JOINT INSPECTIONS OF OLDER PEOPLE'S SERVICES 2004 –2005

EVIDENCE COLLATION

Last updated 12/01/2016

Date	Inspector	Source	Evidence / Findings	Conclusion / judgement	Provisional evaluation	Criterion
3.4.05	BD	19 Prevention Team BV exit report	Report provided was dated 1999 and therefore not reviewed			
3.4.05	BD	19 Residential review of older peoples services dated 2000	Given date report was not reviewed			
13.04.05	BD	Inspection Reports Supporting People Programme Portsmouth City Council Dec 2004	Portsmouth was a pilot site for inspection for Supporting People and had this pilot inspection done in March 2003. Given it was a pilot the report was not formally published. The first formal inspection reported in Dec 2004 found that a large number of recommendations from the pilot had not been put in place leading to similar issues being found. The inspection scored the service as fair (1 star) with uncertain prospects for improvement.	Is the council normally slow to respond to concerns and issues brought to its attention to improve services for its residents	Q	
4.4.05	BD	Fit2eat website	Website has been set up by Portsmouth city council ? and others? to encourage healthy eating in older people. There are helpful recipes and also guides (how to use a microwave) which could be very useful for those suddenly put into new situations	Questions: How many hits Is there the IT in the local area so that people can access this How useful is this for people living in thier own homes who may not use services Is there IT free access at libraries etc that promote this		
18/4	SM	Independent res & nursing home Providers & HCA rep	Low status of care workers needs addressing			
18/4	SM	Independent res & nursing home Providers & HCA rep	Overall PCC need to communicate more effectively with Ind res & nursing providers			
28 Feb	T Hutt	LDP (15)	Statement of no further intermediate care provision? What is the rational for this position	Clarify intended development of intermediate care	Q	1.1
01 Mar	T Hutt	Self Assessment	*Initially the lit was solely focused on NSF standards but has recently shifted its focus into whole systems older persons services.*	What evidence is there for this	Q	1.1

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01 Mar	T Hutt	Self Assessment	Council improvement priorities for the next three-years are divided into two categories: 1: improvements for the community. 2: improvements to corporate working. Within category 1 whilst there is a health and social well-being section there is no specific commitment to older persons services. Category 2 concentrates on more corporate cross cutting strategic development.	Clarify	Q	1.1
01 Mar	T Hutt	Mental Health (4)	Still in the process of developing an older person's mental health strategy. Is their corporate agreement on the strategic way forward? Suggestion that that provision will be by PCT population.		Q/AD	1.1
01 Mar	T Hutt	Self Assessment	*The NSF lit sub-groups have made good progress particularly on falls, stroke and intermediate care.*	Note that older persons mental health are not included in this statement.	Q	1.1
11.02.05	BD	Comprehensive Performance Assessment Dec 2002	Rainbow coalition – NB BD check when elections are on? could be May 2005 No they are next year	Impact on vision?	Q	1.1
11.02.05	BD	Comprehensive Performance Assessment Dec 2002 p12.31	Community safety one of 2 key priorities	Impact on older people	Q	1.1
11.02.05	BD	Comprehensive Performance Assessment Dec 2002	Overall did not mention older people once as a target group	Are they a priority if not why not and where do they stand in the pecking order	Q	1.1
22/4	SM	Code A NSF standard 1(age discrim)-	• Haven't got local baseline info • Lisa feels this project needs senior officer to lead as apose to a TM • Age discrimination working group is at the forming stage of group process • Still clarifying role of group, scope, leadership and required actions	Lisa's opening sentence, "we struggled with it", sums it up frankly..	AD	1.1
28/04/05	ME/TH/SM	Interview Code A 11.04.05	Concentrate on quality and not just meeting targets. Regular review of cases, most users happy but may not get all they want because of assessment. Thinks domiciliary care is good standard. Need to change investment to promote independence and dignity. Need to improve nursing home provision.			1.1
28/04/05	TH/ME	Interview Code A Code A 17/04/05	OP are a priority but balanced with other priorities. Will not be affected by £8.3m shortfall this year. All CEO have signed local delivery agreement, 4 hr waits have been a strong driver.			1.1

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19/05/05	ME	Jane Williams telephone interview	The acute trust is now more engaged in the stroke agenda and the issue of the number of beds needed			1.1
25.04.05	BD	Meeting with voluntary organisations	Met with: Salvation Army they provide a: - good neighbour scheme – with 200 clients and 90 volunteers - advocacy scheme to help people get grants and links to services - meals on wheels - furniture service e.g. moving beds downstairs when someone is too old to get up the stairs - shopping service Portsmouth City (CVS) equivalent. They provide: Dial a ride – well used Gardening service focused mainly on older people who need help to keep their gardens looking nice Southern Focus Trust Home improvement services - e.g. heating, insulation Adaptations – often put in showers Handy person scheme – vetted handy people to do odd jobs Health and safety checks on property Do on going informal consultations with clients and users including coffees mornings Yearly funded so feel they cannot plan and are very concerned about the SRB funding coming to an end soon (April 06) with no discussions re take up yet. Link into the Prevention Network – lead officer Nick Bishop but do not have any shared strategy,	If there is shared vision or strategy agreed with City Council and health bodies – which I think not- it has not been shared with the voluntary sector that provide a wide range of preventative and independence services for older people. The lack of longer term funding inhibits planning and potential income maximisation from other funders Code A	AD	1.2
11.02.05	BD	Comprehensive Performance Assessment Dec 2002 p10	Health of local population poorer than other parts of the south Life expectancy also older than neighbours	Impact on older people? Access to healthy living centre?	Q	1.2

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11.02.05	BD	Comprehensive Performance Assessment Dec 2002 p23 76	Cross service strategies are being developed e.g. anti poverty strategy	Has it happened Impact	Q	1.2
1.4.05	BD	1 Community Strategy p24	Council is developing a 5 year Supporting People strategy -The strategy will set out the priorities for the provision of support services to vulnerable people in the city, such as older people, homeless families and young people at risk. Strategy to be in place March 05	Have we got the latest version Planned impact	Q	1.2
1.4.05	BD	1 Community Strategy p27	**Winter deaths amongst older people** The number of winter deaths amongst older people in Portsmouth is significantly above the national average. By 2009, we will reduce the number of deaths amongst older people during winter in Portsmouth (142 per year for 1997-2002) to at least the level we would expect if we had the same as the national average (102 per year for 1997-2002). A range of measures have been planned e.g. the warmth and repair although I am confused as these were in the CPA 2002 and it sounds like they have not moved on? Carer breaks, and increased access to grants and loans for repairs and adaptations	Impact What has been delivered to date	Q	1.2
1.4.05	BD	1 Community Strategy	Did NOT mention older people as a target group for reducing fear of crime which is an unusual admission	Why	Q	1.2
1.4.05	BD	2 Portsmouth City Council corporate plan 2004 – 2007 p 40	Older people 65ys or over helped to live at home BVPI 54 – performance has fallen and is in the worse performing unitaries	Impact What remedial action has been agreed with CSCI	Q	1.2
1.4.05	BD	18 Safer Portsmouth Partnership- Crime, disorder and substance misuse audit 2004 and strategy p19 -20	Highlights that older people are at greatest risk of distraction robbery To deal with this there will be a continuation of the Home Check scheme for older and vulnerable people – basically checking peoples home and put in things to make them more secure e.g. door chains, peepholes That was the only mention of older /elderly people as a specific group in this document	Impact Nb no targets or numbers give	Q	1.2
3.4.05	BD	19 Day Care review not dated	Acknowledged that services had not changed since the 60/70's 1.4 states that the population of Portsmouth who are over 65 will be 20% by 2010 did not really make any concrete plans for the future just asked for more mapping, agree a plan etc etc	What has happened since and the impact please!	Q	1.2

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3.4.05	BD	19 Recreation BV report July 2002 p10	It was proposed that GP referral for exercise would be extended to older people who were at risk of falls – there was a referral to gym for cardiac patients but no age given	Has this happened, impact	Q	1.2
01/03/05	ME	Portsmouth city council SSD older person sector commissioning plan 2004-06	People over 65 15% of pop. Highest hospital episode rate is in Fratton. Falls rate is higher than average and also THR, revisions and # NoF. Over 65 suffering a stroke are significantly higher and CHD is also high.	Scope for health promotion to reduce rates. Need to check why more people in Fratton are admitted. Does this link to CGR which found high admission rates for diseases amenable to primary care intervention?	Q	1.2
02/03/05	ME	NHS plan and LDP review – AC 2003/04	Most trusts are doing well with acute aspect of the NSF but still finding stroke patients may not follow correct pathways and miss vital care. Portsmouth is to re-launch their care pathway. Need more input from GPs in prevention, identifying at risk patients and providing correct treatment. Little or no extra funding given to strokes	Still appear to be problems in practice with stroke care especially outside of acute care. Ability to progress with improvements may be hindered due to funding issues. Considered high risk	Q	1.2

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20/4	**TH/ME**	Meeting with Health improvement and prevention and the Director of Public Health.	Examples of integrated teams and co-location. With regard to the city strategy the Director of Public Health chairs the health and social well-being partnership board. This relates to the LSP. Transport and education were initially difficult to engage. The council corporate changes will benefit both prevention and public health. There is a level of contractual monitoring of all projects. A report on the emergency admissions in September 2004 by public health identified particular difficulties with older people and children under four. Older people from seven GP practices in particular were referring to A&E. Access to winter warmth is a successful project over the last three years. They have a good relationship with the local media. Black and minority ethnic communities require more work although development workers have been appointed and the meals-on-wheels service offers culturally appropriate meals. We need to get better. There are 37 new communities in the last five years.		**s/ad**	**1.2**
20/4	SM	POVA	POVA policy/procedures in place since 2000 Measuring and monitoring of outcomes is weak as pink forms completed by s/w's rarely get to co-ordinator. GP's reluctant to support POVA process Awareness of POVA and associated matters at best variable Some good case scenarios shared and case vignettes requested.	Monitoring of no's of refs, investigations and crucially OUTCOMES desperately need recording on systems which make info retrievable/ monitoring systems..	AD	1.2
20/4	SM	Mtg with continuing Care team	• continuing care process appears to be effectively managed • use of generic auxiliary workers for terminally ill		?S	1.2
28/04/	TH/ME	Interview Code A 1/04/05	Overall quality of provision is good but some OP may not get as much as			1.2

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05			they want. Promoting independence is not reflected in current investments pattern, not enough domicilary care. Have issues with nursinghomes care and have closed a residential care home.			
28/04/05	ME/CB	Website demonstration 14/04/05	Several websites mostly aimed at professionals to access information that can be given to the public. Not really aimed at BME and not all have facility for visually impaired. Library of equipment for carers is well used. Fit2 eat is for older people and recipies are available in hard copy. Clear and friendly website, demonstrations of cooking and home economics in day centres etc Many other activities can be found on websites – healthy walks			1.2
4/05/05	CB	Voluntary organisations 14/04/05	Some services provided for older people who are not receiving services from SS or PCT. Prevention network is reported as being good and results in many initiatives. PCT are not always well thought of or supportive eg lack of consultation re podiatry.and issues re contracts SS are reported as being supportive eg by Alzheimers society Carers are well supported. Range of voluntary services including: equipment service, home from hospital (Red Cross), day centre and 11 support goups (Alzheimers), dail a ride, gardening service, lunch clubs, critical friend, home improvement service.			1.2
4/05/05	CB	Visit to the allotment	Referrals to the allotment by psychiatric nurse, Ots older peoples team, residential homes and GPs. Can't cope with many referrals as not enough staff. Difficult for some people to get to due to buses and intimidation on buses. Get a bag of vegetables at end of day to encourage healthy eating and physical and mental well being			1.2
19/05/05	ME	Telephone interview Dr Rogers	Do a lot of stroke prevention as part og GP contract most practices run a vascular clinic for assessment of patients. Community pharmacists get involved by doing BP and cholesterol checks.			1.2

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19/05/05	ME	Telephone interview Dr Rogers	Are able to provide a range of information from EMIS on patient activity eg smoking cessation, flu immunisations and blood pressure management, they give the PCT whatever they ask for.			1.2
11.2.05	BD	Comprehensive Performance Assessment Dec 2002	5.7%BME pop page 7	Unsure of older people BME % and if services reflect %	Q	1.3
11.02.05	BD	Comprehensive Performance Assessment Dec 2002 page 8	LPSAs theme was children and young people	LPSA for older people? Is there one? If not why not?	Q	1.3
11.02.05	BD	Comprehensive Performance Assessment Dec 2002 p21 25	Welfare benefits advice to people in their own homes have been planed	Has it happened Impact	Q	1.3
1.4.05	BD	1 Community Strategy p28	Portsmouth state they want to further develop services to reduce social isolation amongst older people, including those from minority ethnic communities. But does not say how?	How? Planned Impact?	Q	1.3
1.4.05	BD	20 From the Hill to the Sea transforming the cultural life of Portsmouth	No mention of older people or elderly as a specific group	How does the city seek to address equality and equitable access to culture and leisure	Q	1.3
28.02.05	ME	National sentinel audit of stroke 2004	Emergency scanning available within 24 hours for in patients only. No outpatients scans within 2 weeks for strokes or TIAs.	Could be unable to prevent major strokes following a minor stroke or TIA	Q	1.3
28.02.05	ME	National sentinel audit of stroke 2004	There is an acute stroke unit (19 beds), rehabilitation stroke units (63 beds). Does not meet all criteria for acute unit – no access to scans within 3 hours of admission, direct admission from A&E. there is no admission criteria to acute unit and it is age related to rehab. There is a mobile stroke team and the rehab unit takes patients other than stroke patients. No specialist early discharge or community teams	May be issues regarding appropriate use of beds and limited pathways to aid discharge.	Q	1.3
28.02.05	ME	National sentinel audit of stroke 2004	There is a neurovascular clinic but average waiting time is 42 days and there is no service to see and investigate people within 14 of minor stroke or TIA.	This doesn't meet national clinical guidelines to see patients within one week.	Q	1.3

