Hampshire County Council

NOTICE OF MEETING

Meeting	Health and Adult Social Care Select Committee
Date and Time	Monday, 6th July, 2020 at 10.00 am
Place	Virtual Teams Meeting - Microsoft Teams
Enquiries to	members.services@hants.gov.uk

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

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

AGENDA

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

2. DECLARATIONS OF INTEREST

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

3. MINUTES OF PREVIOUS MEETING (Pages 5 - 16)

To confirm the minutes of the previous meeting.

4. DEPUTATIONS

To receive any deputations notified under Standing Order 12.

5. CHAIRMAN'S ANNOUNCEMENTS

To receive any announcements the Chairman may wish to make.

6. PROPOSALS TO VARY SERVICES (Pages 17 - 60)

To consider the report of the Director of Transformation and Governance on proposals from the NHS or providers of health services to vary or develop health services in the area of the Committee.

a. Modernising our Hospitals and Health Infrastructure Programme - Hampshire Hospitals Foundation Trust
b. Building Better Emergency Care Programme – Portsmouth Hospitals Trust

7. HAMPSHIRE AND ISLE OF WIGHT COVID-19 SYSTEM APPROACH OVERVIEW (Pages 61 - 174)

To receive an overview on the HIOW system approach to COVID and work completed as part of the Local Resilience Forum response.

To receive Trust specific written updates from:

a. Hampshire Hospitals Foundation Trust
b. Southern Health Foundation Trust
c. Portsmouth Hospitals Trust

8. PUBLIC HEALTH COVID-19 OVERVIEW, IMPACT ON HEALTH AND WELLBEING, AND OUTBREAK CONTROL PLANS (Pages 175 - 186)

To receive an overview on the three different aspects in relation to COVID-19: the pandemic context, the impact on health and wellbeing, and the development of Outbreak Control Plans.

9. ADULTS' HEALTH AND CARE RESPONSE AND RECOVERY (Pages 187 - 198)

To receive an overview of the response and support provided across the county of Hampshire to vulnerable residents and people supported by adult social care services and the moves toward recovery of our services and usual support services.

10. CARE HOME SUPPORT OFFER AND UPDATE (Pages 199 - 214)

To receive an overview of the progress of Covid-19 and its significant impacts upon the care home sector in Hampshire during the period March 2020 to 12 June 2020.

11. WORK PROGRAMME (Pages 215 - 230)

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

ABOUT THIS AGENDA:

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

ABOUT THIS MEETING:

The press and public are welcome to attend the public sessions of the meeting. The link to view the webcast will be published on the meeting page prior to the meeting. If you have any queries, please contact members.services@hants.gov.uk for assistance.

This page is intentionally left blank

AT A MEETING of the Health and Adult Social Care Select Committee of HAMPSHIRE COUNTY COUNCIL held at the castle, Winchester on Wednesday, 4th March, 2020

Chairman:
* Councillor Roger Huxstep

* Councillor David Keast
* Councillor Martin Boiles
* Councillor Ann Briggs
Councillor Adam Carew
* Councillor Fran Carpenter
Councillor Tonia Craig
* Councillor Alan Dowden
* Councillor Jane Frankum
* Councillor David Harrison
* Councillor Marge Harvey
* Councillor Pal Hayre
* Councillor Neville Penman
* Councillor Mike Thornton
Councillor Rhydian Vaughan MBE
* Councillor Michael White
* Councillor Graham Burgess
Councillor Lance Quantrill
* Councillor Dominic Hiscock
Councillor Martin Tod

*Present

Co-opted members
Councillor Alison Finlay

Also present at the invitation of the Chairman: Councillor Liz Fairhurst, Executive Member for Adult Social Care and Health, and Councillor Judith Grajewski, Executive Member for Public Health.

190. **APOLOGIES FOR ABSENCE**

Apologies were received from Councillors Tonia Craig, Rhydian Vaughan, and Adam Carew. Councillors Graham Burgess and Dominic Hiscock attended as deputies for Councillors Rhydian Vaughan and Tonia Craig respectively.

Apologies were also received from Co-Opted Members, Councillors Diane Andrews, Trevor Cartwright, and Rosemary Reynolds.

191. **DECLARATIONS OF INTEREST**

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

Councillor Dominic Hiscock noted that his wife is a consultant radiologist at University Hospital Southampton. The Trust were attending to present items 7b and 8a.

192. **MINUTES OF PREVIOUS MEETING**

The Minutes of the meeting of the Health and Adult Social Care Select Committee (HASC) held on 15 January 2020 were confirmed as a correct record and signed by the Chairman.

It was noted that when meetings have "Moved" after the date listed online, it can be confusing for the public and press. This is a known issue and currently being addressed.

193. **DEPUTATIONS**

Deputations were received from:

Item 6 (Orchard Close) --

Mr David Humphries (Carer)

On behalf of parent carers at Orchard Chose, David Humphries returned to address Members. He thanked Member for listening and unanimously making the right decisions. Carers save millions of pounds by continuing caring but continue to need the support of vital services. They are happy to work together with Hampshire County Council to protect these services and provide very good value for money.

Some carers were confused about the wording on the consultation which may be reflected in the percentages. While running with reduced services, carers want to better understand the impact on levels of service. Selling beds at other sites is a cautious estimate but can generate more revenue. Flexible staffing and using social care students could help further with staffing. Carers would like to build trust and transparency with management and the Council as work has begun setting up Friends of Orchard Close to secure a longer-term future and improve the already excellent services being provided. David thanked the Members for their time and their efforts.

Item 8b (Southern Health Foundation Trust) --

Mr Geoff Hill

Mr Hill wished to speak on Item 8 and specifically 8b, the Southern Health CQC Inspection Report. He drew attention to the independent report and limited public investigation, which led to NHS Improvements engagement. He felt the CQC had not accurately reported the work with families affected and that the family liaison officer had not been in touch with bereaved families. Mr Hill was offered an opportunity to act as a critical friend but direct engagement with the Trust stopped soon afterwards. He does not believe the Trust is well-led, that the Trust conducts needs reassessment and has concerns about issues

remaining unresolved and the leadership distancing itself from Trust failures. He noted systemic problems and the lack of following recommendations and learning from the Trust's failings.

Mrs Teresa Skelton

Mrs Skelton spoke about her negative experiences and concerns about the Police and psychiatric care provided by Southern Health. She had received help from Geoff Hill.

The Chairman noted her statement.

Item 9 (Adult Safeguarding) --

Mr Russell Stevens

Mr Stevens provided a deputation on behalf of himself and his wife regarding the safeguarding of vulnerable adults who need to be kept safe from harm. He had tried to raise concerns with individuals and agencies with little understanding or assistance, which included failure to adequately provide protection from abuse by the Hampshire County Council and appropriate action not being taken to understand and address concerns. He noted that a lack of adequate resources was being used as a defence. He noted that an independent regulator rather than self-auditing and regulation would better manage risks. Mr Stevens noted that he is standing in the Southern Health elections to be a public governor to help and do further work in this respect. He thanked Members for their time.

The Chairman noted that one other statement was emailed to Members directly as the deputation request was not received in time.

194. **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman made the following announcements:

A. Written Updates on Whitehill & Bordon Health and Wellbeing Hub and Details on Current Fiscal Arrangements for Out of Area Beds

Written updates had been shared via email on Whitehill & Bordon Health and Wellbeing Hub from South Eastern Hampshire CCG and details on current fiscal arrangements for out of area beds by Southern Health. Members did not raise any questions or concerns about these written briefings.

B. Dr Nick Broughton Leaving Southern Health

The Chairman noted that Dr Nick Broughton would be moving on from his leadership at Southern Health to his new role at Oxford Health NHS Foundation Trust.

C. Coronavirus Update

The Director of Public Health provided an update about COVID-19 being contained in Hampshire and the UK. Hand hygiene, where handwashing is more effective than using an alcohol-based gel and using disposable tissues and throwing them away, remains the main advice. Public Health is working closely with partners in emergency planners and critical authorities on this dynamic situation in Hampshire and the Isle of Wight.

195. **OUTCOME OF THE CONSULTATION AND RECOMMENDATIONS ON PROPOSED CHANGES TO HAMPSHIRE COUNTY COUNCIL'S LEARNING DISABILITY RESPITE SERVICES**

The committee received a report from the Director of Adults' Health and Care. Mr Humphries and the Orchard Close group were thanked for their deputation.

Members received a brief history of the proposals and overview of the report to the Executive Member of Adult Social Care and Health. Secondary consultations for considering other options for the future of Orchard Close were undertaken as well as extensive engagement and coproduction with the two working groups (included Members and carers) and Healthwatch, Carers Together and Speakeasy advocacy involvement.

Members heard that the two proposals outline a reduction of beds at Orchard Close and market capacity at 3 other respite services. Savings of £140million are still required with a reduction of 19% across service and a £55.9million reduction in addition to previous rounds of transformation. The findings of the 8-week public consultation and recommendations are before Members for scrutiny.

The target occupancy is 85% with safe levels of staffing at all times and reductions worked out on that basis. In addition to reducing beds, attracting more service during slower months is a priority. Based on the underoccupancy at 3 other sites, 25% of capacity will be marketed with an estimated income of £126,000 per annum. For equitable access at Orchard Close occupancy will be temporarily increased over 85% for summer months and booking groups together will be encouraged in quieter months.

With regards to the future of Orchard Close beyond March 2020, services will need to be reassessed regularly and no assurances of any respite services can be given beyond that date, given the current Covid19 pandemic. Changes to how respite is taken may be required as part of the process, matching requests against availability in an equitable manner while continuing to maintain a personalized and fair approach. In relation to the loss of expertise in terms of losing staff, only two members of staff would be impacted – one with a reduction in hours, another redeployed to fill another internal vacancy. There would be no staffing implications at any of the other locations and staffing impact would be mitigated because several posts are currently vacant.

The same rules and practices would be in place by Hampshire County Council care services for any external service users. The Council is being cautious and there will be minimal effect on Hampshire respite users. If the change is agreed, it would commence on 1 October 2020. Respite will be spread more

proportionately but remain the same amount and there will be no difference felt for any service users. Usage will be continually monitored with minimized impact for Hampshire residents. Equality Impact Assessments were completed for each individual proposal. Some shortfall would remain.

The Chairman thanked the officer-team for their ongoing efforts.
Members appreciated all the work being done but noted the lack of funding from the central government. Going forwards, including autistic service users in the proposals was requested by Members and noted by Officers.

In response to questions, Members heard:

For understanding the disruption of summer months, the 3-bed change has been modelled for minimal disruption and would not have a significant impact. Fair, equitable access and incentives would encourage bookings for low-season accommodation. For planned respite, bookings are made considerably in advance. There may be occasions with having higher requests than availability, not unlike other organizations but the impact would be managed, and other alternatives considered.

Hampshire County Council Care are Care Quality Commission regulated and managers are very familiar with looking at compatibility and person-centred care with similar needs and would only be commissioned from a different authority or provider. This already happens and is business as usual. There are no additional security concerns or escalation of risks by using market capacity.

A huge amount of work, thought, and care has gone into these recommendations and the impact will continue to be monitored.

Safeguarding responsibilities would remain the same and retained by Hampshire.

With regards to increasing bed occupancy sales, subject to getting there and establishing interest, this would continually be reviewed moving forwards. The department is deliberately cautious to mitigate the impact.

Officers are continuing to work closely with carers and making positive developments with the Friends of Orchard Close group. It has been a long process and engagement, and the recommendations do reflect it – the safety of loved ones have not been compromised and will not be.
Some facilities replaced older estates to reflect the needs of respite users who could not be accommodated elsewhere.

Members noted that in cuts to budget and further savings the most vulnerable people who need looking after can be affected. Members thanked the officers and wished to reiterate the lack of adequate funding to the central government, prioritizing fair, rather than equal funding reduction.

RESOLVED -

That the Health and Adult Social Care Select Committee:

Supported the recommendations being proposed to the Executive Member for Adult Social Care and Health in section 2 of the report.

196. **PROPOSALS TO VARY SERVICES**

Items for Monitoring

a. Orthopaedic Trauma Modernization Pilot (Hampshire Hospitals Foundation Trust)

Representatives from Hampshire Hospitals Foundation Trust confirmed that the pilot is 12 weeks into the changes and reported on progress to date from the 2 December reconfiguration due to end in March 2020.

Members heard:

The Trust is working closely with South Central Ambulance Service (SCAS) for transporting patients safely to sites.

There have been changes to processes and pathways to cope with additional demand and capacity. Models have been successful in predicting bed capacity.

Consultation exercises with staff highlighted concerns such as disruptions or changes to work location which have been addressed. The feedback now is positive with good working conditions, as well as supervision and training opportunities for junior work force. Successful recruiting of new staff has led to the highest staff in post for trauma staff.

A comprehensive dedicated system with specialist nurses, Hampshire County Council community partners, and Integrated Intermediate Care services has allowed for moving patients who need supported discharge and improvements have been noticeable.

The general election purdah effect was taken into consideration during the consultation. Outcomes of further consultation and engagement surveys will continue to be considered alongside collaboration with Healthwatch.

Transport was a concern and actions taken on that front, making sure up to date information is available to patients, carers, and families regarding changes in travel between Winchester and Basingstoke with clear signposting and robust ambulance coverage.

Previously, the quality of trauma and orthopaedic care and fatality rate was higher than the national average. There were long wait time issues, longer stays in hospitals, and cancellations during winter pressure periods.

Centralization was undertaken to address these issues. People can be treated quickly with access to the right surgeon for the right, timely treatment with better

outcomes. A dedicated rehabilitation unit provides further benefits returning patients to pre-trauma condition with reduced time in hospital.

Those in pain have not had planned operations cancelled as those beds have been ring-fenced. Emergency departments continue to carry on and only a small number of people need to be moved.
Looking at patient outcomes, times, and quality of care, data for the test period has been collated and reviewed with partners. The Trust is grateful for the support of patients, staff, and partner organizations.

RESOLVED -

That the Health and Adult Social Care Select Committee:

a. Noted the implementation update, engagement data, and current challenges as well as any recorded issues addressed and/or resolved
b. Requested a further update on outcomes in September 2020

b. Spinal Surgery Service Implementation Update (University Hospital Southampton)

Representatives from University Hospital Southampton provided an update on the transfer of elective spinal services from Portsmouth Hospital Trust in December 2018 and changes in the pathway.

In response to questions, Members heard:

Access to operation theatres remain a problem and one additional theatre has been added to manage the volume. Trauma has doubled since December and affects getting elective cases into the theatre. More work remains to be done.

Out of hours scanning allows more timely movement and care of patients but is not universal. Scans to confirm diagnoses are not always accessible or affordable.

Centres of excellence providing better care outweighs the distance travelled for care.

A new surgical colleague coming on board in March will help alleviate workload pressures and help address surgical capacity. Less complex cases will be directed to Salisbury.

GPs are the first call and have guidelines of service recommendations. While accessible services like physiotherapy would be a useful investment in prevention to reduce the need of operations, time with therapist is short but the patient must do the exercises. An education program is ideal, but many patients don not use the exercises. There are first lines of treatment available and people are told if they do no need operations.

Recruitment and retention of surgeons are not currently issues, but balancing nursing staff across departments can be. There is a level of autonomy with

running a spinal practice and recruitment and retention are positive but varies in other parts of the organization. Overseas hiring, other incentives, valuing staff, and maintaining the education budget have had a positive impact.

Audits are considered business as usual and the staff score high on sending their friends and family to the hospital.

RESOLVED --

That the Health and Adult Social Care Select Committee:

a. Noted the progress update and current operational challenges as well as any recorded issues addressed and/or resolved
b. Requested a written update on outcomes in September 2020

A 10-minute comfort break was taken at this time.

197. **ISSUES RELATING TO THE PLANNING, PROVISION AND/OR OPERATION OF HEALTH SERVICES**

a. CQC Inspection Update from University Hospital Southampton Foundation Trust

Representatives from University Hospital Southampton provided an update on the action plan, must do items, and range of actions to be completed by April 2020.

Members heard that the Trust's overall rating was "Good", and areas of improvement are being addressed by working differently and prioritizing patient driven care. Posts are being filled timely and updates made to the facility.

In response to questions, Members heard:

Wait time for consultants is being addressed alongside keeping patients informed so they are aware.

Improvements in outpatient care requires more work to be done and expected to be addressed by next year's inspection.

Infection control remains above national average and assurances are easier for newer estates.

Nursing leadership been updated, and exemplary committed teams are in place with the best interests of patients in mind and are being nationally recognized with awards.

Members commended the improvements in service provisions for the ophthalmology department. Monitoring of services continue, and efforts are being made to not shift the bottleneck into surgeries.

RESOLVED -

That the Health and Adult Social Care Select Committee:

a. Noted the findings of the latest CQC inspection report for the Trust and the improved rating of “Good”
b. Noted the approach of the Trust to respond to the findings
c. Requested a further update in September 2020

b. CQC Inspection Report from Southern Health NHS Foundation Trust

Representatives from Southern Health NHS Foundation Trust provided an update regarding their October 2019 CQC inspection and the four core services reviewed.

Members heard:

The most recent report reflected positive changes, but the Trust are not complacent and a lot more work remains to be done. Workstreams are being led by Trust leadership and clinicians with an equality improvement plan in place. Listening to feedback from service users, patients, and families and with their support, improvements can be made with the efforts of compassionate and passionate staff for better services.

Members noted:

While mental health services do not receive adequate services as their physical counterparts, serious issues such as patient notes, infection control, access, etc. should not be on this list. These must-dos should have already been addressed.

Certain concerns are not systemic but can stem from individual cases on individual wards, but some are issues across the NHS. In some cases, the errors are administrative, and policies are not updated in a timely manner before inspections.

In response to questions, Members heard:

There is a constant process of learning, training, evidence-based practice, and taking feedback seriously. The Trust follow up with individuals and update processes as needed.

The Trust use a proactive program where to engage with users and community services to listen to people’s views and opinions.

RESOLVED -

That the Health and Adult Social Care Select Committee:

a. Noted the findings of the latest CQC inspection report for the Trust and the improved rating of “Good”
b. Noted the approach of the Trust to respond to the findings

c. Requested a further update in September 2020 with specific attention to engagement and addressing concerns with the Chief Executive in attendance

c. CQC Inspection Report from Portsmouth Hospitals NHS Trust

Representatives from Portsmouth Hospitals Trust presented their improved rating and noted that they were experiencing similar challenges faced by other Trusts. Members heard that meeting required issues on a timely basis has been a Trust priority and further work continues.

In response to questions, Members heard:

There has been less dependency on agency staff and international hiring from countries with similar training programmes has helped though currently it is less attractive to work in the UK.

Services for children and young people were not inspected but work to address concerns from 2018 has taken place.

Approximately a third of the must dos are isolated incidents rather than systemic issues. A high level of reporting and low level of harm is ideal with over 95% of staff having had statutory mandatory training packages.

Further information and details can be found on Trust website.

Members commended the improved rating, appreciated responsiveness to resident concerns and noted the excellent work being done even under great pressures.

RESOLVED -

That the Health and Adult Social Care Select Committee:

a. Noted the findings of the latest CQC inspection report for the Trust and the improved rating of “Good”
b. Noted the approach of the Trust to respond to the findings
c. Requested a further update in September 2020

The Chairman invited the Chief Executive to attend the September HASC.

d. CQC Inspection Update from Frimley Health NHS Foundation Trust

The presenter for this item was unable to attend due to an emergency Covid19 planning meeting.

RESOLVED -

That the Health and Adult Social Care Select Committee:

Noted the update from the Trust and requested a further update in September 2020.

198. **ANNUAL HAMPSHIRE SAFEGUARDING ADULTS BOARD REPORT**

The Director of Adults Health and Care, interim chair of the Hampshire Safeguarding Adults Board, provided an annual update for the 2018-19 business year.

Members heard:

The report sets out details regarding delivery against the necessary elements.

An independent scrutiny function is being put in to oversee and challenge the work undertaken by the board which will address the concerns noted by one of the deputations. The Board is keen to take this action and this independent scrutiny function will add another level of audit to the process.

Lower numbers of referrals are being maintained, but there has been a higher percentage of Section 42 investigations. Slightly fewer referrals have been converted into formal inquiries and 2 out of 10 referrals go to a formal review.

The Board is working to review and challenge multiagency arrangements and prevent multiagency failure. Learning across the partnership continues while collectively and individually providing support and challenge to each other.

Concerns are addressed by the original organization and they are held to account. Safeguarding is everyone's business.

Hampshire Constabulary act proactively and diligently in terms of learning and addressing issues that need to be taken forward.

The Board must provide a vital safety net and are working to respond better, earlier in the process - upstream and in collaboration with service providers.

Hampshire remains marginally above the national average.

Cllr Grajewski left the meeting at 13:36.

In response to questions, Members heard:

The goal remains seeking to prevent the thing that did happen, but there is often media attention when organizations get this wrong. Positive messages and stories are often not shared to protect identities.

There are civil, criminal, and reputational consequences from media attention that can damage relationships with partners and public trust.

Neglect or act of omission is failure to do something that could have been done.

It's possible that comes cases are not reported as they remain private matters.

Patterns of service delivery are looked at and work with partners continue from all vantage points and activities to get a view to ensure there is no stone left unturned.

Adults Health and Care, Police, and CCGs are statutory members but there are a large number of associate members (including advocacy, carer organizations, and key delivery partners) and all have an equal opportunity to speak.

Members commended the work of the Board and the steps taken to be independently scrutinized. Annual reports going forwards would include a statement from independent scrutineer.

RESOLVED -

That the Health and Adult Social Care Select Committee:

a. Noted the content of the annual report, and
b. Endorsed the further work in support of the HSAB strategic plan

199. **WORK PROGRAMME**

The Director of Transformation and Governance presented the Committee's work programme.

The Chairman requested any suggested items be emailed in for consideration.

RESOLVED -

That the Committee's work programme be approved, subject to any amendments agreed at this meeting.

The meeting closed at 13:45.

Chairman,

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date of Meeting:	6 July 2020
Report Title:	Proposals to Develop or Vary Services
Report From:	Director of Transformation & Governance

Contact name: Members Services

Tel: 0370 779 4072 **Email:** members.services@hants.gov.uk

Purpose

1. The purpose of this report is to alert Members to proposals from the NHS or providers of health services to vary or develop health services provided to people living in the area of the Committee. At this meeting the Committee is receiving updates on the following topics:

   a. Modernising our Hospitals and Health Infrastructure Programme - Hampshire Hospitals Foundation Trust
   b. Building Better Emergency Care Programme - Portsmouth Hospitals Trust

Summary

2. Proposals that are considered to be substantial in nature will be subject to formal public consultation. The nature and scope of this consultation should be discussed with the Committee at the earliest opportunity.

3. The response of the Committee will take account of the Framework for Assessing Substantial Change and Variation in Health Services (version agreed at January 2018 meeting). This places particular emphasis on the duties imposed on the NHS by Sections 242 and 244 of the Health and Social Care Act 2006, includes new responsibilities set out under the Health and Social Care Act 2012, and takes account of key criteria for service reconfiguration identified by the Department of Health.

4. This Report is presented to the Committee in three parts:

a. *Items for action:* these set out the actions required by the Committee to respond to proposals from the NHS or providers of health services to substantially change or vary health services.

b. *Items for monitoring:* these allow for the monitoring of outcomes from substantial changes proposed to the local health service agreed by the Committee.

c. *Items for information:* these alert the Committee to forthcoming proposals from the NHS to vary or change services. This provides the Committee with an opportunity to determine if the proposal would be considered substantial and assess the need to establish formal joint arrangements

5. This report and recommendations provide members with an opportunity to influence and improve the delivery of health services in Hampshire, and to support health and social care integration, and therefore assist in the delivery of the Joint Health and Wellbeing Strategy and Corporate Strategy aim that people in Hampshire live safe, healthy and independent lives.

Items for Monitoring

The recommendations for each topic are also given under the relevant section below, regarding each item being considered at this meeting:

6. **Modernising our Hospitals and Health Infrastructure Programme - Hampshire Hospitals Foundation Trust**

Context

7. In October 2019, the government announced its Health Infrastructure Plan, a long-term, rolling five-year programme of investment in health infrastructure, including capital to build new hospitals, modernise primary care estate, invest in new diagnostics and technology, and help eradicate critical safety issues in the NHS estate. Hampshire Hospitals NHS Foundation Trust (HHFT) is part of phase 2 of this plan and has been given £5m seed funding to produce a Strategic Outline Case by 2022. It is anticipated that further funding will be released to produce an Outline Business Case and Full Business Case, with the aim of being able to build between 2025-2030.

HHFT are working with its health and care system partners as part of the Hampshire and Isle of Wight (HIOW) Sustainability and Transformation Partnership (STP), and North & Mid Hampshire Integrated Care Partnership (ICP), the Partnership of Clinical Commissioning Groups and West

Hampshire Clinical Commissioning Group (together referred to as CCGs) on this goal.

Recommendations

8. That the Committee:

- Note the report, engagement plan, and current challenges as well as any recorded issues addressed and/or resolved,
- Make recommendations as necessary, and
- Request a further update in November 2020

9. Building Better Emergency Care Programme - Portsmouth Hospitals Trust

Context

10. The ED at the QA site is 40 years old and was not designed for the number of patients the Trust now sees. Last year there were 16,000 more attendances than there were five years ago, and current projections show demand continuing to increase by 3% each year. The constrained size and layout of the ED limit the Trust's ability to make improvements in the way care is delivered and to implement best practice. In addition, the physical condition of the department does not provide a good enough experience for patients, visitors or staff.

In recognition of these challenges, and with the support of local partners and stakeholders, the Trust was awarded a £58.3m investment for new emergency care facilities at QA as part of the NHS England Wave 4 Sustainability and Transformation Partnership capital allocations, subject to standard business case approvals.

Recommendations

11. That the Committee:

- Note the report, engagement plan, and current challenges as well as any recorded issues addressed and/or resolved,
- Make recommendations as necessary, and
- Request a further update in November 2020

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

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

Other Significant Links

Links to previous Member decisions:	
Title Proposals to Vary Services	Date April 2019, May 2019, July 2019, September 2019, January 2020, March 2020
Direct links to specific legislation or Government Directives	
Title	Date

Section 100 D - Local Government Act 1972 - background documents

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

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. **Equality Duty**

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

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

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

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

2. **Equalities Impact Assessment:**

This is a covering report which appends reports under consideration by the Committee, therefore this section is not applicable to this covering report. The Committee will request appropriate impact assessments to be undertaken should this be relevant for any topic that the Committee is reviewing.

This page is intentionally left blank

Hampshire Together
Modernising our Hospitals and Health Services

Committee:	Health and Adult Social Services (Overview and Scrutiny) Committee
Meeting Date:	Monday 6 July 2020
Title:	**MODERNISING OUR HOSPITALS & HEALTH SERVICES (MOHHS) PROGRAMME**
Report From:	Shirlene Oh, Director of Strategy, Dr Lara Alloway, Chief Medical Officer & Elliot Nichols, Associate Director of Communications and Engagement - Hampshire Hospitals NHS Foundation Trust

1. BACKGROUND

In October 2019, the government announced its Health Infrastructure Plan, a long-term, rolling five-year programme of investment in health infrastructure, including capital to build new hospitals, modernise primary care estate, invest in new diagnostics and technology, and help eradicate critical safety issues in the NHS estate. Hampshire Hospitals NHS Foundation Trust (HHFT) is part of phase 2 of this plan and has been given £5m seed funding to produce a Strategic Outline Case by 2022. It is anticipated that further funding will be released to produce an Outline Business Case and Full Business Case, with the aim of being able to build between 2025-2030.

HHFT are working with its health and care system partners as part of the Hampshire and Isle of Wight (HIOW) Sustainability and Transformation Partnership (STP), and North & Mid Hampshire Integrated Care Partnership (ICP), the Partnership of Clinical Commissioning Groups and West Hampshire Clinical Commissioning Group (together referred to as CCGs) on this goal.

2. CHALLENGES

The four key drivers for change are:

Our Changing Population
Our population is growing in two ways. Estimates show that the population served by Hampshire Hospitals NHS Foundation Trust could increase by 9.6% over the next decade and by 23% between 2018 and 2050. But our population is also aging rapidly. The predicted growth in the over 75s in Hampshire between 2017 and 2024 is 35%. And it is well documented that older people require more healthcare. This trend is particularly noticeable in Basingstoke as the town expanded rapidly in the 1960s and 1970s and the young families who moved there, then, are now reaching older age.

Clinical Sustainability
It is critical that our clinical services not only deliver outstanding patient care but that they are sustainable. This means that we need to be sure we can provide them consistently and predictably so that people know they can trust and rely on them. It also means that services are able evolve to take advantage of new technology or adapt to a new challenge. However, to achieve this some very difficult decisions will need to be made about what services we provide and where.

Condition of our Estates
All of the Trust's hospitals require a significant amount of urgent maintenance. The current estimate of the cost to make the improvements needed to bring the buildings up to the standard required to support services as they are delivered at the moment is £73 million; more than three times the national average.

Moreover, it would require more than £700m in maintenance spend to keep the buildings functioning over the course of the next 30 years. This is simply unaffordable.

The Trust is committed to both reducing its carbon footprint and expanding its use of digital technology. Unfortunately the age, condition and design of the current buildings often stops such projects in their tracks or means they deliver less than was intended.

Finally, it is vital that all the different strands of care - community services, mental health, primary care etc. - are able to be as joined up as possible. The current estate is a barrier to this becoming a reality due to its design, condition and structure.

Financial Resilience
The way we currently deliver care and treatment costs more every year and will continue to do so as we try to keep up with technological advances, population growth and the fact that medical advances and lifestyle changes mean that more of us will live much longer than our grandparents had expected to. This final point is clearly something to celebrate, but it does mean that there are a larger number of frail, elderly people requiring our help than our health system was designed for. The local health system struggled financially in 2019/20, with Hampshire Hospitals in particular ending the year in a deficit.

3. GOVERNANCE & ORGANISATION STRUCTURE

The governance and organisation structure is attached in Appendix 1.
The governance structure takes into account the legal accountability of HHFT, the CCGs, as well as the transformation that is taking place in system governance at both the STP and North and Mid-Hampshire levels. Systems governance has been discussed with system partners. It also considers learning from engaging system partners and stakeholders from previous Critical Treatment Hospital and Transforming Clinical Services programmes.

HHFT's approach to managing this programme is to develop a core in-house team, supplemented with expertise and capacity from consultancies as required.

Design of services fit for the future will be a key driver for this programme. The clinical services and patient pathway team members will include doctors, nurses, allied health professionals, community, primary care and mental health practitioners. This team will be supported by quality improvement and innovation resources.

Terms of Reference are available for the Steering Groups, Programme Teams and workstreams.

4. CLINICAL VISION

Our vision is for our health and social care services to provide outstanding care for all our people within north and mid Hampshire:

- All health and social care services will work together to deliver the best care for our people
- People will have easy, timely access to the help and support they need
- Services will be designed to meet their requirements
- Services will be sustainable, efficient and high quality; with a focus on delivering the best clinical outcomes possible
- Where practical, care will be provided in people's homes or as close to them as possible
- People will be empowered to self-manage wherever they can, with the information and support required to do so; including access to diagnostic tests and specialist advice when needed
- Where necessary, services will be centralised to ensure the best possible care and outcomes
- We will be able to live within the money allocated to our area; reducing duplication and inefficiency

- We will ensure our healthcare facilities are accessible, fit for purpose and improve a sense of wellbeing for those using them and working there
- Our services will attract the best staff, being renowned for high quality, innovation, research and training support

5. TIMELINES

The high level timelines is attached in Appendix 2. Although timelines for HIP funding for phase 2 hospitals are planned for 2025-2030, the ambition to complete the Full Business Case and to begin construction by 2024. Timelines attached reflect this ambition.

6. STATUS

The Trust has been awarded £5m of seed funding to deliver a Strategic Outline Case (SOC). Work has been progressed on site options, public engagement, health planning on clinical services and capacity modelling, workforce, finance and estates.

7. COMMUNICATIONS & ENGAGEMENT

As part of a joint communications and engagement plan 'formal' engagement was commenced on 1 June with a well-attended (106) launch conference and will run up until the 31 July.

This will comprise of over 40 events, ranging from focus groups, public meetings, NHS staff and governor briefings, elected member forums and more. Events will be hosted by presenters from across the NHS system.

Due to COVID-19 these events will be run digitally - though the decision was made to increase planned (print) newspaper advertising by 800% in an effort to ensure accessibility for those who are not able or who prefer not to use digital means. Throughout every effort will be taken to ensure hard to reach groups and those with protected characteristics - as well as past, present and likely future service users - are engaged fully and equally.

In order to prepare for the engagement period a significant quantity of collateral was produced. Including but not limited to:

- An interactive microsite
- An engagement animation
- Social media profiles and content
- Press releases
- A listening document - setting out the challenges and aims of the programme
- A resource pack to assist with localised focus groups

Extensive stakeholder mapping has also been undertaken to ensure ideas and views are gathered from across the community - though this remains a 'living document' which will be added to on a rolling basis.

Initial (as of 24 June) responses to the call for feedback has been positive and reasonably well attended; though we are taking steps to enhance numbers over the next few weeks.

Once complete, a full independent analysis of the engagement responses will be undertaken in August ahead of a formal engagement report being published. It is currently anticipated that further focus groups will continue as until the start of consultation.

The communications and engagement plan is attached in Appendix 3.

The patient, staff and stakeholder advisory group was launched in June and has now met twice - feedback from the group is presented to the system steering group. The terms of reference is attached in Appendix 4.

8. SYSTEM ENGAGEMENT

The system will be engaged through:

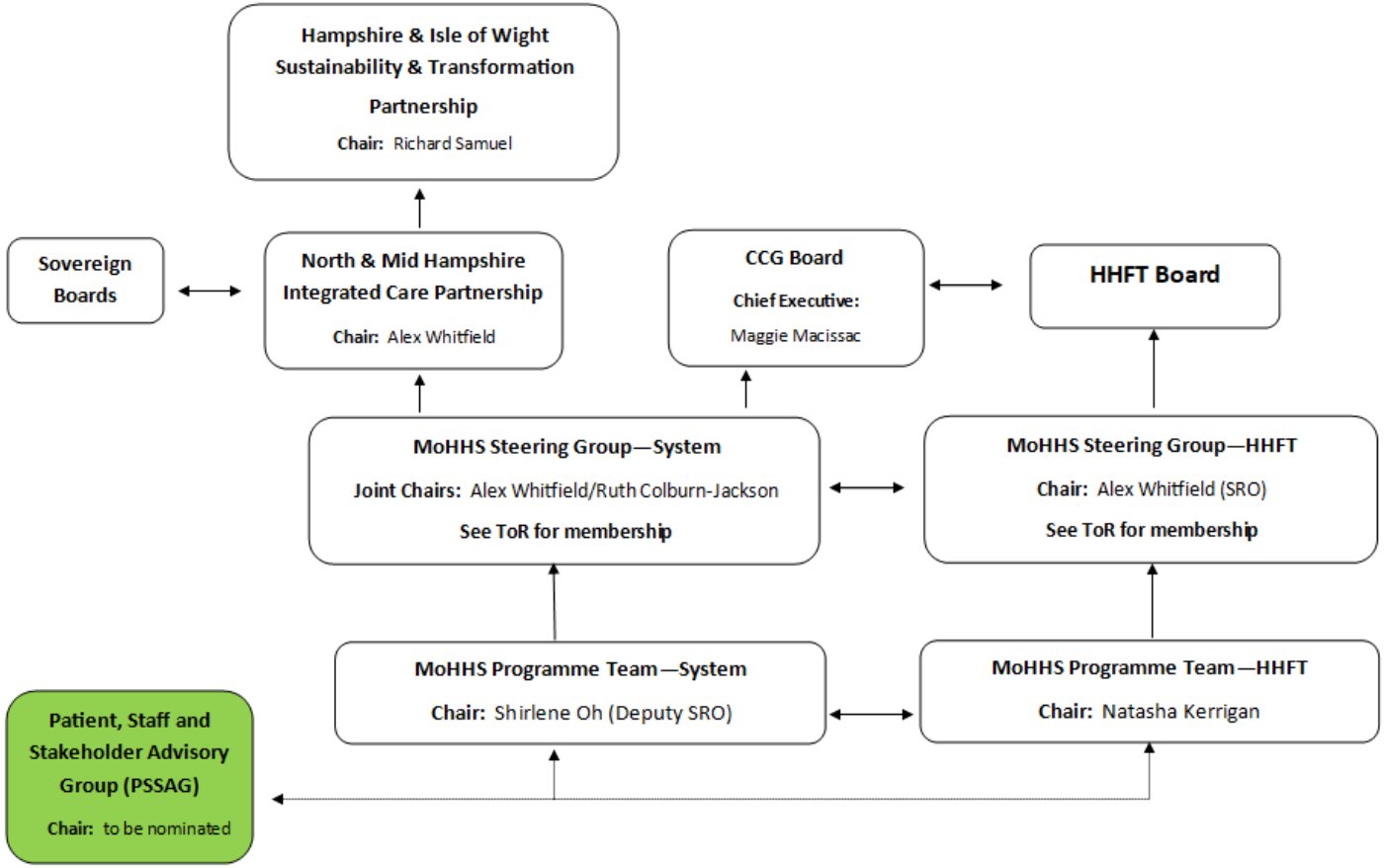
a. The governance structure with oversight at STP, the North and Mid Hampshire Integrated Care Partnership Board and representation at the System Steering Group, System Programme Team as well as through relevant work streams.
b. The Patient, Staff and Stakeholder Advisory Group (PSSAG) to offer advice, views, suggestions and opinions to this programme through regular meetings.
c. Participating in relevant workstreams
d. Events arranged for wider system engagement beyond the governance of the programme to include staff from partner and stakeholder organisations, patients and families and members of the public.

Partners are requested to provide input on how they wish to be involved in the programme.

Hampshire Together

Modernising our Hospitals and Health Services

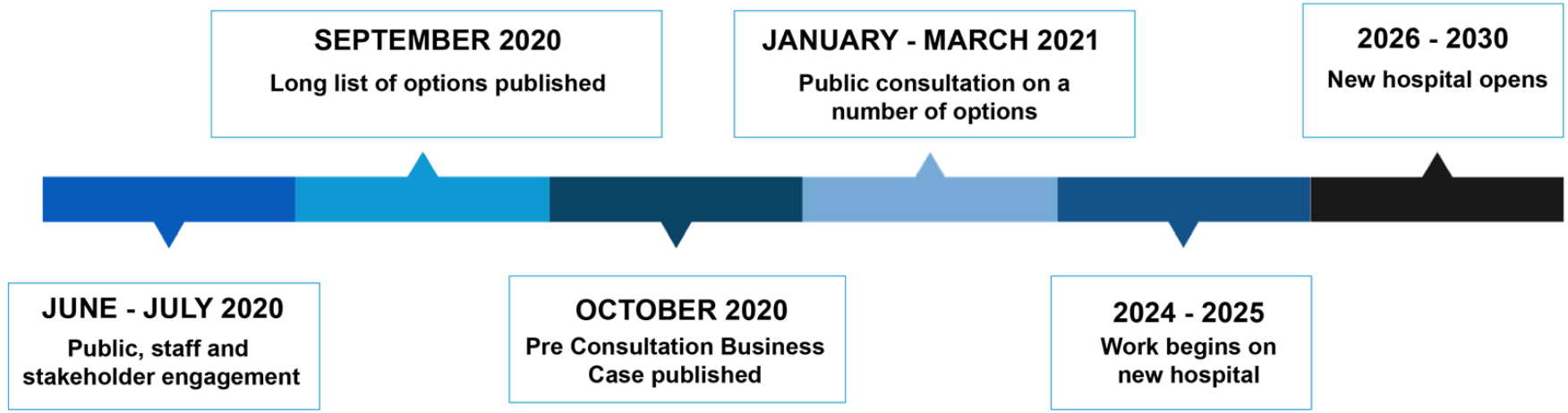
Appendix 1. Governance Structure



Hampshire Together

Modernising our Hospitals and Health Services

Appendix 2. Timelines



Hampshire Together
Modernising our Hospitals and Health Services

Appendix 3. Communications and Engagement Plan

Modernising our Hospitals: Communications and Engagement Plan

Investing in care - together

1. Issue and Context

The health and care system across North & Mid Hampshire has - in conjunction with other key partners - been set six ambitions for the next five years and beyond to support patients, their families and/ or their carers to access the right care, in the right place, at the right time in order to keep them healthy.

