultations.

There were also concerns about General Data Protection Regulation (GDPR) compliance in adult social care. Examples included shared access to care records, as well as use of mobile phones by carers, and GPs supporting care homes to work digitally but restricting access to care records at appropriate levels.

There was awareness from providers about the need for increased safeguarding measures through digital consultations. While additional procedures and training were put in place, and it was suggested that it was positive to see the patient in their own home, there remained concerns that the safety assessment measures did not guarantee patient safety.

Learning and improvement

During our reviews, we wanted to know where and how learning and improvement was considered and shared.

Across the places and systems, there were different kinds of operational and strategic groups or teams where learning and improvement was recognised. There were local resilience forums, health and scrutiny boards, cell structures and clinical practitioner forums – all appeared to be mechanisms for learning and sharing. These groups brought providers and other system partners together for discussion, reflection and decision-making.

We heard about groups at provider, sector and system level, as well as regional groups. We also heard how STPs and ICSs played a valuable role in supporting, capturing and co-ordinating learning and improvement.

Research and evaluation activities and specific learning events were highlighted in some systems, to help to identify successes, limitations and key learning points. Other approaches that supported learning and improvement included the reviewing of data, incidents and deaths, and quality improvement processes.

We heard that enablers for learning and improvement included good leadership, supportive relationships between partners and providers, and a positive culture – the openness and willingness to change and develop.

Staffing skills and safety

Key learning

Providers created new collaborative relationships, sometimes sharing staff or helping ensure services were adequately staffed. Staff have been flexible and risen to many challenges. But exhaustion and burnout were concerns everywhere, especially with the impact of winter.
We saw little evidence of widespread shared strategies, at a whole-system level, for managing anticipated increased demand for UEC services this winter. Systems didn't always feel it was in their remit to plan for system-wide staffing.

Providers created new collaborative relationships during the pandemic [https://www.cqc.org.uk/publications/themes-care/collaboration-urgent-emergency-care#staff-safe], and built on existing ones, to share staff and ensure that services were adequately staffed.

Established relationships helped services in the height of the pandemic, but while they rallied to cope locally, we saw little evidence of widespread shared strategies at a whole-system level, for managing an anticipated increase in demand for UEC services. Some systems told us that winter planning did not always relate specifically to staffing for UEC providers.

Workforce strategies

Staffing strategies were addressed at a local provider level and some winter planning was always shared, even before COVID-19, which was indicative of a system culture that values collaboration. But it was not always clear whether plans were being shared across the whole system – or just between similar providers, such as other NHS trusts within the system.

In our 2018 report, Beyond Barriers [https://www.cqc.org.uk/publications/themed-work/beyond-barriers-how-older-people-move-between-health-care-england], we said that national workforce strategies need to set the tone to ensure that health and care staffing has parity and is joined up. During the review, some interviewees from oversight bodies felt it was not within their remit to set up cross-system staffing strategies. We heard that overlapping geographical footprints and general complexity within the health and social care system are barriers to this happening. Geographically-isolated trusts were also less likely to be able to share staff.

In this review, providers explained how they had increased staffing levels and expanded skill-sets at a local level. Often, we heard these were within providers, but we also heard about shared initiatives between providers across a system.

One initiative we heard about was the 'passporting' of staff between NHS trusts. An NHS competencies passport enabled staff to move between providers within a system more easily with the aim of reducing gaps in staffing and improving patient care.

We heard about initiatives deployed across the summer months to ensure staffing levels were maintained within UEC services. These included joint recruitment strategies, use of staff from private providers and agencies, redeployment within providers, taking on apprentices, and training furloughed or non-essential staff from other organisations and workers from sectors such as hospitality.

Keeping staff safe

We found that a wide range of measures were introduced to keep staff safe. Providers changed their ways of working to support staff during the pandemic, with examples included remote working and changing the design of workspaces, such as fitting protective screens.

There were various strategies to support mental and physical wellbeing, and risk assessments for all staff to ensure that they both felt safe and were safe at work. Some providers extended risk assessments and related support to immediate families of their staff, to give extra reassurance.

We also heard about some enhanced risk assessments – in content and/or frequency – for staff from vulnerable groups including people from Black and minority ethnic backgrounds. However, this was not a universal approach and we found that not all providers appeared to be taking significant action to mitigate the increased risks from COVID-19 to Black and minority ethnic people.

Where practical, changes had been made to working arrangements so that staff who needed to work from home were able to work from home. There were also changes to job roles and greater flexibility to make best use of staff members' skills and experience.

There was extra help for staff: mental health support; increased informal 'catch up' calls or sessions; staff networks; care packages and additional breakout spaces. Some mental health trusts provided support for staff across other NHS organisations with access to counselling or other psychological therapies.

Providers were concerned for their staff members' mental health and resilience and pointed to the impact on resilience as their biggest risk, despite their workforce plans for winter.

Easy access to enough and appropriate PPE had been a problem for some providers at the beginning of the pandemic, particularly for staff at adult social care services, but was mostly no longer an issue. PPE was shared across systems, too – hospitals helped adult social care providers to get supplies nearer the beginning of the pandemic.

Using technology

Key learning

Technology increased and changed the way people were encouraged to access UEC, although some systems were more advanced than others in their approaches to equality of access.
Many people benefitted from the quick responses of primary care to offer virtual access. Rapid technology advancements were seen to significantly improve transfers of care.
Where electronic patient records were shared across all sectors, we heard of a positive and timely impact for people accessing care.

During the pandemic, technology has transformed the way many people have accessed health and social care services [https://www.cqc.org.uk/publications/themes-care/collaboration-urgent-emergency-care#technology], but not everyone has enjoyed a good or improved experience. Some people have lost out because they cannot access the newer or replacement services enabled by digital advancement.

The pandemic has required a speedy shift towards more online care consultations. Digital consulting systems were largely viewed by patients and doctors to have improved access for people who needed UEC.

Some collaboration that improved outcomes was behind the scenes for patients. Digital consulting systems have improved access to care for many people. Electronic patient records enabled quicker access and shared information from multiple providers. We found this was underpinned by evidence of quality, risk and data impact assessments to ensure digital information governance processes were being followed.

In some places, services were aware of the groups most at risk of digital exclusion and proactively explored – and tried to counteract – any disproportionate impact digital systems due to the pandemic on people from Black and minority ethnic communities, people with a disability and those in socially deprived areas. There were also initiatives to support those who couldn't access digital services, such as deaf or visually impaired people, including helplines and volunteer networks.

Good use of technology helped collaboration over transfers of care for people and there was evidence of good sharing of records across sectors. Where people could access the right technology, they were able to communicate with GPs in real time and sharing photos. Technology also helped collaboration with the voluntary sector.

In dentistry, video and phone consultations were introduced. People were able to send photos digitally, to help diagnosis and inform triage options or remote prescribing. But as we pointed out in our review of collaboration among services for older people, there was inconsistent use of NHS email, which was inhibiting for some communications. Also, access to summary care records is a continued barrier to ensuring people can move through a system effectively with one record.

Before the pandemic, we knew that the safe use of technology in health and care services was making a positive impact on many people's lives. In this review, we found across UEC services that technology was used to increase people's ability to access healthcare remotely. It also helped providers to share information and continue essential services. Examples of this included:

Ambulance providers were able to share information with emergency departments regarding medication prior to the patient entering the emergency department.
The electronic prescription service allows prescriptions to be sent to pharmacies electronically. The pandemic saw an increase in the use of this service, which promotes efficiency and convenience for staff and patients.

Child protection meetings occurred remotely. This improved the timeliness of the decisions made as people could attend from anywhere, although there was some concern that remote meetings limited the voice of the child.

Information sharing

Information sharing was critical. When patients entered UEC services, it was important that care professionals knew about people's vulnerabilities so that care could be adapted. The electronic patient record (EPR) helped, as well as access to any 'flags' – notes on GPs' patient records highlighting important medical information about a patient. We heard how the EPR was used to record known patient vulnerabilities. It was available to emergency departments (EDs) before a patient arrived at hospital – shielding letters that had been sent to patients were also shared with EDs and added to patient records so this would flag if the patient attended ED. At a care home, people's vulnerabilities were included on residents' care plans – these were shared with ambulance crews, as well as visiting clinicians and hospital staff.

In our 2018 report, Beyond Barriers [https://www.cqc.org.uk/publications/themed-work/beyond-barriers-how-older-people-move-between-health-care-england], we found that information sharing was a significant challenge for systems and we identified issues particularly with discharge arrangements from urgent and emergency care facilities. We also found that a misunderstanding of information governance rules sometimes led to information not being shared between health and social care services when it was legitimate to do so and in the best interest of people receiving care.

There is work to do for all local systems to achieve lasting solutions for information sharing, but during the pandemic these issues were overcome in some circumstances. Provision of UEC was supported by the way providers were able to share records across sectors: GPs accessing care records from care agencies, and ED staff accessing patient records before a patient had arrived by ambulance. There was some evidence of informal information sharing through encrypted communication such as WhatsApp.

There was also evidence of how electronic records and record sharing were used proactively to support people at home and avoid the need for urgent and emergency care. GPs and patients were in touch by mobile phone or devices, with information or photos shared directly. In adult social care, people using services and their families (if they had the rights) were able to see aspects of their care records, including visit times for home care agencies, and other information such as prescription and medication records – they were helped to be aware if issues were arising, proactively supporting that person to reduce the risk of them experiencing a crisis.

Partnership working

Partnership working was supported by digital systems, with staff using familiar software platforms to communicate and attend meetings. This has improved communication, visibility of teams and productivity. This supported care providers in connecting with local alliances such as NHS, CCGs, the Kings Fund and Healthwatch to improve collaboration and partnership working.

There were examples where safeguarding staff have been attending more meetings virtually, enabling them to be effective and inclusive when safeguarding issues occurred regarding urgent and emergency care. Video conferencing had also improved productivity and been used for staff engagement.

Partnership working between system providers and the voluntary sector has been implemented to support remote care for patients. Examples include:

- Funding for devices to be distributed to those who require it.
- Supporting people who need new technology skills.
- Devices delivered and picked up from people who are digitally excluded.

Enhanced communication

Across systems and urgent and emergency care, messaging services have been used between staff and people who use services to avoid people needing to physically attend urgent and emergency care. Systems include booking appointments, responding to queries, providing updates and advice, and disseminating training/guidance. Examples included:

- SMS service being used to detail time and location of prescription pick-up, which has decreased time spent in the pharmacy and prevents patients going to the wrong pharmacy.
- Using apps to post messages and information about services, offering communication channels for families and loved ones.

Oral health and digital initiatives

Access to dental care became a problem when lockdown occurred. Dental practices did what they could remotely and where active treatment was necessary, referred patients to urgent dental care centres.

