Southern Health
NHS Foundation Trust

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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

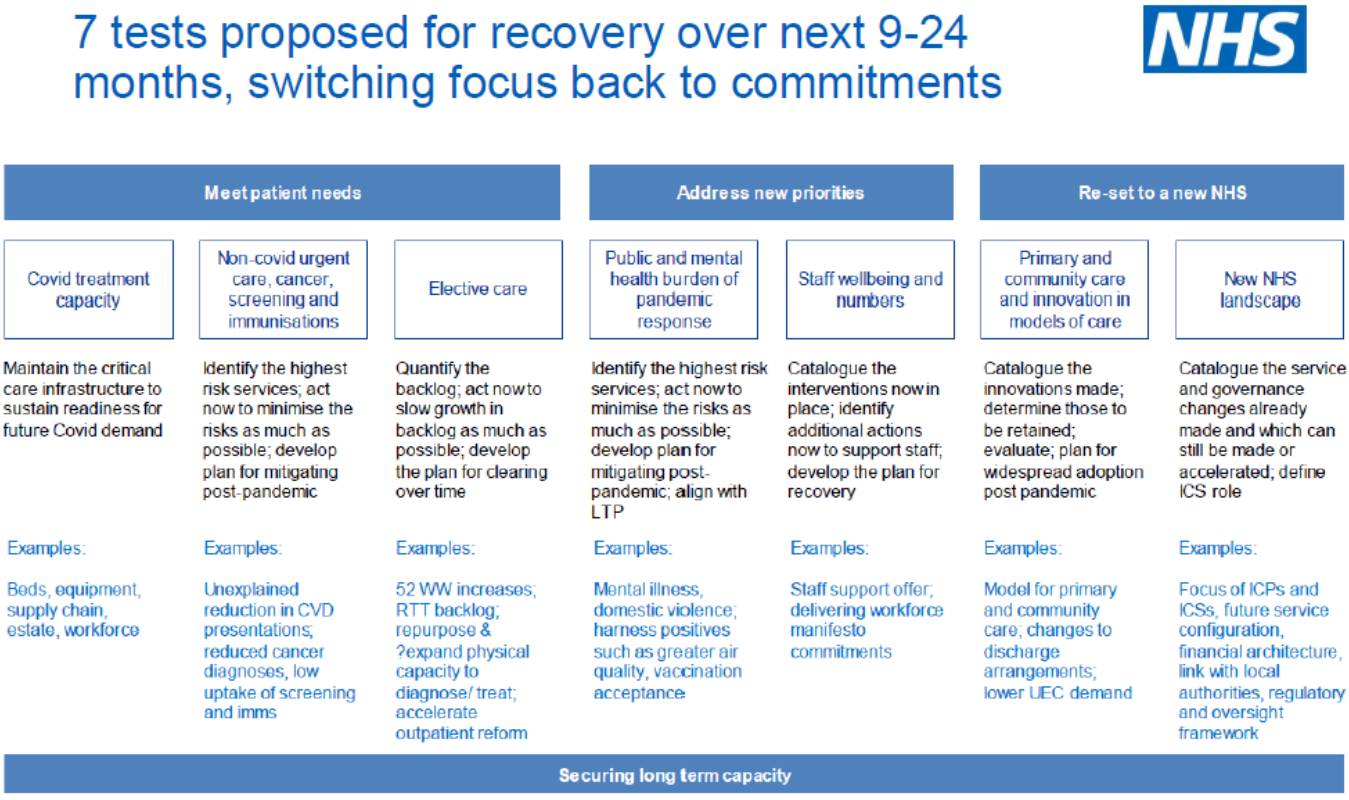
The following bullet points set out the work that is already underway to begin restoring services as part of phase 2:

- 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