An integral part of this model is to modernise the hospitals of Hampshire Hospitals NHS Foundation Trust (HHFT) as part of the governments Healthcare Infrastructure Plan (HIP). It is intended that this investment be fully in line with the aims and objectives of the Hampshire and Isle of Wight Sustainability and Transformation Plan (STP).

There are a number of strategic, structural, commercial, and financial considerations driving the modernisation; on top of the overarching healthcare delivery and outcome factors.

Namely:

- Changing **demographics** and new housing developments leading to a growing population - estimated at 9.6% over the next decade
- The general **condition** of Hampshire Hospitals NHS Foundation Trust's (HHFT) estate, with an estimated £275 million investment being required to support a further extension of the service life at the Basingstoke (BNHH) site alone
- To **align** with local government strategies on infrastructure, transport, climate and sustainability
- To **align** with the NHS Long Term Plan; in particular the drive towards a system based approach to delivering healthcare
- To provide an **enhanced** working environment for staff - facilitating professional and personal development
- **Modernise** the facilities at HHFT for the benefit of the whole NHS - focusing on integrated care, seamlessly bringing together health, social care, the community, health and wellbeing promotion and prevention, research and new technology

In terms of context it is important to note that this proposal comes on the back of the decision in 2017 to not proceed with the previously proposed Critical Treatment Hospital (CTH). Although this project is significantly different to the CTH important lessons have been learned regarding the process required.

2. Programme Structure

Communications and engagement will proceed in four distinct phases (dates are estimates based on information correct at the time of drafting - June 2020):

- **Pre-engagement** - informal process with establishment of key bodies and structures; notably the Patient, Staff and Stakeholder Advisory Group (PSSAG) a draft terms of reference for which can be found below.

  It is designed to establish a baseline of public, patient, stakeholder and staff attitudes/ priorities towards healthcare infrastructure investment.
  - February to April 2020
  - Report on results and findings April 2020

- **'Full' engagement** - a more formalised engagement round with stakeholders, public, patients and staff building on the baseline established in pre-engagement but with a more targeted focus on scenarios as laid out in and Listening paper
  - May 2020 Listening paper published setting out a range of considered scenarios
  - June and July 2020 intensive formal engagement
  - Report on results and findings August 2020

- **Formal public consultation** - legally governed 12 week procedure initiated if the Health and Scrutiny Committee of Hampshire County Council deems a proposed service change to be a 'significant variation'.

  It is managed by the CCG - it is the current working assumption that consultation will be required.
  - January to March 2021
  - Report on results and findings July 2021

- **Development** - on-going programme of communications and feedback during design and construction; carrying on into opening
    - August 2021 to 2023 (TBC)

3. Objectives

The key objectives of this plan are to:

- **Communicate** the challenges, opportunities and scenarios presented by the Modernising our Hospitals and Health Services (MoHHS) programme
- **Share** the vision, concept and goals behind the programme with the Trusts staff, stakeholders, partners, patients and residents
- **Encourage** those same groups to become part of the programme - imparting their views, ideas and aims - and to scrutinise both the process and outcome
- **Incorporate** the results of engagement into the decision making process
- **Support** the development of an on-going culture of engagement on the future provision of care
- **Ensure** that no group or audience is left unheard; placing inclusivity at the heart of the programme in line with both the Trusts and wider NHS values
- **Promote** the active involvement of NHS staff from across the Trust and wider healthcare ecosystem
- **Enable** the programme team to respond to changing public or stakeholder concerns
- **Facilitate** the development of clear scenarios for engagement and (ultimately) options for formal public consultation

And ultimately:

- **Support** the successful design, construction and opening of a new major hospital and complimentary healthcare system.

4. Vision & Narrative - moving forward together

It is critical that the following factors are taken into consideration as part of the overall narrative. Our narrative is therefore to:

- **Admit** the difficulties which arose from 2017 and the CTH; learn the lessons from it
- **Collectively** look forward to an exciting and innovative new model of care/ facility - developed with and for the community which places Hampshire at the forefront of (integrated) healthcare thinking
- **Deliver** an environment worthy of the staff who work in the NHS and which facilitates an enhanced, positive patient experience
- **Promote** outstanding care at all times

Each stage of the programme will necessitate an updated vision, taking into account the evolving journey of the MoHHS programme and routed in feedback from engagement.

To begin (pre-engagement) with the vision for the MoHHS is:

*"To work together as **one** NHS and **one** community; developing future healthcare for everyone. We will invest in all our **staff**, **facilities** and the latest **technology** - delivering integrated, flexible care in the right place, at the right time; in the right environment and administered by the right health professional."*

5. Channels and means

The tactics employed will vary according to the specific demands of a) each stage and b) changing requirements. However, to illustrate, it is currently envisioned that the following will be employed across both public and staff engagement:

- Media engagement
- 'Owned' online - website etc.
- 'Earned' online - third party sites and blogs
- Social media
    - Full spectrum, with a particular emphasis on Facebook groups
- Presentations
- Working groups
- Focus groups

- Advertising (paid)
    - Facebook
    - Digital/ online
    - DAX (streaming services)
    - Print (local only)
- Roadshows/ public meetings
- Digital marketing
- Influencer engagement

This will require trained speakers from a range of managerial, clinical leadership and specialised positions.

At a minimum:

- An executive lead
- A clinical lead
- A representative from:
    - Surgery
    - Medicine
    - Family & Clinical Support Services
    - Nursing
    - AHP's
    - Operational management
    - Any service which it emerges will be especially impacted upon - notably if it becomes the public or staff focus of the engagement

Partner organisations would also be invited to establish 'lead' spokespeople. To ensure procedural rigor and conformity to the highest standards of both engagement and consultation it is envisioned that The Consultation Institute (TCI) - an independent advice and accreditation body - be commissioned to advise at the earliest possible stage; initial scoping meetings have (January 2020) now taken place.

It is not anticipated that any external agency or consultancy be used to implement the programme; instead it will be managed using 'in-house' (NHS) resources complimented by advice and accreditation from TCI.

6. Pre-engagement

During pre-engagement we would aim to establish and sustain a sense of inclusion and transparency; both around the process and any decisions taken. Staff, public, patient and stakeholder engagement would be aimed at creating a clear sense of shared ownership, of ground up decision making and collaboration.

As noted above its primary aim is to establish a baseline of public, patient, stakeholder and staff attitudes/ priorities towards healthcare infrastructure investment. In addition, as well as informing and shaping the work undertaken by the various work streams, it will also enable a preliminary assessment of the likely public reaction of possible scenarios to be made.

This is to be achieved by:

- Establishing the PSSAG, agreeing terms of reference and beginning initial conversations
- Begin informal one-to-one briefings by executives of critical stakeholders (i.e. Southampton/ MPs/ Unions)
- An easy to access survey with the purpose of gathering opinions towards healthcare infrastructure spending and the associated priorities
- Starting initial staff engagement - characterised as a 'brainstorm' to gather ideas and comments
    - Utilising existing staff communications channels (email, staff FB etc.)
    - Expanding executive roadshows/ briefings
- Initial press briefings - not with the aim of securing coverage but to explain the process and aims of the project to the relevant journalists
- Identifying social media micro influencers who can/ will be targeted at a later date
- Concurrently, pre-engagement would support the on-going delivery of a robust due diligence process
- Setting up a page of the HHFT website to hold all relevant information in an easy to access and sharable format

The phase would conclude by the submission of a formal report, summarising the findings/ outcomes and making recommendations as to the future shape of the communications programme and the overall programme.

It would also conclude with a full briefing for the executive team on the likely shape of activity during the subsequent engagement and formal consultation phases. Training for senior figures who would undertake public events would also be arranged at this point.

7. Engagement

The engagement phase will build on the foundations of the pre-engagement and significantly expand and deepen the process. It will take account of and build on the baseline established in pre-engagement. Engagement will have a targeted focus on a range of scenarios as laid out in a published 'issues' paper.

In addition to the above, engagement will consist of:

- Publishing an 'issues' paper setting out a number of possible scenarios for consideration
- Formal staff and stakeholder briefings by senior leadership on the initial scenarios and the relative costs and opportunities of both
- A series of information and opinion gathering pop ups for staff and patients at a variety of times and venues
- A full media briefing and multiple press releases
- A full scale, multimedia, awareness campaign across social media
- Targeted, direct, outreach to influential groups/ individuals on social media - i.e. Facebook groups
- A series of public roadshows in easy to access locations
    - Inclusive of public meeting(s)
- An easy to use, multi-channel survey to gather views from across staff and community sources. This to include, physical and digital scenarios; as well as those tailored for protected characteristics and in instances where English isn't the first language

The ultimate purpose is to be able to demonstrate that the matters ultimately consulted upon have been arrived at in collaboration with staff, the public, patients, the wider community, stakeholders and NHS partners; with differing perspectives and viewpoints reflected in the decision making.

As with pre-engagement, this period would culminate in the presentation of a formal report summarising the results of the engagement.

8. Consultation

Formal consultation - likely a 12 week period - will represent the culmination of the engagement and pre-engagement. It will present a range of options to the public, patients, NHS staff, NHS partners and stakeholders for consideration and proactively seek their views on them.

Every effort will be made to ensure that the consultation process is inclusive, accessible, fair and transparent; utilising a range of traditional and digital methods and is undertaken in line with the very latest in best practice.

9. Development

In line with best practice rigorous public and staff engagement should not just occur for the lifetime of a project/programme or to the conclusion of a formal consultation exercise but is an on-going activity.

A regular series of engagement events/ activities would continue throughout construction and opening and beyond.

It is during this phase that a formal report on the consultation and preceding engagement process would be completed.

10. Patient, Staff and Stakeholder Advisory Group (PSSAG)

Terms of reference for the PSSAG are attached

11. Conclusion and next steps

The purpose of this communications and engagement plan is to ensure that objectives set out in section two are delivered in a transparent, collaborative and inclusive manner; in line with best practice and core NHS principles. It will run for the life of the programme and continue beyond it - keeping the community at the heart of HHFT's activities and decision making.

This plan has now been reviewed and accepted by the HHFT executive team and CCG communications lead. The Consultation Institute (TCI) are supporting the programme.

Contact for further information and document author:
Elliot Nichols, Associate Director of Communications and Engagement (HHFT)
elliot.nichols@hhft.nhs.uk
07850 321292

Hampshire Together
Modernising our Hospitals and Health Services

Appendix 4. PATIENT, STAFF AND STAKEHOLDER ADVISORY GROUP (PSSAG) TERMS OF REFERENCE

1. Introduction

1.1 Hampshire Hospitals NHS Foundation Trust - in conjunction with the North Hampshire and West Hampshire Clinical Commissioning Groups (CCG), its staff, patients, stakeholders, other local NHS organisations and other public sector organisations - is currently examining the possible scenarios, methods and processes to invest in modernising the health infrastructure within Hampshire. Based on national Health Infrastructure Plan (HIP) guidance this will include a new hospital.

1.2 This will culminate in formal public consultation on a number of options before proceeding to construction - estimated to take place in early 2021.

1.3 The Trust, in collaboration with its partners, has agreed to establish a Patient, Staff and Stakeholder Advisory Group (PSSAG) to support this work by offering advice, views, suggestions and opinions.

2. Objectives

2.1 The PSSAG will offer advice, views, suggestions or opinions on:

a) The plan of engagement activities to be undertaken including, for example, locations of public meetings
b) The content of plans or proposals made by the steering group
c) The language, tone and style of materials including, for example, consultation documents or information leaflets
d) Which seldom-heard groups should be consulted and what forms of consultation would be most appropriate for these groups
e) Which organisations and stakeholders should be engaged/ consulted and at what point

3. Chair & Membership

3.1 The membership of the group will comprise representatives of communities and organisations of interest from across Hampshire. The role is not an individual one, but rather to bring the views of the community they represent to the group and to share the thinking of the group with that community between meetings.

3.2 Provisional membership - please note that this list is not exhaustive and is subject to amendments and additions:

- Basingstoke and Deane Borough Council
- Winchester City Council
- Hart Council
- Hampshire County Council
- Test Valley Borough Council
- Healthwatch Hampshire
- Eastleigh Borough Council
- Other appropriate local authorities
- Local third sector representatives
- Campaign groups/ League of Friends
- Chamber of Commerce
- NHS partners
    - CCG's
    - University Hospital Southampton NHS Foundation Trust
    - Frimley Health NHS Foundation Trust
    - Royal Berkshire NHS Foundation Trust
    - Salisbury NHS Foundation Trust
    - Portsmouth Hospital NHS Foundation Trust
    - Southern Health NHS Foundation Trust
    - Solent NHS Trust
    - South Central Ambulance Services NHS Foundation Trust
- MP's offices
- HHFT staff & public governors (3)
- Union representatives

3.3 The chairperson will be agreed and appointed at the first meeting. Each meeting will be attended by a representative of the HHFT communications and engagement team as well as staff from the project itself. This will vary as appropriate.

3.4 Key workstream leads, specialist staff and advisors may be invited to attend meetings as appropriate.

4. Criteria for consideration

4.1 Advice, views, suggestions or opinions from PSSAG will take full account of the following established criteria:

- The engagement and any subsequent consultation should include some traditional activities (e.g. public meetings or attendance at established forums) and some more innovative activities such as influencer marketing
- It should be proportionate (i.e. neither excessive nor modest in scale)
- It should take account of views expressed by the relevant local authorities
- All communication should be clear, concise, inclusive and as easy to comprehend as possible
- Documents intended specifically for the public should be jargon free and couched in plain English; with accessible formats available on request
- Any more detailed information should be regularly published on the programme section of the HHFT website

5. Process

- The PSSAG will initially meet quarterly from February 2020 through to the end of the public consultation period; though the frequency may be increased or decreased as the members and chair deem appropriate
- Meetings of the PSSAG will be attended by representatives of the HHFT and the North, East and West Hampshire CCG's - the former will take minutes. The minutes will be approved as accurate by the subsequent meeting of the PSSAG
- The minutes will be placed on the HHFT website
- Any advice, views, suggestions or opinions expressed by the PSSAG will be presented to the Modernising our Hospitals steering group and senior programme team
- The PSSAG will receive formal responses in writing in order to establish a clear two-way audit trail.

6. Conduct of meetings

6.1 The meetings will be formal, with appropriate agendas and papers prepared and circulated in sufficient time for members to give them due consideration. Minutes should be formally recorded and reported to the programme board as required.

6.2 The HHFT administrative lead will act as secretary to the PSSAG.

7. Conclusion

7.1 The role of the PSSAG is to offer advice, views, suggestions or opinions on the matters described in these terms of reference with this advice being given due consideration throughout the project; both during engagement and formal consultation.

7.2 The PSSAG will not be required to collectively advise on any scenarios which may be presented for formal consultation. This means that individual members of PSSAG will be free to express their own views or the views on any organisation they represent in any way they wish.

Contact for further information and document author:
Elliot Nichols, Associate Director of Communications and Engagement (HHFT)
elliot.nichols@hhft.nhs.uk
07850 321292

Hampshire Together

Modernising our Hospitals and Health Services

Hampshire **Together**

Modernising our Hospitals and Health Services

NHS Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups
NHS Hampshire Hospitals NHS Foundation Trust
NHS West Hampshire Clinical Commissioning Group

Hampshire Together
Modernising our Hospitals and Health Services

Background

- Opportunity arises out of the government's programme for new hospitals – The Health Infrastructure Programme 2 (HIP2)

- Hampshire is part of the second round - with construction aimed for **2025 to 2030**

The money is for a new hospital. But a new building can be a catalyst for **so much more**

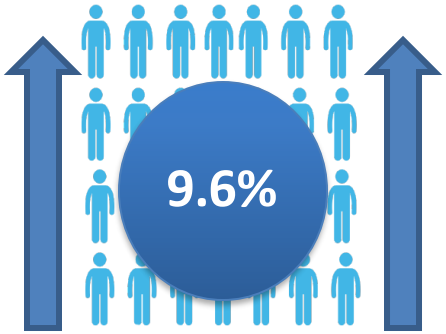
- We've received £5 million to start developing the plan that will deliver for **all the people** of Mid & North Hampshire

But we need your help to make **sure we get it right**

Hampshire Together

Modernising our Hospitals and Health Services

The challenges



Our changing population
- Increasing population
- Age range
- Accessibility

Clinical sustainability
- Clinical standards
- Patient needs
- New technology
- Recruitment

Condition of buildings
- Maintence issues
- Old buildings
- Carbon footprint

Financial resilience
- Staying within budget
- Lifestyle changes
- Healthcare advances

NHS Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups

NHS Hampshire Hospitals NHS Foundation Trust

NHS West Hampshire Clinical Commissioning Group

Hampshire Together

Modernising our Hospitals and Health Services

And – COVID 19

NHS Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups

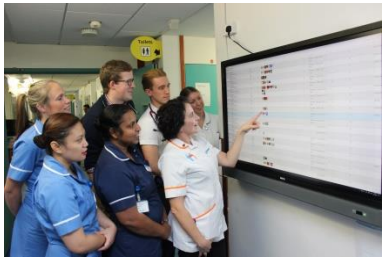
NHS Hampshire Hospitals NHS Foundation Trust

NHS West Hampshire Clinical Commissioning Group

Hampshire Together

Modernising our Hospitals and Health Services

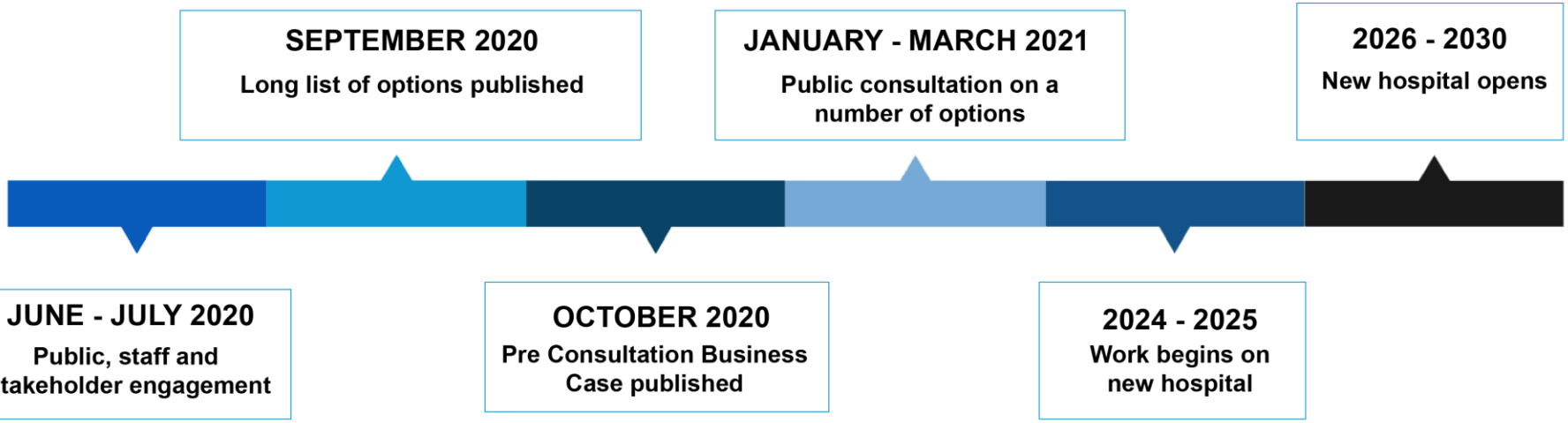
The opportunity



Hampshire Together

Modernising our Hospitals and Health Services

Timeline



Hampshire Together

Modernising our Hospitals and Health Services

Next steps – we need your help!

This is the **start** of the process – and your views, insights and opinions are **critical** to getting this right.

So please let us know what **matters to you** and why.

Nothing is off the table and all ideas are **hugely welcome**.

Hampshire Together

Modernising our Hospitals and Health Services

OUR **CLINICAL VISION**

Hampshire **Together**

Modernising our Hospitals and Health Services

NHS Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups
NHS Hampshire Hospitals NHS Foundation Trust
NHS West Hampshire Clinical Commissioning Group

Hampshire Together

Modernising our Hospitals and Health Services

Working together

Working together to provide joined up health services across north and mid Hampshire

NHS Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups

NHS Hampshire Hospitals NHS Foundation Trust

NHS West Hampshire Clinical Commissioning Group

Hampshire Together

Modernising our Hospitals and Health Services

Our vision

A health, well-being and care service which will support people to access the **right care, in the right place at the right time.**

Hampshire Together

Modernising our Hospitals and Health Services

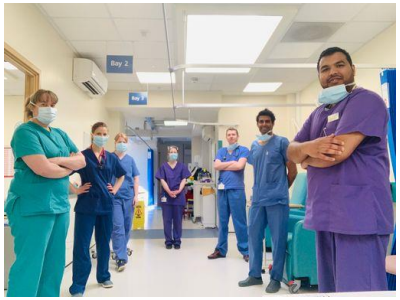
Our case for change:
Clinical sustainability

Hampshire Together

Modernising our Hospitals and Health Services

What has COVID-19 taught us?

Vision + Skills + Incentives + Resources + Action plan = Change



NHS Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups

NHS Hampshire Hospitals NHS Foundation Trust

NHS West Hampshire Clinical Commissioning Group

Hampshire Together

Modernising our Hospitals and Health Services

Principles of our vision

- All health and social care services will work together to deliver the best care for our people
- People will have easy, timely access to the help and support they need
- Services will be designed to meet their requirements
- Services will be sustainable, efficient and high quality; with a focus on delivering the best clinical outcomes possible
- Where practical, care will be provided in people's homes or as close to them as possible
- People will be empowered to self-manage wherever they can, with the information and support required to do so; including access to diagnostic tests and specialist advice when needed
- Where necessary, services will be centralised to ensure the best possible care and outcomes
- We will be able to live within the money allocated to our area; reducing duplication and inefficiency
- We will ensure our healthcare facilities are accessible, fit for purpose and improve a sense of wellbeing for those using them and working there
- Our services will attract the best staff, being renowned for high quality, innovation, research and training support

NHS Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups
NHS Hampshire Hospitals NHS Foundation Trust
NHS West Hampshire Clinical Commissioning Group

Hampshire Together

Modernising our Hospitals and Health Services

WE NEED **YOUR HELP**

Please help us develop our health services to provide outstanding care to all the people of north and mid Hampshire now and for future generations.

Hampshire County Council Health and Adult Social Care Select Committee
6 July 2020

Portsmouth Hospitals NHS Trust update on the Building Better Emergency Care Programme

1. Background

The configuration and condition of the Emergency Department (ED) at Queen Alexandra Hospital (QA) has been a longstanding challenge for the Trust.

The ED at the QA site is 40 years old and was not designed for the number of patients the Trust now sees. Last year there were 16,000 more attendances than there were five years ago, and current projections show demand continuing to increase by 3% each year. The constrained size and layout of the ED limit the Trust's ability to make improvements in the way care is delivered and to implement best practice. In addition, the physical condition of the department does not provide a good enough experience for patients, visitors or staff.

In recognition of these challenges, and with the support of local partners and stakeholders, the Trust was awarded a £58.3m investment for new emergency care facilities at QA as part of the NHS England Wave 4 Sustainability and Transformation Partnership capital allocations, subject to standard business case approvals.

In the meantime, work continues on a daily basis to improve emergency care for patients at QA within the existing constraints.

2. Developing a new model of care

Simply providing a new facility will not enable the Trust to make the improvements needed for local people. The capital investment is an opportunity to go much further than is presently possible in re-designing how unscheduled and emergency care are organised and provided. Working with partners, clinicians at the Trust are also designing a new clinical model that will support the timely assessment and care of all patients requiring emergency care, minimising handovers, duplications and delays, and ensuring patients receive care in the right place from the appropriate health care professional in a timely way. The new ED will be designed to deliver this new model of care, with a flexible design that could adapt to accommodate future enhancements to service models.

The focus of the build is on the provision of those services provided on the QA site, System partners have been involved in the planning process to align the wider Portsmouth and South East Hampshire planning for emergency care across the whole patient pathway.

Planning for the clinical model for emergency care has continued throughout, and been informed by, our response to the Covid-19 pandemic which has provided further opportunity to test and refine emergency pathways, and the ability to provide responsive, flexible and efficient care. Learning from this response will form an essential part of continued work on the clinical model.

3. Programme objectives

The aims of the Emergency Department capital build programme are to:

a. Develop and deliver a new clinical model to serve current and future emergency care requirements at QA
b. Reconfigure urgent and emergency care facilities at the QA site to maximise productivity and efficiency of the urgent and emergency care pathway, streamlining patient flow through ED and beyond
c. Provide capacity to meet current and future demand, enabling the Trust to meet national urgent care quality and access standards
d. Deliver modern facilities, meeting required standards and promoting a positive patient experience and staff wellbeing.

In summary, the programme will deliver safer, more timely care, greater efficiency and an improved experience for patients, visitors and staff.

4. Size of new facilities

Emergency care is currently delivered in facilities at multiple locations across the QA site (including ED, acute medical unit, surgical assessment unit, and ambulatory care settings). Currently, over 120,000 patients each year access these pathways through ED. The new development will be able to accommodate up to 150,000 patients each year through the ED with streamlined pathways to alternative emergency care settings. The flexible design will also ensure that further changes to the size and pathways can be accommodated in the future.

5. Location of new facilities

The Trust has undertaken a detailed option appraisal to identify the most appropriate location in the QA site to design and build the new facility. This appraisal considered a range of criteria to inform the outcome:

- Sufficient space to accommodate the physical requirements to deliver the clinical model
- Adjacencies and travel distances to other essential services within the hospital
- Phasing & timing – whether multiple decants and moves will be required to create space for a new facility prolonging the timetable
- Disruption to essential clinical services during construction
- Implications for amendments to site infrastructure (eg provision or re-routing of utilities) and subsequent budget available to spend on clinical accommodation
- Budget implications (for example if underground services need to be re-routed).

The options appraisal identified the East Car Park as the preferred location. Note that the image below identifies a site location only. There are a range of design solutions in this location that are now being developed that will determine the size, layout access, number of levels, and options for joining with the existing building. All patient car parking impacted by this development will be replaced on site, and a traffic solution included as part of the design.

6. Timeline

The timeline and process are dictated to a large extent by the NHSI/E and Treasury (HMT) approvals processes. Committee Members will recall that the Outline Strategic Case was originally submitted for approval at the end of September 2019. The Outline Business Case is in preparation. The Trust continues to plan on the timetable below planning as follows, but this is an anticipated, rather than definitive, timeline at this stage due to the national approvals timescales, and acknowledging the potential impact following the Covid-19 pandemic and any impact of this on approvals and construction:

Now – Q3 20/21	Develop Outline Business Case, including clinical model and preferred estates solution. Receive approval of Strategic Outline Case and submit Outline Business Case.
Q4 20/21 – Q3 21/22	Develop Full Business Case confirming clinical model, estates and workforce solutions. Receive approval of Outline Business Case and submit Full Business Case.
Q4 21/22	Receive approval of Full Business Case and release of funds by NHSI/E and HMT.
Q1 22/23	Commence construction.
Q4 23/24	Handover and new facilities open to patients.

7. Patient and public engagement

The Trust is committed to the development of patient-centred emergency care services and facilities that truly reflect the needs and preferences of the communities we serve. The Trust has already begun engaging with patients and the public to explain the initial plans and gather high level feedback on what is important to them about the new clinical model and facilities.

A Patient and Public Engagement Steering Group has been established to help shape on-going engagement plans. Recruitment to this group is underway, and plans are being developed with Healthwatch and other partners.

In the coming months, the Trust will carry out in-depth engagement to inform the clinical model and the design principles that will underpin the new facilities. In later stages there will be wide-ranging engagement activities to inform the detailed design.

As the capital investment enhances the current provision of services, rather than changing their nature or location, the Trust does not currently anticipate ta formal public consultation will be required at this stage. However, we are fully committed to continuing to engagement members to identify and respond to any change to this position as required.

8. Further updates

The Trust will provide a formal update to HASC before the submission of the Outline Business Case and again before the submission of the Full Business Case. The Trust would be pleased to provide any further information that is required in the meantime.

ENDS

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date:	6 July 2020
Title:	Hampshire and Isle of Wight Covid-19 System Approach Overview
Report From:	Hampshire and Isle of Wight Integrated Care System Southampton City, West Hampshire and Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups

Contact name:	Members Services		
Tel:	0370 779 4072	**Email:**	members.services@hants.gov.uk

Purpose of this Report

1. To receive a report setting out the Hampshire and Isle of Wight Local Resilience Forum response and the health element of this; the impact to date of Covid-19; the changes to services made by the local NHS and the successes of some of these; details of the Help Us Help You campaign and the health restoration and recovery work including seeking the views of key stakeholders and local people.

2. To receive Trust specific written updates.

Recommendations

3. That the Health and Adult Social Care Select Committee:

a. Note this briefing and consider the next steps outlined in Section 13.

b. Note the Trust specific written updates.

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

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

Other Significant Links

Links to previous Member decisions:	
Title	Date
Direct links to specific legislation or Government Directives	
Title	Date

Section 100 D - Local Government Act 1972 - background documents
The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)
Document Location
None

EQUALITIES IMPACT ASSESSMENT:

1. Equality Duty

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

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

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

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

2. Equalities Impact Assessment:

This is a covering report which appends reports under consideration by the Committee, therefore this section is not applicable to this covering report. The Committee will request appropriate impact assessments to be undertaken should this be relevant for any topic that the Committee is reviewing.

This page is intentionally left blank

HIOW NHS Response to Covid-19
Briefing for HIOW Overview and Scrutiny Committees/Panels

1. Introduction

The NHS response, as part of the Hampshire and Isle of Wight Local Resilience Forum response to Covid-19 has required unprecedented and rapid change in the way services are prioritised and delivered. As a result, a number of temporary service changes have been made across Hampshire and the Isle of Wight that in more normal times would have involved seeking the views of local people, key stakeholders and brought to the Overview and Scrutiny Committees/Panels before implementation.

This briefing paper sets out the Hampshire and Isle of Wight Local Resilience Forum response and the health element of this; the impact to date of Covid-19; the changes to services made by the local NHS and the successes of some of these; details of the Help Us Help You campaign and the health restoration and recovery work including seeking the views of key stakeholders and local people.

2. Hampshire and Isle of Wight Local Resilience Forum response

Local Resilience Forums (LRFs) are multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and others. The Strategic Coordination Group (SCG) operates within the nationally agreed concept of LRFs.

The SCG enables a coordinated strategic response to emergencies, such as the Covid-19 Pandemic. The role of the SCG is to capture and agree the most reasonable worst-case scenario and plan to mitigate this.

The agreed mitigation focuses on sharing information to achieve the following five main objectives:

1. Preventing the Spread of Infection
2. Maintaining Critical Services
3. Protecting the most Vulnerable
4. Maintaining Public Order and Confidence
5. Recovering to New Normal

Key highlights of the health element of the HIOW LRF response to date include:

- Taking a co-ordinated approach to work together across multiple agencies and build relationships with other key players
- Being instrumental in HIOW LRFs approach to Covid-19 and have been represented across the different cells

- Leading locally on a number of different workstreams including testing, providing media response and support to other agencies throughout this time
- Sharing national advice and resources from the Department of Health and Social Care and NHS England/Improvement with other organisations. Likewise health receives national updates via LRF channels to enrich the picture of the situation
- Contributing to data and analysis to aid the collective understanding of the situation
- Seeking support if and when needed, for example with some PPE such as gowns
- Encouraging social distancing supported by multiple other agencies, including police, Forestry Commission and HM Coastguards who patrol hotspots
- Supporting the protection of the most vulnerable in our community, including care homes, homeless and individuals shielding
- Contributing to updates for key stakeholders, including MPs and local councillors.

3. HIOW NHS response to Covid-19

The NHS across HIOW has been working with our Local Resilence Forum to provide a co-ordinated system response to the pandemic.

The developing HIOW Integrated Care System works in four Integrated Care Partnerships which consist of health and social care organisations and a range of partners working together in a geographical area – Portsmouth and South East Hampshire, Southampton and South West Hampshire, North and Mid Hampshire, and the Isle of Wight.

The Partnerships have led the delivery of the NHS response to Covid-19 at local level and made a number of temporary changes to NHS services. The majority of the recent service changes were implemented in direct response to requirements of national guidance (Appendix One) with a smaller number made locally to enable the NHS to focus on the response to the major incident.

All changes across the Hampshire and Isle of Wight system have fallen into one of the criteria below:

- Change in method of access
- Change in location of service
- Reduction in service
- Suspension of service
- Increase in service.

Changes determined locally were done so for the following range of reasons:

- Embed social distancing
- Manage staffing pressures
- Increase (bed) capacity
- Support flow / discharge
- Manage demand
- Prepare for redeployment of staff to other roles
- Protect staff and patients.

4. Impact of Covid-19 on Hampshire and the Isle of Wight

Up to 21 June, 2020 there have been 304,331 lab-confirmed cases in the UK with 42,632 Covid-19 associated UK deaths. The numbers of confirmed cases and deaths across Hampshire and the Isle of Wight have been as below:

- Total lab-confirmed cases and rates by unitary authority area:
  - Hampshire 3,383 (245.8 rate)
  - Southampton 612 (242.1 rate)
  - Portsmouth 324 (150.6 rate)
  - Isle of Wight 202 (142.7 rate)

  (Rates per 100,000 resident population) Source: Public Health England Data)
- Number of deaths as reported by Trusts:
  - Hampshire Hospitals NHS Foundation Trust – 159
  - Isle of Wight NHS Trust – 39
  - Portsmouth Hospitals NHS Trust – 229
  - Solent NHS Trust – 2
  - Southern Health NHS Foundation Trust – 17
  - University Hospital Southampton NHS Foundation Trust – 194

  Source: NHS England Data up to 5pm 20 June (announced 21 June, 2020)

Across HIOW staff sickness has averaged 9% in April and 6.5% in May with 4% and 3.4% respectively related to Covid-19. We have provided support to our staff in a number of ways with mental health and wellbeing programmes and bespoke support in place for all staff groups. This support will be provided on an ongoing basis to support the impact on staff from responding to the incident.

We have also successfully supported 444 returners to work in both health and social care along with 990 second and third year students to work on the frontline.

5. Service benefits from the response to Covid-19

Whilst the changes were made in response to a national major incident there have been a number that have resulted in a better service or experiences for patients and local people. Highlights of these include:

- Partners working together in the Integrated Care Partnerships to increase acute and community bed capacity in a range of settings
- Improving hospital discharge processes with people only staying in hospital when they clinically needed to with delayed transfers of care significantly reduced
- Introducing telephone and video consultations for primary care and outpatient appointments
- A significant reduction in the number of inappropriate Emergency Department attendances
- A significant increase in NHS 111 contacts (both by telephone and online) with patients being advised on self-care or directed to the most clinically appropriate service
- Working far more closely with local authorities and the voluntary sector to provide support to those advised to shield
- An acceleration on working in partnership with a range of partners with organisations and leads focussing on a clear, common purpose
- Using digital solutions to link acute, community and primary care clinicians to effectively support patients at home

- Introducing telemedicine in a number of care homes so patients can be seen virtually in their own home and only taken to hospital is clinically needed
- All HIOW GP practices now using the NHS App which enables patients to access a range of services including booking appointments, checking symptoms and ordering repeat prescriptions.

In addition Covid-19 has positively helped to accelerate bringing together the different parts of the health and social care system which we have been trying to achieve for a number of years. This has helped to progress our work to deliver more joined up care across organisational boundaries, bring together teams across primary, community, mental health, acute and social care to deliver the Long Term Plan, and working with our partners to make faster progress on prevention, improving health and reducing inequalities.

6. Temporary service changes made

During March and April temporary service changes were made across HIOW in primary care, acute care, community care and mental health. These changes are detailed in a spreadsheet (Appendix Two) and include:

Service area	Service changes
Primary Care	• GP practices working together within Primary Care Networks to establish hot and cold sites including a number of hot hubs and service specific sites • All GP practices implementing eConsult and the NHS app • Increasing the use of telephone and video consultations • All patients triaged remotely with face to face appointments arranged as required • Providing the majority of prescriptions electronically with paper prescriptions being the exception • Identifiying shielding and vulnerable patients and providing ongoing care plans and support • Reducing routine activity including health checks, routine smears, annual reviews i.e. diabetic, respiratory, routine blood tests, travel vaccinations, face to face routine consultations and medication reviews • Aligning Primary Care Networks and GP practices with care homes to reduce duplication, footfall and increase continuity of care (patients still retain the right of choice of GP practice) • Suspension of all non urgent specialist dental services • Reducing face to face and increasing telephone and video consultations with homeless patients including providing mobile phones to support this
Acute Care	• Providing additional acute bed capacity to use if required at a number of hospital sites • Suspending all elective activity and investigations including diagnostic testing and pathology • Suspending all inpatient unit visiting unless in certain situations such as end of life • Enhancing acute therapies teams skills with respiratory physiotherapy training across the wider teams
Community Care	• Increasing community bed capacity to use if required in a range of settings • Suspending all inpatient unit visiting unless in certain situations such as end of life

	• Suspending stroke six month follow up assessments • Changing appointments from face to face to telephone and video consultations where appropriate • Suspending group education and group work with some groups meeting virtually where possible • Suspending all routine appointments and investigations including diagnostic testing and pathology • Implementing telehealth and remote monitoring to support patients to be cared for at home • Increasing nursing homes pro-active support provision
Mental Health	• Suspending all inpatient unit visiting • Suspending annual health checks for those with learning disabilities • Changing inpatient services to provide isolation wards within units • Increasing specialist capacity within NHS 111 with safe haven and crisis support services available • Implementing telephone and video consultations in services as appropriate • Proactively contacting and supporting current patients • Delaying non urgent referrals • Allocating Beechwood Ward at Parklands Hospital, Basingstoke to a Covid-19 ward for mental health patients requiring physical care for the virus
Urgent Care	• Implementing a NHS 111 Covid-19 response service both by phone and online • Increasing capacity within NHS 111 • Implementing Emergency Department diverts (diverting patients to the most appropriate service for their need) • Directly admitting patients to appropriate wards rather than all being directly conveyed through Emergency Departments • Implementing telephone and video consultations for urgent Rapid Assessments • South Central Ambulance Trust NHS 111 call handlers trained to handle 999 calls • 999 capacity available due to a decline in activity used to support the patient transport service
Children and young people	• Increasing Child and Adolescent Mental Health services specialist capacity within NHS 111 • Suspending non urgent appointments • Implementing telephone and video consultations for urgent appointments for paediatric services, including mental health services, with face to face appointments provided if clinically required • Identifiying shielding and vulnerable patients and providing ongoing care plans and support • Limiting health visiting to critical services only with telephone and video consultations with face to face appointments provided if clinically required • School nursing reduced to critical services only or suspended with school aged vaccinations postponed • Child health clinics, community group baby clinics and group work has been suspended with some groups meeting virtually where possible • Solent East COAST team in partnership with NHS 111 has moved to

	telephone, support, advice and guidance service only rather than face to face

There have also been some specific temporary changes made in the systems including:

Systems	Change
Portsmouth and South East Hampshire	• Moving the Grange Birthing Unit in Petersfield to a different floor in the hospital • Relocation of the mental health psychiatric liaison service from Queen Alexandra Hospital to St James Hospital • Temporary closure of Urgent Care Centre and Cosham Park House Emergency Department Redirection Service • Increasing the patient acuity accepted in Minor Injuries Units/Urgent Treatment Centres • Extending the operational hours for Gosport War Memorial Hospital's Minor Injuries Unit from 20.00hr to 23.59hr • Relocating some 0-19 service clinics (Antenatal / Child clinics) Queen Alexandra Hospital to the Children's Development Centre at Battenburg • Changing walk-in chest x-rays and blood tests at Queen Alexandra Hospital to appointment services • Temporary relocation of Community Heart Failure and Integrated Community Team services from Waterlooville Health Centre to Denmead and Havant Health Centre
North and Mid Hampshire	• Hampshire Hospitals NHS Foundation Trust centralising emergency surgery to Royal Hampshire County Hospital, Winchester – emergency surgery has now resumed at Basingstoke hospital • Minor Injuries Unit at Andover War Memorial Hospital closed • Cancer services relocated to private facilities where possible • Hampshire Hospitals NHS Foundation Trust suspending home births – partially due to lack of demand
Southampton and South West Hampshire	• The Lighthouse, a mental health service run with partnership between Southern Health NHS Foundation Trust and Solent Mind, changed to a virtual crisis lounge • Urgent outpatient appointments relocated from Southampton Hospital to Southampton Independent Sector Treatment Centre at the Royal South Hants Hospital or the Nuffield Hospital • Cancer services relocated to private facilities where possible
Isle of Wight	• Suspension of public access defibrilation network implementation programme

7. Changes to NHS England and NHS Improvement commissioned services

NHS England and NHS Improvement South East commissions a number of local services and has implemented changes in direct response to national guidance. These include:

- **Pharmacy services**
  The CCGs across HIOW are in close contact with the Local Pharmaceutical Committee and NHS England and NHS Improvement to provide support to pharmacies where we can.