Some places responded quickly to set up urgent hubs as they had well-established system relationships. Problems included managing people's expectations of what was classed as urgent. Digital solutions were put in place to support people with urgent and emergency dental needs, including:

Video and telephone communication services, used for triaging patients in need of urgent and emergency dental treatment. Video and photographs were used to help diagnose patients remotely and enable prescribing.
'Attend anywhere' was introduced nationally to enable access for people and reduce travel needs.

Focus on: Safeguarding

Key learning

The usual routes for recognising safeguarding concerns were affected by the pandemic.
In the light of this, some providers put extra measures in place to ensure safeguarding concerns were recognised and addressed.

Our review looked at what measures were taken to protect vulnerable people, and this included what happened to address any increased safeguarding concerns.

Some systems identified increases in concerns. For example, Leeds Community Healthcare saw more safeguarding referrals, as did Southampton and South West CCG – specifically for children and young people and for domestic abuse.

However, GPs in Hampshire and the Isle of Wight noted a drop in safeguarding referrals when schools were closed during lockdown. This showed how a usual route for recognising safeguarding concerns was affected by the pandemic.

UEC providers highlighted extra measures in place to ensure safeguarding concerns were recognised and addressed, including additional training, specialist support and supervision, and increased collaboration and information sharing.

In east London, we heard how cases were also being re-reviewed to check if anything was missed. Locally and during the first peak of the pandemic, there were some increases in safeguarding issues locally, but the local authority in Newham described very good links between the safeguarding team and the hospital emergency department. A GP and chair of the CCG training hub in Newham described extra safeguarding training that happened. They told us that during remote consultations, GPs "were able to actually see inside patients' homes for the first time and identify any potential safeguarding issues from the patient's home environment". Cases were also re-reviewed by specialist teams due to increased pressures in emergency departments.

We heard about a strong awareness of safeguarding and how improvements were made, including extra training for an ambulance service so that its safeguarding knowledge was at a higher level.

Focus on: Children and young people

Key learning

There were shared concerns about the increasingly complex mental health needs of children and young people during the pandemic.
Systems redeployed some of their children's workforce to meet the adult COVID demand during the first lockdown, leading to reduced capacity and support for the most vulnerable children and their families.
There was evidence of children and young people's safeguarding needs being part of local area strategic discussions, and efforts were made to ensure that carers and families knew urgent care was still available.

Urgent and emergency care providers have collaborated to protect and care for children and young people (CYP) [https://www.cqc.org.uk/publications/themes-care/collaboration-urgent-emergency-care#children-young-people], often by adapting their services.

Children and young people in the right place, at the right time, by the right person

Children were presenting with increased clinical, emotional and social care needs, and there were concerns about delayed presentation and increasingly complex mental health needs.

Processes were adapted in some systems to ensure CYP were seen safely and at the right place. Senior decision-makers triaged referrals to ensure CYP went to the right urgent care site and offered advice to GPs. Some GPs had access to paediatric wards for advice and could send CYP straight to the appropriate ward.

Safeguarding prompts were shared across primary care to remind practitioners to keep safeguarding on the agenda. Practitioners were reminded of the importance of face to face or video consultation when undertaking assessments.

There were some enhanced multi-agency approaches, with established teams notified of children and young people attending emergency departments. The voluntary sector was involved in meeting emotional and mental health needs via an online counselling service.

Children in care or leaving care have been supported through commissioned services, such as Barnardo's. The early identification of a vulnerable group has meant that the right services have supported them.

The numbers of children attending for UEC in hospital dropped, so safeguarding prompts were shared across primary care to remind practitioners to keep safeguarding on the agenda and encourage face-to-face or video appointments, and to carry out the consultations with safeguarding in mind.

There was collaboration between departments and IT-enhanced oversight between ED and paediatrics. And a modified care pathway meant young people attending an ED were seen in a paediatric assessment unit, with paediatric specialists. This prevented unnecessary admission – previously, some young people would have gone to a ward to wait for their assessment. There were other examples of diverting CYP away from EDs, including a children and adolescent mental health services (CAMHS) crisis team that extended its hours and offered more home care.

The Think Family initiative [https://webarchive.nationalarchives.gov.uk/20130323053534/https:/www.education.gov.uk/publications/eOrderingDownload/Think-Family.pdf] was noticeably increased across multi-agency health and care partners to help recognise potential neglect among CYP, and we heard that some hospitals were admitting young people due to social care issues, not always medical conditions. New care pathways were created so CYP could access in-patient wards without having to go through the ED. And for young people in mental health distress, were heard about efforts to ensure quicker safe access to paediatric wards.

Shared plans and system wide governance and leadership

We consistently heard safeguarding specialists in the acute setting were not redeployed - often they offered additional support and oversight. There was evidence of CYP's safeguarding needs being part of local area strategic discussions.

There were efforts to ensure that carers and families knew urgent care was still available because there had been a decrease in attendances. Social media, newsletters, helplines and primary care networks were used to communicate with the public.

Refining systems

Most areas reported shared challenges for staff in meeting the increased mental health needs of CYP and managing their needs in ED and paediatric wards. Many had extended their mental health support through the availability of specialist practitioners and advice lines.

Areas worked with partner agencies to refine systems to identify and review vulnerable children known to them. Children were regularly reviewed by multi-agency partners; providers and CCG safeguarding colleagues met virtually to identify safeguarding risks. Some areas undertook audits to assess the impact of their work, for example of holding virtual strategy meetings and monitoring ED attendance trends.

For adults attending ED with childcare responsibility, some systems had initiated or strengthened approaches to identifying 'the hidden child'. This included confident collaborative working within ED across West Yorkshire and Harrogate, where 28% of adult mental health presentations led to referrals of children for assessment.

There was agreement that collaborative working had been strong and had helped pathways to change quickly. For example, we saw how a local authority and an ED worked together with a flagging system to increase identification of vulnerable children.

Sometimes children and young people with complex mental health issues were admitted to hospital inappropriately, but new pathways had helped to rectify this. We heard about how a daily 'mental health huddle' was introduced so that discussions about action plans for young people could happen – then CAMHS visits to the wards would help with the appropriate discharge.

We heard about system-wide monitoring of trends and there was positive feedback about collaboration across the local system. We heard there was also recognition of positive impact from the voluntary sector and its work across the integrated care system.

Collaborations between health and social care helped identify priority children on the hospital IT system in the ED with a 'flag'.

We also heard about collaboration with primary care to help avoid hospital admissions avoidance [https://wearespotlight.com/news/health-spot-has-landed]. There was an initiative to make services more accessible to young people, and dedicated GP-run clinics with a collaborative approach with youth workers, sexual health and mental health services. However, we also heard some concern about delayed presentations to ED, so social media and a primary care network were used to reassure families that services across north east London were open.

There was evidence that providers adapted the scope of their work. Feedback from partners, families and carers was sought - and services tried to get children's views to inform their work, sometimes working Healthwatch.

Ensuring the safety of staff and enough health and care skills across providers

We heard how systems redeployed some of their children's workforce to meet the adult COVID demand during the first lockdown. This workforce would ordinarily be working to identify and support families and vulnerable children, and we heard that there was concern about the reduced capacity for this as a result of redeployments.

Areas adapted their approach to training to meet their safeguarding responsibilities. Online training covered topics that were emerging during lockdown, including serious risk-taking behaviours and increased mental health concerns.

We heard a 'Think Family' model was strengthened through staff training and ambulance crews were taught to 'Think family' to strengthen their assessment of potential safeguarding issues for children. Training was also delivered in children's homes to ensure everyone was aware that the EDs remained open.

Digital solutions and technology

Local areas used virtual, electronic systems to deliver meetings. Some areas reported an increase and more timely attendance at meetings and response to safeguarding concerns. In some cases, more colleagues can attend child protection meetings through video conferencing. However, some practitioners told us that virtual consultations and 'attend anywhere' appointments limited the ability to "capture the voice of the child".

Where care pathways were adapted, providers met online to discuss adaptations. There was also online information to support children and young people in looking after themselves and those around them. Going into the second wave, some providers were keen to continue their engagement via online solutions.

At least one ED worked with a safeguarding team with a focus on mental health issues – a record was kept and then follow-up by safeguarding was initiated for any child or young person attending where there was concern about self-harm, suicide, or potential mental health problems. We were also told about the launch of the Handi app, which gives specialist paediatric advice to parents, carers and professionals.

We heard about learning such as data analysis that showed the cause of someone's attendance at ED. In East London, there was also something called the 'YES' group, where COVID information was shared for other young people [https://children.bartshealth.nhs.uk/our-news/play-team-2020-update-interview-about-the-new-yes-covid19-leaflet-8489] and circulated via social media and on the organisation's website.

Online solutions had helped with timely responses to children and young people's need – and there were efforts to share important information, using local radio and social media, to ensure families knew that it was safe to attend the ED.

Focus on: Medicines optimisation

Key learning

There was significant planning across medicines optimisation teams to help avoid admissions to hospital. Medicines teams were involved in pathway redesign to support people moving through services, but their level of integration was mixed.

Through the UEC reviews we were told about significant planning across medicines optimisation teams, focused on avoiding admissions to hospital. This was across many of the areas and to help ensure that capacity was maintained.

People at the centre of their care

There was a range of initiatives that included changes to the range of medicines available from ambulance crews to treat people with COVID, as well as for other medical conditions that might otherwise result in admission to UEC.

We found systems developing processes to support and ensure access to intravenous (IV) antibiotics administered in people's homes and access to medicines for end of life care (EOLC). One provider delivered an admission avoidance initiative in their locality – this included 'rapid IV pathways' where both first dose IV antibiotics and IV fluids were administered in people's own homes to help reduce admission risks.

We were told about systems for the delivery of both regular and urgently dispensed medicines to people's homes, and about triaging to community pharmacy via NHS 111 and the Community Pharmacist Consultation Service to support the flow of medication to the right people at the right time. An ambulance service deployed pharmacists in NHS 111 or 999 call centres, where they were able to refer people to the pre-existing community pharmacist consultation service (CPCS). In one example, over 6,000 repeat prescription requests were received in a month, and appropriate referral to CPCS helped to avoid undue pressure on ED footfall and wider primary care providers.

Supporting end of life care

Initiatives were seen to avoid admissions and support EOLC. Medicines were available from community pharmacies and within the urgent treatment centres, in take away packs, for symptomatic relief and palliative treatment. A patient group direction for end-of-life care medicines was also developed for use by hospice community nursing teams and ambulance service paramedics [https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-19-patient-group-directions-pgdspatient-specific-directions]. This meant patients had rapid access to immediate doses, with arrangements for follow up treatment on prescription the following day. This followed EOLC guidelines and was supported by the appropriate governance. We heard how one acute hospital provided symptom control packs (EOLC medicines) to allow these to be easily accessed by healthcare professionals for their patients when needed. This reduced over-ordering of stock and ensured a sustainable supply throughout the pandemic.

