Portsmouth CITY COUNCIL

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NOTICE OF MEETING

HEALTH OVERVIEW & SCRUTINY PANEL

THURSDAY, 9 JULY 2020 AT 1.30 PM

VIRTUAL REMOTE MEETING - REMOTE

Telephone enquiries to Anna Martyn - Tel 023 9283 4870
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Membership

Councillor Chris Attwell (Chair)
Councillor Lee Mason (Vice-Chair)
Councillor Graham Heaney
Councillor Leo Madden
Councillor Steve Wemyss
Vacancy
Councillor Vivian Achwal
Councillor Arthur Agate
Councillor Trevor Cartwright
Councillor David Keast
Councillor Philip Raffaelli
Councillor Rosy Raines

Standing Deputies

Councillor Geoff Fazackarley
Councillor Gemma New
Councillor Robert New
Councillor Luke Stubbs

(NB This agenda should be retained for future reference with the minutes of this meeting.)

Please note that the agenda, minutes and non-exempt reports are available to view online on the Portsmouth City Council website: www.portsmouth.gov.uk

A G E N D A

1 **Welcome and Apologies for Absence**

2 **Declarations of Members' Interests**

3 **Minutes of the Previous Meeting** (Pages 3 - 10)

4 **Update from Portsmouth Hospitals Trust** (Pages 11 - 14)

Mark Cubbon, Chief Executive, will answer questions on the attached report.

5 **Update from NHS Southern Health Foundation Trust** (Pages 15 - 24)

A representative will answer questions on the attached report.

6 **Update from Public Health** (Pages 25 - 38)

Helen Atkinson, Interim Director of Public Health, will answer questions on the attached report.

7 **Update from Adult Social Care** (Pages 39 - 46)

Andy Biddle, Assistant Director of Adult Social Care, will answer questions on the attached report.

8 **Update from NHS England on dental practices** (Pages 47 - 48)

The update is presented for noting.

HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held on Thursday, 12 March 2020 at 1.30 pm at the The Executive Meeting Room - Third Floor, The Guildhall

Present

Councillor Chris Attwell (Chair)
Councillor Lee Mason
Councillor Graham Heaney
Councillor Leo Madden
Councillor Hugh Mason
Councillor Arthur Agate, East Hampshire District Council
Councillor David Keast, Hampshire County Council
Councillor Philip Raffaelli, Gosport Borough Council

Also in Attendance

14. Welcome and Apologies for Absence (AI 1)

Apologies for absence were received from Councillors Vivian Achwal, Trevor Cartwright and Rosy Raines.

15. Declarations of Members' Interests (AI 2)

Councillors Lee Mason and Leo Madden both declared personal, non-prejudicial interests in agenda item 9, Portsmouth CCG update as they are patients at the Portsdown GP practice.

16. Minutes of the Previous Meeting - 30 January 2020 (AI 3)

RESOLVED that the minutes of the meetings held on 30 January 2020 and 21 February 2020 be agreed as a correct record.

17. Care Quality Commission and State of Care Report (AI 4)

The Chair advised that the two representatives due to attend from the CQC for this item, Rebecca Bushell-Bauers and Kay Puddle, had advised that they would no longer be attending this meeting due to the COVID-19 risk to them and others. The Chair had therefore stood down the representatives due to attend for this item from the Clinical Commissioning Group and Adult Social Care team.

The panel expressed their disappointment that the two representatives had made the decision not to attend, which was contrary to current guidance issued from Public Health England and commented that the HOSP was a

statutory body. The panel agreed that the Chair would send a letter to the Chief Executive of the CQC, PHE and the Chief Executive of Portsmouth City Council to express their disappointment. The panel agreed a form of wording at the end of the meeting.

RESOLVED that this item be deferred to the panel's next meeting in June.

18. Care Quality Commission report on QA inspection (AI 5)

Sarah Ivory -Donelly, Inspection Manager was present was for this item. She gave apologies from Claire Oakley who was no longer able to attend the meeting as she was unwell. The following points were clarified:

The CQC inspect to see what is not in line with policy or guidance, highlight breaches and will go back to the Trust to advise. It is not for the CQC to tell PHT how to fix the issues identified. PHT had taken mitigation steps to ensure that they were protecting people from infectious patients. Areas of concern raised would be followed up at the next inspection. The CQC engage with the Trust throughout the year and have regular meetings with them. They will not go into the hospital to look around until the next inspection but will ask for evidence and assurances on how they are addressing areas of concern before they go back in to inspect. All the must do actions have a formal action plan.

With regard to infection control the CQC had received assurances from the Trust that this is being managed. Infection control is very important particularly with the current situation, but this would not be a reason for the CQC to go into the hospital. They would only re-visit if they receive new information about failures. PHT are making sure they are able to respond to new concerns regarding COVID-19.

With regard to specific actions that the Trust had carried out in response to the CQC inspection, Ms Ivory-Donelly said that Dr Knighton who was present for the next item would be better able to clarify this.

Ms Donelly felt secure that the Senior Leadership Team understood the risks and took these seriously. She did not think there was anything the CQC had identified that PHT were not already aware of.

One of the trends the CQC saw was management of training targets. Mandatory training is not completed to their own targets and the reasons for this varied including sickness and having the time to do training. The CQC had been concerned about the trend across these areas.

Another area where the CQC identified concern was the ED which was predominately due to nurses using personal protective equipment (PPE). Another issue was with maternity services, this was a very specific issue with regard to birthing pools and this was highlighted to the Trust. The CQC had received assurances with them that steps had been taken to resolve this.