  Locally, pharmacies have seen a significant increase in demand. This is partly due to an increase in prescriptions, higher staff absence rates and social distancing measures.

CCGs have provided guidance to GP surgeries with regards to not extending the duration of supply on repeat prescriptions and to not issue prescriptions too early, to help manage workload and supply. The CCGs have also communicated with the community pharmacies who provide supervised consumption of methadone and end of life drugs to keep them updated about changes to usual policy due to Covid-19.

The CCGs and local authorities have worked together and with voluntary groups to help deliver medicines to the most vulnerable patients.

In line with a nationally agreed standard operating procedure, pharmacies have been allowed to "work behind closed doors" for up to two and a half hours a day. This has been in order to allow time to catch up and clean. However, this should not be between 10am-12pm and 2pm-4pm for most pharmacies or between 10am-12pm and 2pm-6pm for 100 hour pharmacies. This was to help give a consistent message about pharmacy opening times to the public. If pharmacies chose to work behind closed doors they were required to put a sign on the door giving information on how to contact the pharmacy if urgent help was needed.

- **Dentistry services**
  From 25 March during the Covid-19 pandemic all routine NHS and private dentistry was suspended. Patients who had scheduled appointments were contacted by their dental practice. NHS England and NHS Improvement worked with the dental profession to put in place urgent dental care hubs to provide urgent and emergency dental care to both NHS and private patients.

  Revised guidance has seen the resumption of some dental care services from 8 June. The dates on which dental practices will reopen and what services they provide will vary by individual practice according to measures they are able to put in place to ensure the safety of both patients and practice staff. This include ensuring that infection control procedures and social distancing requirements are in place, that practice staff have appropriate PPE and that this has been fit tested and staff are available to work at the practice following risk assessments.

  If a patient needs dental treatment they should contact their dental practice. All practices can offer telephone advice, prescribe medication to help to relieve pain or treat an infection and refer patients to an urgent dental care hub as needed following an assessment. Some practices may be able to offer additional services on a face-to-face basis from their site.

  If people do not have a regular NHS dentist they can search for a local dentist on the NHS website at www.nhs.uk. In the evening and at weekends patients can contact NHS 111 who will provide advice and direct patients to an out of hours service if necessary.

- **Optometry services**
  High street optometry practices have been providing urgent and essential eye care. Patients have been advised to contact their usual optician, if they have one, for further advice with a telephone or face to face appointment arranged if needed.

  Similar to dentists, national guidance has now been issued and opticians will be determining when it will be safe to reopen for routine appointments having considered requirements such as PPE (personal protective equipment), staffing and social distancing requirements.

- **Immunisation and screening services**
  All immunisation programmes apart from shingles and school aged immunisations continued though with some changes to delivery for example, prioritising high risk patients. There was a national and regional media campaign to encourage people to attend for screening and immunisation appointments. A summary of some key points regarding screening and immunisation programmes is below:

  - Immunisations delivered in schools were put on hold when schools closed. NHS England and NHS Improvement are currently working with providers to restore those programmes as soon as possible using schools or community venues with Covid-19 safety measures in place
  - Cervical screening invitation times were extended and invitations have started to be sent. GP practices were advised either to reschedule women who had already had an invitation or to screen them if practical
  - Antenatal and newborn screening continued as normal with some minor pathway adaptations for safety purposes. There was some disruption to audiology services for babies referred from newborn hearing screening but these are in the process of restarting
  - Breast screening has continued to screen high risk women and to continue with assessment of women already in the pathway
  - Diabetic Eye Screening has been impacted by lack of access to primary and community venues and hospital eye services are not yet receiving non urgent referrals. Programmes are screening high risk and pregnant women.

8. Help Us Help You campaign

During the response period NHS activity for non Covid-19 related conditions dropped including the number of people attending Emergency Departments, contacting their GP and attending routine appointments where these have been going ahead.

This was seen across the country and in response NHS England launched the national Help Us Help You campaign to promote NHS services and encourage people to use them when they need help, advice or treatment.

We have been supporting this locally, with input from our Local Resilience Forum partners, and have been seeing a steady increase in NHS activity. We are also using the campaign as an opportunity to promote the range of urgent care services available locally and when to use each one appropriately.

9. Regional lockdowns and potential second wave planning

As part of the national response R numbers are being published for each regional area. This may result in local lockdown arrangements if a regional R number starts to increase. If this happens across HIOW then Covid-19 temporary service changes may be retained or reintroduced if they have been changed.

Work has also been ongoing to plan for a potential second wave of Covid-19. This planning takes into account the restoration and recovery work and winter. This includes considering issues such as PPE (personal protective equipment) requirements, staffing and social distancing requirements.

10. Moving to the new normal

There will be distinct phases as the NHS moves to a 'new normal'. The initial phases are:

- Restoration phase
  Restarting non-urgent, critical services that were paused during the response. This is a national requirement with clear guidance (Appendix Three) around which services need to be restarted and when. It is anticipated that further national requirements will follow.

- Recovery phase
  The temporary service changes made include the accerleration of service transformation that were being developed pre-Covid-19 and changes that have potentially led to better outcomes and/or experience for local people. As such work will be undertaken to review the service changes made to ensure services are not simply restored to pre-Covid-19 arrangements but developed for the future. This review will need to include a number of key lines of enquiry including:

    - Has the change impacted on the way patient care is delivered or received?
    - Has the change reduced the number of people seeking help or getting care and has this been appropriate?
    - Has the change delivered efficiencies, and was this a key drive for making it?
    - Who has or could be affected?
    - Has any engagement taken place with patients and staff prior to the change being enacted or previous engagement activities which offer relevant insights? If so, what?
    - Has this change improved the outcomes or experience for patients?
    - Has this change increased or created inequalities? If so, has an Equality Impact Assessment (EIA) been completed?

Whilst the restoration and recovery work has started this is balanced with ensuring that we are able to respond to a potential second spike of Covid-19. This will include ensuring that plans to restart postponed NHS activity takes this into account. Likewise, the restoration and recovery work will need to take into account Covid-19 guidance as it is issued such as potential social distancing requirements within buildings such as hospitals and GP practices.

11. Restoration and recovery principles

All of the NHS partners across HIOW have agreed that the following guiding principles will be used to shape our restoration and recovery plans.

- Safety: Patient and staff safety is paramount. Our restoration plans will be founded on the identification and mitigation of risk
- Outcomes: Our purpose is to maximise outcomes for local people. This means ensuring we identify and care for patients requiring time-critical treatment which, if not provided immediately, will lead to patient harm
- Preparedness: We will at all times retain sufficient aggregate capacity across HIOW to respond to demand related to Covid-19 and time-critical care
- Strategic: We will ensure, where possible, our approaches are in line with our strategic ambitions as set out in the HIOW Strategic Delivery Plan
- Subsidiarity: Individual organisations and Integrated Care Partnerships (and care system footprints where relevant) will lead the development and delivery of plans for restoring services guided by a common set of principles
- Commonality: All partners in HIOW are committed to alignment and ensuring a common approach

- Forward-looking: We will lock-in beneficial changes and not restore by default to pre-Covid service models.

12. Seeking the views of local communities

It is key that we seek the views of our stakeholders, partners and local communities as we develop our restoration and recovery plans both within local systems but also across HIOW.To support this the engagement will align to the phased approach but recognise that the different systems may have different requirements at any one time and the engagement approach needs to be adaptive whilst also aligned to enable common themes across areas to be identified and wider pieces of work supported.

There may be some proposed changes that will require further bespoke NHS led engagement activity and/or formal consultation to meet the needs of the five tests of service change. This may include temporary service changes which require more detailed engagement, such as outpatient digital appointments, or new projects, such as NHS 111 First.

In addition, NHS England is determining if there are opportunities to carry out engagement programmes on a regional footprint for common temporary service changes, for example the changes in access to primary care services. These will be taken into account in the HIOW approach as and when they are developed.

13. Next steps

The HIOW Overview and Scrutiy Committees/Panels are asked to advise how they would like to monitor service changes and the recovery plans as they are developed and implemented over the next 18 months.

14. Recommendation

The Committee is asked to note this briefing and consider the next steps outlined in section 13.

Appendices
The following appendices accompany this briefing paper:

- **Appendix One**
  Letter from Sir Simon Stevens, NHS Chief Executive, dated 17 March 2020: Important and Urgent – Next steps on NHS response to Covid-19

- **Appendix Two**
  Hampshire and Isle of Wight Covid-19 temporary service changes spreadsheet

- **Appendix Three**
  Letter from Sir Simon Stevens, NHS Chief Executive, dated 29 April 2020: Important – For Action – Second phase of NHS response to Covid-19

This page is intentionally left blank

To:
Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers
GP practices and Primary Care Networks
Providers of community health services

Copy to:
Chairs of NHS trusts, foundation trusts and CCG governing bodies
Local authority chief executives and directors of adult social care
Chairs of Local Resilience Forums
Chairs of ICSs and STPs
NHS Regional Directors
NHS 111 providers

NHS England and NHS Improvement
80 London Road
Skipton House
London SE1 6LH
england.spoc@nhs.net

17 March 2020

Dear Colleague,

IMPORTANT AND URGENT – NEXT STEPS ON NHS RESPONSE TO COVID-19

Thank you for your extensive work to date to prepare for this rapidly increasing pandemic, following the NHS declaration of a Level 4 National Incident on 30 January.

Last night the Government announced additional measures to seek to reduce the spread across the country. It is essential these measures succeed. However as the outbreak intensifies over the coming days and weeks, the evidence from other countries and the advice from SAGE and the Chief Medical Officer is that at the peak of the outbreak the NHS will still come under intense pressure.

This letter therefore sets out important actions we are now asking every part of the NHS to put in place to redirect staff and resources, building on multiple actions already in train. These will:

- Free-up the maximum possible inpatient and critical care capacity.
- Prepare for, and respond to, the anticipated large numbers of COVID-19 patients who will need respiratory support.
- Support staff, and maximise their availability.

- Play our part in the wider population measures newly announced by Government.
- Stress-test operational readiness.
- Remove routine burdens, so as to facilitate the above.

Please therefore now enact the following measures:

1. Free-up the maximum possible inpatient and critical care capacity

The operational aim is to expand critical care capacity to the maximum; free up 30,000 (or more) of the English NHS's 100,000 general and acute beds from the actions identified in a) and b) below; and supplement them with all available additional capacity as per c) below. To that end, trusts are asked now to:

a) Assume that you will need to postpone all non-urgent elective operations from 15th April at the latest, for a period of at least three months. However you also have full local discretion to wind down elective activity over the next 30 days as you see best, so as to free up staff for refresher training, beds for COVID patients, and theatres/recovery facilities for adaptation work. Emergency admissions, cancer treatment and other clinically urgent care should continue unaffected. In the interim, providers should continue to use all available capacity for elective operations including the independent sector, before COVID constraints curtail such work. This could free up 12,000-15,000 hospital beds across England.

b) Urgently discharge all hospital inpatients who are medically fit to leave. Community health providers must take immediate full responsibility for urgent discharge of all eligible patients identified by acute providers on a discharge list. For those needing social care, emergency legislation before Parliament this week will ensure that eligibility assessments do not delay discharge. New government funding for these discharge packages and to support the supply and resilience of out-of-hospital care more broadly is being made available. (See section 6f of this letter). Trusts and CCGs will need to work with local authority partners to ensure that additional capacity is appropriately commissioned. This could potentially free up to 15,000 acute beds currently occupied by patients awaiting discharge or with lengths of stay over 21 days.

c) Nationally we are now in the process of block-buying capacity in independent hospitals. This should be completed within a fortnight. Their staff and facilities will then be flexibly available to you for urgent surgery, as well as for repurposing their beds, operating theatres and recovery facilities to provide respiratory support for COVID-19 patients. As soon as we have the detailed capacity map of what will be available in each part of the country we will share that with you via Regional Directors. NHS trusts and foundation trusts should

free up their own private pay beds where they exist. In addition, community health providers and social care providers are asked to free up community hospital and intermediate care beds that could be used flexibly within the next fortnight. These measures together could free up to 10,000 beds.

2. Prepare for, and respond to, large numbers of inpatients requiring respiratory support

Emerging international and UK data on COVID-19 patients suggests that a significant proportion who are hospitalised require respiratory support, particularly mechanical ventilation and to a lesser extent non-invasive ventilation.

a) Work is well in hand nationally to secure a step change in oxygen supply and distribution to hospitals. Locally, hospital estates teams have now reported on their internal oxygen piping, pumping and bedside availability. All trusts able to enhance these capabilities across their estate are asked to do so immediately, and you will be fully reimbursed accordingly. The goal is to have as many beds, critical care bays, theatre and recovery areas able to administer oxygen as possible.

b) National procurement for assisted respiratory support capacity, particularly mechanical ventilation, is also well under way in conjunction with the Department of Health and Social Care. In addition, the Government is working with the manufacturing sector to bring new manufacturers online. These devices will be made available to the NHS across England, Wales, Scotland and Northern Ireland according to need. Mark Brandreth, chief executive of Agnes Jones and Robert Hunt foundation trust is now supporting this work.

c) In respect of PPE, the DHSC procurement team reports that nationally there is currently adequate national supply in line with PHE recommended usage, and the pandemic influenza stockpile has now been released to us. However locally distribution issues are being reported. Michael Wilson, chief executive of SASH, is now helping resolve this on behalf of the NHS. In addition if you experience problems there is now a dedicated line for you: 0800 915 9964 / 0191 283 6543 / Email: supplydisruptionservice@nhsbsa.nhs.uk.

d) A far wider range of staff than usual will be involved in directly supporting patients with respiratory needs. Refresher training for all clinical and patient-facing staff must therefore be provided within the next fortnight. A cross-specialty clinical group supported by the Royal Colleges is producing guidance to ensure learning from experience here and abroad is rapidly shared across the UK. This will include: a short education package for the entire NHS workforce; a service guide, including for anaesthetics and critical care; COVID-19 clinical management guides in collaboration with NICE.

e) Segregate all patients with respiratory problems (including presumed COVID-19 patients). Segregation should initially be between those with respiratory illness and other cases. Then once test results are known, positive cases should be cohort-nursed in bays or wards.

f) Mental Health, Learning Disability and Autism providers must plan for COVID-19 patients at all inpatient settings. You need to identify areas where COVID-19 patients requiring urgent admission could be most effectively isolated and cared for (for example single rooms, ensuite, or mental health wards on acute sites). Case by case reviews will be required where any patient is unable to follow advice on containment and isolation. Staff should undergo refresher training on physical health care, vital signs and the deteriorating patient, so they are clear about triggers for transfer to acute inpatient care if indicated.

3. Support our staff, and maximise staff availability

a) The NHS will support staff to stay well and at work. Please ensure you have enhanced health and wellbeing support for our frontline staff at what is going to be a very difficult time.

b) As extra coronavirus testing capability comes on line we are also asking Public Health England as a matter of urgency to establish NHS targeted staff testing for symptomatic staff who would otherwise need to self-isolate for 7 days. For those staff affected by PHE's 14 day household isolation policy, staff should - on an entirely voluntary basis - be offered the alternative option of staying in NHS-reimbursed hotel accommodation while they continue to work. Sarah-Jane Marsh, chief executive of Birmingham Women's and Children's foundation trust is now supporting this work.

c) For staff members at increased risk according to PHE's guidance (including pregnant women), if necessary, NHS organisations should make adjustments to enable staff to stay well and at work wherever possible. Adjustments may include working remotely or moving to a lower risk area. Further guidance will be made available and the Royal College of Obstetrics and Gynaecology will provide further guidance about pregnant women.

d) For otherwise healthy staff who are at higher risk of severe illness from COVID-19 required by PHE's guidance to work from home, please consider how they can support the provision of telephone-based or digital / video-based consultations and advice for outpatients, 111, and primary care. For non-clinical staff, please consider how they can continue to contribute remotely. Further guidance will be made available

e) The GMC, NMC and other professional regulators are also writing to clinicians who have relinquished their licence to practice within the past three years to see whether they would be willing to return to help in some capacity.

f) Urgent work is also underway led by chief nursing officer Ruth May, NHS chief people officer Prerana Issar and Health Education England, the relevant regulators and universities to deploy medical and nursing students, and clinical academics. They are finalising this scheme in the next week.

g) All appropriate registered Nurses, Midwives and AHP's currently in non-patient facing roles will be asked to support direct clinical practice in the NHS in the next few weeks, following appropriate local induction and support. Clinically qualified staff at NHSE/I are now being redeployed to frontline clinical practice.

h) The four UK chief medical officers, the national medical director, the Academy of Medical Royal Colleges and the GMC have written to all UK doctors stressing that it will be appropriate and necessary for clinicians to work beyond their usual disciplinary boundaries and specialisms under these difficult circumstances, and they will support individuals who do so. (see https://www.aomrc.org.uk/wp-content/uploads/2020/03/0320_letter_supporting_doctors_in_COVID-19.pdf) Equivalent considerations apply for nurses, AHPs and other registered health professionals.

4. Support the wider population measures newly announced by Government

Measures announced last night are detailed at:
https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people/guidance-on-social-distancing-for-everyone-in-the-uk-and-protecting-older-people-and-vulnerable-adults

a) Ministry of Housing, Communities and Local Government (MHCLG) and local authorities in conjunction with their Local Resilience Forums (LRFs) have lead responsibility for overseeing support for older and vulnerable people who are going to be 'shielded' at home over the coming months. Community health services and voluntary organisations should engage with LRFs on how best to do this.

b) A number of these individuals would be expected to have routine or urgent GP, diagnostic or outpatient appointments over the coming months. Providers should roll out remote consultations using video, telephone, email and text message services for this group as a priority and extend to cover all important routine activity as soon as possible, amongst others. David Probert, chief

executive of Moorfields foundation trust, is now leading a taskforce to support acute providers rapidly stand up these capabilities, with NHSX leading on primary care. Face-to-face appointments should only take place when absolutely necessary.

c) For patients in the highest risk groups, the NHS will be identifying and contacting them over the coming week. They are likely to need enhanced support from their general practices, with whom they are by definition already in regular contact. GP services should agree locally which sites should manage essential face-to-face assessments. Further advice on this is being developed jointly with PHE and will be available this week.

d) As part of the overall 'social distancing' strategy to protect staff and patients, the public should be asked to greatly limit visitors to patients, and to consider other ways of keeping in touch such as phone calls.

5. Stress-test your operational readiness

a) All providers should check their business continuity plans and review the latest guidance and standard operating procedures (SOP), which can be found at https://www.england.nhs.uk/coronavirus/.

b) Trust Incident Management Teams – which must now be in place in all organisations - should receive and cascade guidance and information, including CAS Alerts. It is critical that we have accurate response to data requests and daily sitrep data to track the spread of the virus and our collective response, so please ensure you have sufficient administrative capacity allocated to support these tasks.

c) For urgent patient safety communications, primary care providers will be contacted through the Central Alerting System (CAS). Please register to receive CAS alerts directly from the MHRA: https://www.cas.mhra.gov.uk/Register.aspx.

d) This week we are undertaking a system-wide stress-testing exercise which you are asked to participate in. It takes the form of a series of short sessions spread over four days from today. Each day will represent a consecutive week in the response to the outbreak, starting at 'week six' into the modelled epidemic. We would strongly encourage all Hospital Incident Management Teams with wider system engagement (including with primary care and local government representation) to take part.

6. Remove routine burdens

To free you up to devote maximum operational effort to COVID readiness and response, we are now taking the following steps nationally:

a) Cancelling all routine CQC inspections, effective immediately.

b) Working with Government to ensure that the emergency legislation being introduced in Parliament this week provides us with wide staffing and regulatory flexibility as it pertains to the health and social care sector.

c) Reviewing and where appropriate temporarily suspending certain requirements on GP practices and community pharmacists. Income will be protected if other routine contracted work has to be substituted. We will issue guidance on this, which will also cover other parts of the NHS.

d) Deferring publication of the NHS People Plan and the Clinical Review of Standards recommendations to later this year. Deferring publication of the NHS Long Term Plan Implementation Framework to the Autumn, and recommending you do the same for your local plans.

e) Moving to block contract payments 'on account' for all NHS trusts and foundation trusts for an initial period of 1 April to 31 July 2020, with suspension of the usual PBR national tariff payment architecture and associated administrative/ transactional processes.

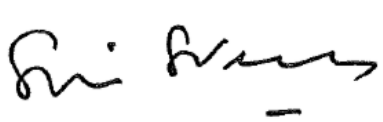
f) Additional funding to cover your extra costs of responding to the coronavirus emergency. Specific financial guidance on how to estimate, report against, and be reimbursed for these costs is being issued this week. The Chancellor of the Exchequer committed in Parliament last week that *"Whatever extra resources our NHS needs to cope with coronavirus – it will get."* So financial constraints must not and will not stand in the way of taking immediate and necessary action - whether in terms of staffing, facilities adaptation, equipment, patient discharge packages, staff training, elective care, or any other relevant category.

COVID-19 presents the NHS with arguably the greatest challenge it has faced since its creation. Our health service - through our skilled and dedicated staff - is renowned for the professional, flexible and resilient way that it responds to adversity. Please accept our sincere thanks for your leadership, and that of your staff, in what is going to be a highly challenging period.

This is a time when the entire NHS will benefit from pulling together in a nationally coordinated effort. But this is going to be a fast-moving situation requiring agile

responses. If there are things you spot that you think we all should be doing differently, please let us know personally. And within the national framework, do also use your discretion to do the right thing in your particular circumstances. You will have our backing in doing so.

With best wishes,



Sir Simon Stevens
NHS Chief Executive

Amanda Pritchard
NHS Chief Operating Officer

ANNEX: CORONAVIRUS COST REIMBURSEMENT

This guidance sets out the amended financial arrangements for the NHS for the period between 1 April and 31 July. These changes will enable the NHS and partner organisations (including Local Authorities and the Independent Sector) to respond to COVID-19. We will continue to revise this guidance to reflect operational changes and feedback from the service as the response develops.

We will shortly be making a payment on account to all acute and ambulance providers to cover the costs of COVID-19-related work done so far this year, with final costs for the current financial year being confirmed as part of the year end processes. This initial payment will be based on information already submitted by providers. Future payments will be based on further cost submissions.

All NHS providers and commissioners must carefully record the costs incurred in responding to the outbreak and will be required to report actual costs incurred on a monthly basis. Accurate record keeping during this time is crucial - record keeping must meet the requirements of external audit, and public and Parliamentary scrutiny.

To support reimbursement and track expenditure we will in due course be asking all relevant organisations to provide best estimates of expected costs from now until the expected end of the peak outbreak. We will provide further guidance with relevant assumptions in order to support you in making these estimates.

REVENUE COSTS

Contractual payments and provider reimbursement

We are suspending the operational planning process for 2020/21.

We will provide all NHS providers a guaranteed minimum level of income reflecting the current cost base on the following basis:

a) Commissioners should agree block contracts with the NHS providers with whom they have a contract (NHS Trusts, Foundation Trusts, Mental Health, Community and Ambulance trusts) to cover the period 1 April to 31 July. This should provide a guaranteed monthly payment. For CCGs the value of this payment will be calculated nationally for each CCG/provider relationship. This figure will be based on the average monthly expenditure implied by the provider figures in the M9 Agreement of Balances return plus an uplift that allows for the impact of inflation (including pay uplifts and CNST) but excluding the tariff efficiency factor. It will not include activity growth. For mental health trusts the uplift will include an additional sum consistent with

delivering the Mental Health Investment Standard. The monthly payment should include CQUIN and assume 100% delivery.

b) Trusts should suspend invoicing for non-contracted activity for the period 1 April to 31 July. A sum equivalent to the historical monthly average will be added to the block contract of the provider's coordinating commissioner. Providers should continue to record all activity including NCAs in SUS in the normal way.

c) A national top-up payment will be provided to providers to reflect the difference between the actual costs and income guaranteed by steps 1 and 2 where the expected cost base (which will be calculated as the average monthly expenditure over the period November to January uplifted for inflation) is higher. The Financial Recovery Fund and associated rules will be suspended during this period. The top-up payment will take into account individual provider CNST contributions compared to that funded in the allowance for cost inflation.

We will provide these numbers to Commissioners and Providers on Monday 23 March.

Providers should claim for additional costs where the block payments do not equal actual costs to reflect genuine and reasonable additional marginal costs due to COVID-19. These reasonable costs should include:

a) Evidenced increases in staffing costs compared to the baseline period associated with dealing with increased total activity.

b) Increases in temporary staffing to cover increased levels of sickness absence or to deal with other caring responsibilities (e.g. to look after other family members).

c) Payments for bank or sub-contractor staff to ensure all sickness absence is covered consistent with Government's announced policy and public health advice which aren't otherwise covered under normal practice; and

d) Additional costs of dealing with COVID-19 activity. For example: the costs of running NHS111 assessment pods; increases in the volumes required or prices of equipment to deal with the response to the virus which aren't offset by reductions elsewhere; extra costs of decontamination and transport for the ambulance service; higher testing volumes in acute-based laboratories; and community-based swabbing services.

Claims should be made on a monthly basis, alongside regular monthly financial reports. This should provide sufficient funds for providers to deliver a break-even

position through the period and will provide the basis against which we will monitor financial performance.

We will monitor the impact of any changes in income levels from non-NHS services, in particular from local authorities. Providers should escalate to regional teams as appropriate.

The payments made by commissioners under block contract arrangements should not be revised to reflect any short falls in normal contractual performance during this period. The majority of NHS acute providers are already exempt from the majority of contract sanctions; for the duration of the outbreak until further notice any remaining contract sanctions for all NHS provider groups are to be suspended.

It is important that providers and commissioners pay promptly during this time, so that cash flow for NHS and non-NHS suppliers of goods and services does not become a barrier to service provision.

The arrangements described above should mean there is minimal requirement for interim working capital support during this period. Providers that believe they require supplementary working capital support should follow the normal procedure to access such support.

Funding for commissioners

Commissioner allocations for 2020/21 have already been notified as part of operational planning and will not be changed. However, in assessing individual commissioner financial positions and affordability we will take into account:

a) The impact of the block contracting approach set out above including both the cost of removing the tariff efficiency factor and the benefit of excluding activity growth from the calculation.

b) Expected reductions in investments for service developments
    - the temporary arrangements for non-contracted activity, transferring funding to make sure that lead commissioners have adequate funds to pay providers; and
    - the costs of additional service commitments as described below for example for out of hours provision, additional NHS111 investment, purchase of step-down beds and provision of rapid discharge/ additional social care capacity.

c) We will also be reviewing planned transformation initiatives, and where we consider that these will not be able to proceed during the coronavirus emergency we will reflect this in the distribution of transformation funding.

d) In addition, a number of NHS commissioners are dependent on additional central support to fully cover their expenditure. NHSE/I will calculate a central top up payment on broadly the same basis as FRF to cover the difference between allocations as set out above and expected costs.

Financial Governance

The maintenance of financial control and stewardship of public funds will remain critical during the NHS response to COVID-19. Chief Executives, Accountable Officers and Boards must continue to comply with their legal responsibilities and have regard to their duties as set out in Managing Public Money and other related guidance. Any financial mismanagement during this period will be dealt with in exactly the same way as at any other time.

We recommend that NHS organisations undertake an urgent review of financial governance to ensure decisions to commit resources in response to COVID-19 are robust. Naturally, all organisations should test the resilience of their finance functions and business continuity plans to make sure that the most important elements (running payroll, paying suppliers, core reporting) can continue even with significant staff absences. We are also asking you to consider the resilience of your fraud prevention arrangements.
As normal financial arrangements have been suspended, no new revenue business investments should be entered into unless related to Covid-19 or unless approved by NHSE/I as consistent with a previously agreed plan. Where costs have already been committed or contractual commitments entered into, providers should agree an approach with NHSE/I as above.

Normal consultancy approval and agency reporting requirements must be maintained during this period.

SPECIFIC ADDITIONAL FUNDING CONSIDERATIONS

Purchase of enhanced discharge support services

CCGs will be asked to work with their local authority partners to commission additional out-of-hospital care and support capacity, in particular to facilitate step down of patients from secondary care and so free up acute beds. These are expected to be a blend of care home beds, hospices, and home-care support.

Detailed operational guidance for the procurement and management of these beds will be issued separately including more detailed finance guidance. To make sure that funding decisions do not restrict the pace of discharges, additional resources will be provided to pay for the community bed or a package of care post-discharge for any

patient that needs it. New guidance will also ensure that eligibility assessments do not delay new care packages being put in place. We will continue to review this approach and will ask CCGs and local authorities to move to standard commissioning and funding routes once the impact of Covid-19 sufficiently diminishes – you should plan therefore on the basis of an average length of care package.

Additional funding will be provided based on monthly cost returns from CCGs.

Specialised services

As described above, Specialised Services contracts will follow the same principles as CCG commissioned activity, and block values will be based on the average 2019/20 expenditure up to month 9, with an uplift to recognise the impact of pay uplifts and other cost increases.
Arrangements for pass through Drugs and Devices costs will continue to operate as currently on a cost and volume basis, to ensure that providers do not face any financial consequences of any increases in activity or cost.

Specialised providers will be required to respond to the most serious cases of COVID-19 through the provision of High Consequence Infectious Disease units, Extracorporeal Membrane Oxygenation services and other specialised care functions. Any specific investments and costs incurred by these units are being coordinated through the National Highly Specialised team.

NHS 111

NHS 111 has been commissioned nationally to provide a dedicated Covid-19 response service. This service will continue to be contracted for and funded nationally. In addition, having reviewed the pressures on the wider NHS 111 service additional funding will be released from NHSE/I via lead commissioners, who will then make necessary arrangements for payment to NHS 111 providers.

General Practice

The key principle is that from 1 April we free up practices to prioritise workload according to what is necessary to prepare for and manage the outbreak, and therefore guarantee that income will be protected if other routine contracted work has to be substituted. This does not prevent us from continuing to measure activities (for example those undertaken with QOF) but it ceases to put 2020/21 income at risk for performance.

We will make sure that funding does not influence clinical decision making by ensuring that all GP practices in 2020/21 continue to be paid at rates that assume they would

have continued to perform at the same levels from the beginning of the outbreak as they had done previously, including for the purposes of QoF, DES and LES payments.

CCGs should plan to make payments on this basis. NHSE/I will reimburse any additional costs as part of our wider finance agreement on Covid-19.

Out of Hours Provision

CCGs have been asked to procure additional GP out of hours provision in order to provide home-based care for any patients that have tested positive for coronavirus in the community. CCGs will be reimbursed for the additional costs incurred in delivering this service through the allocations process. CCGs will be required to submit a monthly return of additional cost incurred which will provide the basis of additional payments. To keep the administrative burden to a minimum, where a CCG has contracted for this service on behalf of itself and others, reimbursement will be directed through the lead CCG.

Community Pharmacy

Where required, CCGs will be reimbursed for the following:

a) An NHS Urgent Medicines Supply Service for patients whose General Practice is closed.

b) A Medicines Delivery Service to support Covid-19 positive and vulnerable patients self-isolating at home.

c) Payments to contractors who are required to close due to Covid-19 related reasons.

Optometry and dental

For the time being we expect that funding for dentistry and optometry will continue in line with existing contractual arrangements using assumptions rolled over from 2019/20 where required. We will keep this under review and address any issues as they arise.

Third and Independent Sector Providers

Details of reimbursement for any additional services to be procured from the third sector or from independent sector organisations will be issued in due course.

CAPITAL COSTS

NHSE/I will shortly issue indicative capital allocations for 2020/21. Additional capital expenditure will be required to support our response to the virus in a number of areas, including purchase of pods, capital modifications to existing estate, purchasing of ventilators and other medical equipment, and IT assets to enable smarter working including remote consultations. In a number of cases NHSE/I may bulk-purchase assets to secure the necessary resource as quickly as possible. However, this will not always be practical or desirable, so below are the arrangements for providers and commissioners to access capital in relation to the COVID-19 response. The key criteria against which we will assess claims are:

a) The proposed expenditure must be clearly linked to delivery of our COVID-19 response;
   NHS
b) In the case of asset purchases, the asset must be capable of being delivered within the expected duration of the outbreak; and

c) In the case of modifications to estate, the works must be capable of being completed within the expected duration of the outbreak.

Commissioner capital

We anticipate that individual claims for capital expenditure by commissioners will fall within the delegated budgetary limits for NHSE/I of £10m. Any requests for capital expenditure by commissioners including any assets being purchased on behalf of general practice should be relayed to NHSE/I regional teams for assessment with the national team, following which the required capital allocation will be issued.

Provider capital

We anticipate that individual claims for capital expenditure by providers will fall within the delegated budgetary limits for trusts of £15m. Any requests for capital expenditure by providers should be relayed to NHSE/I regional team for rapid assessment with the national team to enable swift decision making and disbursement of cash where appropriate. PDC charges will not be levied on any funding supplied in connection with COVID-19.