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01/03/05	ME	Portsmouth and SE Hants stroke services final report May 2004	This project was for 1 year funded by private company to set up a stroke register and collect information regarding all strokes. It revealed great differences in LOS and input by stroke specialists and variation in pathways taken. No data entered onto register after April 2004 as funding stopped. 55% patients admitted to acute general wards only. Some patients not referred to stroke specialists after admission to A&E or MAU. Variations between patients under 65 and over 65. communication was highlighted as a big problem. Recommendations to develop stroke coordination and an admin role to maintain the stroke register.	Obvious inequalities of care and provision highlighted. Need to check what has happened since and how data from register was used to inform commissioning and service development.	Q	1.3
13.04.05	BD	Inspection Reports Supporting People Programme Portsmouth City Council Dec 2004	12 There were no clear places for addressing the needs of BME3 groups in the five year SP strategy	Rationale and impact on older people from BME3 groups	Q	1.3
19/4	SM	Chinese elders group	Many Chinese elders extremely isolated and not accessing healthcare, GP's, hosp services One or two speak English			1.3
28/04/05	ME/CB	CT scanning interview 13.04.05	Patients with a stroke are prioritised to have a CT within 24 hours if in-patient. A new CT (third) will be in use in July but there is no funding for staffing it. This happened with second MRI which is used 2 days a week. . Currently unable to improve the position regarding outpatient access to scanning for TIAs.			1.3
28/04/05	ME/CB	MAU interview and visit 13.04.05	MAU is very busy and patients are moved through quickly. Scope to improve system for specialist nurses to identify which patients they need to see to pull through the pathways and also for MAU staff to have better understanding of what services are available to support early discharge. Not all over 65's are assessed by a geriatrician and some with multiple needs could slip through and end up accessing no specialist care.			1.3
28/04/05	Me/cb	A&E visit 13.04.05	Has been significant problems with 4hour waits in A&E which the trust is trying to address. Emphasis now on preventing admission and getting people discharged safely and timely. SPOT generally used in A&E but no fast track pathway for stroke patients to allow for thrombolysis. May not always be referred for CT. Do not see many patients from BME groups Stable nursing workforce with good access to training.			1.3

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09/05/05	DN/CB/BD	Stroke visits – Mary ward 12/04/05	Delays in accessing acute stroke ward and TIA clinics as lack of awareness in primary and secondary care,			1.3
09/05/05	ME	Interview Dr Jarrett 12.04.05	Patients with TIAs were sent home from A&E but stroke coordinator follows through these patients. Access to scans is getting better, GP can't order CT. 3 month wait for Doppler.			1.3
19/05/05	ME	Telephone interview Dr Rogers	TIA/strokes – has no open access to scans which have long waits but thinks Doppler waits are ok. Do sometimes admit a patient in order to get a scan, has guidelines for TIAs and is aware of clinic.			1.3
19/05/05	ME	Telephone interview Dr Rogers	BME- is low in numbers think it is representative of those who access service, the refugee and asylum seekers have increased numbers of BME.			1.3
19/05/05	ME	Jane Williams telephone interview	TIAs go to the geriatricians out patient clinic but no provision for under 65s, no protocols for strokes but GP advised to admit via training and development sessions with them.			1.3
19/05/05	ME	PCT medicine mgt	Do older people in regulated services in your area have direct access to pharmacists and pharmacy services? E.g.- Smoking cessation, advice on medication, promoting healthy living/eating. Where home contracts with pharmacy for advice these services could be offered – otherwise it is unlikely			1.3
28 Feb	T Hutt	SAP (14)	SHA glossary of terms	Very good tool	S	1.4
28 Feb	T Hutt	SAP (14)	Information sharing protocol from SHA	Has it been signed off	Q	1.4
01 Mar	T Hutt	Self Assessment	The revision of older persons people services in the City is outlined in the community strategy and the city council corporate plan. It *seeks to promote well-being and maintain the independence to*		S	1.4

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			prevent people going into long-term care.			
01 Mar	T Hutt	Self Assessment	The new joint accommodation strategy will draw the links between supporting people funded provision and other sources of accommodation such as residential homes. There is cross-party political support for these developments.	This requires further investigation.	Q	1.4
01 Mar	T Hutt	Self Assessment	*There have been a significant increase in the number of respite breaks provided to carers*	What evidence and over what period.	S	1.4
01 Mar	T Hutt	Strokes (4).	Lacking an overall strategy.	Stroke co-ordination project May 2004 is a good report detailing levels of activity.	Q/S	1.4
11.02.05	BD	Comprehensive Performance Assessment Dec 2002 page 29	States there are effective partnerships Not sure what ones are involving older people	Impact on older people?	Q	1.4
11.02.05	BD	Comprehensive Performance Assessment Dec 2002 p12.30	SSD and PCT attempting to develop virtual trust	Impact on older people? Are older people part of this? Progress?	Q	1.4
11.02.05	BD	Comprehensive Performance Assessment Dec 2002 p12.32	Work in silos	Does this inhibit coordination of services for older people?	Q	1.4
21/04	**TH/BD**	Meeting with officers from both health and social care responsible for single assessment process implementation	There has been a strong lead from the strategic health authority which included mapping work in 2003 around pathways in intermediate care. They feel very positive with regard to the single assessment process and it has bought practitioners and clinicians together. The client records will include the Contact Assessment and Overview assessment This will be paralleled in swift. swift will be available in September October 2005 for the Contact Assessment . Graphnet can interface with swift and the strategic health authority are running a range of pilots as part of the interim arrangements across all of Hampshire		**S**	**1.4**
19/4	SM	Senior Housing officers	Fit for purpose strategy 2005-2010 being produced Good needs mapping and analysis conducted	Clear hsg strategy although working up fit for purpose hsg strategy currently for 2005-2010.	S	1.4
6.5.05	ME	Telephone interview with **Code A** e OOH	Feel there is more need to provide support to enable patients to stay at home and avoid admission			1.4
19/05/05	ME	Telephone interview Dr Rogers	Do not use protocols for EMH haven't seen any for dementia and depression but do get quite a lot of local			1.4

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			guidelines			
11.02.05	BD	Comprehensive performance Assessment Dec 2002 p16.52	Joint working arrangements with health partners are in place, SSD and PCT working together have 'significantly 'reduced delayed transfers of care	Is this still working? Trends>	Q	1.5
1.4.05	BD	2 Portsmouth City Council corporate plan 2004 – 2007 p 19	Reduce accidents – older people have a key improvement action – to develop a whole systems falls prevention programme for older people – lead officer Nick Bishop Target is to reduce the number of older people who suffer from falls by 1% by 2005	Progress Impact	Q	1.5
24/02/05	ME	Portsmouth City Teaching PCT Clinical Governance Report July 2004	High admission rates for diseases amenable to primary care intervention including diabetes and ischemic heart disease. The PCT is developing intermediate care and strategies for chronic disease.	Lack of development in this area. Need to check relationships with GPs	Q	1.5
02/03/05	ME	HES data	No 28 day emergency admission for FNOF at Ports City PCT otherwise all other indicators are in line with expected activity	Most likely because coded to East Hamps.	S	1.5
02/03/05	ME	East Hamp PCT CGR report 2004	Poor communication between GP and hospitals especially on discharge. Difficulty placing into nursing homes. The PCT is working with SSD to develop 140 nursing home placements locally. The capacity issues mean that elderly patients don't all go to the elderly medical or follow the stroke pathway	Not clear where the elderly patients go. Capacity issues and inequality of access and care and discharge problems	Q	1.5
02/03/05	ME	NHS plan and LDP review – AC 2003/04	Delayed transfers of care in Portsmouth city PCT above LDP targets and will have difficulties meeting intermediate care targets due to reduction in nursing home beds, re-provision of residential capacity and financial issues. SSD is good for intensive home care but needs to improve OP helped to live at home. Overall joint initiatives and and appointments have improved discharges and independence at home	Mixed picture with more issues in Portsmouth PCT. Need to check what is happening with accommodation	Q	1.5
02/03/05	ME	NHS plan and LDP review – AC 2003/04	Emergency admissions and re-admissions are above LDP targets in Portsmouth.	This is linked to intermediate care and bed capacity and schemes to avoid admissions	Q	1.5
18/4	SM	Independent res & nursing home Providers & HCA rep	Perception is that OP often inappropriately discharged from hosp directly into nursing care. Health and other key info not shared with receiving nursing home.		AD	1.5
19/4	SM	South West cluster care mgrs & qualified s/w's	Discharge arrangements from the health side need improving in terms of use of S2 (notification).		AD	1.5

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20/4	SM	Mtg with assessment & reimbursement team	delayed transfer causes concern sometimes in respect of inappropriate discharge.			1.5
28.04.05	ME/CB	Ambulance interview 13.04.05	Ambulance trust is now linked into arenas to improve care across the district and within Portsmouth, the clinical audit work could be very good but is not rolled out to Portsmouth and should help avoid admissions and pick up repeat callers.			1.5
4/05/05	ME	Managed care nurse 20.04.05	Managed care project started Dec 04, 4 nurses employed by PCT to manage a case load of 50 patients each with chronic diseases who have regular hospital admissions to prevent further admissions. They will be able to prescribe and aim to work closely with all depts to avoid admissions. Link with GPs rapid response, PHT & MAU to get referrals. Rough target of 50% of admissions to be avoided. Good response from patients and professionals. Auditing work to secure funding after the one year, posts are substantive and aim to employ generic workers in future. Client held records used.			1.5
4/05/05	ME	RAPID RESPONSE 20/04/05	Rapid response is 8am-10pm, referrals from GP professionals going to patients homes A&E< MAU. Are criteria for referral. Don't usually take on patients who need physio and ot as work load would be too big, patients may go to Rembrandt unit, nursing home or get enhanced care at home. Seen by nurse on day of referral, use social worker on CRT or patients own, will use client held notes if available. Able to top up health and social care temporarily to prevent admission. Few negative comments from patient surveys. Lack of equipment out of hours can prevent a patient staying at home			1.5
5/5/05	ME/BD	Elderly medicine visit and interview	Bed meetings each day at PHT to keep patients moving through the system are concerns regarding the number of bed moves some patients make. Post acute beds at St Marys use medical model of care and have a rota of a consultant for one week to oversee care (may be issues re discharge,mdm and access to early support and care packages) PHT has been working with PCT re standard 4 of the NSF. Social workers send their care plan to GPs, work in clusters to cover several surgeries.			1.5

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5/5/05	ME/BD	Elderly medicine visit and interview	Would need to spend £5-7k on Graphnet to allow specialist nurses to easily find their patients via a print out, currently have to trek round wards etc to establish which ones may be theirs – timewasting.			1.5
6/5/05	HDW/BD	EMH services visit and interview 18.04.05	No dedicated psychogeriatric liaison service to acute hospitals. No funding available to provide a service to PHT to facilitate discharge of confused patients. Are delays to discharge psychiatric patients into social services as these patients do not incur fines for delays.			1.5
19/05/05	ME	Telephone interview Dr Rogers	Discharges have improved and the problems now are acceptable. Have been getting a greater quantity of TTO and less drugs are wasted, there is better communication re discharge and if there are problems he is able to contact the necessary people to deal with it.			1.5
19/05/05	ME	Code A elephone interview	A lot of work re discharge has gone on in the medical wards, there is a discharge team to facilitate complex discharges who liaise with all the professional necessary. They are also implementing the DOH guidance on achieving a timely simple discharge.			1.5
19/05/05	ME	Jane Williams telephone interview	There is an acute pathway and exclusion criteria for patients to be admitted to acute stroke ward, organisational chart shows the route for patients to follow for accessing stroke care. (documents sent by email and are clear to use)			1.5
11.02.05	BD	Comprehensive Performance Assessment Dec 2002 p16 50	Put in place repair and warmth initiatives for older properties	Impact on older people	Q	1.6
3.4.05	BD	19 Meals on Wheels BV exit document July 2002 p22	Stated there was a meals on wheels service 5 days per week, with an additional weekend service running. It had a waiting list Had a plan of action which included 7 day week hot and frozen food	Has this happened and what has been the impact on older people Is there still a waiting list	Q	1.6