Ms Ivory-Donelly was not able to say what specific actions the Trust had taken on the management of sepsis or the action taken. Sepsis was highlighted throughout their key lines of enquiry due to its importance. The CQC are looking at the Trust's sepsis care and what they have in place on site e.g. a sepsis box to provide essential care.

With regard to unnecessary care failings and what has been done to mitigate this Ms Ivory-Donelly did not know and said she would find out and provide a written response to the panel.

In response to a question about failing equipment, the CQC asked PHT to risk assess where the failing equipment is and assess what needs to be replaced now and what it nearing the end of its lifespan. The impact on patients will also need to be assessed.

The CQC meet with PHT repeatedly. They met at the end of the core service inspection and then go back a month later to go through the well led inspection. A lot things identified in the report they would expect to see a quick turnaround and will expect to see a plan to address the concerns.

The panel said they were delighted to see the journey that PHT had made since the last CQC inspection.

RESOLVED that the report be noted.

19. Portsmouth Hospitals' Trust update (AI 6)

Dr John Knighton, Medical Director introduced the report and clarified the following points.

Many of the areas the CQC identified were areas that PHT were already aware of, particularly around ambulance handover delays. They were already on the cusp of making some changes to improving the performance of ambulance handovers. There was still more however that needed to be done. There are some constraints around the complexities of the physical estate.

CQC had provided the Trust with a list of specific actions in the ED. PHT have now put in place a number of steps to ensure they have an accurate log of the time a patient spends in the ED.

With regard to paragraph 1.10 of the report, PHT had communicated with the CQC what their response has been to those points and the steps put in place to address these. PHT had been expecting the CQC to come and make their own assessment with a repeated focussed inspection, but this would now likely be delayed due to the current situation with COVID-19.

PHT already new there were concerns with maternity services before the CQC inspection. Despite outcomes being good for mothers and babies there were some concerns which they shared with the CQC. The only issue that

PHT did not have visibility about prior to the inspection was around safely removing women from the birthing pools. In response to this PHT have invited a service review from the Royal College of Obstetricians and Gynaecologists which primarily looks at outcomes and the medical force elements. They have also just started an external whole scale maternity review to look at where can learn from others best practice. All the must do actions were completed but there were a few that would take a bit longer.

The panel felt that PHT had done incredibly well on their CQC inspection since the last inspection, particularly in terms of leadership and governance.

A question was raised regarding the three proposed locations on the site for a new/redeveloped ED. Dr Knighton said these were three locations the Trust had identified where there is the physical capability to build something of this scale. Locations B and C are both separate across a road and are physically dislocated from the main hospital but there are options to link.
If the ED was built in locations B or C they would ensure that this would link into the main corridor to ensure that patients are not taken on journeys that would be disadvantageous to them.

Car parking will continue to be a difficult issue on the site. PHT have made a commitment that where parking is compromised when the new building is built, they will provide that parking through a redistribution of the types of spaces. The priority will be for patients and visitors to have parking on site with the appropriate level access. This means that more staff car parking may need to provided offsite at the fort.

Members asked for an update on the current COVID-19 situation at the hospital. Dr Knighton explained that PHT have strengthened a well-established daily executive led planning meeting which is their sole focus. They are trying to get ahead of the situation and responding to national guidance and anticipating things that they know will happen. Staff are currently waiting for the Cobra meeting to finish and Dr Knighon said he thought it was likely that there will be a change to the national management of the disease, and PHT are ready for that. PHT will need to decompress the site quite significantly and are working with system partners to enable that. The hospital are not currently cancelling wholesale elective activity but are looking at when they may need to do this to free up capacity for side rooms and isolations. Dr Knighton added that they are talking to their commissioners to look at the outpatient clinic lists to see if phone calls could be used as an alternative. Primarily this is to ensure social distancing to prevent additional risks to patients.

There have not as yet been any positive cases of COVID-19 within the hospital but he was aware that this will soon change. Dr Knighton said they are looking at reducing the footfall into the hospital over the next few weeks. It is vital that as few people as possible to come to the ED, the GP or the walk in centre if they suspect they have the virus. PHT are also looking at critical care capacity as it is likely this will exceed existing demand and already have looked at contingency plans.

In response to a follow up question, Dr Knighton said bringing back staff from retirement would be very tricky if it were to happen following national guidance. These people may be more vulnerable to look after patients and are less familiar and practiced. PHT are currently focussing on informing their workforce and training them in some of the things they need to do in addition to their normal practice.

With regard to COVID-19 testing, there is a clear directive to step up testing. Currently PHT are sending tests to another centre but as of next week PHT should have the capability in house to do their own testing which will make a massive difference.

In response to a question regarding manning the 111 service Dr Knighton explained PHT were not involved in the provision of this service. Nationally the 111 service normally receives about 40,000 calls, and they are currently receiving around 200,000 a day. Last week they started stepping up capacity but in terms of response times he was not sure. For patients directed by 111 for testing there are good processes in place. They are tested quickly and those well enough to be sent home, which was the vast majority, are being sent home quickly. At the request of Councillor Agate, the Chair said Democratic Services would try and obtain this information from the 111 service. - ACTION.

In response to a query on the Public Engagement Steering Group referred to in paragraph 2.13, Dr Knighton said that public consultation is not required as this is not a new service or a change in service but a re-provision of facilities of service. PHT are keen to have public engagement in the clinical modelling. They want to improve performance and the patient experience.

RESOLVED that the update be noted.

