# HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held on Thursday, 12 September 2019 at 1.30pm in the Executive Meeting Room, the Guildhall.

**Present**

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| Councillor | Chris Atwell (Chair) |
| | Vivian Achwal |
| | Arthur Agate |
| | Trevor Cartwright |
| | Graham Heaney |
| | Leo Madden |
| | Gemma New |
| | Philip Raffaelli |
| | Steve Wemyss |

**31. Welcome and Apologies for Absence (AI 2)**

Apologies were received from Councillor Rosy Raines. Councillors New and Cartwright apologised as they would have to leave at 3pm and Councillor Heaney as he would have to leave at 4pm.

**32. Declarations of Members' Interests (AI 3)**

Councillor Wemyss declared a personal and non-pecuniary interest as he is employed by the NHS in the CSU. Councillor Heaney declared a personal and non-pecuniary interest as he employed by the University of Portsmouth but is not connected to the Dental Academy.

**33. Minutes of the Previous Meeting (AI 1)**

**RESOLVED that the minutes of the meeting held on 13 June 2019 be noted as a correct record subject to the amendment that Councillor Steve Wemyss was present.**

**RESOLVED that the minutes of the meeting held on 18 July 2019 be agreed as a correct record.**

**34. Clinical Commissioning Group (CCG) update - Enhanced Care Home scheme (AI 4)**

Jo York, Director of New Models of Care, gave a verbal update in which she explained the Enhanced Care Home (ECH) scheme is run by an alliance comprising the CCG, GPs, Solent NHS and Adult Social Care (ASC). The aim is to pro-actively support and improve residents' quality of life so they can stay in their care homes for as long as possible and avoid hospital admissions. Another two homes are going to be added to the original six though expansion has challenges. Primary care support is improved through an MDT (multi-disciplinary team meeting), weekly visits to assess and review, and appropriate care plans. Trust is built up and queries and crises can be resolved on the day. The maintenance phase comprises a three-weekly MDT combined with weekly nurse visits and is more manageable than weekly MDTs due to staffing constraints.

The scheme has had a big impact on primary care demand. Some of the larger care homes deal with GPs from 10 to 12 practices but under the scheme one practice takes responsibility for a home's residents while still maintaining relationships with residents' individual GPs. Calls to GPs have reduced by about 70% and ambulance call-outs and hospital admissions are lower.

Next steps are to work with the two additional care homes, see if Telecare can provide homes with a better alternative if there is a crisis, how to make the MDTs more manageable and for GP practices to work with care homes as a joint network. A single template for the SystmOne record system is needed rather than the current three versions so that staff in care homes can access the same information as GPs and nurses.

In response to questions Ms York clarified the following points:

The aim of Telecare is help carers, relatives and staff find appropriate help, for example, avoid using NHS 111. The "news and restore" structure for homes helps them with triage to get the right information.

The team worked with partners to see where the biggest issues were when choosing which homes to include in the scheme, for example, the CCG over the number of hospital admissions and ASC with residents from the former Edinburgh House.

The team is working on several other projects such as Hydrate (awareness of importance of hydration of care home residents) and Six Steps (end of life). They are liaising with Gosport and working closely with Fareham; however; the project is easier to run at city level than over a wider area such as South East Hampshire where there about 200 homes. The team is also working with the Frailty Team to see how residents can return sooner from hospital.

The panel was very impressed with the scheme and thought NHS England should be aware of the consequences of not implementing it. Ms York explained the Primary Care Network (PCN) have picked areas where the scheme is likely to have the most impact. The PCN will be at the heart of networks. The team will continue to monitor and develop the "phased development and implementation" (pilot). There is scope to add social workers to the scheme, for example, if a resident moved from a care home to a nursing home a social worker may be needed at the MDT.

Councillor Attwell thanked Ms York and the staff of the care homes he visited for their time and patience in answering his questions.

**RESOLVED that the update be noted and that an update be provided on the implementation of a shared version of SystmOne in care homes.**

**35. Portsmouth Hospitals Trust update (AI 5)**

Jane Druce, Deputy Director Information & Governance, and Mark Roland, Associate Medical Director, presented the report and elaborated on some aspects.

Psychiatric provision in the Emergency Department (ED)
Approach to support has been piecemeal for years and although there were pockets of support for some areas such as severe asthma or nutritional disorders it was not co-ordinated. In addition, some services like podiatry are not hospital based.