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01/03/05	ME	FALLS PATHWAY	Diagram of the pathway and actions to be taken	Appears clear and easy to use, no indication of review date	S	1.6
02/03/05	ME	East Hamp PCT CGR report 2004	Public health may be lacking capacity but the team has been increased. MEDICINES MGT WAS UNDERGOING REVIEW AN INTERIM MEDICINES MANAGEMENT GROUP WAS IN PLACE BUT UNCLEAR OF BOARD ACCOUNTABILITY UNTIL NEW POSTS. THERE IS NO PRESCRIBING STRATEGY BUT A JIONT PRESCRIBING PLAN DEVELoped. Some good practice examples for medicine mgt	Need to check the progress with medicines mgt but seems ok. Need to check how public health is progressing now with more capacity	AD	1.6
02/03/05	ME	NHS plan and LDP review – AC 2003/04	Mental health protocols – providers of elderly mental health considered to be low risk and progress is being made in developing and agreeing protocols for depression and dementia.	Considered to be low risk	AD	1.6
11/4	SM	PCT Dir of service+ Assoc Dir OP and Promoting Ind	Progress on NSF standards is good overall			1.6
19/05/05	ME	Jane Williams telephone interview	The specialised stroke service meet the milestone as described in the service model from 2004. with an acute stroke unit that is non age related but rehab beds and CSRT are for over 65s. UNDER 65S go to Hasler neuro ward for rehab. There is a patient group direction for aspirin that has been implemented. Need to improve access to scans and are looking to see if the stroke coordinator can order them. The number of strokes going through the acute stroke unit has gone from 30% to 70% because of the coordinator and better awareness of staff and improved outflow from the unit.			1.6
19/05/05	ME	Jane Williams telephone interview	Medicine for older people run lists for rehab if on a medical bed and all patients must be seen by stroke coordinator or geriatrician. Most get seen now but there can be gaps on surgical wards if a patient has a stroke whilst in hospital.			1.6
01	T Hutt	Self Assessment	The continuing care panel meets on a monthly basis	How effective is this	Q	1.7

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Mar						
01 Mar	T Hutt	Self Assessment	A pooled budget for palliative care is in development for continuing care	When is this due to become operational?.	S	1.7
20/4	**TH/SM**	Meeting with continuing care co-ordinators.	There are three separate panels for the different care groups. The panels meet on a monthly basis. Authority has been delegated to make decisions outside of the panel arrangements. The likely to die group are counted within a four to eight week period. Only four per cent go over the likely to die period. People are encouraged to die at home when appropriate. They have purchased four continuing care nurses to replace agency useage. They have been some difficulty in obtaining assessments with regard to older people with mental health needs.		**s**	**1.7**
20/4	SM	Mtg with OT's health & SSD @ ST Mary's hosp	Impressive relationships effecting joint working	Really impressive, co-location	S	1.7
20/4	SM	Mtg with OT's health & SSD @ ST Mary's hosp	Waiting lists exist for adults in SSD total 86 OP and go back to Nov 04			1.7
28/04/05	ME/CB	CEO PHT Interview 13/04/05	About 18 patients in St Mary's waiting for choice of home. SWAT teams walk wards to identify patients and arrange care packages.			1.7
25.04.05	BD	Discussions with Portsmouth pensioners at Older People Strategy Group	Portsmouth City Council engage with older people in a number of ways: Citizens panel – which has a number of older people on it Through Portsmouth Pensioners – who also make representation to health trusts – the podiatry service was reduced without consultation and this has been an on going issue of contention since No group attended by BD had any BME representation No group attendees could name or remember seeing the older peoples champion Carers group staff members attended (Darlington and Farley?) had felt that the carers voices were heard through more informal feedback that they gave to senior staff on issues they raised	Although Portsmouth has a very active Pensioner Group, as well as the traditional Citizens Panel there was little evidence of effective engagement that impacted on older peoples services	AD	1.8
11.2.05	BD	Comprehensive Performance Assessment Dec 2002 page 10	Uses neighbourhood forums for consultation	Are older people involved? BGOP?	Q	1.8

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Date	Inspector	Source	Evidence / Findings	Conclusion / judgement	Provisional evaluation	Criterion
24/02/05	ME	Portsmouth City Teaching PCT Clinical Governance Report July 2004	Citizens panel established in 2001 and have been consulted on PALS strategy and involved in electronic booking . have their own PALS officer, informs public on services and developments.	PCT appears committed to improving public and service users involvement but a lot more could be done. A score of iic given	AD	1.8
01/03/05	ME	Falls workshop	Briefing paper re a workshop carried out in August 2004. this was the second workshop and key points were recorded.	Not clear what happened with the actions from this workshop, the table gave no timescales or clear accountability for delivery	AD	1.8
01/03/05	ME	Stroke services strategy group meeting notes 6 Dec 2004	Purpose of meeting was to relaunch district wide NSF stroke group and get agreement on developments. Identified a need to develop a strategy and utilise resources effectively. Identified lack of rapid response nuero vascular clinic. Wait for TIA appointments is 7 weeks not 1 week recommended and patients are having strokes whilst waiting. No slots for under 65s, 3 months wait for carotid scans. Links with GPs needs development. Funding has been provided for 1 year from drug company for stroke coordinator post. Priority for 2005 is development of CSRT. Lack of specialist care for under 65s.	Can't tell where attendees are from. Impetus from stroke project seemed to have declined without improvements to care being made. Funding is not coming from PCTs or is recurring. Ned to check what is in the LDP re stroke care and development. Highlights the inequalities in care and those between the under and over 65s.	Q	1.8
01/03/05	ME	Portsmouth city council SSD older person sector commissioning plan 2004-06	SSD and PCT have held events to involve older people and carers and find out what they want.	Evidence of public consultation	S	1.8
02/03/05	ME	East Hamp PCT CGR report 2004	Knowledge of PPI strategy is weak at service level and there is scope to improve involvement in strategic decision making. Awareness of Pals is not consistent and how to complain is not well publicised	PPI needs improvement	Q	1.8
14/04	TH	Interview comm/comp	Feedback with users and carers has led to review of discharge planning.		S	1.8

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15/4	**TH/BD**	Meeting at of the older persons strategy group .	It is noticeable that there were no obvious representatives of black and minority ethnic groups. Presentation on the progress of the implementation of the single assessment process. There are joint leads from both within the PC T and social care. They are piloting a "Graphnet" short-term solution to the IT difficulties. They have developed an information-sharing policy and a training pack. They are developing client held recolds. They believe that their GP colleagues are not yet on board with the single assessment process.		**S/AD**	**1.8**
13.04.05	BD	Inspection Reports Supporting People Programme Portsmouth City Council Dec 2004	12 a weakness was the lack of direct service user involvement in the development, delivery and monitoring of the SP provision	What steps have they taken to improve this and impact on older peoples services	Q	1.8
11/4	SM	Strategic director/head of service SSD	Direction of travel involves greater levels of integration ? care trust.. Health strategic boards and most other processes integrated.	No clear strategic intent for OP service	S	1.8
11/4	SM	PCT Dir of service+ Assoc Dir OP and Promoting Ind	Board has good public representation and OP well engaged in strategic processes although need to be engaged at the start of process		AD	1.8
11/4	SM	PCT Dir of service+ Assoc Dir OP and Promoting Ind	Forum for NEDS & council members to meet is LIT		AD	1.8
11/4	SM	PCT Dir of service+ Assoc Dir OP and Promoting Ind	Use of 'World Cafes' to facilitate NSF strategy group, giving info and hearing views		ADS	1.8
13/4	SM	OP service users	Limited evidence of GP involvement in Care mgt & assess process		AD	1.8
19/4	SM	South West cluster care mgrs & qualified s/w's	There is scope to improve GP involvement			1.8
19/4	SM	Senior Housing officers	Whole market perspective to hsg which engages all key partners.			1.8
21/4	SM	Mtg with older peoples relatives group and chairs at Harry Sotnick hse	Concerns raised regarding • poor communication from SSD with relatives group and its chairs • none of those present had met the CEO or Director	Overall, relatives x6 were not impressed by SSD in respect of the matters mentioned under evidence.	AD	1.8
28/04/05	TH/ME	Interview **Code A** **Code A** 11/04/05	Good public relationships and involvement – good attendance at board mtg There are BME groups that are hard to engage. The LIT is a good			1.8

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			way for public involvement.			
28/04/05	TH/ME	Interview Code A 1/04/05	Good relationships with members, OP champion. Also with BME but low take up of services. SWIFT is problematic.			1.8
28/04/05	TH/CB/ME	Interview with PALS and PCC complaints and comms 14/04/05	Range of ways to link to public – radio station, lunch clubs newsletter. Freephone number for PALS. Good information shop run by PALS in entrance of QA.			1.8
6/5/05	HDW/BD	EMH services visit and interview 18.04.05	Alzheimer society strong input to NHS and social provision. Runs a day centre.			1.8
6/5/05	HDW/BD	EMH services visit and interview 18.04.05	GPs have leaflets produced by Alzheimers society and CHMN carry information with them, Alzheimers soc run a helpline.			1.8
28 Feb	T Hutt	SAP (14)	Looking to use Graphnet IT system across Hampshire and Isle of Wight	Implementation date?	Q	2.1
01 Mar	T Hutt	Self Assessment	An independent sector treatment centre is being developed for the City.	We would like more information about this project.	Q/S	2.1
01 Mar	T Hutt	Self Assessment	*A joint commissioning plan will be produced by the LIT for 2005/6.*	Statement of intent? Achievable?	Q	2.1
02/03/05	ME	NHS plan and LDP review – AC 2003/04	Integrated falls – little or no funding made available from LDP. It does seem that target will be met by 2005 but still have a lot to do to achieve integrated falls service set out in NSF. Avoidable harm (Falls and hypothermia) highlighted for urgent investigation as major causes of emergency admissions.	Ability to progress may be hindered due to funding. Considered low risk Need to follow up emergency admissions	AD	2.1
11/4	SM	Strategic director/head of service SSD	Good and effective relationships with PCT			2.1
11/4	SM	PCT Dir of service+ Assoc Dir OP and Promoting Ind	Strong commissioning network in PCT Have not signed EMH SLA as requires modernising	? providers aware of required service shifts		2.1
18/4	SM	Independent dom care providers	Contracting arrangements are a strength- David Stokes is a breath of fresh air.		S	2.1
18/4	SM	Independent dom care providers	Lack of funding is a major concern for providers this has many implications		AD	2.1
28/04/05	TH/ME	Interview CEO PCC & PCT 11/04/05	Difficulty engaging GP with practice based commissioning. Business plan done by the PEC Have collected health information that is analysed by geographical areas and this will pick up some OP issues Concern re access to dentristry			2.1

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Date	Inspector	Source	Evidence / Findings	Conclusion / judgement	Provisional evaluation	Criterion
09/05/05	ME	Interview Dr Jarrett 12.04.05	Is now a 65 year and over service, under 65 go to Hasler, do take some under 65 but not formally as he is a geriatrician and would like to have the service for all ages and run by a stroke consultant. Would like a 30 bed unit but not in PFI scheme. Neurovascular clinic uses 2 sessions as TIA but not funded for these-waiting list is 7-8 weeks and are having strokes in that time.			2.1
09/05/05	ME	Interview Dr Jarrett 12.04.05	Has found working with 3 PCTs difficult with the NSF and have just had to get on with things, the 30 patients are in the hospital but not in stroke beds, finds commissioning can get in the way. Try to get past the blocks to work with systems and people. Commissioning has been historical.			2.1
28 Feb	T Hutt.	PCT Commissioning (7)strategy	Visioning document. Very much about explaining the role and purpose of commissioning. No effective data. Some statement of intent.	only the first stage of a long process. No overall reference to LDP intentions	AD	2.2
28 Feb	T Hutt	SS commissioning plans (8)	Basic description of services. Some statement of intent for next 3 years. No obvious synergy with Health LDP or commissioning strategy	First stage. Needs more detail, especially needs analysis with input from Health	AD	2.2
28 Feb	T Hutt	SS commissioning plans (8)	Over provision of residential beds in city.2 in-house homes have been closed. What is long term view of correct numbers especially with Health view of acute pressures	Long term joint strategy needed. What is the view of the independent sector	AD	2.2
28 Feb	T Hutt	SS commissioning plans (8)	No shortage of Nursing care beds, but not enough OPMH provision	As above	AD	2.2
01 Mar	T Hutt	Self Assessment	A baseline assessment older persons services in the city was carried out in autumn 2004. This is being used to develop a joint older persons strategy.		S	2.2
01 Mar	T Hutt	Self Assessment	An intermediate care review was commissioned by the PCT in October 2004 and has made recommendations on same site accommodation for teams and a single point of access to services. How far has this progressed		S/AD	2.2
01 Mar	T Hutt	Self Assessment	The PCT public health department provides a range of demographic and needs assessment information.		S	2.2
01 Mar	T Hutt	Self Assessment	Discussions are taking place on how to strengthen the nursing home care market with emphasis on the development of more dementia care for the future.	Where are these discussions happening and how far have they progressed	Q	2.2
01 Mar	T Hutt	Self Assessment	*Portsmouth City commissioning strategy takes a pragmatic approach*	What does this mean.?	Q	2.2
01/03/05	ME	Portsmouth city council SSD older person sector commissioning plan 2004-06	Commissioning priorities include rehabilitation, equipment within 7 days, assessment beds, direct payments worker, implement single assessment and joint accommodation strategy.	Unclear of financial commitment to these or activity levels or if any of these have been achieved.	Q	2.2

