Hampshire County Council

NOTICE OF MEETING

Meeting Health and Adult Social Care Select Committee

Date and Time Thursday, 21st September, 2017 at 10.00 am

Place Ashburton Hall, Elizabeth II Court, The Castle, Winchester

Enquiries to members.services@hants.gov.uk

John Coughlan CBE
Chief Executive
The Castle, Winchester SO23 8UJ

FILMING AND BROADCAST NOTIFICATION
This meeting may be recorded and broadcast live on the County Council's website. The meeting may also be recorded and broadcast by the press and members of the public – please see the Filming Protocol available on the County Council's website.

AGENDA

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence received.

2. DECLARATIONS OF INTEREST

All Members who believe they have a Disclosable Pecuniary Interest in any matter to be considered at the meeting must declare that interest and, having regard to the circumstances described in Part 3 Paragraph 1.5 of the County Council's Members' Code of Conduct, leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with Paragraph 1.6 of the Code. Furthermore all Members with a Non-Pecuniary interest in a matter being considered at the meeting should consider whether such interest should be declared, and having regard to Part 5, Paragraph 2 of the Code, consider whether it is appropriate to leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with the Code.

3. MINUTES OF PREVIOUS MEETING (Pages 5 - 12)

To confirm the minutes of the previous meeting

4. DEPUTATIONS

To receive any deputations notified under Standing Order 12.

5. CHAIRMAN'S ANNOUNCEMENTS

Approx. timings

To receive any announcements the Chairman may wish to make.

6. ADULTS' HEALTH AND CARE - TRANSFORMATION TO 2019 (Pages 13 - 46) — 1 hour

To consider and make recommendation to the Executive Member for Adult Social Care and Health and the Executive Member for Public Health on the departmental transformation to 2019 savings proposals and public consultation feedback.

7. ISSUES RELATING TO THE PLANNING, PROVISION AND/OR OPERATION OF HEALTH SERVICES (Pages 47 - 84) — 1 hour

To consider a report of the Director of Transformation and Governance on issues brought to the attention of the Committee which impact upon the planning, provision and/or operation of health services within Hampshire, or the Hampshire population.

- Portsmouth Hospitals Trust: Care Quality Commission Re-Inspection

8. ADULTS' HEALTH AND CARE - SUBSTANCE MISUSE SERVICES — 45 mins

To receive a presentation setting out the work being undertaken by Public Health to transform and redesign substance misuse services in Hampshire, and to provide feedback on the proposals.

9. 'SOCIAL INCLUSION AND TRANSFORMATION TO 2019' WORKING GROUP - TERMS OF REFERENCE (Pages 85 - 88) — 10 mins

To agree the draft Terms of Reference for the 'Social Inclusion Transformation to 2019' working group of the Health and Adult Social Care Select Committee.

10. 'SUSTAINABILITY AND TRANSFORMATION PARTNERSHIPS' WORKING GROUP - TERMS OF REFERENCE (Pages 89 - 92) — 10 mins

To agree the draft Terms of Reference for the 'Sustainability and Transformation Partnerships' working group of the Health and Adult Social Care Select Committee.

11. WORK PROGRAMME (Pages 93 - 104) — 5 mins

To consider and approve the Health and Adult Social Care Select Committee Work Programme.

ABOUT THIS AGENDA:

On request, this agenda can be provided in alternative versions (such as large print, Braille or audio) and in alternative languages.

ABOUT THIS MEETING:

The press and public are welcome to attend the public sessions of the meeting. If you have any particular requirements, for example if you require wheelchair access, please contact members.services@hants.gov.uk for assistance.

County Councillors attending as appointed members of this Committee or by virtue of Standing Order 18.5; or with the concurrence of the Chairman in connection with their duties as members of the Council or as a local County Councillor qualify for travelling expenses.

This page is intentionally left blank

AT A MEETING of the Health and Adult Social Care Select Committee of HAMPSHIRE COUNTY COUNCIL held at The Castle, Winchester on Friday, 21st July, 2017

PRESENT

Chairman:
p Councillor Roger Huxstep

Vice-Chairman:
p Councillor David Keast

p Councillor Martin Boiles
p Councillor Ann Briggs
a Councillor Adam Carew
p Councillor Fran Carpenter
p Councillor Charles Choudhary
a Councillor Tonia Craig
p Councillor Alan Dowden
a Councillor Steve Forster
p Councillor Jane Frankum
p Councillor David Harrison
p Councillor Marge Harvey
p Councillor Pal Hayre
p Councillor Mike Thornton
a Councillor Jan Warwick

Substitute Members:
p Councillor Neville Penman

Co-opted Members:
p Councillor Alison Finlay
p Councillor Barbara Hurst
VACANT
VACANT

In attendance at the invitation of the Chairman:
p Councillor Liz Fairhurst, Executive Member for Adult Social Care
p Councillor Patricia Stallard, Executive Member for Health and Public Health

12. **APOLOGIES FOR ABSENCE**

Apologies were received from Cllrs Steve Forster and Jan Warwick. Cllr Neville Penman, as the Conservative standing deputy, was in attendance in their absence.

13. **DECLARATIONS OF INTEREST**

Members were mindful that where they believed they had a Disclosable Pecuniary Interest in any matter considered at the meeting they must declare that interest at the time of the relevant debate and, having regard to the circumstances described in Part 3, Paragraph 1.5 of the County Council's Members' Code of Conduct, leave the meeting while the matter was discussed, save for exercising any right to speak in accordance with Paragraph 1.6 of the Code. Furthermore Members were mindful that where they believed they had a Non-Pecuniary interest in a matter being considered at the meeting they considered whether such interest should be declared, and having regard to Part 5, Paragraph 2 of the Code, considered whether it was appropriate to leave the

meeting whilst the matter was discussed, save for exercising any right to speak in accordance with the Code.

No declarations were made.

14. MINUTES OF PREVIOUS MEETING

The Minutes of the meeting of the Health and Adult Social Care Select Committee (HASC) held on 20 June 2017 were confirmed as a correct record.

There were two matters arising from the Minutes:

- Minute 3: The Chairman had circulated the response from the Executive Member, and would leave the local County Councillors to take forward the suggestion to work with the Kings Worthy Parish Council.
- Minute 9: The Care Quality Commission report has not yet been published for the Trust; once available, this would be distributed to the Committee.

15. DEPUTATIONS

No deputations were received at this meeting.

16. CHAIRMAN'S ANNOUNCEMENTS

The Chairman did not make any announcements.

17. HAMPSHIRE AND ISLE OF WIGHT SUSTAINABILITY AND TRANSFORMATION PLAN

The Sustainability and Transformation Plan (STP) Director of Transformation and Delivery attended for this item alongside officer leads for the work streams covering estates, workforce and new models of care/the GP forward view (see Item 6 in the Minute Book). The Director of Adults' Health and Care and the Director of Public Health also joined the meeting for this item, in order to speak to work streams they were leading or contributing to.

The Director of Transformation and Delivery noted that she was newly in post and responsible for overseeing the 11 programmes taking place under the STP heading, which covered the geographical areas of Hampshire, Isle of Wight, Portsmouth and Southampton. The STP itself was incredibly broad and wide-ranging in its delivery, and therefore there was a significant amount of information in the update. The HASC would wish to consider how it could break down this information in future, but the aim of today's session would be to drill down in to the areas of estates, workforce and primary care.

Currently the STP was on course to deliver a surplus, but this was not guaranteed; to this end, significant work was being undertaken to understand the financial risks, with mitigation plans put in place where needed. This also included checking the commissioner and provider alignment, ensuring that there was a system-wide approach to cost reduction, and no risk of cost shunting from

one part of the NHS to another, or from health to social care. The efficiencies and savings that successful implementation of the STP might realise would see benefits for both providers and commissioners, with, for example, better sharing of back office functions fundamental to savings being achieved. Another key area where savings could be achieved just through better partnership working was procurement, and using the purchasing power of large organisations working together.

Southern Health NHS Foundation Trust had recently taken the decision as part of their clinical strategy to cease the provision of community physical health services, which would require a transition of these services to a new provider. Southern Health had requested that this take place by April 2019, when contracts were due to end, and would from this time be a specialist mental health and learning disabilities provider. A transition board had been set up to this end, with Hampshire CCG Partnership leading this work. The key aim of this work would be to ensure that services remained safe and of a high quality whilst a new provider was procured.

Overviews were provided of core delivery and enabling programme activity. Further to the paper circulated, Members heard:

- That it was important that the STP remained linked into national work in order to exploit resources available and learn from best practice in other areas.
- That work was being accelerated around out of hospital care, and ensuring that primary care was sustainable. The STP aimed to enable best practice to be shared and built on faster through local delivery systems. This would be achieved by setting a consistent framework for delivery, acknowledging that local teams best understand their population and how services can be organised to best meet their needs. This also included targeted work on those at high risk of requiring intense support from health and social care, and planning for their needs in an integrated way, preventing the need for urgent care services and repeat admissions.
- One of the benefits of the new models of care programme was the ability for these to be locally determined and accessible, but also tasked with empowering people to take responsibility for looking after their own health. To this end, success had been found by using the skills and experience of the voluntary sector and community assets, e.g. through the care navigator role in GP surgeries, who would be better able to signpost patients on to support services, providing a greater holistic care model than just the GP.
- On the estates enabling programme, regular meetings were taking place between Directors of Estates in provider organisations, NHS Property Services and commissioners in order to push forward on efficiency of the estate (i.e. making better use of buildings) or to identify estate for new models of care (i.e. urgent care centre locations). This programme would focus on proactivity, and creating space in the right places.
- The estates work stream worked to the ethos of ‘one public estate’, with work specifically being undertaken with district and borough councils to get the best use out of community assets.
- One of the key deliverables for the estates enabling programme had been the creation of a centrally-held database, which listed all of the 657 buildings used by health and social care, with locations, use and condition

all now recorded. This had made finding buildings for new services and hubs easier, and had removed some of the silo-working mentality from the previous approach to estates.

- It was felt that the workforce enabling programme was one of the key priorities across the geography, as the entire STP was dependent on having the right staff, in the right place, at the right time.
- Currently approximately 87,000 staff were employed across the STP geography, with approximately 44,000 working in health, and 43,000 in social care.
- Staff turnover was approximately 5% above the national average for these sectors in the STP geography. In domiciliary care, this turnover was as high as 40% annually. Of the workforce leavers in the NHS, approximately 24% were moving to another provider in the same geography, with the annual cost of recruiting to a vacant position being between £6,000 to £9,000. In February 2017, approximately 2000 of these leavers would have moved between provider organisations, costing the system on average £1.5m in recruitment and transactional costs.
- Therefore retention was a major challenge for the STP to consider and find solutions to; reviewing how organisations offer attraction and retention rates, the range of pay scales, incentive schemes, and development programmes for staff. Standardising some of this practice, and tackling the variance of pay across the geography would be one of the likely outcomes.
- There were five key work programmes within the workforce strand; attracting and retaining staff; temporary staffing; statutory and mandatory training; policies and procedures; and talent management and leadership. Many of the organisations across the geography had best practice approaches to these topics and part of the STP's role would be to identify those that could be shared and benefitted from by all. Collaboration would be key to the workforce issue; currently all providers tended to act as sovereign entities but benefits would be realised if the approach to staffing was tackled together.
- A large volume of work was ongoing relating to prevention, with Hampshire, Isle of Wight. Portsmouth and Southampton seeing work take place around being second wave implementers for diabetes education, training and conversations, leading work around digital solutions for lifestyle services, and reviewing approaches to falls prevention, obesity and alcohol. The prevention at scale delivery programme would also act as an enabler for other areas, ensuring that prevention is fully embedded in health and social care services, delivering improvements now to realise savings further upstream.
- The Director of Adults' Health and Care had been specifically involved in the urgent and emergency care work stream, where much of the focus related to people remaining in hospital for longer than necessary, and not being enabled to live with support at home as quickly as they needed it to remain independent for as long as possible.
- Nationally approximately 9% of beds in acute settings were being used by those who were medically fit but waiting for a care package or further onward NHS care, either through adult social care, NHS providers or privately, and the Government's challenge was to reduce this to 3.5% by September. A significant amount of work was being undertaken nationally and locally to realise this.

- The Integrated Better Care funding, of which £2bn had been announced for social care, was short term money that would drop off in three years' time. Hampshire had been allocated £37m of this spread across three years, which would be targeted in the following areas:
    - Supporting social care around demographics and complexity of need, noting the ageing population and cost of providing serviced to people with co-morbidities.
    - Reducing pressure on the NHS by supporting more rapid discharge.
    - Supporting provision in the private market, given the national experience of providers handing contracts back or failing.

Councillor Mike Thornton arrived at this point in the meeting.

In response to questions, Members heard:

- That there were many important areas of health, social care and wellbeing that aren't covered in the STP; the core programmes in this document were those where significant change could be achieved by partnership working. Services for people with autism were primarily commissioned by CCGs.
- That significant savings could be made by reviewing back office functions and joint procurement activity. National reviews, such as the Carter review, had highlighted how provider organisations can do more to be efficient. In addition, working in partnership would achieve greater economies of scale, both through commissioned services and the buying of supplies.
- The transition board overseeing the move of Southern Health's community physical health services would also be considering how services could be delivered differently, contracting for different and better quality outcomes.
- One of the major challenges for the STP would be how to make the GP workforce sustainable. Retention of GPs was a significant issue, both through pressures relating to workload and vacancy management, and with the workforce generally being older and more likely to retire in the next five years. Part of the solution might be creating sustainable roles, which would see GPs working in a portfolio way with particular specialisms, and new roles being developed to reduce the workload impact on doctors.
- That a key focus of the core work streams was supporting people to stay well for as long as possible, so that the finite resource that is available can be targeted towards those with life-limiting and complex conditions. Better use can also be made of technology, which is a key underpinning work stream, to support people at home.
- Following the Government's ambition to reduce delayed transfers of care from 9% to 3.5% nationally, the Director of Adults' Health and Care expected to meet this target, but did not have full confidence that this would be achieved by 1 September. However, measures were in place and trajectories agreed with each local system to reach the targets by April 2018.
- Part of the role of the STP Director of Transformation and Delivery was to ensure that each work stream had tangible dates and outcomes attached to them, including outlining the key tasks that would need to be

completed. A group met on a monthly basis to understand progress and where there were risks to delivery.

The Chairman noted that the STP was a complex and detailed document, and suggested that in order to ensure timely and regular scrutiny of this and the Frimley STP, the Committee may wish to consider convening a working group for this purpose. Members were agreeable, and the Chairman suggested that those with an interest in this subject matter correspond with the scrutiny officer, in order to register their interest in its membership.

RESOLVED

That the STP core programme update is noted.

That Terms of Reference for an STP working group be brought to the next meeting for consideration.

18. **ADULTS' HEALTH AND CARE: TRANSFORMATION TO 2019**

The Director and Deputy Director of Adults' Health and Care attended before the Committee in order to present the Transformation to 2019 report, as well as an accompanying presentation (see Item 7 in the Minute Book).

Members noted that briefings on Transformation to 2019 were starting to begin, which would see an additional £140m in savings from the County Council's budget being identified over the next two years. Of this, £56m would need to be achieved by Adults' Health and Care.

The report and presentation aimed to provide the Committee with details around the previous transformation programmes, as well as an overview of the potential work streams in the future. Paul Archer, the Deputy Director, had previously led a number of cost reduction programmes across the Council in his other role as Director of Transformation and Governance, and would bring this experience to Adults' Health and Care.

Although the transformation programmes often focused on cost-saving, many of the changes since 2010 have seen investments in technology in order to work as digitally as possible, enabling frontline workers to spend the largest proportion of their time helping people. Further efficiencies would not result solely in cost reduction through contracts, but would focus more on innovation, reducing specifications where this was not helpful to providing sustainable services, and improving joint working.

The outline budget for Transformation to 2019 would be heard in September, which would outline the major themes of this work:

- Prevention and demand management
- Older People and Physical Disabilities – assisting to live (more) independently
- Learning Disabilities and Mental Health – assisting to live (more) independently
- Working differently

Similar to the discussions held during the STP item, the Department were aware that changes made should not shunt costs from one organisation to another, and that service users needed to be at the heart of changes proposed. Additionally, it would be important to remain alive to ensuring that changing ways of working would not result in service users presenting with greater challenges in future because prevention has not central to services.

The £37m being allocated over a three-year period would be monitored by the Health and Wellbeing Board and the Department of Health, and the aim of this funding was primarily investing to save.

In response to questions, Members heard:

- The 'Balancing the Budget' public consultation began at the start of July and would run towards the end of August. The decision-making cycle would work to a February Full Council budget meeting.
- That funding for disabled facilities grants are paid to upper tier authorities and routed to District and Borough Councils, a sum of approximately £10m a year. Decisions on such grants should be collaborative, as the County Council has the social care responsibility and is often therefore required to make recommendations to the District or Borough Council for their funding approval.
- The County were aware that each District and Borough Council in Hampshire also have their own efficiencies to make and corporate priorities, but the question should still be asked on how all public sector bodies can work better together. Adults' Health and Care had very good working relationships with local authorities across the geography and already worked well collaboratively. A lot of the challenges were replicated at both tiers of local authority, and all worked for the same population. The topic of social inclusion was a key area where all Councils would need to work well together.
- Hampshire offered a range of carer support services, some formal and some informal. Not all carers identify themselves, but given that the value of informal care nationally is estimated to be over £150bn a year, it was imperative that support and respite was made available to those carers who require it. Part of the Council's role in this would be in creating supportive communities, and it also had a duty to provide caring support to people who are eligible to receive this.
- The Director of Public Health was leading work in the Council on how to reduce demand for Adult Services, ensuring a holistic approach to prevention. There were opportunities to make better use of the assets and resources that the Council already has.
- The £37m previously noted was short term money, and this will have been exhausted by the time the £56m of savings would come out of the budget, as a recurrent saving. The aim would be to pump prime some of these efficiencies, by investing to save in the short-term.
- The vast majority of people do leave hospital in a timely manner. The majority of those whose discharge is delayed have complex needs, need a specific care package, or require time to make a decision about where they should receive future care. The Department takes regular snapshots of performance, and routinely less than 80 people in Hampshire are delayed for a social care reason.