Medicines in care pathway redesign

Medicines teams have been involved in pathway redesign to support people moving through services. However, across different areas, the level of integration of medicines differed. Where there was engagement, we heard of areas where physical changes to wards and ED areas were made to support safer movement of patients through different clinical areas. Where changes had been made, pharmacy teams responded by ensuring that enough of the right medicines were accessible in the right area. This helped to support timely access to treatment for patients. We also heard of pre-packed medicines were provided in some areas, to help facilitate faster discharge out of hospitals and where providers looked to increase the capacity of UEC services, medicines were also part of these considerations.

Some providers in systems redesigned medicines supply and administration pathways, specifically with infection prevention and control in mind to ensure that vulnerable people, including those who needed to be shielded, were kept safe. Other providers ensured that spaces which were used for blood tests, including those for monitoring medicines could provide a high level of assurance around infection control. For example, one system created a 'super green hub' specifically for shielding patients. This

helped to provide extremely clinically vulnerable patients with a safe space for clinical monitoring, including blood tests for monitoring medicines

Systems

Across the systems we reviewed, we were told local medicines optimisation leadership cells supported UEC providers and other bodies to work more collaboratively than previously. In planning to provide assurances around availability of medicines, we saw examples of providers that put in place a memorandum of understanding to support this.

Across systems we were told there was a proactive response to flu vaccination which was supported by medicines teams. Flu vaccination of staff is key in supporting staff working in UEC services and, more widely, during the winter period. This feeds into service capacity by preventing avoidable sickness. Providers, including the community pharmacy sector, have been involved in the planning and delivery of this.

We saw examples where system leaders and service providers were, and are still, working creatively to deliver agreed services and manage increase in demand. To avoid admission, virtual ward rounds were piloted and trialled in one area. This included monitoring of patients remaining at home with oxygen saturation monitors. Patients also received daily support calls from clinicians who could escalate any concerns quickly or refer to community pharmacy, where appropriate.

Last updated: 06 April 2021

Print this document

Hampshire and Isle of Wight Integrated Care System update
Portsmouth Health Overview and Scrutiny Panel
June 2021

1. Introduction

1.1 This paper provides an update on the ongoing development of Hampshire and Isle of Wight Integrated Care System (ICS). We continue to work closely with health and care partners, in-line with national policy and local plans for health and care to support people to stay as healthy as possible and achieve the best possible health outcomes for the communities we serve.

1.2 The update follows publication of the Government White Paper, *Integration and Innovation: working together to improve health and social care for all*, in February which outlines plans to support the development of Integrated Care Systems (ICSs) as statutory organisations.

2. Summary of key White Paper proposals relating to Integrated Care Systems

2.1 The White Paper outlines plans for ICSs across every part of England to become statutory bodies, taking on commissioning functions of Clinical Commissioning Groups and some of those of NHS England. This is very much in the same direction as work we are already progressing locally.

Under the proposals ICSs will comprise:

- an **ICS NHS Body** (responsible for developing a plan to meet the health needs of the population - directly accountable for NHS spend, performance and the day to day running of the ICS);

- an **ICS Care Partnership** (with representation from health, social care, public health, local authorities, and Health and Wellbeing Boards, responsible for developing a plan that addresses the wider health, public health, and social care needs of the system).

2.2 Under plans ICSs (composed of both the ICS NHS Body and the ICS Partnership) will be accountable for the health outcomes of the population. A central intention of the legislation is to drive improved integration and collaboration to reduce inequalities and support people to live longer, healthier and more independent lives. Importantly, Health and wellbeing boards (HWBs) will remain in place and will continue to have a key responsibility at place level to bring local partners together, as well as developing the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

2.3 A duty to collaborate will be created to promote collaboration across the healthcare, public health and social care system. This will apply to all partners within systems, including local authorities. The White Paper identifies two primary forms of collaboration/integration which will be underpinned by the legislation:

- **Places**: integration between the NHS and others, principally local authorities, to deliver improved outcomes to health and wellbeing for local people. The White Paper cites the primacy of place within successful ICSs;

- **Provider Collaboratives**: integration, typically but not exclusively between NHS partners, to remove barriers and make working together across the NHS an organising principle. These collaboratives can be shaped by geography or service.

2.4 The proposals set out minimum consistent requirements, which the partners that make up each system are free to supplement with further arrangements. We anticipate, therefore, that there will not be any legislative provision about arrangements below ICS level – with flexibility given to develop decision-making processes and structures that work most effectively for us. The White Paper does, however, set a clear ambition/expectation that the ICS NHS Body will be able to delegate significantly to 'place' level and to 'provider collaboratives.'

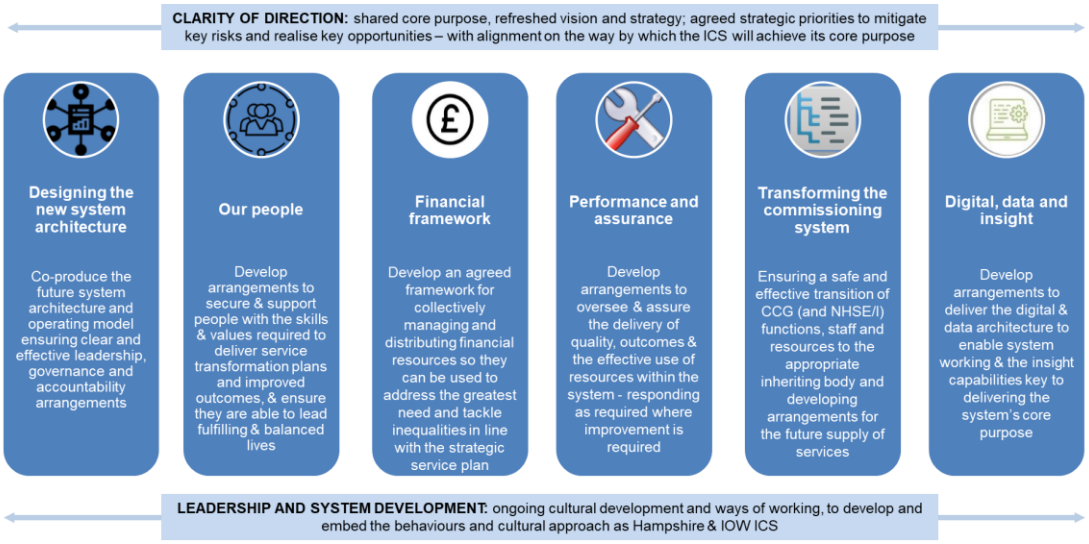
3. Hampshire and Isle of Wight Integrated Care System progress

3.1 Hampshire and Isle of Wight Integrated Care System was established following approval by NHS (Joint) Executive Group on 5 December 2020. This recognises the good progress that has already been made in working together as a partnership of NHS, local government organisations and other colleagues, to join up the planning, transformation and delivery of health and care services for our population. As part of this development process, Hampshire and the Isle of Wight Sustainability and Transformation Partnership [STP] had set out both its proposed development priorities, proposed ICS governance arrangements and operating model.

3.2 The proposals set out in the Hampshire and Isle of Wight ICS submission are broadly in-line with the Government White Paper, which reflects the work we are already progressing locally across Hampshire and the Isle of Wight to build on our existing partnerships to meet the needs of our population, further joining up health and care services for the benefit of the communities we serve.

3.3 The anticipated permissive nature of the forthcoming legislation as it relates to integration and delivery arrangements in place and at provider collaborative is positive in that allows for the continued development of arrangements for 'place' based integration across Hampshire and the Isle of Wight and for the development of provider collaboratives (both in local geographies and across provider sectors). We continue to work closely with health and care partners across the Hampshire and Isle of Wight system on the development of these arrangements.

3.4 Following publication of the White Paper, the Hampshire and Isle of Wight Health and Care Leadership Group reviewed and approved a framework that would form the basis of the Hampshire and Isle of Wight system development plan. This framework is set out in Fig 1. below:



3.5 A process of mapping current arrangements across place and provider collaborative is now underway with an update on progress and first draft System Development plan reviewed at the meeting of the Health and Care Leadership Group on 23 June.

3.6 The timeline for the implementation of future arrangements remains 1 April 2022, with a further development programme envisaged for a period thereafter to ensure the full opportunities presented to the local health and care system are realised. At the time of submitting this update, we await further national updates and guidance on from NHS England and NHS Improvement.

3.7 Meanwhile Hampshire, Southampton and Isle of Wight Clinical Commissioning Group has been in existence since 1 April following the successful merger of West Hampshire, Southampton City and Hampshire and Isle of Wight Partnership of CCGs (which enabled closer joint working between Fareham and Gosport, Southern Eastern Hampshire, the Isle of Wight and North Hampshire CCGs). Portsmouth CCG remains a statutory body and continues to work closely with the CCG. Maggie MacIsaac is Accountable Officer for Portsmouth CCG, as well as Chief Executive of Hampshire, Southampton and Isle of Wight CCG and Hampshire and Isle of Wight ICS.

3.8 For 2021/22 the ICS is a non-statutory body that brings together NHS providers, local authorities and commissioners to provide collective leadership to the Hampshire and Isle of Wight health and care system.

3.9 The Government's proposals set out an ambitious legislative programme that seeks to accelerate the development journey that health and care in Hampshire and the Isle of Wight have been on for more than years. The proposals are founded on the core principle that health and care must be based on collaboration and partnership working – and the legislative programme is designed to enable this at local levels.

3.10 The development programme being progressed in partnership across Hampshire and the Isle of Wight will equip local health and care partners to secure the greatest benefit for our population from the opportunities created by the coming legislation.

