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Portsmouth CITY COUNCIL

NOTICE OF MEETING

HEALTH OVERVIEW & SCRUTINY PANEL

THURSDAY, 17 SEPTEMBER 2020 AT 1.30 PM

VIRTUAL REMOTE MEETING - REMOTE

Telephone enquiries to jane.didino@portsmouthcc.gov.uk
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If any member of the public wishing to attend the meeting has access requirements, please notify the contact named above.

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 Gemma New
Councillor Robert New
Councillor Luke Stubbs
Councillor Ian Bastable

(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 - 12)

4 Portsmouth Hospitals' NHS Trust - update. (Pages 13 - 18)

Penny Emerit, Deputy CEO and Dr Mark Roland, Deputy Medical Director will answer questions on the attached report.

5 Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups (Pages 19 - 32)

David Bailey, Deputy Managing Director, Fareham and Gosport and South Eastern Hampshire CCGs will answer questions on the attached report.

6 The Director of Public Health's update. (Pages 33 - 82)

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

HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held on Thursday, 9 July 2020 at 1.30 pm at the Virtual Remote Meeting - Remote

Present

Councillor Chris Attwell (Chair)
Councillor Lee Mason
Councillor Graham Heaney
Councillor Leo Madden
Councillor Steve Wemyss
Councillor Vivian Achwal, Winchester City Council
Councillor Arthur Agate, East Hampshire District Council
Councillor David Keast, Hampshire County Council
Councillor Philip Raffaelli, Gosport Borough Council
Councillor Rosy Raines, Havant Borough Council

23. Welcome and Apologies for Absence (AI 1)

Apologies for absence were received from Councillor Trevor Cartwright.

24. Declarations of Members' Interests (AI 2)

Councillor Chris Attwell declared a personal and non-prejudicial interest as he had met the deputee (agenda item 6); in addition, the deputee lives in Councillor Attwell's ward. Councillors Lee Mason and Leo Madden both declared personal and non-prejudicial interests as they are patients at the Portsdown Group practice. Councillor Steve Wemyss declared a personal and non-prejudicial interest as he works for the NHS. The Local Democracy Officer declared a personal and non-prejudicial interest as she knows the deputee (agenda item 6).

25. Minutes of the Previous Meeting (AI 3)

RESOLVED that the minutes of the meeting held on 12 March 2020 be agreed as a correct record.

Agenda item 22 (Portsmouth CCG update)
In response to a query from Councillor Madden the Chair said he had received email notification on 20 April of the decision over the future of the Hanway Group that was taken on 26 March 2020. Councillor Madden asked if the decision was available so the panel could see the rationale behind it.

26. Update from Portsmouth Hospitals Trust (AI 4)

Mark Cubbon, Chief Executive, introduced the report and update the panel on developments since it was written.

It has been a month since any Covid 19 related deaths at Queen Alexandra Hospital (QA) and there are currently just four patients with the virus. There is a much stronger testing regime (all patients, whether they are elective or emergency, are tested) and a lower prevalence of the virus in the community. For some weeks there have been near normal levels of emergency activity. QA is still working out how to do more planned and routine care whilst maintaining very stringent infection control and effective treatment. A new appointment booking service via the NHS 111 service is being trialled (it has been mentioned in local media) to ensure appropriate patients receive timely treatment with the right clinicians without needing to attend the Emergency Department (ED). If they attend, they will have an appointment and not have just turned up. The 111 service is run with the ambulance service but is connected closely with the Trust, primary care and GPs in SE Hampshire. The call centre has GPs, nurses, mental health staff, a midwife and a social worker so callers can be navigated to the most appropriate person or service without being passed around multiple services. The new model will show for the first time how appropriate patients can access urgent care services in the community and others access services directly within hospital rather than through the ED.