- In terms of the domiciliary and nursing care at home market, consideration was being given as to how staff are given the time they need to enable service users to look after themselves independently e.g. assisting an individual to get dressed on their own, rather than dressing them. Care should always be of a good standard, but the wider issue remained that capacity in the care market was shrinking, so thought had to be given as to how to use finite capacity in the best way possible, e.g. through better use of technology (such as medicine reminders) and reducing social isolation.

It was outlined that the recommendations in the paper requested that the Committee note the challenges facing the Department in terms of this further round of transformation activities, and requested Members' help in forming a working group, which would provide appropriate checks and balances to the social inclusion work stream of the programme. Members were agreeable to this suggestion.

RESOLVED:

That the Committee:

a) Noted the £140m Tt2019 programme challenge, headline timetable and within this noted the Adults' Health and Care target of £56m.

b) Noted the T19 approach being adopted by the Department and some of the key highlights emanating from the early opportunity assessment work described in section three of the report.

c) Acknowledged the engagement challenge across a range of important stakeholders as set out in section four of the report.

d) Agreed to the establishment of a HASC Member working group to specifically provide oversight and scrutiny to a forthcoming review of Social Inclusion services. That Terms of Reference are provided to the September meeting of HASC for consideration and agreement..

19. **WORK PROGRAMME**

The Director of Transformation and Governance presented the Committee's work programme (see Item 8 in the Minute Book).

RESOLVED:

That the Committee's work programme be approved, subject to any recommendations made at the meeting.

Chairman, 21 September 2017

HAMPSHIRE COUNTY COUNCIL

Decision Report

Decision Maker:	Executive Member for Adult Social Care and Health
Date:	21 September 2017
Title:	Transformation to 2019 – Revenue Savings Proposals
Report From:	Director of Adults' Health & Care and Director of Corporate Resources – Corporate Services

Contact name: Gary Smith and Dave Cuerden

Tel: 01962 847402
01962 847473

Email: Gary.smith@hants.gov.uk
Dave.cuerden@hants.gov.uk

1. Executive Summary

1.1. The purpose of this report is to outline the detailed savings proposals for the Adult Social Care budget that have been developed as part of the Transformation to 2019 Programme. The combined total departmental Transformation to 2019 savings requirement is £120m, with £55.9m of this required from the Adult Social Care budget.

1.2. The report also provides details of the Equality Impact Assessments (EIAs) that have been produced in respect of these proposals and highlights, where applicable, any key issues arising from the public consultation exercise that was carried out over the summer and how these have impacted on the final proposals presented in this report.

1.3. The proposals align with the Department's continued emphasis on positively maximising the independence of individuals so that they are able to do more for themselves and draw from wider community support. The Council will continue to invest in service models that enable this.

1.4. The Executive Member is requested to approve the detailed savings proposals for submission to Cabinet and then full County Council in October, recognising that there may be further public consultation for some proposals.

2. Contextual information

2.1. Members will be fully aware that the County Council has been responding to reductions in public spending, designed to close the structural deficit within the economy, since the first reductions to government grants were applied in 2010/11 and then as part of subsequent Comprehensive Spending Reviews.

2.2. Reductions in government grant together with inflationary and service pressures, notably within social care areas, have created an average County

Council budget gap of around £50m per annum, meaning that circa £100m has needed to be saved every two year cycle.

2.3. This position has been exacerbated following the changes announced in the Local Government Settlement in February 2016 which provided definitive figures for 2016/17 and provisional figures for the following three years to 2020. The settlement included a major revision to the methodology for distributing Revenue Support Grant (RSG) which had a major impact on shire counties and shire districts and also reflected a clear shift by the government in council tax policy.

2.4. Consequently, even after allowing for council tax increases over the settlement period, the County Council's forecast gap for the two years to 2019/20 is £140m, and after allowing for savings arising from prudent internal treasury management and other measures of £20m, targets were set for departments based on a reduction of approaching 19% in cash limited spend.

2.5. One of the key features of the County Council's well documented financial strategy and previous savings programmes has been the ability to plan well in advance, take decisions early and provide the time and capacity to properly implement savings so that a full year impact is derived in the financial year that they are needed.

2.6. This approach has also meant that savings have often been implemented in anticipation of immediate need and this has provided resources both corporately and to individual departments to fund investment in capital assets and to fund further change and transformation programmes to deliver the next wave of savings. This approach has enabled the County Council to cushion some of the most difficult implications of the financial changes.

2.7. Whilst this has been a key feature of previous cost reduction programmes it was recognised without doubt that the Transformation to 2019 (Tt2019) Programme, the fourth major cost reduction exercise for the County Council since 2010, would be significantly more challenging than any previous transformation and efficiency programme against the backdrop of a generally more challenging financial environment and burgeoning service demands.

2.8. Departments have looked closely at potential opportunities to achieve the required savings and unsurprisingly the exercise has been extremely challenging because savings of £340m have already been driven out over the past seven years, and the fact that the sheer size of the 19% target requires a complete "re-look"; with previously discounted options having to be re-considered. It has been a significant challenge for all Departments to develop a set of proposals that, together, can enable their share of the Tt2019 Programme target to be delivered.

2.9. The opportunity assessment and planning work has confirmed the sheer complexity and challenge behind some of the proposals as a consequence of which in a number of areas across the County Council significantly more than two years will be required to develop plans and implement the specific service changes.

2.10. The cashflow support required to manage the extended delivery timetable will in the most part be met from departmental cost of change reserves and

further contingency options to cover any shortfall will be considered as part of the updated Medium Term Financial Strategy (MTFS) that will be reported in October.

2.11 The County Council undertook an open public consultation called *Serving Hampshire – Balancing the Budget* which ran for six weeks between 3 July – 21 August 2017. The consultation was widely promoted to stakeholders and residents and asked for their views on ways the County Council could balance its budget in response to continuing pressures on local government funding, and still deliver core public services.

2.12 Responses to the consultation will help to inform the decision making by Cabinet and Full Council in October and November of 2017 on options for delivering a balanced budget up to 2019/20, which the Authority is required by law to do.

2.13 In addition, Equality Impact Assessments have also been produced for all of the detailed savings proposals and these together with the broad outcomes of the consultation and the development work on the overall Transformation to 2019 Programme have helped to shape the final proposals presented for approval in this report.

3. Budget Update

3.1. The savings targets that were set for departments were based on forecasts produced over the summer of 2016 and included a wide range of variable assumptions to arrive at the total predicted gap of £140m.

3.2. Last year the Local Government Finance Settlement provided definitive figures for 2016/17 and provisional figures for local authorities for the following three years to aid financial planning for those authorities who could 'demonstrate efficiency savings'. The County Council has now had its 2017/18 figures confirmed as part of the budget setting process and following acceptance by the Department for Communities and Local Government (DCLG) of the County Council's Efficiency Plan for the period to 2019/20 the expectation is for minimal change for 2018/19 and 2019/20. No figures have been published beyond this date.

3.3. The offer of a four year settlement provided greater but not absolute funding certainty. However, following the Queen's speech to Parliament in June this year, the planned changes to implement 100% business rate retention by 2019/20 are effectively suspended with no indication of when this might be resumed, although the Government has just invited applications for pilots to operate during 2018/19, the detail of which will be considered in due course. Work to carry out a fair funding review is set to continue as it does not require legislation.

3.4. An updated MTFS will be presented to Cabinet in October and then Full Council in November and the County Council will continue to review the assumptions on an ongoing basis in light of information that is made available.

4. Transformation to 2019 – Departmental Context

4.1. The Tt2019 Adult Social Care budget reduction of £55.9m alone is a significant challenge. This position needs to be seen within the context of the County Council's wider budgetary position, outlined above, continued adult social care demand pressures and the financial challenges being experienced by NHS organisations which have a direct bearing on social care pressures and vice versa.

4.2. The underlying financial position remains challenging in the extreme. Demand continues to increase. This includes both numbers of vulnerable/frail older people, (particularly those aged 85 or above set to rise markedly over the coming 3-5 years), and sustained increases in the numbers and cost of children with disabilities and complex needs transitioning to adulthood. Further, other factors such as regulation and the national living wage to name but two are impacting in terms of increasing inflationary pressures. It is estimated that these pressures will exceed £30m by 2019/20.

4.3. The pressures outlined above are not unique to Hampshire. They are representative of the position nationally. To help address this, the Government have recently announced changes to the funding that local authorities receive for Adult Social Care. The changes include:

- additional flexibility with the adult social care precept,
- an additional non-recurrent grant in 2017/18,
- an additional non-recurrent Improved Better Care Fund (IBCF) allocation to be received over three years commencing in 2017/18.

4.4. Whilst welcome, the above do not address the long term increase in demand as they are all only one off increases in funding. Combined, they do provide the opportunity to invest in transformational programmes to reduce costs in the long term to provide some mitigation. This is still unlikely to be sufficient, on its own, to off-set both the increase in demand and support the achievement of £55.9m savings necessary as part of the Tt2019 programme.

4.5. It follows therefore that the Department faces a significant funding cliff edge by 2020/21, when the above grants have ceased. By 2020/21 the only additional funding available is through the IBCF allocation, announced as part of the Autumn 2015 Local Government Spending Review. For this reason the Adult Social Care budget, in the medium term, remains reliant on the availability of Corporate support up to a maximum of an additional £10m per year outlined within the MTFS presented to Full Council in July 2016.

4.6. The Adults' Health and Care Department faces, in addition to the Tt2019 budget reduction of £55.9m, a further £4m of recurring Public Health savings which need to be achieved by 2019/20. By 2019/20 the County Councils' Public Health grant will be £49.5m after total cash reductions of £8.3m since 2015/16. These budget reductions are being taken forward on a different timescale from Tt2019 and will report to the Executive Member for Public Health.

4.7. The challenge for the Department is clear in that it must deliver the right quality of care for clients, at a rate that is affordable, whilst transforming the mechanisms and channels by which care is provided. Achieving the Tt2019 Adult Social Care budget reduction of £55.9m will be extremely challenging and cannot be achieved without impact on frontline services.

4.8. That said, the Department has a strong track record which has seen it deliver on previous budget reductions. It has achieved this through seeking to maximise service transformation, efficiencies and innovation, alongside service reductions. A key component of this has been the sustained investment by the County Council which has enabled significant building developments and the exploitation of new technology which is demonstrated by the following:

- Revenue investment of £3.3m in telecare annually
- Capital investment of £45m currently delivering an increase in the capacity of available Extra Care provision for older people in the county
- Capital investment of £35m currently delivering greater volumes of available supported living accommodation for younger adults.

4.9. This will continue to be the Department's approach and change will remain a constant as the Department builds on the achievements and outcomes of the Transformation to 2017 (Tt2017) savings programme. In many instances, this will mean building on tried and tested existing initiatives as well as continuing with positive innovations and investments – circa £17.6m of savings from the proposed Tt2019 programme are a direct continuation of the principles and practices adopted within Tt2017. Forging new ways to enable greater independence across client groups, further expanding the use of Technology Enabled Care (including Telecare), continued investment in Extra Care/alternative accommodation and changing social care practice will all play their part and are having a significant positive impact on the quality of life of adult social care clients and others.

4.10. At the same time there are areas of existing policy and practice where the Department will need to redouble its efforts to engage with and manage the expectations of the public and service users as to what the Department can and cannot offer. Tt2019 will, inevitably, mean re-defining the Department's relationship with the community and where necessary adapting policies further.

4.11. The approach the Department is taking to opportunities for Tt2019 is to focus on:

- **Prevention:** Developing a strengthened prevention strategy to reduce and/or contain, in the face of the continued pressures, service demand growth across a wide range of business areas
- **Independence:** Increase the number of clients and prospective clients living independently of formal adult social care services and reduce the overall net costs of care

- **Productivity:** Improve efficiency and productivity of the Department's operations
- **External spend:** Increase outcomes and service efficiency arising from commissioned activity.

4.12. The joint dependencies with the NHS cannot be ignored and will affect the achievability of opportunities in a number of ways. Close working and integration with the NHS locally continues to be critical to the future in specific areas of joint business activity and there is evidence of good recent progress being made in this regard.

4.13. Overall, the Department's estimated savings are made up of four main blocks. These four blocks comprise:

- **Health and social care integration**
- **Living Independently** (older people and physical disabilities)
- **Learning disabilities, Children's to Adults transitions, mental health and Social Inclusion** and
- **Working Differently**.

4.14. These are all underpinned by a further block which involves a concerted effort to reinvigorate the Department's **demand management and prevention** activities – this will provide the foundation for the other blocks, rather than directly achieve savings. A summary of each of these blocks is included in the following paragraphs.

4.15. Tt2019 will require the Department to continue to be effective in terms of its **demand management and prevention** work. Containing and then reducing demand for services will be key to living within a reducing budget envelope. Within this area of focus will be initiatives to help potential service users and their families and friends to do more for themselves wherever and whenever possible, partly assisted by improved access to better advice and information including how technology can play an important role in maintaining and/or increasing independence. Undoubtedly there will be a range of things that the Department will look to take forward in this area with partners, providers, community groups and volunteers all aimed at enabling residents to live healthier and more independent of social care paid for support, for longer.

4.16. The biggest block of savings relates to the £18.9m savings opportunities associated with operational efficiencies, improved client outcomes and reduced service demand pressures linked to **health and social care integration**. This relates to the use of the increased IBCF in order to continue to support a wide range of existing services and joint / integrated service delivery instead of reducing or removing them altogether. The intention is to use the resource to protect core adult social care services that would otherwise see their funding reduced by £18.9m by 2019. The planning assumption remains that the Department's existing commitment to integration with health partners will continue and that system wide performance targets will be achieved using the totality of the Department's budget.

4.17. The next biggest savings area, some £18.3m, comes from **Living (more) Independently** as the Department looks to further transform its services for older people and people with physical disabilities. There will be a focus on strengths based approaches, intermediate care and reablement to improve the health and wellbeing of residents so that increasing numbers can remain in their own homes, living as independently as possible. This approach will aim to see lower or reduced needs following a short-term intervention, enabling, wherever possible, people to return home with appropriately sized care packages as opposed to being transferred to residential and nursing care provision at current levels of demand. These proposals are entirely in keeping with the wishes of people the Department supports; staying living independently in their own homes for as long as possible. Greater use of technology and focused investment in short-term provision and in Extra Care will be important enablers as will new and improved relationships with care providers alongside more flexible and modern commissioning and procurement approaches. Consideration would also be given to income from client contributions and in-house efficiencies. In addition, consideration would be given to consult on the future of day services in favour of potential alternative and more individualised provision.

4.18. The third biggest saving area represents £14.6m. The living (more) independently theme is continued in the **Learning Disabilities and Mental Health** work areas as the Department looks to continue the successful journey started ahead of Tt2017 to move increasingly away from institutional, long-term care settings and move instead to support people into more flexible, more modern ways of living that provide much greater independence for service users with learning disabilities and/or mental health needs. This will include more supported living, creating more opportunities for employment including supported employment and enabling people to do more for themselves, including developing opportunities for people to find a greater level of support from within their local communities. As part of this, work will continue with Children's Services and with providers to manage costs and outcomes for **young people transitioning to adult social care** services.

4.19. A separate piece of work will focus on engaging with district council partners to redesign **Social Inclusion** services for people who are homeless or at risk of homelessness to release savings when the current service comes to an end in March 2019. A Health and Adult Social Care Select Committee Member working group is being established to specifically assist in undertaking this vital area of work.

4.20. The final block of savings covers £4.1m of savings and relates to the entire workforce and how from top to bottom across the Department each and every member of staff can be enabled to **work 'differently'**, e.g. more productively, more efficiently and more effectively. This will enable the Department to operate, over time, with fewer staff but in a manner that is least disruptive to service users. A range of opportunities exists within this strand of the overall programme, the most obvious of which is how the Department looks to optimise the use of technology in every day working from work scheduling and assessment work for social workers, to flexible working involving less travel and fewer offices for everyone. This work area will also consider end-

to-end business processes so that unnecessary cost can be driven out with minimal impact for residents. Areas of existing business will be considered for automation and some areas of business activity may cease (where an existing process can be achieved differently or it provides no customer value).

4.21. As stated, whilst an emphasis will be placed on positively achieving these budget savings, there remains significant risks.

4.22. It is recognised that difficult service decisions/changes will need to be made across the programme to achieve the decreased departmental expenditure. There is a risk that a reduction in the Department's service offer may reduce, or may be perceived to reduce, client choice. The Department is mindful of its legal duties and eligible needs will be met. The Department will continue to closely monitor the actions of other local authorities and legal judgements. The impact of decisions on service users is carefully considered and mitigated where possible. It should be noted that adult social care case law turns upon circumstances in individual cases and as such some areas of risk are by their nature less predictable.

4.23. Progress and success will require a very thoughtful and careful engagement approach across a myriad of different but important stakeholders. Some of these have already been referred to above. Additionally, there is a significant work programme ahead which would require a huge focus on how the Department works with people who use services and a determination to undertake positive engagement to develop co-produced solutions with a broad range of representative groups.

4.24. There is also much ongoing work with the NHS at acute hospital, community provider and Clinical Commissioning Group (CCG) level. The Department looks to take forward integration opportunities where they can add most value and to improve and simplify existing joint working - to take out cost and importantly to improve the service user experience. It is recognised that there will continue to be external scrutiny on discharge performance and how the County Council uses the IBCF to protect and enhance social care provision across Hampshire.