20. Podiatry Hub update - Solent NHS Trust (Al 7)

Katie Arthur, Head of Operations for Primary Care Services, Fiona Garth, Communications Manager, Chris Box, Associate Director of Estates and Facilities and Debbie O'Brien, Podiatry Lead and Robena King, Business Development Manager and Tiptoe Manager introduced the report.

The panel thanked all present for the report and said that the revised proposal was a good outcome. Members could remember where the process started initially and were pleased that their concerns had been listened to in order to reach the revised proposal.

The panel had welcomed the tour of the new facility at St Mary's Hospital and had been very impressed. Members were grateful that Solent had made the decision to support the continued delivery of services at Cosham Health Centre and that there would be a scaled back presence at the Lake Road Health Centre which serves a need in the city.

Ms Arthur thanked the panel for their comments and said it had been an informative process. She added that they had learnt a lot as a service and as

an organisation as a result of the consultation. Healthwatch colleagues had also been very supportive throughout the process.

The Chair thanked all present for their report.

RESOLVED that the report be noted.

21. Solent NHS Trust - Jubilee House Update (AI 8)

Suzannah Rosenburg, Deputy Chief Operating Officer/Director of Transition and Chris Box, Associate Director of Estates and Facilities introduced the report.

In response to questions, the following points were clarified:

The east side of Jubilee House is currently being used by Southern Health and PHT for Hampshire patients to help with the winter pressures at Queen Alexandra Hospital. This was originally a temporary measure until March, but this will now continue for a further six months due to capacity.

There is pressure from central government nationally to sell off the site for private sector housing, which is not Solent NHS Trust's intention as they believe they can do something much more valuable with this land. Chris explained that he has been working with Tristan Samuels, PCC Director of Regeneration, on a strategic partnership in terms of how to approach the different options for the site, which is linked to the regeneration opportunities currently being considered in Cosham. There are six options, one of which is to strategically partner with PCC and the intent is that the site will be used to support the Health and Care sector. It was likely that in a further three or four months a clearer idea would be known and he said Solent would be happy to share the details once these are available. A document has been agreed on how the strategic partnership will work, but this was not yet signed, and Chris and Tristan meet quite regularly.

RESOLVED that the report be noted and a further update be brought to the next meeting.

22. Portsmouth CCG update (AI 9)

Jo York, Director, New Models of Care, NHS Portsmouth Clinical Commissioning Group introduced the report and clarified the following points from the panel:

Hanway Road practice have two partners due to retire. The decision to approve the merger sits with the CCG and the Primary Care Commissioning Committee which is due to meet on 26 March where a formal decision will be made. This will be for the merger and the closure; two separate decisions.

Two of the panel members said that as members of the Portsdown Group practice that they had not been contacted regarding the proposed merger as stated in the report. Councillor Madden also said that he had been unaware of the information sessions held at Kingston Crescent and was concerned that this would be the case for many other patients. Jo York explained that the CCGs understanding was that the practices had sent that information out to their patients. As part of that proposal they are required to engage with their practice population to hear concerns. The CCG's application form requires the practice to detail the engagement that had been undertaken. The information provided was that they had sent a text to all Kingston Crescent patients of the Portsdown Group; approximately 11,000 patients. Jo would go back to the Portsdown Group practice to find out what communication was sent to those patients who do not have mobile phones or emails.
Hanway Road patients, all patients aged 16 and over were sent a letter.

It is the intention to keep the Hanway Road site open for a further six months to allow some of the changes to take place within the Kingston Crescent surgery. Hanway Road will not close from 1 May.

In terms of patient engagement, it was the CCG's understanding from the practices that comments boxes had been in both Hanway Road and Kingston Crescent surgeries. About 16 comments were received in the Hanway Road. Hanway Road set up a dedicated email address for patients to feedback and five patients fed back using this method. Hanway Road had two patient engagement events; 39 attended the first event and 38 attended the second event. She explained that they are collating the feedback from the people who attended the Kingston Crescent drop in session.

Hanway Road has over 11,000 registered patients over the age of 16. Kingston Crescent has 11,000 registered patients over the age of 16. The Portsdown Group as a whole has approximately 48,000 registered patients. It was therefore a very low return on the patient engagement. As part of the equality impact assessment the CCG have worked with them to look at further engagement. The CCG can support practices but it is the practices role to engage with patients. This will be considered at the meeting on 26th March.

The consultation flowchart diagram says in the middle 'inform chair of HOSP' however the decision to merge sits with each individual practice. The application process is what the CCG follow based on national guidance. This process is different from a formal consultation that the CCG were planning. If the Primary Care Commissioning Committee does not approve the merger application there is a risk that the Hanway Road practice would have to hand back their contract to the CCG and patients would be dispersed across the city which could have a negative impact across the city.

Portsdown Group is a GP Partner model as is Hanway and there is a lot of value in that model. Portsdown Group are proving that they can do that and provide good quality care.

The Primary Care Team along with the Chief of Health and Care Portsmouth recognises that they have to do something to keep residents updated and met with Healthwatch recently to have a conversation about letting residents of the city know that the primary care model is changing to help people understand the changes. Conversations have taken place with the Leader and Cabinet Member for Health and Social Care to look at how PCC can support primary care in terms of the opportunities the council provides as a property owner and making it clear about how they can provide services differently. She felt that the relationship with the CCG and PCC should be a real enabler in terms of having these conversations.

The CCG are following national guidance in terms of the COVID-19 outbreak and what to do. They are working with the Hampshire and Isle of Wight lead to co-ordinate everything but also work at system level at the CCG and PCC. Also working with the Hive and NHS Solent and Adult Social Care to see how to co-ordinate the response. The CCG are consistently telling people to follow national advice, phone 111 and self-isolate if necessary. The CCG have also set up across Hampshire and Isle of Wight a service where people who have tested positive but do not need to go to hospital can be managed in the community and those conversations will be happening with out of hours providers.