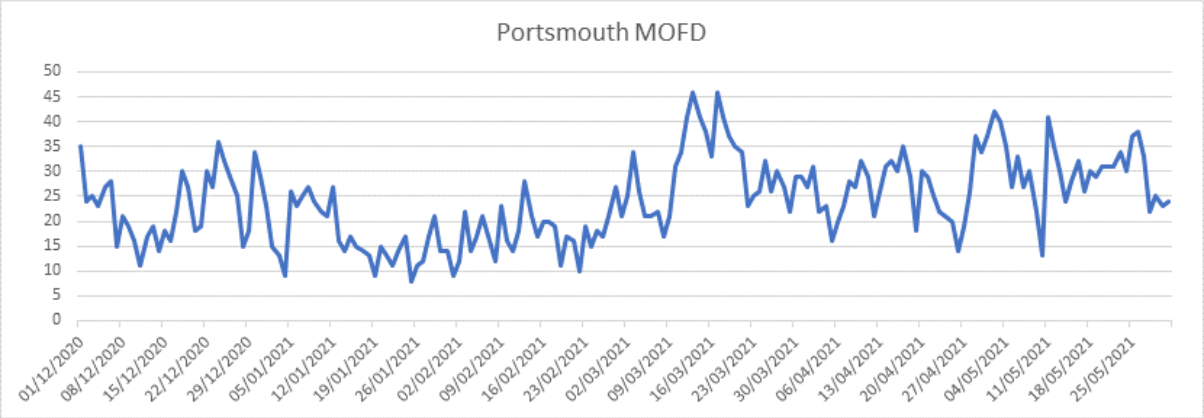
3.11 In May the Queen's speech set out a bill to legislate for the Government's proposals, due for readings in Parliament in July. We will continue to share any developments in a timely way.

ENDS

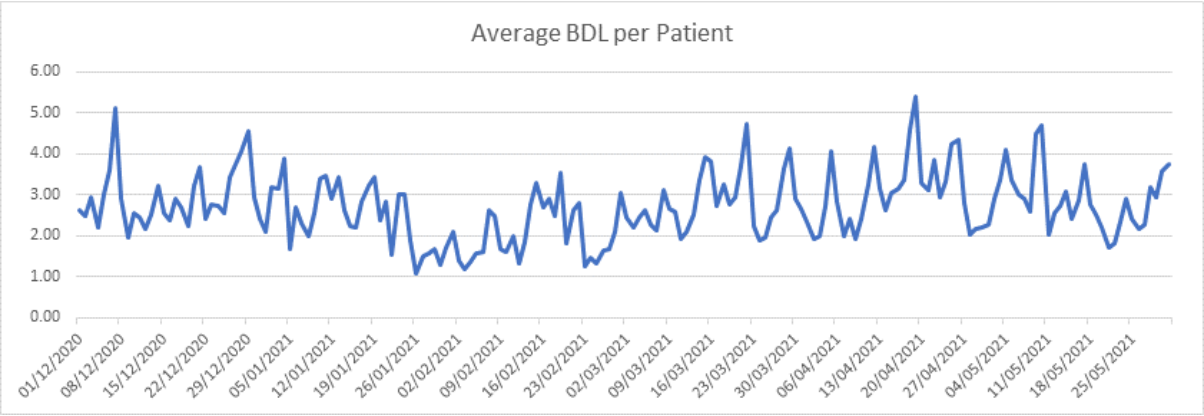
Portsmouth HOSP – June 2021 update

1. PSEH System Working

The Portsmouth Health & Care system continues to support discharges from Portsmouth Hospitals through the integrated discharge hub at St Mary's. The daily target of 10 MOFD (medically optimised for discharge) is challenging as seen from the graph below.



However, system partners recognise that the MOFD target on its own is a crude measure and the Bed Days Lost (BDL) is an important indicator of the speed of discharge consistently achieved for Portsmouth residents.



2. Jubilee Update

The closed wing at Jubilee House was opened in December 2020 as a temporary measure to help meet the demand of hospital admissions and discharged during the second wave of the pandemic. The wing closed shortly after Easter, leaving 12 beds open. Discussions between Portsmouth City Council, Portsmouth CCG and Solent about the future of Jubilee have now restarted. The pandemic has significantly changed how organisations are working together in the city and we now have the

opportunity to reconfigure the city's health and social care bed provision to best meet the needs of our residents.

2. COVID-19 Vaccination Programme

Solent has been delivering Covid-19 vaccinations to NHS community and mental health staff and members of the public from across HIOW as part of the largest vaccination programme the NHS has ever undertaken. Solent runs dedicated Covid-19 vaccination hubs in St James's Hospital in Portsmouth, Oakley Road in Southampton, Basingstoke Fire Station and the Riverside Centre in Newport on the Isle of Wight.

The vaccination rollout has been going extremely well across all four sites, with more than 353,000 vaccinations carried out at these venues and with the latest eligible cohort as set out by the JCVI (and at time of writing) being those aged 25 and over.

3. Staff Survey

Solent carried out its latest annual staff survey, to which 66% of people responded. It is the best response rate amongst organisations of its type. Solent's scores are amongst the best when compared with other combined community and mental health/learning trusts. Solent was the top performing trust in three of the 10 key themes. The Trust scored above average in 9 themes and average in 1 theme. An action plan will be developed, focussing on improvement work in the areas which need attention. The survey also included some specific questions around people's experiences of working during COVID-19. Solent's Research and Improvement Team will feed these responses into the 'learning from the pandemic' work.

4. The Orchards Refurbishment

There are ongoing works at The Orchards on the St James Hospital Campus to improve the environment of our Inpatient Mental Health facilities. Whilst works were started as part of an internal programme of enhancements on both this and the adjacent Limes buildings in late 2020, the scope of improvement has been greatly increased by the successful allocation of £2.4m of Department of Health funding in January 2021. This funding has enabled a host of internal upgrades and the creation of a new fit-for-purpose seclusion suite. This work is due to complete in autumn 2021.

5. New Ways of Working

As organisations begin to consider a return to offices, Solent like many others are working through the implications and potential benefits of continuing to support the new ways of working introduce through COVID-19. Some of these approaches and cultural change may also be important to addressing future flexibility and potential increases in demand for building-based healthcare. Measures such as more flexible space allocation, room and desk booking and directed training in these areas are some of things being worked through.

6. Staff Garden

Solent has recently completed works on a staff garden at St Mary's Hospital. This work is the result of funding awarded by NHS Charities Together, thanks in part to money raised by late former British

Army officer Captain Sir Tom Moore in tribute to the NHS staff in the fight against the pandemic. The garden provides staff with a quiet space away from busy wards and departments. It is a very welcome addition to the St Mary's Campus.

Suzannah Rosenberg
Chief Operating Officer, Solent NHS Trust
9 June 2021

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NHS
Portsmouth
Clinical Commissioning Group

Guildhall Walk Healthcare Centre update report for HOSP June 2021

Introduction

This paper provides an update to Health Overview Scrutiny Panel following the requirement from the panel at the meeting on 18 March 2021, for the CCG to work with Health and Well Being Board and Guildhall Walk patients and practice to secure alternative provision for patients in the event of the practice closure.

Background

As described in the paper brought to the Health Overview Scrutiny Panel meeting on 18 March 2021, the CCG's Primary Care Commissioning Committee made the decision not to re-procure the APMS contract currently held by Partnering Health Limited (PHL) for the Guildhall Walk Healthcare Centre. The contract will cease on 30 September 2021. A key factor influencing this decision was uncertainty about the future of the building, the Landlord has recently served notice for the practice to vacate the building by 4 September 2021. An extension is being sought until the end of September, though it was always planned for patients to move to new practices ahead of Guildhall Walk closing to allow for a smooth transition.

The Guildhall Walk Healthcare Centre is located close to the city centre, with a list size of 8,400 patients. A project plan has been developed to support the closure of the practice and to secure alternative provision for all patients currently registered with the practice.

Patient engagement

Patients have now received three letters regarding the closure. The first informed them of the decision to close the practice; the second invited them to engagement events held by the CCG to

provide more information; and the third letter gave people the opportunity to choose a new practice from a list specific to their home address.

Three engagement events were held between the 21st - 29th April at different times of the day to help ensure there was an option that would work for patient's varying availability. Given Covid restrictions these were online events but in the letter a phone number was given so that anyone without online access could dial in. Questions were invited ahead of these events and there was also chance to raise these during the sessions.

Approximately 50 patients attended these events and the feedback was positive. A presentation was used which went through why the practice was closing, the process for patients being moved to a new practice and answering some questions that patients might have. After each session, any new questions raised by patients, either during the event or received via email/phone, were added to the presentation. These included questions around repeat prescriptions, access to online systems e.g. E-consult, the Covid-19 vaccination programme and what would happen if you were moving house shortly. A copy of the presentation has been included (Appendix A). The frequently asked questions and answers were added to the CCG website: https://www.portsmouthccg.nhs.uk/guildhall-walk/faq/. The link for this was included in the third patient letter inviting them to choose a new practice.

In all letters issued an email address and phone number were provided in case patients had questions.

Supporting patients to find alternative provision

In the letter inviting patients to make a choice of new practice they'd like to attend, a link and QR code were provided to an online survey so they could register their choices. For patients without online access a phone number was provided for them to make their choice by telephone. Thirty five patients used this telephone option. Patients initially had just over two weeks to make their choices. A text message reminder was sent out on 26 May which extended the deadline for responding from 31 May to 2 June to give patients additional opportunity to make their choices. This text message also served to help reach any patients who may not have received the letter as they hadn't updated the practice with a change of address. A small number of patients got in touch following the text reminder. The letter outlined that if you didn't wish to make a choice then you would be assigned to a practice within the boundary of your home address, where people didn't make a choice the allocation is usually to the practice closest to their home address.

1,075 patients responded expressing a preference of which practice to move to with 6,547 choosing not to complete the survey and to have the allocation done for them. During this patient engagement process we identified that approximately 700 patients on the Guildhall Walk Healthcare Centre register had left the practice or moved out of area, meaning the list size of the practice is smaller than originally thought.

Around the end of June a letter will go to patients confirming their new practice. Any patient who didn't express a choice of new practice to move to and may subsequently be unhappy with the practice they've been allocated can of course choose to move themselves to an alternative practice which has availability. Patients will be able to do this by completing a registration form online through a practice's website or by making direct contact with the practice to obtain such a form.

At the outset of this patient engagement work we looked to work with Guildhall Walk Healthcare Centre's patient participation group but were informed that there wasn't an active group within the practice.

Practice engagement

The CCG held initial discussions with practices across the city prior to any decision being made and received assurances that there was capacity with regard to premises and workforce to accommodate the Guildhall Walk patients. Now that we have received responses from patients on which practice they want to move to, and allocated those who didn't make a choice, more detailed discussions with individual practices will take place mid-June. This will be to gain further assurance on the numbers that can be accommodated and the support that may be required so that the transfer of patients can be accomplished in a safe and managed way.

From an initial review of the patient choices received, and in lieu of the practice discussions, we are expecting to be in a position to accommodate the first choice for all patients who gave their ranking of preferred practices.

The CCG is supporting the receiving practices in taking on these new cohorts of patients. This is largely through a funding scheme which allows additional time for managing the transfer and dealing with on-going health and care needs over a short period of time.