4.25. The culture change challenges for staff within the Department and for County Council staff more widely, remain significant. Continuing to build on the strengths based approach adopted at the beginning of Tt2017 and improving its focus and results will be fundamentally important. Creating the right conditions for staff at all levels to perform consistently effectively across all staff groups and all teams will continue to challenge leaders and senior managers grappling with higher levels of service demand and reducing budgets and staff. Operating effectively will require all front line staff to engage positively with service users, with families and with community groups/volunteers. The resetting of public understanding and the development of a compelling narrative to support a broader cultural change and set of expectations that our public understands, accepts and agrees with has to run through everything the Department does.

4.26. Technology has been mentioned in numerous places within this report and is another key enabler to a successful future. There are clear opportunities to

build upon the very successful assistive technology arrangement that the County Council has enjoyed with Argenti over recent years and with the present contractual arrangements due to conclude in the summer of 2018, there is work to do in terms of what might follow. As described earlier, technology is going to be increasingly important in terms of the prevention and reducing reliance upon 'traditional' forms of social care support in favour of increased social networking and remote support available to people. Increasing the ability of the County Council and the desire of the public in relation to maximising private pay opportunities is largely untested territory which will be fully tested over the coming period.

4.27. Some of these issues are as much an opportunity as a challenge. There also remains a significant amount of both Tt2017 and Tt2019 programmes which will have a positive effect on the levels of independence and the quality of life of the Department's clients and prospective clients.

5. Summary Financial Implications

5.1. The savings target that was set for Adult Social Care was £55.9m and the detailed savings proposals that are being put forward to meet this target are contained in Appendix 1.

5.2. The Department is currently forecasting to achieve savings of up to £49.0m of the £55.9m required by 2019/20, the year by which the Tt2019 budget reductions will come into effect. The remaining £6.9m is expected to follow in 2020/21. In cashflow terms, the Department will cover this £6.9m from cost of change reserves in 2019/20, along with any planned delayed delivery which is to be expected in a programme of this magnitude. The Department will continue to focus on safely achieving as much savings as early as possible.

5.3. It is forecast, based on current planning assumptions that the Department will have sufficient cost of change reserves to cover this requirement in 2019/20. The Department has been able to top up its cost of change reserve through some early delivery of Tt2017 savings and is planning to add further to this through early delivery of some Tt2019 savings.

6. Workforce Implications

6.1. Appendix 1 also provides information on the estimated number of reductions in staffing as a result of implementing the proposals.

6.2. As a consequence of the proposals, if agreed, it is envisaged that there could be an overall reduction in the adult social care workforce in the region of 150 full time equivalent posts which are likely to come primarily from non-direct care related service areas. The exact posts and teams potentially affected will not be known until significant further work is undertaken. This would focus on identifying opportunities to make current processes more efficient, and on the continuing deployment of modern technology.

6.3. Any reductions in staffing levels would be managed in a sensitive and considerate way, through natural turnover, redeployment and voluntary means wherever possible

7. *Serving Hampshire-Balancing the Budget* consultation

7.1. As part of its prudent financial strategy, the County Council has been planning since February 2016 how it might tackle the anticipated deficit in its budget by 2019/20. As part of the Medium Term Financial Strategy, which was last approved by the County Council in July 2016, initial assumptions have been made about inflation, pressures, Council Tax levels and the use of reserves. Total anticipated savings of £140m are required and of this sum, savings targets to the value of £120m were set for departments as part of the planning process for balancing the budget.

7.2. The proposals in this report represent suggested ways in which departmental savings could be generated to meet the target that has been set as part of the Transformation to 2019 Programme. Individual Executive Members cannot make decisions on strategic issues such as Council Tax levels and use of reserves and therefore, these proposals, together with the outcomes of the *Serving Hampshire - Balancing the Budget* consultation exercise outlined below, will go forward to Cabinet and County Council and will be considered in light of all the options that are available to balance the budget by 2019/20.

7.3. The County Council undertook an open public consultation called *Serving Hampshire – Balancing the Budget* which ran for six weeks from 3 July – 21 August. The consultation was widely promoted to stakeholders and residents through all available channels, including online, via the County Council's website; Hampshire media (newspapers, TV and radio); and social media. Hard copies were also placed in Hampshire libraries and alternative formats, such as easy read, were made available on request.

7.4. The *Balancing the Budget* consultation asked for residents' and stakeholders' views on ways the County Council could balance its budget in response to continuing pressures on local government funding, and still deliver core public services. Specifically, views were invited on several high level options as follows:

- reducing and changing services;
- introducing and increasing charges for some services;
- lobbying central government for legislative change;
- generating additional income;
- using the County Council's reserves;
- increasing Council Tax; and
- changing local government arrangements in Hampshire.

7.5. A total of 3,770 responses were received to the consultation. The key findings from consultation feedback are as follows:

- The majority of respondents **(65%) agreed** that the County Council should continue with its **financial strategy**.

- Responses were relatively evenly split between those who tended to support **changes to local services** and those who did not (**50% agreed**, 45% disagreed and 5% had no view either way).
    - Of all the options, this was respondents' **least preferred**.
- Two thirds of respondents **(67%) agreed** that the County Council should raise existing **charges** or introduce new charges to help cover the costs of running some local services.
- Over half of respondents **(57%) agreed** that the County Council should **lobby the Government** to vary the way some services are provided, and enable charging where the County Council cannot levy a fee due to statutory restrictions.
- Of all the options presented, generating **additional income** was the **most preferred** option.
- On balance, the majority of respondents **(56%) agreed** that the County Council should retain its current position not to **use reserves** to plug the budget gap.
    - Of all the options, this was respondents' **second least preferred**.
- Respondents would prefer the County Council to continue with its plans to raise **Council Tax** in line with Government policy (**50%** ranked this as their preferred approach to increasing Council Tax).
    - Of all the options, increasing Council Tax was respondents' **second most preferred**.
- More than half of those who responded **(64%) agreed** that the County Council should explore further the possibility of **changing local government structures** in Hampshire.

7.6. Executive Lead Members and Chief Officers have been provided with the key findings from the consultation to help in their consideration of the final savings proposals. In particular, as a result of the feedback on service issues, the County Council will seek wherever possible to:

- **minimise reductions and changes to local services**, and continue to ensure that resources are prioritised on those who need them most, i.e. vulnerable adults and children;

- **increase and introduce charges** to cover the costs of some local services. Where the County Council is unable to charge for services due to statutory restrictions, the County Council will continue to **lobby the Government for legislative change**;

- maximise further **income generation** opportunities.

7.7. The proposals set out in Appendix 1 have, wherever possible, been developed in line with these principles but inevitably the effect of successive reduction programmes over a 9 year period will begin to have an impact on the services that can be provided.

7.8. In some cases, the proposals in this report will be subject to further, more detailed public consultation if they are ratified by the Cabinet and Full Council in October and November respectively, at which the overall options for balancing the budget will be considered in light of the consultation results.

7.9. In addition to the consultation exercise, Equality Impact Assessments have been produced for all of the detailed savings proposals outlined in Appendix 1 and these have been provided for information in Appendix 2. These, together with the broad outcomes of the consultation, have helped to shape the final proposals presented for approval in this report.

8. Equality Impact Assessment

8.1. Appendix 2 contains the EIAs that have been completed for the Tt2019 programme. It should be noted that the EIAs are at this stage at a high level as each block of the saving proposals still have a lot of detail that needs to be worked through. The Department would continually review the equality impacts of the individual initiatives to ensure that any emerging impacts are taken into account.

8.2. The EIAs show that the saving programme would have a high impact on older people and people with disabilities. Some proposals would have a positive impact and, where possible, actions have been identified to mitigate against the negative impact and careful thought has been given to ensure that actions can be justified.

8.3. The main impacts and proposed mitigating actions under each block are set out below.

Health and social care integration

8.4. The anticipated **impact** would be positive and would mainly benefit older people, people with life long conditions and people with disabilities. It is likely that people with long-term conditions would experience improved health related quality of life. The changes should help older people to recover their independence more quickly after illness or injury and increase independence and self reliance so that people retain control of their lives. In the longer term these changes to lifestyle would aim to reduce premature and total mortality from the major causes of death and reduce the difference in life expectancy between people living in the least and most deprived areas.

Living (more) independently (older people and physical disabilities)

8.5. The main anticipated **impacts** are that some older people and people with physical disabilities may receive less support through purchased domiciliary, residential and nursing care as it is the department's intention to reduce use of these routes. People may receive less funded support and there would be greater expectations on families and communities to support older, vulnerable people. There could be increased risk to the safety and wellbeing of vulnerable adults as less formal social care support would be provided. Some people might need to contribute more to meeting the cost of the care and support they receive.

8.6. To **mitigate** against these potential negative impacts the Department would develop ways of working, including working with partners, that would increase or maintain people's independence for longer through the use of their own resources, and that of their family/friends and their community. People would continue to only pay what they are assessed (using national rules) as able to afford to contribute towards their care costs. This means that although an individual's bill could increase to an extent, it would not be by more than they could reasonably expect to be able to afford based on their income and outgoings.

Learning disabilities, Children's to Adults transitions, mental health and Social Inclusion

8.7. The main anticipated **impacts** are that fewer service users would be supported in residential care and day opportunities as these services would be reduced and alternative provision would be identified for the most vulnerable. As part of the review of the services commissioned by the Department, some people may find that the services they access change, including day services and respite services. For people attending day services this could mean they receive a different type of offer, or it is provided by a different organisation. People in receipt of mental health aftercare under s117 Mental Health Act 1983, will continue to receive services free of charge. There may be an increased emotional and financial strain on families and carers of adults with learning disabilities and/or mental health support needs.

8.8. To **mitigate** against these impacts the Department would continue to ensure that packages of care are personalised to the needs of the individual and that Direct Payments are actively promoted to maximise service user choice. Where appropriate, people who are currently living in residential care settings may be supported and enabled to move to supported living environments, allowing them to exercise greater control and choice over their day to day lives. Alternatively, working with them, the home owner, their family and carers their current residential care home may be converted into a supported living environment. Alternative services would be made available to meet people's needs for daytime activities. As above, people will only pay what they are assessed (using national rules) as able to afford to contribute towards their care costs. The department will continue to work with Children's Services and related providers to manage costs and outcomes for **young people transitioning to adult social care** services. A separate piece of work would focus on engaging with district council partners to redesign **Social Inclusion** services for people who are homeless or at risk of homelessness to release savings when the current service comes to an end in March 2019.

Working Differently

8.9. The main **impact** of these changes would be that there would be a reduction in the number of staff employed, as outlined in section 6 of this report. At this stage it is not yet known which teams would be affected.

8.10. The Department's **mitigating** action would be to manage down staff levels in a planned and sensitive way through the use of managed recruitment,

redeployment of staff where possible and voluntary redundancy where appropriate.

9. Conclusion

9.1. Inevitably, Tt2019 would involve complex transformational, policy and service change across the range of adult social care services in the context of an unrelenting business as usual agenda and a somewhat uncertain national picture.

9.2. Extensive public engagement and co-design of services would need to feature strongly and the Department would need to build on the work started in the past 18 months in terms of appropriately re-setting public expectations of the Department in the future, including changes to expectations of the way in which people's needs are met.

9.3. None of what has been described above is straightforward or easy to deliver on because it would have happened by now if it were. That said, there are a number of strong elements of the programme which would continue to have a positive and beneficial impact for clients.

10. Recommendation

10.1. To approve the submission of the proposed savings options contained in this report and Appendix 1 to the Cabinet.

CORPORATE OR LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	yes
People in Hampshire live safe, healthy and independent lives:	yes
People in Hampshire enjoy a rich and diverse environment:	yes
People in Hampshire enjoy being part of strong, inclusive communities:	yes

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

IMPACT ASSESSMENTS:

1. Equality Duty

1.1. The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act;

Advance equality of opportunity between persons who share a relevant protected characteristic (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, gender and sexual orientation) and those who do not share it;

Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant characteristic connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity which participation by such persons is disproportionally low.

2. Impact on Crime and Disorder:

2.1. The impact on crime and disorder is expected to be minimal, however, any specifically implications will be monitored with relevant partners as they arise.

3. Climate Change:

a) How does what is being proposed impact on our carbon footprint / energy consumption?

There isn't expected to a big impact on our carbon footprint or energy consumption, however, the Working Differently project will seek to further reduce unnecessary staff travel through better use of technology and other means.

b) How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts?

No specific climate change adaptions have been identified.

Adults' Health and Care – Proposed Savings Options (Subject to consultation where appropriate)

Ref	Service Area & Description of Proposal	Impact of Proposal	Expected Savings			FTE Impact
			2018/19 £'000	2019/20 £'000	Full Year £'000	
B2	**Health and Social Care Integration** Maintaining and integrating health and social care services for predominantly older people and clients in need of physical support.	The integration agenda will have a positive impact on service users who will receive a more joined up service; it will also reduce duplication within the health and care system. Business areas associated with the following will be impacted; health related quality of life for long term conditions, older people after illness or injury and older persons' independence. Much of the change required is covered in other Tt2019 projects. This funding is protecting social care services that otherwise would have to be reduced by 2019.	-	18,900	18,900	N/A
B3/ B4	**Living Independently (Older People & Physical Disabilities)** To generate care models that increase service user independence which will reduce the number and financial value of care packages. The contribution received from service users for their care and support will also be reviewed.	Potential service users will be diverted to non adult social care services to reduce the projected number of new clients by approximately 300 service users (links to demand management & prevention). Existing clients will be targeted with interventions at appropriate times to avoid escalation of their level of need. The strengths based approach from Tt2017 will continue and exploit new opportunities. This should provide a better outcome for clients and change the profile of commissioned care with providers, including fewer service users requiring residential care. Self-funding clients receiving care at home would see an increase in their charge by changes to the way provider costs are dealt with to take into account wider costs (ie bringing the payment by results element into the core price paid). Consideration would be given to consult on the future of day services in favour of potential alternative and more individualised provision. Consideration would be given to consult on proposals to increase the contribution from service users who are eligible to pay towards the cost of their care (mostly related to in-house homes) – those financially assessed as unable to contribute or who are at their personal cap will not need to pay any more.	7,628	14,242	18,366	N/A

Ref	Service Area & Description of Proposal	Impact of Proposal	Expected Savings			FTE Impact
			2018/19 £'000	2019/20 £'000	Full Year £'000	
B5	**Working Differently** This is a department wide project to reduce staff time spent on non-statutory activity and increase staff productivity to create more efficient ways of working.	There would be a significant impact on staff due to reduced staff numbers over time, potential changes to the skill and capabilities mix and a move towards a more flexible workforce. Increased productivity, more efficient processes, smarter working and exploitation of modern technology would all play their part in this. Specific operational teams and headquarters functions may become less flexible to respond to non-standard requests. There would also be a greater reliance on service users and their families to be active participants in care assessment process.	-	2,935	4,052	Circa 160 (TBC)
B6	**Learning Disabilities & Mental Health** To generate care models that increase service user independence to reduce the financial value of care packages. There will also be some contract renegotiations and cost recovery through client contributions.	All current care packages would be reviewed to ensure they are appropriate and maximise new opportunities for independence. Many of the approaches to deliver cashable savings are extensions of tried and tested T17 initiatives. The profile of commissioned care with providers would change as a result and provider rates would also be renegotiated, this would include fewer service users who require residential care. Consideration would be given on the way in which respite provision is provided.	8,531	9,216	10,216	N/A
B7	**Children's to Adults** To engage earlier with young people who will transition from Children's Services to adult social care to encourage independence and enable lower cost care packages.	There will be engagement with young people and their parents from the age of 14 to encourage them to retain and gain further independence through strengths based conversations. This should provide a better outcome for clients and change the profile of commissioned care with providers. Children's Services providers will adopt the South East region cost model that is already rolled out in adult social care Learning Disabilities; this may have an impact on these providers.	800	1,600	2,400	N/A

Ref	Service Area & Description of Proposal	Impact of Proposal	Expected Savings			FTE Impact
			2018/19 £'000	2019/20 £'000	Full Year £'000	
B8	**Social Inclusion** To work with district council partners to redesign Social Inclusion services for people who are homeless or at risk of homelessness to release savings when the current service comes to an end.	There will be engagement with district council partners to review the future provision and investment in services for those socially excluded. The impact depends on the options selected after engagement and the level of joint investment. However, it is likely to impact on how districts, boroughs, non-statutory and statutory agencies provide the service in future. The level of service available may reduce resulting in fewer individuals being able to access the service.	-	2,000	2,000	N/A
		Total	**16,959**	**48,927**	**55,934**	**160**

Equality Impact Assessment

Name of project/proposal	T19 - Health & Social Care Integration
Originator	Ashton, Karen
Email address	Karen.Ashton@hants.gov.uk
Department	Adult Services
Date of Assessment	31 Aug 2017

Description of Service / Policy

The Integration and Better Care Fund policy has been in place to accelerate the integration agenda for system partners, to transform care delivery and address the growing financial challenges across the whole of local health and social care economies. Initial agreed plan, assured by NHS England in December 2014, covered a five year timespan. Following announcements in the Chancellors Spring Budget in March 2017, additional resource has been made available to support social care services, social care providers and introduce schemes that reduce the pressures on the NHS related to social care particularly in respect of delayed transfers of care.

Geographical impact* All Hampshire

Description of proposed change

Our vision for 2020, reflecting the assumptions and aspiration of the Integration and Better Care Fund policy framework is to transform local care services delivery; accelerate implementation of new models of care in each local system and address the issues that delay people from being transferred for acute hospital across a system of sustainable acute and mental health services. The intention is to use the resource to protect core adult social care services that would otherwise see their funding reduced.