Bed occupancy
The PHT is working on continuous improvements and re-testing of evidence of performance. When hospitals are full it is difficult to deliver safety and quality. The goal is 92% occupancy as it enables the hospital to cope with daily variation. Occupancy is now around 95%. Initiatives aim to avoid admissions and having medically fit patients in hospital. The longer elderly people are in hospital the more they decline physically and mentally. Modelling has shown that if discharges are earlier in the day then peaks are fewer and more beds can be released to the ED. A reduction in hospital stay of 0.9 of a day can have a palpable effect on occupancy. In addition, if about one third of the patients ready for discharge have gone home by 1 pm that has a significant effect on the ED flow and ambulance holding. Pareto charts are used to identify key areas of focus, for example, booking patient transport.

The "Early Bird" initiative aims to have about 20 out of 130 or 140 patients ready to go home by using a simple checklist so that the ED can have the bed for occupation by 10 am.

The importance of having prescriptions and medication ready on discharge is fundamental to decompressing the ED; it is frustrating for patients and families having to wait. NHSI guidance recommends the "Four Questions" for which patients should have answers, for example, What's wrong with me? What happens when I get home? However, this is more difficult than it sounds to implement.

A multi-disciplinary team approach is being taken on long stay patients (those in hospital for more than 100 days). The perception they are all frail and waiting for a place in a nursing home is inaccurate as some have surgical needs and others have complex health problems, not necessarily social issues.

In response to questions Ms Druce and Mr Roland explained that

The weekly group bed occupancy is still in its early days but shows that more work needs to be done.

Retention as well as recruitment is making excellent progress. Staff have noticed the positive difference of having more nurses on the wards. The panel congratulated the PHT on recruiting more nurses.

Delayed transfers of care is a complex domain but PHT is taking full responsibility for its area. There are still challenges but Hampshire have more challenges than Portsmouth.

The staff passport has had some impact but not as much as anticipate. The situation is unclear about "DBS check porting."

Ambulances holds are subject to significant scrutiny and last year the PHT examined the efficiency and safety of ambulance handovers. Generating better flow from the ED is fundamental to reducing holds.

Early discharge is an imperative part of winter planning. Last year a kit for flu testing was trialled in some departments (ED, renal, oncology, paediatrics). The result is ready in 20 to 30 minutes and shows if a patient needs isolating, thereby helping reduce cross-infection.

With regard to CQC comments on some areas such as maternity requiring improvement the PHT will examine all areas, not just those specific to the CQC report, at a granular (ward) level to inform priorities. Although there is always work to do much improvement has been made and talking to staff on the wards helps them to see the difference they have made. Staff welcomed the opportunity and those wards that were not visited were disappointed. The PHT also talks to patients and the CCG to see their point of view, for example, to gather feedback from GPs once patients go home.

The new model of having GP cover (including double-up at peak times) in the ED aims to prevent people leaving before being seen because they are frustrated with waiting. The pilot will see how many people for whom seeing is a GP is more appropriate. The Urgent Care Centre is a rationalisation of existing support and a focus for future models of working, for example, diverting people from the ED to ambulatory care or clinics. Significant further opportunities are part of the transformation of the new ED building. Putting extra chairs in some areas for four weeks reduced numbers in the waiting room, where there can be 80 to 100 patients. The impact on dignity for patients and families when the ED is very crowded is acknowledged. There is also awareness that being asked the same questions several times is frustrating and the PHT is trying to improve this.

It was acknowledged there are still problems with discharge prescription. Only one third of patients had a TTO (To Take Out) on the day of discharge or before and the situation is worse at the weekends as the Pharmacy service is reduced. The TTO is needed a day before discharge. Prescriptions will be part of a targeted refresh at the stakeholders' meeting on 25 September. Although there is an out-patient dispensary resources are concentrated on the in-patient Pharmacy. It is recognised this is inconvenient for patients but some medications are very specialised. Some acute wards now have ward based pharmacists who can process prescriptions in 25 minutes, depending on the complexity.

Patients with mental health conditions presenting at the ED need to be identified. Staff are inducted on how to deal with them and when to refer to other services. There are links to trained mental health nurses who can support and also specific support from community colleagues. Some patients are in the ED as they have nowhere else to go but the ED is not set up for them. There are a limited number of absconders. Some wards are locked if

they have patients who wander. Security supports the PHT to reduce the risk of tailgating. Staff aim to manage challenging behaviour without resorting to physical restraint. Incidents are taken seriously but it is very hard to prevent them completely.