Summary

Group	Service line	Funding method
Revenue costs		
All NHS organisations	Contracting basis	All providers to move to block contract,
	Self-isolation of workers	To be directly reimbursed as required
	Increased staff costs in the event of sick or carer's leave	To be directly reimbursed as required
	Other additional operating costs	Reasonable costs to be reimbursed
Acute providers	Pod provision	Initial on-account payment based on submissions received so far Final 19/20 payment based on updated cost template Ongoing 20/21 costs to be reimbursed monthly based on cost submissions
	Laboratory costs	To be directly reimbursed as required
CCGs	Purchase of step-down beds	Final 19/20 payment based on cost submissions Ongoing 20/21 costs to be reimbursed monthly based on cost submissions
	Out of Hours (primary care) capacity increase	Additional allocations to be paid to CCGs to pass on to providers
Specialised services	Patient admissions	To be funded through block contractual payments
	Drugs costs	Payments for drugs not included in tariff will continue in the normal way
Ambulance providers	Additional PPE and cleaning	Initial on-account payment based on submissions received so far Final 19/20 payment based on updated cost template Ongoing 20/21 costs to be reimbursed monthly based on cost submissions
Community	Swabbing services	Final 19/20 payment based on updated cost template Ongoing 20/21 costs to be reimbursed monthly based on cost submissions

Group	Service line	Funding method
NHS 111	National CRS function	Costs to be reimbursed nationally
	Additional local 111 funding	Additional allocations to be paid via CCGs where agreed
Capital costs		
Acute providers	Equipment and estate modification as required	PDC allocation from DHSC to provider trust
CCGs (including primary care)	Equipment as required	NHS England allocation to CCGs funded via DHSC mandate adjustment

This page is intentionally left blank

Mental Health Services

Provider	Service Category	Impacted Service	Type of Change	Detail of Change	Rationale	Directive
IOW	Mental Health & Learning Disability	Inpatient Services	Increase in service	Changes to our inpatient services in order to create capacity for a mental health isolation ward. Afton ward (10 beds, older people's functional mental illness ward) is now the adult and older adult isolation ward. Osborne ward is therefore now accepting both adult and older adult mental health admissions for people who do not require isolation. All visiting has been suspended in inpatient units. Providing inpatients with technology to enable them to maintain contact with loved ones, and to provide activities.	Social distancing	National guidance
IOW	Mental Health & Learning Disability	Inpatient Services	Increase in service	Changes to our inpatient services in order to create capacity for a mental health isolation ward. Afton ward (10 beds, older people's functional mental illness ward) is now the adult and older adult isolation ward. Osborne ward is therefore now accepting both adult and older adult mental health admissions for people who do not require isolation. All visiting has been suspended in inpatient units. Providing inpatients with technology to enable them to maintain contact with loved ones, and to provide activities.	Social distancing	Local decision
IOW	Mental Health & Learning Disability	LD Healthchecks	Service suspension	Discussions taken place with NHS Region as it is inappropriate to be bringing in LD patients the majority of which are shielded for F2F health checks. There is also further review on the constitution of an LD AHC.	Social distancing	National guidance

IOW	Mental Health & Learning Disability	MH - Community services	Change in pathway	Essential community health services have continued with appropriate risk assessments to support return to new business	Improve discharge coordination and efficiency	Local decision
IOW	Mental Health & Learning Disability	MH - Crisis provision	Change in access method	All MH Providers have 24/7 access to Mental Health Services either through established SPA and/or the 24/7 Mental Health Triage Service in NHS 111. Crisis hub is established and operational.	Improve discharge coordination and efficiency	National guidance
IOW	Mental Health & Learning Disability	MH - Crisis provision	Change in pathway	All Regions have either a Safe Haven or extended wellbeing offer to support out of hours Crisis support.Crisis and Urgent apps done remotely. Teams have capacity and working through waitiing list to manage list size to increase available capacity. Manage routine appointments to prevent backlog of cases.	Improve capacity Improve discharge coordination and efficiency	National guidance
IOW	Mental Health & Learning Disability	MH - BAME patients and staff	Increase in service	Targeted support for BAME is under discussion in MH with action underway from Workforce corporately	Responsive to emerging need	National guidance
IOW	Mental Health & Learning Disability	MH - service demands	Increase in service	Discussions with local providers and NHSE on modelling and expectations of demand and capacity for services. Working with comissioners around MHIS	Improve capacity Improve discharge coordination and efficiency	National guidance
IOW	Mental Health & Learning Disability	MH - psychological support	Increase in service	IoW NHS Trust has a full programme to support Key NHS staff. They have been supporting key services with Support for staff for during and post pandemic. CCG has commissioned online resource for support and self guided help.	Response based on need	National guidance

IOW	Mental Health & Learning Disability	MH Care (Education) and Treatment Reviews	Change in access method	Digital resources including virtual clinics and attend anywhere being used across services where appropriate to do so. Reviews should continue using online and digital approaches	Improve capacity Improve discharge coordination and efficienc	National guidance
IOW	Mental Health & Learning Disability	MH - Children and Young People	Change in access method	Currently in place. CYP are working across the integrated division and with third sector partners. Currently in discussion with the commissioners to develop further. Ensure that children and young people continue to have access to mental health services, liaising with your local partners to ensure referral routes are understood, particularly where children and young people are not at school	Needs based assessment improve capacity Improve discharge coordination and efficiency	Local decision based on national guidance
IOW	Mental Health & Learning Disability	MH - For existing patients	Change in access method	For existing patients known to mental health services, continue to ensure they are contacted proactively and supported. This will continue to be particularly important for those who have been recently discharged from inpatient services and those who are shielding. Services across MH are exploring how this information could be sourced , addressing and ensuring equality and need	Infection prevention	National guidance
Solent	Mental Health & Learning Disability	Adult Mental Health Community Service	Change in access method	Reducing face to face contacts and carrying out services remotely based on risk assessments	Remote working of staff / social distancing	National guidance
Solent	Mental Health & Learning Disability	Learning Disabilities Service	Change in access method, change in pathway	Reducing Face to face contacts with staff working remotely from home. 1) Delaying non-urgent referrals 2) Reducing direct patient contact 3) Supporting home working	Remote working of staff / social distancing	National guidance

Solent	Mental Health & Learning Disability	Talking Change/ IAPT services	Change in access method	Reducing face to face contacts and increasing remote working within the IAPT service. Administrators to work from home with reception closed. Very little change to service	Remote working of staff / social distancing	National guidance
Solent	Mental Health & Learning Disability	Adult Mental Health Recovery Team	Reduction in service	Partial reduction to service in Community AMH, Learning disability, IAPT and SMS- Reducing F2F contacts. For OOH service - Medics will come out for urgent psychiatric needs. Partial restriction to service from 27/03/2020 - Out of hours inpatient care - medics to come out for urgent psychiatric needs only. Safe remote plans including remote prescribing to be put in place. Non urgent medical reviews, medication adjustment, administrative work and other non-urgent care will be delayed until the daytime staff return. Urgent medical reviews, including requests for section 52 assessments will remain face to face with staff provided appropriate PPE where required.	Remote working of staff / social distancing	National guidance
Solent	Mental Health & Learning Disability	Jubilee House	Change in pathway	In order to simplify systems/processes and the overall management of the workforce Solent (Adults Portsmouth Service Line) to take back the management of patients in East wing of Jubilee House by Friday 3rd April.	Health risk	Local decision
Solent	Mental Health & Learning Disability	Secure Care	Increase in service	Due to the unprecedented and emergent challenges due to Covid 19 our Pan Hampshire 136 Partners Secure Care UK are offering to undertake additional activity in response to sudden challenges.	Health risks	Local decision
Solent	Mental Health & Learning Disability	Mental Healht PICU Service	Reduction in service	Partial restriction to service, reviewing seclusions remotely as required.	Remote working of staff / social distancing	

Solent	Mental Health & Learning Disability	Access to Communication Team	Reduction in service; change In access method	Reduction in face to face availability and reduced access.	Remote working of staff / social distancing	
Solent	Mental Health & Learning Disability	Autism Assessment Service	Change in access method	Partial reduction to service from early April 2020 -will not be booking face-to-face appointments.	Social distancing	National guidance
SHFT	Inpatient Services	Inpatient Wards	Increase in service	Additional capacity established for 136 Suite at Elmleigh	Increase capacity	
SHFT	Inpatient Services	Inpatient Wards	Change in service	Mental health inpatient wards temporary change to no section 17 leave and no family visits	Social distancing	
SHFT	Mental Health & Learning Disabilities	Psychiatric Liaison	Change of location of services	Psychiatric Liaison has been relocated away from EDs across Hampshire	Social distancing	
SHFT	Mental Health & Learning Disabilities	Beechwood House	Change in service provision	Beechwood ward (mental health ward for older people at Parklands Hospital) will temporarily become a ward for adult/older people with mental health issues who require physical health care for COVID-19. It will operate in this capacity as an 18 bedded ward from Monday 6 April 2020.	Increased bed capacity	National guidance
SHFT	Mental Health & Learning Disabilities	Community LD Teams	Change in service provision	This service has moved to a central referral point.	Social distancing	National guidance
SHFT	Mental Health & Learning Disabilities	Eating Disorder Service, April House	Change in method of access	Face to face clinics and groups changed to telephone support	Social distancing	National guidance
SHFT	Mental Health & Learning Disabilities	IAPT (Improving Access to Psychological Therapies) Services	Change in method of access	Face to face sessions have been cancelled and replaced with virtual consultations/appointments.	Social distancing	National guidance
SHFT	Mental Health & Learning Disabilities	Lighthouse Service	Change in method of access	The Lighthouse (run in partnership with Solent Mind) will temporarily run as a 'virtual' crisis lounge, as the premises in Shirley are too small to maintain safe social distancing.	Social distancing	Local decision

SHFT	Mental Health & Learning Disabilities	OPMH – community services	Change in method of access	face to face reviews replaced with video/tel. memory matters groups. Urgent clinical visits only. Dr clinics stopped clinics. Face to face CPAs replaced with telephone meetings	Social distancing	National guidance
SHFT	Mental Health & Learning Disabilities	Psychology Services	Change in method of access	Both acute and crisis teams have stopped ISP (Integral Somatic Psychology) group interventions for adult mental health inpatients, due to the risks posed by patients from the ward accessing ISP. In replacement, patients are being offering interventions via telephone and via Visionable.	Social distancing	National guidance
SHFT	Mental Health	Eating Disorders	Reduction in service	Southern health temporarily reduced face to face clinics and support groups for eating disorders to telephone support	Social distancing	National guidance
SHFT	Mental Health	Psychological	Reduction in service	Southern health temporarily changed face to face clinics and support groups for psychological services to 'zoom' support	Social distancing	National guidance
SHFT	Mental Health	Older Peoples' Mental Health	Reduction in service; change in method of access	OPMH face to face reviews temporarily reduced (only for high risk patients) other activity replaced with telephone / video support	Social distancing	National guidance
SHFT	Mental Health	ECT	Reduction in service; change in method of access	Mental health ECT service centralised to Parklands, day therapy service postponed, home visits replaced with telephone/video calls	Social distancing	National guidance
SHFT	Mental Health	EIP	Reduction in service; change in method of access	Mental health EIP service temporarily postponed face to face physical health reviews, home visits replaced with telephone/video calls, face to Face only for High Risk Patients	Social distancing	National guidance
SHFT	Mental Health	Community Services	Change in method of access	Mental health community teams temporarily reduced use of face to face services and working remotely via visionable	Social distancing	National guidance

SHFT	Mental Health	Crisis and Home Treatment	Reduction in service; change in method of access	Mental health crisis and home treatment service day therapy temporarily reduced use of face to face services (only for High Risk patients) and working remotely via visionable / telephone support	Social distancing	National guidance
Sussex Partnership	CAMHS	CAMHS	Increase in service	CAMHS 24/7 Telephone helpline linked to NHS 111 for children and young people who need emotional support mobilised	Social distancing	National guidance
PSEH	Site Changes	Mental Health Psych Liaison	Change in service location	Temporary relocation of mental health psych liaison service from QAH to Turner Centre, St James Hospital	Social distancing	Local decision

Urgent & Emergency Care and Acute Services

Provider	Service Category	Impacted Service	Type of Change	Detail of Change	Rationale	Directive
IOW	Ambulance Service	Conveyance Pathway	Increase in service	Pathway for direct admission into Acute Medical Ward and new referral pathways for Paediatrics agreed, rather than direct conveyance to ED	Social distancing	National guidance
IOW	Ambulance Service	Defib Network	Increase in service	Cessation of public access defib network implementation	Social distancing	Local decision
IOW	Medical	Cardiology (inc investigations)	Service suspension	Cardiac Investigation Unit. Urgent appointments only (including rapid access and pacemakers) Telephone or face to face where absolutely necessary Urgent Echo and 24 hour tapes only	Social distancing	National guidance
IOW	Medical	Care of the Elderly - respiratory	Change in pathway	Urgent appointments only Telephone or face to face where absolutely necessary		Local decision
IOW	Medical	Respiratory	Reduction in service change in access method	Urgent appointments only (including cancer fast track) Telephone or face to face where absolutely necessary		National guidance
IOW	Medical	Rheumatology – Diabetes Centre	Change in pathway	Urgent appointments only. Telephone or face to face where absolutely necessary Helpline available for prescriptions/advice Urgent infusions only	Improve capacity Improve discharge coordination and efficiency	National guidance
UHS	Urgent Care	Minor Injury and illness	Increase in service	Minor injury and illness moved from SGH to the Urgent Treatment Centre (RSH)	Responsive to emerging need	National guidance

SCAS	IUC	CAS	Increase in service	New COVID-19 Clinical Assessment Service has been commissioned an mobilised.	Improve capacity Improve discharge coordination and efficiency	National guidance
SCAS	IUC	Covid Response Service	Increase in service	New COVID Response Service (CRS) has been commissioned to take traiged 111 callers throught the NHS 111 Online Tool thus populating the CCAS queue.	Capacity	National guidance
HHFT	Emergency Services	Emergency Surgery	Change of location of services	Emergency Surgery centralised to RHCH	Improve capacity Improve discharge coordination and efficiency	National guidance
HHFT	Emergency Services	MIU at AWMH	Suspension of service	Andover War Memorial Hospital (AWMH) Minor Injuries Unit closed to move staff to ED	Staffing pressures	Local decision based on national guidance
SHFT	Community Services	Stroke Assessment 6mth F/U	Reduction in service	This service has stopped in line with national guidance.		National guidance
SHFT	Site Changes	Inpatient Physical Health	Change in access method	Therapy model changes to 20% staffing - reducing therapy, CHC work suspended	Remote working of staff / social distancing	National guidance
SHFT	Site Changes	RAU at Petersfield & Lymington	Change in access method, change in pathway	RAU: Gosport and Petersfield: stopped all routine consultations, only triaging urgent referrals.	Remote working of staff / social distancing	National guidance

SHFT	Site Changes	Additonal Beds: Petersfield, Romsey, Lymington, Gosport	Change in access method	Additional beds on Anstey Ward, Lymington New Forest Hospital, Ford Ward, Romsey Hospital, Gosport War Memorial Hospital and Petersfield Hospital.	Remote working of staff / social distancing	National guidance
PSEH	Community Services	Urgent Care	Suspension of service	Temporary closure of Urgent Care Centre and Cosham Park House ED Redirection Service	Remote working of staff / social distancing	National guidance
PSEH	Urgent Care	Voluntry Sector	Change in pathway	St Johns Ambulance 'hub' established temporarily on QA site to see minor injury and minor ailments patients overnight	Health risk	Local decision
PHT	Urgent Care	Rapid Assessment Unit	Increase in service	Temporarily postponed face to face clinics in Rapid Assessment Unit with move to video and telephone support	Health risks	Local decision
PHT	Site Changes	Inpatient Wards	Reduction in service	Temporary increase in bedded capacity at Spinnaker, Jubilee and Brooker wards - St James' Hospital	Remote working of staff / social distancing	
PHT	Urgent care	Minor Injuries	Reduction in service; change In access method	Temporarily redirect minor injury patients from QA ED to GWMH MIU, Petersfield MIU, St Marys UTC between the hours of 0800 and 2345	Remote working of staff / social distancing	
PHT	Urgent care	MIU/UTC	Change in access method	Increase in patient acuity accepted in MIUs/UTCs by review of the Directory of Service and increasing conditions accepted	Social distancing	National guidance
PHT	Urgent care	Minor Injuries Unit	Increase in service	Temporary extension of operational hours for GWMH MIU from 2000 to 2359	Increase capacity	
PHT	urgent care	Rapid Assessment Unit	Change in service	Temporarily postponed face to face clinics in Rapid Assessment Unit with move to video and telephone support	Redeployment of staff	
SCAS	Urgent Care	Call handling	Change of location of services	111 call handlers have been trained to do 999 calls	Social distancing	

SCAS	Urgent Care	Capacity	increase in service	999 spare capacity has been used to support PTS	Increased bed capacity	National guidance

Primary Care services

Service Category	Impacted Service	Type of Change	Detail of Change	Rationale	Directive
General Medical Services	Routine and Urgent Care	Change in method of access and change in location	GP Hot and cold sites, numerous locations Moving to hot and cold sites across East Central and West PCNs. To minimise the risk of exposure to patients by splitting locations in to appropriate Covid categories. Patients will be seen face to face by clinicians across PCN area rather than own GP surgeries.	Social distancing	National guidance
General Medical Services	Homeless Healthcare	Change in method of access and change in location	Partial restriction to service with reduced face to face care by increasing remote consultation and telephone triage. Face to face appointments only where required. Access to mobile phones is being mitigated by the provision of some phones to the most vulnerable individuals.	Social distancing	Local decision
General Medical Services	Gosport Practices	Suspension of service	GP routine appointments in Gosport: including health checks, routine smears, annual reviews (ie diabetic, respiratory, routine blood tests, travel vaccinations, face to face routine consultations/medication reviews) are cancelled	Social distancing	National guidance
General Medical Services	Red Hubs	Change in pathway / change in location	Operationalise 5 primary care red hubs across FG & SE Hants Forest Surgery, Bordon Waterlooville HC Forton Medical Centre, Gosport Highlands surgery , West Fareham Westlands surgery, East Fareham	Social distancing	Local decision

General Medical Services	Red Hubs across Portsmouth	Change in pathway / change in location	Operationalise 5 primary care red hubs across Portsmouth Wooton Street Practice Kingston Crescent Surgery Eastney Health Centre Milton Park Practice (St Marys Campus) Stubbington Avenue Waverley Road Derby Road Lake Road HC	Social distancing	National guidance
General Medical Services	Routine and Urgent Care	Change in access method	All patients triaged remotely - significant change in the way people access and receive general practice	Social distancing, improve capacity Improve discharge coordination and efficiency	National guidance
General Medical Services	Digital Econsult	Change in access method	Provision of e-consult deployed across all sites	Social distancing, improve capacity Improve discharge coordination and efficiency	National guidance
General Medical Services	Digital - video	Change in access method	Provision of video consultations deployed across all sites	Social distancing, improve capacity Improve discharge coordination and efficiency	National guidance

General Medical Services	Prescribing	Change in access method	Electronic prescribing - paper prescriptions are now the exception	Social distancing	National guidance
General Medical Services	Routine and Urgent Care	Change in pathway	Shielded patients -identifcation process; flagging patient records remotely	Social distancing, improve capacity Improve discharge coordination and efficiency	National guidance
General Medical Services	Hot/cold Sites	Change in service location	Hot/cold sites; people having to travel to access GP services	Social distancing, improve capacity Improve discharge coordination and efficiency	Local decision based on national guidance
General Medical Services	Infection & Prevention	Change in access method	Infection control - people being seen in alternative locations - e.g. cars, waiting in cars	Social distancing, improve capacity Improve discharge coordination and efficiency	National guidance
General Medical Services	LTC mangement	Supension of service	Services have been prioritised e.g. LTC management and routine checks reduced (many patients are shileded), therefore activity reporting stopped - QoF etc.	Managing demand	National guidance

General Medical Services	Routine and Urgent Care	Change in access method	General practice moved from face to face consultations to total triage model in line with national guidance	Social distancing, remote working of staff, social distancing	National guidance
General Medical Services	Routine and Urgent Care	Change in location of service	Gosport primary care temporary site consolidation to support workforce resilience for patients with non-covid symptoms (Green sites) for necessary primary care ie baby imms, leg dressings. Planning commenced 19/3/20 and operational from Mon 6/4/2020. Primary care staffing shared amongst the practices to support f2f at Rowner – Baby imms, Solent View - triage, GMC – bloods and nursing. Other sites reduced to admin functions – Bridgemary, Brockhurst, Bury Road, Stoke Road, Waterside, Brune	Social distancing	National guidance
General Medical Services	Routine and Urgent Care	Suspension of service	Southern Health ceased temporarily all routine appointments including health checks, routine smears, annual reviews i.e. diabetic, respiratory, routine blood tests, travel vaccinations, face to face routine consultations/medication reviews in line with national guidance	Remote working of staff / social distancing	National guidance

General Medical Services	Gosport Practices	Change in location of service and suspension of services	Gosport primary care temporary site consolidation to support workforce resilience for patients with non-covid symptoms (Green sites) for necessary primary care ie baby imms, leg dressings. Planning commenced 19/3/20 and operational from Mon 6/4/2020. Primary care staffing shared amongst the practices to support face to face at Rowner – Baby imms, Solent View - triage, GMC – bloods and nursing. Other sites reduced to admin functions – Bridgemary, Brockhurst, Bury Road, Stoke Road, Waterside, Brune	Social distancing	Local decision
General Medical Services	Routine Care	Suspension in service	Acute trusts focusing on urgent care therefore electronic referrals for routine care may be suspended	Social distancing	Local decision
General Medical Services	Enhanced Services screening and immunisations	Suspension of services and change in location	Reduction in face to face and potential change in location	Remote working of staff / social distancing	National guidance
General Medical Services	LD healthchecks	Change in access pathway, suspension of services	Reduction in face to face appointments may mean LD healthchecks are not competed. Consider what can be captured using remote technology and prior to the reintroduction of f2f	Remote working of staff / social distancing	National guidance
General Medical Services	NHS 111	Increase in service , change in pathway	Expansion of NHS 111 – establishment nationally of COVID-19 Clinical Assessment Service to triage and assess patients with symptoms of COVID-19. Direct booking of patients requiring assessment by primary care into GP Practice workflow	Increased virtual triage and assessment of patients with suspected COVID-19; Decreased demand on practices	National guidance

General Medical Services	Routine and Urgent Care	Change to pathway	Move to total triage system, initially assessed either by phone or online and where appropriate, given advice, managed remotely and/or ongoing monitoring by video consultation or other remote monitoring technology. Face to face assessments where required, provided at hot or cold site or as a home visit	As above – supports the safety of both patients and staff	National guidance
General Medical Services	Face to Face Services	Changes of location	Practices are either designated as 'hot sites' or may operate zoning where hot and cold workflow is separated across a geographically area. Patients may have to travel further to access care.	As above – supports the safety of both patients and staff	National Guidance
General Medical Services	Routine and Urgent Care	Changes of location.	Consolidation plans have been agreed across Primary Care Networks as agreed by CCG. Small number of branch sites temporarily closed which are kept under regular review.	General Practice resilience; supports continued provision of care	National Guidance
General Medical Services	Vulnerable Patients	Change in access method	Focus shielded patients and those who are vulnerable, and these have agreed care plans in place and are receiving the care and support they need. Strong links with Local Authority, voluntary sector and community networks to provide help and support with shopping, prescriptions and health and wellbeing.	Ensures people at highest risk from COVID-19 are safe and receive the care and support they need	National guidance
General Medical Services	Routine Care	Suspension of service	Temporary suspension of some general practice activity in line with national guidance.	capacity	National guidance

General Medical Services	Care Homes	Increase to service provision	PCNs and practices to align with care homes to reduce duplication, footfall and increase continuity of care, patients still retain the right of choice of general practice. Provision of weekly virtual MDT review with each care home abd provision of care and support, remotely or face to face. Personalised care plans to be agreed and in pace for all residents. Provision of pharmacy and medication support	Greater support to care homes and high risk patients. Education and training to care home staff and greater continuity of care	National guidance
Specialist Dental Services	Domicilliary service	Suspension of service	Suspended routine care and dental care on a domiciliary basis reduced to emergency care only to minimise contacts.	Social distancing	National guidance
Specialist Dental Services	Conscious sedation and GA services	Suspension of service	Suspended dental care under conscious sedation to minimise GA's on patients who may be in prodromal stage of Covid-19. All routine GA sedation services have been cancelled.	Social distancing	Local decision
Specialist Dental Services	Specialist dental care	Suspension of service	Cessation of all non-urgent dental care. Will only see patients with urgent dental care needs. Will defer all new patient referrals and telephone triage all patients providing advice where appropriate.	Social distancing	National guidance
Primary care	General practice	Change in pathway	Across Fareham, Gosport and South East Hants the Out of Hours and GP Extended Access site provision has been rationalised to align to hot and cold provision within primary care Green site - Portchester Health Centre Red site - Waterlooville Health Centre Red site - Forton Medical Centre, Gosport	Separate facilities for COVID suspected patients, and alignment to in hours primary care provision	National guidance

Community Services and Care Homes

Provider	Service Category	Impacted Service	Type of Change	Detail of Change	Rationale	Directive
IOW	Acute	Acute Therapies (Physio/SLT/OT)	Increase in service	Continuing to provide acute therapies input and further training carried out across wider team on respiratory physiotherapy to enhance skill set.	Social distancing	National guidance
IOW	Community Services	Podiatry	Increase in service	Moved to provision of life critical services only – continuing to provide urgent podiatry assessment and management and diabetic foot clinic . Teleconsultation being used where possible to further shield patients.	Social distancing	Local decision
IOW	Community Services	Orthotics and Prosthetics	Service suspension	Moved to provision of life critical services only. Team supporting manufacture of PPE and also continuing to provide New Amputees support (including discharge support) and O&P Emergency repairs or provision.	Social distancing	National guidance
IOW	Community Services	Community Rehabilitation (inc. Neuro Rehab and Community Rehab Bedded care)	Change in pathway	Moved to provision of life critical services only – Continuing to provide telephone or on line consultations where necessary whilst capacity available (will be utilised to support discharge once pressure rises) Use of teleconsultation continues across service e.g. Teleswallowing for SLT. Provision continues in bedded care settings and review of flow continues to ensure continued capacity to support acute pressure throughout period of increased demand.	Change in elective services	Local decision

IOW	Community Services	Community Nursing	Reduction in service; change in access method	Moved to provision of life critical services only including but not limited to Insulin dependent diabetics, EOL palliative care, urgent catheter care, urgent medicines management, support for immunosuppressed Patients, urgent bladder & bowel care, IV Antibiotic Management . Ongoing work also includes reviews of all caseloads and care plans, additional training provision to carers and Care Homes to administer low level support to residents, implementation of telehealth and remote monitoring for patients where suitable and daily review of any deferred work.	Staffing pressures	National guidance
IOW	Community Services	Community Therapies (Physio/SLT/OT/MSK/Dietetics)	Change in pathway	Moved to provision of life critical services only – Continuing to provide telephone or on line consultations where necessary whilst capacity available (some of resource will be utilised to support discharge once pressure rises) . Urgent spinal MSK triage and urgent dietetics assessment & management continue where required.	Improve capacity Improve discharge coordination and efficiency	National guidance
IOW	Site Changes	Community Unit	Increase in service	Move of Community Unit which provides step down bed backed care supporting patients rehabilitation and confidence on discharge from hospital. Moved from St Marys site into community (Ryde Health and Well Being Centre).	Responsive to emerging need	National guidance
Solent	Community Services	Pulmonary Rehab Service	Increase in service	Cessation - Pulmonary group closed. Staff redeployed to other services. Cancelling all 1:1 pulmonary Rehabilitation assessment in Face to face setting.	Improve capacity Improve discharge coordination and efficiency	National guidance

Solent	Community Services	Podiatry Routine and Remote Care	Increase in service	Tip Toe service has ceased in full. Podiatry service - ceased walk in provision, moved to remote triaging and consultations. Domiciliary visits will be carried out on a risk based approach.	Social distancing	National guidance
Solent	Community Services	Respiratory Hub	Suspension of service	Long term conditions Hub Respiratory. Cessation of service. LTC nurse to work with home oxygen team.	Improve capacity Improve discharge coordination and efficiency	National guidance
Solent	Community Services	Speech and Language Therapy Service	Change in access method ; reduction in service	Stopping non-urgent referrals & outpatient activity. Team are prioritising those at risk. All activity in to nursing homes stopped but staff will support with telephone and virtual consultations.	Social distancing	Local decision based on national guidance
Solent	Community Services	Specialist Palliative Care Service	Reduction in service	Partial restriction to service with early palliative care clinic stopped.	Unknown	National guidance
Solent	Community Services	Stoma Care	Change in access method	Partial reduction to service with home visits for pre-op cancer patients carried out. Admin to contact patients prior to visit re Covid screening questions. Support UHS inpatients emergency pre and post ops to support discharge ASAP. Telephone consultation provided for all patients following discharge from UHS for initial 6-8 wks after surgery. Staff working remotely and carrying out video consultations where practical.	Remote working of staff / social distancing	National guidance

Solent	Community Services	Cardiac Service	Change in access method, change in pathway	Cessation - Cardiac Rehab 3 (CR3) F2F appointments ceased. Patients will be called by service once a week at the time they would normally be attending rehab to make sure they are well, discuss concerns and to provide support. GPSI clinics and CR2 to continue based on patient choice. CR2 can have telephone assessment and home visit should it be required.	Remote working of staff / social distancing	National guidance
Solent	Community Services	Bladder and Bowel Service	Change in access method	Cessation of service - All Bladder and bowel non essential services have ceased during the Covid-19 period. For those with complex needs, contact numbers will be provided. Southampton: Patients will be phoned in order to carryout assessments and reviews.	Remote working of staff / social distancing	National guidance
Solent	Community Services	Tissue Viability Team	Reduction in service	Vulnerable patients identified and clinic appointments cancelled. Home visits arranged for clusters of patients in the localities across the city. No further visits to nursing homes to reduce risk of cross infection. TVNs will carry out tele consultations and share photographs via email.	Remote working of staff / social distancing	National guidance
Solent	Community Services	Spasticty Services	Change in pathway	Cancelling all clinic appointment for Spasticity and Botox clinic during the Coronavirus Pandemic for those patients on caseload and waiting list - all clinic sessions closed.	Health risk	Local decision

Solent	Community Services	Diabetes Adult Specialist Nursing	Increase in service	Ceased delivery of DESMOND programme (with exclusion of activity within pilot LTC Hub) from 18/03/2020. Partial cessation and partial restriction to service from 27/03/2020 - Cancelling all group education sessions and non essential F2F consultations. The diabetes service will have team mobile for UHS diabetes service to refer patients to Solent diabetes service who are requiring discharge from UHS following a 'live event related to diabetes'. The diabetes service will assess and provide intervention to manage the patient within UHS and then follow up within the community setting.	Health risks	Local decision
Solent	Community Services	Admiral Nursing Memory café	Reduction in service	Closed memory café due to high risk patients.	Remote working of staff / social distancing	
Solent	Community Services	Harry Sotnick House	Reduction in service; change In access method	Provision of an additional 20 beds. The Portsmouth system (PCC/Solent) have been requested to open 20 additional beds within Harry Sotnick House. Solent have been asked to provide 5 RN's to support the additional bedded capacity	Remote working of staff / social distancing	
Solent	Community Services	Community Neuro Rehab and Assessments	Change in access method	Western Community Hospital service. Partial reduction of service. Closed all non essential services. Closed VRS with immediate effect. Selected services will provide telephone consultations rather than F2F.	Social distancing	National guidance
Solent	Community Services	Tuberculosis Service	Increase in service	Partial restriction to service - Increasing remote consultation and telephone triage.	Increase capacity	

Solent	Community Services	Community Nursing	Change in service	Closure of night OOH service from 20/03/2020 - Patients will be advised of self-care process. Partial reduction of service - Identify vulnerable patients with RAG rating of Red/High on caseload. Arrange home visits for treatment based on Red RAG rating. Reduced visits to care homes to prevent spread of disease. Nursing Team are supporting care homes to deliver non-complex wound care through training and observation and then follow up support through phone/virtual consultation. Fortnightly reviews of care plans to take place.	Reduction due to capacity	
Solent	Sexual Health	HIV services	Change of location of services	Changing face to face consultations to telephone consultations. Consultants to identify stable patients that can have their bloods postponed for up to 6 months.A text message will be sent to patients advising that their face to face appointment will be changed to a telephone appointment.	Social distancing	
Solent	Sexual Health	Termination of pregnancies	Change in access method/change in location	Continue with telephone triage and treatment where required. If no contra-indications – treatment for EMA will be postponed. Those with contra-indications or over 10 weeks gestation will be seen after telephone consultation. No BPAS staff running out of Andover at this time, so clients who need to be seen will be seen in either Southampton or Basingstoke.	Increased bed capacity	National guidance
Solent	Sexual Health	Level 3 promotion service	Change in access method	Ceased delivering group work with 1:1's completed over the phone. schools have closed but SHP are picking up vulnerable clients and continuing 121s via phone.	Social distancing	National guidance

Solent	Sexual Health	Level 3 Outreach service	Change in access method	Outreach nurses will no longer be delivering services in to schools and colleges. They will complete telephone triage before visiting anyone in their homes.	Social distancing	National guidance
Solent	Sexual Health	Level 3 Psychosexual counselling Service	Change in method of access	Therapists self-isolating if in vulnerable groups. Conducting therapeutic consultations by phone and/or video. Ceasing new assessments for psychosex clients in line with national guidance, thereby pausing new referrals. This will be 5 members of staff in total	Social distancing	National guidance
Solent	Sexual Health	Level 3 Spoke Clinics - various locations	Change in method of access	Phased closure of spokes clinics depending on staffing levels, assessed daily. Reduced activity into clinics in line with national guidance from BASHH and FSRH by changing all initial appointments to phone calls where patient is assessed and only patients meeting the national urgent criteria are invited into clinic. Patients with symptom of COVID-19, COVID-19 positive or symptomatic household members are unable to attend clinic for up to 14 days. If patients require treatment that cannot be postponed, will be reviewed by a doctor to assess clinical risk of delaying treatment by 14/7. Closure of 3 hour clinics at Royal South Hants hospital on Saturdays.	Social distancing	Local decision
Solent	Sexual Health	Service Treatment by Post	Change in method of access	Patients requiring treatment for Chlamydia, herpes or emergency contraception who are self-isolating, will be contacted by a doctor who will complete a full telephone consultation including risk assessment for under 18's and vulnerable adults and prescribe medication for the patient.	Social distancing	National guidance

Solent	Sexual Health	Level 3 Remote Patient Consultation	Change in method of access	IOW Local authority / Public Health funded service. All patients will now have an initial consultation via the phone either with a nurse or a doctor to reduce the amount of patienst attending face to face appointments. The walk in model has ceased – all clients have to be invited into service- i.e. only if absolutely necessary	Social distancing	National guidance
Solent	Sexual Health	HIV services	Reduction in service	Changing face to face consultations to telephone consultations. Consultants to identify stable patients that can have their bloods postponed for up to 6 months.A text message will be sent to patients advising that their face to face appointment will be changed to a telephone appointment.	Social distancing	National guidance
Solent	Site changes	Assessment to Intervention	Reduction in service	Partial restriction. Change in management for A2i team to manage routine referrals differently- GP colleagues to be asked to delay non urgent referrals to wait until after the Covid 19 pandemic. Referrals will be more robustly screened and declined where it is felt assessments can wait. Telephone contact wherever possible rather than face to face, even for assessments. Will offer a route into services for GP's to ask questions or seek specialist advice without the need for patient assessment.	Remote working of staff / social distancing	National guidance
Solent	Site changes	MSK, Podiatry, GP Surgery, Tissue Viability - Southampton Services	Reduction in service; change in method of access	Adelaide Health Centre - Services will be temporarily displaced from the site: Southampton CCG services. Partial reduction of services - to facilitate increase in bed capacity in response to Covid-19.	Increase bed capacity and social distancing	National guidance

Solent	Site changes	Heart Failure Service	Reduction in service; change in method of access	Partial restriction - discontinue full service - Priority patients to continue to be seen for home visits. Each visit will be risk assessed as no PPE available. In addition can provide telephone support.		National guidance
Solent	Site changes	Home Oxygen Service	Reduction in service; change in method of access	Continue service in full as a priority. Routine activity ceased and focus on priorities. Reviews can occur both face to face and telephone.	Priority service review	National guidance
SHFT	Community Services	Rehabilitation	Change in method of access	Essential for discharge: The service has reduced in frequency based on national guidelines.		National guidance
SHFT	Community Services	Respiratory Services	Reduction in service; change in method of access	Routine appointments and routine home oxygen assessments cancelled, urgent o2 assessments continue. Spirometry and pulmonary function tests (PFT): This service has now ceased.	Social distancing	National guidance
SHFT	Community Services	Parkinson's Routine clinic	Increase in service	This service has stopped in line with national guidance.		National guidance
SHFT	Community Services	Blood Testing (Routine)	Change in service location	This service has stopped in line with national guidance.		Local decision
SHFT	Community Services	MS	Reduction in service	Reduced service continues with NHCCG - telephone service remains available for patients or professionals with queries.	Social distancing	Local decision
SHFT	Community Services	Vitamin B12 injections	Reduction in service	The service has reduced in frequency based on national guidelines.		National guidance
SHFT	Community Services	Heart Failure	Suspension of service	Face to face routine work cancelled.	Social distancing	National guidance
SHFT	Community Services	Wound Therapy Dressings	Reduction in service	The service has reduced in frequency based on national guidelines.		National guidance

SHFT	Community Services	Dietetic Clinics	Suspension of service	This service has stopped in line with national guidance. DESMOND patient group education stopped and nurses supporting care homes and ICTs with insulin administration.		National guidance
SHFT	Community Services	Diabetes Services	Reduction in service and change of access method	The diabetes service has moved to a single team across all sites to maintain a safe service. Group education is cancelled and the team are working on videos and webinars to replace this. The team is also updating its procedures regarding diabetes specialist nurses visiting people at home.	Social distancing	National guidance
SHFT	Community Services	Wound Clinics - routine	Suspension of service	This service has stopped in line with national guidance however self-care packs in relation to wound care will be given to all care home.Pressure Ulcer Panels: This service has stopped in line with national guidance.		National guidance
SHFT	Community Services	Continence Assessment	Suspension of service	This service, including urology and stoma, has stopped in line with national guidance.		National guidance
SHFT	Community Services	Nephrostomy	Reduction in service	Urinary tubes/bags care: The service has reduced in frequency based on national guidelines.		National guidance
SHFT	Community Services	Depot Injections	Reduction in service	For Prostap, Denusomab, Epoetin and Zoladex: The service has reduced in frequency based on national guidelines.		National guidance
SHFT	Community Services	Catheter Care	Reduction in service	The service has reduced in frequency based on national guidelines. PICC lines (peripherally inserted central catheter): The service has reduced in frequency based on national guidelines.		National guidance
SHFT	Community Services	Community Nursing	Reduction in service	Including Twilight and EPCT, P&SE: Reduced training, leg clinics stopped, caseload regularly reviewed.		local decision
SHFT	Community Services	Wheelchair Services	Reduction in service	The service has partially stopped, urgent work is continuing but routine has stopped.		National guidance

SHFT	Community Services	Continuing Health Care (NH Placements)	Suspension of service	This service has stopped in line with national guidance.		National guidance
SHFT	Community Services	Falls Assessment Clinics and Classes	Suspension of service	This service has stopped in line with national guidance.		National guidance
SHFT	Community Services	Medicine Or Dressing Deliveries	Suspension of service	This service has stopped in line with national guidance:		National guidance
SHFT	Community Services	Nursing Home Provision	Increase in service	Provision has increased	Support staffing pressures	National guidance
SHFT	Community Services	Pulmonary Rehabilitation	Suspension of service	This service has stopped in line with national guidance.		National guidance
SHFT	Community Services	QA Inreach	Increase in service; change in pathway	New discharge to assess process implemented, skeleton team working from QA rest in LAP at Fareham Reach	Support discharge	National guidance
SHFT	Community Services	Bowel care	Reduction in service	The service has reduced in frequency based on national guidelines.		National guidance
SHFT	Community Services	Leg Clinics	Suspension of service	Southern Health temporarily ceased leg clinics	Social distancing	National guidance
SHFT	Community Services	Falls	Reduction in service	Southern Health temporary reduction in service capacity for balance and safety classes and chronic condition management	Social distancing	National guidance
SHFT	Community Services	Community Diabetes	Suspension of service	Community diabetes DESMOND patient group education temporarily postponed	Social distancing	National guidance
SHFT	Community Services	Home Oxygen	Suspension of service	Routine appointments and routine home oxygen assessments temporarily postponed	Social distancing	National guidance
SHFT	Nursing Homes	Nursing Home Group Sessions	Suspension of service	Southern Health temporarily cease nursing home Forums/group sessions. Ceased intense and focused support to small number of Homes to broaden reach	Social distancing	National guidance

SHFT	Site Changes	Community Services	Change in location	Temporary relocation of Community HF and ICT services from Waterlooville Health Centre to Denmead and Havant Health Centre	Increase capacity	Local decision
NDPP	Community Services	Diabetes Prevention	Suspension of service	National Diabetes Prevention Programme temporarily paused until a digital model can be mobilised	Social distancing	National guidance
PSEH	Community Services	Nursing Homes	Increase in service	Temporary additional bedded capacity purchased in Wellington Vale, Greenbanks, Denmead Grange and Peel House Nursing / Rest homes	Increase capacity	Local decision
PSEH	Community Services	Nursing Homes	Increase in service	Temporarily re-open Woodcot Nursing home	Increase capacity	Local decision
PSEH	Community serivces	Community beds	Increase in service	Temporarily increase community bedded sites at Petersfield Community Hospital and Gosport War Memorial Hospital	Increase capacity	Local decision

Networked Care Services

Provider	Service Category	Impacted Service	Type of Change	Detail of Change	Rationale	Directive
IOW	Diagnostics	Diagnosic Imaging	Increase in service	Urgent/Cancer & Emergency Only	Social distancing	National guidance
IOW	Diagnostics	Phlebotomy	Increase in service	Urgent GP walk in Only Phlebotomy Ryde clinic- closed	Social distancing	Local decision
IOW	Diagnostics	Pathology	Service suspension	Urgent/Cancer & Emergency Only	Social distancing	National guidance
IOW	Diagnostics	Outpatient Services	Change in pathway	Urgent/Cancer & Emergency Only	Staffing pressure	Local decision
IOW	Diagnostics	Pathology	Reduction in service	Pathology St Mary's Hospital - Emergency Only		National guidance
IOW	Medical	Asthma & Allery Services	Change in pathway	Relocated to GP surgery due to repurposing of normal location for urgent care. Reduced outpatient service, telephone clinics taking place instead of face to face clinics. Only carrying out emergency Xolair and immunotherapy interventions	Improve capacity Improve discharge coordination and efficiency	National guidance
IOW	Medical	Dermatology (Crocker Street)	Increase in service	Urgent appointments only Telephone or face to face where absolutely necessary	Responsive to emerging need	National guidance
IOW	Medical	Diabetes and Endocrinology - Diabetes Centre	Increase in service	Urgent Appointments only Telephone or face to face where absolutely necessary Foot clinic still taking place	Improve capacity Improve discharge coordination and efficiency	National guidance