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Date	Inspector	Source	Evidence / Findings	Conclusion / judgement	Provisional evaluation	Criterion
01/03/05	ME	Portsmouth city council SSD older person sector commissioning plan 2004-06	Partnership working is in evidence e.g. NSF LIT, prevention network, care homes, intermediate care, mental health services and joint accommodation.	Evidence of joint working with health.	S	2.2
19/4	**TH/ME**	meeting with commissioning and performance	Contracts are being renegotiated as part of an overall commissioning strategy. Contracts are being renegotiated on managed care, Help at home service from the voluntary sector and night time support They had been difficulties moving rehab services into the community. There is a realistic view of some of the future governance difficulties. Quote" we are far more interested in stopping people going in to hospital. 40 per cent shouldn't be in beds. The strategy is now moving towards admission avoidance. There is a panel of 10 GPs who've comment on the commissioning strategy. Regarding workforce there is a need for a work force delivery group with a move towards competency based approach. The score card system in social care is likely to be adopted by the PCT. In December the trust spent 84 hours talking to staff in A+E		**s/ad**	**2.2**
18/4	SM	Independent dom care providers	Providers meetings and dom care assoc provides effective forum to share & disseminate info. Very effective engagement of dom care providers in strategic planning process	Good engagement of dom care provider-independent sector		2.2

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18/4	SM	Independent res & nursing home Providers & HCA rep	• Concerns about the direction of travel- decline in use of res care and implications. This has not been discussed in open transparent way with PCT/PCC. Therefore not aware of required service shifts to meet changes. • Overall poor engagement of independent nursing & res providers in strategic planning & commissioning process also in respect of fees • Shortage of EMI res/ nursing care placements • Funding for T & D is available and is of a good quality	This group highlighted many AD's, notably; poor engagement between SSD and some res/nursing care providers despite the role of Hampshire Care Association. This results in providers not being aware of councils direction of travel and implications for the sector, lack of trust.	AD	2.2
18/4	SM	Independent res & nursing home Providers & HCA rep	Delays in payment of fees			2.2
19/4	SM	South West cluster care mgrs & qualified s/w's	There are thought to be some resource issues in respect of waiting times for day care & home care on some occasions.			2.2
22/4	SM	Homecare Service visit & interviews	• currently homecare nightservice works with PCT healthcare wkrs • service experiencing 300hr shortfall (equivalent of 20 carers) • unit cost of in house is £16ph- higher than Ind sector • BVR conducted 7-8 years ago			2.2
28/04/05	TH/ME	Interview Judy Hillier/ David Clements 11/04/05	Has been too much commissioning without evidence base eg elderly mental health so SLA isn't signed. There are joint commissioning posts, GP commissioning group in place. To pick up patients earlier in disease management to change commissioning. Practice based physio is an example of a change. Strokes and falls are a key priority from the NSF.			2.2
6/5/05	HDW/BD	EMH services visit and interview 18.04.05	Each PCT has its own LIT and no evidence of process to to address financial deficit impact on services. EMH not sure if services will be cut and that changes to provison will be difficult. There are no joint operational/financial arrangements for older people with MH problems only CRT, rapid response etc. There are no specialist teams for older people with MH problems. High grade Social workers now attend ward rounds but no dedicated SW but relationships between SW and CMHT are excellent although operating in an unstructured environment.			2.2
09/05/05	DN/ME	Stroke meeting 12/04/05	NSF meetings – now have a commissioner on the group to try and make changes. Changed structure of this strategy group as it was not working,			2.2

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			stroke now high on PCT agenda.			
28 Feb	T Hutt	Eligibility criteria/FACs (13/11)	Information not available.	info required		2.3
01 Mar	T Hutt	Self Assessment	Has the work of the Medical Assessment Unit been audited in terms of impact and outcomes?		Q	2.3
01 Mar	T Hutt	NSF OPMH (4)	The older persons mental health good practice document gives excellent examples of practice (4).	Example of good older persons mental health practice is the development of a specialist nurse in the medical admissions unit.	S	2.3
01 Mar	T Hutt	Self Assessment	A review of continuing care has resulted in the need for an on going option appraisal of accommodation solutions. In addition a review of older people mental health Continuing Care is being carried out to inform strategy and further purchasing arrangements.	This needs clarifying.	Q	2.3
11.02.05	BD	Comprehensive Performance Assessment Dec 2002 p14.39	Performance management is weak in the council	Has it improved and can we rely on their self assessed performance	Q	2.3
24/02/05	ME	Portsmouth City Teaching PCT Clinical Governance Report July 2004	Audits linked to NSFs are undertaken, audit of patient and service users have been undertaken and physiotherapy has audited intervention for falls prevention. Strategies and plans for audit are in their infancy and the PCT is linking audit with clinical effectiveness which also are developing. There are local implementation groups for each NSF	Score of iib for both components. Not much evidence of audit other than national initiatives. No clear link to commissioning	AD	2.3
24/02/05	ME	Portsmouth City Teaching PCT Clinical Governance Report July 2004	Community information systems are weak eg PAS used in community is not yet linked to the acute trust. There are issues with data quality. Information informs quarterly performance reports (uses a balanced scorecard approach and focuses on national indicators and activity) and is collected on commissioned services to monitor activity and waiting times. Local quality indicators have not been agreed. Commissioning is done through a district commissioning group for all 3 PCTs. The use of health needs assessment data is not developed to inform the commissioning strategy.	Information may not be robust enough to support commissioning and monitoring of services.	Q	2.3

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02/03/05	ME	East Hamp PCT CGR report 2004	Use of information is weak, reports focus on targets and waiting times. Information sharing with SSD needs improvement. Access for community staff to IT is poor. Data sharing with practices is difficult as 5 systems in operation. There are also data quality issues	Not clear how information is used to improve services or aid commissioning	Q	2.3
02/03/05	ME	East Hamp PCT CGR report 2004	There is no commissioning strategy but priorities are set out in other strategies and plans. The PCT recognises the need for quality indicators and not just focus on targets		AD	2.3
13/04	TH	Interview 1+2 social worker	Annual appraisal s may not be happening.		AD	2.3
14/04	TH	Interview comm/comp	Operate a score card and traffic light system for teams. Current evaluation, "too many or too few"	Good audit	S	2.3
13/04	TH	Social worker interviews	Team managers accessible and effective.		S	2.3
13/04	TH	Social worker interviews	Quality feedback from re Dom care not applied to in house services	Why?	Q	2.3
13.04.05	BD	Inspection Reports Supporting People Programme Portsmouth City Council Dec 2004	Inspection was prompted as Portsmouth had been highlighted by ODPM as having the highest service costs in the country along with 18 other administering local authorities.	High service costs can to less money being available to front line services and limits the provision available. However there were also strengths see below	Q	2.3
13.04.05	BD	Inspection Reports Supporting People Programme Portsmouth City Council Dec 2004	11 – the Supporting People inspectors found innovative services with 'outcomes for some service users among the best to be found within the Supporting People Services'	Were any of these services for older people?	Q	2.3
20/4	SM	Professional Advisor to PEC (Physiotherapist)	PEC is decision making body PEC chair is a GP Good GP representation All PEC, EXEC and board members meet routinely in other forums Senior clinicians feed back to professional groups Engagement of bme communities in consultation exercises needs developing further.	Seems to be functioning well and has been effective in delivering outcomes. Comment from interviewee: there are some good services locally, but the whole system needs knitting together. "It's a bit like fire works going off".	S	2.3
28/04/05	ME/CB	CEO PHT Interview 13/04/05	Have been problems with ambulance service, too many ambulances turning up at A&E without notice, delays in tranfering patients and now running pilot vehicle to deal with this. Relationships improving and provide information to them regarding repeat attenders.			2.3
4/05/05	ME	Clinical nurse manager, HMS Kingston prison 15.04.05	Now monitoring waiting times for prisoners biggest issue is the time of an appointment eg within lockdown times.			2.3
4/05/0	ME	Community equipment store	Follows DoH guidelines and NSF standards and AC recommendations			2.3

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5		20.04.05	Trend analysis shows some over prescription of equipment. Have overspent by supplying continuing care and LD. In the process of setting up district wide equipment store but are problems with current patterns of service and agreeing budgets. Are to agree a county criteria for manual handling equipment eg number of hoists to be issued per person.			
4/05/05	ME	RAPID RESPONSE 20/04/05	High numbers of referral not accepted only have 8-9 patients on case load at any time. Need to do more PR with GPs. Not much contact with NHSD. Could do more admission avoidance if 24 hour service are advertising for generic workers to aim for this.			2.3
6.5.05	ME	Telephone interview with Code A re OOH	OOH working well, few complaints but not yet surveyed users. Meet targets to call back patients, majority have advice only but are able to be seen in a base, no transport provided for this.			2.3
09/05/05	ME	Interview Dr Jarrett 12.04.05	With the financial situation feels that he has the attention of the acute Trust for the first time to identify inefficiencies.			2.3
19/05/05	ME	Jane Williams telephone interview	Audits do take place, have just done the sentinel and also undertake uni and multi disciplinary audit. GP are not involved in these audits. With the new data from the GMS contract it is able to identify if each practice is treating stroke and TIAs correctly and will highlight and training issues. They have been letting GPs know a patients functional levels on discharge and will be working to correct this.			2.3
19/05/05	ME	PCT medicine mgt	Is the PCT able to separate out prescribing levels for care homes to determine whether prescribing differs significantly from that for older people who live independently; and if so, what is the nature of that prescribing, e.g. use of sedative or mood altering			2.3

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			products? *No – not without detailed audit in practices*			
25.04.05	BD	Discussions with Portsmouth pensioners at Older People strategy group Conversations with taxi drivers Conversations with older people waiting for transport at QM Interview with Steve Dixon (Portsmouth director for resources, social care and housing)	**Transport** was raised as an area of concern. Half price bus passes are provided to pensioners or they can have £31 taxi vouchers. Although the uses have improved (there are more level buses for easy access) the routes have not which can mean a long journey round to the hospital sites – this is a problem for older carers who may have to go to visit QM or QA sites now outside the city. Transport at the hospital is often delayed as routes are planned to pick up and drop people off. One lady said that due to her 'problem' (slight incontinence) she preferred to pay for a taxi rather than wait and not know for how long, or how long the journey would be (on basic state pension only). Taxi drivers were having a 'good' month as the vouchers for the year got given out early April – 'we always know' and also reported having regular pick ups from the transport area at the hospital sites due to delays. Steve Dixon thought transport issues would improve as there is now a member of social care staff on the transport planning group at the city.	Transport is an area of concern for older people which needs to be addressed.	AD	3.1
28 Feb	T Hutt	SAP (14)	About to begin pilot in A+E,MAU and intermediate care	When is evaluation. Feedback from staff needed	AD	3.1
28 Feb	T Hutt	Self Assessment	Range of developments	No stated timescales	Q	3.1
01 Mar	T Hutt	Self Assessment	Strategy regarding Falls	Partners would prefer us to choose this as the Lens	Q	3.1
01 Mar	T Hutt	Self Assessment	Funding has been diverted to develop a multi-agency community stroke rehabilitation team. This will be worth visiting.		S	3.1
01 Mar	T Hutt	Self Assessment	A joint foot Care Service was set up funded by social services with accommodation and ongoing training provided by the PCT. 857 older people receive personnel care and foot care service.	The foot care services will be worth a visit.	S	3.1
01 Mar	T Hutt	Self Assessment	Four direct payments support workers together with administrative support have been created from the direct payments development fund.	What work are they undertaking and how successful have they been.	Q/S	3.1
01	T Hutt	Self Assessment	From March the PCT will be co- locating its out-of-hours Nursing		S	3.1

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Mar			Services, night nursing and night sitting to enhance flexibility and speed of response.			
01 Mar	T Hutt	Self Assessment	The Rembrandt unit	This is a 12 bedded nurse led unit supported by the Lake Road GP practice. It is currently a step down facility.	S	3.1
01 Mar	T Hutt	Self Assessment	Project development workers have been recruited from ethnic minority communities		S	3.1
01 Mar	T Hutt	Self Assessment	Not a lot of information re carers	Need to clarify	Q	3.1
3.4.05	BD	12 Supporting People Strategy executive summary p 5/6/7	Older people and frail elderly are classified as two distinct groups – their total allocation is 14.5% of the £9.9m 04/05 grant. However this relates to over 2500 units – the largest provision compared to over groups There is unmet need in older people with support needs but the council could not give any information on frail elderly as there was no data kept	Impact	Q	3.1
3.4.05	BD	12 Supporting People Strategy executive summary p 9 – 13,14	To meet the grant reduction the plan seems to be reduce the units available for the frail and older people, although there was unmet need for older people and no data re unmet needs available fro frail elderly. The groups that have got the increases are young people, young families, drug and alcohol users. The council ahs identified that its current older peoples and frail elderly provision does not meet new expectations. A joint accommodation strategy is being planned for 2005 and it is acknowledged that there is a risk that this could impact on DToC. The 05/06 spend for frail elderly and older people will reduce	Impact	Q	3.1
3.4.05	BD	12 Supporting People Strategy full document p 51,53	Report shows that although Portsmouth is supplying more than the regional average for older people it is still below the national average and this is before the reduced services Portsmouth units per 1,000 population = 10.90 Regional Average = 9.47 National Average = 11.99 However its rail elderly is above the national average Units per 1,000 population = 2.29 Regional Average = 0.37 National Average = 0.28	impact	Q	3.1