Engagement and consultation

Has engagement or consultation been carried out? Yes

No specific consultation has been carried out on this proposal, however, the County Council carried out a major public consultation exercise over the Summer 2017 on a range of options for finding further budget savings including increasing council tax, using reserves and making changes to the way in which services are delivered, which may mean reducing or withdrawing certain services. The outcome of this consultation will be presented to Cabinet in October 2017. When decisions are made to pursue specific options, and further targeted consultation will be carried out with stakeholders on the detailed options where required. At the heart of each CCG system is a new approach to engagement with local people. In North East Hampshire for example a network of citizen leaders is being developed. 80 Community Ambassadors recruited to date, are being supported, developed and empowered to participate in the design of the new model of care. During 2016/17 additional ambassadors have been recruited to grow our Collaborative Trios programme (citizen leader, managerial leader and clinical leader work together at the heart of each component of the care model programme). Elsewhere focus groups, mid- and large- scale events and creative workshops are being used to enable a greater depth of engagement with local people

Impacts of the proposed change

This impact assessment covers Service users

Statutory	**Impact**

considerations	
Age	Positive
Impact	The New Models of Care Programme aims to ; build a extended joint out- of- hospital infrastructure that support self management, extend access to primary care, streamline access to acute care and reduce the number of steps to access specialist care. These changes will • Improve health related quality of life for people with long-term conditions; • Help older people to recover their independence more quickly after illness or injury. • Increase independence and self reliance so that people retain control of their lives In the longer term these changes to lifestyle will: • Reduce premature and total mortality from the major causes of death; • Reduce the difference in life expectancy between people living in the least and most deprived areas.
Disability	Positive
Impact	The New Models of Care Programme aims to ; build a extended joint out-of-hospital infrastructure that support self management, extend access to primary care, streamline access to acute care and reduce the number of steps to access specialist care. These changes will: • Improve health related quality of life for people with long-term conditions; • Help older people to recover their independence more quickly after illness or injury. • Increase independence and self reliance so that people retain control of their lives In the longer term these changes to lifestyle will: • Reduce premature and total mortality from the major causes of death; • Reduce the difference in life expectancy between people living in the least and most deprived areas.
Sexual Orientation	Neutral
Race	Neutral
Religion and Belief	Neutral
Gender Reassignment	Neutral
Gender	Neutral
Marriage and civil partnership	Neutral
Pregnancy and Maternity	Neutral

Other policy considerations

Poverty	Neutral
Rurality	Neutral

Additional Information

This page is intentionally left blank

Equality Impact Assessment

Name of project/proposal	T19 Living independently
Originator	Cross, Ian
Email address	ian.cross@hants.gov.uk
Department	Adult Services
Date of Assessment	08 Sep 2017

Description of Service / Policy

The county council provides support to older people and adults with physical disabilities. This support is delivered through the provision of domiciliary care, short term beds and respite care, supported living initiatives. Some recipients make a financial contribution to the cost of their care"

Geographical impact* All Hampshire

Description of proposed change

The programme aims to reduce overall spend through the development of new services which will decrease the requirement for spending on traditional domiciliary care and prevent admission to long term residential or nursing care. It is designed to increase independence. It will also further embed the strength based approach to assessment so that those who need care do all that they are able and draw on support from family, friends, neighbours and local community services where appropriate. A fuller description of the changes are set out in the additional information section of this form.

Engagement and consultation

Has engagement or consultation been carried out? Yes

No specific consultation has been carried out on this proposal, however, the County Council carried out a major public consultation exercise over the Summer 2017 on a range of options for finding further budget savings including increasing council tax, using reserves and making changes to the way in which services are delivered, which may mean reducing or withdrawing certain services. The outcome of this consultation will be presented to Cabinet in October2017. When decisions are made to pursue the options, further specific consultation will be carried out with stakeholders on the detailed options where required.

Impacts of the proposed change

This impact assessment covers Service users

Statutory considerations	**Impact**
Age	Medium
Impact	Some older users may receive less service from Adults Health and Care. Some users may need to make a greater financial contribution to the services which they receive.
Mitigation	Some new services will deliver benefits to all age groups which balance the impact of lower levels of service in other areas. Financial Assessment assures that contributions are affordable for individuals with allowance being made for

	additional costs of disability.
Disability	Medium
Impact	Some service users with physical disabilities may receive less service from Adults Health and Care.
Mitigation	New service developments such as increased availability of supported living, shared lives and Extra Care schemes will positively benefit users
Sexual Orientation	Neutral
Race	Neutral
Religion and Belief	Neutral
Gender Reassignment	Neutral
Gender	Neutral
Marriage and civil partnership	Neutral
Pregnancy and Maternity	Neutral

Other policy considerations

Poverty	Neutral
Rurality	Positive
Impact	Development of a new framework for Care at Home will increase availability of service in rural "hard to reach" areas.

Additional Information

Living Independently in the Community is a transformation project which aims to deliver savings against current spending on older people and physical disabilities services by:

- Reducing volume of domiciliary care purchased
- Increasing reablement
- Making better use of shortterm beds and respite care
- Establishing a Joint Hospital Prevention Scheme
- Developing Dementia Hubs and Day Services
- Making increase use of Extra Care Housing
- Increasing the number of Shared Lives services
- Increasing the availability of Supported Living Opportunities for younger people with physical disabilities (PD)

Making some increases to what some people contribute towards their care costs, to help us to recover more of the cost of delivering some of our services.

The proposals identified at this stage may not fully deliver the savings required and work is being undertaken to identify further opportunities and to develop proposals to meet the gap between the current deliverable savings and the target that has been set. It should also be noted that delivery of some savings is dependent on the ability of the Demand Management and Prevention workstream to make available alternative community services and to ensure the sustainability of the significant contribution

made by unpaid carers to the care and support of vulnerable people.

This page is intentionally left blank

Equality Impact Assessment

Name of project/proposal	T19 Adults Learning Disability & Mental Health
Originator	Gibson, Camilla
Email address	Camilla.Gibson@hants.gov.uk
Department	Adult Services
Date of Assessment	08 Sep 2017

Description of Service / Policy

The County Council provides additional care funding for adults with learning difficulties and mental health needs which cannot be supported through universal services. Needs are identified through an assessment process which defines an individual's support plan, personal budget and any financial contribution they are required to make. The council currently supports c 3400 care packages for these client groups.

The proposal is to review all care packages, including aftercare delivered under s117 Mental Health Act, to provide funding only where eligibility criteria has been met and ensure recipients make appropriate financial contributions to their support.

Geographical impact* All Hampshire

Description of proposed change

The service provision delivered to people with learning disabilities, mental health and substance misuse needs will be reviewed, including transport, traditional respite services, day services and leisure activities in favour of voluntary community groups and self directed opportunities.

These proposals are designed to deliver sustainable models of progressive care and supported living, which will increase independence, sense of wellbeing and significantly reduce use of residential care for people with learning disabilities and mental health conditions. These proposals will also reduce the costs of meeting eligible needs.

Engagement and consultation

Has engagement or consultation been carried out? Yes

No specific consultation has been carried out on this proposal, however, the County Council carried out a major public consultation exercise over the Summer 2017 on a range of options for finding further budget savings including increasing council tax, using reserves and making changes to the way in which services are delivered, which may mean reducing or withdrawing certain services. The outcome of this consultation will be presented to Cabinet in October 2017.

When decisions are made to pursue the options, further specific consultation will be carried out with stakeholders on the detailed options where required.

Impacts of the proposed change

This impact assessment covers Service users

Statutory considerations	**Impact**
Age	Neutral

Disability	Medium
Impact	People living in residential care may be enabled to move into supported living. People receiving intensive levels of care, could see the rollout of less intrusive/restrictive care models People with learning disabilities could receive lower levels of support or alternative support (telecare, voluntary sector support etc). People attending day services could receive different types of services, or services provided by different organisations. For people receiving 1:1 support to participate in leisure activities, levels or type of support may change. People using mental health services may see some support they receive through domiciliary care and direct support from mental health staff change. A separate piece of work will focus on engaging with district council partners to redesign Social Inclusion services for people who are homeless or at risk of homelessness to release savings when the current service comes to an end in March 2019. As proposals are developed a separate EIA will be completed as the impact on different groups emerge.
Mitigation	The proposals are designed to promote independence where possible; learning disabilities day services may act as transitional, rather than long-term services; mental health teams will work with wellbeing centres to enable people become more independent. Packages of care will continue to be personalised to the needs of the individual and Direct Payments will be actively promoted to maximise service user choice. All assessments, reviews and support plans will be undertaken in accordance with Care Act guidance. We will try to ensure other agencies are delivering their statutory responsibilities / universal services eg clinical input, housing etc
Sexual Orientation	Neutral
Race	Neutral
Religion and Belief	Neutral
Gender Reassignment	Neutral
Gender	Neutral
Marriage and civil partnership	Neutral
Pregnancy and Maternity	Neutral

Other policy considerations

Poverty	Neutral
Rurality	Neutral

Additional Information

Equality Impact Assessment

Name of project/proposal	T19 - Working Differently
Originator	Burton, Michael
Email address	Michael.Burton@hants.gov.uk
Department	Adult Services
Date of Assessment	08 Sep 2017

Description of Service / Policy

A number of transformation programmes are working on finding the savings needed to meet the Adults' Health and Care (AHC) future budget allocation. The Working Differently programme has been tasked with working with the staffing budget across the department, with the exception of In-House Services. C.1500 employees are in scope for this area of work, with an annual budget of £28m. Associated transport and premises costs of £3m will also be a focus. Savings will be made through a reduction in the workforce, premises and travel costs of the AHC Department.

Geographical impact* All Hampshire

Description of proposed change

As a consequence of the proposals, if agreed, it is envisaged that there could be an overall reduction of the in scope AHC workforce in the region of 150 full time equivalent posts. The exact posts and teams potentially affected will not be known until significant further work is undertaken. Working Differently will involve changing how the department is organised and the way it works. The programme will simplify or stop tasks that are currently undertaken, wherever this is possible. New technology will be introduced and investment will be made to create the necessary changes.

Engagement and consultation

Has engagement or consultation been carried out? Yes

No specific consultation has been carried out on this proposal, however, the County Council carried out a major public consultation exercise over the Summer 2017 on a range of options for finding further budget savings including increasing council tax, using reserves and making changes to the way in which services are delivered, which may mean reducing or withdrawing certain services. The outcome of this consultation will be presented to Cabinet in October 2017. When decisions are made to pursue the options, further specific consultation will be carried out with stakeholders on the detailed options where required.

Impacts of the proposed change

This impact assessment covers HCC Staff (and partners)

Statutory considerations	**Impact**
Age	Medium
Impact	The demographic mix of departments workforce shows a higher number of older staff. Further work is required to identify who falls within the affected staff group this will clear after the analysis has been carried out.
Mitigation	Project will continue to review and update the EIA as and when it determines which staff members are to be affected.

	Strategies used for previous restructures redundancy offers, managed recruitment and redeployment where possible will be used as necessary. Any future trade union consultation will be designed to ensure that all staff, taking into account their protected characteristic, are equally consulted on the proposals to come.
Disability	Medium
Impact	Relative to the Hampshire County Council average, the department includes a higher percentage of disabled staff than the County Council overall
Mitigation	Project will continue to review and update the EIA as and when it determines which staff members are to be affected. Strategies used for previous restructures redundancy offers, managed recruitment and redeployment where possible will be used as necessary. Any future trade union consultation will be designed to ensure that all staff, taking into account their protected characteristic, are equally consulted on the proposals to come.
Sexual Orientation	Neutral
Race	High
Impact	The affected group has a higher percentage of BME staff than the County Council overall
Mitigation	Project will continue to review and update the EIA as and when it determines which staff members are to be affected. Strategies used for previous restructures redundancy offers, managed recruitment and redeployment where possible will be used as necessary. Any future trade union consultation will be designed to ensure that all staff, taking into account their protected characteristic, are equally consulted on the proposals to come.
Religion and Belief	Neutral
Gender Reassignment	Neutral
Gender	High
Impact	Relative to the Hampshire County Council average, the department includes a higher percentage of female staff than the County Council overall.
Mitigation	Project will continue to review and update the EIA as and when it determines which staff members are to be affected. Strategies used for previous restructures redundancy offers, managed recruitment and redeployment where possible will be used as necessary. Any future trade union consultation will be designed to ensure that all staff, taking into account their protected characteristic, are equally consulted on the proposals to come.
Marriage and civil partnership	Neutral

Pregnancy and	Neutral

Maternity

Other policy considerations

Poverty	Neutral
Rurality	Neutral

Additional Information

If agreed, these proposals will create a significant impact on staff due to reduced staff numbers over time, potential changes to the skill and capabilities mix, changes to the day-to-day work that people undertake and a move towards a more flexible workforce. Increased productivity, more efficient processes, smarter working and exploitation of modern technology will all play their part in this. Specific operational teams and headquarters functions may become less flexible to respond to nonstandard requests. There will also be a greater reliance on service users and their families to be active participants in care assessment processes. Given that the overall staff numbers will reduce there could be an impact on service users too. At this stage of the programme it is not yet known what service areas or client groups will be affected. As the detail is emerging more in depth EIAs will be carried out to identify the impact not only of staff but also on service delivery

This page is intentionally left blank

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date of Meeting:	21 September 2017
Report Title:	Issues Relating to the Planning, Provision and/or Operation of Health Services
Report From:	Director of Transformation and Governance

Contact name: Members Services

Tel: (01962) 847336 **Email:** members.services@hants.gov.uk

1. Summary and Purpose

1.1. This report provides Members with information about the issues brought to the attention of the Committee which impact upon the planning, provision and/or operation of health services within Hampshire, or the Hampshire population.

1.2. Where appropriate comments have been included and copies of briefings or other information attached.

1.3. Where scrutiny identifies that the issue raised for the Committee's attention will result in a variation to a health service, this topic will be considered as part of the 'Proposals to Vary Health Services' report.

1.4. New issues raised with the Committee, and those that are subject to on-going reporting, are set out in Table One of this report.

1.5. The recommendations included in this report support the Strategic Plan's aims of supporting people to live safe, healthy and independent lives, and to enjoy being part of strong, inclusive communities, through the overview and scrutiny of health services in the Hampshire County Council area.

Topic	Relevant Bodies	Action Taken	Comment
Care Quality Commission (CQC) re-inspection of services *(Monitoring items)*	Portsmouth Hospitals Trust (PHT) CCGs and partner organisations CQC	Follows on from original CQC inspection in February 2015 (with re-inspections in February and March 2016, and September 2016), The HASC has monitored this item since this time – last reviewed January 2017. The most recent CQC report on PHT is attached as Appendix 1.	The CQC's remit was, amongst others, to make sure that the improvements required by previous inspections had been made. The CQC carried out a responsive focused inspection of the corporate and leadership functions of Portsmouth Hospital NHS Trust on 10 and 11 May 2017, inspecting the key question of 'well led'. Following the inspection of Queen Alexandra Hospital in May 2017, the CQC has served further action under Section 31 to protect vulnerable patients from immediate risks of harm. Details of these notices are included at the end of the report. Full report and commentary: http://www.cqc.org.uk/provider/RHU/reports

Recommendations:

That Members:

a. Note the update from the Trust, and consider what steps the Committee should take in response to the findings of the re-inspection report.

b. Determine a suitable date to further consider progress made against the recommendations of the Care Quality Commission report.

c. Make any further recommendations as appropriate.

CORPORATE OR LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	No
People in Hampshire live safe, healthy and independent lives:	Yes
People in Hampshire enjoy a rich and diverse environment:	No
People in Hampshire enjoy being part of strong, inclusive communities:	Yes

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

IMPACT ASSESSMENTS:

1. Equality Duty

1.1 The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, gender and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Due regard in this context involves having due regard in particular to:

a) The need to remove or minimise disadvantages suffered by persons sharing a relevant characteristic connected to that characteristic;

b) Take steps to meet the needs of persons sharing a relevant protected characteristic different from the needs of persons who do not share it;

c) Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity which participation by such persons is disproportionally low.

1.2 **Equalities Impact Assessment:** This is a covering report for items from the NHS that require the attention of the HASC. It does not therefore make any proposals which will impact on groups with protected characteristics.

2 Impact on Crime and Disorder:

2.1 This paper does not request decisions that impact on crime and disorder

3 Climate Change:

3.1 How does what is being proposed impact on our carbon footprint / energy consumption?

3.2 How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts?

No impacts have been identified.

Portsmouth Hospitals NHS Trust

Quality Report

Queen Alexandra Hospital
Southwick Hill Road
Portsmouth
PO6 3LY
Tel: (023) 92286000
Website: www.porthosp.nhs.uk

Date of inspection visit: 10 and 11 May 2017
Date of publication: 24/08/2017

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Not sufficient evidence to rate
Are services at this trust safe?	Not sufficient evidence to rate
Are services at this trust effective?	Not sufficient evidence to rate
Are services at this trust caring?	Not sufficient evidence to rate
Are services at this trust responsive?	Not sufficient evidence to rate
Are services at this trust well-led?	Not sufficient evidence to rate

Summary of findings

Letter from the Chief Inspector of Hospitals

Portsmouth Hospital NHS Trust is located in Cosham, Portsmouth and is a 975 bedded District General Hospital providing a comprehensive range of acute and specialist services to a local population of approximately 610,000 people. The trust provides specialist renal services to a population of 2.2 million people across Wessex. On our announced inspection on 10 and 11 May 2017, we inspected the key question of 'well led' for Portsmouth Hospital NHS Trust.