IOW	Medical	Gastroenterology – Respiratory department (or Endsocopy)	Increase in service	Urgent appointments only (including appropriate endoscopies) Telephone or face to face where absolutely necessary		National guidance
IOW	Medical	Multiple Sclerosis – Diabetes Centre	Reduction in service change in access method	Urgent appointments only Telephone or face to face where absolutely necessary Disease modifying therapies taking place	Improve capacity Improve discharge coordination and efficiency	National guidance
IOW	Medical	Neurology – Respiratory department	Reduction in service change in access method	Urgent appointments only Telephone or face to face where absolutely necessary		Local decision based on national guidance
IOW	Medical	Osteoporosis – Respiratory department	Reduction in service change in access method	Urgent appointments only Telephone or face to face where absolutely necessary Urgent Infusions only		National guidance
IOW	Medical	Parkinsons	Change in access method	Urgent appointments only.Telephone or face to face where absolutely necessary Any patients who require support or advice can call the Parkinson Nurse Patient link with the neurologist regarding medication issues as GP's continuing to refer to Parkinsons Nurse for this	Remote working of staff / social distancing	National guidance
IOW	Medical	Rheumatology – Diabetes Centre	Change in access method, change in pathway	Urgent appointments only. Telephone or face to face where absolutely necessary Helpline available for prescriptions/advice Urgent infusions only	Remote working of staff / social distancing	National guidance

IOW	Surgical	Gynaecology	Change in access method	Routine face to face appointments ceased or switched to phone appointments if possible. Hysteroscopy, colposcopy and cancer outpatients continuing if in RCOG guidance.	Remote working of staff / social distancing	National guidance
IOW	Surgical	ENT Services	reduction in service change in access method	Reduced outpatient service, telephone clinics taking place instead of face to face clinics. Only carrying out emergency and selected cancer interventions.	Remote working of staff / social distancing	National guidance
IOW	Surgical	Maxillofacial	Change in pathway	Reduced outpatient service, telephone clinics taking place instead of face to face clinics. Only carrying out emergency and selected cancer interventions.	Health risk	Local decision
IOW	Surgical	Chronic Pain	Increase in service	Reduced outpatient service, telephone/ virtual clinics taking place instead of face to face clinics. No new patients being seen and all interventions have been cancelled.	Health risks	Local decision
IOW	Surgical	General Surgery	Reduction in service	Telephone and video link assessment appointments being undertaken as deemed appropriate by relevant clinician. Small percentage of Cancer Fast Track Surgery on a case per case basis. Ceased Endoscopy and Gastroscopy interventions and all other inpatient/daycase surgery.	Remote working of staff / social distancing	National guidance
IOW	Surgical	Orthopaedic Surgery	Reduction in service; change In access method	Urgent Trauma Surgery being undertaken as necessary, Fracture clinic appointments when deemed urgent undertaken face to face. Telephone assessments in place. All other non emergency Orthopaedic surgery has ceased.	Remote working of staff / social distancing	National guidance
IOW	Surgical	PAAU (Pre-assessment and Admission Unit)	Change in access method	Cancer Fast Track patient pre-assessments being undertaken as deemed clinically appropriate by admitting surgeon. Anaesthetic reviews as required for said patients. .	Social distancing	National guidance

IOW	Surgical	Urology	Increase in service	Telephone and video link assessment appointments being undertaken as deemed appropriate by relevant clinician. Small percentage of Cancer Fast Track Surgery on a case per case basis. Ceased Cystoscopy and straight to test interventions and all other inpatient/daycase surgery.	Increase capacity	
IOW	Surgical	Ophthalmology	Change in service	Telephone and video link assessment appointments being undertaken as deemed appropriate by relevant clinician. Urgent outpatients seen face to face following consultant triage. Emergency patients being seen as referred from ED. No elective surgery being undertaken. Sight-saving emergency surgery continuing. Macular injections continuing for high risk patients.	Social distancing	
UHS	Outpatients	Outpatients	Change of location of services	Outpatient services moved from f2f to telephone/video call	Social distancing	
UHS	Outpatients	Outpatients & Diagnostics	Change of Location	Services moved off site, Spire Southampton ISTC at RSH,Nuffield	Increased bed capacity	National guidance
UHS	Surgery	Elective Surgery	Change of Location	Services moved off site, Spire Southampton ISTC at RSH,Nuffield	Social distancing	National guidance
UHS	Inpatients	Inpatient Care	Change of Location	Services moved off site, ISTC at RSH,Nuffield	Social distancing	National guidance
UHS	Cancer	Cancer services	Change in method of access	Chemotherapy and day treatments provided from private facilities were possible	Social distancing	National guidance
UHS	Elective Surgery	Elective Surgery	Change in method of access	All elective surgery has been paused at SGH	Social distancing	Local decision

UHS	Outpatients	Face to face	Change in method of access	All face to face outpatient appointments have been paused at SGH	Social distancing	National guidance
UHS	Elective Surgery	Elective Surgery	Change in method of access	All elective surgery has been paused at Lymington	Social distancing	National guidance
HHFT	Maternity	Maternity Home Births	Reduction in service		Staffing pressure	National guidance
HHFT	Cancer Services	Haemotology/Oncology	Reduction in service	Haemotology / Oncology moved from BNHH and RHCH to Private Facility (Sarum Road, BMI)	Reduction of risk of infection for vulnerable patients	National guidance
HHFT	Cancer Services	Pseudomyxoma	Reduction in service; change in method of access	Pseudomyxoma moved to Wellington, London – 2 prioritised cases	Reduction of risk of infection for vulnerable patients	National guidance
HHFT	Cancer Services	Urgent and Cancer surgery	Reduction in service; change in method of access	Urgent and Cancer surgery managed through prioritisation panel and facilitated at DTC (BNHH) / Hampshire Clinic, BMI	Reduction of risk of infection for vulnerable patients and staffing pressures	National guidance
HHFT	Cancer Services	Breast Surgery	Reduction in service; change in method of access	Breast surgery from BNHH and RHCH moved to Sarum Rd (BMI)	Reduction of risk of infection for vulnerable patients	National guidance

Solent	Community services	MSK	Change in method of access	Partial reduction in services reduced face to face work - telephone triage and telephone appointments will be utilised. MSK and pain group work reduced. MSK diagnostics (via Inhealth) ceasing all non urgent diagnostic tests.		National guidance
Solent	Community services	Vasectomy procedures	Reduction in service; change in method of access	Vasectomy Service provided by Marie Stopes International within the IOWT - Vasectomy procedures have ceased from 24.03.2020. GPs will not forward referrals during the Covid-19 period	Social distancing	National guidance
Solent	Community services	Vasectomy procedures	Increase in service	Vasectomy Service, various locations including GP vasectomy providers / Southampton CCG service - Vasectomy procedures have ceased from 24.03.2020. GPs will not forward referrals during the Covid-19 period	Social distancing	National guidance
SHFT	Community Services	DEXA bone scanning	Change in service location	This service has stopped in line with national guidance.		National guidance
SHFT	Community Services	Diagnostics (Outpatient Routine)	Suspension of service	This service, i.e. 24 hour tapes, plain film x-ray, MRI, CT, ultra-scan, has stopped in line with national guidance.		National guidance
SHFT	Community Services	Endoscopy (Routine)	Suspension of service	This service has stopped in line with national guidance.		National guidance
SHFT	Community Services	Electro-Convulsive Therapy	Reduction in service	ECT has had to be reduced due to availability of Acute Trust staff and have moved to providing in Acute theatres for high risk patients	Staffing pressures	

SHFT	Community Services	Ultrasound Routine Appointments	Service suspension	These, including guided injections, have now stopped:	Prepare for redpeloyment of staff	Local decision to stop services - national guidance was to prioritise
SHFT	Community Services	Medical Outpatient Depts	Service suspension	This service, i.e. respiratory, cardiology, medical, ENT, has stopped in line with national guidance.		National guidance
SHFT	MSK	Orthopaedic Choice	Service suspension	This service, except urgent triage, has stopped in line with national guidance.		National guidance
SHFT	MSK	Outpatient Services (particularly MSK & Podiatry	Change in discharge process	Patients who are cancelling and not wishing to reschedule are discharged on SOS (self-referral of symptoms) so that they can self-refer back into the service at any point over the next 12 months.	Social distancing	National guidance
SHFT	MSK	All MSK	Change in method of access	MSK services are currently only providing a telephone service and this is predominantly triage, advice and discharge.	Social distancing	National guidance
SHFT	Site Changes	Gastro Services Lymington	Service suspension	This service is now closed.	Social distancing	
SHFT	Site Changes	Rhuematology Services Lymington	Service suspension	This service is now closed.	Social distancing	
SHFT	Site Changes	MRI's Routine	Exclusion criteria for patient cohort	This service is being cancelled for those over 70 years old at Lymington	Social distancing	
PSEH	Community Services	MSK	Change in access method	Community MSK services temporarily providing telephone and triages service and postponing face to face activity	Social distancing	National guidance

PSEH	Elective	MSK	Change in access method	Introduction of MSK app for use by patients presenting to primary care	Social distancing	National guidance
PSEH	Diagnostics	Endoscopy	Increase in service	Temporary increase in service provision for endoscopy at CareUK	Increase capacity	
PSEH	Indepedant sector	Elective	Suspension of service	Temporary cessation of private activity at SPIRE in line with NHS IS contract		National guidance
PHT	Outpatients	Outpatient Appointments	Change in access method	New outpatient appointments to be conducted in QA temporarily by telephone for renal patients	Social distancing	National guidance
PHT	Diagnsotics	Chest X-ray	Change in access method	Temporarily move from walk in chest x-ray provision at QA to booked appointment only	Social distancing	National guidance
PHT	Diagnostics	Endoscopy	Reduction in service	Temporary reduction in number of endoscopy suites at QAH from 6 to 2	Social distancing	National guidance
PHT	Maternity Services	Maternity Services	Change in location	Temporarily relocate maternity service from Grange ward to Willow Ward - Petersfield Hospital	Increase capacity	Local decision
PHT	Diagnostics	Phlebotomy	Suspension of service and change in access method	Temporary closure of walk in Phlebotomy service at QA – booked appointments for patients with acute requirements and increase in service provision in community hubs for routine blood taking	Increase capacity	National guidance
PHT	Surgery	Elective surgery	Increase capacity	Temporary change in use of capacity at St Marys Treatment Centre to convert elective area to 44 step down beds	Increase capacity	Local decision
PHT	Surgery	Elective	Suspension of service and change in access method	Routine elective work temporarily stood down including outpatients, diagnostics and procedures – moved to virtual model where possible at specialty level		

PHT	Surgery	Gastro	Change in pathway	GPs asked to use A&G for Gastro patients with lower risk patients being managed in primary care with management plan following clinical triage		
PHT	Cancer Services	2WW Gastro	Change in pathway	All 2ww and urgent Gastro patients being contacted by phone temporarily to make appropriate clinical plan	Social distancing	
PHT	Surgery	ENT	Reduction in service	Only emergency and cancer care routinely being provided temporarily for ENT patients with extended advice and guidance service being offered for routine requests	Social distancing	
PHT	Surgery	Gastrology	Change in pathway	GPs asked to use A&G for Gastro patients with lower risk patients being managed in primary care with management plan following clinical triage	Social distancing	National guidance

Children and Young People

Provider	Impacted Service	Type of Change	Detail of Change	Rationale	Directive
IOW	Paediatric Services	Change in access method and reduction of service	Telephone & Video Link Assessment appointments being undertaken as deemed appropriate by relevant clinician. Shielded children being supported at home. No non urgent face to face appointments. Provision of 8:00-24:00, 7/7 urgent care in paediatric footprint.	Social distancing	National guidance
IOW	0-19 Services - Health Visiting, CHIS & School Nursing	Reduction in service	Moved to provision of life critical services only – continuing to provide duty helpdesk with phone and online consultation taking place to ensure continued support for families, safeguarding, birth visits and CHIS birth notifications in liaison with GP Practices, 6-8 week infant visits and immunisation continuing .	Staffing pressures / social distancing	Local decision
IOW	Children's Therapies (OT/Physio/SLT	Reduction in service	Moved to provision of life critical services only – Continuing to provide telephone or on line consultations where necessary to support families, Paediatric ward discharge facilitation, Urgent assessment & Reviews (Inpatient & Community), and Urgent Paediatric Mental Health	Staffing pressures / social distancing	National guidance
Solent	Paediatric Therapies Services	Change in access method and reduction of service	Thornhill & Adelaide Health Centre - reduced service to 0-19 Service (Antenatal / Child clinics) - Reduction in face to face contacts. Telephone consultations offered as alternative.	Social distancing	National guidance

Solent	Antenatal/ Child Clinics	Reduction in service; change in access method; change in location	Reduced service to 0-19 Service (Antenatal / Child clinics) with reduction in face to face contacts. Plan to move some clinics from the QA Hospital to the Children's Development Centre at Battenburg	Social distancing	National guidance
Solent	Children and Families Service	Change in access method; reduction to service	Providing as much business as usual as possible using digital options/skype/phone etc. alongside face to face interventions where clinically indicated.	Improve capacity Improve discharge coordination and efficiency	National guidance
Solent	Health Visiting	Reduction in service; change in access method	Partial restrictions with increase in telephone contacts and use of technology to provide services remotely.	Remote working of staff / social distancing	National guidance
Solent	School Nursing	Suspension of serivce	School nursing service and school aged immunisations . Service cessation due to school closures. SAI are currently postponed whilst schools have closed and will be resumed post COVID response incorporating plans for catch up programmes.	Improve capacity Improve discharge coordination and efficiency	National guidance
Solent	Community Nursing Service	Reduction in serivce	Reduced service - All essential face to face clinical activity and interventions for children on CCN caseload or referred from PHT – will be assessed case by case and considered for either home visit or clinic appointment.		National guidance

Solent	CAMHS Psychiatry Jigsaw	Change in access and suspension of service	CAMHS care, eating disorders and behavioural resource services. Reduced CAMHS appointments with telephone consultations taking place. Duty cover will still be in place to escalate any young people that become unwell whilst waiting. Urgent care will still be offered. Stopping routine referrals.	Improve capacity Improve discharge coordination and efficiency	National guidance
Solent	Community Paediatric Medical Service	Reduction in service; change in access method; change in pathway	St James Hospital/Battenburg Clinic service - partial reduction of service - face to face clinical appointments for neurodevelopment/neurodisability (ND) will only be where clinically indicated for immediate management of clinical care. Telephone or skype consultations to be provided where possible. New referral criteria remains as at present, however, waiting lists managed according to RAG rating criteria. 8 EHCP assessments to be carried out by telephone and based on RAG priority cases. All review LAC and adoption appointments to be carried out by telephone.	Reduction due to capacity	Local decision based on national guidance
Solent	Coast	Suspension of service	Solent East COAST team in Partnership with NHS 111: temporary move to telephone, support, advice and guidance service only rather than face to face.	Social distancing	National guidance
SHFT	Child Health Clinics	Suspension of service	Child health clinics, community group baby clinics and group work have been suspended and staff have been redeployed (The ChatHealth service is open as usual). School Nursing has stopped and health visiting services are reduced.	Remote working of staff / social distancing	National guidance
SHFT	Maternity and Health Visiting	Reduction in service	A number of appointments and assessments have now been temporarily postponed; including booking appointments which are undertaken via phone	Remote working of staff / social distancing	National guidance

Homelessness

Provider	Service Category	Impacted Service	Type of Change	Detail of Change	Rationale	Directive
Local authorities	Housing allocations	Housing provision to prevent and reduce homelessness	Increase in service	Government 'everyone in' directive' meant HIOW local authorities sourcing c500 units of accommodation temporary accommodation to enable people self-isolate and move off the streets	Social distancing	National guidance
Local authorities	Housing advice	Housing advice to prevent and reduce new homelessness cases	Increase in service	Less face-to-face, more contact online/phone	Social distancing	Local decision
Support Providers	Housing / health advice	Visiting support, street outreach services, appointments to sustain people in accommodation & meet health & support needs	Service suspension	Less face-to-face, more contact online/phone	Social distancing	National guidance
Registered Providers	Housing allocations	Day to day letting of properties on hold / minimised	Change in pathway	Lettings only taking place when necessary re health, risk	Physical distancing	Local decision
Hostel providers	Housing allocations	Reduction in capacity where people normally share rooms	Reduction in service	Shared rooms now single occupancy	Physical distancing	National guidance
Hostel providers	Health & wellbeing	Allocation of washing facilities & management of food provision to reduce number of people sharing	Change in pathway	Designated washing and dining areas in hostels for residents	Improve capacity Improve discharge coordination and efficiency	National guidance
Acute Hospitals	Hospital discharge	Discharge hubs	Increase in service	Acute staff informed of need for communications with local authoritiess, hostel and support providers to plan safe and effective discharge	Responsive to emerging need	National guidance

Primary Care	Homeless health	Bespoke service offers in Portsmouth, Southampton & Winchester. Inconsistent across HIOW.	Increase in service	Partial restriction to service with reduced face to face care by increasing remote consultation and telephone triage. Face to face appointments only where required. Access to mobile phones is being mitigated by the provision of some phones to the most vulnerable individuals. Meant less access to health services.	Improve capacity Improve discharge coordination and efficiency	National guidance
Acute Hospitals	Hospital triage	Assessment of people experiecing homelessness on arrival at ED	Increase in service	Acute staff informed of need for communications with local authorities, hostel and support providers to ensure people not told to self-isolate when not achievable.	Physical distancing	National guidance
Primary Care	Find & test	COVID19 testing	increase in service	Provision of testing in hostels where people displaying COVID19 symptoms - new service	Improve capacity Improve discharge coordination and efficiency	National guidance
Southern / Solent	Mental health	Community offer being directed into hostels and temporary accommodation where required	increase in service	Supporting individuals to maintain acommodation offer / placement	Health, recovery & safety	Local decision based on national guidance
Inclusion	Substance misuse	Community offer being directed into hostels and temporary accommodation where required	increase in service	Supporting individuals to maintain acommodation offer / placement	Health, recovery & safety	National guidance
Day Centres	Day services	Provision of accessible drop in food, wellbeing, training, acccommodation finding services across HIOW	Change in access method	Closure of services, reduction in face to face health interventions, support and food provision	Remote working of staff / social distancing	National guidance

Discharge

Provider	Service Category	Impacted Service	Type of Change	Detail of Change	Rationale	Directive
HCC	Community Services	In-Reach	Increase in service	In-reach across all acute settings withdrawn from hospital and working from Single Point of Access	Social distancing	National guidance
Hampshire multi-agency	Community Services	All community services	Increase in service	Single Point of Access: Multi-agency and multi-disciplinary team in place to drive discharge out of hospital using Discharge to Assess approach. New processes and SOP in place.	Social distancing	Local decision
Hampshire multi-agency	Acute	All community services	Service suspension	Change in referral process from acute into community via the single point of access	Social distancing	National guidance
HCC	Acute	Social work teams	Change in pathway	Hospital social work teams no longer working from acute sites, referrals via the single point of access	Social distancing	Local decision
Hampshire multi-agency	Community Services	All community services	Change in access method	SharePoint site accessible by all health and social care partners to enable sharing of patient data and oversight of delivery service	Support discharge	National guidance
Hampshire multi-agency	Community Services	All community services	Change in pathway	Discharge tracker database created to support management of patients through the discharge process, accessible by all organisations	Improve capacity Improve discharge coordination and efficiency	National guidance
Hampshire multi-agency	Acute	All community services	Increase in service	Referral form created for Single Point of Access referrals	Responsive to emerging need	National guidance
Hampshire multi-agency	Community Services	All community services	Increase in service	Suspension of funding panels - arrangements in place between HCC and CCG for funding under Covid	Improve capacity Improve discharge coordination and efficiency	National guidance

HCC	Nursing Homes	Reablement	Increase in service	In-house reablement bed capacity redirected to Single Point of Access	Support discharge	National guidance
Hampshire multi-agency	Nursing Homes	Nursing home provision	Increase in service	Continued winter provision where available and sourced extra capacity via CCGs	Improve capacity Improve discharge coordination and efficiency	National guidance
Hampshire multi-agency	Community Services	All community services	Change of location	Cross organisational executive lead appointed in each system to lead Single Point of Access model	Support discharge	Local decision based on national guidance
Hampshire multi-agency	Community Services	All community services	Change in access method	Interim leadership and management structure, roles and responsibilities for Single Point of Access	Support discharge	National guidance
Hampshire multi-agency	Acute	All community services	Change in access method	Twice daily virtual Single Point of Access Multi-disciplinary Team meetings enabling communication between acutes and community services	Remote working of staff / social distancing	National guidance
HCC	Community Services	Reablement	Change in access method, change in pathway	Key triage staff only accessing reablement hub	Remote working of staff / social distancing	National guidance
Hampshire multi-agency	Community Services	All community services	Change in access method	Single Point of Access operational 7 days per week 8am - 5pm	Remote working of staff / social distancing	National guidance
Hampshire multi-agency	Community Services	Community therapies	Increase in service	Therapy and physio in place 7 days per week	Remote working of staff / social distancing	National guidance

HCC	Community Services	All community services	Change in pathway	Equipment store working 7 days per week	Health risk	Local decision
CHC	Community Services	Continuing health care	Increase in service	Continuing health care staff transferred to discharge to access activity and providers	Health risks	Local decision
CHC	Community Services	Continuing health care	Reduction in service	Continuing health care assessments stood down	Remote working of staff / social distancing	
Hampshire multi-agency	Community Services	All community services	Reduction in service; change In access method	Additional bed capacity commissioned in Hotels	Remote working of staff / social distancing	
Hampshire multi-agency	Community Services	All community services	Change in access method	New process for referrals into interim hotel beds	Social distancing	National guidance
Hampshire multi-agency	Community Services	All community services	Increase in service	New homeless referral process	Increase capacity	
IOW	Community Services	Discharge out of Hospital	Change in service	Single Point of Access: Multi-agency and multi-disciplinary integrated team in place to drive discharge out of hospital using Discharge to Assess approach.	Hospital flow	
IOW	Community Services	Community Rapid Response	Change of location of services	Service will continue but with focus on non-COVID19 patients to support admission avoidance in conjunction with Primary Care. Also implemented use of Telehealth and remote monitoring.	Social distancing	
Solent	Community Services	Community Independence Service	Reduction in service	Stopped all non-essential activity - admission avoidance and early discharge support provided. Patient caseloads put on hold.	Increased bed capacity	National guidance
SHFT	Community Services	HC - fast track provision assessments	Reduction in service	The service has reduced in frequency based on national guidelines.	Social distancing	National guidance

SHFT	Community Services	Crisis and Home Treatment Team	Suspension of service	Day therapy stopped, contacts via video and telephone.	Social distancing	National guidance
SHFT	Community Services	ICT Admission and Palliative Care	Change in method of access	Increase ICT admission avoidance and Palliative Car	Social distancing	National guidance

This page is intentionally left blank

Skipton House
80 London Road
London SE1 6LH
england.spoc@nhs.net

From the Chief Executive Sir Simon Stevens
& Chief Operating Officer Amanda Pritchard

To:
Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers
GP practices and Primary Care Networks
Providers of community health services
NHS 111 providers

Copy to:
NHS Regional Directors
Chairs of ICSs and STPs
Chairs of NHS trusts, foundation trusts and CCG governing bodies
Local authority chief executives and directors of adult social care
Chairs of Local Resilience Forums

29 April 2020

Dear Colleague,

IMPORTANT - FOR ACTION - SECOND PHASE OF NHS RESPONSE TO COVID19

We are writing to thank you and your teams for everything you have achieved and are doing in securing the remarkable NHS response to the greatest global health emergency in our history.

On 30th January the first phase of the NHS's preparation and response to Covid19 was triggered with the declaration of a Level 4 National Incident. Then in the light of the latest SAGE advice and Government decisions, on 17th March we wrote to initiate what has been the fastest and most far reaching repurposing of NHS services, staffing and capacity in our 72-year history.

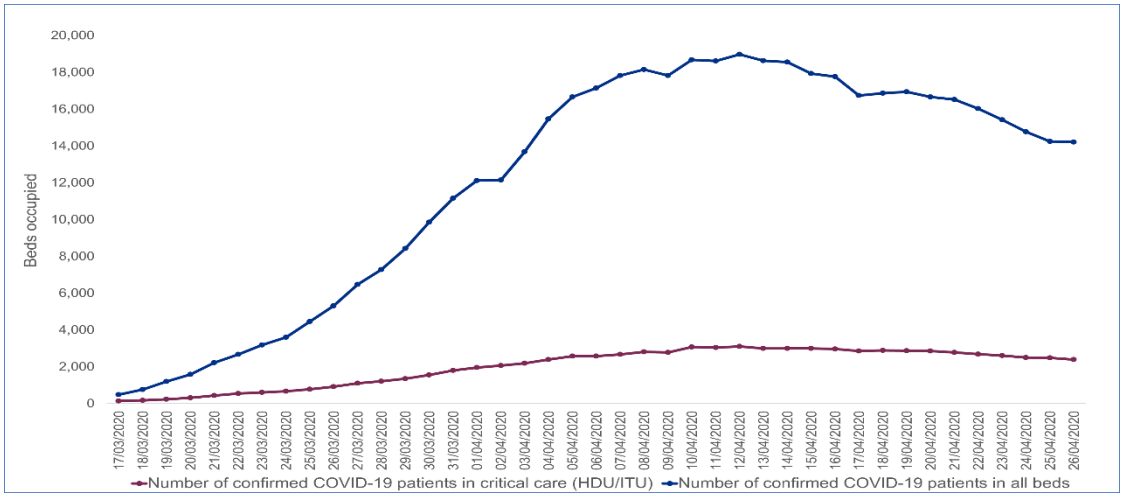
This has enabled us in the space of the past six weeks to go from looking after zero such patients to caring for 19,000 confirmed Covid19-positive inpatients per day, many of whom have needed rapidly expanded critical care support. Alongside this, the majority of patients the Health Service has continued to look after have been receiving care for other important health conditions. Despite real concern going in to the pandemic – following difficult international experience – every coronavirus patient needing hospital care, including ventilation, has been able to receive it.

This has largely been possible as a result of the unparalleled commitment and flexibility of NHS staff, combined with the public's 'social distancing' which remains in

place to cut the spread of the virus. We have also been greatly strengthened by over 10,000 returning health professionals; 27,000 student nurses, doctors and other health professionals starting their NHS careers early; 607,000 NHS volunteers; and the work of our partners in local government, social care, the military, the voluntary sector, hospices, and the private sector.

Sadly coronavirus looks set to be with the us for some time to come, so we will need continuing vigilance. We are, however, now coming through this peak of hospitalisations, as seen by the drop of nearly 5,000 in the daily number of confirmed Covid19-positive patients in hospitals across England over the past fortnight.

Patients with confirmed Covid19 in hospital beds, England



As the Prime Minister set out on Monday, we are therefore now entering the second phase in the NHS's response. We continue to be in a Level 4 National Incident with all the altered operating disciplines that requires. NHS organisations therefore need to fully retain their EPRR incident coordination functions given the uncertainty and ongoing need. The purpose of this letter is to set out the broad operating environment and approach that we will all be working within over the coming weeks.

Based on advice from SAGE, we still expect to be looking after several thousand **Covid19-positive patients**, though hopefully with continuing weekly decreases. This means:

- Ongoing and consistent application of PHE/NHS Infection Prevention and Control guidance in all NHS organisations, with appropriate cohorting of Covid/non-Covid patients (https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control).

- In response to the global shortage, DHSC and the Cabinet Office together with BEIS (for UK manufacture) and DIT (for international suppliers) continue to expand the sourcing and procurement of HSE/PHE-recommended PPE for the NHS, social care and other affected sectors of the UK economy, but it is likely that current Covid-specific logistics and distribution arrangements will need to continue for the time being.

- Increased lab capacity now enables testing of all non-elective inpatients at point of admission, the introduction of pre-admission testing of all elective patients, testing prior to discharge to a care home, as well as expanded testing for staff. The corollary is the operational importance of fast turnaround times for test result reporting.

The pressure on many of **our staff** will remain unprecedented, and they will need enhanced and active support from their NHS employers to ensure their wellbeing and safety.

- Increased testing capacity means that we will now be able to extend the offer of regular testing to asymptomatic staff, guided by PHE and clinical advice. This approach is being piloted in a number of acute, community and mental health providers this week, which will inform further roll out from next week.

- As set out in our letter of 17th March, NHS organisations should continue to assess staff who may be at increased risk - including older colleagues, pregnant women, returnees, and those with underlying health conditions - and make adjustments including working remotely or in a lower risk area. Educational material, training and appropriate protection should be inclusive and accessible for our whole workforce, including our non-clinical colleagues such as cleaners and porters.

- Emerging UK and international data suggest that people from Black, Asian and Minority Ethnic (BAME) backgrounds are also being disproportionately affected by Covid19. Public Health England have been asked by DHSC to investigate this. In advance of their report and guidance, on a precautionary basis we recommend employers should risk-assess staff at potentially greater risk and make appropriate arrangements accordingly.

- Now more than ever a safety and learning culture is vital. All our staff should feel able to raise concerns safely. Local Freedom to Speak Up Guardians are able to provide guidance and support with this for any concerned member of staff. As we know, diverse and inclusive teams make better decisions, including in the Covid19 response.

- Employers are also asked to complete the process of employment offers, induction and any necessary top-up training within the next fortnight for all prospective ‘returners’ who have been notified to them.

We are going to see increased demand for Covid19 aftercare and support in **community health services, primary care, and mental health.** Community health services will need to support the increase in patients who have recovered from Covid and who having been discharged from hospital need ongoing health support. High priority actions for mental health providers in this next phase are set out in the Annex. General practice will need to continue to stratify and proactively contact their high-risk patients with ongoing care needs, including those in the ‘shielding’ cohort to ensure they are accessing needed care and are receiving their medications.

Given the scale of the challenges they face, we must also continue to partner with **local authorities** and Local Resilience Forums (LRFs) in providing mutual aid with our colleagues in **social care**, including care homes. This includes:

- Continuing to ensure that all patients safely and appropriately being discharged from hospital to a care home are first tested for Covid19; care homes can also check that these tests have been carried out.

- Under the direction of the LRF, local authority public health departments and CCG infection control nurses can help 'train the trainers' in care homes about PHE's recommended approach to infection prevention and control - particularly focusing on those care homes that lack the infrastructure of the bigger regional and national chains.

- To further support care homes, the NHS will bring forward from October to May 2020 the national roll out of key elements of the primary and community health service-led Enhanced Health in Care Homes service. Further detail will be set out shortly.

- Opportunities to support care homes should also be provided to younger health professional 'returnees' and public volunteers who have offered to help (subject to appropriate personal risk assessment, as described above).

As also seen in a number of other countries, **emergency activity** has sharply reduced in recent weeks. Last week emergency hospital admissions were at 63% of their level in the same week last year. This is likely due to a combination of: a) changed healthcare seeking behaviour by patients, b) reductions in the incidence of some health problems such as major trauma and road traffic accidents, c) clinical judgements about the balance of risk between care in different settings, and d) some NHS care being provided through alternative access routes (eg ambulance 'see and treat', online appointments).

There is therefore considerable uncertainty as to the timing and extent of the likely rebound in emergency demand. To the extent it happens, non-elective patients will potentially reoccupy tens of thousands of hospital beds which have not had to be used for that purpose over the past month or so.

This means we need to retain our demonstrated ability to quickly repurpose and **'surge' capacity** locally and regionally, should it be needed again. It will also be prudent, at least for the time being, to consider retaining extra capacity that has been brought on line - including access to independent hospitals and Nightingale hospitals. The national Nightingale team will work with Regions and host trusts to develop and assure regional proposals for the potential ongoing availability and function of the Nightingale Hospitals. Independent hospitals and diagnostics should be used for the remainder of the current contract which runs to the end of June. Please also start now to build a plan for each STP/ICS for the service type and activity volumes that you think could be needed beyond the end of June, which can inform discussions during May about possible contract extensions with the independent sector.

Over the next six weeks and beyond we have the opportunity to begin to release and redeploy some of the treatment capacity that could have been needed while the number of Covid19 patients was rising so sharply.

This means we are now asking all NHS local systems and organisations working with regional colleagues fully to step up **non-Covid19 urgent services** as soon as possible over the next six weeks, including those set out in the Annex. This needs to be a safe restart with full attention to infection prevention and control as the guiding principle.

In addition, you should now work across local systems and with your regional teams over the next 10 days to make judgements on whether you have further capacity for at least some **routine non-urgent elective care**. Provisional plans will need to factor-in the availability of associated medicines, PPE, blood, consumables, equipment and other needed supplies. We will continue to provide new ventilators to trusts over the coming weeks so as to sustain critical care 'surge' capacity should it again be needed in future, while progressively returning operating theatres and recovery suites to their normal use.

We should also take this opportunity to **'lock in' beneficial changes** that we've collectively brought about in recent weeks. This includes backing local initiative and flexibility; enhanced local system working; strong clinical leadership; flexible and remote working where appropriate; and rapid scaling of new technology-enabled service delivery options such as digital consultations.

In terms of wider action that will also be underway, DHSC will be designing and establishing its new 'Test, Track & Trace' service. The leadership and resourcing of local authority public health departments will be vital. Trusts and primary care networks should continue to support clinicians to enrol patients in the three major phase III clinical trials now underway across the NHS, initially testing ten potential Covid19 treatments. In addition, at least 112 Covid19 vaccines are currently in development globally. We also expect an expanded winter flu vaccination campaign alongside a school immunisation 'catch up programme'.

Looking forward, at the right time and following decision by Government, we will then need to move into the NHS's phase three 'recovery' period for the balance of the 2020/21 financial year, and we will write further at that point.

In the meantime, please accept our personal thanks and support for the extraordinary way in which you and your staff have risen to this unprecedented global health challenge.

With best wishes,

Simon Stevens
NHS Chief Executive

Amanda Pritchard
NHS Chief Operating Officer

ANNEX

ACTIONS RECOMMENDED FOR URGENT CLINICAL SERVICES OVER THE NEXT SIX WEEKS

Urgent and routine surgery and care

- Strengthen 111 capacity and sustain appropriate ambulance services 'hear and treat' and 'see and treat' models. Increase the availability of booked appointments and open up new secondary care dispositions (SDEC, hot specialty clinic, frailty services) that allow patients to bypass the emergency department altogether where clinically appropriate.
- Provide local support to the new national NHS communications campaign encouraging people who should be seeking emergency or urgent care to contact their GP, go online to NHS 111 or call 999 if necessary.
- Provide urgent outpatient and diagnostic appointments (including direct access diagnostics available to GPs) at pre-Covid19 levels.
- Ensure that urgent and time-critical surgery and non-surgical procedures can be provided at pre-Covid19 levels of capacity. The Royal College of Surgeons has produced helpful advice on surgical prioritisation available at: (https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0221-specialty-guide-surgical-prioritisation-v1.pdf)
- In the absence of face-to-face visits, primary and secondary care clinicians should stratify and proactively contact their high risk patients to educate on specific symptoms/circumstances needing urgent hospital care, and ensure appropriate ongoing care plans are delivered.
- Solid organ transplant services should continue to operate in conjunction with the clinical guidance developed and published by NHS Blood and Transplant.
- Where additional capacity is available, restart routine electives, prioritising long waiters first. Make full use of all contracted independent sector hospital and diagnostic capacity.
- All NHS acute and community hospitals should ensure all admitted patients are assessed daily for discharge, against each of the Reasons to Reside; and that every patient who does not need to be in a hospital bed is included in a complete and timely Hospital Discharge List, to enable the community Discharge Service to achieve safe and appropriate same day discharge.

Cancer

- Providers have previously been asked to maintain access to essential cancer surgery and other treatment throughout the Covid19 pandemic, in line with guidance from the Academy of Medical Royal Colleges and the NHS (https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0239-Specialty-guide-Essential-Cancer-surgery-and-coronavirus-v1-70420.pdf and https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0239-Specialty-guide-Essential-Cancer-surgery-and-coronavirus-v1-70420.pdf). An exception has been where clinicians consider that for an individual patient the risk of the procedure at the current time outweighs the benefit to the patient.

- Local systems and Cancer Alliances must continue to identify ring-fenced diagnostic and surgical capacity for cancer, and providers must protect and deliver cancer surgery and cancer treatment by ensuring that cancer surgery hubs are fully operational. Full use should be made of the available contracted independent sector hospital and diagnostic capacity locally and regionally. Regional cancer SROs must now provide assurance that these arrangements are in place everywhere.
- Referrals, diagnostics (including direct access diagnostics available to GPs) and treatment must be brought back to pre-pandemic levels at the earliest opportunity to minimise potential harm, and to reduce the scale of the post-pandemic surge in demand. Urgent action should be taken by hospitals to receive new two-week wait referrals and provide two-week wait outpatient and diagnostic appointments at pre-Covid19 levels in Covid19 protected hubs/environments.
- High priority BMT and CAR-T procedures should be able to continue, where critical care capacity is available.

Cardiovascular Disease, Heart Attacks and Stroke

- Hospitals to prioritise capacity for acute cardiac surgery, cardiology services for PCI and PPCI and interventional neuroradiology for mechanical thrombectomy.
- Secondary care to prioritise capacity for urgent arrhythmia services plus management of patients with severe heart failure and severe valve disease.
- Primary care clinicians to continue to identify and refer patients acutely to cardiac and stroke services which continue to operate throughout the Covid19 response.
- Hospitals to prioritise capacity for stroke services for admission to hyperacute and acute stroke units, for stroke thrombolysis and for mechanical thrombectomy.

Maternity

- Providers to make direct and regular contact with all women receiving antenatal and postnatal care, explaining how to access maternity services for scheduled and unscheduled care, emphasising the importance of sharing any concerns so that the maternity team can advise and reassure women of the best and safest place to receive care.
- Ensure obstetric units have appropriate staffing levels including anaesthetic cover.

Primary Care

- Ensure patients have clear information on how to access primary care services and are confident about making appointments (virtual or if appropriate, face-to-face) for current concerns.
- Complete work on implementing digital and video consultations, so that all patients and practices can benefit.
- Given the reduction of face-to-face visits, stratify and proactively contact their high-risk patients with ongoing care needs, to ensure appropriate ongoing care and support plans are delivered through multidisciplinary teams. In

particular, proactively contact all those in the ‘shielding’ cohort of patients who are clinically extremely vulnerable to Covid19, ensure they know how to access care, are receiving their medications, and provide safe home visiting wherever clinically necessary.

- To further support care homes, the NHS will bring forward a package of support to care homes drawing on key components of the Enhanced Care in Care Homes service and delivered as a collaboration between community and general practice teams. This should include a weekly virtual ‘care home round’ of residents needing clinical support.
- Make two-week wait cancer, urgent and routine referrals to secondary care as normal, using ‘advice and guidance’ options where appropriate.
- Deliver as much routine and preventative work as can be provided safely including vaccinations immunisations, and screening.

Community Services

- Sustain the Hospital Discharge Service, working across secondary care and community providers in partnership with social care. Includes daily reviews of all patients in a hospital bed on the Hospital Discharge List; prompt and safe discharges when clinically and in line with infection control requirements with the planning of ongoing care needs arranged in people’s own homes; and making full use of available hospice care.
- Prepare to support the increase in patients who have recovered from Covid and who having been discharged from hospital need ongoing community health support.
- Essential community health services must continue to be provided, with other services phased back in wherever local capacity is available. Prioritise home visits where there is a child safeguarding concern.

Mental Health and Learning Disability/ Autism services

- Establish all-age open access crisis services and helplines and promote them locally working with partners such as local authorities, voluntary and community sector and 111 services.
- For existing patients known to mental health services, continue to ensure they are contacted proactively and supported. This will continue to be particularly important for those who have been recently discharged from inpatient services and those who are shielding.
- Ensure that children and young people continue to have access to mental health services, liaising with your local partners to ensure referral routes are understood, particularly where children and young people are not at school.
- Prepare for a possible longer-term increase in demand as a consequence of the pandemic, including by actively recruiting in line with the NHS Long Term Plan.
- Annual health checks for people with a learning disability should continue to be completed.
- Ensure enhanced psychological support is available for all NHS staff who need it.
- Ensure that you continue to take account of inequalities in access to mental health services, and in particular the needs of BAME communities.