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3.4.05	BD	19 Environment and transport best value review	Did not mention frail or older people once	Impact and ability access services and support	Q	3.1
3.4.05	BD	19 Homeless Review 2003p51	States there is an older peoples resettlement officer	Impact	Q	3.1
28.02.05	ME	National sentinel audit of stroke 2004	Can perform carotid endarterectomy on site 3 surgeons performed 56 procedures in 12 months There is access to specialist nurses for continence, pressure sore and stroke care advice.	Specialist advice is available.	S	3.1
29/02/05	ME	Integrated falls service position statement	Document is not dated. Falls coordinator in post, good multi agency planning is in place. Pilots for risk assessment as part of falls pathway to be rolled out. Home safety and fall hazard checklist ready for roll out. Guidelines for assessment are being rolled out. Falls pathway to be rolled out from Jan 2005. falls clinic set up. Education programmes have funding but not clear of uptake. Medication reviews need further development with GPs.	Progress has been made but links with GPs need developing. Implementation of falls pathway may highlight capacity issues need to check if referred to in LDP	AD/Q	3.1
01/03/05	ME	Portsmouth city council SSD older person sector commissioning plan 2004-06	Service delivery – Help the aged to look at falls prevention in ethnic minorities, major re-configuration of day care, community network for voluntary organisations, carers strategy updated, outcomes for promoting independence set out, progress with social work e.g. single assessment and impact of NMC standards. OT and equipment stores, 8 bed rehab assessment unit, integration of health and social care, direct payments. Joint accommodation strategy and res/nursing/continuing care	Unclear what progress has been made with these issues or how they relate to budgets and activity.	Q	3.1
02/03/05	ME	Screening outputs of NSF older people – East Hampshire PCT	Weak on independence at home, providing information on exercise, GPs participating in health promotion, falls and mental health. Better at other health promotion topics, robust protocols for OP with mental health problems.		Q	3.1
02/03/05	ME	Screening outputs of NSF older people – Portsmouth City PCT	Weak on independence at home, falls and some health promotion including GP participation. Mental health seems less of a problem except ability to sustain performance.		Q	3.1
02/03/05	ME	Screening outputs of NSF older people – Portsmouth hospitals NHST	Independence at home low, weaker on falls and strokes than mental health, better on the age discrimination toolkit markers		Q	3.1

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13.04.05	BD	Inspection Reports Supporting People Programme Portsmouth City Council Dec 2004	12 there was a lack of easily accessible information for users and carers abut Supporting People	Q– Is this a trend for other areas?	?AD	3.1
13.04.05	BD	Inspection Reports Supporting People Programme Portsmouth City Council Dec 2004	12 a weakness was highlighted through an undated 'better care, higher standards' charter does not refer to Supporting People – this is a lost opportunity to promote joined up working	Why is the charter undated and does this highlight inconsistency in policy and practice	Q	3.1
13.04.05	BD	Inspection Reports Supporting People Programme Portsmouth City Council Dec 2004	12 a weakness was highlighted through the inspectors findings that corporate commitment to address diversity is not consistently demonstrated in practice	Is this a theme?	Q	3.1
13.04.05	BD	Inspection Reports Supporting People Programme Portsmouth City Council Dec 2004	Recommendations included establishing a local eligibility criteria for Supporting People	Q has this been done Q impact on older people Q are other areas lacking in eligibility criteria	Q	3.1
13.04.05	BD	Inspection Reports Supporting People Programme Portsmouth City Council Dec 2004	94 at the time of the 'platinum cut' in services the highest cost services related to people with learning disabilities and had a unit cost of £1,109.13p per week while the lowest cost was £1.13 per week for older people with support needs.	Q this seems a very wide spectrum and did older people only have the cheapest services?	Q	3.1
20/4	**TH/SM**	Meeting with OTs from both health and social care.	There has been variable quality referrals from both health and social care. They have now established co-location and one access point for both health and social care OT services. This was a recommendation from the change agents report. The current waiting list for older people is 100 from November. The joint equipment store functions well and the intention is that there is a pooled budget in July. The technical service has a waiting list of three to four months.		**s**	**3.1**
19/4	TH/ME	Rembrant I C unit	Very good.see handouts		**s**	**3.1**
19/4	TH/ME	Victory I C unit	very good .see handouts		**s**	**3.1**

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13.04.05	BD	Inspection report – Repairs and Maintenance Service Portsmouth City Council Audit Commission Dec 2004	Inspection of service was reported in Dec 2004. Scoring was good (2 stars) and promising prospects for improvement. P68 the council have set up focus groups to look at service issues and improvement - for older people and other vulnerable groups this has led to a flag system being put onto the IT repairs and maintenance system to prioritise older and vulnerable people and also to inform the repairs and maintenance staff of any issues (such as waiting longer for the door to be opened, taking an interpreter, taking their Braille printed cards with them)	The council have made use of older peoples experience to improve services	s	3.1
13.04.05	BD	Inspection report – Repairs and Maintenance Service Portsmouth City Council Audit Commission Dec 2004	The council was at the time of the report being written planning to split the old housing service following the Moving to Excellence Review. Housing management and maintenance would be one function while the strategic housing (homeless, housing needs etc) would go under the Director for health housing and social wellbeing. Housing benefits would go to finance services. At the time of the report there was a lot of uncertainty about how this would work and if it would lead to improvements.	The moving towards excellence review is still in early days but inspectors thought it was a positive move in the right direction hence the 2 stars and promising prospects	S?	3.1
13.04.05	BD	Inspection Reports Supporting People Programme Portsmouth City Council Dec 2004	11 some culturally specific services had been developed e.g. for Chinese elders	How did these get prioritise Impact	Q But also poss S	3.1
22/4	**TH**	meeting with council diversity officers.	agreed that community development workers need to encourage people from ethnic minorities to use mainstream services. As part of the corporate recruitment strategy they will review all contracts including the equal OPs policy statement. The diversity officers were unable to tell me whether gay and lesbian people were included in the contractual equality statement. They agreed that more needed to be done in terms of engaging with a diverse community in Portsmouth.		**ad**	**3.1**

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22/4	**TH**	meeting with Code A /direct payments.	The Shaw trust have provided the department with a grant for 18 months since November 2004. This has allowed the Department to increase its direct payments support workers from one to four. 68 people physical disability. 12 people older people. 4 people learning disability. 6 children and families. There has been a recent drive by the Department to broaden the impact of direct payments. Both learning disability and older people have been identified in day-care provision for direct payment assessments. They are also trying to broaden the approach at the point of Referral. On a weekly basis care management teams are required to report back to the head of adults services on the application of direct payments. The Shaw Trust have a well established payroll service and the council are looking at offering a banking accounts for direct payment users. He feels there is a mixed attitude towards direct payments from both social workers and care managers. 10 per cent of the carers grant is allocated to the provision of direct payments to carers. This has included the provision of holidays and one-off payments. Direct payments have also been used to buy equipment for people with disability.		**S/AD**	**3.1**
11/4	SM	Strategic director/head of service SSD	Need to address balance of re & domiciliary care New director seizing opportunities to raise profile of OP services		?AD	3.1
11/4	SM	PCT Dir of service+ Assoc Dir OP and Promoting Ind	MH capacity mapping being conducted- there is a capacity issue			3.1
19/4	SM	South West cluster care mgrs & qualified s/w's	Community rehab team is very effective as a resource			3.1
19/4	SM	South West cluster care mgrs & qualified s/w's	Focus on the needs of carers			3.1

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19/4	SM	Chinese elders group	60 op in attendance each Tuesday at luncheon club. Mable- social worker appears capable Service only operates one day a week on Tuesday.	Brilliant resource that needs further investment to be honest. Many OP isolated and not getting what they're entitled to in terms of access to health care etc. feels a bit like ad hoc service disengaged from wider system.	AD	3.1
19/4	SM	Code A ? GP practice		Didn't learn a great deal actually ??should have visited healthy living centre, but it hasn't been built yet..!!		3.1
20/4	SM	Mtg with OT's health & SSD @ ST Mary's hosp	• OPMH- one OT is developing expertise and will disseminate to team of OT's • Joint equipment store has been around for some time and there are plans for it to combine with Hampshire • Quality and effectiveness of joint store is felt to be good by OT's			3.1
21/4	SM	Mtg with older peoples relatives group and chairs at Harry Sotnick hse	Concerns raised regarding • difficulties obtaining free podiatry whilst in res care • concerns were raised about the limited no of continuing care beds in Portsmouth city			3.1
22/4	SM	Homecare Service visit & interviews	• change in focus to OP in most need/ complex cases and less complex to independent sector	Get the sense of a good effective homecare service	S	3.1
4/05/05	ME	Clinical nurse manager, HMS Kingston prison 15.04.05	Prisioners would need to be able to care for themselves to remain at Portsmouth with no adaptions to the cell, would be able to have physio if needed. Some health promotion is carried out and there is access to gyms. Prisoners with chronic conditions get seen regularly eg diabetics. Listening service and access to Samaritans for prisoners.			3.1
4/05/05	ME	Community equipment store 20.04.05	Do have a catalogue of what is available for staff to order using a PIN Good standard of delivery but more difficult to retrieve. Will have disinfection unit on site and are reviewing contract for maintainance and repair of equipment			3.1
6/5/05	HDW/BD	EMH services visit and interview 18.04.05	Difficult to arrange respite care and also can be hard to obtain appropriate medical cover for these patients. Intermediate care team but not clear how much is done with EMH patients, consists of one CMHN and 5 care workers and will soon supervise medication of community patients. The review document of intermediate care does not mention EMH patients. Excellent day hospital open 6 days a week. Out patient clinic for monitoring patients on cholinesterase inhibitors are			3.1

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			reviewed regularly but delay of 4 months once starting the drug. Follow guidelines from NICE.			
6/5/05	HDW/BD	EMH services visit and interview 18.04.05	There are no clinical links between the Learning Disability Service and the Psychogeriatric service, There appear to be no protocols dealing with the use of cholinesterase-inhibitors in the Learning Disability Service and the Memory Clinic does not take referrals from that service. There are no designated rehab beds in the Older People's Mental Health Service: should the need for such a bed arise then Social Services would be tasked with finding a suitable placement in the private sector.			3.1
9/05/05	CB	Visits around Portsmouth	Information for older people is available at the library but it is not displayed well and staff could be more helpful. The healthy walks scheme is well attended and appreciated, walkers would like more publicity to encourage new attenders. Tai Chai classes very popular and also provides health information to participants. Over fifties fitness classes in leisure centre with wide range of activites led by trained staff but complex pricing structure, Bus journeys – difficult to obtain up to date information over the phone and at bus stops and journey times were very long 50 minutes for 2-3 miles.			3.1
19/05/05	ME	Telephone interview Dr Rogers	Thinks the rapid response team is brilliant and the step down at Rembrandt is excellent if you can get a patient in it. Thinks elderly care services are good and the quality of provision is excellent with very motivated staff. Are issues with EMH re staff levels. The feedback from patients regarding the acute hospital is better than the newspapers portray and patients are grateful. Access to non acute services are an issue.			3.1
19/05/05	ME	Telephone interview Dr Rogers	OOH – works for the service, it is well resourced and good quality of doctors, it is well thought of and gets			3.1

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			much fewer complaints now it is run by PCT			
19/05/05	ME	PCT medicine mgt	Within regulated services in this area are medications and dressings retained by the care home/District nurses following discontinuation or death of the service user? (note should remain the property of the service user and not be re used for others) **NO – care homes are encouraged to return unwanted medications and dressings to the pharmacy who supplied them**			3.1
19/05/05	ME	PCT medicine mgt	Are there any areas of good practice to note? Our scheme for pharmacist to provide advice to care homes including a basic medicines use review			3.1
19/05/05	ME	PCT medicine mgt	Are PCT directing schemes for 'minor ailment treatment' towards care home residents, and does this automatically involve training of the care home staff to deliver? *NOT at present – most homes maintain a homely remedies list*			3.1
25.04.05	BD	Elderly medicine group – Dr Pearson GP and Helen Loder social services	When older people move into nursing or residential care GPs will often NOT maintain the local GP link – this can mean places are lost. Dr Pearson said that this was due to the poor transport links in the city and that although small it can take 20 mins to get from one side or other or longer. Helen L., also reported that this caused problems as without a GP some homes will not take the older person.	Impact on continuing care due to poor transport	AD	3.1?
01 Mar	T Hutt	Self Assessment	Selection at end of document of joint roles. The assessment and reimbursement team consists of health and social care staff in shared PCT accommodation.	Examples of good practice and partnership in delivery? Worth interviewing if possible	Q	3.2
01 Mar	T Hutt	Self Assessment	Jointly developed posts and new roles. City falls co-ordinator. In reach nurse to support intermediate care services. District nurse care manager to ensure nursing input to social work teams.	Worth seeing	S	3.2