We carried out a responsive focused inspection of the corporate and leadership functions of Portsmouth Hospital NHS Trust on 10 and 11 May 2017, inspecting the key question of 'well led'. This inspection was carried out following our inspection of the emergency medical pathway in February 2017 which highlighted concerns regarding culture, governance and leadership within the trust. The specific concerns required us to visit the emergency department and medical care areas as part of the May 2017 inspection in order to review ward to board governance arrangements. During this May 2017 inspection we identified concerns in the emergency department, four medical care wards and the Acute Medical Unit (AMU). The findings are reported in the February 2017 report for the emergency department and medical care services for Queen Alexandra Hospital. To view our findings and report from the February 2017 inspection of the Queen Alexandra Hospital please refer to our website.

During this inspection, we found that there had been deterioration in the quality of services provided, and that improvements had not been sustained. Immediately following our inspection of Queen Alexandra Hospital in February 2017 inspection we issued enforcement action under Section 31 of the Health and social Care Act 2008 to protect patients on the acute medical pathway from the immediate risk of harm. During this inspection, in May 2017, we did not see evidence that services had sufficiently improved following our feedback to the trust senior leadership team in February 2017. Following our inspection of Queen Alexandra Hospital in May 2017, we served further action under Section 31 to protect vulnerable patients from immediate risks of harm. Details of these notices are included at the end of this report.

There was a lack of management oversight and lack of understanding of the detail of issues which we observed on both inspections. We found that the trust had significant capacity issues and were not addressing the concerns regarding the acute medical pathway in a timely or effective way. The pressure on beds meant that patients were allocated the next available bed rather than being treated on a ward specifically for their condition placing patients at risk of harm. Across all areas inspected there were significant concerns regarding the care for vulnerable patients and the application of the Mental Health Act 1983, Mental Capacity Act 2005, and Deprivation of Liberty Safeguards.

We have not rated the well led element for Portsmouth Hospital NHS Trust as we did not collate sufficient evidence to do as we had only inspected in relation to the emergency department and medical care areas. However, there were significant concerns in safety, responsiveness and leadership, with an apparent disconnect between the trust board and the ward level. It was evident that the trust leaders were not aware of many of the concerns we identified through this inspection. Staff perceived there was bullying and did not feel able to speak out about concerns. We were not assured that the processes for raising concerns internally were open and free from blame.

Our key findings were as follows:

- There was a lack of leadership oversight of mental health provision at all levels.
- Not all staff complied with the requirements of the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards. We raised five safeguarding alerts to the trust for reporting to the local authority during the inspection.
- We found that in the majority of areas the staff were committed to providing the best care they could with the resource levels, skills and training within the area they were working in.
- Several staff were identified by the inspection team as being strong in their work.

Summary of findings

- The process for the induction of agency nurses across the trust was not effective. This was because the process for formal checks on the nursing competencies for the administration of IV fluids on the wards was inconsistent.
- We were concerned that the emergency department medical staff were working outside the scope of their clinical skills and competencies. The emergency department staff were providing acute medical care to patients due to the medical staff not willing to take medical patients outside of their specialist area. This placed the emergency medical doctors at risk.
- The medical model for acute care was to be launched on 8 May 2017 but some doctors refused to take part in implementation of the model. There were insufficient mitigations in place and this meant emergency department doctors were caring for medical patients for extended periods of time.
- The culture of medical staff throughout the medical division and unscheduled care was of significant concern to us. We found that there was a culture that was not supportive to patient safety, quality or care. This resulted in delays for patients to receive medical care.
- Following CQC enforcement action in March 2016, the trust had appointed an Executive Director of the Emergency Care pathway. During our interviews there was a lack of clarity from the Medical Director and the Exec Executive Director of Emergency Care pathway as to who held executive accountability and responsibility for the acute medical pathway.
- Delayed care and breaches of the four hour timeframe and 12 hour trolley breaches appeared to be normalised.
- Mortality has increased at a steady rate over the last 12 months. We were not assured this was being addressed. We were informed that mortality was high due to the 'unscheduled care pathway'. However no audits or evidence had been gathered to support this. Since the inspection, the trust has provided information which demonstrates they are working to improve their processes for monitoring mortality.
- We were significantly concerned about the processes and practice for safeguarding adults and children within the trust. We were not assured that all known events were being appropriately reported or investigated as safeguarding concerns.
- The safeguarding children training rates at level three were significantly below what would be expected in some departments including the emergency department.
- We were made aware of two incidents involving children that demonstrated the trust did not follow best practice safeguarding children procedures.
- We were significantly concerned about the lack of oversight on safeguarding matters within the trust at senior management and executive board level.
- The governance processes to highlight issues within the trust were not effective.
- The private board papers, in the majority, should have been shared in public board to demonstrate an open and transparent approach from the trust.
- There was a backlog of complaints, and the quality of complaint responses was variable. Some responses did not fully address the concerns raised by the complainant.
- The quality of incident investigations were very poor. There was limited evidence or assurance that lessons learned from incidents were implemented.
- The application of the Duty of Candour regulation to incidents was variable, with incidents found where duty of Candour had not been undertaken.
- We received several positive examples of good practice and positive experiences from staff working throughout the hospital.
- However, many staff perceived there was bullying and didn't feel able to speak out about concerns. This was expressed by different staff groups who raised concerns to CQC before, during and after the inspection.
- We were not assured that the processes for raising concerns internally were open and free from blame. This discouraged staff from feeling free to speak about concerns.
- The role of the trust's freedom to speak up guardian was not working effectively. Staff we spoke with in the majority were not aware of who the freedom to speak up guardian was.
- The process for checking if a person working at board level in the organisation is fit and proper to work in their role, was undertaken in accordance with the regulations.

Summary of findings

- There was work being undertaken to ensure compliance with the workplace race equality standards.
- Most specialties provided care and treatment in line with NICE guidelines and royal college guidelines. Trust policies were in line with these guidelines
- During 2015/2016, 38 national clinical audits and eight national confidential enquiries covered NHS services that Portsmouth Hospitals NHS Trust provides. During that period Portsmouth Hospitals NHS Trust participated in 97% (37/38) national clinical audits and 100% (8/8) national confidential enquiries of those it was eligible to participate in
- Between November 2016 and February 2017, 96% of patients said they would recommend the trust to family and friends, higher than the national average of 95%.
- Between November 2016 and March 2017 93% of patients said they would recommend the A&E service to family and friends, higher than the national average of 87%
- There were specific care pathways for certain conditions, in order to standardise the care given. Examples included stroke pathways, sepsis, acute kidney injury, non-invasive ventilation and falls
- During 2015/2016, Portsmouth Hospitals NHS Trust has participated in a total of 316 clinical research studies, 84% of these studies were NIHR Portfolio adopted.
- There was an improved and dedicated focus to providing care to patients with a learning disability.
- Many staff reported good experience of culture and openness within their local departments
- In areas such as paediatrics, maternity and critical care staff provided good examples of how leadership and culture was positive in their areas. This included being open and raising concerns.

For the areas of poor practice the trust needs to make the following improvements.

Importantly, the trust must:

- Ensure that staff are assessed and signed off as competent to deliver patient care.
- Ensure that the culture within the organisation of staff not being willing to raise concerns openly and concerns around bullying are given sufficient priority by the board.
- Review the governance functions and processes for the trust to ensure they are fit for purpose.
- Improve compliance with regulation 28 coroner reports for preventing future deaths.
- Ensure that improvements are made to the classification of incidents to ensure that they are reported, escalated and graded appropriately.
- Ensure that the conditions imposed by the Commission on the Acute Medical unit, and Emergency Department are effectively implemented.
- Improve identification and management of incidents requiring duty of candour.
- Improve the quality of Root Cause Analysis investigations.
- Review the processes for the safeguarding of vulnerable adults and children the ensure that safeguarding processes work effectively in the trust.
- Improve the processes, policies, staffing and understanding of mental health for staff at ward to board level.
- Ensure that staff have knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards, and implement them effectively.
- Ensure that patients do not have procedures undertaken on them without appropriate consent being obtained, and best interest assessments are completed where applicable.
- Ensure that records completed for the purpose of care are completed accurately.
- Immediately review the risks associated with reporting of chest x-rays in radiology. Including the undertaking of a patient harm review on all cases not reported on.
- Undertake patient harm reviews and audits to identify where lessons can be learned or mortality ratios reduced.
- Immediately review the medical model within acute care to ensure that patients are seen by a treating physician and treated at the earliest opportunity.
- Improve the flow and capacity throughout the hospital.

Summary of findings

- Review the board assurance framework, board minutes, and processes for reporting at board to ensure risks are identified and managed by the trust, and that the minutes are appropriately recorded.
- Develop a vision and strategy for the trust.
- Improve the complaints processes, oversight of complaints and reduce the backlog of complaints to ensure patients receive responses in a timely way.

Following the inspections of the Queen Alexandra Hospital in February and May 2017 we took immediate action to ensure the safety of patients. We have taken this urgent action as we believe a person will or may be exposed to the risk of harm if we did not do so. Details of this action are included at the end of the report.

Professor Sir Mike Richards Chief Inspector of Hospitals

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Portsmouth Hospitals NHS Trust

Sites and Locations:

The trust has four registered locations;

- Queen Alexandra Hospital,
- Gosport War Memorial Hospital,
- St Mary's Hospital,
- Petersfield Hospital.

Population served:

- Portsmouth Hospital NHS Trust is located in Cosham, Portsmouth and is a 1200 bedded District General Hospital providing a comprehensive range of acute and specialist services to a local population of approximately 208,900 people.
- The trust provides specialist renal services to a population of 2.2 million people across Wessex.
- According to 2011 census, the ethnic breakdown of Portsmouth's population is as follows: 84.0% White British, 3.8% Other White, 1.3% Chinese, 1.4% Indian, 0.5% Mixed-Race, 1.8% Bangladeshi, 0.5% Other ethnic group, 1.4% Black African, 0.5% White Irish, 1.3% Other Asian, 0.3% Pakistani, 0.3% Black Caribbean and 0.1% Other Black.

Health Profile and Deprivation:

- The health of people in Portsmouth is generally worse, than the England average. Deprivation is higher than average and about 25.2% (9,000) children live in poverty.
- Life expectancy for men is lower than the England average.
- Levels of teenage pregnancy, GCSE attainment and smoking at time of delivery are worse than the England average.
- In 2012, 25.1% of adults are classified as obese.
- The rate of alcohol related harm hospital stays represents 1,139 stays per year.
- The rate of self-harm hospital stays represents 654 stays per year, worse than the average for England.
- Almost half of all the deaths in Portsmouth are caused by heart disease, stroke, cancers and respiratory conditions.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Leanne Wilson, Interim Head of Hospital inspections, Care Quality Commission

The inspection team consisted of two CQC Heads of Inspection, three CQC inspectors, one mental health act reviewer and two Inspection Managers. We were supported by a variety of specialists including, a chief executive, a director of nursing, medical director, HR Director, and governance specialists.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?

Summary of findings

- Is it well-led?

The unannounced inspection took place on 16, 17 and 28 February 2017 and looked at the urgent and emergency service and medical care (including older people's care) service. The announced focused inspection took place on 10 and 11 May 2017 and focused on the key question of 'well led' at provider level.

Before visiting, we reviewed a range of information we held, from organisations on what they knew about the hospital. These included the clinical commissioning group (CCG); NHS England; Health Education England (HEE); General Medical Council (GMC).

During our inspections we spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff. We also spoke with the executive leaders of the trust as well as staff in support functions including governance and complaints. We also spoke with the trust's freedom to speak up guardian.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Queen Alexandra Hospital NHS Trust.

What people who use the trust's services say

Results from the CQC in-patient survey from June 2016 showed the trust is performing about the same as other trusts for all of the indicators.

The trust's friends and family test results showed that of the percentage of patients who recommend the service, that overall the trust scored an average of 96% between November 2016 and February 2017. This was above the England average of 95%.

For areas which were the focus of our inspection:

- Urgent and emergency care the results between November 2016 and March 2017 showed that on average 93% of people would recommend the A&E service to friends and family. This was above the England average of 87%.

For Medical care areas we visited the majority of areas showed results above the England average. However the areas where concerns were noted were:

- Acute Medical Unit scored between 86% and 90% during this period.
- Ward C5 scored between 86% and 96% during this period.
- Ward D2 scored between 91% and 93% during this period.
- Ward F3 scored between 21% and 67% during this period.

Facts and data about this trust

- This organisation has four locations.
- There are approximately 975 beds in the trust, the majority of which are general beds.
- The trust serves a population of approximately 610,000 people from Portsmouth.
- The renal centre provides services to 2.2 million people.
- The trust employs 6,300 staff (WTE).
- There were approximately 132,000 A&E attendances, over 55,000 inpatient admissions. There were 6,300 births between April 2015 and March 2016.
- There was one mortality outlier in this trust. This related to 'pleurisy, pneumothorax, pulmonary collapse'.

Summary of findings

- For the 12-month period from Oct 15 - Sep 16, HSMR was higher than expected with a value of 111.42. Performance had declined compared to the previous year.
- SHMI for July 2015 to June 2016 was 110.77 which although above the national average is within control limits.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We have not rated safe because this was a focused inspection undertaken in response to concerns. We found: • We identified 24 incidents which had been incorrectly graded with 'low harm'. For example, a misdiagnosed fracture was graded as 'low harm'. • The quality of how Duty of Candour was undertaken was variable. • We were not assured the training met the requirements of level two safeguarding for adults. • The quality of root cause analysis investigations was variable with many being poorly investigated and completed. • We were concerned by the high prevalence of safeguarding events being reported and investigated. In some of these cases we were not assured that appropriate investigation or actions to protect other patients from the risk of harm had taken place. • There was a lack of ownership, oversight and lack of risk management regarding patients in the hospital with a mental health condition. • There was no protocol for the safe clinical management of patients awaiting admission in the waiting room, or how to escalate concerns regarding crowding or patient safety in this area However: • The named safeguarding adult nurse for the trust is 'PREVENT' trained. • There were clear protocols and pathways in place for recognising and managing female genital mutilation (FGM). **Duty of Candour** • The trust's Duty of Candour policy was out of date, dated for review in January 2017. The policy definitions of what constituted harm was not in accordance with the definition from the National Patient Safety Agency 'Seven steps to patient safety' tool. • Staff were aware of duty of candour, which ensured that patients and/or their relatives were informed of incidents which had affected their care and treatment and were given an apology.	**Not sufficient evidence to rate** 

- We were provided with examples of where duty of candour had been applied. These were also recorded in the incident investigation record if the event was more serious.
- The quality of how Duty of Candour was undertaken was variable. We saw in two cases the family were informed of the investigation at the time they were informed their relative had died. The letters did not detail what Duty of Candour meant and what the investigation would entail.
- We reviewed 350 incidents selected at random reported by the trust between February and April 2017. Of those we found that Duty of Candour or being open was not recorded as being undertaken for 24 (7%) incidents when the type of incident required it.
- In one case, a patient who unexpectedly went into cardiac arrest was resuscitated due to staff not having access to the notes which contained a DNACPR. There is no evidence on the incident report that Duty of Candour or being open was undertaken to the next of kin regarding the resuscitation.
- In a second case an incident recorded that 'This could have an impact on [their] mental wellbeing for, possibly, a long time'. There was no evidence on the incident record that duty of candour or being open was undertaken.
- In a third case of a patient receiving palliative care being required to have a further CT scan reportedly caused distress to the patient and her family prior to the patient's death. This incident was graded as a 'low harm', despite the psychological trauma experienced. There was no evidence on the incident record that duty of candour had been completed.

Incidents

- We reviewed incidents reported prior to the inspection. These demonstrated that the level of harm a patient experienced as a result of an incident was not always correctly graded.
- We reviewed a selection of 350 incidents reported between 01 February 2017 and 30 April 2017. We found that some incidents reviewed were categorised incorrectly. For example, 'consent, communication, confidentiality' when it related to failure to recognise a deteriorating patient, and a grade three pressure ulcer recorded as a records issue.
- We identified 24 incidents which had been incorrectly graded with 'low harm'. For example a misdiagnosed fracture was graded as 'low harm', a missed tendon injury was graded as 'low harm'.
- Another incident related to a missed cervical spine event, with delay in identification of the issue and treatment required of four hours. The patient was moved between departments

during this time without the cervical spine being secured. The patient had progressive changes in how much they could move their limbs during this time. The incident recorded as a 'low harm' with an investigation outcome of 'Anything done differently would not have made any difference to this patient outcome'. However this outcome had not been confirmed through a thorough serous incident investigation.

- A patient arrested following a catastrophic bleed. The suction in the bed space and the next bed space were not assembled correctly and therefore did not work thus preventing airway management. This was graded as a low impact. The impact of not having functioning equipment to treat the patient was not detailed on the incident investigation.
- We reviewed eight root cause analysis investigation reports that had been signed off as completed. The quality of these investigations was variable with many being poorly investigated and completed. The terms of reference for investigation often did not cover the broad scope of issues related to the incident. The terms were generic and pre-populated in each report reviewed.
- The root cause analysis investigations were not always completed to a good standard. The identification of care and service delivery problems, as well as understanding the root cause of an incident was poor. For example in a case of a patient deterioration resulting in the patient death three care problems were identified. The lessons learned were minimal and did not cover the range of care issues identified. The investigation outcome stated, 'It is the view of the report authors that the lack of escalation of the EWS score had no impact on the eventual outcome'. This was written despite the range of failings to this patient's care.
- There was limited assurance that staff completing investigations were trained in root cause analysis investigation. There was no evidence available which demonstrated what training the panel members, who signed off the final reports, had received.

Safeguarding and Mental Health

- Safeguarding adults training was provided across the trust. On review of the content of the safeguarding adult training we were not assured the training met the requirements of level two safeguarding for adults, as described by the 'Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document'. In addition medical staff at consultant grade within the trust have not all been trained to level three as required by the intercollegiate document.