With regard to end of life care, this is not a formal consultation as there are no substantial changes proposed. This was about gaining views of carers that will feed development of a local strategy and improvement plan. Jo York said she was happy to bring back to a future HOSP meeting.

In terms of enhanced support for care homes, the CCG are at the phase of rolling out the pilot further. All primary care networks have agreed to go with a citywide model. There will be a review phase, maintenance phase and sustainable phase and they are working through the finances in the model. The CCG are taking a proposal to the primary care networks clinical leads in April.

RESOLVED that the report be noted and a further update on End of Life care be brought to a future meeting.

The formal meeting endedat 3.35 pm.

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Councillor Chris Attwell
Chair

Portsmouth Hospitals NHS Trust

Portsmouth City Council Health Overview and Scrutiny Panel
9 July 2020

Portsmouth Hospitals NHS Trust update

Portsmouth Hospitals NHS Trust (PHT) is providing updates to the Health Overview and Scrutiny Panel (HOSP) on our response to the COVID-19 pandemic

Portsmouth Hospitals NHS Trust response to COVID-19

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 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

1. 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.

2. 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.

3. 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

Southern Health
NHS Foundation Trust

15 06 2020
Media and Communications Team

Briefing note:
Southern Health's response to coronavirus epidemic: update for Portsmouth HOSP

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 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, are summarised below. For ease, a brief overview of the services in the Portsmouth and South East Hampshire that were affected is also below:

Specific service changes (Portsmouth and South East Hampshire)

- Care Home Team: nursing home forums/group sessions were cancelled.
- Primary Care Teams: routine appointments including health checks, routine smears, annual reviews (ie diabetic, respiratory, routine blood tests, travel vaccinations, face to face routine consultations/medication reviews) cancelled.
- Adult MHLT (mental health liaison team): the team has temporarily changed location and is undertaking assessments and triaging by telephone, with minimal face to face contact.
- Respiratory: routine appointments and routine oxygen assessments

have now temporarily ceased.

- Parkinson's: face to face consultations have temporarily ceased.
- MS (multiple sclerosis): face to face consultations have temporarily ceased.
- Continence urology stoma: face to face routine work has temporarily ceased.

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 (Improving Access to Psychological 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) muscular skeletal 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.

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.
- Currently, Beaulieu Ward (an OPMH ward based at Western Hospital in Southampton) is also temporarily closed to admissions – this is as a result of 3 staff (all asymptomatic) and 4 patients testing positive for Covid19 since 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. Since the closure, the number of patients who are Covid19 positive has risen to 6 and the number of staff self-isolating whilst awaiting test results is at 5. A comprehensive strategy is in place to manage this limited outbreak which includes developing 'hot' and 'cold' areas and revised procedures to ensure all staff are fully informed regarding area management, PPE and safe IPC working practices. Whilst this ward will remain temporarily closed to protect the safety of patients and staff, it is hoped to reopen the ward later this month when risk assessments deem it safe to do so.

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.

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

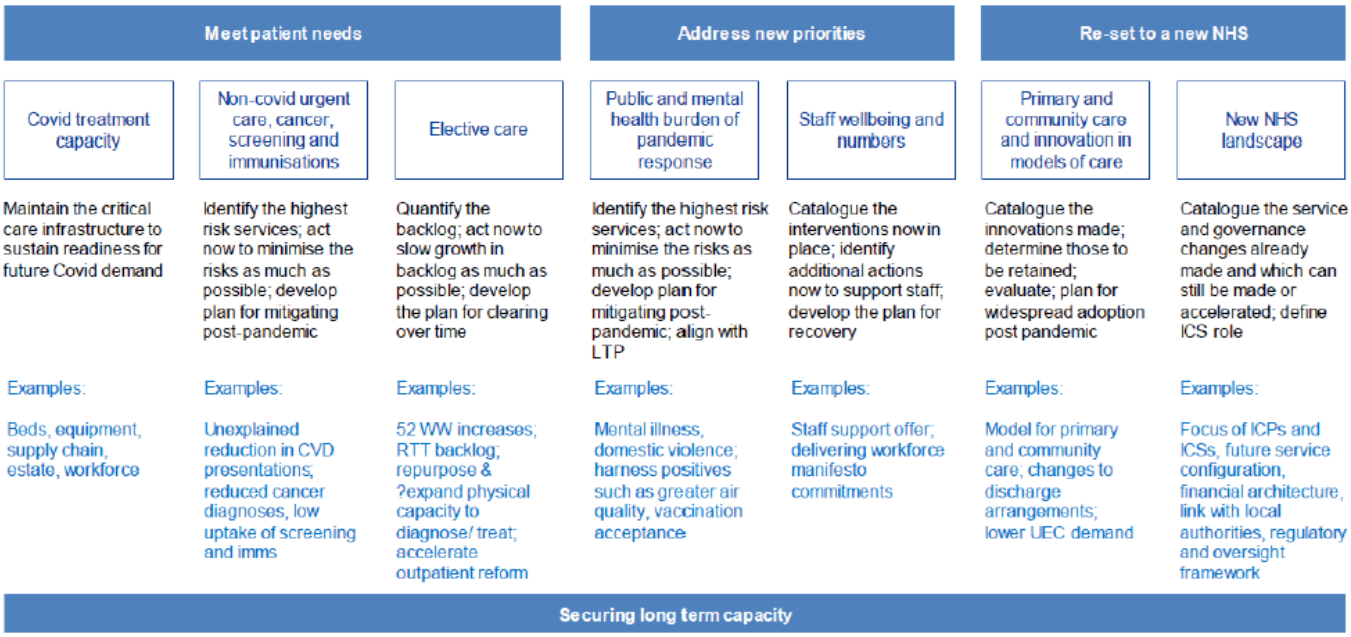
The following bullet points set out the work that is already underway to begin restoring services as part of phase 2:

- 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:

7 tests proposed for recovery over next 9-24 months, switching focus back to commitments



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.