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			Community matron to lead on clinical governance and links across agencies. Continuing care health care support workers to maintain continuing care patients in the community.			
14/04	TH	Interview comm/comp	Using roadshow model to approach faith groups.	Better access	S/AD	3.2
14/04	TH	Interview comm/comp	Angel Radio run by volunteer		S	3.2
13.04.05	BD	Inspection Reports Supporting People Programme Portsmouth City Council Dec 2004	129 supporting people leaflets for sheltered housing are in plain language but not offered in other languages, Braille or tape. In the hospital we found that there were no stroke information leaflets in other languages 'due to space' – although staff felt they could get hold of information from the web if needed	Is this a trend and does it impact on the access to services – we have already seen a lack of people from BME groups in stroke services?	Q	3.2
22/4	**TH**	Meeting with Justin regarding transport issues	Portsmouth council community services run transport facilities and operate a nominal charge. They provide transport to the voluntary sector and use voluntary drivers. Of the 4 Social Care day centres each has its own vehicle. If you're referred you will be provided with transport either by the day centre vehicle or by taxi. Some people contribute to taxi cost but the numbers are very low. If the service user has a mental health profile then all vehicles will have an escort. Day centres run till 8 o'clock in the evening and transport is provided up until that point.		**s/?**	**3.2**
11/4	SM	PCT Dir of service+ Assoc Dir OP and Promoting Ind	"Local ethnic mix means we don't always do the work"			3.2
20/4	SM	Mtg with assessment & reimbursement team	• team feel OP have improve rehab potential now • reimbursement monies are going into The Victory unit			3.2
21/4	SM	Better Care Higher Standards focus group	• grave concerns raised regarding services for dialysis patients • one woman spoke about her late husbands experience of services • she did not feel listened to by hosp staff/ nursing • she felt the quality of the care her husband rec'd was very poor		AD	3.2
09/05/05	DN/ME	Stroke meeting 12/04/05	Stroke coordinator - Graphnet IT system used to track patients.but has to use an aware list to find patients also are bleeped by wards to inform of suitable patients.			3.2
09/05/05	DN/ME	Stroke meeting 12/04/05	Local policy agreed for admission of stroke patients to A&E but no clear pathway ie ordering of scans, access to rehab beds. Some patients will always be outliers. Can only access CSRT via inpatient services. will get scanned within 24-48 hours but some patients will miss out. A number of patients are never admitted. Only 19 acute stroke beds – identified need			3.2

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			for 30. patients were meant to stay 7 days in acute stroke ward but not always possible as some are under 65 and have fewer onward options. Historical age limit on beds and also issue re geriatrician.			
09/05/05	DN/ME	Stroke meeting 12/04/05	May not get a multidisciplinary discharge if not on a stroke ward and equipment needs may not be assessed by a stroke specialist. No formal protocol for discharge of patients. Joined up working with social services and housing, link social worker to stroke wards. No psychological support for over 65 this is historical			3.2
19/05/05	ME	Telephone interview Dr Rogers	In his practice area there are no nursing homes so do have to travel to maintain a resident on his list, is willing to do this but thinks some aren't.			3.2
19/05/05	ME	Telephone interview Dr Rogers	Does use morphine to enable patients to remain at home at the end of their life but thinks some OOH doctor won't carry it to administer for security reasons so these patients may be admitted. Have good palliative care services with district nurses.			3.2
19/05/05	ME	PCT medicine mgt	Homes are encouraged to enter into an arrangement with a local community pharmacy to access information and advice about safe storage and recording of medicines. Independent inspection is not undertaken by the PCT			3.2
01 Mar	T Hutt	Self Assessment	*Home from hospital* is a service commissioned from the British Red Cross.	This requires further investigation.	S	3.3
02/03/05	ME	East Hamp PCT CGR report 2004	Concern from patients and relatives re standards of care in local hospitals. Confidentiality can be compromised due to nature of some facilities		Q	3.3
02/03/05	ME	East Hamp PCT CGR report 2004	Have worked with local partners on NSF and the acute trust to integrate elderly care pathway	No indication of stage this is at	AD	3.3

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13.04.05	BD	Inspection Reports Supporting People Programme Portsmouth City Council Dec 2004	128 sheltered housing services had developed information for services users explaining the aims and service standards. However in the inspection there were concerns that 'some service users appear to be judging the quality of the services on the basis of what support they actually receive, rather than an informed expectation of what they should receive. Further work could be carried out to raise services user's expectations.'	Q has this happened Is this a theme of service delivery	Q	3.3
18/4	**TH/BD**	Interview with representatives from the carers Centre.	carers report feeling pressurised to get partners out of hospital and into residential care. Generally respite care is available. there is a shortage of EMI respite care good communications with the council and they are represented on the older persons strategy group. Of a total budget of 707,000/260,000 is spent on older persons services. the general view of carers is that social work practice is good.		**AD/S**	**3.3**
13/4	SM	OP service users	Evidence of good attention to needs arising from race, ethnicity, linguistics		S	3.3
19/4	SM	South West cluster care mgrs & qualified s/w's	Direct payment officers have provided clarity about use of scheme		?	3.3
19/4	SM	Senior Housing officers	Aim to provide a range of flexible housing options for OP to choose from. CHOICE is important concept in strategic thinking			3.3
28.04.05	ME/CB	Chronic disease self management interview 13.04.05	Education package for newly diagnosed diabetics, relies on referrals from GP and other health professionals. Does cover the risk of strokes to this group of patients. No funding to link to other related programmes eg exercise for patients with angina. Many patients refered to hospital could be referred to them but not happening yet to increase awareness and self management thereby reducing future admissions.			3.3
28/04/05	ME/TH/SM	Interview 11.04.05 **Code A**	Have done some work on ethnicity, feels Portsmouth is hostile and low numbers from BME access services			3.3
4/05/05	ME	Continence service 20.04.05	Pathways in place and information sheets available.			3.3

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			High proportion of falls due to continence issues but have not been included in falls pathway.			
5/5/05	ME/BD	Elderly medicine visit and interview	End of life issues – in reach service, twilight, Ashdown 1 is for palliative care and Rowen unit, link with Mac Millan nurses. Since OOH contract it is easier for GP to send patient to A&E or MAU. Plan to have out reach nurses to enable patients to remain at home. Do see inappropriate admissions from nursing homes and GPs say they are reluctant to use morphine.			3.3
09/05/05	DN/ME	Stroke meeting 12/04/05	No dedicated TIA clinic, 2 clinics a week as part of older people clinics, identified need for 7 clinics. Not all GPs aware of clinics and some patients are falling through the net.			3.3
09/05/05	DN/ME	Stroke meeting 12/04/05	The CSRT has 10 patients at moment and is restricted by staff problems full capacity would be 18 patients. Stroke coordinator filters patients for them and are linking in with preventative work and falls.			3.3
09/05/05	DN/CB/BD	Stroke visits – REHAB TEAM12/04/05	3-4 week wait for SS package of care, rehab team is a point of contact post discharge, BP followed up by team, use voluntary sector – stroke clubs. Good access to urgent equipment eg hoist. Outflow of patients to rehab team rather than CSRT.			3.3
19/05/05	ME	Telephone interview Dr Rogers	The practise doesn't have a patient involvement group and not many have. Have talked about it and probably will when they move premises. A lot of patient information is available and do down load info for patients from EMIS and print it for them.			3.3
19/05/05	ME	PCT medicine mgt	Is it general practice in care homes to crush medication to enable medication to be administered-(product licence implications)? Homes encouraged to speak to local pharmacist to seek advice about whether this is appropriate or whether alternative formulation s required			3.3
19/05/05	ME	PCT medicine mgt	In your opinion is the use of PRN or as required medication medication appropriate and is clear guidance issued? (eg pain killers masking symptoms,			3.3

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			laxatives masking poor diet) Has no been formally audited. But this is a key target area for pharmacists to look at when undertaking basic medicines use review in care homes as part of the care home advice service			
11/4	SM	PCT Dir of service+ Assoc Dir OP and Promoting Ind	Patient experience- most OP do not want to go to Portsmouth hospital- OP like the Rembrant unit- very good service			3.5
28 Feb	T Hutt	Care management procedures (13/11)	Good ,comprehensive up to date procedures. The good practice boxes were especially impressive	Good procedures. Are they used in practice?	S/Q	4.1
28.02.05	ME	National sentinel audit of stroke 2004	A single set of notes for all disciplines is not used and there is no inter disciplinary care pathway. Protocols to measure impairments are used. No TIA protocols between primary and secondary care (only for stroke).	Can hinder communication and therefore patient care. Patients may receive variations to care	AD	4.1
29.02.05	ME	National sentinel audit of stroke 2004	Team meeting are held weekly, no input from dietetics or social worker, clinical psychology only available in rehab. Staff have access to evidence based care to inform their practice	Lack of input from specialties may be an issue. Staff should be able to keep up to date	Q	4.1
12/04	TH/SM	Social Care Case Files	Examples of good documents. City files checklists, permission to share form. Review comments form. Feedback and suggestions forms. Adult abuse monitoring form and team managers checklist.	Good documents	S	4.1
12/04	TH/SM	Social Care Case Files	Examples of multi-agency working throughout.	Joint working	S	4.1
12/04	TH/SM	Social Care Case Files	Files in good order.	Good CM procedures	S	4.1
12/04	TH	Social Care Case Files	Good, comprehensive carers assoc		S	4.1
13/14 04	**TH**	interviews with the care managers.	Care management of a generally high standard.		**S**	**4.1**
13/14 04	**TH**	interviews with the care managers	Assessments that promote independence and maintained the dignity of the service user.		**S**	**4.1**
13/14 04	**TH**	interviews with the care managers	Evidence of a carers Assessment that was both comprehensive and thorough		**S**	**4.1**
13/14 04	**TH**	interviews with the care managers	Line management both accessible and informed. Supervision regular and effective.		**S**	**4.1**
13/14 04	**TH**	interviews with the care managers	Evidence of a degree of mental health knowledge within the mainstream teams.		**S**	**4.1**

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20/4	**TH/SM**	Meeting with POVA.	There is a county level multi-agency management committee. At a local level there is an Adult protection committee which is chaired by a senior manager from social services. They had been difficulties in ensuring attendance. There is good working relationships at multi-agency level. The police have recently changed to a Community Support Unit in response to delays in the system. Last year there were 22 investigations of older persons. The department is unable to provide outcome reports because these have not been received back from the care management system. GPs are a sticking-point in that they will not follow up a place of safety if a client moves to another area. We need to clarify the PCT position. A recent study carried out by the PCT indicates that there is a variable awareness of POVA within health.		**s/ad**	**4.1**
20/4	**TH/SM**	interview with hospital social workers.	The help desk is located on the hospital site and receives approximately 20 to 30 referrals per day. They have a good working relationship with the out-of-hours service. And generally the services in the hospital work efficiently including referrals and communication with community services.		**s**	**4.1**
11/4	SM	PCT Dir of service+ Assoc Dir OP and Promoting Ind	No electronic solution for SAP			4.1
13/4	SM	OP service users	Assessments could be improved by further analysis and focus on desired outcomes Chronologies were not in use		AD	4.1
13/4	SM	OP service users	Use of information to share form on file was good		S	4.1
20/4	SM	Mtg with assessment & reimbursement team	• One direct point of access via a telephone number, access staff filter or signpost • 120-220 calls per day • 20 or 30 of those calls go to centralised duty	Effective access, assessment service, good level of joint working with health and appropriate levels of 'challenge' appear to exist	S	4.1
6/5/05	HDW/BD	EMH services visit and interview 18.04.05	Protocols for depression and dementia have been issued to primary care but no monitoring of them or auditing. Only care pathways for dementia and depression no plans for any others and unclear how they are used.			4.1

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09/05/05	DN/ME	Stroke meeting 12/04/05	FAST not used consistently in A&E or MAU or by ambulance. The stroke coordinator is trying to build up data set of patients after stroke register lapsed.			4.1
09/05/05	DN/ME	Stroke meeting 12/04/05	Patients notes are uni disciplinary but do write in each others notes therefore duplication			4.1
09/05/05	DN/ME	Stroke meeting 12/04/05	Stroke coordinator monitors quality with length of stay, uses outcome indicators and checks what assessments done. For 6 month assessment would need a community stroke coordinator and need GPs on board.			4.1
09/05/05	ME	Interview Dr Jarrett 12.04.05	No multi disciplinary notes, things are written in triplicate, OT having issues with electronic notes. Grahpnet only used in 2 PCTs			4.1
19/05/05	ME	PCT medicine mgt	Responsibility for medication review remains with GP. Practices are expected to include care home patients in these targets. We have provided incentives, support and encouragement to undertake these reviews but do not collect information about care home patients separately to overall QOF targets			4.1
19/05/05	ME	PCT medicine mgt	Some community pharmacists do simple medicines use reviews if they have an agreement with the home. May or may not involve service user directly depending on the individual circumstances. *GPs have overall responsibility for ensuring medication review*			4.1
01 Mar	T Hutt	Self Assessment	Through the Prevention Network voluntary organisations are able to support older people.	How does this work	Q	4.2
28.02.05	ME	National sentinel audit of stroke 2004	Patients and carers are given information about their condition and how to manage it but are not given national/local standards/guidelines	Although patients and carers have access to information and guidance they may not be aware of what they should be getting	AD	4.2
02/03/05	ME	East Hamp PCT CGR report 2004	PCT has analysed falls information and developed a strategy to reduce falls, concerns re manual handling after HSE notice	Issues re manual handling may be linked to staffing levels, availability of equipment and education	Q	4.2