In response to questions, Mr Cubbon clarified

Patients who usually call 111 will be part of the programme, which involves clinical triage leading to the appropriate service for their condition, either in or outside hospital. The trial will be increased in the next couple of weeks with messaging to the local community encouraging better use of 111. It will allow some services both in and outside the hospital to be more accessible. There are currently about 20 to 30 patients per day in the ED with booked appointments. The ED is still open 24/7 so people can walk in and the new trial is not a replacement for GPs.

The Trust has stringently followed advice from Public Health England regarding PPE, which often changed in the light of emerging evidence about transmission and protection, and has been very prompt to adapt. The supply of PPE at first was a little tight day to day but never ran out; supply chains have been strengthened.

Some staff had Covid 19 symptoms or had to self-isolate because family member had symptoms. Asymptomatic people pose a transmission risk but an antibody test shows who has been exposed. All inpatients are now screened and the Trust is considering how they will test health workers more proactively and not just when they have symptoms.

Throughout the pandemic there has been a big focus on protecting time critical urgent and cancer care, which has remained at near normal levels. Clinicians carried out very individual assessments which considered the risks of patients being in hospital against continuing treatment. However, some diagnostic tests were slowed down because of transmission risks but normal levels are now being gradually resumed. Some chemotherapy treatments were modified after a risk assessment. A key challenge has been the reduction in the number of referrals into specialities from GPs, particularly for head and neck cancers, where there was a significant reduction in people self-presenting or going via their GP. The Trust is working closely with GPs and supports national health messaging urging people to seek help if they have symptoms. In June QA met all nine cancer treatment standards. Staff continually have to assess if it is always in a patient's best interest to continue treatment.

During Covid 19 people were asked to use other services for minor injuries, for example, the St Mary's Treatment Centre. In the early days of Covid 19 ED attendance numbers were slightly reduced as patients were worried about going to hospital but numbers rose after a couple of weeks. Levels have been normal for about six weeks; staff are managing to cope. The arrangements for minor injuries will continue as they are for the time being.

The Trust has learnt that services can be delivered in different ways, for example, telephone or video consultations instead of face-to-face. Some conditions still need a physical assessment but support for long-term conditions can often be provided remotely. Changes had to be made overnight but they are enhancements rather than fundamental shifts in access.

The fact that Portsmouth is not part of the merger of the Hampshire and Isle of Wight CCGs (due to take effect from 1 April 2021) should not be an issue for the Trust as its work is about continually improving day-to-day working relationships so as to have fewer hand-offs in patient care. The Trust has good relationships with other providers. As two-thirds of QA's patients are from South East Hampshire the Trust is passionate about working together.

At the start of the pandemic numbers of Covid 19 patients increased rapidly; the critical care unit had to expand up to 150% of its normal capacity. There were about 250 patients waiting for some form of ongoing care in the community who were also at risk of transmission. Collaborative working with NHS Solent, Southern Health and other local authorities helped discharge them into their own homes with support or care homes. The standard for safe discharge is now three hours. At first only patients with symptoms were tested as per national testing guidance but now all of them are; they have to be confirmed as negative before being discharged into care homes. At that time the level of transmission between patients and within care homes and also the level of staff overlap in moving between homes was unclear. QA recognises the difficulties and has used its expertise in infection control to help care homes. Some evidence guiding national policy became clearer, for example, PPE requirements changed during the first few months.

National policy on visitors is followed and remains strict though exceptions are made for people with mental health or learning difficulties as visitors and carers support and have a calming influence. For maternity only one birthing partner was allowed; now it is a partner plus someone else. Sensible conversations have been held with loved ones about visits to end of life patients. The policy is kept under constant review and it is expected gradual changes will be made soon.

For catching up on elective work QA has had to expand into recovery areas as well as using the St Mary's Treatment Centre and the Spire hospitals. Teams have been spread out to reduce transmission risk. Some elective work halted in patients' interests but there is a fine balance to ensure low risk patients are not left to become high risk. All patients on the waiting list have a full clinical review. PPE and social distancing measures reduce the amount of work clinicians can do, even if working at full pelt. The Trust is working with Public Health England to see if changes may be afoot. A further step-up in elective work is expected in September.