Timeframe for transfer of patients to alternative primary care provision

The transfer of patients to their new practice is to be undertaken by the end of August at the latest with an aim of trying to achieve this by the end of July where possible. The Guildhall Walk practice is starting to lose some of its workforce and whilst mitigations are being put in place, this alongside the notice from the Landlord, means it may be sensible to move patients across slightly earlier than originally intended. This will be discussed with the receiving practices.

Support for vulnerable patients during the transfer to a new practice

The CCG, in conjunction with the practice, completed an Equality Impact Assessment (see Appendix B for a final draft undergoing approval) to draw out the potential impact on patients and any mitigation that can be implemented. Vulnerable patients that may need additional support when moving practice have been identified as below –

- Shared Care prescribing patients = 55 patients
- Homeless = 70
- Housebound = 6
- Cystic Fibrosis = 2
- Care Homes = 5
- Mental health issues and other vulnerable patients that require regular appointments = 98
- Safeguarding concerns = 32
- Learning Disabilities = 20
- Cancer Patients = 34
- TOTAL = 324

The CCG will be able to tailor their next communication offering further support. A number of patients have also been identified that will require on-going care, such as wound dressings, and

this will also be flagged to the receiving practices. A meeting has been arranged to for mid-June to firm up the support that patients may require and this includes learning any lessons from another practice closure that occurred previously in the city and how this was managed.

The Medicines Optimisation Team will support both PHL and receiving practices with the process of transfer including disposal of any controlled drugs as required and ensuring an extended repeat prescription period to enable receiving practices time to action new requests.

The CCG project team is working to ensure that other services, either provided by PHL or by others at the Guildhall Walk premises, are available by alternative means in a timely manner. This includes the Safe Space service which provides an all-round health and wellbeing service as well as a safe place for anyone who is looking for a short respite on a night out and can help individuals contact friends and or family if they have any health or safety concerns. The provision of this service is being reviewed in terms of its scope and potential new location, and there are two viable options for an interim solution if required.

Homeless services

There are around 100 homeless patients registered at the Guildhall Walk practice. The existing outreach service in the city will be in place until September and a business case is being developed by a local Primary Care Network (PCN - group of GP practices working together) for a revamped and enhanced service. At the same time, three practices have been identified within that PCN that are located close to the existing homeless accommodation in the city. Homeless patients registered at Guildhall Walk will be re-registered at one of these practices unless they have specifically chosen somewhere else. This will mean that the PCN and the practices within it will be able to collectively manage the majority of homeless patients, sharing knowledge and using peer support to offer the best service possible. The CCG is also developing a local add-on to contractual requirements for practices in the city to support homeless patients. This will reflect pro-active and enhanced care above core contract requirements, including but not limited to the following –

- the proactive promotion of health services to the local homelessness community ensuring that they are aware of the services available to them
- flexible registration procedures allowing for permanent registration to anyone who wants it
- flexible appointment systems including walk in surgeries and longer appointment times for people with multiple needs
- the provision of training to appropriate practice staff (such as care navigators) ensuring an understanding of and sensitivity towards the particular problems faced by homeless people.
- As well as the issues associated with health and homelessness, training should provide staff with a general understanding of the range of problems faced by homeless people, eg access to appropriate housing and problems with benefits
- appropriate referral to counselling and CPN services if applicable

The CCG is confident that homeless patients will not experience a reduction in service as a result of the closure of the Guildhall Walk surgery and subsequent need for patients to transfer to an alternative practice.

It should also be noted that some of the homeless patients registered with Guildhall Walk may already be receiving support through some other initiatives, for example the Homeless Healthcare Team located in Hope House Hostel and the mobile van that was used to deliver Covid-19 vaccines to the city's homeless residents.

Special Allocation Service

The Guildhall Walk practice, through PHL, currently provides this service for patients that have been removed from other practices in the city for violent or threatening behaviour. Advanced discussions have been held with PHL to continue providing the service for Portsmouth and other parts of Hampshire and the Isle of Wight, utilising the appropriate workforce within PHL. The intention is to use digital solutions where appropriate and operate from strategic sites for face to face appointments (including one in or close to Portsmouth). It is therefore anticipated that the service will continue seamlessly.

Project plan

An extract from the project plan detailing some of the key steps is provided below.

Action	Start Date	End Date	Progress
Primary Care Commissioning Committee made decision not to re-tender APMS contract but to disperse patient list	28/01/2021	28/01/2021	Completed
First patient letter to be sent outlining closure & process for moving to new practice.	02/03/2021	02/03/2021	Completed
Speak to all practices regarding potential patient numbers	04/03/2021	30/03/2021	Completed
Process for patient transfer confirmed	15/03/2021	19/03/2021	Completed
Identify most vulnerable patients and agree how transfer is going to be managed	15/03/2021	31/05/2021	Identification completed. Work with receiving practices on-going
Development and implementation of preliminary EIA	16/03/2021	30/04/2021	Completed
All practice boundaries to be confirmed	18/03/2021	23/04/2021	Completed
Stakeholder correspondence sent to all relevant parties	22/03/2021	26/03/2021	Completed
Second patient letter to be sent providing engagement event details	01/04/2021	01/04/2021	Completed
Special Allocation Scheme re-provision	01/04/2021	31/08/2021	In progress
Safe Space re-provision	01/04/2021	31/08/2021	In progress

Patient engagement event - 21/4/21	21/04/2021	21/04/2021	Completed
Patient engagement event - 28/4/21	28/04/2021	28/04/2021	Completed
Patient engagement event - 29/4/21	29/04/2021	29/04/2021	Completed
Development and implementation of full EIA	26/04/2021	30/04/2021	Completed (awaiting approval)
Third patient letter to be sent inviting patients to choose a new practice	12/05/2021	12/05/2021	Completed
Patient survey closes	02/06/2021	02/06/2021	Completed
Analysis of patient survey results and assessment against agreed capacity per practice	02/06/2021	18/06/2021	In progress
Fourth patient letter to be sent informing them of their new practice and the date they will be registered with this practice from.	25/06/2021	30/06/2021	Planned
Transfer of patients and supportive measures	01/07/2021	31/08/2021	Planned

Unfortunately, due to Purdah, we have been unable to actively engage with the Health and Wellbeing Board in its full capacity but will be looking to do so at its first meeting since then on 7 July. The new Cabinet Member for Health, Wellbeing and Social Care, Cllr Jason Fazackarley, who is also joint chair of the Health and Wellbeing Board, has been briefed about the decision and process for the transfer of patients.

Conclusion

The CCG has worked closely with patients and practices in the city to secure alternative provision for all patients of the Guildhall Walk surgery, following the decision not to re-procure the contract. We expect to be in a position to accommodate the expressed wishes of those patients who made a choice of preferred new practice and plans are in place to support vulnerable patients.

The project plan is on track to help ensure that patient transfers are conducted in a timely and seamless fashion.

The Panel is asked to note the update briefing.

Guildhall Walk Healthcare Centre
Patient information event

- Why is the practice closing on 30 September 2021?
- How and when will patients be moved to a new practice?
- Q&A

Why is the practice closing on 30 September 2021?

- A move away from the current site is necessary

- A move away from the current site is necessary
- Not able to renew contract with current provider

- A move away from the current site is necessary
- Not able to renew contract with the current provider
- Nearby practices have capacity to take on new patients

Overall, the decision to close Guildhall Walk was felt to be the option that offered **patient choice**, alongside **minimum disruption** for patients.

How and when will patients be moved to a new practice?

We will manage this for you.

In May, you'll receive a letter letting you know which practices in your area you can choose to move to based on your address.

All you need to do is let us know your preferences and we'll take care of registering you with a new practice.

Answering your questions

Will I definitely get a new practice?

- Yes – other practices have capacity to take all patients from Guildhall Walk Healthcare Centre

Will I get my first choice?

- Yes, we are hopeful that everyone will get their first choice

Will I get the same practice as my family?

- We will be looking to ensure that families stay together

When will I know which practice I'm moving to?

- You'll receive a letter in June

Will I have to wait longer to see a GP if practices will have more patients?

- It isn't expected that waiting times will be impacted

When is the last time I can use Guildhall Walk?

- Guildhall Walk Health Centre closes on 30 September. You'll be moved to your new practice by the end of August
- You are encouraged to remain with Guildhall Walk until there is a need to move to a new surgery

How will a new GP know about my medical history and what care I need?

- Medical records will transfer
- Guildhall Walk will flag any patients receiving active care so that a new GP can pick these up as a priority

Will I be able to use the same online services?

- We're working on this with practices

Will the closing of this practice affect roll out of the COVID 19 vaccination to those registered here?

- The practice will continue to run vaccination clinics until it closes
- Your new practice will have visibility of who requires a vaccination

Are staff from Guildhall Walk moving to other practices?

- Other practices in the city are, and will be, recruiting during the practice closedown timescales

What should I do if I'm due to be moving house shortly?

- If outside of Portsmouth – do nothing
- If different part of Portsmouth – check boundaries

Any further questions?

Thank you

pccg.guildhallwalk@nhs.net

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NHS
Portsmouth
Clinical Commissioning Group

Portsmouth CITY COUNCIL

Equality Impact Assessment

Full assessment form 2018

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

Directorate: CCG-NHS Commissioning

Service, function: Primary Care

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

Guildhall Walk Healthcare Centre site closure and a patients' list dispersal

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

- ☐ Existing
- ☐ New / proposed
- ★ Changed

Lead officer Steve McInnes, Head of Primary Care Commissioning

People involved with completing the EIA: Steve McInnes, Head of Primary Care Commissioning
Mike Witt, Head of Operations - Primary Care, PHL Group
Claire Pond, Equality and Diversity Manager, Portsmouth CCG

Introductory information (Optional)

This EIA relates to the proposed service change brought about by the planned closure of Guildhall Walk Health Centre site and patient's list dispersal. This EIA is largely centered around the impact on Guildhall Walk Health Centre patients and staff if the service change is agreed.

Step 1 - Make sure you have clear aims and objectives

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

The Guildhall Walk Healthcare Centre is located close to the city centre, with a list size of 8,400 patients. The practice holds an Alternative Provider Medical Service (APMS) contract with the CCG. This contract is time limited and was recently extended for a year until the end of September 2021. Under the NHS regulations, this contract cannot be extended again.
In regard to the premises there has been a change of landlord and a request for change of use from NHS use have been submitted. This means that the primary care provision under the contract would have to be delivered from a different site.

Portsmouth Clinical Commissioning Group (CCG) has identified and reviewed the options available for the future registration and general practice care of the patients currently registered at Guildhall Walk Surgery. These are:

Option 1 – Re-procure an APMS contract
This is against the national and local direction of General Medical Services contracting. The practice list size of 8,197 (Sept 2020) is just smaller than average across England but the national trend is for increased practice list sizes to enable economies of scale and efficiency of the practice making this contract less viable. APMS contracts attract a premium value to the contract which does not support the direction of travel to an equitable contract price. A re-procurement would require significant financial and project management resource.