- There was a policy and procedure for the safeguarding of vulnerable adults in the trust. We were not assured that all elements of this policy were being adhered to.
- The incident reporting processes in the trust was not capturing all potential safeguarding concerns. For example, one incident reported was classified as, 'Access, admission, transfer, discharge (including missing patient)'. The incident related to a case of suspected financial abuse towards a vulnerable patient. This was graded as a low impact and there was no evidence on the incident record of safeguarding input, an alert being raised, follow up or outcome.
- Through conversations with external stakeholders regarding safeguarding reporting, investigation and processes significant concerns were raised to us regarding the trust's safeguarding practices.
- We were concerned by the high prevalence of safeguarding events being reported and investigated. At the time of the inspection there were three serious allegations of physical abuse between staff and patients under investigation by the police and local authority. There were three cases of where a patient with a learning disability had died as a result of poor care, documentation and decision making. These were going through a serious case review at the time of our inspection. There was a case subject to police investigation in relation to wilful neglect of patient care.
- In some of these cases we were not assured that appropriate investigation or actions to protect other patients from the risk of harm had taken place. This concern was also shared by external stakeholders.
- Following our February 2017 inspection we asked for safeguarding concerns to be raised to the local authority on three patients whose care we witnessed constituted a safeguarding investigation. We were provided with no assurances that the trust reported these concerns to the local authority.
- During our May 2017 inspection we asked for formal confirmation that safeguarding concerns were raised to the local authority in respect of four patients we observed. We received confirmation that these cases were reported.
- We were not assured that the processes for safeguarding children were effective within the emergency department. We were informed of two cases that occurred in the week prior to our inspection where children under the age of one year old were sent home despite bruising of unknown origin being found.

- The 'Protocol for the management of actual or suspected bruising in infants who are not independently mobile', states, 'This protocol must be followed in all situations where an actual or suspected bruise is noted in an infant who is not independently mobile'. However, on discussion with the safeguarding team they informed us that the bruises were "open to interpretation" by the medical staff. Therefore we were not assured that the protocol was being adhered to.
- Concerns were raised through a serious case review regarding the trust's processes for identification and management of domestic abuse cases. The outcome of the case identified failings from the trust to protect the woman. A repeat audit undertaken showed that domestic violence knowledge amongst staff was still limited, and further work was needed to improve this.
- Following our inspection in February 2017 the trust produced a training needs analysis for mental health training. The needs analysis did not identify the correct training needs and subsequently meant that when we returned in May 2017 staff were still not sufficiently trained in mental health awareness. This was evidenced by a lack of knowledge on how to care for patients with a mental health concern or learn from incidents.
- There had been a suicide in December 2016 of an individual who had left the emergency decision unit whilst awaiting an assessment by the mental health liaison team. The patient was considered to be high risk of suicide and was reported in the Serious Incident Requiring Investigation (SIRI) report. Although there were clear potential opportunities for learning, the SIRI report identified no care or service delivery problems.
- We reviewed medical records for a non-detained patient and found their record showed they were high risk to self and potentially others. According to their notes, they had been admitted to the unit following a self-harm event. The patient was awaiting an assessment by the mental health liaison team through referral to another trust. On reviewing the patient record, inspectors observed there was no care plan in place to manage the patient's risks to self or others whilst the patient awaited review by the mental health liaison team. We later identified that the patient had left the ward without challenge, and staff were not aware of the patient's whereabouts.
- Staff in frontline areas were offered training in safe breakaway techniques.However, this training was not considered mandatory for frontline staff, and, as such, could not provide assurance of staff safety in the event they needed to safely

remove themselves from a volatile situation.This may also have presented a risk to patients as staff may cause injury if attempting to breakaway without appropriate training.The course had not been attended by medical or clerical staff.

- We reviewed four sets of clinical records of patients with mental health conditions. Three out of four patients did not have a risk assessment or corresponding care plan detailing interventions required to maintain the safety and wellbeing of the patients whilst in their care.
- There were no local audits undertaken for quality in safeguarding. The only audit completed was the nationally required section 11 audit.
- The named safeguarding adult nurse for the trust is 'PREVENT' trained. The PREVENT duty's aim is to help stop vulnerable people from being exploited and drawn into terrorism.
- There were clear protocols and pathways in place for recognising and managing female genital mutilation (FGM).

Assessing and responding to patient risk

- During our February 2017 inspection there was no protocol for the safe clinical management of patients awaiting admission in the waiting room, or how to escalate concerns regarding crowding or patient safety in this area. A direct access for GP Heralded Patients to AMU standard operating procedure was provided to the CQC in March.
- To ensure that there was an effective system in place to ensure that the treatment provided to patients being treated in the Acute Medical Unit at Queen Alexandra Hospital protects them from the risk of harm we took urgent action to impose conditions on the trust's registration in respect of the Acute Medical Unit. We have taken this urgent action as we believe a person will or may be exposed to the risk of harm if we did not do so.
- The trust consistently has high reported numbers of 12 hour Decision to Admit (DTA) trolley breaches. In February 2017 there were 87 and 95 in March. There was no clear plan to address the significant capacity issues causing crowding in the emergency departments in the short or medium term. Delayed care and breaches of the four hour timeframe and 12 hour trolley breaches appeared to be normalised.
- Medical staff from specialties were not fully engaged to support the acute medical model, this meant that there often delays to see a consultant or senior member of medical staff. In some cases this could be several days. This could place patients at risk of harm.

Summary of findings

- We attended bed meetings and observed flow. We found that the level of consideration to be given on where a patient was to be placed was not sufficient and inconsistent between shifts. Through data analysis we identified two incidents where patients on wards, outside of their specialist condition, died due to staff not recognising their specialist needs.
- Radiology as a service have placed on their risk register the lack of capacity in the service to report on chest x-rays. The decision was taken not to report on any chest x-rays within radiology. Review of chest x-rays is being undertaken by medical staff of all grades and not qualified radiology staff. Radiology compliance against local procedures is low and that over 40% of x-rays that are taken do not have an associated clinical evaluation. The trust has a policy that states if a formal report is required then they will provide one but if a suspicious lesion is not seen in the first instance this process would not be triggered. The Trust has accepted this risk with no associated action plan in place to mitigate the risks to patients. Therefore patients are at risk of harm through limited diagnostic assurance on diagnosis.

Are services at this trust effective?

Not sufficient evidence to rate

We have not rated effective because this was a focused inspection undertaken in response to concerns. We found:

- We found examples during this inspection that not all staff complied with the requirements of the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards.
- We found patients who had procedures undertaken on them without appropriate best interest decision or mental capacity assessments being conducted for consent.
- Understanding of Derivation of Liberty Safeguards (DoLS) was inconsistent across the areas we inspected. We found four cases of DoLS being used on patients without appropriate authority being given by the local authority, and no paper work completed.
- The understanding of use of chemical restraint on patients was poor.

However:

- Most specialties provided care and treatment in line with guidelines from the National Institute for Health and Care Excellence (NICE) and Royal College guidelines. Local policies were written in line with these guidelines.

Evidence based care and treatment

- Most specialties provided care and treatment in line with guidelines from the National Institute for Health and Care Excellence (NICE) and Royal College guidelines. Local policies were written in line with these guidelines.
- There were specific care pathways for certain conditions, in order to standardise the care given. Examples included stroke pathways, sepsis, acute kidney injury, non invasive ventilation and falls.
- During 2015/2016, 38 national clinical audits and 8 national confidential enquiries covered NHS services that Portsmouth Hospitals NHS Trust provides. During that period Portsmouth Hospitals NHS Trust participated in 97% (37/38) national clinical audits and 100% (8/8) national confidential enquiries of those it was eligible to participate in.
- During 2015/2016, Portsmouth Hospitals NHS Trust has participated in a total of 316 clinical research studies, 84% of these studies were NIHR Portfolio adopted.

Patient outcomes

- A self-assessment of the emergency department against the 5 NICE guidelines relating to Major Trauma, in February 2016, showed the service was compliant at: 98% for complex fractures (NG37), 91% for non-complex fractures (NG38), 96% on assessment and initial management (NG39), 93% on service delivery (NG40).
- The Patient Reported Outcome Measures (PROMs) finalised (EQ5D Index) report for 2015/16 showed the trust performed better than the England average on groin hernia, but worse than average on hip replacement surgery, varicose vein surgery and knee replacement surgery.
- The percentage of patients to be re-admitted within 28 days of being discharged was better than the England average (10.8% against 11.4%) for patients over 16 years of age. However the percentage was worse for patients under 16 years (12% against the average of 10%).

Competent staff

- We identified that the process for the induction of agency nurses was not effective. This was because the process for formal checks on the nursing competencies for the administration of IV fluids on the wards was inconsistent. This placed patients at the risk of harm without sufficient evidence to demonstrate staff are competent to administer IV's.
- There were general concerns regarding some competencies for clinical experience and use of equipment in areas including theatres, the emergency department and the wards.

- We were concerned that the emergency department medical staff were working outside the scope of their clinical skills and competencies. The emergency department staff were providing acute medical care to patients due to the medical staff not willing to take medical patients outside of their specialist area. This placed the emergency medical doctors at risk.

Multidisciplinary working

- Wards teams had access to the full range of allied health professionals. Staff from various teams who spoke with us described good, collaborative working practices. There was generally a joined-up and thorough approach to assessing the range of people's needs, and a consistent approach to ensuring assessments were regularly reviewed and kept up to date.
- This was not the case for the medical services, where concerns were raised to us regarding joint working in medicine. This predominantly linked to the work across the acute medical pathways.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- We found examples during this inspection that not all staff on the emergency decision unit, ward C5 and ward F2 complied with the requirements of the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards.Understanding of Derivation of Liberty Safeguards (DoLS) was inconsistent across the areas we inspected. We found four cases of DoLS being used on patients without appropriate authority being given by the local authority, and no paper work completed.
- One patient on AMU had a known mental health concern and was left unobserved on the ward. The patient was recorded as being at risk of suicide, yet was identified as fit to leave the department.
- We found that two patients had procedures undertaken on them without appropriate best interest decision or mental capacity assessments being conducted.
- The understanding of use of chemical restraint on patients was poor. We identified three cases of where chemical restraint was used on a patient without appropriate paper work being completed to authorise this as being in the patient's best interests.
- Since our inspection in February 2017, the trust had produced a guide for staff on the covert administration of medicines. This

guide was not appropriate in its style. The images used on the guide were pictures were not appropriate and could be misinterpreted. For example, next to the word covert there was a picture of a detective.

- In the trust private board minutes from March 2017 the covert administration of medicines was discussed. It was noted that the medical director stated that it was essential that the full and appropriate paperwork was kept to demonstrate the thought processes behind the decision to administer medications appropriately. These included best interested meeting and Deprivation of Liberty Safeguards (if appropriate) It was recorded that the medical director said, 'this becomes more of a problem the longer the patient remains on the unit'.

Are services at this trust caring?

Not sufficient evidence to rate

We have not rated caring because this was a focused inspection undertaken in response to concerns.

We found:

- We observed that staff did not always provide compassionate care to patients and did not always respond to patients when they called out for assistance. For example on AMU a member of staff stood next to the patient did not respond to these calls, and as a result the patient was incontinent.
- We observed situations where vulnerable patients were at risk of harm and the inspection team had to request staff intervene to maintain the patients' safety.
- Staff did not always protect patients' dignity and did not always keep personal information about patients confidential.
- Results of the friends and family test for some medical areas were consistently low.

However:

- Across the emergency department and wards patients were mostly happy with the care they were receiving.
- Results from the CQC in-patient survey from June 2016 showed the trust is performing about the same as other trusts for all of the indicators.
- The trust's friends and family test results showed that of the percentage of patients who recommend the service, that overall the trust scored an average of 96% between November 2016 and February 2017. This was above the England average of 95%.

Compassionate care

- Across the emergency department and wards patients were mostly happy with the care they were receiving.
- However we observed that staff did not always provide compassionate care to patients and did not always respond to patients when they called out for assistance. We observed situations where vulnerable patients were at risk of harm and the inspection team had to request staff intervene to maintain the patients' safety.
- For example on AMU a member of staff stood next to the patient did not respond to these calls, and as a result the patient was incontinent.
- Staff did not always protect patients' dignity and did not always keep personal information about patients confidential.

Understanding and involvement of patients and those close to them

- Results from the CQC in-patient survey from June 2016 showed the trust is performing about the same as other trusts for all of the indicators.
- The trust's friends and family test results showed that of the percentage of patients who recommend the service, that overall the trust scored an average of 96% between November 2016 and February 2017. This was above the England average of 95%.
- For areas, which were the focus of our inspection, urgent and emergency care results showed that on average 93% of people, would recommend the A&E service to friends and family. This was above the England average of 87%.
- For Medical care areas we visited the majority of areas showed results above the England average. However the wards where concerns were noted were the Acute Medical Unit (86%-90%), ward C5 (86% and 96%), ward D2 (91% and 93%), and ward F3 (21% and 67%) during the period of November 2016 and March 2017.

Emotional support

- At the previous inspection in September 2016 we found patients and their representatives were not involved in planning and making decisions about their care and treatment. Following the inspection, the trust was issued with a requirement notice with regard to the regulation concerning person centred care. This required the trust to submit an action plan detailing how they planned to address the concerns raised

in our inspection report. The trust submitted an action plan stating they would revise nursing documentation to re-enforce registered nurses to sign that the patient and/or their representative had been involved in their care planning.
- The documentation audit for February 2017 submitted by the trust showed out of 30 patients on medicine wards only 27% had their care record discussed with them or a relative. We reviewed 22 patient's medical records and none of them had evidence the patient or their family had been involved in their care planning.

Are services at this trust responsive?

Not sufficient evidence to rate

We have not rated responsive because this was a focused inspection undertaken in response to concerns. We found:

- There were no mitigations in place at the time of our inspection should the new medical model not work, which meant that the trust was in an unsafe position with the emergency department doctors caring for medical patients.
- Trust performance for average length of stay for non-elective admissions was generally worse than the England average.
- The trust had a backlog of complaints through the CSC's, which did not appear to have priority focus. In some cases patients were waiting several months for a response to their initial complaint.
- We were not assured that learning from complaints was shared across the CSC's

However:

- There was an improved and dedicated focus to providing care to patients with a learning disability.
- There was trustwide access to language line and translation services for those whose first language was not English.
- Dementia formed part of the quality objectives for the trust. There were provisions in place to support someone living Dementia. This included staff training, and the use of dementia champions in the hospital.

Service planning and delivery to meet the needs of local people

- The emergency department staff were providing acute medical care to patients due to the medical staff not willing to take medical patients outside of their specialist area. This placed the emergency medical doctors at risk, and could also affect training placements for emergency medical trainees in the department.

- We were informed during an engagement meeting with the trust in December 2016 that the job plans for the medical staff were reviewed and medical staff would soon start to care for medical patients on the acute care pathway, that were outside of their specialty. Despite these assurances, during our inspection we found this not to be the case. The medical model for acute care was to be launched on 08 May 2017 yet the doctors refused to take part in caring for patients on the pathway.
- There were no mitigations in place at the time of our inspection should the new model not work, which meant that the trust was in an unsafe position with the emergency department doctors caring for medical patients. There were no clear lines of accountability for the acute pathway.
- Stakeholders were aware of the new model being launched, however the trust failed to communicate with them in a timely manner that this launch had failed, or that additional support was required.

Meeting people's individual needs

- Prior to our inspection we were alerted to concerns regarding the care for patients with learning disabilities. There was a two year gap in the provision of learning disability care across Hampshire. During this time there were three incidents involving patients with a learning disability. The care of those patients was found to be substandard and the cases have gone to a serious case review.
- Within the last six months the contract has been recommissioned, and the service provision for patients with a learning disability is now fully established. The processes observed during the inspection demonstrated that there were now effective measures in place to support patients with a learning disability requiring care. We observed that there was a dedicated focus to the learning disability patient group, who were actively seeking to learn the lessons from the incidents and improve the service for patients.
- There was trustwide access to language line and translation services for those whose first language was not English.
- Dementia formed part of the quality objectives for the trust. There were provisions in place to support someone living Dementia. This included staff training, and the use of dementia champions in the hospital.

Access and flow

- There were significant concerns with flow through the hospital. Due to the flow issues the acute medical unit, where patients would normally stay for 72 hours, was being used as a short stay ward. The acute medical unit function was predominantly in the main majors area of the emergency department.
- There were significant challenges with flow throughout the hospital. There was a normalised focus to the number of patients who were medically fit for discharge. This was partly impacted by challenges within the wider Hampshire system, however the normalised approach meant that length of stay was longer than expected.For example, during the inspection of their 1050 acute beds there were 253 patients medically fit for discharge.
- Concerns were raised to us regarding the new discharge service introduced at Queen Alexandra Hospital which staff felt was making the discharge process slower, and increasing length of stay.
- We reviewed the acute medical pathway and data on flow in response to this. Between April 2016 and March 2017, the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was 39%. This was against the national average of 12%.
- Trust performance for average length of stay for non-elective admissions was generally worse than the England average. Cardiology showed a slightly better average length of stay than the England average.
- The ambulance service within the region is also significantly impacted by the flow through the Queen Alexandra Hospital. Of all hospitals across south central England the Queen Alexandra Hospital is consistently the trust that loses them the most hours on the road.

Learning from complaints and concerns

- The trust board received data about complaints and complaints were discussed at the local governance and audit meetings. All complaints were seen and signed off by the interim Chief Executive Officer (CEO).
- Literature and posters were displayed within the wards, advising patients and their relatives how they could raise a concern or complaint, both formally and informally. This literature was available in other languages besides English.
- Although staff told us that learning from complaints took place at a ward level, we were not assured that learning from complaints was shared across the CSC's.