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HOSP – Public Health general update for Portsmouth

Helen Atkinson– Interim Director of Public Health

Thursday 9th July

Commissioned Areas – Drug and Alcohol service

- There are currently 1032 people in drug and alcohol treatment. Since the Covid 19 pandemic we have seen a slight net reduction of people in treatment, however this is primarily for alcohol and non-opiate clients.
- We have seen a slight net increase in opiate users in treatment, from 645 to 656
- The service has adapted to lockdown and social distancing measures by providing telephone assessments and support and online support such as Zoom therapy groups
- Substitute medication has prioritised low risk prescribing of Espranor (buprenorphine) rather than methadone, as this can be prescribed via telephone assessment. There are currently limited face to face appointments (10 per week) for methadone prescribing.
- There has been a reduction in the provision of inpatient detoxification and rehabilitation during the pandemic
- There has been excellent joint working and information sharing between the service provider and police throughout this period regarding the drugs market and impact on vulnerable service users
- There is an expectation that demand for drug and alcohol treatment will increase once lockdown eases further and services normalise

Joint working – homelessness and health

- The Homeless healthcare team has been delivering clinics and support to the residents of the homeless hotels, this includes physical and mental health
- As we currently have over 200 people in two hotels, PCC, along with Public Health England and Portsmouth Hospitals NHS Trust are planning for mass TB and blood borne virus screening of the sites later this month
- Public Health have been supporting the management and exit planning from the hotels to support homeless people move on.

Commissioned Areas – health visiting and school nursing

- Section 75 agreement in place for integrated Early Help and Prevention service 0 - 19, integrating council and community health services
- Full performance framework in place
- The intensive health visiting offer (ECHO) proving to be highly effective in targeting and supporting the most vulnerable families
- School nursing working effectively with wider school support offer
- Strong response to Covid including risk assessed prioritisation of families
- Joint work with PHT to improve maternity to health visiting flow
- Continued high performance of Family Nurse Partnership offer

In house service - Wellbeing Service

Combined service delivering smoking cessation, weight management and alcohol support.

Also provide training to Health Care Professionals

Provides support to approx. 2100 referrals per annum

- Smoking cessation (66%)
- Healthy weight (29%)
- Alcohol (5%)

Screening for 4 risk factors, mental wellbeing and activation level:

- Smoking status
- BMI
- Physical Activity
- Alcohol consumption
- Warwick Edinburgh
- Patient Activation Measure

Smoking: 1094 set quit date of which 48% quit at 4 weeks and 29% remained quit at 12 weeks

Weight: 70% of clients lost an average of 2 kilos, with 28% clients losing over 3% of start weight

Activation: average increase of 6.35% in individual's activation following Wellbeing Support

Training:

Trained 481 Health Care Professionals in Connect 9 (Mental Health), MECC (Making Every Contact Count), Smoking Cessation Practitioner Level 2

Covid-19:

Still providing support via phone/Zoom

Currently 220 active clients and supporting over 50 homeless residents to reduce/quit smoking with support of e-cigarette

Joint working – childhood obesity

- The Project Bridge on “whole systems” approach to childhood obesity climaxed with a final workshop attended by colleagues across the council and VCS.
- The ‘pilot superzone’ with a local primary school was the outcome of project bridge and three years of work on whole systems obesity. It started in January, unfortunately it was postponed because of the coronavirus pandemic, but it will be re-launched at appropriate time.
- Family weight management via Wellbeing Service and work with key professionals (maternity, health visitors and school nurses) and community physical activity organisations will continue to assist with trying to tackle childhood obesity.

Mental health and emotional wellbeing

- Review of conduct disorders completed and recommendations made. This work will be picked up again in the following months
- Mental Health Alliance set up jointly with Solent NHS trust to support response and recovery to COVID-19 and the likely negative impact on mental health of the pandemic and associated interventions
- Communications around mental health and wellbeing and COVID-19 including a refreshed crisis card for the vulnerable and packages of support for staff and volunteers
- Training in Connect 5 – recognising and supportive conversations re mental health – to be rolled out further along with Making Every Contact Count
- Suicide prevention programme set up across HIOW, Southampton, Portsmouth pre COVID-19. Priorities include: bereavement, debt/financial hardship and real time surveillance

Joint working – air quality

- Chairing and supporting with health information and evidence to air quality board
- Strong links with transport and planning teams, as well as environmental health
- Complex
  - Responding to ministerial directive is first priority
    - Risk of legal challenge on anything we do – will inevitably disappoint someone somewhere
  - Really an infrastructure problem
    - Need integrated public transport and active transport infrastructure to offer acceptable alternative to private cars
    - Hard to deliver this in timeframe required by central govt
  - Also need to recognise health and economic co-benefits
  - Challenge of ensuring that any proposed CAZ does not worsen inequalities, and need to be considerate of links to IoW and other ferry linkages