- Care (Education) and Treatment Reviews should continue, using online/digital approaches.

Screening and Immunisations

- Ensure as a first priority that screening services continue to be available for the recognised highest risk groups, as identified in individual screening programmes.
- Increase the delivery of diagnostic pathways (including endoscopy) to catch up with the backlog of those already in an active screening pathway, followed by the rescheduling of any deferred appointments.
- Antenatal and Newborn Screening Services must be maintained because this is a time critical service.
- Providers and commissioners must maintain good vaccine uptake and coverage of immunisations. It is also likely that the Autumn/Winter flu immunisation programme will be substantially expanded this year, subject to DHSC decision shortly.

Reduce the risk of cross-infection and support the safe switch-on of services by scaling up the use of technology-enabled care

- In response to Covid19, general practice has moved from carrying out c.90% of consultations with patients as face-to-face appointments to managing more than 85% of consultations remotely. 95% of practices now having video consultation capability live and the remaining few percent in the process of implementation or procurement of a solution. GP Practices should continue to triage patient contacts and to use online consultation so that patients can be directed to the most appropriate member of the practice team straight away, demand can be prioritised based on clinical need and greater convenience for patients can be maintained.
- Referral streaming of new outpatient referrals is important to ensure they are being managed in the most appropriate setting, and this should be coupled with Advice and Guidance provision, so that patients can avoid an outpatient referral if their primary care service can access specialist advice (usually via phone, video too).
- All NHS secondary care providers now have access to video consultation technology to deliver some clinical care without the need for in-person contact. As far as practicable, video or telephone appointments should be offered by default for all outpatient activity without a procedure, and unless there are clinical or patient choice reasons to change to replace with in-person contact. Trusts should use remote appointments - including video consultations - as a default to triage their elective backlog. They should implement a ‘patient initiated follow up’ approach for suitable appointments - providing patients the means of self-accessing services if required.

This page is intentionally left blank

Hampshire Hospitals
NHS Foundation Trust

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Services (Overview and Scrutiny) Committee
Meeting Date:	Monday 6 July 2020
Title:	Update from Hampshire Hospitals NHS Foundation Trust (HHFT) on the response to COVID-19
Report From:	Dr Lara Alloway, Chief Medical Officer - Hampshire Hospitals NHS Foundation Trust

Contact name: Stuart Wersby, Trust EPRR Lead

Tel: 01256 313510 **Email:** Stuart.wersby@hhft.nhs.uk

1. PURPOSE

To provide an update to HASC on the response of Hampshire Hospitals NHS Foundation Trust to the COVID-19 epidemic.

2. HAMPSHIRE HOSPITALS PREPAREDNESS FOR COVID-19

2.1 Prior to the epidemic, the Trust had in place a High Consequence Infectious Diseases Plan (HCID) and a Pandemic Flu Plan which provided a framework for our response to this emerging disease.

2.2 The Trust established a COVID-19 working group in January, with representation from clinical and non-clinical disciplines to develop detailed scalable plans designed to protect essential services whilst providing care to patients admitted with COVID-19.

2.3 Whilst Emergency Department and Minor Injuries staff had already received enhanced PPE trained as part of their normal role in order to manage other high consequence infectious diseases (HCIDs), this was not normally offered to a wider group of staff. From January additional groups of staff were rapidly trained to enhanced standards to safeguard them and our patients.

3. IMPACT OF COVID-19 ON HAMPSHIRE HOSPITALS

3.1 Significant changes to the configuration of each of our hospitals estate has taken place in order to segregate hot (highly probable) and cold (low likelihood) COVID-19

patients. Reconfiguration has included changes to the emergency departments, wards and radiology designed to minimise the risks to patients and staff.

3.2 Critical Care capacity was significantly increased during the peak of COVID-19 activity with critical care patients being cared for within Theatres and Recovery in addition to the existing critical care departments.

3.3 Over 200 beds were opened ready to manage the surge of COVID-19 activity anticipated, converting many areas of our hospitals, not previously used for inpatient care. Equipment was purchased and adaptations to the estate were made very rapidly, where required.

3.4 Urgent and Emergency Surgery have been maintained throughout the COVID-19 pandemic using a mixture of isolated on-site capacity and independent sector capacity. Surgical activity has been prioritised by a clinically led prioritisation panel to ensure that those patients most at risk from delays in operative procedures received the care that they required. Chemotherapy activity has been temporarily relocated to BMI Sarum Road to minimise the risk to these highly vulnerable patients.

3.5 To minimise risk to patients the majority of outpatient appointments have taken place via video/teleconferencing during the COVID-19 pandemic, with only those who this is not appropriate for visiting our hospital sites. We moved from <10% non face to face consultations to > 85%, within two weeks.

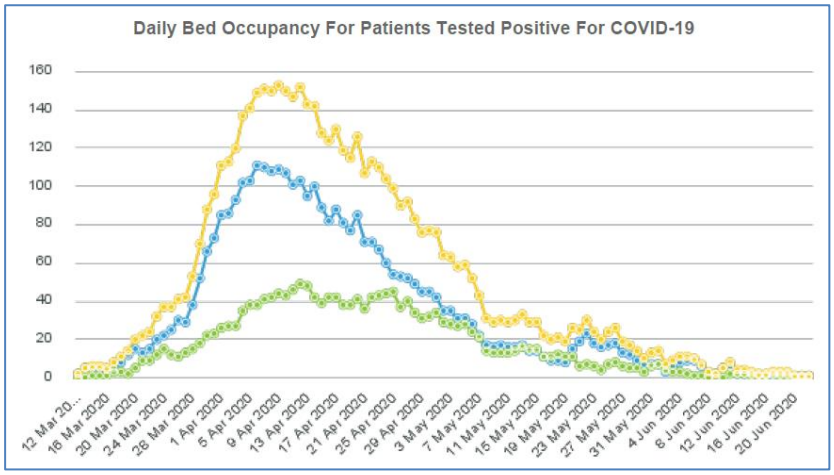
3.6 COVID-19 has had a significant impact on Hampshire Hospitals' workforce, both directly as a result of staff displaying COVID-19 symptoms and indirectly as a result of being required to self-isolate or shield. The impact on staffing has been minimised by redeploying staff and also early testing of staff and staff index cases, however remains between 20-30% loss of staff from our hospitals.

3.6 Many staff were redeployed to support new roles and the increasing critical care and medical ward capacity. Rapid training was provided for these staff moving roles. Over 1000 of our staff were also supported to work from home.

3.7 To support our staff, the Health4work occupational health service was expanded, we redeployed clinical psychologists to this team, we have set up a staff well being line, well being lounges on all hospital sites, free hot meals for staff and catering 24/7.

3.8 Hampshire Hospitals Trust had its first positive COVID-19 patient on 10 March 2020 and as of 23 June 2020 have treated 612 COVID positive in-patients, 73 in critical care. Of the 612 COVID-19 patients 444 were discharged and sadly 160 passed away.

The graph below shows the daily bed occupancy for COVID positive patients each day for Winchester (green line) Basingstoke (blue line) and total for Hampshire Hospitals.



3.9 We have communicated daily to all our staff via a daily COVID-19 update from 10 March 2020 and we have recorded a number of films and podcasts to replace large briefings. We have also engaged with local media: TV and radio to get messages to our local population, aimed to reassure them that we were "open for business", when attendances at our Emergency Departments dropped significantly.

4. TESTING, RESEARCH AND INNOVATION

4.1 Initial testing of patients meeting the case definition was undertaken by PHE (Public Health England) laboratories in Colindale and later University Hospital Southampton.

4.2. It was clear early in the COVID-19 response that rapid testing would be important in the effective management of symptomatic patients and staff. The Trust's microbiology team, with the support of PrimerDesign, a Hampshire based biotech company, developed an assay using existing PCR technology. In March, this development allowed Hampshire Hospitals to become the first non-PHE hospital based laboratory in the UK to be able to test for the COVID virus, significantly increasing the speed at which results were available.

4.3 The Trust's microbiology team have continued to innovate to improve testing for Coronavirus and have worked with OptiGene, another UK firm, to trial and validate a test which can reduce the time taken to undertake testing to as little as five minutes. As this process requires less infrastructure to perform tests, it is planned to use this capability within community settings through a 'lab-in-a-van' service.

4.4 In addition to the work undertaken by the microbiology teams, Hampshire Hospitals has also been involved with a number of COVID-19 clinical trials including national priority trials such as Recovery (79 recruited), REMAP-CAP (2), Genomicc (41), Clinical characterisation protocol severe emerging infections (557) and Psychological impact of COVID-19 (441). We have recruited volunteers to trials in collaboration with PHE Porton Down (CBEVAL and DASH) to determine the course of viraemia and antibody response to infection. We have developed local trials, including sinus wash to reduce viral load in those infected (18) and Near Patient Rapid Testing for SARS-CoV 2 Using a Loop-Mediated Isothermal Amplification (LAMP) Assay (see 4.3). We have also contributed to National evaluations on the impact of COVID-19 on clinical care in a number of specialties including emergency surgery, cancer, heart disease and pregnancy.

5. NON-COVID ACTIVITY, RESTORATION AND PREPARATION FOR A NEW NORMALITY

5.1 In order to minimise the risk of infection and the significant additional demands on the Trust as a result of COVID-19, non-emergency elective activity was significantly reduced. Whilst emergency and urgent surgery has been maintained, the refocusing of efforts to manage the impact of COVID-19 has meant that elective outpatients, diagnostics and surgery have been significantly impacted.

5.2 The Trust is currently working to restore as many elective services as practicable, following infection prevention and control precautions, whist maintaining the ability to manage COVID-19 activity and unscheduled / emergency patients. The Trust's restoration programme has been designed to maximise the use of its facilities whilst continuing to prioritise patients requiring procedures on their clinical need.

5.3 In order to ensure that patients attending for elective procedures are safeguarded from the risks associated with COVID-19, the Trust has introduced routine COVID screening 48-72 hours before admission. In addition, dedicated areas have been identified on both acute sites and within the independent sector which provide segregated facilities. All patients having a planned procedure, under general anaesthetic are asked to shield for 14 days prior to admission.

6. ON-GOING RISK AND PREPARATION FOR POTENTIAL OF A SECOND WAVE

6.1 Whilst over the past few weeks, the focus of the Trust has been the restoration of services, the risk of a second wave remains a significant threat. As such, the Trust has been mindful to maintain its ability and capability to escalate its COVID-19 response should it be required.

6.2 It was clear, early in the preparation and response to COVID-19 that the virus impacted a proportion of patients severely, resulting in them requiring intensive care treatment. In order to respond to the increasing demand it was necessary to deploy nursing and medical staff to these areas. In order to maintain resilience for any second wave (or other event requiring escalation to critical care capacity) the Trust has developed a Critical Care Academy. This academy teaches both theoretical and practical critical care skills to enable nurses to learn and maintain competencies so that they can rapidly redeploy to support the critical care of patients. As of 19 June 2020 the Critical Care Academy has trained 93 additional nurses with critical care skills.

6.3 In order to increase the physical capacity for managing critical care patients during the peak of the first wave of COVID-19 it was necessary to place patients within Theatres and recovery. Future plans aspire to minimise disruption and improve the care environment during any subsequent peaks in activity Hampshire Hospitals by working to provide the infrastructure (including medical gases) required to escalate critical care capacity in a pre-identified ward areas on both sites.

6.4 Whilst the intensity of the COVID-19 response has reduced over recent weeks, in line with the ongoing National Level 4 Major Incident, the Trust has maintained its response structure including an Incident Coordination Centre which can be re-escalated if necessary.

7. RECOMMENDATION

That this report is noted by the Committee.

This page is intentionally left blank

22 06 2020
Media and Communications Team

Briefing note:
Southern Health's response to coronavirus epidemic: update 4

Introduction

As a result of the current and ongoing coronavirus epidemic, Southern Health (along with all other NHS organisations across the country) has had to adapt its healthcare services to protect our patients, staff and local communities.

During these unique times, our aim has been to provide our local overview and scrutiny committees with regular updates on all those healthcare services where changes have been necessary as a result of the national crisis.

This paper is the fourth in a series of updates – and follows the first written briefing on 27 March 2020 (which also provided some background on the coronavirus), the second one on 6 April 2020 and a third paper on 29 April 2020.

Copies of these past papers can be provided upon request to provide the detail of all those services which were either temporarily ceased, reduced in frequency or offered in an adapted way (i.e. digitally/virtually).

This fourth paper is focused on providing a round-up of the past three months (Phase 1 of our response to Covid19) as well as looking at what we are now referring to as 'Phase 2' of the Covid19 response (covering the period May to July 2020). Phase 2 is where NHS organisations across the UK begin to fully re-establish all non Covid-19 urgent services, together with maintaining their ability to quickly re-purpose and establish 'surge' capacity should the number of new Covid19 cases again increase.

Southern Health's focus now is on both restoring services that have been paused or reduced in any way as part of our original crisis response, together with expanding those services which are likely to see a significant increase in demand as a consequence of the medium to long term impact of the pandemic. At the same time we are working to ensure the flexibility of service delivery to respond to any further outbreaks of the virus.

Overview of Service Changes

Since March 2020, we have made a number of changes to our services to adapt to the fast-changing environment we found ourselves in. These changes, which were agreed with commissioning colleagues, can be summarised as follows:

Within our community services:

- We risk assessed physical, learning disability and mental health patients with only high risk and urgent referrals seen through April and early May. Patients were managed remotely through calls and/or using a secure video conferencing tool called Visionable where possible. Depo and clozapine clinics continued.

- IAPT services were expanded with technology use including some group sessions, increased access to advice and brief interventions.
- Patients were supported to self-manage and to use voluntary and other community resources. Covid19 crisis plans were put in place.
- We adopted a 'one team' approach with ICTs, primary care and social services - with daily virtual MDT (multi-disciplinary team) calls.
- There was a rapid implementation of the 7 day D2A (discharge to assessment) model, with a single point of contact in each system. We also saw the removal of legislative and funding barriers to enable same day discharge (ensuring there was bed capacity in acute hospitals to treat to sick patients in need of acute care).
- We redeployed clinical staff (most notably staff from our MSK and 0-19 children's services) to provide D2A and community rehab support.
- We operated a 7 day Older People's Mental Health (OPMH) service.
- There was wider community care home support, for example the diabetes team provided insulin injections.
- The ECT (electro-convulsive therapy) service was provided at fewer sites for prioritised patients, due to reduced anaesthetist cover. A TMS (transcranial magnetic stimulation) machine was also purchased to provide a future alternative service model for appropriate patients.
- The Lighthouse in Southampton (run in partnership with Solent Mind) has been running as a 'virtual' crisis lounge, as the premises in Shirley are too small for social distancing. However discussions are underway to reopen the premises as soon as possible.

Within our inpatient services:

- All wards across the Trust saw an improvement in flow, an increase in bed capacity (empty beds) and a reduction to zero in the number of out of area beds being used.
- Within our community hospitals, we achieved significantly increased capacity, daily board rounds, early discharge, rehab outreach, and created 'hot and cold' beds for the management of coronavirus patients.
- Within our AMH/OPMH (adult and older people's mental health) units, we worked to achieve a reduction in admissions (with an increased number of patients being managed in the community).
- Beechwood ward at Parklands Hospital in Basingstoke was converted into a Covid19 ward (for adult/older people with mental health issues who require physical health care for Covid19).
- We also implemented restrictions to patients' leave (i.e. section 17), as per national guidance.
- Physical health training and support was put in place for mental health wards.
- Increased infections control training and support across all inpatient services was also quickly established.
- On Tuesday 24 March, we took the difficult but necessary decision to close our wards to visitors with immediate effect. This is being continually reviewed as lockdown measures ease.
- From 10 April until 11 May, Ford Ward (a 15 bedded rehabilitation unit based at Fordingbridge Hospital) was temporarily closed to admissions and merged with Romsey Hospital to support the clinical need for patients requiring a Covid19 recovery ward. This enabled us to reinforce our staffing (which had been affected by sickness and enforced isolation) to meet the increased physical and psychological needs of patients and their families.
- For a short period of time, Beaulieu Ward (an OPMH ward based at Western Hospital in Southampton) was also temporarily closed to admissions – this was as a result of 3 staff (all asymptomatic) and 4 patients testing positive for Covid19 from 28 May. The decision to temporarily close was due to the fact that all new admissions require patients to be isolated for 14 days, which was not possible since the isolation area was full. During the closure, the number of patients who were Covid19 positive rose to 6 and the number of staff self-isolating whilst awaiting test results rose to 5. A comprehensive strategy was in place to manage this limited outbreak which included developing 'hot' and 'cold' areas and revised procedures to ensure all staff were fully informed regarding area management, PPE and safe IPC working practices. Beaulieu Ward reopened on Monday 22 June and the temporary closure had no impact on bed availability as we had typically had around 60 unoccupied OPMH beds within the Trust during the period it was closed.

Elective treatments:

- There was a temporary cessation (or reduction in frequency) of elective and routine outpatient services across community hospital sites, using risk assessment and triage to ensure the high risk patients continued to be seen.
    - These included: radiology, orthopaedic choice, pulmonary rehab, continence assessments, dietetic clinics, Parkinson's clinics, bone density scanning, endoscopy, falls assessments and classes, follow up stroke assessments, bloods, wound clinics, catheter and bowel care and vitamin B12 injections.
    - However, a number of these services are now starting up again and beginning to accept referrals (i.e. Orthopaedic Choice was ready to accept referrals again from mid-May).
- There was a significant reduction in referrals from GP surgeries. Triage of referrals and a review of waiting lists was put in place to manage high risk patients.
- We've been providing virtual assessments and follow ups where appropriate. Our postponement backlog has been growing during the pandemic but we are managing our 18 week targets.
- There has been a temporary suspension of the majority of face to face children's services apart from safeguarding/vulnerable and antenatal/new-born screening. Instead we have increased the use of digital solutions and ChatHealth (launching a new helpline service for parents of 5-19 year olds at the end of May).

Workforce:

- Our recruitment processes for staff and volunteers was reduced from weeks to days, and was delivered 7 days a week thanks to the efforts of our HR team.
- We adopted a flexible approach to the redeployment of available staff - including MSK staff to work in community and inpatient services, health visitors and school nursing teams to support PPE hubs and community testing, and volunteers and corporate staff to deliver supplies, food and donations to wards and teams.
- Home working for non-essential services and shielded staff was quickly adopted.
- There has been a significant increase in the staff wellbeing support offer that we have at Southern Health - and more than 1000 staff have accessed the new pages detailing this support on our staff intranet.
- We have in place a staff risk review process, which was developed to protect/shield BAME, pregnant and other higher risk staff.
- We appointed a number of 3rd year students, returning retirees and also redeployed all corporate ex clinical staff - some to neighbouring Trusts' ITUs (intensive therapy units).
- We worked hard to train new staff and current staff in various new skills, with a shift to a 7 day training service and bespoke delivery (both online and safely face-to-face)
- Our media and communications team began working 7 days a week, delivering daily messages and updates and introducing a new Staff Connect mobile phone app (which already has 2500 staff users) – particularly useful for those staff who are not desk-based (i.e. on wards and in the community). The team also organised weekly Facebook Live sessions which have been hosted on our intranet and also on a new internal Southern Health Facebook Group (which has more than 1000 active staff).
- In terms of our work with staff unions, the chair of our Staff Side has been part of our daily Gold Command calls and part of our daily workforce briefings. Additional JCNC and LNC meetings have also been held.

Wider support:

- Infection control training and the provision of PPE Hubs for all Trust services were established - firstly in inpatient units, and including staff, patients and families.
- Significant additional requirements were effectively managed - including developing an internal supply chain and 8 local distribution hubs for 2.7million pieces of PPE, and the rapid purchase of 4,500 sets of uniform (scrubs, polo shirts and trousers for non-uniformed staff) and around 1,000 pieces of furniture and equipment for planned surge bedded capacity.
- Environments and workforce issues in care homes created capacity issues which led to an increase in support from Southern Health.

- Additional cleaning hours were introduced to all clinical areas and non-clinical essential areas.
- Establishing accommodation arrangements for staff and for service users.
- Identifying and supporting colleagues with innovative solutions for supply challenges.
- Maintaining strong financial controls and due diligence without compromising on pace and agility.
- Working with the IPC Team (infection prevention and control) and staff to support product requirements for changing guidance and new products coming safely into the organisation.
- Mobilising individuals from across the organisation to support on deliveries across the Trust's various sites.
- Supportive to other teams across Hampshire with mutual aid and shared best practice when required.
- Establishing a Trust-wide taxi service, e.g. to ensure staff were able to get to work.
- To aid capacity, there was a system-wide 'pause' in the NHS complaints process for three months (although complaints were still logged, triaged and acknowledged) – normal service resumes in July 2020.

Digital solutions:

- Significant increase in the use of telephone and video consultations. Teleconferences/meetings pre-Covid19 were about 150+ daily. There are now 650+ teleconferences daily. Video consultations pre-Covid19 were about 4-10 daily. There are now 300+ daily, with 1,750 remote users and 3800 laptops deployed.
- The technology team handled 4 times the number of IT helpdesk calls.
- Total mobile App used through smartphones for planning and record keeping.
- iPads have been made available for patients to keep in contact with their families, when visiting hasn't been possible.
- The system has also been working hard to review and improve data sharing.

Governance:

- Clear command and control structure established early through the organisation and across the system.
- Business continuity plans enacted and adapted as required.
- System wide demand and capacity modelling undertaken for the Covid19 planning and now also for our phase 2 response.
- Strengthened clinical leadership, decision making and shared risk management.
- Ethics committee in place to support decision making at pace.
- Rapid implementation of changes and PDSA (plan, do, study, act) approach to solutions.
- Compliance with NHS England's major incident regulatory framework.
- Initially, some committees were stopped for capacity reasons, but were restarted in May.
- Continued incident and SIRI (serious incident requiring investigation) reporting throughout pandemic.

Changes to clinical guidance:

- Emergency record keeping guidance started with the pilot of a new RIO App (for electronic patient records).
- Palliative care guidance shared.
- AGP (aerosol generating procedures) guidance re PPE, based on national guidance.
- Safer staffing guidance prepared but not implemented as not triggered.
- Changes to guidance such as resuscitation and IPC.

An audit trail of all our decision making has been captured with regard to any changes to clinical guidance.

Key Points

Following these changes, that were implemented at pace, there are a number of key points to note.

- We have been (and continue) working with our staff, patients and carers across Hampshire to **ensure our local communities have access to our services**, especially those needing urgent or ongoing support.
- We have adapted our services to ensure we are able to **support our patients in different ways**, such as via telephone, text messaging or video calls. Crucially though, face-to-face contact with patients is still taking place where this is important to their safety.
- Where services and support groups have had to temporarily be suspended to prevent the risk of infection, **alternative arrangements** have been put in place to ensure people can still access care, advice and support.
- All such **service change is carefully risk assessed** by the teams delivering the care, to ensure any adaptations are in the best interests of patients and are as temporary as possible. Any significant service changes are added to the Trust's central risk register and the Trust Board then makes informed decisions based upon the latest risk evidence and the mitigating factors that have been put in place by teams locally.
- We are currently in the process of supporting a national 'Help Us Help You' **campaign to remind patients that the NHS is still here for them** and that if they need to go to hospital or seek urgent treatment, they should still do so. It is important that these messages are shared with the local population to encourage people to seek help without delay, even during the pandemic, as there is otherwise a risk that people may wait too long to get help which could adversely affect their health.
- Whilst it is true that the methods for delivering care may have temporarily changed, the **vast majority of the care we provide is still available for people to access** - and we have been working hard to share this message with our patients to avoid any unnecessary negative consequences of service change.

Key Learnings

Following all the changes, there are also a number of key learnings arising from the pandemic which we are now working through and which could positively impact on how we deliver services in the future. These include:

- **Technological solutions** have helped us provide services for patients. Virtual working and the use of technology to digitally empower teams to deliver care in a different, and often more efficient, way has been significant. We believe video conferencing has been a real success story and should be built upon further. Whilst anecdotal patient feedback has generally been very positive, we now need to evaluate how well our solutions have worked for our patients and carers.
- We have been able to **transform and adapt** at pace – bureaucracy is reduced which enables us to be more agile in terms of service delivery. How can we continue to do this and ensure safety and quality?
- We have worked as a **single health and care system** for the benefit of patients and this 'one team' approach needs to continue. Our improved links with GPs and care homes in recent weeks, added to the health and social care system's 'can-do' approach to the virus, are real building blocks to the desired 'one team approach' and better integrated services in the future.
- **Care models have been adapted and improved locally** – this needs to be sustained and standardised where appropriate.
- We need to continue to **risk stratify** patients and individualise care plans and our response.
- We must continue to empower patients through support for **self-management and behaviour change,** plus tools for physical health monitoring and telemedicine.
- We should aim to keep the focus on **community rehabilitation** as the current model needs further development to meet current and post-Covid demand.
- **Virtual communication** with staff and in teams has kept people connected. In addition, **remote working** has provided staff with more time to support patients and get work done, it has also freed up our estate which could be used for increased clinical space. We have seen **reduced costs** for travel and printing, as well as significantly reduced estate usage. Could there be an opportunity to cement these changes to maintain productivity gains?

Moving to Recovery

The NHS has now entered the second phase of its response to coronavirus. Whilst this is not yet a return to 'business as usual' (as we remain in a level 4 national incident so all Emergency Prevention, Preparedness and Response measures remain), it does mean that:

- our community health services will be supporting the increase in patients who have recovered from Covid19 and who, having been discharged from hospital, need ongoing health support
- we are stepping-up non-Covid19 urgent services as soon as possible over the next few weeks
- there is now a renewed focus on mental health services and providing support to people as the lockdown is set to ease
- we will begin to make decisions on whether we have further capacity for some routine non-urgent elective care.

However, as the first wave of the pandemic eases, there are a number of pressures that remain to be managed. These include the backlog of routine care appointments, the impact of isolation and stress on the local population's longer term mental health (and the impact of this on our services), and of course the welfare of our staff who have been working longer and harder than ever before, often with annual leave cancelled or postponed. These are all issues which we are developing plans for at this current time.

We are also specifically looking at:

- Returning need - a proportion of service users in need of both physical and mental health support will have not sought this due to fears of catching Covid19 and this may have the potential to exacerbate symptoms in the future. Also, as referrals into our IAPT services have decreased, potentially delaying support for low to moderate anxiety and depression, we are looking at whether this could lead to more complex levels of need.
- Vulnerable groups - these include the homeless (as there will be significant challenges to secure sustainable, longer-term housing placements to develop and maintain improved mental and physical wellbeing) and care homes/shielded people and carers (considering the impact on our ability to diagnose and support clients with dementia; the increased acuity in conditions, with greater requirements for rehabilitation and complex end of life care; the requirement for ongoing socially distanced services; and the increasing impact on mental wellbeing of being socially isolated).
- Community physical health - the impact of future surges and winters pressures on system capacity; rehabilitation care needs of patients discharged from hospital; complex care needs of shielded patients and how our staff best interact; complexity of delayed primary care demand; and social care pressures in home care and care homes.
- Demand modelling - using a system modelling approach that assesses the risk of a number of factors and assumptions (undertaken in the context of wider population health analysis).

How we are planning for restoration and recovery

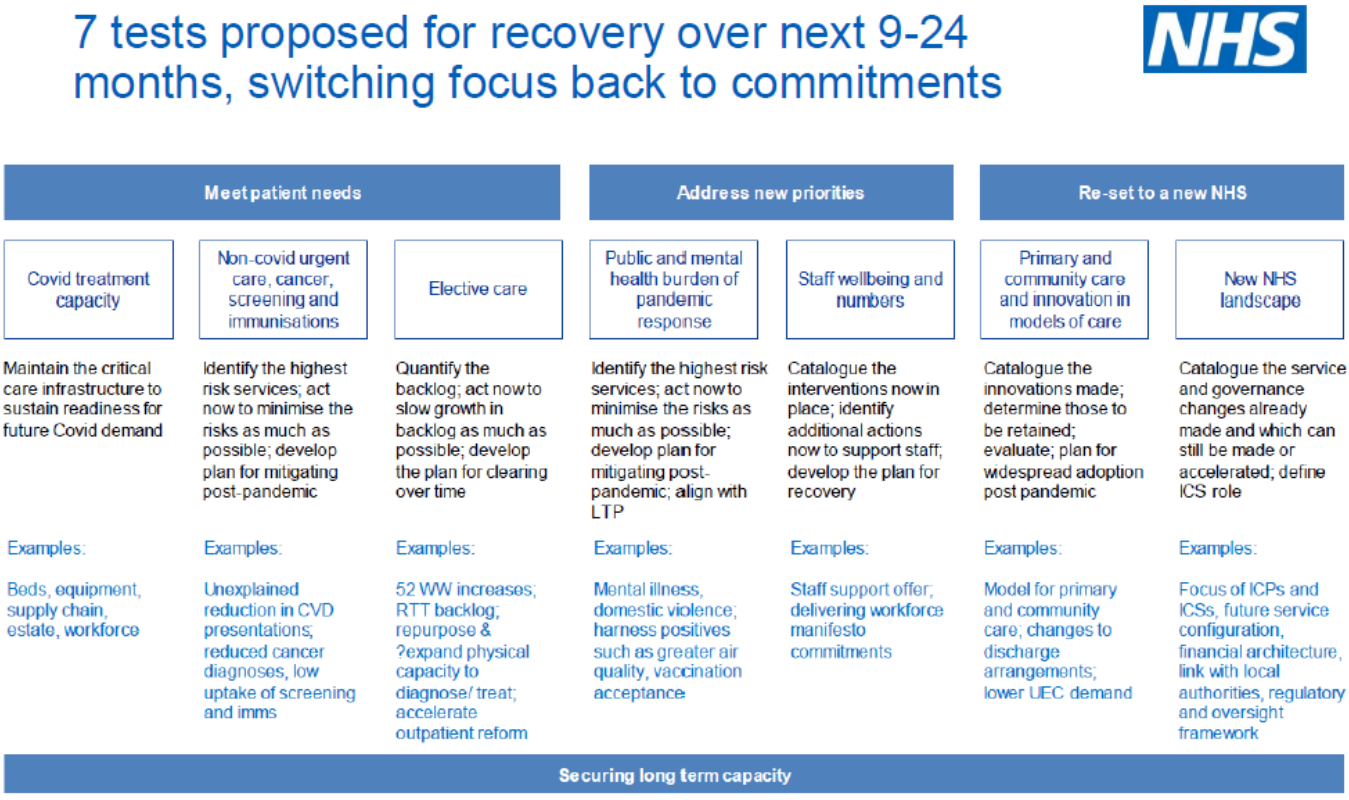
The following bullet points set out the work that is already underway to begin restoring services as part of phase 2:

- A review of patient caseloads is already underway.
- We are also reviewing all the work that we stopped doing and what the impact of that was.
- We are undertaking an evaluation of service changes from a patient and quality impact perspective.
- Where possible, we are starting to recommence services using a clinically led risk based approach.
- We are planning to increase capacity in mental health services, to manage the impact of social isolation and post Covid19 patients, including suicide risk.

- We are continuing to develop our care home response and our offer to PCNs (primary care networks) as part of a 'single team' approach and in relation to IIC (integrated intermediate care) plans.
- A rapid evaluation of all the digital innovations we've introduced since March has been implemented.
- We are continuing to support system analysis and modelling as well as internal demand and capacity modelling – particularly on unmet need and any post lockdown surge.
- We have met as a Board and are resetting our Trust's operating plan in light of the pandemic.
- We are working with colleagues and partners to cement non clinical process and governance changes, with the aim of streamlining and removing red tape wherever possible and safe to do so. (This will include how we reflect service changes into contracts and commissioning decisions with our CCG/LA/NHSE colleagues).
- We are putting into place longer term support for our staff's health and wellbeing (this includes individual risk assessments to safeguard staff based on age, gender, ethnicity and health vulnerabilities).

At the same time as undertaking all these recovery measures, we are also mindful of a number of risks and considerations, particularly as there is ongoing uncertainty about how the virus will develop and the impact of this on winter capacity. For example, we have to start reintroducing services whilst also ensuring we have space to deliver 'hot and cold' capacity and maintain social distancing for staff and patients. There will be a greater need for PPE equipment in order to resume some non-urgent services. How quickly national and local testing schemes can be proven effective and how quickly any shortages of equipment and drugs can be resolved (with all the inherent supply chain challenges) will all impact on service delivery.

The illustration below sets out how the NHS is approaching the recovery phase and identifies seven tests which have been proposed for recovery:



When?

Service changes took place with immediate effect and these were communicated to our overview and scrutiny committees (over the March-May period). As we now move into the recovery phase, we are keeping you

updated of the measures we are taking to safely restore services. This will be a gradual, service-by-service process as teams undertake localised risk assessments and patient engagement to step up services.

Engagement Activity & Next Steps

We continue to work closely in partnership with our CCG colleagues and those across the local healthcare and social care system to agree and implement future changes, as we focus on the recovery phase of our Covid19 response.

We are also working with our local teams to encourage them to share any necessary service adaptations and/or return to 'business as usual' with patients and carers as quickly as possible and to offer support and guidance.

Additionally, the Trust's communications team is working to share messages regularly on Southern Health's website and across our various social media channels.

Any questions?

If you have any questions, please contact Heather Mitchell (Southern Health's Executive Director for Strategy, Infrastructure and Transformation) via email: heather.mitchell@southernhealth.nhs.uk.

Ends

Hampshire County Council Health and Adult Social Care Select Committee
6 July 2020

Portsmouth Hospitals NHS Trust response to the COVID-19 pandemic

1. Introduction

The COVID-19 pandemic has had a significant impact on the delivery of NHS services. In response to national modelling and the local situation, we rapidly put in place a clinically supported decision framework as part of our preparedness plans. We followed all national guidance and worked closely with our partners across Hampshire and the Isle of Wight as part of a co-ordinated response to COVID-19.

We acted quickly to reconfigure areas of our hospital and changed many of our policies and procedures, acting in the interests of all of our patients and supporting individuals and teams across the organisation. We increased our critical care capacity by 150% and developed plans to be able to increase beyond this should the need arise.

We planned for worse-case scenarios and were able to respond to all the challenges that this first wave of COVID-19 presented. Early concerns amid changing national guidance around Personal Protective Equipment presented some challenges for operational and management teams but our staff were appropriately protected at all times.

Our response was facilitated across the Trust by teams and individuals working well together, with strong clinical leadership and engagement. The dedication and professionalism across staff groups continues to be exemplary. Colleagues across the Trust continue to be personally affected by the sad deaths of patients from COVID-19, and we are providing support for their
physical and mental wellbeing.

Phase one of the national response included the planning and implementation of measures to tackle the first wave of COVID-19 and is described in more detail below. We are now planning for phase two and focusing on how we deliver for all our patients, both those with COVID-19 and those who need to access other services.

2. Current picture

As of 23 June 2020:

- There have been no COVID-19-related deaths at Queen Alexandra Hospital for 14 consecutive days
- We have cared for 572 inpatients with a positive diagnosis of COVID-19
- Sadly 229 inpatients with a positive diagnosis of COVID-19 have died

3. Phase one planning and implementation

Our incident response is governed through our command and control framework for decision making, as part of the ongoing national and regional incident management response.
In accordance with national direction, we paused routine and non-urgent activity following a Clinically-led review and quality impact assessments of outpatient, day case and inpatient activity. This allowed us to re-purpose hospital space for COVID-19 activity and to free staff for additional training and redeployment. We created a capacity plan based on national modelling data and supported by detailed operational and workforce planning.

Working with our health and social care system partners across Portsmouth and South East Hampshire, the steps we have taken to provide care for all our patients during this incident include:

- In-line with national guidance, we prioritised the discharge of patients deemed medically fit.
- We are particularly grateful for the support of our partners in helping us to ensure the safe discharge of appropriate in-patients at the start of the pandemic period.
- We developed clinical pathways to reduce patients' attendance where not absolutely necessary, working with partners across the system. Access to mental health services was made available for patients through alternative routes of care. The minor injury service and outpatient blood testing have been temporarily re-located away from the QA site.
- We significantly increased virtual outpatient consultations by telephone and video.
- We worked closely with Hampshire and Isle of Wight acute partners to develop detailed plans for mutual aid if required, and to ensure consistency in clinical and operating rules.
- We re-purposed areas of the hospital to expand the number of critical care beds available for patients with COVID-19.
- We zoned our medical wards to reduce the risk of transmission of the virus, for patients and staff.
- We have continued to provide cancer and urgent surgery, with two COVID-free wards designated for this.
- We increased our capacity to test for COVID-19 significantly during April and expanded our service to include system partners, providing testing for patients, members of staff and their families.
- A national contract has been agreed with Independent Sector providers, funded by the Department of Health and Care, to allow the NHS access to increased capacity. As part of this arrangement, we have been able to temporarily use capacity at the St Mary's Treatment Centre (Care UK) and The Spire Hospital in Havant, to support ongoing access to time critical conditions.

4. Support for staff and patients

As part of our preparedness planning, we carried out more than 5,700 staff training sessions, to upskill and reskill individuals across the Trust. Many staff were redeployed outside their areas of expertise and normal scope of practice, supported by others and by the Trust to do so. We have been joined by colleagues returning to clinical work and by newly qualified colleagues. Support from our military colleagues has also been significant and much valued.

The health and well being of our staff is central to our planning and response and we have introduced a range of support:

- We follow all national guidance with appropriate action for groups of staff who are considered vulnerable with underlying health conditions or who are pregnant.
- Members of staff on our sites have appropriate PPE and social distancing measures. Those who are able to do so are working from home. We have also provided accommodation for members of staff who are living apart from their families.
- A staff support line and manager support line remain open seven days a week to provide advice, guidance and access to professional occupational health support and welfare services.
- A staff support pack has been distributed to all staff with access to counselling services, assistance programmes, salary finance loans and national NHS support services.

- We continue to engage with staff, asking them directly about additional services and support they would find helpful.
- We have been overwhelmed by the support shown to our staff during this period, with many donations of food, wellbeing gifts and gestures of support. The Portsmouth Hospitals Thank You Appeal launched by The Portsmouth News in April has now received more than £42,000 in generous donations which will significantly benefit staff through the provision of longer term support for their health and wellbeing.
- We took the difficult decision to suspend patient visiting, to reduce the risk of transmission of the virus, except in exceptional circumstances, and have introduced alternative methods to support patients during their hospital stay building on the work of our Patient Advice and Liaison Service. Staff and volunteer Family Liaison Officers provide support for families and patients facilitating video contact, telephone calls and email messages, with messages also played on hospital radio. We created a drop off and collection station for family and friends to drop off essential items, which are then delivered to patients on the wards.

5. Planning for the second phase

We are working within the national framework provided by NHS England to plan for the next phase of COVID-19. Our priorities are to continue to deliver urgent and cancer work while stepping up clinically determined routine work where capacity allows, while still maintaining our preparedness for additional COVID-19 patients especially in respiratory and clinical care. This will require significant changes to the way that we work, with added complexity as winter approaches. We are co-ordinating our response to this challenge with partners across Hampshire and the Isle of Wight using the framework set out nationally. We are also implementing recent government guidance for employers about workspaces, transport and other activities.

With significant uncertainties about the levels of COVID-19 we can expect to see, our next phase will require significant operational flexibility to deliver the levels of urgent and cancer care we anticipate, and additional more routine care that can be safely delivered for patients.