Option 2 – Disperse the list
There are other practices within the Somerstown Hub and walking distance (0.6m) that could provide for a dispersed list.
List dispersal would require financial and project management resource
Other practices within the city would increase their list sizes making them more sustainable and bringing economies of scale.
Medical contracts within the city would be at an equitable contract price

As at March 2021 NHS Portsmouth CCG currently has 12 member GP practices operating out of 25 sites across the city. In addition to their core opening hours (08:00-18:30, Monday-Friday), practices also offer patients extended access through additional clinics either in the early morning (before 08:00) or late evening (after 18:30) during weekdays, or through additional clinics on Saturdays; this is dependent on patient preference within individual surgeries.

All member practices also offer same day access for patients with urgent primary care needs.

In addition to in-hours GP service provision (08:00-18:30), Portsmouth patients also have access to an out-of-hours GP service between 18:30-08:00 on weekdays, and 24 hours a day at weekends and on

bank holidays. Access to GP Out of hours is determined on the outcome of clinical pathways operated by NHS 111.

The majority of GP surgeries and branch surgeries in Portsmouth are within a 2 mile radius of Guildhall Walk Healthcare Centre and the practices located nearest to the surgery are;

• The University Surgery – currently located a four-minute walk from Guildhall Walk and scheduled to move to new and improved premises in 2021 in the city centre (short walk from Guildhall Walk)
• Portsdown Group Practice via The Somerstown Hub site – currently located an eight-minute walk from Guildhall Walk
• The Lighthouse Group Practice via Southsea Medical Centre – currently located a 13-minute walk from Guildhall Walk
Lake Road Practice via John Pounds site – currently located a 12-minute walk from Guildhall Walk

All of these surgeries are rated 'Good' by the Care Quality Commission. This means that people will have the opportunity to choose to move to a practice that best meets their needs.

Pharmacies are another important access point to primary care within Portsmouth city; currently all pharmacies within Portsmouth are commissioned to deliver at least one enhanced service with many providing multiple enhanced services. There are pharmacies close by to other local GP practices and one within walking distance of the St Marys Treatment Centre. Many pharmacies in Portsmouth are adopting the Pharmacy First scheme that offers support with medicines and treatments for patients on low incomes and benefits or those with young children.

These options have been reviewed and discussed in detail by the Primary Care Commissioning Committee of Portsmouth CCG. The membership of this committee includes the CCG's clinical lead who represents GPs across Portsmouth, a Portsmouth City Public Health doctor, CCG commissioning lead, and representatives from NHS England and Portsmouth Healthwatch.

The decision of this Committee is that it is in the best interests of the 8,400 patients registered at Guildhall Walk surgery to be offered registration with a nearby practice of their choice (i.e. list dispersal). This will be through a "managed transfer" liaising with nearby general practices who have confirmed they have capacity to take all patients.

It is recognised there will be an impact on staff, with the practice due to now close at the end of the contract, 30 September 2021. Affected members of staff were informed of the changes on Wednesday 24 February, giving them just over seven months to find other roles. The commissioner and provider will work with the practice to support staff, particularly to encourage a smooth closure of the practice with minimal disruption on the quality of care on offer.

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

It is recognised that the closure of a GP practice can be a worrying and disruptive experience for patients, and this is not a decision that was taken lightly.

There are a number of high-quality practices available in the area ready to take on new patients as listed above.

PRACTICE POPULATION
The practice population fluctuates between 8200 and 8500 patients - there is a slightly more transient element to the population figures perhaps due to the fact that a large proportion of the patient population are students and mature students, due to the proximity of the Portsmouth University. There is a high annual turnover of patients due to students starting and completing their courses. As at March

2021 the proportion of patients was:
• Ages 0 -14: 1,021 patients
• Ages 15-24: 2,520 patients
• Ages 25-34: 2,278 patients
• Ages 35-44: 1,405 patients
• Ages 45-54: 663 patients
• Ages 55-64: 382 patients
• Ages 65 + : 232 patients
with a roughly equal proportion of male to female (slightly more male) at 4,603 : 3,898.

The ethnic make up of the practice population is as follows:

• British or Mixed British 3047
• Other White 1488
• Other 1468
• Indian or British Indian 477
• African 405
• Other Mixed 285
• Chinese 250
• Other Asian 202
• White & Black African 123
• Other Black 116
• Bangladeshi or British Bangladeshi 96
• White & Asian 93
• Caribbean 71
• Irish 65
• White & Black Caribbean 46
• Pakistani or British Pakistani 40
• (refused 870)

Figures for March 2021 suggest the practice also had a registered population of the following at risk groups:
• Homeless patients; 107
• Drug misusers; 106
• Alcohol misusers; 123

There may be a detrimental effect on some patients who live further away from other practices in the city compared with the Guildhall Walk Healthcare Centre site although the distance might be marginal.

There may also be an impact on patients currently registered at with other practices due to larger numbers attending these sites, and more generally on patients trying to make appointments.

No impact is envisaged under the following groups: Age, Disability, Race, Sex, Pregnancy and maternity, Marriage & civil partnership and other groups.

Unclear impact has been noted under the following groups: Gender assignment, Sexual orientation, Religion or belief.

For asylum seekers / refugees, there is no known impact
For homeless patients the impact is unclear, although there are plans in place to broaden an existing outreach service with an intention to pick up patients that may be registered at Guildhall Walk. Re-registration for homeless patients has been identified as a specific area of focus.

It is hoped that disruptions for patient care are kept to the minimum and the closure of the practice will have a neutral impact on patients overall. The CCG will continue to work closely with the surgery to

ensure that all patients affected by the changes are supported to make sure they continue to receive the care they need and that the transfer of patients can be accomplished in a safe and managed way.

The Guildhall Walk practice is also home to the Special Allocation Scheme, a service that ensures that patients who have been removed from a practice patient list can continue to access healthcare services. This contract is also due for renewal, and work was already underway with commissioning colleagues across the region to re-procure this service to make sure it continues to meet the needs of this particular cohort. The change of location of this service may not be significant, as many of these patients access services remotely.

As listed above, with the current information available, there are no benefits to practice staff.

What outcomes do you want to achieve?

To ensure general practice services are sustained for patients of Guidhall Walk Surgery in a managed way and patients are moved to a practice of their preferred choice.

What barriers are there to achieving these outcomes?

Involves the closure of 1 existing physical site which may impact on some patients.

Step 2 - Collecting your information

What existing information / data do you have? (Local or national data) look at population profiles, JSNA data, surveys and patient and customer public engagement activity locally that will inform your project, natioinal studies and public engagement.

Public Health data :
JSNA/Fingertips https://fingertips.phe.org.uk/

Anonymised reporting from the GP Practice.

Some feedback from patients has been received at engagement events that were held to seek their views on the proposals. Other feedback has been received from patients via feedback forms.

Using your existing data, what does it tell you?

The population is 4th highest in the city in terms of IMD deprivation level score (31.1) and is above the national average of 21.7 (Fingertips).

The percentage of patients with a long term health condition (53.5%) is close to the Portsmouth (51.5) and England (52.4) average. (Fingertips)

Life expectancy for males is lower (75.8) than the England average (79.5) (Fingertips)
Life expectancy for females is lower (80.7) than the England average (83.1) (Fingertips)

There is a relatively young population profile,particularly for the 20-45 yr age group (Fingertips).

There are around 120 homeless patients registered at the practice.

Approximately 35% of the practice list is made up of students.

Feedback from patient engagement events and other patient contacts have helped inform an FAQ, detailed below -

https://www.portsmouthccg.nhs.uk/guildhall-walk/faq/

Local councillors, via the Health and Overview Scrutiny Panel (HOSP), have -
"RESOLVED that in the event that the CCG confirms its decision to close the Guildhall Walk Healthcare Centre, the panel asks it to pledge to work with the Patient Partnership Group and others including the Health & Wellbeing Board to secure alternative provision as soon as possible to the current surgery and to bring a report to the HOSP prior to September 2021"

Step 3 - Now you need to consult!

Who have you consulted with?

Guildhall Walk Practice staff
Registered patients incl Patient Participation Group
All Portsmouth CCG Practices
Local pharmacy
Local councillors
Local Medical Committee
Healthwatch Portsmouth
University of Portsmouth

If you haven't consulted yet please list who you are going to consult with

Individual patients from specific vulnerable groups.

Further discussions to be held with local councillors.

Please give examples of how you have or are going to consult with specific groups or communities e.g. meetings, surveys

Three letters were sent to registered patients at Guildhall Walk Healthcare Centre Practice aged 16 and over (total practice list size of 8,400 patients). Letter 1 - advising of the closure; Letter 2 - invitation to engagement events; Letter 3 - asking for their preferred choice of new practice.

Three on-line engagement events have been held for patients of Guildhall Walk Healthcare Centre which included a presentation by the CCG and a Q&A at the end. Around 50 patients participated in these meetings in total.

The practice was unable to meet with the Patient Participation Group as this consisted of only one person and they left the area. There has been no other interest from patients in joining a group.

FAQ posted on CCG and practice websites.

CCG email address provided for patients to raise queries or concerns regarding the closure.
Themes from the responses from this and the engagement events are covered under Step 2 above.

As part of this EIA exercise the practice has identified specific groups where a tailored letter may be necessary to ensure they are supported with moving practice and any potential impact assessed and mitigated or removed. This includes homeless patients, housebound patients, and those with Learning Disabilities or Dementia. The practice has also identified patients that will require specific on-going care as soon as they are re-registered, for example people having regular wound dressings, those on cancer or palliative care registers. These patients will have their records flagged such that the new practice will be able to pick up on these health issues.

Step 4 - What's the impact?

Is there an impact on some groups in the community? (think about race, gender, disability, age, gender reassignment, religion or belief, sexual orientation, sex, pregnancy and maternity, marriage or civil partnerships and other socially excluded communities or groups)

Generic information that covers all equality strands (Optional)

The relatively high level of deprivation is acknowledged for the practice population.
Also the high student numbers.

Ethnicity or race

The practice is not an outlier in terms of ethnicity.

Neutral impact as Translation services will be maintained (available at all local GP practices).

Gender reassignment

This group faces complex challenges such as isolation, fear, rejection and lack of understanding or acceptance form others. They subsequently suffer depression, anxiety and other mental health issues. They experience the same challenges as lesbian, gay and bisexual people and the need for a non-discrimination policy and clear policy on confidentiality is important.

There should be no impact on transgender people. All practices policies and procedures including staff training will be expected to cover non-discrimination and confidentiality in view of the complex challenges faced by this group.