Public Health Intelligence

- Working with HIOW Public Health analyst teams to provide a suite of products to support the Covid-19 response and recovery. This has included providing models of Covid-19 scenarios for the Local Resilience Forum, and developing a Compendium of key Covid-19 data and analysis that is available to organisations across HIOW.
- Continuing to develop a refreshed Joint Strategic Needs Assessment that will underpin and enable cross-system priority setting through the next Health and Wellbeing Strategy for Portsmouth
- Supporting commissioners and managers within the council and with our partners by providing high quality intelligence products to inform decision-making
- Building on the learning from joint work to address Covid-19 in order to effectively implement Population Health Management

Joint working – violent crime

- Working with Police, Community Safety and colleagues across HIOW, we supported a strategic process to understand and tackle serious violence by applying a 'public health' approach (focus on prevention rather than just protection and prosecution.
- First task was supporting production of the Problem Profile for Portsmouth, which showed
  - significant rises in serious violence, though numbers remain low
  - Key drivers include domestic violence; high demand for heroin and crack cocaine fuelling a county lines drug market that risks children being drawn into violence; and an increasingly challenging cohort of young offenders that see under-25s as the most likely victims and perpetrators of knife crime in particular
- We continue to support the implementation of the serious violence strategy, including further research to understand the cohort at risk of being drawn into serious violence, though this work has been delayed by Covid-19 response.

Joint Working – CCG

- Merging commissioned functions where appropriate with CCG and adults / children's
  - Shared resources
  - Potential to pool funding on programme areas
  - Main benefits from PH services perspective
    - Better join up of sexual health commissioning (remove false barriers between funding / provision)
    - Opportunity to improve join between mental health and addiction services
    - Link / support into Primary Care Networks as they develop

- Strengthened Intelligence links including:
  - Supporting intelligence-led Population Health Management approaches across PSEH
  - Providing reports and analysis to Primary Care Networks on key issues facing their communities
  - Providing maps and analysis e.g. using SHAPE to support CCG decision-making, and securing training opportunities to build capacity in the CCG in the future
  - Engaging the CCG in joint approaches to key city challenge through the Knowledge Network

Locally Commissioned Services

Local Commissioned Services (LCS) are health services which provide a response to local health needs and priorities, sometimes adopting national service specifications, and ensure additional local provision in the areas of sexual health, smoking cessation, NHS Health Checks and substance misuse (alcohol and drugs), delivered by GP and Pharmacy providers:

- Contracts extended for 12 months – until March 2021
- Cabinet Office PPN notice applicable until end June 2020
- Providers following RCPG guidance around prioritisation e.g. pause in NHS Health Checks until July 2020
- All services to be retendered for next financial year

COVID-19 Public Health Response

- PH rota provide advice and interpretation of the national guidance into HR plans for staff including use of PPE, social distancing, resident home visits, volunteering and infection control in care homes, schools, sheltered housing and our homeless accommodation
- Via our Communications lead, much of the internal and external facing communication messages on our intranet and internet sites have a PH focus
- Public Health Portsmouth has worked in partnership with colleagues across HIOW to develop a range of Covid-19 Intelligence products that are being used to inform the local response and recovery efforts – incl. modelling, recovery timeline and PCC GOLD dashboard
- PH are part of local Test and Trace arrangements (working with PHE) in terms of managing more complex outbreaks in Portsmouth.
- PH have led the development of the local outbreak plans and the DPH Chairs the local Health Protection Board and sits on the local Member Led Engagement Board

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Title of Meeting:	Health Overview and Scrutiny Panel
Date of Meeting:	July 2020
Subject:	Adult Social Care Update
Report By:	Andy Biddle, Assistant Director, Adult Social Care

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1. Purpose of Report

To update the Health Overview and Scrutiny Panel on the key issues for Adult Social Care, (ASC) in the period October 2019 to March 2020.

2. Recommendations

The Health Overview and Scrutiny Panel note the content of this report.

2.1. Overview

Portsmouth City Council Adult Social Care, (ASC) provides support and advice to adults aged 18 years and over who require assistance to live independently. This may be the result of a disability, long term health condition or frailty associated with growing older. The aim is to help people have as much choice and control as possible over how their needs for care and support are met. For some, when independent living is no longer possible, the service will help people find the longer term care arrangements that best suit them.

ASC's purpose is defined as:

- Help me when I need it to live the life I want to live

3. Health and Care Blueprint Priorities

3.1. Implementing the Strategy that ASC adopted in 2018 aims to enable the service to be financially stable and sustainable whilst achieving outcomes for residents. By 2022, the aim is that adult social care in Portsmouth will be:

- Delivering services that have technology at the heart of the care and support offer;
- Working in way that recognises the strengths that people have, and have access to in their networks and communities - and draws on these to meet their needs;
- Working efficiently and responsively, using a reablement approach centred around the needs of the customers;

- Delivered through a market based on individual services to people that meet their needs and helps them achieve the outcomes they want to achieve and keeps them safe;
- Delivered, (where appropriate) through PCC residential services in one service area to enable quality and maximum effectiveness.

These outcomes align to the priorities in the 'Blueprint for Health & Care in Portsmouth' published in 2015, which were:

- Improve the range of services people can access to maintain their independence;
- Give people more control, choice and flexibility over the support they receive;
- Do away with multiple assessments and bring services together in the community;
- Bring together services for children, adults and older people where there is a commonality of provision, including a family centred approach; and
- Create better resources and opportunities for vulnerable people and their carers.

Furthermore, the ASC Strategy is being viewed alongside Solent NHS Trust Business Planning to identify opportunities for further developing the work programme for Health and Care Portsmouth to deliver the 'Blueprint for Health & Care in Portsmouth.