Our planning is clinically led and provides the opportunity to work with our system partners to maintain some of the changes introduced in the first phase that have delivered improvements in patient care, including alternative pathways and virtual consultations to reduce the requirement for patients to attend the hospital.

We continue to support national communication messaging throughout the crisis response, emphasising to our local communities the measures needed to reduce the prevalence of the virus. In more recent weeks, we supported national campaigns to encourage people who do need to access NHS services to overcome any reluctance and not to delay seeking treatment for potentially serious conditions.

ENDS

This page is intentionally left blank

HAMPSHIRE COUNTY COUNCIL

Report

Committee	**Health and Adult Scrutiny Committee (HASC)**
Date:	**6 July 2020**
Title:	**Public Health Covid-19 Overview and Impact on Health and Wellbeing and Outbreak control Plans**
Report From:	**Director of Public Health**

Contact name: Simon Bryant

Tel: 02380 383326 **Email:** Simon.bryant@hants.gov.uk

Purpose of this Report

1. The purpose of this report is to provide an outline on the three different aspects in relation to COVID-19:
   - The pandemic context
   - The impact on health and wellbeing
   - The development of Outbreak Control Plans

Recommendation(s)

2. To note the Context of COVID-19

3. To note the impact on Health and Wellbeing and the need to monitor outcomes and take work forward to tackle the impact reviewing service development plans.

4. To note the development of Outbreak Control Plans

The Pandemic Context

5. The current COVID-19 outbreak is due to a new coronavirus from animals, which first came to light in China in December 2019. The first cases in the UK were identified in January 2020. With more and more countries around the world experiencing outbreaks, the World Health Organization declared a global pandemic in March 2020.

6. Coronaviruses are a large family of viruses which, in humans usually cause mild illness, including common colds. The COVID-19 disease is spread through cough droplets either directly from an infected person or from touching surfaces contaminated with the virus through someone coughing onto them. The virus is estimated to last for up to 72 hours on hard surfaces.

7. The symptoms of coronavirus disease (COVID-19) are typically (but not exclusively) a cough, a high temperature and shortness of breath. It is now additionally advised that a loss of sense of smell may also be a key symptom. The virus can affect anyone and for most people the symptoms will be mild, and people will recover in around two weeks. However, the individuals at highest risk for severe disease are those over 70 years and those with underlying health conditions where symptoms could require hospitalisation. There is further developing evidence about possible increased risks to BAME communities and those individuals with obesity. It remains difficult to accurately estimate the mortality rate because not all cases are identified. However, data from around the world suggests it is likely to be around less than 1%. The disease in children appears to be mild in most cases, though there have been instances of deaths.

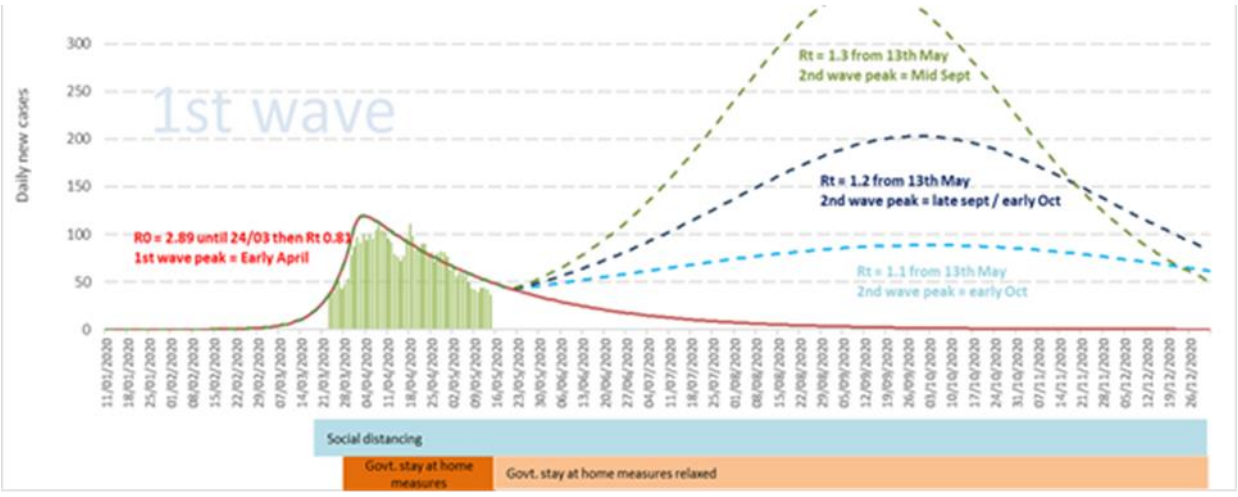
8. Within Hampshire there has been a steady rise in cases and deaths in line with the national spread and epidemic. As of 8June 2020, there are 3,358 diagnosed cases in Hampshire. The first peak was well managed through social distancing and effective planning. The modelling of the virus suggests further waves of disease will develop during the Autumn. We are working to manage further waves of disease.

9. Due to the lack of immunity in the population the disease can easily spread between people causing a large outbreak and ‘peak’ in cases. If allowed to spread without intervention the resulting level of disease would overwhelm our health and social care services due to the extreme volume of those requiring specialist care and support. Therefore, a number of measures, many of which were based on existing national plans to respond to influenza pandemics, were put in place by the government to manage the outbreak. The first phase was to CONTAIN the disease, tracking those who had the disease and contact tracing those they had been in close contact with. Working with Public Health England, the County Council’s public health team supported this through connecting with and supported key settings affected.

10. Following this phase and once the disease was understood to be spreading in the community, the country as a whole moved to the DELAY phase. This phase has increasingly involved measures to slow the spread through social distancing for the whole population and shielding for the most vulnerable. These measures have been largely successful, and we appear to have now seen a predicted peak much reduced and delayed, albeit with many people experiencing severe disease and significant numbers of COVID-19 related deaths. As referenced above, while recognising the success of these significant

measures in terms of lives protected and saved, the County Council has also to be concerned about the economic impact of this crisis upon the welfare of the Hampshire population.

11. The following graph depicts a predictive assessment of the potential severity and timing of a second peak or wave of the outbreak, relative to the first in April 2020. This is based on three scenarios linked to the future "R number" (the analysis of the reproductive pace and spread of the virus) and the prevalence of infection. Firstly, it should be stressed that it will not be feasible to construct an R value for localities or even the county of Hampshire. It is a broad statistical analysis over time and a wide population – it is likely we may see regional R values in time. We know that the first peak was based on a very high R number but from what was a low base of prevalence at that time. Crucially, that first peak, for all of the challenges and tragedies it brought, was contained within the capacity of the NHS so the worst national calamity was avoided. We also know, as we have come gradually down from the first peak through near total lockdown, that to avoid any second wave (as per the lower red line in this graph) would depend on continued high levels of lockdown that keep R well below the value of. But the closer the R number gets consistently towards or beyond a rate of 1.2, the more severe would be the second peak and the more intense would be the pressures upon the NHS and wider services. That is why the new local authority public health duties of outbreak control planning, discussed further in this report and separately to this Cabinet, and will be so critical to the management of and recovery from the crisis.



12. As the pandemic has developed and the impact of the interventions is becoming better understood we will have seen an easing of some of the measures but importantly maintaining social distancing wherever possible. This is not least because we appear now to be in a period of the middle of the end of the first peak or surge in the spread of the virus. However, in the absence of an effective vaccine, as long as there are cases of infection in the community, the likelihood of a resurgence of spread remains. As restrictions are eased, the

UK may then see a rise in the disease again leading to a second wave. This will need to be managed in a similar way to the current measures, with increased local leadership through the Outbreak Control plan

13. The programme of testing for COVID-19 is key for understanding the spread of disease and prevent further cases. The testing programme has been developed over the life of the epidemic. In the 'contain' phase testing was for people who had travelled to affected areas or those in contact with cases who were symptomatic. The next phase testing was for those admitted to hospital who were symptomatic and for potential outbreaks in care homes. A programme of testing for key workers has commenced in Hampshire recently to support business continuity. Finally testing was made available for everyone symptomatic. Testing programmes have developed through a variety of delivery models. Under the Director of Public Health these models are being reviewed to ensure they meet local needs. The progress and coordination of testing, and a stronger local authority role in that coordination will be key to the effective management of outbreak control plans.

14. We have now moved to a phase, as the start of outbreak management, of testing and tracing community cases. This involves increased testing in the community, tracing those who have been in contact with a case and supporting people to self-isolate with symptoms and NHS care where needed. It is intended to be a more targeted and "surgical" approach to management of the spread of the disease which can apply controls which do not have such widespread and economically as well as socially disruptive effects. The contact tracing will be the NHS Test and Trace programme overseen by Public Health England and Local Directors of Public Health. Further intervention will be via the mobile phone app developed by the NHS. The Director of Public Health is leading the early implementation of the programme through his leadership role on the Isle of Wight.

15. A vaccine is still being researched which would enable society to gain population immunity, preventing the spread of disease and protecting the vulnerable from illness. This is most likely to be available during 2021, if a vaccine can be developed.

Public Health – Leadership of the System

16. Through the Local Resilience Forum (LRF), Hampshire County Council has provided public health leadership to the multiagency response to ensure that the emergency is managed in a way that is proportionate and ensures that the local system, especially in health and care, is able to cope with the pandemic. The Director of Public Health (DPH) is the Deputy Chair of the Strategic Command Group of the LRF, working to the Chief Fire Officer. (The LRF is the umbrella term for the formal legal partnership of key statutory agencies in a given area, in our case that is Hampshire and the Isle of Wight, including the

two cities and the island. The LRF is not a legal entity in itself and holds no direct budgets or accountabilities but is the sum of its constituent statutory partners in the area who must work together during a time of crisis).

17. The public health team, working with Southampton and Portsmouth Directors of Public Health, has ensured that the data on the disease is understood by the partners for effective response. Key workstreams led directly by the County Council's DPH include preventing the spread of infection through effective social distancing, setting up testing with national government and ensuing national guidance on PPE is communicated and interpreted for effective use by local agencies. Throughout all stages of the pandemic, support and advice has been given to all parts of the council dealing with different aspects of the public health emergency.

Impact on Health and Wellbeing

18. There are direct and indirect impacts of COVID-19 on both physical and mental health. These impacts are yet to be quantified we are still in the first wave of the pandemic; also, cumulative impacts will take time to understand. With that consideration there is a lack of national figures and the understanding is developing. There has been a disruption to healthcare services due to re-designed non-COVID-19 services to prepare for COVID-19 Cases. This includes:
    - Drop in Urgent care use including for strokes and heart attacks
    - Treatment delays/modifications for cancer
    - Non-acute care including general practice with the impact on management of patients with Long Term Conditions
    - Impact of low immunisation update resulting in possible surge in vaccine-preventable diseases
    - Paused cancer screening leading to a backlog and undiagnosed/delayed cancer diagnosis and treatment
    - Reduced access to public health programmes – smoking, substance misuse, weight management, NHS health checks leading to poorer health outcomes

19. We need to monitor excess mortality to understand the full impact of COVID-19 on the health of the population and how these impacts on different population which may widen health inequalities. This is likely to lead to a drop in life expectancy and healthy life expectancy.

Mental Health Impacts

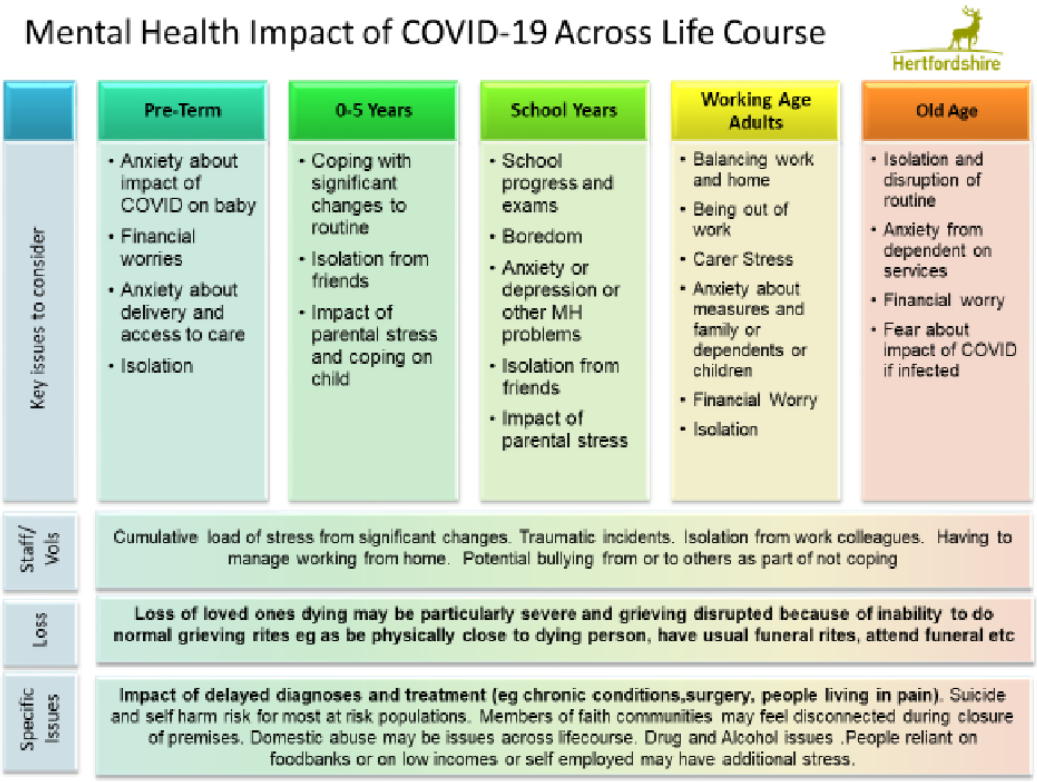
20. The psychological impacts of epidemics and protracted physical distancing measures, including those that are expected (such as loss of identity, disruption to usual activity, increases in feelings of loneliness) and those that may be

unintended (including increases in domestic violence, child maltreatment and cyberbullying).

21. For many, several coping strategies to deal with this psychological impact can be detrimental to mental health; including alcohol and drug misuse, and online gambling. Early studies have also highlighted the impact of stigma and discrimination targeted at certain communities.

22. Lessons from past epidemics are also helpful to understand some of the impacts on mental health. A higher concentration of social determinants associated with self-harm and suicidal ideation in this period, including isolation, stress, financial worries, disruption of personal recovery plans, and relationship discord. There is a recognised increased risk for post-traumatic stress disorder, both for those surviving hospitalisation in Intensive Care Units and the frontline healthcare workers and people with existing mental health vulnerabilities

23. Many people across the world will also be dealing with the effects of the pandemic's excess bereavement burden.



We need to ensure our recovery plans further our understanding of the issues and address them

Outbreak Control Plan

24. On Friday 22 May, national Government announced the requirement for Local Outbreak Control Plans (COVID-19) to be developed to reduce local spread of infection and for the establishment of an officer-led COVID-19 Health Protection Board for each upper tier Local Authority, supported by existing Local Resilience Forum command structures and a new member-led Board to communicate with the general public.

25. The primary objectives of the national Test and Trace service previously rolled out on the IOW, and new local requirements for outbreak plans, will be to control the COVID-19 rate of reproduction (R), reduce the spread of infection and save lives. In doing so, we can help to return life to as normal as possible, for as many people as possible, in a way that is safe, protects our health and care systems and releases our economy.

26. Achieving these objectives will require a co-ordinated effort from local and national government, the NHS, GPs, businesses and employers, voluntary organisations and other community partners, and the general public. Local planning and response will be an essential part of the Test and Trace service, and local government has a central role to play in the identification and management of infection. To that end, £300m in national government funding will be provided to local authorities in England to develop and action their plans to reduce the spread of the virus in their area.

27. Building on the statutory role of Directors of Public Health (DsPH) at the upper tier local authority level, and working with Public Health England's local health protection teams, local government will build on existing health protection plans to put in place measures to identify and contain outbreaks and protect the public's health.

28. Local Directors of Public Health will be responsible for defining these measures and producing the plans, working through COVID-19 Health Protection Boards. They will be supported by and work in collaboration with Gold command emergency planning forums and a public-facing Board led by council members to communicate openly with the public.

29. Cross-party and cross-sector working will be strongly encouraged, and all tiers of Government will be engaged in a joint endeavour to contain the virus, including Local Resilience Forums, NHS Integrated Care Systems and Mayoral Combined Authorities. Councils are free to work at wider geographic levels if they so choose.

30. £300m funding for upper tier Local Authorities accompanied this announcement, for Hampshire this is £4.8m although the requirements of the spend has not been published. The level of this resource is unclear at this time

but may include mobilising trained staff, such as public health practitioners and environmental health officers to undertake risk assessment and contact tracing within our local communities and high-risk settings

Local Plans

31. The aim of the Plan is to provide a framework as to how we will work as a system to respond to COVID 19. The objectives of this plan are as follows:

a) To provide the board with an understanding of data sources to manage the outbreak.
b) To reduce transmission of COVID 19, protect the vulnerable and prevent increased demand on healthcare services.
c) To provide consistent advice to settings to prevent the spread of COVID 10.
d) To oversee the test and trace programme for Isle of Wight
e) To coordinate testing across Isle of Wight.
f) To ensure a collaborative and coordinated approach to supporting settings across the Isle of Wight.

32. The plan has seven themes:

I. Planning for local outbreaks in care homes and schools (e.g. defining monitoring arrangements, identifying potential scenarios and planning the required response).

II. Identifying and planning how to manage other high-risk places, locations and communities of interest including sheltered housing, dormitories for migrant workers, transport access points (e.g., ports, airports), detained settings, rough sleepers etc (e.g. defining preventative measures and outbreak management strategies).

III. Identifying methods for local testing to ensure a swift response that is accessible to the entire population. This could include delivering tests to isolated individuals, establishing local pop-up sites or hosting mobile testing units at high-risk locations (e.g. defining how to prioritise and manage deployment).

IV. Assessing local and regional contact tracing and infection control capability in complex settings (e.g. identifying specific local complex communities of interest and settings)

V. Integrating national and local data and scenario planning through the Joint Biosecurity Centre Playbook (e.g., data management planning including data security, data requirements including NHS linkages).

VI. Supporting vulnerable local people to get help to self-isolate (e.g. encouraging neighbours to offer support, identifying relevant community groups, planning how to co-ordinate and deploy) and ensuring services meet the needs of diverse communities.

VII. Establishing governance structures led by existing COVID-19 Health Protection Boards and supported by existing Gold command forums and a new member-led Board to communicate with the general public.

33. All upper tier local authorities need to develop local outbreak control plans in June ahead of further phases of the national infection control framework.

34. This work is being supported by eleven pilot areas that are rapidly developing best-practices and capturing learning. Local councils outside these areas will be invited to participate in regular engagement and best-practice sharing sessions.

35. A National Outbreak Control Plans Advisory Board will be established to draw on expertise from across local government and ensure the national Test and Trace programme builds on local capability, and to share best practice and inform future programme development.

36. Directors of Public Health will lead the development of Local Outbreak Plans and with Public Health England's local health protection team will lead the work on contact tracing and managing outbreaks in complex settings and situations.

37. The management of local outbreaks is resource-intensive work and so local authorities, through the leadership of their Directors of Public Health and PHE, will work closely together in building capacity of both the local authority public and environmental health teams and the PHE local health protection teams. This will be a key part of delivering the Local Outbreak Control Plans.

Governance

38. Two new local boards will be set up for the Island with key partners to take this forward linking nationally to the Joint Biosecurity Centre, regionally with the LRF, and locally for the best outcomes.

39. The Health Protection Board will have the right expertise and relevant ICP members to take this work forward. It will be responsible for the ongoing development and delivery of the Local Covid-19 Outbreak Control Plan, including:
    - Planning to prevent and respond to local outbreaks in settings such as care homes and educational settings

- Identification and management of other high-risk places, locations and communities of interest
- Identifying methods for local testing to ensure a swift response that is accessible to the entire population.
- Oversight of contact tracing and infection control capability and capacity in local complex settings and identifying and escalating requirements
- Ensuring local services can support vulnerable people to self-isolate

The Member Led Board will bring local accountability and connection to the local community. Membership to include The Leader, Relevant Executive Members and Opposition Members.

Conclusions

40. The response to Covid-19 pandemic has been through a number of phases and actions. The development of the Outbreak Control plan is the next phase of the management of the pandemic which brings further local leadership to the response

41. The Health and wellbeing impacts of the COVID are wide and complex. The Board should note these and the work underway to ensure these needs are addressed.

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

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

Other Significant Links

Links to previous Member decisions:	
Title	Date
Direct links to specific legislation or Government Directives	
Title	Date
COVID-19 recovery strategy	12 June 2020

Section 100 D - Local Government Act 1972 - background documents

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

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. **Equality Duty**

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

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

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

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

2. **Equalities Impact Assessment:**

2.1 This paper does not contain any proposals for major service changes which may have an equalities impact other than to improve outcomes and manage the pandemic.

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date:	6 July 2020
Title:	Adults' Health and Care Response and Recovery
Report From:	Director of Adults' Health and Care

Contact name: Graham Allen

Tel: 03707 795574 **Email:** Graham.allen@hants.gov.uk

Purpose of this Report

1. This report provides an overview of the response and support provided across the county of Hampshire to vulnerable residents and people supported by adult social care services and the moves toward recovery of our services and usual support services.

Recommendations

2. That the Health and Adult Social Care Select Committee notes the work that has taken place to date by Adults' Health and Care, public and voluntary sector organisations and their partners in Hampshire to support the needs of its most vulnerable citizens and the wider community.
3. That the Health and Adult Social Care Select Committee is assured by the systems that have been put in place across Hampshire, as set out in this report, to support the county's most vulnerable residents as well as the wider community during the Covid-19 pandemic.
4. That the Health and Adult Social Care Select Committee notes actions currently underway to support moves toward recovery of services, system and processes across Adults' Health and Care.

Executive Summary

5. This report outlines the extensive work already undertaken in Hampshire; provides details of response of the different organisations who have come together to meet the needs of people in Hampshire, particularly the most vulnerable, due to the impact of Covid-19; and provides details of the number of people who have been supported in Hampshire to date.
6. Measures being identified and taken to support recovery of services across Adults' Health and Care, including the restoration of support provided by social care provider partners are also outlined.

Contextual information

7. The coronavirus pandemic has had a pervasive impact on all aspects of life and upon Adult Social Care. The impact of the illness is causing distress for a larger proportion of the population than was known to Adults' Health and Care before the crisis. For example, social isolation and shielding have led to an increase in the number of vulnerable people requiring support with items such as access to food, medication, and social contact.

8. There are new demands on the existing health and social care system. For example, increasing requirements around swift hospital discharge with a need for the creation of extra capacity in care homes and domiciliary care, and in some situations increased complexity of need for services to manage.

9. Necessary requirements around social distancing are leading to social isolation and this is especially challenging for those with dementia, learning disabilities, mental health problems or autism and is also very difficult for their carers. Some services, such as day opportunities, have had to be stopped in their current form, to comply with social distancing. In addition, family carers may become ill, or their loved one may become ill with Covid-19 and require more support.

10. Hampshire is a geographically large county with approximately 1.3m residents. It has a two-tier system of local government with 11 borough and district councils as well as Hampshire County Council, therefore an effective and co-ordinated response to dealing with impacts of the pandemic has been required.

11. Adults' Health and Care have operated in response to Covid-19 on a number of levels; service specific responses within our usual operating frameworks to meet the requisite adult social services duties, working with NHS partners to ensure sufficient 'surge' capacity was created and supported in the event of reasonable 'worst case' scenario planning for wave1 of the Covid-19 pandemic, creating a broad 'welfare' response across the county of Hampshire with district / borough councils and the voluntary / community sector, providing support at a Hampshire County Council level and, operating and leading elements of response as part of the Covid-19 response.

Aspects of the Response phase

Adults' Health and Care departmental response

12. Adults' Health and Care, along with all other Hampshire County Council departments, moved quickly to ensure continuity and safety of its services and support to the circa 20,000 people receiving social care support in Hampshire. This included moving quickly to identifying mechanisms and arrangements by which all office-based staff could work from home. Arrangements were also put in place, in line with national requirements, to ensure operational front line services were fully mobilised to support 'surge' arrangements mandated across all NHS services. This was at the direction of national Government in response to a Level 4 Pandemic response.

13. Usual adult social care services were amended in light of the social-distancing and lockdown across all activities. This saw the cessation of many services in their usual form, ranging from the suspension of day opportunities, ensuring our 'front door' services such as the Contact, Assessment and Resolution Team could operate remotely (whilst maintaining full service coverage), through to establishing new ways of supporting people discharged from hospital settings. Many of our services had to adapt, literally overnight, to new ways of working. I want to both thank colleagues across the whole department and recognise the unprecedented nature of the challenge, to which all have risen brilliantly. It is also vitally important to confirm that all usual services that safeguard individuals have been maintained during our Covid-19 response; safeguarding, mental capacity and mental health assessments, as well as deprivation of liberty safeguards. We have continued to work relentlessly with Police and other partners regarding domestic abuse and other key service areas.

14. Partners and providers worked tirelessly to ensure that despite the cessation of usual service provision support has continued to individuals and families, at distance through the use of telephone and on-line systems. Clearly, there are impacts as a result of this different support and we are increasingly aware off the pressures and stresses being experienced by individuals and families as lockdown measures have endured. Adults' Health and Care have continued to fund providers at their usual contractual values, despite the changes to services. Additionally, the department has moved quickly to support the care sector through increases in usual invoice values being paid across a range of service / support types.

15. An internal 'Bronze' operational response structure was established within the department to manage and oversee all aspects of our response to the pandemic. This structure reports both the departmental management team and links with the Hampshire County Council's Silver and Gold operational requirements and, where necessary, operates with partners across the health and social care economy.

Welfare response across Hampshire to vulnerable / shielded residents

16. Significant progress has been made in a very short time to coordinate support at local level to meet vulnerable people's urgent needs in response to Covid-19. This response has been in addition to the response provided to those individuals known to adult social care services. The Director of Adults' Health and Care has chaired the welfare response hub for Hampshire across local authorities in the Hampshire area and in collaboration with Public Health, district councils, the voluntary and community sector and faith communities as part of the Coronavirus response (known as the Hampshire and Isle of Wight Local Resilience Forum - LRF).

17. The LRF co-ordinates responses, disseminates learning, escalates issues and provides mutual aid when protecting the most vulnerable in response to Covid-19, including support for those who might struggle to access services, such as rough sleepers and the provision of support for all frail and vulnerable adults requiring help due to their vulnerability, because they are

shielding or due to social isolation. Vulnerable residents have been one of five strategic themes across the Covid-19 response of the LRF.

18. As part of the Hampshire County Council area response, a Helpline called Hantshelp4vulnerable was established and widely advertised where advisers triage calls from vulnerable people who are seeking help. Callers are:

- provided with information and signposting including, where appropriate, to the NHS;
- referred to 11 district based Local Response Centres where they are connected to local support to access food, prescription collection and other forms of support – provided by district councils in partnership with local voluntary sector organisations, groups and local councils, drawing on local volunteers;
- referred to the County Council's Adults' Health and Care Welfare Team where more complex needs and personal care requirements are identified. They may also draw on voluntary support from the Local Response Centres in addition to other care and support. They would pick up any issues related to adult safeguarding or domestic abuse and any urgent issues.

19. Hampshire County Council Adults' Health and Care has taken the responsibility of proactively contacting all residents identified as extremely clinically vulnerable by the Government who have not yet registered on line for the scheme, or who have registered and have requested support due to delays in provision of food parcels or priority delivery slots through the Government scheme, or where the Government scheme does not meet their specific dietary requirements. As of 9 June 53,223 residents in Hampshire have been identified by the NHS as extremely vulnerable and advised to shield, of whom 31,281 have subsequently registered and 6,597 have required direct support locally. A further 13,839 vulnerable people have contacted the County Council's welfare contact centre and 5,945 referrals then passed to local response centres, other calls having either been dealt with either by providing information and advice or urgent social care responses.

20. The County Council have been using a range of communication methods, such as texts, messaging to land lines, outward bound calls and home visits depending on the circumstances and contact details made available by the Government. Where required, regular follow-up reviews are arranged. A proportion of the extremely vulnerable residents and indeed, other vulnerable people who are not on the extremely vulnerable list are already known to, or in receipt of social care services from the County Council and are being contacted through community social work teams. Many GPs are also separately contacting their own vulnerable patients to ensure they are aware of support available. These arrangements provide a comprehensive system of support for all residents although the LRF are continuing to review and improve our response. Of course, many vulnerable residents are accessing local support directly from friends, neighbours and family, from local volunteers and support groups, district and local (parish and town) councils.

21. A welfare team was formed from Adults Health and Care staff taking on additional roles and extending from five to seven day working in order to make these welfare calls. Calls have been reassuring to the public and there has been significant positive feedback from people. We are now in the process, along with partners across Hampshire of stepping down aspects of this overall response phase as the progress and impacts of Covid-19 have begun to reduce and lockdown restrictions begin to ease.

Role of the Borough and District Councils and Local Response Centres

22. There are 11 borough and district councils across Hampshire. Each of these councils have set up, and are running, Local Response Centres. The Local Response Centres bring together local council and voluntary sector professionals (via local Council for Voluntary Services organisations) with volunteers to co-ordinate support at a neighbourhood level. They are working closely with local supermarkets and charities including foodbanks as well as with parish and town councils.

23. Borough and District Councils, along with the CVS (Council for Voluntary Services) organisations, have been able to use their extensive local community contacts and knowledge to ensure that the response within local communities is as effective as possible. This has also included tapping into resources at parish and town council level.

Role of the Voluntary Sector and volunteer capacity

24. Hampshire CVS Network is an alliance of 9 charity infrastructure organisations who work together to help Hampshire's charities, community groups and social enterprises to succeed and flourish. During the pandemic it has played a significant role in co-ordinating the response of the voluntary sector to help mitigate the impacts of the pandemic on local communities as well as providing support for voluntary organisations.

25. Around 4000 volunteers have signed up to new and existing frontline projects supporting vulnerable people across Hampshire. Organisations requiring volunteers are encouraged by Hampshire CVS network to visit their website to find the details of their local CVS, which will be able to match organisations with local volunteers.

26. Hampshire has seen a significant response in terms of people volunteering to help their local communities during this time. This has meant that on some occasions there have been more volunteers available than work for them to do. It has also meant that there has been less pull on the NHS volunteers that were recruited by central government. Currently, feedback is that there is sufficient volunteer capacity to support vulnerable people in Hampshire with their essential needs. However, this will be subject to continuous review and improvement through the Local Resilience Forum.

27. During this time the County Council along with its partners, including the Hampshire CVS network and Community Pharmacy South Central, has developed guidance for volunteers to help keep them safe. This guidance covers areas such as hygiene, reporting wellbeing and safeguarding

concerns, as well as practical advice on topics such as handling money and dog walking.

Food Supply

28. One of the key priorities for the welfare response in Hampshire has been to ensure that those people who are isolating or shielding have sufficient food and other basic items. The LRCs have been instrumental in ensuring that people have had food, as well as medicines and other basic supplies, delivered to them by volunteers where required.

29. The County Council and its partners have worked with supermarkets to ensure that from mid- April there was a prioritisation of delivery slots and click and collect slots for vulnerable people. Alongside this, work has taken place with local food producers and retailers to expand alternative home delivery networks, particularly for those people in need and who have been unable to receive supermarket deliveries.

Impact of COVID-19 on Mental Health

30. The mental health and emotional wellbeing of the population during the pandemic is a widely reported issue and cause for concern. A range of initiatives have been implemented alongside other statutory and voluntary sector partners in view of social distancing measures and closure of key services. Hampshire Mental Health Well Being Centres are now remotely accessible and continue to offer a service to those in need. The Hantshelp4vulnerable helpline has been strengthened by a dedicated advice line staffed by Solent MIND assisting people including carers feeling anxious in isolation. Specialist mental health support has been set up to provide advice and guidance to homeless accommodation schemes.

Impact of COVID 19 on People in Caring Roles

31. People who care for family members or others have largely been disproportionately impacted by the consequences of social distancing, isolation and shielding. Day services have been closed or have moved some services online; respite provision, particularly for people with learning disabilities, has largely been closed and carers have in some cases chosen to take over additional caring duties themselves in order to minimise carers coming into their homes.

32. Since the outbreak of the pandemic, carers' organisations, including Andover Mind, Carers Together and Princess Royal Trust for Carers have responded to support both carers and the wider community in Hampshire. They have extended the opening times of their helplines and have adapted and widened their service offerings to provide listening services, virtual peer groups for carers, making welfare calls to carers and running online workshops for carers, as well as making their services available to people who are self-isolating or shielding. In order to help those carers who need a physical break from their caring activities, Age Concern Hampshire has also set up a sitting service, to enable this to happen.

33. Operational teams are carefully monitoring the situation for families to ensure that individuals with disabilities and older people continue to have their needs met and that carers are supported.

34. In order to have oversight of the ongoing response to support carers, the County Council has set up a carers sub-group as part of its formal response to dealing with the pandemic. This group, which meets weekly online consists of carers, representatives from carers organisations in Hampshire and operational staff from the County Council's Adults' Health and Care department.

Domestic Abuse

35. In the first three weeks of lockdown nationally there were sixteen domestic abuse related murders of women and children. Statistics show that this a rise of 165%. Domestic abuse charities Women's Aid and Refuge have seen an increase of calls since lockdown began but more significantly both are reporting growth in online calls for help.

36. Support and advice continue to be available in Hampshire for people if they, or someone they know, is experiencing domestic violence or abuse or is struggling to control their behaviour. This is provided by Hampshire Domestic Abuse Service and other methods including facebook messenger.

Rough sleepers

37. Significant effort has been made in collaboration across Local Authorities to meet the Government requirement that all homeless people living in Hampshire should be offered accommodation and move off the streets. This has largely been successful although risks lie in arrangements as we move into the recovery phase.

Recovery

38. Adults' Health and Care are using a "start stop model" to capture what was stopped or started during Response, and the related proposed Recovery action, templates have been completed by all services areas / recovery workstreams which provide a baseline reference in the case of a future COVID-19 peak, and agility to 'switch back on' Response if necessary. Assistant Directors are responsible for the development and delivery of detailed Recovery plans for their service areas.

39. Each of these Start or Stop templates will have a related plan varying in complexity dependent on the task and any plans which have a potential financial, reputational, political or department-wide implication are escalated to the Adults' Health and Care Recovery Executive Group for decision, to the Departmental Management Team if necessary and then to Gold. The Adults' Health and Care Recovery Governance approach agreed links in with the corporate Gold / Silver / Bronze Response, and the Hampshire County Council Gold Recovery, as well as the Public Health and local/national Recovery planning.

40. One of the recovery workstreams is that of Community Recovery, the purpose of this recovery model is to:

- Manage the risks and opportunities presented by work with the wider shielded community.
- Collaborate and share innovative practice and shared opportunities with other Local Authorities within the Local Resilience Forum (LRF) hub.
- Take advantage of funding and technological opportunities that are now available due to the COVID-19 Response.
- Co-ordinate recovery of services for rough sleepers.

41. Working closely in collaboration with the Insights and Engagement Team led by Deborah Harkin, with strong links into District Councils. There are also close links into the Adults' Health and Care Demand Management & Prevention programme.

- Membership of Partnership Delivery Group expanded, with focus on risks, opportunities and issues relating to Volunteering and the Voluntary Community Sector (VCS).
- Also, in scope of the Community Recovery model will be a separate Mental Health and Wellbeing Recovery Board under the Mental Health and Wellbeing Recovery LRF cell led by Nick Broughton, Southern Health. Both of these groups are system collaborations.
- The Mental Health and Wellbeing Recovery Board will be chaired by Simon Bryant / Public Health and is a collaboration across Hampshire County Council, Mental Health VCS and Southern Health.

42. All psycho-social support work will sit with the Mental Health and Wellbeing Recovery Board.

43. There is a workstream on workforce recovery, the 4 main strands within this model are:

- Welfare and wellbeing support offer, including Bereavement support.
- Welfare support for HCC leavers following their exit from our employment.
- Interface with the AHC Working Differently Transformation to 2019 and 2021 programmes.
- Direct Care workforce recruitment.

44. A diagnostic tool is in development to understand the main issues and concerns regarding staff welfare, and how this varies across the department. The Connect 5 offer is being carefully considered to support staff mental health, particularly in response to COVID-19. It is recognised that teambuilding will be significant in the context of Recovery and staff wellbeing.

45. In terms of recruitment and training of staff during this period, recovery planning underway to support virtual recruitment and Values Based conversations and the majority of training can be delivered virtually but our

planned offer is likely to be impacted by costs and an increase in alternative providers.

46. Learning lessons will be undertaken at various levels to examine good practice, areas of learning and the degree of compliance with national and local policy, guidance and directives:

- Surveys and reviews of key teams and services
- Reflective sessions – e.g. use of PPE
- Targeted reviews – HCC Care and care homes
- Participation in system wide reviews – e.g. hospital discharge arrangements
- Review led by Hampshire Safeguarding Adults' Board on health and care sector impacts and learning.
- Regional and national reviews and inquiries.

Conclusion

47. The response to the Covid-19 pandemic across all aspects of our services and communities has been significant. The impacts of the pandemic have been similarly significant and the consequences upon our communities and individuals profound. It will take some time for the full impacts of restrictions and the lockdown upon our communities to be known.

48. In line with Government's progress toward reducing the current restrictions, services and responses will be amended over the coming period, whilst a weather-eye is kept upon the risk of a second wave, in line with the Local Outbreak Management Plan.

49. Whilst there is still much further work to be undertaken as we slowly move from response to recovery and learning and analysis is undertaken it is hoped this overview provides Health and Adult Social Care Select Committee with a degree of assurance and confidence in the approach undertaken.

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

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

Section 100 D - Local Government Act 1972 - background documents

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

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. **Equality Duty**

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

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

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

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

2. **Equalities Impact Assessment:**

2.1 This paper is an update report, so an Individual Equalities Impact Assessment have not been completed.

This page is intentionally left blank

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date:	6 July 2020
Title:	Care Home Support offer and update
Report From:	Director of Adults' Health and Care

Contact name: Graham Allen

Tel: 0370 779 5574 **Email:** Graham.allen@hants.gov.uk

Purpose of this Report

1. The purpose of this report is to provide an overview of the progress of Covid-19 and its significant impacts upon the care home sector in Hampshire during the period March 2020 to 12 June 2020**.**
2. The report also provides an update of work underway across partner organisations in response to support the care home sector following the publication of the Social Care action plan in mid-April 2020 and following publication of the requirements set out in the Minister for Health's letter to local authority's with adult social care responsibilities, dated 14 May 2020.

Recommendation(s)

3. That the Health and Adult Social Care Select Committee is assured by the work underway to support the care home sector through the development of a care home plan and notes the contents of this report.
4. That the Health and Adult Social Care Select Committee recognise the impacts upon the care home and wider social care sector and thank all those staff working across the sector for the humanity, compassion and care shown throughout their responses to Covid-19.
5. That the Health and Adult Social Care Select Committee receive further updates at future meetings on continuing work to support the care sector.

Executive Summary

6. This report seeks to detail impacts upon the social care home sector in Hampshire during the progress of the Covid-19 pandemic, from early March 2020 until 12 June 2020**.** The report provides an interim view of issues, given that all organisations continue to be in a 'response' phase to the pandemic, with work continuing to plan for a second and potentially further successive waves of the pandemic.

7. This report should also be seen, therefore, in the light of significant work being undertaken across the County Council, with partners, on a range of key issues including the Local Outbreak Management Plan. A complimentary report, relating to Adults' Health and Care's approach to welfare provision and recovery of services, is also on this agenda.