Age

Overall there is a young population profile, especially aged 20-45. No impacts are anticipated for any age group given the locality of other nearby practices that they can register with.

Disability

Some patients may find it more difficult to cope with change, for example those with dementia, learning disabilities, and frailty. Further communication with these groups will be undertaken.

All local practices are compliant where possible with NHS guidance for primary care premises in terms of disability access to include space for mobility aids, good signage and loop/sign language facilities.

Patient information systems are compatible and include flagging of patients who have information and communication support needs in accordance with the NHS Accessible Information Standard. Alternative formats such as Easy Read and audio are available on request and the practices have access to BSL interpretors.

Religion or belief

Every reasonable effort is made to meet individual requests relating to religion of belief in the provision and delivery of primary care health across the city.

Sexual orientation

Lesbian, gay and bisexual people, like transgender people, report negative experiences of health care in relation to their sexual orientation. These include being treated as heterosexual, unable to discuss their sexual orientation or have the partner welcome during a consultation.
There should be no impact as all practices policies and procedures including staff training will be expected to cover non-discrimination and confidentiality in view of the complex challenges faced by patients.

Sex

Every effort will be made to meet gender specific requirements. There will be the ability to see male/ female GPs and other clinicians at practices. Patients have the choice of selecting a new practice based on information such as the make-up of the GP workforce.

Marriage or civil partnerships

There should be no impact on marriage and civil partnership.

Pregnancy & maternity

Patients can expect the same services at all practices across the city.

Other socially excluded groups or communities

Homeless patients - there are just over 100 homeless patients registered at the practice. It has been agreed that, subject to patient choice to the contrary, patients will be re-registered at a practice that is closest to the day centre / night accommodation that the person may attend.

Patients will continue to be able to access outreach services that may be provided in the city, regardless of which practice they are registered at.

An enhanced homeless healthcare service is also being proposed which all practices will be able to sign up to and deliver over and above core contract requirements.

Note: Other sociallyexcluded 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?

Health Impact

Have you referred to the Joint Needs Assessment (www.jsna.portsmouth.gov.uk) to identify any associated health and well-being needs?

★ **Yes** ☐ **No**

What are the health impacts, positive and / or negative? For example, is there a positive impact on enabling healthier lifestyles or promoting positive mental health? Could it prevent spread of infection or disease? Will it reduce any inequalities in health and well-being experienced by some localities, groups, ages etc? On the other hand, could it restrict opportunities for health and well-being?

A positive health impact could be that more people are screened for cancer and vaccinated against diseases, given that other practices in the city have higher uptake rates for this.

A potential negative impact could be that some patients have slightly further to travel. However the impact of this is considered to be minor given the location of other practices. It should be noted that patients reserve the right to move to another practice if they are unhappy in any way with the new practice.

Health inequalities are strongly associated with deprivation and income inequalities in the city. Have you referred to Portsmouth's Tackling Poverty Needs Assessment and strategy (available on the JSNA website above), which identifies those groups or geographical areas that are vulnerable to poverty? Does this have a disproportionately negative impact, on any of these groups and if so how? Are there any positive impacts?, if so what are they?

For more help on this element of tackling poverty and needs assessment contact Mark Sage: email:mark.sage@portsmouthcc.gov.uk

Neutral impact, as primary medical services will be maintained locally at other practices.

Step 5 - What are the differences?

Are any groups affected in a different way to others as a result of your policy, service, function, project or strategy?

Please summerise any potential impacts this will have on specific protected characteristics

Some vulnerable patients may require additional support in terms of moving practice and/or their on-going care needs. This will be covered off between the CCG, the Guildhall Walk practice and the new (receiving) practices as appropriate.

Does your policy, service, function, project or strategy either directly or indirectly discriminate?

☐ **Yes** ★ **No**

If you are either directly or indirectly discriminating, how are you going to change this or mitigate the negative impact?

Step 6 - Make a recommendation based on steps 2 - 5

If you are in a position to make a recommendation to change or introduce the policy, service, project or strategy clearly show how it was decided on and how any engagement shapes your recommendations.

No recommendation can be made as it is the responsibility of the Portsmouth Clinical Commissioning Group's Primary Care Commissioning Committee to agree the proposed closure.

What changes or benefits have been highlighted as a result of your consultation?

The need to consult with specific cohorts of patients to further test out the impact on them and how any issues may potentially be mitigated.

If you are not in a position to go ahead what actions are you going to take?
(Please complete the fields below)

Action	Timescale	Responsible officer

How are you going to review the policy, service, project or strategy, how often and who will be responsible?

The CCG project team has weekly review meetings and b-monthly meetings with PHL to review the closure process and re-registration of patients. This will continue until all patients have been transferred and the practice contract has ended. The CCG will also review with the receiving practices how they are managing in regard to taking on (in some cases substantial numbers) new patients. The CCG will also link with Portsmouth Healthwatch and others to check if there are any issues reported by patients and the CCG mailbox for patient queries will remain open for a period of time after the closure.

Step 7 - Now just publish your results

This EIA has been approved by: Simon Cooper, Director Primary Care

Contact number: 02392 899500

Date: May 2021

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 full EIA. Email: sehccg.equalityanddiversity@nhs.net

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NHS Portsmouth Clinical Commissioning Group

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14 June 2021

Cllr Ian Holder
Chair, Portsmouth Health Overview and Scrutiny Panel
Members Services
Civic Offices
Portsmouth PO1 2AL

Dear Cllr Holder,

Update letter for HOSP - June 2021

Firstly I'd like to welcome you to the role of chair for the Portsmouth Health Overview and Scrutiny Panel. This letter is intended to update you and the members of the Panel on some of the activity that the Clinical Commissioning Group has been involved with since the last update in March 2021.

Our website – www.portsmouthccg.nhs.uk – provides some further details about what we do if members are interested and, of course, we are always happy to facilitate direct discussions if that would be helpful. As an aside, we have recently launched this improved version of the website which meets new accessibility criteria that all public sector websites need to adhere to by September 2021.

Health and Care Portsmouth update

Integrated Care System (ICS)
As outlined in our March update, in February 2021 the government published its white paper that sets out expectations around the future working in Integrated Care Systems. This recognises the need both for a robust and effective system at scale but also the importance of effective place-based delivery, which will typically align to

local authority boundaries. With our well-established Health and Care Portsmouth model, we are in an excellent position to work with partners in the Hampshire and Isle of Wight ICS to deliver the aspirations set out in the white paper. We have been active participants in the development of the Hampshire and Isle of Wight (HIOW) Strategic Transformation plan and subsequent integrated care system (ICS) plan**.**

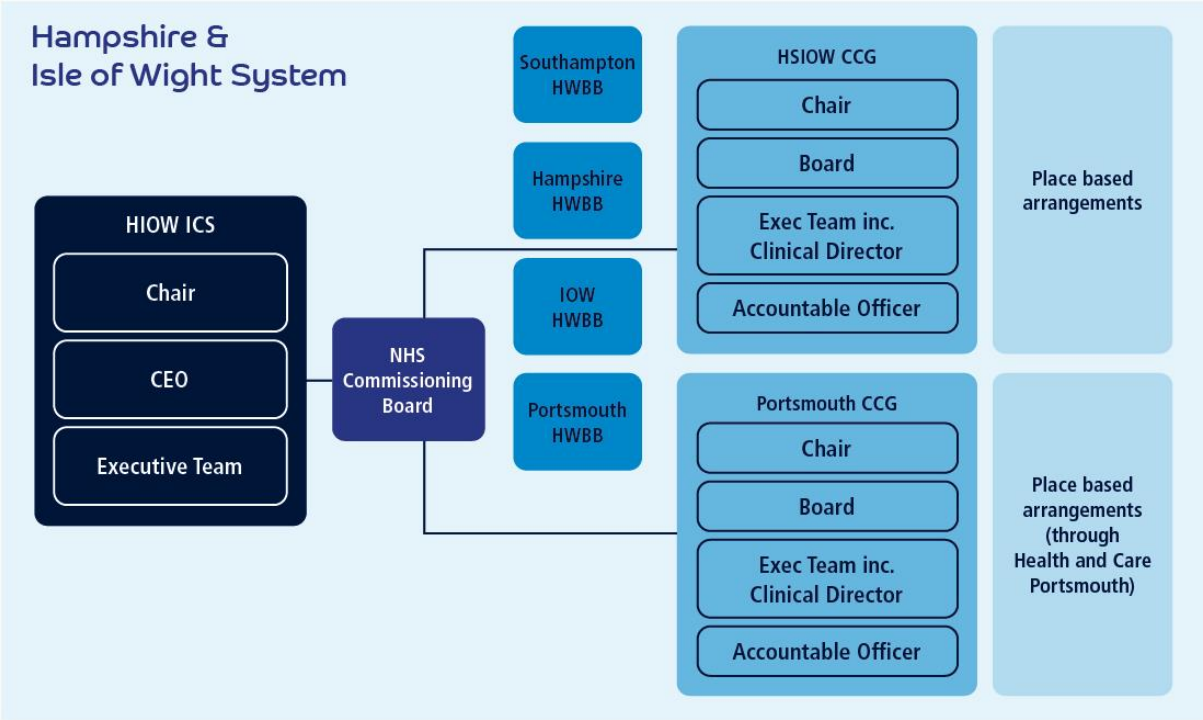
We will have transitioned to this new way of working as part of the Hampshire and Isle of Wight ICS by April 2022 and are continuing to develop the close ways of working across the system by sharing an accountable officer, Maggie MacIsaac, with the new joint Hampshire, Southampton and Isle of Wight CCG. Our previous Accountable Officer, Dr Linda Collie, has become the new Clinical Lead for the CCG and Health and Care Portsmouth to ensure we retain our strong clinical focus as an organisation. These changes came into effect from 1 April 2021. We are working closely with partners across the ICS in preparation for the forthcoming changes from April 2022 to ensure we have strong place- based health and care partnership arrangements in place for the city; these will be led by the Health and Wellbeing Board and we have a plenary session on Wednesday 16 June to consider this. We are also continuing to work in partnership across the ICS and within Portsmouth and South East Hampshire (PSEH) in order to influence the local development of the ICS.