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15/4	**TH**	interview with social care residential and domiciliary care providers.	Senior management changes haven't yet filtered down to their services although they report feeling supported by line managers. As part of quality monitoring they regularly "walk the floor" and encourage regular resident meetings. They sometimes feel that the assessments from the hospital staff do not adequately match the needs of clients. the provision of respite care has increased within the last 16 months. They are actively trying to encourage relatives to become volunteers within the residential units. They believe that CSCI are not consistent in their approach to inspection.		**S**	**4.2**
22/4	**TH**	**Service Manager/Disability**	**Code A** is also the Service Manager for clients with sensory loss of which 80 per cent are older people. There is a waiting list for equipment and he believes access could be improved. He also believes that the care management process has deskilled these areas.		**AD**	**4.2**
13/4	SM	OP service users	OP generally positive about their experiences	Good overall.		4.2
13/4	SM	OP service users	Most assessments were multi-disciplinary- assessments of a good quality overall OP had signed assessments/ care plan and had rec'd copies		S S	4.2
18/4	SM	Independent dom care providers	Carers given limited time to carry out tasks this can lead to basic quality issues not being addressed	Independent providers cannot pay for travelling time therefore carers are having to complete tasks quickly- this does impact on the quality of the care provided	AD	4.2
20/4	SM	Mtg with OT's health & SSD @ ST Mary's hosp	Op waiting total 100 people since Nov 04			4.2
20/4	SM	Mtg with OT's health & SSD @ ST Mary's hosp	• Again there are delays of 6 months for assessment and a further 3 months for the rail, for instance, to go up • Training and dev opps are felt to be very good			4.2
20/4	SM	Mtg with assessment & reimbursement team	• person centred planning is integral to teams approach • good use of eligibility criteria			4.2
28/04/	TH/ME	Interview Judy Hillier/ David	Feels there are culture and dignity issues in PHT			4.2

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05		Clements 11/04/05				
28/04/05	TH/CB/ME	Interview with PALS and PCC complaints and comms 14/04/05	In PCC ¾ of complaints re care packages due to budget, . PCC use balanced score card to monitor performance PALS pick up concerns re communication PALS survey most returned by elderly and most positive, send reports to board and all issues discussed at operationl level to ensure action. Problems accessing dentists.			4.2
5/5/05	ME/BD	Elderly medicine visit and interview	Ward visits at St Marys Exton 4 rehab - Light airy and spacious, no smell and clean plenty of showers/toilets. No MD notes except #NOF pathway. Patients are involved in care plans and discharge. Dedicated physio and OT. Dining room, day room, rehab room. Exton 7 – patients in large ward had no control over the music which staff leave on – lack of personal choice. Nurses station not in view of any beds.			4.2
6/5/05	HDW/BD	EMH services visit and interview 18.04.05	Inpatient- -2 wards at ST James – issues re access to bathroom/toilets though opposite sex wards. Continuing care ward is very poor facilities. Nursing care on wards appears to be very good. There are several routes for carers to gain support fromhealth social and voluntary sector. There is care and user representation at LIT and other groups and involvement in training of doctors and other staff (all this is above average) SS do offer routine carer assessments.			4.2
09/05/05	DN/ME	Stroke meeting 12/04/05	Patient experience group meets every 3 months and also stroke feedback sheet. Outcomes – activity trolley, perching stools in bathrooms, change of environment.			4.2
09/05/05	DN/CB/BD	Stroke visits – Geurnsey ward 12/04/05	Access to interpreting services. becoming more slow stream rehab as CSRT takes out fast stream. Will need more staff as patients will be more depandant. Do involve patients and carers in care. Have an activity therapist. Do home visits, weekend leave and phased discharges. Self medication on wards.and plan to have nurse prescribing.			4.2
09/05/05	DN/CB/BD	Stroke visits – Mary ward 12/04/05	Problem with A&E catheterising patients and agency staff in MAU need increased education of staff in MAU. Today have 4-5 patients on list to come to ward, take newest stroke first. Do less rehab on Mary ward than other stroke wards, the rehab room is also a linen and strore room, nuero gym is miles away. Not always aware of stroke outliers. Bladder scanners to assess retention.			4.2

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			Have family meetings on Wednesdays and consultant review at weekends.			
19/05/05	ME	PCT medicine mgt	Do service users in regulated services have a choice of pharmacy for receiving medication and pharmacy services? *In theory YES. In practice if homes contracts with paharamcy for advice and support (not all do) the likelihood is that all medicines will be dispensed by that one pharmacy.*			4.2
19/05/05	ME	PCT medicine mgt	Within regulated services do older people generally have the right to exercise choice re self medication? YES			4.2
19/05/05	ME	PCT medicine mgt	What is the general level of use of sedatives within care home settings? Data not available			4.2
13/4	SM	OP service users	Reviews were not always timely		AD	4.3
18/4	SM	Independent dom care providers	Dom care providers sometimes not invited to reviews			4.3
28.04.05	ME/CB	Ambulance interview 13.04.05	The ambulance service are slow in developing vulnerable adult guidance			4.3
4/05/05	ME	Continence service 20.04.05	Weekly clinic for referrals and physio. Are reassessing patients. Each DN team has a link nurse to do assessments. Training programme for staff in residential and nursing homes.			4.3
09/05/05	DN/CB/BD	Stroke visits – Mary ward 12/04/05	Improvements include – new seating systems, reflective sessions for staff, activity trolleys, ward clerk in charge of leaflets to ensure they are up to date.			4.3
19/05/05	ME	PCT medicine mgt	We do have a formulary but it is not "imposed" on prescribers. Prescribers are always encouraged to involve service users in decisions about what is prescribed for them			4.3
01 Mar	T Hutt	Self Assessment	Recently appointed non-executive directors and a council member have taken up portfolios to act as older person Champions.	Do these representatives meet together?	Q	5.1

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24.02.2005	ME	2003/04 Annual public health report, Portsmouth City PCT	This document is exclusively about children and young people.	No relevance .	Q	5.1
01/03/05	ME	Business case to develop a community stroke rehab team Aug 2004 East Hampshire PCT	Provision of 20 beds fast stream rehab and 18 slow stream rehab with low therapy input were proposed to change to 20 rehab beds and a community team funded by pay and non pay costs from closure of 18 beds. The CSRT would operate 7 days 7am-11pm. Therapy roles to be supported by stroke rehab assistants. GPs to provide medical care from discharge home.	Comprehensive business case with financial, activity, equipment and staffing information. Also contains referral criteria. Need to check if all proposals have been implemented	Q	5.1
02/03/05	ME	Screening outputs of NSF older people – Hampshire Ambulance	Scored poorly because of CGR report	Need to check progress	AD	5.1
02/03/05	ME	Performance rating 2003/04	Portsmouth Hospitals- 3*** but underachieved 4 hour wait in A&E and medium patient focus Ambulance trust – no stars significantly weak in financial mgt and improving working lives. Low on clinical and patient focus East Hamp PCT – 2** underachieved access to primary care professional, smoking cessation and 4 hour A&E waits, high for access to quality service and improving Healthcare Commission's Portsmouth city PCT – 2** underachieved 4 hour A&E waits, high for service provision, medium for access to quality service and improving health	Significant variation amongst providers, PCTs are similar		5.1
02/03/05	ME	East Hamp PCT CGR report 2004	Management is generally felt to be supportive but limited awareness of strategy and vision of PCT. Good relationships with GPs and much evidence of working with other partners in the local economy but some stakeholder would like to have further engagement and closer working		AD	5.1
02/03/05	ME	East Hamp PCT CGR report 2004	There is a joint review led by SHA to consider mgt capacity, financial position and service configuration cross the area. Are problems with quality, staffing and facilities within elderly mental health		AD	5.1
02/03/05	ME	NHS plan and LDP review – AC 2003/04	SHA did not have good overview of LITs and implementation of NSFs or what information they needed to do this	Not able to see if progress is on target	Q	5.1

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19/4	**TH**	Interview with councillors including representatives from the Labour group, Liberal-Democrats and the Conservatives.	The older persons champion has only been in post for six weeks. The relationship with the PCT is very good and there is a high level of co-oporation. Performance information is good and understandable. The performance reports are received every four months. There is a political consensus for decision-making. There is no older persons strategy for transport.		**s/ad**	**5.1**
22/4	**TH/SM**	Meeting with the leader of the council.	Budgets for social services have been protected this year. All monies have been parsported across to the Department. The Pompey pensioners' campaign group are used as a consultation group. The council and executive have discussed in the last six months home care payments and home closure. The council in general are moving towards more transparency in their process. The leader recognised that with diversity" there is more that we could do."		**s/ad**	**5.1**
28/04/05	ME/CB	CEO PHT Interview 13/04/05	Elderly are a priority in order to improve 4 hr waits. Did not hit 4 hr waits in A&E in Dec and called in the intensive support unit and johnathan Aashridge who recommended a whole systems approach. All CEOs have met and as part of recovery plan to get 4hr wait and elderly care pathway next week.			5.1
28/04/05	ME/TH/SM	Interview Margaret Geary 11.04.05	Directorate now includes housing as well as health and social care. Have a good stocktake of where OP services are and want to improve social care. Not afraid to be more imaginative. Relationships are good, sits on PEC Prevention team is good Mental health is more ahead with integration and need to learn from them			5.1
28/04/05	TH/ME	Interview Judy Hillier/ David Clements 11/04/05	3 GPs sit on PEC where clinical decisions are made. Margaret Geary sits on this from social care. Her remit now includes housing so much			5.1

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			improved. A lot of trust between organisations.			
28/04/05	TH/ME	Interview CEO PCC & PCT 11/04/05	Putting social care,health and housing together removes silos in council. Now more open eg corporate approach to the budget. Feel that mental health is a good model of integration to follow, have to work in partnership. Op are inherently in the planning documents but no sperate section for them but couldn't provide example of alcohol misuse work specifically for OP. have cross cutting agendas. Public health is joint staffed and shared budgets and history of joint initiatives.			5.1
28/04/05	TH/ME	Interview Code A 11/04/05	New to post as is Code A green papers recently published all provide opportunity to take stock. Need to raise profile of OP services and get balance of residential and domiciliary care.			5.1
6/5/05	HDW/BD	EMH services visit and interview 18.04.05	There is a LIT for the NSF but a 2nd draft strategy has not been developed. No attempt to carry out a population needs analysis. No evidence that whole systems issues and use of resources form a structured part of decision making.			5.1
09/05/05	DN/CB/BD	Stroke visits – Geurnsey ward 12/04/05	Feel strategic vision is not embedded in PCTs and that the stroke nurse consultant drives the vision.			5.1
19/05/05	ME	Telephone interview Dr Rogers	Feels the PCT is open and seeks views of GPs, there is a strong group of GP with reps from each practice that links to the PCT. The PCT chair chairs it bimonthly, the notice taken of the GPs is variable but it works well.			5.1
19/05/05	ME	Jane Williams telephone interview	Refocusing the leadership in PCTs has led to a dip in the joint strategy and there was a period of not knowing who would take decisions etc. there is discussion at district level on how to take it forward			5.1
01 Mar	T Hutt	Self Assessment	*Social services have a supervision process in place to ensure cases are discussed on a regular basis, risks identified and managed and contingency plans are put in place where*	What evidence is there for these statements?	Q/S	5.2

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			appropriate.			
01 Mar	T Hutt	Self Assessment	Core education and training needs of staff have been identified and P H T is currently implementing a project focusing on improving the skills and knowledge of multi-disciplinary clinical teams in areas where there is a high population of older people.	Staff feedback on effectiveness	S	5.2
24/02/05	ME	Portsmouth City Teaching PCT Clinical Governance Report July 2004	HR strategies in place, PCT is chair of the local workforce reference group to develop interagency workforce plans. There is a workforce planning steering group as part of the NSF local implementation team. There are some recruitment difficulties. Some team working with other agencies. Score of iii given. PCT committed to education and training and there is much available for staff.	No clear evidence of joint appointments with other agencies but staff are happy and supported.	AD	5.2
28.02.05	ME	National sentinel audit of stroke 2004	Staffing of nurses is higher than average especially care assistants but therapy staffing was lower. Higher than average junior doctor sessions in acute unit and less in rehab units, there is a consultant for 13 sessions. No named social worker to MDT. There is a stroke coordinator, specialist nurse and consultant nurse.	May be recruitment problems, need to check if care assistants take on therapy work. May not be enough medical input to rehab. These may also indicate poor use of beds. Nursing input may be good.	Q	5.2
02/03/05	ME	East Hamp PCT CGR report 2004	Concern re limited medical cover, high use of agency staff and continuity of nursing staff, review of staff levels and skill mix in elderly mental health are ongoing. 50% vacancy rate for consultants. Some staff in elderly mental health were concerned re team working and morale	Clear staffing and skill mix issues, they have a workforce strategy but not clear how it is being implemented or if there are financial restraints	Q	5.2
02/03/05	ME	East Hamp PCT CGR report 2004	The PCT works with partners to provide training. Some staff say difficult to access and attendance at mandatory training seems low but this may be with recording issues. Over half have PDPs	It is not easy to ensure that all staff are getting the training they need	AD	5.2
02/03/05	ME	NHS plan and LDP review – AC 2003/04	Lack of strategic overview means that WDC unable to ensure workforce issues are planned for to meet NSF requirements	Evidence elsewhere of staffing problems	Q	5.2
13/14 04	**TH**	interviews with the care managers	some disruption caused by vacancies with team managers.		**AD**	**5.2**