Summary of findings

- We discussed learning from complaints with the complaints team and found that the processes and policies for complaints were there. However, they were not effective in practice.
- For example, complaints should be responded to in a timeframe set within the trust policy. The trust had a backlog of complaints through the CSC's, which did not appear to have priority focus. There was also no highlighting of the backlogged reports to the board for executive oversight. In some cases patients were waiting several months for a response to their initial complaint.
- The way in which responses to complaints and concerns were handled by the trust was not consistent. Some poorly investigated and non-supportive responses were being issued by the trust. This resulted in further complaints being raised about the complaints process. This was supported by a number of concerns coming to CQC about the quality of their complaint response, and length of time taken to respond to a complaint.
- The Parliamentary Health Service Ombudsman had 11 open cases with the trust. The trust felt this reasonable given their overall complaint numbers. The outcomes of these cases were not yet known.

Are services at this trust well-led?

Not sufficient evidence to rate

We have not rated well led because this was a focused inspection undertaken in response to concerns.

We found:

- The uncertainty around leadership and the various changes had created a feeling of instability within the trust and meant that the direction and leadership approach to the organisation was not clear.
- There were no clear lines of accountability for the acute pathway. This meant that no executive member of the trust was taking responsibility for the acute pathway.
- There were no mitigations in place at the time of our inspection should the new model not work, which meant that the trust was in an unsafe position with the emergency department doctors caring for medical patients.
- There was a culture of 'specialism' within the trust. The trust was largely focused on their specialist services and provisions that the main district general hospital areas such as general medicine were forgotten.
- We were not assured that the processes for raising concerns internally were open and free from blame. This discouraged staff from feeling free to speak about concerns.

- Staff perceived there was bullying and did not feel able to speak out about concerns.Examples were given to us of how staff became unwell through stress and anxiety about these concerns.
- The culture amongst medical staff has been identified as a concern by unions and other stakeholders.

However:

- The trust had a defined process for fit and proper person's employed.
- Many staff reported good experience of culture and openness within their local departments.
- The trust had defined policies and process for the fair and equal treatment of all staff in employment. Consideration was given to WRES as part of recruitment, and education opportunities within the trust.
- We reviewed the trust's policies and processes for raising concerns, and found that there was an expansive range of options available for staff to speak openly about any concerns they may have.
- The NHS staff survey was in line with the England average.

Leadership of the trust

- The senior team were made up of mainly Interim leaders. The Chief Executive, Chief Operating Officer, Director of Nursing, and Director of Human Resources were all interim. The Medical Director was due to retire, and the Chair was scheduled to end their term in June 2017. Recruitment for all of these posts was underway at the time of our inspection.
- The uncertainty around leadership and the various changes had created a feeling of instability within the trust and meant that the direction and leadership approach to the organisation was not clear.
- The Non-Executive Directors mostly had backgrounds unrelated to healthcare. Through review of the minutes of board minutes there was little recorded challenge by the non-executive directors. The Chief Executive informed us that two new Non-Executive Directors had recently joined, and were providing a higher level of useful challenge, which the board found useful.
- We were not assured following our interviews with the trust board members that the team were cohesive and had sufficient skill set to be able to understand the tasks ahead, the risks they faced and could articulate a way of driving delivery at a pace that would show improvements to patient care.

- We were informed during an engagement meeting in December 2016 that the job plans for the medical staff were reviewed and medical staff would soon start to care for medical patients on the acute care pathway, that were outside of their specialty. Despite these assurances, during our inspection we found this not to be the case. The medical model for acute care was to be launched on 08 May 2017 yet some doctors refused to take part in caring for patients on the pathway. A letter was subsequently sent on 31st May 2017 to all in scope consultants to secure their agreement to the change in job plan.
- There were insufficient mitigations in place at the time of our inspection should the new model not work. This meant that the trust was in an unsafe position as emergency department doctors were caring for medical patients for extended periods of time.
- There was lack of clarity around the lines of accountability for the acute pathway. This meant that no executive member of the trust was taking responsibility for the acute pathway. Neither the Medical Director nor the Director of Unscheduled Care felt this was an issue or had any plans to direct the medics to look after these patients after decision to admit. This placed patients at risk of harm.
- We were significantly concerned about the lack of oversight on safeguarding matters and mental health care within the trust at senior management and executive board level.

Culture within the trust

- There was a culture of 'specialism' within the trust. The trust was largely focused on their specialist services and provisions that the main district general hospital areas such as general medicine were forgotten. We discussed this with the Interim Chief Executive who agreed that there was a culture where specialist services held greater priority over core District General Hospital services and that this was a challenge that needed to be addressed.
- During the inspection we held drop in events and received communications from staff who worked at the trust. Many staff reported good experience of culture and openness within their local departments. However we received several concerns from staff cross the medical, emergency and surgical areas.
- Prior to this inspection we received four qualifying whistleblowing concerns and more than fifteen separate concerns. Staff perceived there was bullying and did not feel able to speak out about concerns.

- We reviewed the trust's policies and processes for raising concerns, and found that there was an expansive range of options available for staff to speak openly about any concerns they may have.
- We were not assured that the processed for raising concerns internally were open and free from blame. We reviewed case examples of how staff had been treated or supported when concerns were raised. This included staff being excluded or isolated from their work for raising concerns regarding patient safety. This discouraged staff from feeling free to speak about concerns.
- Staff provided statements of their conversations and interviews with leaders of local CSC's and executive directors that made them feel not listened to, not supported, and they perceived this as a form of bullying. One staff member spoke of their treatment to us and was extremely anxious about the impact of raising concerns to us..
- In pathology, concerns were raised to us by staff who felt the culture in cancer pathology laboratory is "corrupt – not open and transparent". They felt there was a culture of "covering things up" and staff were being told not to speak out.
- We spoke with the trust's freedom to speak up guardian, who was unclear about the role and remit of a guardian. When asked about the concerns raised by CQC to the trust on behalf of staff they informed us they were not aware of this. This meant we were not assured concerns on behalf of staff were being shared with the trust guardian.
- Unions including the British Medical Association, and organisations including Health Education England and the GMC also raised concerns with us regarding the culture of the organisation. They believed that there continues to be a culture of bullying and harassment in specific areas within the organisation.
- During our conversations with staff we provided support and guidance on how to seek support and protection during this time. One staff member went to the BMA with their concerns and was advised not to raise concerns due to whistleblowers being targeted in the NHS.
- When we approached the BMA about this, they were aware of concerns in relation to the trust that had been raised by doctors previously.
- The culture of medical staff throughout the medical division and unscheduled care was of significant concern to us. We

found that there was a culture that was not supportive to patient safety, quality or care to those requiring general medical admission or treatment. This resulted in delays for patients to receive medical care.

- In other areas such as paediatrics, maternity and critical care staff provided good examples of how leadership and culture was positive in their areas. This included being open and raising concerns.
- Whilst there was a process for being open and meeting the Duty of Candour requirements, no quality adults were undertaken to assess how open and transparent the trust was to patients, families and carers.
- Portsmouth Hospitals NHS Trust had 3949 staff take part in the national staff survey. This is a response rate of 58%, which was in the highest 20% of acute trusts in England.
- The trust returned 19 positive, six similar to expected and seven negative findings from 32 questions in the 2016 staff survey, placing it in line with other trust's across England.

Vision and strategy

- The trust did not have a current vision or strategy. We were informed that this was due to the changes amongst the leadership team but that there were plans to review the strategy in the near future.

Governance, risk management and quality measurement

- The governance system within the trust was not fit for purpose and required immediate review to ensure that risks are identified, monitored and managed appropriately. There was a disconnect between the CSC's and the senior leadership team particularly in relation to governance and risk management.
- The trust is quick to react when a concern is raised with them by the regulators to resolve the issues raised. However the trust cannot prove a track record of sustained improvements across all areas. For example in February 2017 the Care Quality Commission identified significant concerns regarding safeguarding, and care for patients with mental health conditions in the emergency department. We raised this with the trust who provided assurances that the concerns had been addressed and that patients were safe. However, when we returned in May 2017 the improvements had not been sustained and CQC was required to take urgent action because we believed a person will or may be exposed to the risk of harm if we did not do so. The assurances provided by the trust in this case had not been sustained.

Summary of findings

- In the 2015/16 quality account report the trust identified a priority to 'Improve experience for patients with mental health needs' with a target date of 2016. This has not been delivered due to the significant concerns regarding mental health identified during the inspection that resulted in immediate enforcement action being taken.
- The quality account objectives were not reflective of what was discussed during board meetings. For example mental health care, learning disability care or safeguarding were not routinely discussed by the board. Therefore we were not assured that the quality account objectives were being monitored or achieved.
- The private board papers, in the majority, should have been shared in public board. Not sharing information on complaints, incidents and mortality publicly did not demonstrate an open and transparent approach from the trust.
- Radiology as a service have placed on their risk register the lack of capacity in the service to report on chest x-rays. The decision was taken not to report on any chest x-rays within radiology. The Trust has accepted this risk with no associated action plan in place to mitigate the risks to patients. Without any quality monitoring or audits on risk management of this process, this identifies poor governance with radiology processes in the trust.
- The trust board assurance framework is reviewed at every board meeting. The board assurance framework from May 2017 did not cover the top risks for the trusts. This included the risks identified during the inspection regarding mental health, safeguarding and the acute medical model.
- We discussed the quality of the board meeting minutes, and the approval process with the Chief Executive. The minutes are distributed and checked for accuracy at each meeting. The Chief Executive acknowledged that the minutes were minuted in a way which may not always provide a clear understanding or reflection of the discussion. For example, comments on mortality being caused by 'patients remaining in hospital for too long' are not appropriate for recording without full context behind such statements being included in the minutes.
- The governance processes to get reports to the board, and how committees and meetings feed into the board framework was disjointed. The misalignment of governance functions enabled key risks to go unidentified and unsighted by the trust board. The framework for escalating risk management matters through the governance process required review. For example safeguarding was rarely discussed at board level, despite concerns raised through CQC inspections over the previous few months.

- The board meetings held were not always attended by key members of the trust board, which means that consideration should have been given to cancelling the meeting. For example at the board meeting on 2 February 2017 the board meeting was not attended by the chairman or two non-executive directors.

Mortality and Morbidity

- For the 12-month period from Oct 15 - Sep 16, HSMR was higher than expected with a value of111.42.The SHMI for July 2015 to June 2016 was 111, which although above the national average of 100 was within control limits.
- There was no assurance that the trust had considered or undertaken harm reviews for patients whose care was delayed through the acute care pathway.
- Mortality has increased at a steady rate over the last 12 months, and we were not assured this was being addressed. We were informed that mortality was high due to the 'unscheduled care pathway'. However no audits or evidence had been gathered to support this statement's accuracy.Since the inspection, the trust has provided information which demonstrates they are working to improve their processes for monitoring mortality.
- Mortality reviews were not taking place in a detailed way in every CSC. The trust was rolling out a mortality review panel as an independent process by specialty. The Medical Director chose for an independent panel approach to potentially avoid any bias that may occur within the divisions.
- The trust board were sighted on mortality through regular reports. We were not assured that the gravitas of a steadily increasing mortality were fully understood**;** however, the minutes of the board meeting held in April 2017 said, 'The Chairman recognised the negative effect on the HSMR of patients remaining in hospital for too long'."
- The trust had one mortality outlier alert related to 'pleurisy, pneumothorax, pulmonary collapse'. The trusts response to CQC did not address the key issues regarding the quality of how the mortality review was undertaken. After our inspection the trust provided the CQC with an action plan which had been developed to address areas for improvement identified by the trust. The trust have been asked to provide CQC with further information on this mortality outlier for consideration.

Coroners Correspondence

- We reviewed three regulation 28 notices from the coroner. These are served for the purpose of preventing future deaths.

- We received coroner correspondence with concerns regarding the records presented to inquest being 'materially different' to those held by the family. We reviewed the concerns and responded to the coroner with our concerns regarding the records accuracy within the trust. During our inspection in February 2017 it was observed that staff were entering information into patient records for care that had not been provided. We have asked for the trust to take immediate action regarding these concerns and make significant improvements regarding records entries and accuracy of the care provided.
- We reviewed a regulation 28 in respect of monitoring of INR levels amongst patients. The international normalized ratio (INR) is a standardised number that measures blood clotting factors. We reviewed the care of two patients and found that medical staff were following the trust policy on 'warfarin dosing, monitoring and reversal in adults'. Nursing staff were also observed to adhere to this policy. The records examined supported that INR levels were appropriately monitored.
- We reviewed a regulation 28 in respect of patient placement on the right specialty ward. We attended bed meetings and observed flow. We found that the level of consideration to be given on where a patient was to be placed was not sufficient and inconsistent between shifts. Through data analysis we identified two incidents where patients on wards, outside of their specialist condition, died due to staff not recognising their specialist needs.

Equalities and Diversity – including Workforce Race Equality Standard

- The trust had defined policies and process for the fair and equal treatment of all staff in employment. Consideration was given to WRES as part of recruitment, and education and equal opportunities within the trust.
- This was supported by staff survey question KF21 about equal opportunities for career progression, where the results showed higher than England average responses for both White and BME groups.
- The staff survey question KF25 on experiencing bullying and harassment by patients was higher than the national average for both white and BME staff groups. BME staff groups reported that 34% experienced this against an acute trust average of 26%.

- The staff survey question KF26 on experiencing bullying and harassment by staff was in line with the national average for both white and BME staff groups. BME staff groups were reported a slightly lower rate of 24% against the national average of 27%.

Fit and Proper Persons

- The trust had a defined process for fit and proper person's employed. There was a system in place for senior staff to make a declaration of fitness. Where there are gaps in recruitment files the HR department contact the person for an explanation or to provide the appropriate documentation.
- We reviewed the files of those employed by the trust since the regulation came into force and the trust was meeting the requirements of the regulations.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve

- Ensure that staff are assessed and signed off as competent to deliver patient care.
- Ensure that the culture within the organisation of staff not being willing to raise concerns openly and concerns around bullying are given sufficient priority by the board.
- Review the governance functions and processes for the trust to ensure they are fit for purpose.
- Improve compliance with regulation 28 coroner reports for preventing future deaths.
- Ensure that improvements are made to the classification of incidents to ensure that they are reported, escalated and graded appropriately.
- Ensure that the conditions imposed by the Commission on the Acute Medical unit, and Emergency Department are effectively implemented.
- Improve identification and management of incidents requiring duty of candour.
- Improve the quality of Root Cause Analysis investigations.
- Review the processes for the safeguarding of vulnerable adults and children the ensure that safeguarding processes work effectively in the trust.
- Improve the processes, policies, staffing and understanding of mental health for staff at ward to board level.
- Ensure that staff have knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards, and implement them effectively.
- Ensure that patients do not have procedures undertaken on them without appropriate consent being obtained, and best interest assessments are completed where applicable.
- Ensure that records completed for the purpose of care are completed accurately.
- Immediately review the risks associated with reporting of chest x-rays in radiology. Including the undertaking of a patient harm review on all cases not reported on.
- Undertake patient harm reviews and audits to identify where lessons can be learned or mortality ratios reduced.
- Immediately review the medical model within acute care to ensure that patients are seen a treating physician and treated at the earliest opportunity.
- Improve the flow and capacity throughout the hospital.
- Review the board assurance framework, board minutes, and processes for reporting at board to ensure risks are identified and managed by the trust, and that the minutes are appropriately recorded.
- Develop a vision and strategy for the trust.
- Improve the complaints processes, oversight of complaints and reduce the backlog of complaints to ensure patients receive responses in a timely way.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Section 29A HSCA Warning notice: quality of health care The registered provider is required to make significant improvements to ensure the quality and delivery of safe care.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Section 31 HSCA Urgent procedure for suspension, variation etc. Imposition of conditions - The registered provider did not have an effective process in place to ensure the safety of patients during times of high capacity, crowding or demand in the Acute Medical Unit GP referral area is escalated when the need requires it. This meant that patients are placed at the risk of harm.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Section 31 HSCA Urgent procedure for suspension, variation etc. Imposition of conditions - We found a lack of leadership oversight of mental health provision at all levels. The processes and procedures meant that patients who were vulnerable were protected from the risk of harm. The provider had not ensured that care was being provided in accordance with the requirements of the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards.

This page is intentionally left blank

HEALTH AND ADULT SOCIAL CARE SELECT (OVERVIEW AND SCRUTINY) COMMITTEE

TASK AND FINISH WORKING GROUP ON SOCIAL INCLUSION SERVICES

TERMS OF REFERENCE

1. Role and Purpose of the Task and Finish Working Group

The Task and Finish Working Group is a working group of the Health and Adult Social Care Select (Overview and Scrutiny) Committee (HASC), and is appointed in accordance with the Constitution of Hampshire County Council.

The Task and Finish Group's purpose is to review proposals for future 'Social Inclusion' services, as part of the wider programme of 'Transformation to 2019'.

2. Scope of the Task and Finish Group

The HASC considered an introduction to the 'Transformation to 2019' ('T19') programme, including a broad overview of the Council's required savings and the specific efficiencies to be sought from Adults' Health and Care, at their 21 July 2017 meeting. This working group is being formed to provide overview and scrutiny to a review of Social Inclusion services, which forms part of the Department's T19 programme, prior to an Executive Member decision.

Objectives:

- To support the County Council with the partnership approach to reviewing Social Inclusion services alongside District and Borough Councils, together with any other organisations with a statutory responsibility or interest in this provision.
- To review feedback from engagement and consultation with a wide range of stakeholders, including service users.
- To consider and provide comment on impact assessments.
- To scrutinise and review proposals for service reconfiguration developed within the financial envelope available.

Exclusions:

- The overall savings contribution as may be agreed by the Executive Member for Adults' Health and Care on 21 September 2017.
- The consideration of other Adults' Health and Care services not defined as 'Social Inclusion'.