The panel commended the report for its readability.

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

- Progress on the initiatives described in the June and September meetings: psychiatric provision in ED
- Urgent care recovery plan (ED transformation)
- Recruitment, including DBS passporting
- Improvements sprints and initiatives such as "early bird" discharges

Councillor New left the meeting at 3 pm.

**36. Solent NHS Trust - Jubilee House (AI 6)**

Sarah Austin, Chief Operating Officer, gave summarised developments since the previous meeting on 18 July.

Jubilee House's 25 beds will be divided amongst the new building, end of life (EOL) care at home with the support of an enhanced EOL team and care homes. Staff are fully aware and engagement will continue for some months to plan where they prefer to work. CHC (Continuing Healthcare) assessments will take place in care homes. Jubilee House will remain half-full to maintain standards of care and training. The semi-closure has not impacted negatively on hospital discharges. Step down assessments will be distributed amongst several care homes, not just Harry Sotnick House.

One option for the new Jubilee House will be next to the Spinnaker Ward at St Mary's Hospital. Making the new building high quality is taking longer than anticipated but the end result will be worthwhile in meeting patients' needs. The current Jubilee House is adequate for the next 12 months. Ms Austin had agreed the process for building the business case with the Finance Director the previous day. A sideways move, for example, the 10-bed Kite Unit may be considered for some residents before the new building is ready. In the meantime two Advanced Practitioner roles have been appointed to start at the end of October. The paramedic pilot will continue for another six months.

In response to the panel's questions Ms Austin clarified

The Kite Unit is near The Limes, St James' Hospital, and was used for neuro-rehabilitation for Hampshire residents. It is not suitable for the proposed Podiatry Hub as it was an in-patient unit.

Harry Sotnick House is being used as planned; different types of resident are occupying beds.

Portsmouth Pensioners can be included in consultations and Ms Austin awaits an invite.

There was assurance that the city council had had appropriate discussions with Hampshire County Council over Harry Sotnick House (they manage it until April 2020).

Jubilee House has free parking but there are charges at St Mary's and Harry Sotnick House is surrounded by residents' parking zones.

Any care home registered for CHC assessments can accept residents, either on a spot or block purchase basis. As many beds as needed can be arranged in order to ensure flow from QA Hospital. The situation is flexible according to demand.

No staff have resigned over the new approach and developments are still at an early stage. However, some have expressed interest in joining the EOL team.

**RESOLVED that the update be noted and requested the following information be brought to the meeting on 21 November:**

- Solent NHS to involve Portsmouth Pensioners in consultation
- Parking for Harry Sotnick House
- Keep the panel updated on plans for the new Jubilee House building and bring full costings and business case
- Contact Hampshire County Council to inform them of the Harry Sotnick House aspect of proposals and report back

Councillor Trevor Cartwright left the meeting at 3:10pm.

**37. Dental Services update (AI 6)**

Julia Booth, Acting Head of Primary Care (Hampshire, Isle of Wight and Dorset) at NHS England and NHS Improvement South East, presented the report and in response to questions explained that:

Since the report was written, she could confirm that the third provider referred to in the report is Perfect Smile who had said that they could start to provide additional services straightaway and will provide further additional activity in the next financial year. Along with Bupa Dental Care in Cosham and the proposed arrangements with University of Portsmouth Dental Academy, the interim arrangements will provide the same or more activity as the three Colosseum practices did in the year before they closed.

The interim arrangement with the Portsmouth Dental Academy will be an additional temporary contract for general dental services. The existing contract is to provide training and education. The temporary contract will be for 12 months to bridge the gap whilst new services are procured.

Colosseum had initially asked for news of the planned closures to be kept confidential so as not to alarm staff. However, in hindsight it was acknowledged that the way residents had been informed could have been handled better and that communication is vital. NHS England are asking patients for feedback to inform the procurement of the new services and

would like all partners to promote the survey, which will be distributed in the next few days. The survey is available in "easy read" versions or can be done by phone.

**38. Southern Health NHS Foundation Trust update (AI 7)**

Richard Webb, General Manager for East Adult Mental Health, presented the report and in response to questions explained

Since July non-contracted referrals have decreased which is more convenient for families, carers and health staff. The average length of stay in Elmleigh (Havant) has reduced from about 30 to 20 days. Alternative provision is being considered to try and avoid admission.