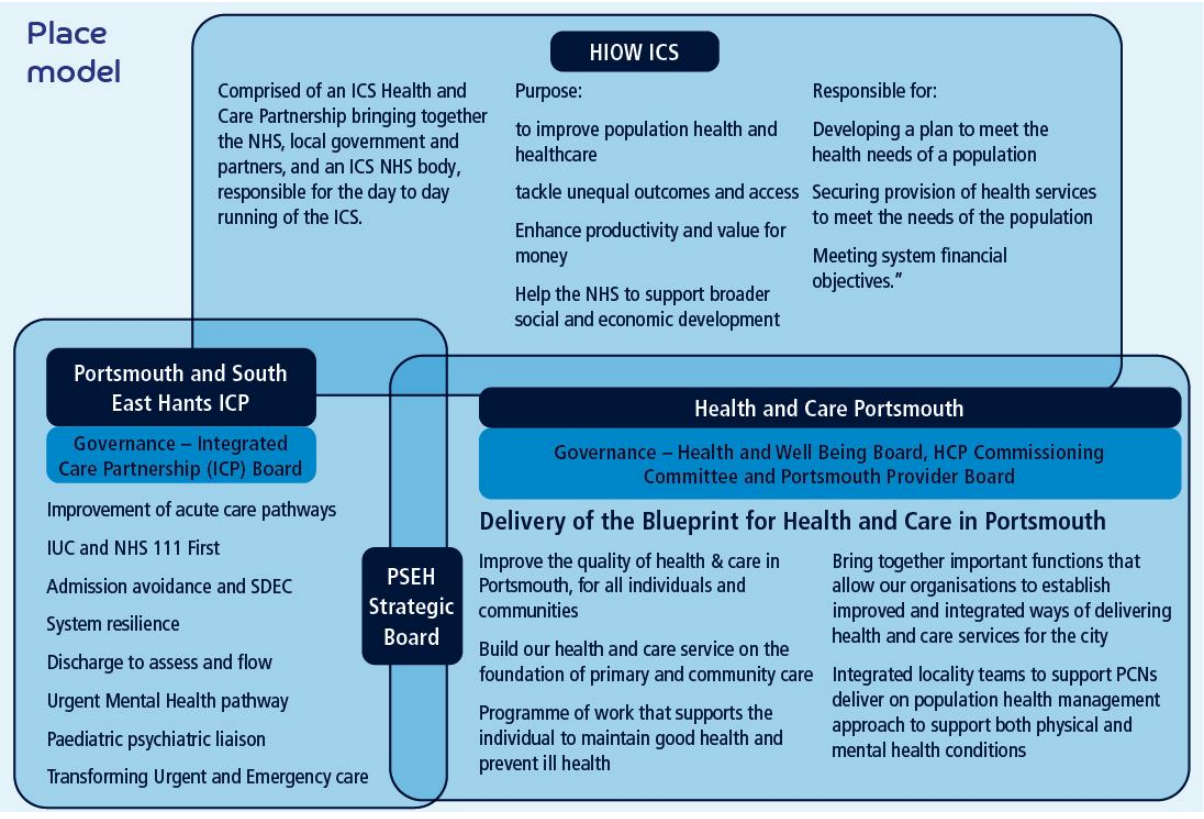
Health and Care Portsmouth Operating Model

To help further strengthen the local partnership working of HCP, we have implemented additional shared appointments with Portsmouth City Council following the delegated responsibility for David Williams, Chief Executive of Portsmouth City Council, to take on executive delivery of the Health and Care Portsmouth agenda. There is now a shared executive team across Portsmouth CCG and the council, comprising of the Director of Adult Social Services (DASS), Director of Children's Services (DCS), Director of Public Health (DPH), Director of Housing and Neighbourhoods, Chief Finance Officer and Managing Director Health and Care Portsmouth, a post that is jointly accountable to both the Chief Executive of Portsmouth City Council and the CCG shared Accountable Officer.

We believe that this offers us an exciting opportunity to build on the work we have done together to date and puts us in a really good position to focus on the wider determinants of health to improve health outcomes and reduce health inequalities within the city. This integrated approach will also provide us with the capacity to work more closely with the HIOW ICS, in developing future ways of working; as well as continuing to develop the PSEH ICP work programme.

Below are some charts which hopefully help to explain the relationships and decision making/activity at a local, PSEH and HIOW ICS level.





Kooth - Online counselling and wellbeing tool

Kooth, the online counselling and emotional wellbeing service for young people, has been well utilised since its launch in January 2021. Looking at the first quarter performance (January - March 2021):

- 426 Portsmouth young people have registered with Kooth (55 identified as being of black, Asian or mixed ethnicity). These registered users completed 1671 log ins. 687 messages have been sent and users have participated in 63 chats. 378 articles have been read with 1812 interactions in a forum. The service is most popular with those aged 14-17 years old, who make up 52.58% of registrations. Those aged 11-13 make up 25.59% of registered users. 100% of those who left feedback would recommend the service to a friend.
- Kooth has achieved good engagement with schools, primary care and CAMHS who are actively signposting into the service, though no referral is needed and young people can register themselves.
- 84 Portsmouth parents attended an information session.

Moving forward the priorities for the service will be:

- Holding transition workshops for young people moving from Y6 to Y7.
- Holding additional parent information events.
- Engaging more with young people at the top age range (it supports those aged 11-18 years or up to 25 years old for care leavers or those with an Education Health and Care Plan).
- Identifying how it can become more accessible for young people with special educational needs and disabilities (SEND).
- Developing relationships with probation and the youth offending team so that they can signpost young people to the service.
- Identifying other agencies that they can develop relationships with to help them reach more young people in Portsmouth who might need emotional and wellbeing support.

Community Mental Health Framework

There is on-going work to engage with current or previous users of mental health services, and their families/carers, to understand their experiences and use these to help design future provision making sure it is accessible to all and meets resident's needs. There are two engagement events taking place in June, one for service users and one for their carers.

Autism services

Health and Care Portsmouth is supporting Portsmouth Autism Community Forum (PACF) who have won funding for three new projects to support autistic adults in Portsmouth. These projects are designed to help create a city that works for autistic people by providing support, information and practical advice for autistic people themselves, as well as their family members and carers. The aim is to improve public understanding of autism, helping businesses and healthcare providers to provide more autism-friendly spaces and deliver better services. You can find out more on the Health and Care Portsmouth website.

Communications were developed to encourage autistic residents and their parents/carers to help shape these new services. At the time of writing 16 people had responded and expressed interest in being involved.

Portsmouth Communication Support Service for Stroke patients

As part of our continued review of services the decision was taken to end the contract for the Portsmouth Communication Support Service for stroke patients run by the Stoke Association. The ability to refer into this service ended on 30 April 2021 with the service closing on 31 May 2021.

The referral numbers into this service were consistently low despite work with the Stroke Association to see if uptake could be improved. This resulted in a very high cost per patient compared to neighbouring CCGs, who this service was jointly commissioned with. The majority of support offered by this service can also be accessed via other services as we have strong support for stroke patients in the city including the Portsmouth Stroke Recovery Service, commissioned by Adult Social Care and provided by the Stroke Association (not available in Hampshire), and Different Strokes, a group of younger, and younger minded, stroke survivors and carers. There are also links in place with the Speech and Language Therapy Service run by Solent NHS Trust.

We are working with the Stroke Association to understand if an element of specialist communication support could be built into the Recovery Service for the small numbers of Portsmouth recovering stroke patients that might require some additional communication help.

Primary care

Guildhall Walk Medical Centre

There has been a significant programme of patient engagement and work with the practice to ensure the smooth transition of patients to alternative practices ahead of Guildhall Walk Medical Centre closing on 30 September 2021. See separate paper for more information on this.

North Harbour Medical Group

Solent NHS Trust is undertaking the project to move North Harbour Medical Group from their current location in Cosham Health Centre to purpose-built premises on the Highclere site by Treetops in Cosham, PO6 3EP. They have refreshed the business case which has had a first review by NHS England. Planning permission will be submitted soon. Solent NHS Trust has purchased the land at Highclere to enable development and due to some delays the projected completion date is now late 2022.

University Surgery Practice

As outlined in the March update the University Surgery Practice will move into new larger modern premises in the heart of Commercial Road. This is necessary due to University redevelopment plans and a growing population, which means the practice needs to be able to accommodate more patients.

The new address is 159-161 Commercial Road, Portsmouth. This is the old Miss Selfridge retail unit within the city centre. This is approximately 0.5miles from the current site, located immediately adjacent to the Cascades shopping centre. Refurbishment work is going well and is on track to be completed by 17 December 2021, with the practice moving in shortly afterwards. As this new space is approximately three times larger the practice will be looking to expand and develop its existing offering.

To better reflect that the practice supports University students and wider Portsmouth residents they are also changing their name to The UniCity Medical Centre. You can find out more on their website: www.universitysurgery.com/premises-relocation

COVID-19

Vaccination

The vaccination programme continues to be a core focus for the NHS, including primary care who are helping to deliver 70% of vaccinations to Portsmouth residents.

Up to the 30 May 2021, over 114,000 Portsmouth CCG patients had received their first dose of the vaccine with over 71,500 having had both doses. We've achieved 100% vaccination rates for several of our age cohorts. This incredible success is due to the great partnership working of the Primary Care Networks (PCNs) and the invaluable support from volunteers who help the clinics to run so well. At the time of writing, people aged 25 and over are being invited for their vaccination meaning we're on target to achieve the aim of offering all adults the vaccination by the end of July.

We continue to work closely with partners to run outreach clinics to help increase vaccine uptake in more hesitant groups, for example a mobile van to reach our homeless residents and a pop-up vaccine clinic at Jami Mosque.

We're also linked with the council on insight work it's conducting around vaccine hesitancy to inform localised campaigns and with further initiatives it's running to try and increase vaccine confidence, for example online events for target groups and a Community Champions programme.

Long COVID

We supported with the creation of the designated Long COVID clinic in Portsmouth and have been promoting the national Your COVID Recovery website to residents.

We'll shortly be part of a newly-established group including representatives from Portsmouth City Council, Solent NHS Trust and Portsmouth Hospitals University

NHS Trust, as well as residents, looking at the impact of Long COVID on the city and what support, education and awareness might be needed.

System pressures

Unsurprisingly the NHS is still seeing significant pressures as it continues to respond to COVID-19, whilst trying to catch up with patients not seen during the pandemic and delivering the vaccination programme. Much of the focus has been on acute trusts/urgent care, but primary care is under incredible strain too. We continue to work closely with practices and wider partners to support and improve the resilience of the local health and care system.

We've joined with Hampshire, Southampton and Isle of Wight CCG and Portsmouth Hospitals University NHS Trust to look at a joint approach to communication to address these pressures and are undertaking a coordinated communications campaign to encourage residents to use the right service so that they can get the best help and also support the NHS. This is divided into short (up to end June), medium (summer) and longer term (winter) activity.

Safe Space, an initiative with South Central Ambulance Service and Public Health, has also been restarted in Guildhall Walk to provide healthcare support on Friday and Saturday evenings to those enjoying the night-time economy to help reduce those needing to attend the emergency department.

Yours sincerely,

Jo York
Managing Director Health and Care Portsmouth

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