Given the significant impact of COVID-19 on both the finances of Portsmouth City Council locally and Adult Social Care nationally, there is understandable uncertainty as to how this impacts on the future strategic direction. It is likely that this will emerge from the recovery work that will take place alongside the continued response to COVID-19.

3.2. Delivering the Blueprint Priorities

A number of work programmes were established to deliver the ASC Blue Print and in turn will meet the priorities of the 2015 City Blue Print. These include:

3.3. 'SystmOne' client record system

Following the successful implementation of SystmOne for ASC in March 2019, the feedback from Social Care practitioners, GPs and NHS colleagues has been extremely positive as SystmOne enables involved parties access to relevant information about the client/patient. The provision of a small SystmOne Support team has enabled end users to have direct access to support them in their day to day functions and assisting the design of solutions to meet new and changing business requirements. The SystmOne Support team also facilitate involvement with practitioners via regular SystmOne User Groups and SystmOne Champion Forums, and

producing a monthly Newsletter which includes new and helpful information for end users.

A social care archive system was made available in December 2019 as the previous client record system was decommissioned in April 2020. The archive allows nominated Adult and Children's Social Care users the ability to view relevant historic Social Care information, and was designed in conjunction with practitioners from both Adult and Children's business requirements.

3.4 Developing the domiciliary care market

In order to move from 'time & task' to more personalised support, the 'systems thinking' intervention, has worked with a cohort of people in Somerstown / Southsea, to design a prototype system which includes:

- Real-time digital care records available to the Care Coordinator, Social Worker, applicable family members, and anyone else who needs access.
- Scheduling care based on the actual time needed by the client, rather than pre-planned multiples.
- Increasing/decreasing the length of care call based on need.
- Chargeable clients being billed on the basis of the actual minutes they received.

'Roll-in' of the new model began in January 2020 and is expected to lead to an improved service to people to improve their independence and give people more control, choice and flexibility over the support they receive. There have been delays in the progress of Roll-in due to the COVID-19 outbreak but progress is now being made toward selecting a provider to pilot an up scaled model and obtaining the necessary electronic monitoring systems to complete this pilot.

3.5 Accommodation based services

Following the closure of Edinburgh House, Council colleagues in regeneration and housing are supporting ASC in repurposing the site to provide extra care for people with dementia. This aims to lead to an improved service to people to improve their independence and give people more control, choice and flexibility over the support they receive. Furthermore, this will create better resources and opportunities for people with care and support needs and their carers.

In addition to Dementia Extra Care and to improve services available for people to improve their independence and give more control, choice and flexibility over the support they receive, ASC are developing a range of

options for the use of Harry Sotnick House. This is in addition to its use of a nursing home and aims to create better resources and opportunities for vulnerable people and their carers in the city.

Following residents and their families identifying placements and wishing to move sooner than the proposed closure date, Hilsea Lodge is also no longer in use as a residential home as of September 2019. Future options for the Hilsea Lodge site need to be explored, however the site will be repurposed to provide for gaps in provision in the city, likely to be extra care, supported living or social housing.

3.6 Integrated Localities

In order to do away with multiple assessments and bring services together in the community where there is a commonality of provision, ASC and Solent NHS Trust commissioned an integrated localities intervention in 2018. This brings together health & social care professionals in a single team, using systems thinking methodology in their work. The development of SystmOne has meant this intervention uses the shared client record system. Challenges with Information Technology have prevented a scale up from a pilot team to the South Locality health & social care teams in the summer of 2019. The increase in this way of working is still anticipated, but was delayed until Spring 2020. As with most other priorities, this was impacted by the pandemic response and will require re-shaping as services begin to move toward the 'new normal'

3.7 Community Independence Service

This service is configured to provide intensive support to people at home, using a reablement approach to prevent avoidable admission to hospital, long term care and care packages at home. Initial feedback from residents and colleagues is positive and the service continues to develop as an ASC priority making an impact on unnecessary hospital admission. The result will be improved services available for people to access to maintain their independence.

3.8 Medium Term Financial Strategy

As detailed previously, the MTFS was drafted in 2018 to enable a single view of known factors affecting the financial position and financial sustainability over the medium term. The MTFS aims to balance the financial implications of decisions against resources, enabling informed decision making. Following demand challenges in the current financial year, the MTFS is being updated.

3.9 Social Work Duty Project

A review using principles from systems thinking methodology has been carried out on ASC's social work duty service. The learning has informed the next stage of the project, which is live experimentation with a dedicated duty team taking calls directly from the public and professionals, rather than these being fielded through a help desk first. This has enabled more calls to be dealt with there and then, rather than having to put cases on a waiting list. The pandemic meant that this duty team quickly adapted to become the duty response, and has responded effectively to this challenge. This change in practice is intended to be maintained in recovery.

4 Demand

The figures below are snapshots of people with care and support needs with open care packages on the last day of the month.

4.1 Domiciliary Care - age group 65+.

	Client numbers	Sum of predicted weekly cost
October	798	£ 157,696.22
November	804	£ 156,358.95
December	804	£ 158,491.50
January	807	£ 160,047.98
February	816	£ 160,417.53
March	827	£ 169,972.99

There is a 4% rise in numbers of people in receipt of care and support October to March and a 7% rise in costs. By the end of March data was available for two weeks of people being funded through the Covid-19 funding who will be included in the March figures. Looking at February 2020 (the last 'normal' month) numbers were up 2% on October and so were the costs, so the March rise is likely to be due to the pandemic.

Looking at cost bands:

COST BANDS	October	November	December	January	February	March
0-50	90	95	91	92	95	87
50-200	444	439	444	441	447	438
200+	264	270	269	274	274	303
TOTAL	798	804	804	807	816	828

There was a 1% drop in people with care and support needs in the £50-200 group and a 13% increase in those in the £200+ group.