8. Covid-19 response planning in Hampshire commenced in February 2020, both through Hampshire County Council and via the Local Resilience Forum for Hampshire and the Isle of Wight. The pandemic response was fully initiated when a major incident was declared in early March 2020.

9. The care sector and the NHS has been at the forefront of the response to the initial wave of the pandemic. Initial focus, in light of national pandemic modelling, identified that NHS acute services might be overwhelmed and there was an urgent need to create capacity in NHS bed-based services. This saw acute bedded -provision availability increase rapidly in advance of a potential surge in patients with Covid-19; with some 50% of acute hospital beds becoming available across our acute hospitals. Aspects of this discharging of patients and subsequent NHS support to residents are subject to updates to be provided to this Committee and are not covered in this report in any detail.

10. However, new services and new responses in the face of reasonable worst-case scenario planning were established across Hampshire, primarily through the NHS Covid-19 response planning. Discharge arrangements have primarily been commissioned and led within NHS local sub-systems, with operational and tactical support through Hampshire County Council and other partners.

11. Subsequently, as services have begun to move toward restoration and recovery within the NHS, as the first wave of the pandemic has reduced, available bed capacity has slowly and in a measured way reduced, whilst arrangements remain in place should further waves of pandemic infection develop.

12. Additionally, Hampshire County Council moved rapidly to recognise the risks and pressures faced by care providers and put in place a 10% immediate uplift in commissioned care in care home settings and 5% in domiciliary commissioned care, payable in advance from 1 April without any requirement being placed upon providers to apply for or submit additional information. Furthermore, as we are not adjusting these uplifts on commissioned care back to 'actuals' the gain for providers financially is likely to be above those levels identified above. We identify that Adults' Health and Care will spend some £10m of additional local financial support on top of our commissioned care provision in the period up to the end of July 2020, with ongoing work to review arrangements to support the commissioned social care sector after this date.

13. Guidance on controlling and containing outbreaks and reducing risks through taking mitigating actions and providing specific support, within the national framework established by Government, has been regularly updated. This has

specifically directed many responses, within a local collaborative framework overseen through the Local Resilience Framework.

14. Government introduced emergency Coronavirus legislation in March 2020. Amongst the measures available have been Care Act Easements. Hampshire County Council have not initiated such measures, though Cabinet received a report and approved recommendations in May 2020 to enable such Easements, if required. https://democracy.hants.gov.uk/ieListDocuments.aspx?CId=134&MId=6847&Ver=4

15. In mid-April 2020 the Department of Health and Social Care published a Social Care Support Plan; https://www.gov.uk/government/publications/coronavirus-covid-19-adult-social-care-action-plan/covid-19-our-action-plan-for-adult-social-care . This covered four key areas; 1) controlling the spread of infection, 2) supporting the workforce, 3) supporting independence, supporting people at the end of their lives and responding to individual needs, and, 4) supporting local authorities and providers of care. Further work is ongoing regarding the creation of a national care home taskforce. Further details on that taskforce is currently awaited.

16. In total 1672 people died in care home settings in the period between the week ending 28 February 2020 and the week ending 12 June 2020, of which 449 had Covid-19 recorded as the cause of death on their death certificate. Clearly, the impacts upon families, staff and organisations has been devasting. Condolences and sympathy have been extended to all family, organisations and communities. Typically, over this same period in previous years we would expect to see between 50 – 30 deaths per week across the 13,000+ care home beds in Hampshire, though variation in any year and month is inevitable. There have also been significant impacts upon care home staffing, with staff needing to self-isolate / quarantine during the pandemic.

17. During the early response teams within both Adults' Health and Care and across NHS Commissioning and Provider partners established dedicated teams and support and re-assigned a range of other services and functions to support the response phase. These include specific 'cells' focussing upon support to the care home / care sector with regard to issues such as emergency Personal Protective Equipment, infection prevention and control and finance, as well as discharge arrangements from hospital settings which saw the establishment of 'discharge hotels' and other resources. As well as risks for older people's care home settings, we have also been extremely focussed upon care settings for other service user groups, including increased risks for people with learning disability and those with other complex care needs. Further work will be brought back to this Committee, in due course.

18. Additionally, in mid-May 2020 the Minister for Care provided details of a £600m fund, https://www.gov.uk/government/publications/coronavirus-covid-19-support-for-care-homes which along with a range of other measures sought to reduce risks of infection transmission within care home settings, they having been identified as key places of risk. Each upper tier local

authority, working with partners, has needed to submit a detailed response to the Minister by 29 May outlining actions in place and progress by which assurance and confidence could be obtained. Hampshire County Council moved quickly, working with a range of partners, and made some £7.8m of direct payments to all qualifying care home providers in Hampshire by 29 May. Details on these actions are set out in the next section.

Contextual information

19. The current Covid-19 outbreak is due to a new coronavirus, which first came to light towards the end of 2019. The first cases in the UK were identified in January 2020. With more and more countries around the world experiencing outbreaks, the World Health Organization declared a global pandemic in March 2020.

20. Coronaviruses are a large family of viruses which, in humans usually cause mild illness. The Covid-19 disease is spread through cough droplets either directly from an infected person or from touching surfaces contaminated with the virus through someone coughing onto them. The virus is estimated to last for up to 72 hours on hard surfaces.

21. The symptoms of coronavirus disease (Covid-19) are typically (but not exclusively) a cough, a high temperature and shortness of breath. It is now additionally advised that a loss of sense of smell may also be a key symptom. The virus can affect anyone and for most people the symptoms will be mild, and people will recover in around two weeks.

22. However, the individuals at highest risk for severe disease are those over 70 years and those with underlying health conditions, where symptoms could require hospitalisation. There is further developing evidence about risks to Black, Asian and Minority Ethic (BAME) communities and those individuals with obesity. Work remains ongoing across our workforces and communities with regard to these heightened risks. It remains difficult to accurately estimate the mortality rate across the whole population, because not all cases are identified. However, data from around the world suggests it is likely to be less than 1%, with potentially 5% of the overall population having been infected with the virus. The disease in children appears to be mild in most cases, though there have been instances of deaths.

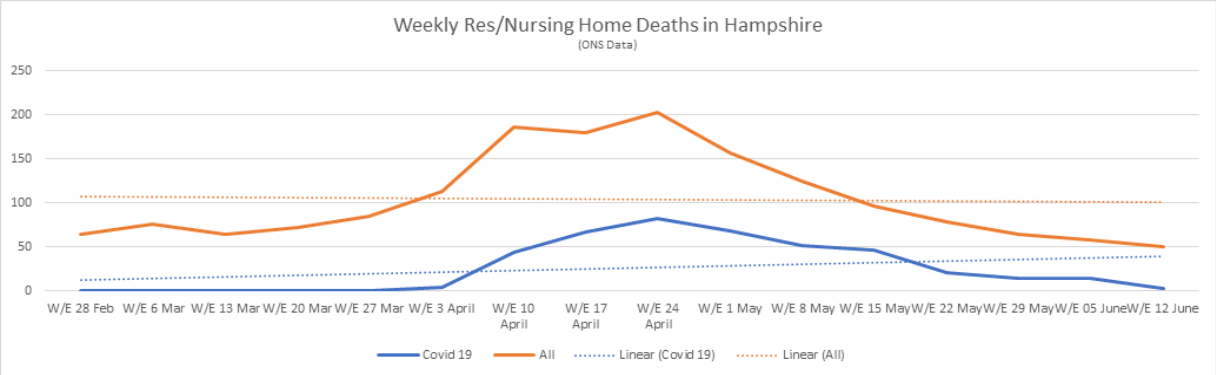
23. Within Hampshire there has been a steady rise in cases and deaths in line with the national spread and epidemic. The first peak was managed through national guidance on social distancing, lockdowns across our communities, organisations and economy. The modelling of the virus suggests further waves of disease may develop during the Autumn.

24. Due to the lack of immunity in the population the disease can easily spread between people causing a large outbreak and ‘peak’ in cases. If allowed to spread without intervention the resulting level of disease would overwhelm our health and social care services due to the extreme volume of those requiring specialist care and support. Therefore, a number of measures, many of which were based on existing national plans to respond to influenza pandemics, were put in place by the government to manage the outbreak.

Care sector impacts

25. As reported above deaths in care homes over the period from the week ending 28 February to 12 June 2020 were 1672 people. The impacts upon families and staff caring for these individuals have been significant. It is vital to underline the compassion and quality of care provided in all settings. Providers, Registered Managers, all staff and families and indeed many communities of support around care home settings have provided exemplary support throughout the response to Covid-19. It is also important to recognise the impacts endure and the sector, families and individuals will continue to be supported with the ongoing effects of Covid-19.

26. Figure 1 below, show the progression of care home deaths during the period referred to throughout this report. Appendix 1 shows the data in a tabular form. Appendix 2 shows the data by HCC Care homes, including additional detail on staffing.



27. It is important to recognise that the number of deaths in care home settings in Hampshire are high, but to also recognise that with 13,000+ registered care home beds the number of Covid-19 deaths per 1,000 registered beds stands at 4.5. this number is in line with much of the sector in England and significantly below the rate in other areas within the national and South East region. Appendix 3 presents this by the regional analysis undertaken by Office of National Statistics data, up to 29 May 2020.

28. For people with Learning Disability / Autism we have also seen national and local media commentary of Covid-19. We continue to undertake specific work in this area and whilst we have seen a small number of additional deaths within this community I am currently unable to confirm whether this is a feature of Covid-119 or not, as the numbers are small and usual processes are continuing following deaths being reported. However, a future report will comment more widely upon this and a broader range of issues across our communities, noting impacts and actions taken in other sections of the care sector, not detailed in this report. Analysis and focus to this area of work is being undertaken within the Hampshire Safeguarding Adults Board and elsewhere.

29. Alongside the individual tragedies that Covid-19 has wrought the care sector has collectively seen many, significant impacts, both at a local and also a national level.

30. Hampshire Care Association, an independent membership organisation of care providers working across the wider Hampshire geography has surveyed its members to identify a wide range of impacts. A link to their survey results can be found here; https://documents.hants.gov.uk/covid-19/HCACovid19FinanceSurvey.pdf

31. Key amongst the financial impacts highlighted by the survey results are that the direct costs to care providers have increased by some 18% since February 2020, essentially as a result of increased infection prevention and control measures (including, but not limited to Personal Protective Equipment) and staffing related expenses. Concerns are extremely high in the sector arising both from these increased costs and also a reduction in occupancy across the sector. Typically, we would expect occupancy levels to be at / around 90%, currently from our own analysis it is closer to 78% and this significantly undermines the viability of care home businesses. At this time the assessment is that the whole sector is in a fragile position, whether care homes are supporting publicly funded or self-funded residents. Local government is not in a position to financially secure and off-set these challenges. We may see increased risks of care home closures, beyond the usual 4 – 6 annual closures across Hampshire. We are actively working with the care sector to mitigate such risks and proactively identify actions that can be taken.

32. These local issues highlighted by care providers are echoed nationally in the two-part ADASS Budget Survey 2020, published on 11 and 18 June 2020 covering the impacts of Covid-19 on the care sector; https://www.adass.org.uk/adass-budget-survey-2020 . In those reports the fragility of the sector nationally is identified, both in advance of Covid-19 and also as a consequence of Covid-19. Learning from the pandemic response is highlighted as needing to be urgently taken forward on a national level by Directors of Adult Social Services in order to establish medium and long-term solutions for the sector in England.

33. There have also been numerous reports during the initial phases of the national response to the challenges to the health and care sector of obtaining Personal Protective Equipment (PPE). Hampshire along with all other parts of the country initially struggled to obtain reliable deliveries of PPE. The national PPE stockpile and its logistics network were extremely stretched through March and much of April 2020. Whilst we received national stockpile deliveries into the Local Resilience Forum arrangements, in order to create an emergency local stockpile, Hampshire County Council acted to procure extensive deliveries, both for our own use and also for the wider LRF organisations on a cost recovery basis, as required.

34. Alongside comments already made in relation to the HCA survey relating to PPE, we also saw costs and also usage increase significantly, with some items initially increasing in cost by a factor of up to 20 fold, given the demand / market pressures to obtain supplies. This was not a national issue, but an international demand / supply challenge. However, notwithstanding this we saw many excellent examples of local groups making and providing many

types of PPE for free – such as face visors created through 3-D printing technology.

35. Hampshire County Council have, from the outset of the pandemic, made emergency supplies of PPE available to providers across the county. It is important to recognise that whilst there were, undeniably, many challenges for care providers obtaining PPE there have been remarkably few instances when PPE supplies were unavailable to providers. We have seen providers of all kinds providing mutual support to one another and in 117 cases we have needed to make emergency supplies available to 86 different organisations.

36. More recently, we have begun to see usual supply chains coming back on-stream, with prices slowly beginning to return to more normal levels, for some, but not all items. Usage by providers and, therefore, ongoing cost pressures continue. In light of this, we continue to operate a logistics operation for the supply of emergency PPE and have allocated funding to support free emergency provision.

37. A further significant impact upon care home settings, following identification of Covid-19 outbreaks has been self-isolation, causing reduced staffing levels, and also the national regime of testing for residents and staff.

38. Care providers have seen reductions in staffing levels in care homes of up to 30% for periods of time and the need to bolster available staffing with agency workers and overtime have increased financial pressures. Responses to this are covered in the next section of this report.

39. The national testing regime, in terms of both increasing capacity and providing access through on-line portals to register and book had proved difficult in the first two months or so of the pandemic. Care homes have been supported throughout the pandemic through the Health Protection Team locally in Hampshire undertaking outbreak tests; up to five residents (subsequently reduced to three) having tests to confirm the presence of an outbreak. However, the nature of the Covid-19 pandemic with a mixture of virulent / terminal to mild symptoms through to people being asymptomatic and the emerging science relating to the pandemic has made all aspects of containing and controlling the virus challenging in the extreme.

40. The Government committed in mid-April to test all people being discharged into care home and other settings from hospitals and since mid-May all care homes for older people with more than 50 beds (seen as being highest risk settings) would be subject to whole-home testing for residents and staff.

41. Positively, this has been put in place locally by NHS acute hospitals and by early June whole home testing for residents and staff was completed in all large care homes across Hampshire. Testing across the rest of the care home sector, for all client types, is currently being rolled out. Locally the military have provided exemplary support through providing both mobile testing units and supporting the logistics around whole care home testing. Hampshire County Council, along with partners, will have published a Local Outbreak Management Plan at the end of June and this will enable a far greater level of local co-ordination and direction of testing, including repeat testing, in high risk settings, at the direction of the Director of Public Health.

Actions taken in respect of the care home support plan

42. As identified earlier in this report requirements were set by Government in relation to general measures to be applied to support the care sector and subsequently a requirement to develop a comprehensive care home support plan, announced in the Minister for Care's letter to Leaders of local authorities on 14 May.

43. Actions required have needed to address; infection prevention and control, testing, PPE and clinical equipment, workforce support and clinical support. Alongside a plan covering these aspects an allocation of financial support was made to each local authority with adult social services responsibility, based upon the numbers of registered care home beds within the area. Hampshire County Council will receive two tranches of £9.2m, £18.4m in total to support the sector, subject to strict grant conditions determining permissible spend areas.

44. Providers must also regularly submit detailed information via a national tool to report on their actions and compliance with national measures put in place. Locally, working with a range of partners we are augmenting the support available and using this nationally provided data, along with other locally obtained data and insights and through regular engagement with all providers and have developed a detailed dashboard which enables a home by home level understanding of risk, staffing, PPE supply, outbreak, etc. A summary of this dashboard can be found here; https://documents.hants.gov.uk/covid-19/Dashboard-summarylevel.pdf

45. A response, detailing the actions being taken across the local authority, Hampshire's CCGs, Hampshire Care Association, supported by HealthWatch Hampshire and local Care Quality Commission partners, was sent by the Chief Executive of Hampshire County Council on 29th May. This response then became part of a regional and national assurance process, essentially to test the robustness and appropriateness of actions being taken and to release the funding allocation. Areas covered with the Hampshire care home plan are;

    - Safe and personalised care
    - Provider workforce resilience
    - Care home clinical support
    - Preventing the spread of infection
    - Financial resilience, and
    - Effective engagement.

46. Positively, we have received confirmation that all areas of our collective response meet, and in some cases provide 'best practice' examples. The response submitted to Government along with additional required information has been published on the Hampshire County Council website along with the care home support plan; https://documents.hants.gov.uk/adultservices/Covid-19-Care-Home-Support-Plan-for-Hampshire.pdf. The care home support plan and its attendant multi-agency oversight board will continue to drive, oversee and monitor actions being undertaken to ensure that local connections into NHS sub-systems and across all partners, working closely with HCA and

others, are achieved in order to further support confidence in and about the care sector.

47. Hampshire County Council took a decision to release funding to care homes as soon as practicable in order to shore up the financial resilience of the sector (note; all care homes regardless of the client groups supported and the presence or otherwise of a commissioning / financial relationship with Hampshire County Council). Payments to providers occurred simultaneously to all providers as the submission of the response by 29th May. Some £7.8m was paid to all care homes, with approximately £500 per registered bed, plus, based upon our analysis of sector risk, an additional amount for small care homes with less scale of economy to 'smooth' some areas of higher cost. A sum of £0.92m was identified to support emergency PPE supplies and other support.

48. We have established a regular senior forum to continue to oversee and progress actions that have been determined. However, it is important to note that every care home has a named clinical lead, a named Primary Care practice, multi-disciplinary team meetings are in place as well as infection prevention and control training and support and we have established mechanisms between the care home sector and Hampshire County Council and NHS partners to be able to deploy emergency staffing support if required.

49. Currently, in line with the grant conditions work is being undertaken to determine that care home providers have spent / are spending the financial support on the designated permissible spend areas. This is critical in order to be able to assure the use of public funds, not breach State Aid regulations and enable receipt of the second tranche of funding in July. Our intention is to make the second payment to providers in early July 2020. By 23 September a detailed report will need to be submitted to Government confirming use of the financial funding and to provide detailed updates on all elements of the support plan.

Next steps

50. It is recognised that there will be a number of lessons to be learned with regard the devastating impact of this terrible disease in various settings. The impact into care homes and similar settings cannot be underestimated and includes far reaching emotional and psychological impact on so many individuals and their families, together with the impact on many staff and carers who have shown dedication, commitment and strength. Hampshire County Council will collaborate in respect of any reviews or inquiries led regionally or nationally and is committed to participating fully.

51. Furthermore, Adults' Health & Care will also be taking a proactive role in ensuring that necessary lessons are learned locally, specifically in respect of services in Hampshire through the undertaking of and the participation in locally commissioned reviews. Learning and review is also being undertaken through the Hampshire Safeguarding Adults Board. It is important to state our intent is to examine good practice, areas of learning and the degree of compliance with national and local policy, guidance and directives at the time

and not to disproportionately respond with the benefit of hindsight nor to apportion blame on individuals or groups of services.

52. Through our care governance arrangements we are undertaking two specific internal 'lessons learned' pieces of work to review the circumstances surrounding the management and response within our internal Hampshire County Council registered residential and nursing home provision and our role with regards to the external market.

53. The Committee will, I hope, understand both the sensitivity and also the importance of this and also recognise that inevitably, given we remain in response mode, this may take some time to conclude. However, it should also be understood that much has been learnt already and embedded into current practice, including the need to cohort and quarantine anyone admitted into a care home setting and establish, where we can new specialist hospital discharge facilities – such as the Clarence Unit at Woodcut Lodge which opened during the week commencing 15th June. https://democracy.hants.gov.uk/ieDecisionDetails.aspx?ID=1484

54. It is important to evaluate a timeline of key episodes, communications, actions taken when and by whom and to understand how outbreak information was handled and responded to in our department. There will also be an exploration of what available national guidance was being followed at the various key episodes. This work will be done in conjunction with partners but has been commissioned by the Director of Adults' Health and Care. The clear intention is to bring back the outcomes of such work to this Committee when available.

55. In addition, at the Hampshire Safeguarding Adults Board on 22nd June there was an agreement for the Board to sponsor a Hampshire wide review of the management of the pandemic within care homes. This is likely to be broadened to consider all care settings.

56. This review will commence in the coming weeks and will need to be a multi-agency piece of work across key partners to include an analysis of factual data, comparisons with usual expected death rates, hospital discharge arrangements and changes to testing policy and other guidance during the response phase.

57. This exercise will be overseen by an Executive Panel to guide and oversee it. The planning for this is in the early stages with the intention for it to be undertaken through a co-production approach, involving experts by experience and care home representatives. It is likely that the agencies in scope for this review will include Hampshire County Council services including Adults' Health and Care, Public Health and Emergency Planning as well as other key partners including NHS (primary, secondary and acute), Care Quality Commission, care providers and many other stakeholders.

Conclusions

58. The response Covi-19 and the support put in place to the care home sector has been undertaken at pace. Furthermore, Covid-19 has severely impacted

on systems and processes usually available to provide support. We remain actively in response mode to the pandemic.

59. The care sector has seen much trauma and the effects of Covid-19 have been devastating. Tribute must be paid to the efforts of the whole care sector, for the resilience and compassion of staff in the most trying circumstances imaginable.

60. Work continues to support the care sector, our residents and their families and this will continue in the months ahead. Health and Adult Social Care Select Committee will be regularly updated on this work.

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

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

Other Significant Links

Links to previous Member decisions:	
Title Covid-19: temporary changes to the County Council's duties under the Care Act 2014	Date 15 May 2020
Direct links to specific legislation or Government Directives	
Title	Date
COVID-19: Our action plan for Adult Social Care Coronavirus (COVID-19): support for care homes	16 April 2020 22 May 2020

Section 100 D - Local Government Act 1972 - background documents

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

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. **Equality Duty**

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

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

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

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

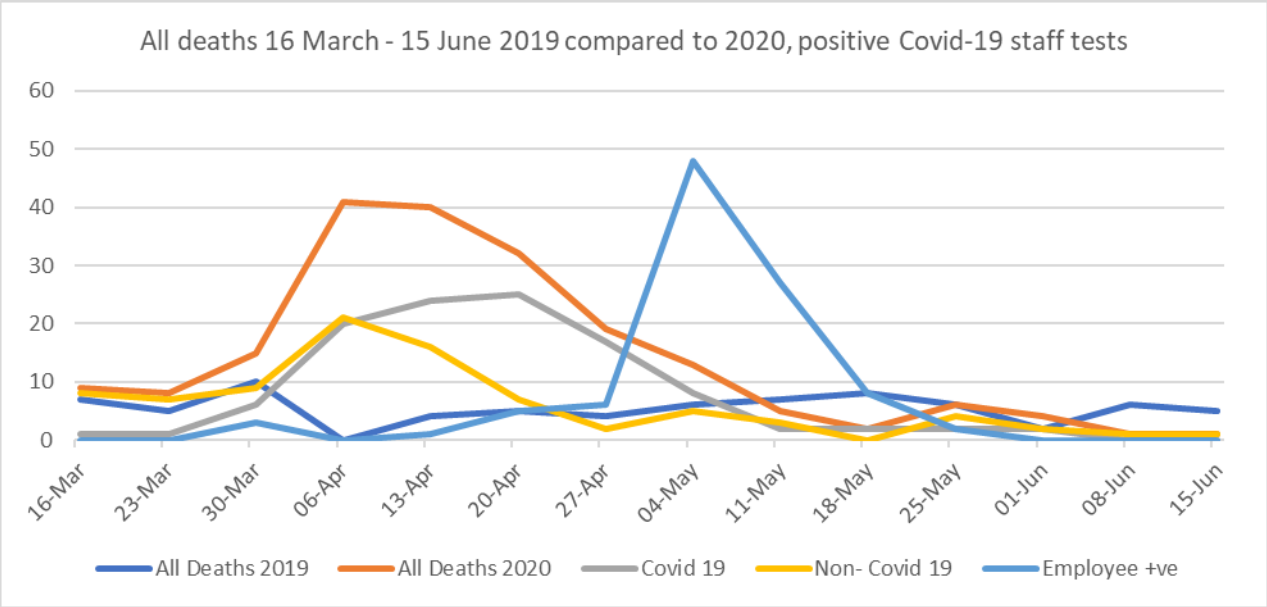
2. **Equalities Impact Assessment:**

2.1 This paper is an update report, so no individual Equalities Impact Assessment has been completed.

Appendix 1

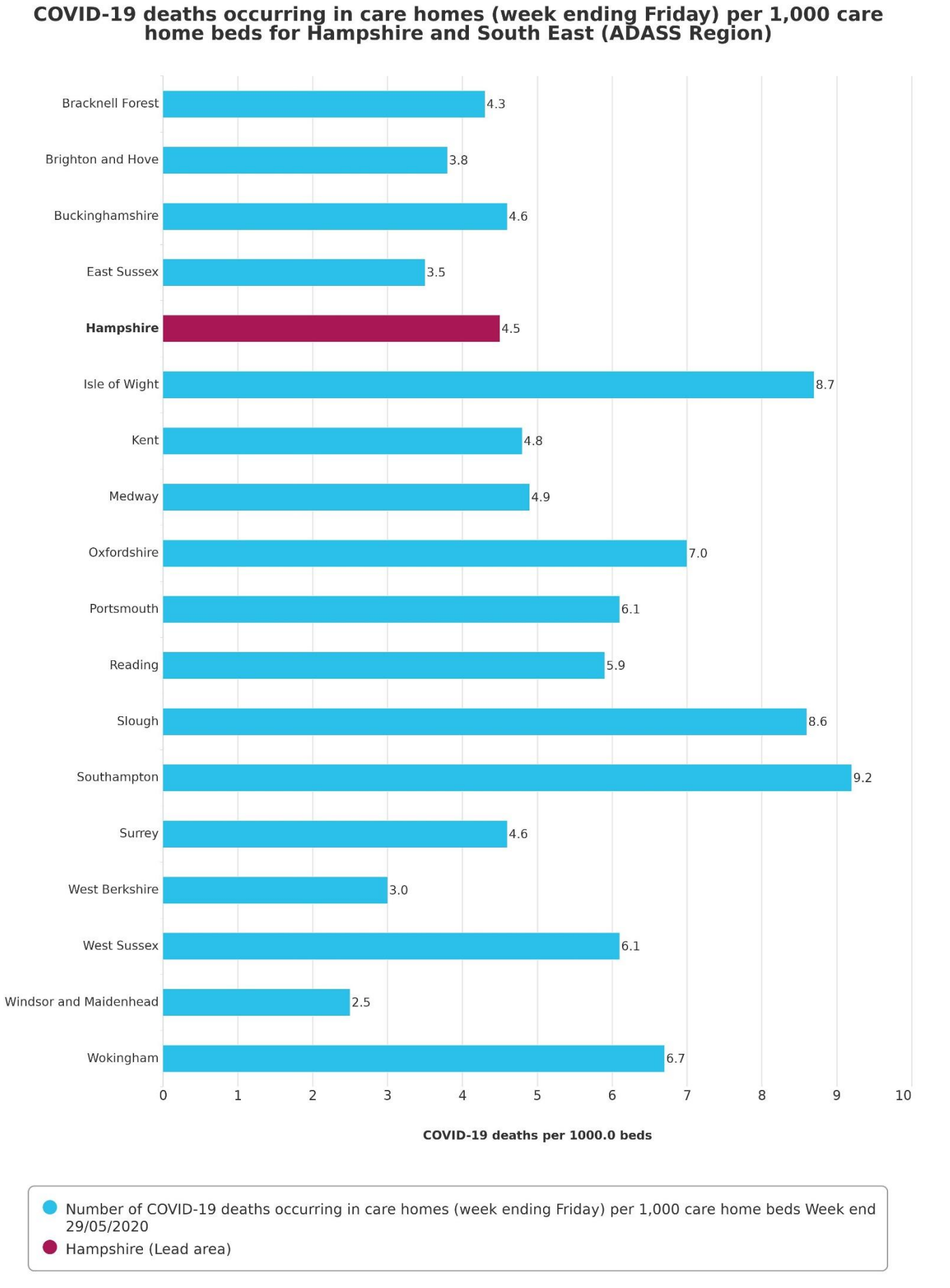
	W/E 28 Feb	W/E 6 Mar	W/E 13 Mar	W/E 20 Mar	W/E 27 Mar	W/E 3 April	W/E 10 April	W/E 17 April	W/E 24 April	W/E 1 May	W/E 8 May	W/E 15 May	W/E 22 May	W/E 29 May	W/E 05 June	W/E 12 June	**TOTALS**
Covid 19	0	0	0	0	1	5	44	67	83	68	52	47	21	15	15	3	421
All	64	76	65	72	85	113	186	179	202	156	125	96	79	65	58	51	1672
% Covid19					1.20%	4.40%	23.70%	37.40%	41.10%	43.60%	41.60%	48.90%	26.58%	23.08%	25.9%	5.9%	25.18%
Non-Covid	64	76	65	72	84	107	142	112	119	88	73	47	58	50	43	48	880

Appendix 2



https://documents.hants.gov.uk/covid-19/5-AllDeathsbyLocationType-March-onwards.pdf

Appendix 3



HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select (Overview and Scrutiny) Committee (HASC)
Date of meeting:	6 July 2020
Report Title:	Work Programme
Report From:	Director of Transformation and Governance

Contact name: Members Services

Tel: 0370 779 4072 **Email:** members.services@hants.gov.uk

Purpose of Report

1. To consider the Committee's forthcoming work programme.

Recommendation

2. That Members consider and approve the work programme.

WORK PROGRAMME – HEALTH AND ADULT SOCIAL CARE SELECT OVERVIEW & SCRUTINY COMMITTEE

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	6 Jul 2020	14 Sep 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
Proposals to Vary Health Services in Hampshire - *to consider proposals from the NHS or providers of health services to vary health services provided to people living in the area of the Committee, and to subsequently monitor such variations. This includes those items determined to be a 'substantial' change in service.* **(SC) =** Agreed to be a substantial change by the HASC.									
Andover Hospital Minor Injuries Unit	Temporary variation of opening hours due to staff absence and vacancies.	Living Well Healthier Communities	Hampshire Hospitals NHS FT and West CCG	Update last heard April 2019, then September 2019. Last update Jan 2020, inc UTC developments (invite West CCG to joint present with HHFT).		**x**			
North and Mid Hampshire Clinical Services Review **(SC)**	Management of change and emerging pattern of services across sites.	Starting Well Living Well Ageing Well Healthier Communities	HHFT / West Hants CCG / North Hants CCG / NHS England	Monitoring proposals for future of hospital services in north and mid Hampshire since Jan 14. Status: last update Jan 2019. Retain on work prog for update if any changes proposed in future. Timing to be kept under review.	If any changes proposed, HASC to receive an update.				

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	6 Jul 2020	14 Sep 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
Spinal Surgery Service	Move of spinal surgery from PHT to UHS (from single clinician to team).	Living Well Ageing Well	PHT, UHS and Hampshire CCGs	Proposals considered July 2018. Determined not SC. Update on engagement received Sept 2018. Implementation updates May 2019 (PHT), Sep 2019 (UHS), and March 2020 (UHS).		**x**			
Chase Community Hospital (Whitehill & Bordon Health and Wellbeing Hub Update)	Hampshire Hospitals NHS FT - Outpatient and X-ray services: Reprovision of services from alternative locations or by an alternative provider.	Living Well Ageing Well Healthier Communities	HHFT and Hampshire CCGs	Item considered at May 2018 meeting. Sept 2018 decision is substantial change, further update Nov 2018 meeting. Latest update Feb 2019 Health hub developments written update provided Sep 2019 and March 2020.					
Mental Health Crisis Teams	Proposed changes to the Mental Health Crisis Teams.	Living Well Ageing Well Healthier Communities	Solent NHS and Southern Health for PSEH	Presented July 2019. Informed Nov 2019 of 9-12 month project delay. Update when work is resumed.			**x**		

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	6 Jul 2020	14 Sep 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
Integrated Primary Care Access Service	Providing extended access to GP services via GP offices and hubs.	Living Well Ageing Well Healthier Communities	Southern Hampshire Primary Care Alliance	Presented July 2019, update expected January 2020.		**x**			
Beggarwood Surgery Closure	Alternate plan to closing, continuing to provide GP services with NHUC provider.	Living Well Ageing Well Healthier Communities	NH CCG NHUC	Presented September 2019, written update January 2020.					
Orthopaedic Trauma Modernization Pilot	Minor trauma still treated in Andover, Winchester and Basingstoke. An elective centre of excellence for large operations in Winchester.	Living Well Ageing Well Healthier Communities	HHFT	Presented September 2019, update March 2020.		**x**			
Out of Area Beds and Divisional Bed Management System	Plan to tackle the Out Of Area (OOA) bed issue within the adult mental health services.	Living Well Ageing Well Healthier Communities	Southern Health NHS FT	Presented September 2019, update January 2020. Written update March 2020.		**x**			

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	6 Jul 2020	14 Sep 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
Modernising our Hospitals and Health Infrastructure Programme	To receive information about a new hospital being built as part of a long term, national rolling five-year programme of investment in health infrastructure.	Starting Well Living Well Ageing Well Healthier Communities Dying Well	HH FT and Hampshire CCGs	Expected in July 2020 following informational briefings.	**x**				
Building Better Emergency Care Programme	To receive information on the PHT Emergency Department (ED) capital build.	Starting Well Living Well Ageing Well Healthier Communities	PHT and Hampshire CCGs	Expected in July 2020 following informational briefings.	**x**				
Issues relating to the planning, provision and/or operation of health services – *to receive information on issues that may impact upon how health services are planned, provided or operated in the area of the Committee.*									
Care Quality Commission Inspections of	To hear the final reports of the CQC, and any	Starting Well Living Well	Care Quality Commission	To await notification on inspection and contribute as necessary.					

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	6 Jul 2020	14 Sep 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
NHS Trusts Serving the Population of Hampshire	recommended actions for monitoring.	Ageing Well Healthier Communities		PHT last reports received Nov 2019. New full report received Jan 2020, update March 2020. SHFT – latest update received Jan 2020, but new full report and update March 2020. HHFT last update heard in May 2019. New report and action plan expected in May 2020. Solent – latest full report received April 2019, written update on minor improvement areas in November 2019. Frimley Health NHS FT inspection report published March 2019 and update provided July 2019. Further update		**x** **x** **x** **x**			

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	6 Jul 2020	14 Sep 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
				March 2020. UHS FT inspected Spring 2019. Update provided July 2019. Further update March 2020.		**x**			
Sustainability and Transformation Plans: One for Hampshire & IOW, Other for Frimley	Subject to ongoing scrutiny the strategic plans covering the Hampshire area.	Starting Well Living Well Ageing Well Healthier Communities	STPs	H&IOW initially considered Jan 17 and monitored July 17 and 18, Frimley March 17. System reform proposals Nov 2018. STP working group to undertake detailed scrutiny – updates to be considered through this. Last meeting in Dec 2019 and report to HASC April 2019. Last report alongside WG report in Oct 19. Final papers circulated Nov 2019 (minus Appendices D and I)					

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	6 Jul 2020	14 Sep 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
Pre-Decision Scrutiny – *to consider items due for decision by the relevant Executive Member, and scrutiny topics for further consideration on the work programme*									
Budget	To consider the revenue and capital programme budgets for the Adults' Health and Care department.	Starting Well Living Well Ageing Well Healthier Communities	HCC Adults' Health and Care (Adult Services and Public Health)	Considered annually in advance of Council in February (January 2020) Transformation savings pre-scrutiny alternate years at Sept meeting. T21 at Sept 2019 and written response to concerns/queries.					
Orchard Close	To consider proposals to close Orchard Close Respite Service, Hayling Island.	Living Well Ageing Well	HCC Adults' Health and Care	Workshop held 4 Dec 2018. Pre scrutinised at additional Feb 2019 HASC prior to Feb EM decision. Call In meeting 14 March 2019 recommended EM re-consider. EM re-considered 29 March and confirmed to undertake further work prior to decision in Nov. April 2019 Working Group agreed, to					

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	6 Jul 2020	14 Sep 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
				meet to consider options and fed back Nov 2019. Update in March 2020 after consultations.					
Integrated Intermediate Care	To consider the proposals relating to IIC prior to decision by the Executive Member.	Living Well Ageing Well	HCC AHC	To receive initial briefing on IIC May 2019, with pre-scrutiny of EM Decision due later in the year (tbc), last update Oct 2019		**x**			
Working Groups									
Sustainability and Transformation Partnership Working Group	To form a working group reviewing the STPs for Hampshire.	Starting Well Living Well Ageing Well Healthier Communities	STP leads All NHS organisations	Set up in 2017, met in 2018 and 2019. Report back to HASC Oct 19.	**Will meet as needed going forwards.**				
Update/Overview Items and Performance Monitoring									
Adult Safeguarding	Regular performance monitoring adult safeguarding in Hampshire.	Living Well Healthier Communities	Hampshire County Council Adult Services	For an annual update to come before the Committee. Last update Nov 2019.					

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	6 Jul 2020	14 Sep 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
Public Health Updates	To undertake pre-decision scrutiny and policy review of areas relating to the Public Health portfolio.	Starting Well Living Well Ageing Well Healthier Communities	HCC Public Health	Substance misuse transformation update heard May 2018. 0-19 Nursing Procurement pre scrutiny Jan 2019. Hampshire Suicide audit and prevention strategy provided July 2019.					
Health and Wellbeing Board	To scrutinise the work of the Board.	Starting Well Living Well Ageing Well Healthier Communities	HCC AHC	Joint Health and Wellbeing Strategy refresh agreed by Board March 2019. Update on Strategy received in May 2019. Business plan update also expected in 2019.		**x**			
Annual Hampshire Safeguarding Adults Board Report	To receive an independent Adults safeguarding report.	Living Well Ageing Well Healthier Communities	Hampshire Safeguarding Adults Board	Update received March 2020					**x**

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	6 Jul 2020	14 Sep 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
Public Health Covid-19 Overview and Impact on Health and Wellbeing and Outbreak Control Plans	To receive an overview on the three different aspects in relation to COVID-19.	Starting Well Living Well Ageing Well Healthier Communities Dying Well	HCC Public Health	Expected July 2020.	**x**				
Adults' Health and Care Response and Recovery	To receive an overview of the systems that have been put in place by Hampshire organizations, partners and voluntary sector.	Starting Well Living Well Ageing Well Healthier Communities	HCC AHC, Borough and District Councils, Hampshire Council for Voluntary Service Network, and voluntary sector	Expected July 2020.	**x**				

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	6 Jul 2020	14 Sep 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
Hampshire and Isle of Wight Covid-19 System Approach Overview	To receive a report setting out the Hampshire and Isle of Wight Local Resilience Forum response	Starting Well Living Well Ageing Well Healthier Communities Dying Well	Hampshire and Isle of Wight Integrated Care System Southampton City, West Hampshire and Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups	Expected July 2020.	**x**				
Care Home Support Offer and Update	To receive an overview of the care home and care sector position and an update on the Care Home Support Plan.	Living Well Ageing Well Healthier Communities Dying Well	HCC Adults' Health and Care	Expected July 2020.	**x**				

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	6 Jul 2020	14 Sep 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
Care Quality Commission Inspection Overview	To receive an update on regional and local activity and to review the full range of inspection activities - health and social care regulated activity.	Starting Well Living Well Ageing Well Healthier Communities Dying Well	CQC	Expected at cancelled May meeting. To be rescheduled.					

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

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

Section 100 D - Local Government Act 1972 - background documents

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

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. Equality Duty

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

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

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

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

2. Equalities Impact Assessment:

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

This page is intentionally left blank