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15/4	**TH**	Interview with training and development staff from social care.	They try to take a holistic approach to training with links to Competency and national standards. They run a locality training group with independent providers from both residential sector and domiciliary care. They believe there is a culture of learning within the organisation which is supported by the director of social services. They have not experienced any real financial cutbacks. They are still able to provide backfill for training.. There has been a good take up by social care staff on the BA for vulnerable adults.		**S**	**5.2**
14/4	SM	Individual Social workers/care managers	Supervision & induction frequency and quality good		S	5.2
14/4	SM	Individual Social workers/care managers	Access to training good			5.2
18/4	SM	PCT T & D	aware of integration agenda	Overall, t & d appears good with some identified Ad's inc, linking training strategy to business planning process and addressing some of the variable quality of training. Joint training between H & SSD appears to happen albeit through default and not design..	AD	5.2
18/4	SM	PCT T & D	There are plans for 06/07 to create close alignment of training strategy with clinical governance and business planning process		AD	5.2
18/4	SM	PCT T & D	Current shared SLA for T & D (across Ports) is under review and need to move towards more locally based training needs Training needs of twighlight & sitting staff requires further attention		AD	5.2
18/4	SM	PCT T & D	Some T & D is of variable quality		S	5.2
18/4	SM	PCT T & D	Emphasis on practice based learning has supported change in culture Amongst NHS staff attitudinal changes are needed more than skills & knowledge		AD	5.2
18/4	SM	PCT T & D	Flexible funding arrangements for T & D has facilitated some training at Msc level			5.2

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18/4	SM	PCT T & D	Joint training happens but ? strategic intent. Seems to happen by default more than design		S	5.2
18/4	SM	PCT T & D	Adult MH have a far more integrated/ joined up approach to T & D			5.2
18/4	SM	Independent dom care providers	There is a desperate need to raise the profile of the carer		S	5.2
18/4	SM	Independent dom care providers	Carers have good access to T & D overall within PCT & PCC	Training gets a plus again		5.2
19/4	SM	South West cluster care mgrs & qualified s/w's	Supervision & support are very good Training & dev is a major bonus			5.2
19/4	SM	South West cluster care mgrs & qualified s/w's	Specialist MH training within the clusters would be good			5.2
19/4	SM	South West cluster care mgrs & qualified s/w's	There is a need to have additional mobiles to support health & safety also need effective back-up systems for when sw's are out on visits.			5.2
22/4	SM	Homecare Service visit & interviews	• Carers and managers have excellent access to T & D opportunities	Get the sense of a good effective homecare service	S	5.2
28.04.05	ME/CB	Ambulance interview 13.04.05	. SPOT training given to paramedics to identify strokes, use mobilmed to communicate from ambulance to A&E. emergency care practitioners are not well developed in Portsmouth. working closely with nursing homes re repeat fallers and link to CSCI and HSE.			5.2
28/04/05	ME/CB	CT scanning interview 13.04.05	Are some issues re experience and skill mix of radiology staff as many are new and less experienced			5.2
28/04/05	TH/ME	Interview Code A 11/04/05	EMH – capacity is an issue.			5.2
4/05/05	ME	Code A clinical nurse manager, HMS Kingston prison 15.04.05	Prisoners are moved from Portsmouth if they have poor health to a specialist unit. There is a healthcare unit in the prison with RGN and RMN and 3 GP sessions a week, visiting chiropodist, dentist and optician. To have 1 session of psychiatrist and psychologist. PCT is advertising 2 nursing posts and carrying out a needs assessment, service run by a clinical nurse manager			5.2
5/5/05	ME/BD	Elderly medicine visit and interview	Elderly medicine – 3 vacant consultant posts and also long term locums used. Aim to test a non medical consultant role on 2 wards as needs are often around complex rehabilitation and long term care needs.			5.2
6.5.05	ME	Telephone interview with				5.2

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		Code A re OOH	Recruitment and mentoring of doctors seems robust. Stable workforce of nurses used.			
6/5/05	HDW/BD	EMH services visit and interview 18.04.05	2 CMHT one with a substantive consultant lead the other with a locum. There are long standing recruitment difficulties. No dedicated clinical psychologists, OT or physio. Early onset dementia team p/t CMHN and f/t care worker with 40 cases – difficult to find residential or nursinghome placements.			5.2
6/5/05	HDW/BD	EMH services visit and interview 18.04.05	Training is available for staff in residential homes, alzheimers society and ad hoc for CMHNs. Difficult to recruit CMHN and also in social services.			5.2
09/05/05	DN/ME	Stroke meeting 12/04/05	Training – both formal and informal run 2-4 day courses and priority to stroke nurses. Do give training to residential homes if they request it.			5.2
09/05/05	DN/ME	Stroke meeting 12/04/05	Insufficient staff on acute wards use of locum and bank. The CSRT is 6 wte short but do have generic workers. Support workers on wards are all uni disciplinary. Stroke coordinator role is for 1 year and will have to prove she is worth investing in.			5.2
09/05/05	ME	Interview Dr Jarrett 12.04.05	Had a education programme and community based teaching when first started stoke unit and keep it going now with all junior doctor teaching. Have done some research projects.			5.2
09/05/05	ME	Interview Dr Jarrett 12.04.05	OT is an issue, miss the specialism and lost some good Ots, not sure how delays are being monitored with new system but they spend a lot of time on the raod.			5.2
19/05/05	ME	Code A telephone interview	There is an operational group set up at St Mary's to look at all issues and the rotation of consultants on a weekly basis is one of these issues.			5.2
19/05/05	ME	Jane Williams telephone interview	Staffing levels on the stroke wards were realigned after using the Nuffield dependency scale to assess staffing establishment. The sentinel audit found nursing levels a bit above average.			5.2
19/05/05	ME	PCT medicine mgt	Training and awareness on of falls has been provided for many care homes by local falls co-ordinator / expert. It hoped that if patient falls , care home staff will flag to GP possible need for mediciation review. It is a stated part of the district falls pathway that this should happen and we are exploring possibility of including this element in a Locally			5.2

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			Enhanced Service for falls.			
19/05/05	ME	PCT medicine mgt	Within regulated services are the staff administering medication receiving appropriate support and training? Working with Pan Hampshire group on training programme for care home staff. In addition working with Portsmouth City Social Services Department to provide medication awareness sessions fro a range of carers. to increase training provided *Advice and support available to are homes is patchy. Much more work to be done on training of care homes staff* The training sessions that are being introduced for care workers has involved close working with social service and the medicines			5.2
15/4	**TH**	Interview with care management team managers.	networking is encouraged. There is good senior management support and good peer support. Training is available. They have been operating the "balanced score card" system since September. They operate an audit of once per week of individual practice. They are developing the notion of mental health expertise across clusters. There is a shortage of EMI nursing care.		**S**	**5.3**

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22/4	**TH**	meeting with Code A responsible for the development of IT	There has been close working with health on the development of IT solutions and there is good networking. As of 06/07 the intention is to enable a" mobile access to information recording systems" in swift. An IT group has been created to develop links between SAP/ graphnet and swift. They are aiming for 2nd September 05 pilot interface. The budget is in place for all of the above. The financial interface for swift will occur on the 31st May. Swift is used by 50 percent of all local authorities and they have confidence in its software. Every social worker has access to a PC and makes use of the e mail system. There are problems in that people get swamped with e mails and reply to all. There can be issues of confidentiality with regard to personal data over the e mail system.		**s**	**5.3**
11/4	SM	Strategic director/head of service SSD	Move towards excellence- resulted in move from 13 depts, to 5 strategic directorates	Has this had any impact at op level ?	S	5.3
14/4	SM	Individual Social workers/care managers	Biggest bug bare currently is SWIFT		AD	5.3
14/4	SM	Individual Social workers/care managers	Managers have good visibility inc, senior ones		S	5.3
19/4	SM	South West cluster care mgrs & qualified s/w's	Strong peer & mgt support is a big plus in team		S	5.3
28.04.05	ME/CB	Older person project interview 13.04.05	The older persons project is aimed at staff who work with elderly patients on general wards within PHT to improve their behaviour and attitude towards them. Many methods for doing this which will be repeated to assess impact. Idea is to make improvements sustainable after the funding has run out.			5.3
6/5/05	HDW/BD	EMH services visit and interview 18.04.05	IT systems are not compatible in MH but awaiting developments within centrally driven IT project.			5.3
09/05/05	DN/ME	Stroke meeting 12/04/05	No overall manager for therapists. Now have Ots that follow patient and not based on dedicated ward (some still are) on mary ward can be 8 OT on the ward. Now not attending MDM and may not have experience to plan care, also now need computer referral to OT now causing timeliness issues. Also more travel time for OT so system is slower.patients may			5.3

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			wait longer for specialist assessment – no monitoring of this			
28 Feb	T Hutt	LDP (15)	Stated financial difficulties with ongoing investment in Stroke services including existing projects	Clarify financial position re LDP	Q	5.4
28 Feb	T Hutt	LDP (15)	Financial pressures or recovery plans are not detailed	Further information required	Q	5.4
01 Mar	T Hutt	Self Assessment	*Portsmouth City Council have made significant shifts in the purchasing budget. They have transferred monies from traditional services to stimulate preventive services.*	How much have they moved and what are the intentions?	Q	5.4
01 Mar	T Hutt	Self Assessment	The integrated community equipment store is pursuing a Section 31 pooled budget	How far has this progressed	Q	5.4
01/03/05	ME	Portsmouth city council SSD older person sector commissioning plan 2004-06	Reimbursement grant was reinvested in new services and incurred minimal fines. 1-2 people a week delayed discharges. Support worker appointed to expand direct payment scheme. To introduce single assessment 2004/5 and new referral criteria for OT. Other proposals in line with government initiatives . Have been overspend 02/03 but not clear how they are now going to fund new developments and existing services. Faster assessments are a target but not clear if these are being met.	Not clear how all will be funded and what activity levels will be. More detail regarding the budget needed	Q	5.4
02/03/05	ME	East Hamp PCT CGR report 2004	PCT is engaged in LIFT for a new local hospital to include elderly mental health		S	5.4

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EVIDENCE COLLATION

Last updated 12/01/2016

Date	Inspector	Source	Evidence / Findings	Conclusion / judgement	Provisional evaluation	Criterion
18/4	**TH/BD**	Interview with representatives of finance from the PCT	Of a total budget of 260 million there is a debt this year of 8.3 million . of this sum 2.4 million has been brought forward. Borrowing accounts for 2 million. And the rest is from existing efficiency targets. The PCT financial recovery plan involves investing in case management systems. Investing in a rapid response team. The rehab service moving towards a community based. General system improvement. Moving to "pay by results" Whilst there is good joint working the budget setting processes are still separate. Whilst there are section 31 budgets in substance misuse and integrated equipment they are not pooled but allowed delegated authority.. there has been a £1 million investment in contiuing care for the current client base. The reimbursement process has worked well and is being used to fund new services. The St Mary's diagnostic and treatment centre will open in December 2005. The PCT are evaluating their free nursing care costs with particular emphasis on the high category .		**AD/S**	**5.4**
11/4	SM	Strategic director/head of service SSD	2003/04 £3million deficit across AD & C&F 2004/2005- Adults and OP come in with slight _ in year			5.4
11/4	SM	PCT Dir of service+ Assoc Dir OP and Promoting Ind	£8.3 million health economy deficit As a PCT we will break even	? impact on SSD	AD	5.4
19/4	SM	South West cluster care mgrs & qualified s/w's	SWIFT is not user friendly			5.4
28/04/05	TH/ME	Interview CEO PCC & PCT 11/04/05	No idea of health economy debts as don't look at it this way but are aware of recovery plans and budget constraints.			5.4
28/04/05	TH/ME	Interview **Code A** 11/04/05	New financial system did not give enough detail, and was overspend, slight underspend in past year.			5.4

JOINT INSPECTIONS OF OLDER PEOPLE'S SERVICES 2004 –2005

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Date	Inspector	Source	Evidence / Findings	Conclusion / judgement	Provisional evaluation	Criterion
4/05/05	ME	Continence service 20.04.05	District wide service for continence, about 4000 patient 2/3 live at home, budget not set to cover this number. Monitor type of pad etc and stringent retrieval of pads Emphasis is on treatment rather than a pad service. Do fund nursing homes to buy pads but may change this to a delivery service to ensure quality of pad. .			5.4
14/04	TH	Interview comm/comp	Effective social care system for complaints.		S	5.5
13.04.05	BD	Inspection Reports Supporting People Programme Portsmouth City Council Dec 2004	12 The governance arrangements for Supporting People were poor which had an impact on the delivery of the programme, joint commissioning arrangements and partnerships 14 the governance arrangements at the time of the inspection would not enable the programme to be driven forward to improve shared housing, health, care and probation outcomes for vulnerable older people	Have these been resolved Are these trends	Q	5.5
11/4	SM	Strategic director/head of service SSD	Margaret Foster is OP champion			5.5
11/4	SM	PCT Dir of service+ Assoc Dir OP and Promoting Ind	PEC is central decision making body		?AD	5.5

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