Again the people funded through Covid-19 will have contributed to the rise in March.

Whilst ASC continues to monitor the domiciliary care market, providers remain under pressure financially both nationally and locally. ASC in Portsmouth pay around 10% below the South East region Hourly[i] rate ASC has a programme of engagement with providers set up in 2019 and is actively working with the sector to redesign the cost model for domiciliary care.

4.2 Residential Care

Residential Occupancy

	RESIDENTIAL PERMANENT	In house residential	Indep Residential
Apr-19	349	74	275
May-19	344	70	274
Jun-19	347	71	276
Jul-19	354	76	278
Aug-19	354	75	279
Sep-19	356	73	283
Oct-19	358	73	285
Nov-19	353	70	283
Dec-19	358	68	290
Jan-20	360	70	290
Feb-20	359	72	287
Mar-20	355	67	288

There was a 3% increase in people in need of residential care from April 19 - October 19 but a subsequent drop of 1% from October to March. Since this drop only happened in March (figures had been stable from October to February) this may also be the start of the Covid-19 effect (there was a 10% drop in people with care and support needs in April 2020).

The residential care market continues to experience challenges locally and there continues to be fewer care homes rated 'good' than the all England average. In response to this, the Quality Improvement Team funded jointly between Portsmouth City Council and Portsmouth CCG are engaged with homes to offer advice and support. The team have worked with providers and completed audit/assessment work, offering feedback for areas of improvement. This work has included providing support to providers for day to day queries, issues and concerns and supporting the set-up of NHS mail, with the ending of fax use in the NHS.

Solent NHS Trust and PCCG are also piloting a new of model of care to support local care homes. The pilot includes all care homes but focuses on a full Multi-Disciplinary Team, (MDT) process for eight care homes. The team is comprised of Nurses; Physiotherapists; GPs and medicines optimisation Pharmacists and Technicians. The support is both proactive and reactive and involves:

- MDT meetings within the home to the 8 care homes within the pilot
- Reactive support when required
- Full medicines optimization review for residents
- Virtual telehealth system provided 24/7 in order to access urgent care advice
- Training within homes around early warning signs for residents where medical advice is required to prevent escalation or hospital admission and training to support good skin and pressure area care.
- Quality audits carried out to support homes to share good practice and focus on areas for development

4.3 Deprivation of Liberty Safeguards, (DoLS)

The number of applications for Deprivation of Liberty Safeguards, (DoLS) authorisations have continued to rise in Portsmouth:

- 786 (2014/15)
- 1473 (2016/17)
- 1695 (2017/18)
- 1787 (2018/19)
- 1917 (2019/20)

The projected figures for 2019/20 were 1876 but the actual figure being higher reflected that a greater number of people were subject to DoLS during this time.

The Department of Health & Social Care, (DHSC) had intended that the 'Liberty Protection Safeguards' (LPS) would replace the current system of DoLS by October 2020. However, the DHSC have announced a delay to the implementation of LPS until April 2021 at the earliest. ASC will be picking up the scoping the impact of the changes and anticipated that this will be likely to need specific project management and a dedicated training resource.

4.4 Acute Hospital Pressures

As previously reported, mitigating the pressure to maintain the flow through the Hospital by discharging patients has been managed by year on year funding committed from the Department for Health & Social Care. Some of the areas this funding was used for include extra domiciliary care, increased Social Work assessment and increased therapy/reablement capacity. These measures decrease the number of people awaiting assessment and make care available in a more timely way. These arrangements were continued in the 2019/20 year and subsequently planned for in the 2020/21 year. The process of allocating funding in conjunction with PCCG colleagues was temporarily interrupted by the COVID-19 outbreak in March 2020, but work has recently started to plan priorities for support. The rationale for allocating PCC resource to this work continues to be that admission to hospital can drive deterioration in ability and lead to greater care needs.

Signed by:

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Cllr Chris Attwell
Portsmouth Health Overview and Scrutiny Panel (HOSP)
Chair

Anna.Martyn@portsmouthcc.gov.uk

26 June 2019

Sent by email

Dear Cllr Attwell

Portsmouth Dental Service Procurement – Update to Portsmouth HOSP

Following our letter of 4 March 2020, we would like to provide an update on the procurement of dental services in Portsmouth.

We have received and evaluated bids for contracts to provide general dental services in the city and following this process have identified preferred bidders. There has been a delay in awarding the contracts due to managing the response to Covid-19 but we are now continuing the process and aim to award contracts by the end of July.

This is some 6 weeks later than originally planned due to consideration of wider procurement issues and the impact of COVID-19 on NHS capacity. It was originally envisaged that the successful bidder would have 3-6 months to mobilise the new contracts and start to deliver services. However, as a result of COVID-19, and the potential financial impact to providers, it will be necessary to undertake additional due diligence. This is to ensure that preferred bidders are still in a position to proceed and to asses any revision to mobilisation timescales in light of the impacts of COVID-19 (e.g. delayed building works, workforce issues etc).

This will be completed in discussion with the preferred bidders to enable the resilient provision of services at the earliest possible time and therefore aim to avoid the need to enter into a re-procurement process. The timeline for contract start is as yet unknown and cannot be determined until discussions have taken place with the preferred bidders and COVID-19 impacts are understood.

We will provide an update to the HOSP including timescales as soon as we have further information.

Yours Sincerely

Nick Spence
Dental Senior Commissioning Manager
NHS England and NHS Improvement – South East Region