The bed stock is what Southern Health are commissioned to provide and the focus is on 85% occupancy as long as the right systems and processes are in place. Patients are followed up 48 hours after discharge to help prevent a relapse and re-admission to an Emergency Department.

The panel were concerned that beds gained in one area were lost in another and that demand may not be met. In particular, they were concerned about the proposed loss of ten beds at Marchwood Priory. They were also concerned that the proposals might be a change in service delivery.

Mr Webb acknowledged the panel's concerns but he could not comment on a similar area model used in 2014/2015 as he was not in his post then. In addition, his area does not cover Portsmouth but he noted that in the East Hampshire area ECRs have reduced dramatically without using out of area beds.

**RESOLVED that the update be noted and requested the following information be brought to the next meeting 21 November:**

- A business case for the proposed ending the contract for ten mental health beds at Marchwood Priory before the beds are closed.
- At the end of September provide a three-month review of the six-month pilot that started in July

**39. Healthwatch Portsmouth update (AI 8)**

Siobhain McCurrach, Healthwatch Portsmouth Manager, presented the report and in response to questions clarified that:

Healthwatch became aware of the closure of the Colosseum practices via a Facebook post. They contacted NHS England and were then asked for comment by The News. Healthwatch then had further discussions with NHS England and were invited to sit on the support committee and were about to be invited to sit on the procurement committee. They were aware patients were being advised to go to Drayton. NHS England's update today was good news and it was acknowledged they had been pro-active in providing information on dentists to residents who did not have one.

Spring 2019 had been very difficult for Healthwatch due to the liquidation of their provider (Learning Links) and the move to the new provider (Help and

Care). The impact was significant on all aspects of activity, for example, re-registering clients and volunteers; it was almost like starting again. However, Healthwatch has been operational since mid-June. There are currently about 23 clients receiving advocacy support.

**RESOLVED that the update be noted.**

**40. Care Quality Commission (CQC) update (AI 9)**

Sarah Ivory-Donnelly, Hospitals Inspection Manager, presented the report and in response to questions clarified that:

The CQC engage with hospitals and have telephone or face to face engagement meetings with NHS trusts on a set schedule according to risk additionally they have ad hoc contacts as necessary. CQC use the information from engagement and other internal and external data to inform when to investigate further. Therefore, inspections are now more proportionate and a more effective use of resources. Inspectors have specific questions in mind as well as a general overview when they inspect.

There have been some organisational changes. Thirteen regions have now become seven and mental health in hospitals has a separate team.

The CQC collect and review a huge amount of all types of data, for example, deaths (reviewed monthly), serious incidents, diseases and all other data that hospitals report on nationally. The CQC looks at outliers and discusses the outcomes with hospitals.

The CQC are keen to be a resource for the panel and build relationships with them. Therefore, they will attend twice a year rather than annually. Their next attendance will be after the publication of the Portsmouth report.

**RESOLVED that the update be noted and that the CQC attend a meeting once the Portsmouth report has been published.**

Councillor Graham Heaney left the meeting at 4.10 pm.

**41. Podiatry Hub at St Mary's Campus (AI 11)**

Katie Arthur, Head of Operations, Primary Care Services, and David Noyes, Chief Operating Officer, presented the report together with Senior Podiatrists Robina King and Lawrence Fisher. In response to questions they clarified that

About 7,000 people use podiatry services annually. The re-location to St James is longstanding and has already been presented to a HOSP meeting. Current buildings are no longer fit for purpose and do not meet NICE clinical guidelines. One of the existing five sites which provides podiatry services, the Turner Centre, is being sold by the NHS, who own it.

The panel were concerned that a centralised service would greatly inconvenience large numbers of people who will have to travel longer distances, especially as many of them will have mobility and transport problems. There was also concern that the NHS selling properties can force service changes.

It was explained that patients wait a long time for podiatry appointments but waiting times would be shorter with a central hub. Multiple appointments (and therefore travel) will be reduced as all services will be together. Podiatry has changed greatly in the last ten years and conditions are much more complex.

The Sustainability Transformation Partnership awarded £10.3 million to re-develop and re-furbish blocks B and C on the St Mary's Campus with £8.3 million for block B and the remainder on block C.

**RESOLVED that the report be noted and that a report showing consultation with key stakeholders, including Portsmouth Pensioners, be brought to the next meeting on 21 November.**

The meeting ended at 4:30pm.

Signed

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Councillor
Chair