Outcomes:

- To provide updates to the wider HASC on the progress of considerations when appropriate.

- To make recommendations regarding proposals to the wider HASC
- To submit a report to the wider HASC when Social Inclusion service recommendations appear before the Committee for pre-decision scrutiny.

3. Method

The working group will meet with department officers to consider the evidence leading to recommendations for decisions on the future of Social Inclusion services. At each meeting, the group will provide oversight, scrutiny and comment on progress towards the stated objectives of the review. Where the working group requires further information in order to pursue the concerns outlined in the scope, such information will be requested.

4. Membership

The working group shall be a cross party group made up of four County Councillor Members of the HASC, with additional membership from one of the District and Borough Co-opted Membership.

5. Meetings

The Working Group will hold an initial meeting to understand the timeline for reviewing and making recommendations on Social Inclusion services. After this meeting, it shall meet as often as required to satisfactorily explore this topic.

6. Code of Conduct

Elected Members of the Working Group shall comply with the Hampshire County Council Code of Conduct applicable to Members.

7. Reporting

The Working Group will make an update to the HASC on the progress of considerations when appropriate. It will provide comment to the wider HASC when Social Inclusion service recommendations appear before the Committee for pre-decision scrutiny.

The Working Group will cease to exist once its purpose has been fulfilled.

Appendix

Background to Social Inclusion services

Social Inclusion services provide short term accommodation-based and community support to vulnerable people who are homeless or at risk of homelessness. The client group includes rough sleepers, people with mental health support needs, substance misuse issues, learning disabilities and those with a history of offending behaviour.

The County Council's annual spend on these services is £4.2m.

The current contracts that commenced in April 2016 and come to an end in March 2019 include the following types of service provision:

- **Street outreach:** support for people sleeping rough.
- **Stage 1 accommodation:** 24/7 support within a hostel environment for single homeless.
- **Stage 2 accommodation:** short term supported accommodation with a lower level of support for single homeless.
- **Community support:** support available regardless of tenure where an individual or family is homeless or at risk of homelessness and has additional needs that are exacerbating or preventing them from addressing their housing situation without support.

The contracts above deliver services in all areas of the County apart from Basingstoke and Deane. The County Council entered into a 3 year grant agreement with Basingstoke and Deane Borough Council on 1 April 2016 to enable them to commission their own Social Inclusion services. This agreement ends on 31 March 2019.

This page is intentionally left blank

HEALTH AND ADULT SOCIAL CARE SELECT (OVERVIEW AND SCRUTINY) COMMITTEE

WORKING GROUP ON SUSTAINABILITY AND TRANSFORMATION PARTNERSHIPS (STPs)

TERMS OF REFERENCE

1. Role and Purpose of the Working Group

This is a working group of the Health and Adult Social Care Select (Overview and Scrutiny) Committee (HASC), and is appointed in accordance with the Constitution of Hampshire County Council.

The Group's purpose is to monitor the progress and provide appropriate scrutiny of the core programmes of the two STPs covering the Hampshire geography.

2. Scope of the Working Group

Objectives:

1. To develop a good understanding and working knowledge of the two STPs in Hampshire (Hampshire and Isle of Wight, and Frimley)
2. To monitor the progress of the various core programmes sitting beneath the STPs, and to provide appropriate scrutiny of these workstreams.
3. To make any recommendations to STP leads, as appropriate, and to refer topics to the HASC for wider scrutiny through formal meetings.

The topic areas that will be specifically explored by the working group in relation to both the Hampshire and Isle of Wight STP, and the Frimley STP shall be:

- New models of care (to include primary care)
- Acute reconfiguration (to include Urgent and Emergency Care)
- Mental Health

The themes of prevention and actions to promote greater self-management are cross-cutting and will feature throughout the above programmes.

Exclusions:

The working group will not review topics that aren't explicitly mentioned under the core programmes within the STP documents, and will not specifically focus on enabling programmes, which sit outside the scope of the HASC.

Outcomes:

The working group will submit a report to the HASC prior to any wider scrutiny of STP core programme items, and will provide oral updates on meetings when appropriate. The format of these reports and when they are provided to the HASC will be determined by the working group, but should be provided in a timely manner to ensure consideration prior to formal meetings.

3. Method

The working group will meet with representatives leading the STPs and core programmes, as well as providers and commissioners of services in Hampshire. It may also choose to invite evidence from a range of stakeholders who have an interest in the core programmes of the STP.

Specifically in relation to objective two, the working group will rotate between core delivery work streams sitting under the themes of care delivered in health environments, and care delivered in the community.

Where the working group requires further information to pursue the concerns outlined in the scope, such information will be requested.

4. Membership

The working group shall be a cross-party group made up of five members. The working group will co-opt any non-voting individuals they may find advantageous during their considerations.

The working group may invite a panel of expert advisers to attend their meetings to provide advice.

5. Meetings

The working group will hold an initial meeting to understand the various core programme work streams sitting under the Hampshire and Isle of Wight STP, and the Frimley STP. It shall meet as often as required to satisfactorily explore this topic thereafter.

The STPs are strategies that run until the 2020/21 financial year. It is anticipated that the working group will conclude once the STPs have been fully embedded across Hampshire.

6. Code of Conduct

Elected Members of the working group shall comply with the Hampshire County Council Code of Conduct applicable to Members.

7. Reporting

The working group will make updates to the HASC on the progress of considerations, and will report to them prior to STP items receiving wider scrutiny at formal meetings.

It will make any recommendations for endorsement by the HASC, for forwarding to the STP leads and partner organisations.

The working group will cease to exist once its purpose has been fulfilled.

Background on STPs

The NHS and local councils have formed STPs in 44 areas covering all of England, with the aim of improving health and care. Each area has developed proposals built around the needs of the whole population in the area, not just those of individual organisations. All of the STPs, and more detail on their purpose, can be found from the link below:

https://www.england.nhs.uk/stps/about-stps/

The central role of the STP is been to support local place-based plans to achieve the changes that that can only be achieved by working in partnership.

Hampshire and the Isle of Wight

The HIOW STP focuses on the following priorities:

- To provide a radical upgrade in prevention, early intervention and self care.
- To accelerate the introduction of new models of care in each community in HIOW.
- To address the issues that delay patients being discharged from hospital.
- To ensure the provision of sustainable acute services across HIOW.
- To improve the quality, capacity and access to mental health services in HIOW.

You can read more about the STP proposals in the HIOW summary document: HIOW STP summary document 23 November 2016.pdf.

You can also see the full STP delivery plan here: HIOW STP Delivery Plan 21 October 2016 (Final draft).pdf.

Frimley

The Frimley STP focuses on the following priorities:

- Making a substantial step change to improve wellbeing, increase prevention, self-care and early detection.
- Action to improve long term condition outcomes including greater self management & proactive management across al providers for people with single long term conditions.
- Frailty Management: Proactive management of frail patients with multiple complex physical & mental health long term conditions, reducing crises and prolonged hospital stays.
- Redesigning urgent and emergency care, including integrated working and primary care models providing timely care in the most appropriate place.
- Reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence.

To view the full Frimley Health and Care STP, pdf click here (5.96 MB) .

To view a summary of the Frimley Health and Care STP, pdf click here (163 KB) .

This page is intentionally left blank

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select (Overview and Scrutiny) Committee (HASC)
Date of meeting:	21 September 2017
Report Title:	Work Programme
Report From:	Director of Transformation and Governance

Contact name: Members Services

Tel: (01962) 847336 **Email:** members.services@hants.gov.uk

1. Purpose of Report

1.1 To consider the Committee's forthcoming work programme.

2. Recommendation

That Members consider and approve the work programme.

WORK PROGRAMME – HEALTH AND ADULT SOCIAL CARE SELECT OVERVIEW & SCRUTINY COMMITTEE: 2017/18

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	21 September 2017	21 November 2017	17 January 2018
Proposals to Vary Health Services in Hampshire - *to consider proposals from the NHS or providers of health services to vary health services provided to people living in the area of the Committee, and to subsequently monitor such variations. This includes those items determined to be a 'substantial' change in service.*							
Andover Hospital Minor Injuries Unit	Temporary variation of opening hours due to staff absence and vacancies	Living Well Healthier Communities	Hampshire Hospitals NHS FT	Updates on temporary variation last heard in June 2017 (via electronic briefing) Update: once temporary hours have been lifted		Further update TBC **(E)**	
Antelope House PICU	Urgent temporary closure of 10 beds due to concerns on safe staffing	Living Well	Southern Health NHS FT	Item heard July 16. Item on reopening heard March 17. Update on staffing to be received in 6 months' time.	Update to be considered **(E)**		
Dorset Clinical Services review	Dorset CCG are leading a Clinical	Starting Well	Dorset CCG / West	First Joint HOSC meeting held July	Verbal update to be received once next		

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	21 September 2017	21 November 2017	17 January 2018
(SC)	Services review across the County which is likely to impact on the population of Hampshire crossing the border to access services.	Living Well Ageing Well Healthier Communities	Hampshire CCG	2015, CCG delayed consultation until 2016. Last meeting Feb 17 to discuss consultation response.	meeting has been held. **(M)**		
North and Mid Hampshire clinical services review **(SC)**	Management of change and emerging pattern of services across sites	Starting Well Living Well Ageing Well Healthier Communities	HHFT / West Hants CCG / North Hants CCG / NHS England	Monitoring proposals for future of hospital services in north and mid Hampshire since Jan 14. Latest update indicated whole system review to report in Jan 17 as part of STP. Status: to next appear once options are available.		To be considered **(M)**	
Move of the Kite Unit	Move of neuropsychiatric inpatient unit from St James Hospital, Portsmouth, to	Living Well Ageing Well	Solent NHS Trust	Considered March 2017 and support provided by Committee. Agreed to monitor		Update on move of unit **(E)**	

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	21 September 2017	21 November 2017	17 January 2018
	Western Community, Southampton			three months after move of service.			
West Surrey Stroke Services	Review of stroke services	Living Well Ageing Well	NE and SE Hampshire CCGs	To be considered once the consultation has closed Heard at June 2017 mtg, where Committee supported proposals		Progress prior to implementation to be heard **(M)**	
Issues relating to the planning, provision and/or operation of health services – *to receive information on issues that may impact upon how health services are planned, provided or operated in the area of the Committee.*							
Care Quality Commission inspections of NHS Trusts serving the population of Hampshire	To hear the final reports of the CQC, and any recommended actions for monitoring.	Starting Well Living Well Ageing Well Healthier Communities	Care Quality Commission	To await notification on inspection and contribute as necessary.	PHT re-inspection **(M)**	Southern Health re-inspection (to include Mazars scrutiny) **(M)**	
Divestment of Community	To consider the transition of	Starting Well	Hampshire CCGs	Following the decision taken by the		Initial overview to	

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	21 September 2017	21 November 2017	17 January 2018
Health services	community health services from Southern Health to a new provider in Hampshire	Living Well Ageing Well Healthier Communities		SHFT Board, to monitor the transition of community health services to a new provider		be considered **(M)**	
Sustainability and Transformation Plans: one for Hampshire & IOW, other for Frimley	To subject to ongoing scrutiny the strategic plans covering the Hampshire area	Starting Well Living Well Ageing Well Healthier Communities	STPs	H&IOW initially considered Jan 17 and monitored July 17, Frimley March 17 STP working group to undertake detailed scrutiny	ToR to be agreed **(M)**	Frimley **(M)**	
Transforming Care Partnership	To consider the implementation of the TCP locally	Living Well	SHIP 8 CCGs	Considered Plan and proposals for Cypress ward Jan 17, to receive quarterly information updates		Quarterly update to be received **(E)**	
Overview / Pre-Decision Scrutiny – *to consider items due for decision by the relevant Executive Member, and scrutiny topics for further consideration on the work programme*							
Budget	To consider the revenue and	Starting Well	HCC Adults' Health and	Considered annually in advance of Council	Social Inclusion		To be considered

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	21 September 2017	21 November 2017	17 January 2018
	capital programme budgets for the Adults' Health and Care dept	Living Well Ageing Well Healthier Communities	Care (Adult Services and Public Health)	in February Transformation to 2019 proposals to be considered September	working group ToR to be agreed Transformation to 2019 report to be considered **(M)**		**(M)**
Scrutiny Review - *to scrutinise priority areas agreed by the Committee.*							
STP scrutiny	To form a working group reviewing the STPs for Hampshire	Starting Well Living Well Ageing Well Healthier Communities	STP leads All NHS organisations		ToR to be agreed **(M)**		
Real-time Scrutiny - *to scrutinise light-touch items agreed by the Committee, through working groups or items at formal meetings.*							
Adult Safeguarding	Regular performance monitoring of	Living Well Healthier	Hampshire County Council Adult	For an annual update to come before the		Update due **(M)**	

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	21 September 2017	21 November 2017	17 January 2018
	adult safeguarding in Hampshire	Communities	Services	Committee.			
Public Health	To undertake pre-decision scrutiny and policy review of areas relating to the Public Health portfolio.	Starting Well Living Well Ageing Well Healthier Communities	HCC Public Health	Substance misuse transformation to be considered September 2017 0-19 services to be reviewed in November 2017	Substance misuse services **(M)**	0-19 children and families model **(M)**	

Key

(E) Written update to be received electronically by the HASC.
(M) Verbal / written update to be heard at a formal meeting of the HASC.
(SC) Agreed to be a substantial change by the HASC.

CORPORATE OR LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	No
People in Hampshire live safe, healthy and independent lives:	Yes
People in Hampshire enjoy a rich and diverse environment:	No
People in Hampshire enjoy being part of strong, inclusive communities:	Yes

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

IMPACT ASSESSMENTS:

1. Equality Duty

1.1. The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, gender and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Due regard in this context involves having due regard in particular to:

a) The need to remove or minimise disadvantages suffered by persons sharing a relevant characteristic connected to that characteristic;

b) Take steps to meet the needs of persons sharing a relevant protected characteristic different from the needs of persons who do not share it;

c) Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity which participation by such persons is disproportionally low.

1.2. **Equalities Impact Assessment:** This is a document monitoring the work programme of the HASC and therefore it does not therefore make any proposals which will impact on groups with protected characteristics.

2. Impact on Crime and Disorder:

2.1 This is a forward plan of topics under consideration by the Committee, therefore this section is not applicable to this report. The Committee will request appropriate impact assessments to be undertaken should this be relevant for any topic that the Committee is reviewing.

3. Climate Change:

3.1 How does what is being proposed impact on our carbon footprint / energy consumption?

This is a forward plan of topics under consideration by the Committee, therefore this section is not applicable to this report. The Committee will consider climate change when approaching topics that impact upon our carbon footprint / energy consumption.

3.2 How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts?

This is a forward plan of topics under consideration by the Committee, therefore this section is not applicable to this report. The Committee will consider climate change when approaching topics that impact upon our carbon footprint / energy consumption.

This page is intentionally left blank

Hampshire County Council: Health and Adult Social Care Select (Overview and Scrutiny) Committee (HASC)

Glossary of Commonly used abbreviations / acronyms across Health and Social Care

Please note this is not exhaustive and is revised on a regular basis.

AAA	Abdominal Aortic Aneurysm
A&E	Accident and Emergency or Emergency Department (ED)
AMH	Adult Mental Health
AOT	Assertive Outreach Team
AWMH	Andover War Memorial Hospital
AS	Adult Services
BCF	Better Care Fund
BNHH	Basingstoke and North Hampshire Hospital (part of HHFT)
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CHC	Continuing Healthcare
CPN	Community Psychiatric Nurse
CQC	Care Quality Commission
CX	Chief Executive
DGH	District General Hospital
DH	Department of Health
DTC	Delayed Transfer of Care
ED	Emergency Department / A&E
ENP	Emergency Nurse Practitioner
F&G	Fareham and Gosport
FHFT	Frimley Health NHS Foundation Trust
FT	Foundation Trust
GP	General Practitioner
G&W	Guildford and Waverley
HASC	Health and Adult Social Care (Select Committee)
HCC	Hampshire County Council
HES	Hospital Episode Statistics
HHFT	Hampshire Hospitals NHS Foundation Trust
HOSC	Health Overview and Scrutiny Committee
HWB	Health & Wellbeing Board
IAPT	Improving Access to Psychological Therapies
ICU	Intensive Care Unit
ICT	Integrated Care Team
IRP	Independent Reconfiguration Panel
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
Local HW	Local HealthWatch
MHA	Mental Health Act
MIU	Minor Injuries Unit
NED	Non-executive Director
NEH&F	North East Hampshire and Farnham
NHS	National Health Service
NHSE	NHS England

NHSI	NHS Improvement
NHSP	NHS Property Services
NICE	National Institute for Clinical Excellence
NSF	National Service Framework
OAT	Out of Area Treatment
OBC	Outline Business Case
OBD	Occupied Bed Days
OOH	Out of Hours
OP	Out-patients
OPMH	Older People's Mental Health (services)
PFI	Private Finance Initiative
PHT	Portsmouth Hospitals Trust
QAH	Queen Alexandra Hospital, Cosham
RHCH	Royal Hampshire County Hospital (part of HHFT)
RTT	Referral to Treatment Time (performance indicator)
S&BP FT	Surrey and Borders Partnership NHS Foundation Trust
SCAS	South Central Ambulance NHS Foundation Trust (Service)
SECAMB	South East Coast Ambulance NHS Foundation Trust
SEH	South Eastern Hampshire
SEN	Special Educational Need
SGH	Southampton General Hospital
SHIP	Southampton, Hampshire, Isle of Wight and Portsmouth
STP	Sustainability and Transformation Plan
UHS FT	University Hospital Southampton NHS Foundation Trust
WCH	Western Community Hospital
WiC	Walk in Centre