Many staff have had to cope with being redeployed to areas outside their usual expertise some have experienced higher numbers than usual of patient deaths. The Trust is recruiting psychological support and psychiatric nurses. Occupational health support is available to everyone and has been increased. All three military services work at QA and their experience of responding to trauma is being shared. The Trust is grateful for the support shown by the community, which has had an indescribable effect on staff morale.

One productivity gain is that there is less time-consuming travel around different sites so there is more clinical time to see patients. The capacity generated will be redeployed to Phase 2 (recovery) and into any second wave of Covid 19.

The Panel wishes to thank Mark Cubbon, the Chief Executive of the Portsmouth Hospital Trust, for his report and to place on record its thanks to all the Portsmouth NHS Hospital Trust staff for their excellent dedication and work during the current Coronavirus pandemic.

RESOLVED that the report be noted and that

- **The panel's thanks and appreciation of the work of all PHT staff be put on record**
- **An update be brought to the next meeting, particularly the "call first" project.**

27. Update from NHS Southern Health Foundation Trust (AI 5)

Nicky Adamson-Young, Director of Operations (Portsmouth & South East Hampshire) introduced the report. She gave apologies from Ron Shields, the new Chief Executive, who was unable to attend the meeting as he was otherwise detained. Mr Shields took up his post in May and has a wealth of experience across mental and physical health services. He was previously the

Chief Executive of Dorset Healthcare, who achieved an Outstanding CQC rating.

Southern Health is starting to revisit the work in the action plans mentioned in their previous update and governance structures have been maintained. Partnership working continues, for example, Southern Health is a key partner in the Woodcot Lodge step-down facility in Gosport which successfully admitted 23 patients, two of whom have been successfully discharged. Hampshire County Council are the partnership lead. Woodcot Lodge means Jubilee House is no longer used.

Southern Health has worked with the local authority to develop the Turner Centre into a mental health assessment unit as a response to Covid 19 so that the right patients are in the right place; these patients have only mental health needs, not physical. Lessons learnt about patient engagement from this initiative are being discussed across the partnership.

The area mental health beds model is very positive. The number of miles from patients' homes to beds has been halved. The length of stay has been reduced so that the median length is 12 days. The model has doubled the referral requirement in the last six months to this time last year. The focus now is on the recovery phase; some services are on still online whereas others are returning to face-to-face contact.

In response to questions Ms Adamson-Young clarified

Maintaining the progress on area mental health beds is a challenge with increasing demand as well as the effect of Covid 19 on mental health and wellbeing, which may impact on bed capacity. It is a wider issue across the strategic partnership and Southern Health is looking at demand capacity. The key is work being done in the community such as supporting frontline primary care conversations and work with community mental health teams and the voluntary sector. Some patients are seen in person, for example, those who are vulnerable and high risk. As part of the recovery phase face-to-face appointments are being reinstated with PPE and social distancing in place. Technology such as smartphones is being used, depending on the approach patients want, as it is recognised "remote" appointments are unsuitable for some patients. On the other hand, some patients prefer "remote" appointments as the response is more timely. Where services were halted it was more that business processes were stopped rather than seeing patients.

Risk management is a responsibility for all clinical and corporate staff, especially when it is currently under extra scrutiny, and includes training. National guidelines mean changes to risk management, for example, around infection control.

There has been significant progress with care homes during Covid 19. Southern Health have offered training and advice to staff based on a coaching style. Those homes which were receptive are positive about the support. There is a very detailed care home action plan. It is sometimes difficult for homes to accept support as they are private businesses; before they had to

comply with the CQC and legal requirements. There have been some difficult conversations but relationships have developed between Southern Health, local authorities and the homes themselves. Real learning has taken place to support homes but winter will be a challenge.

Some of the changes to service delivery can become productivity gains, for example, using virtual communications and remote working means reduced travel time and mileage costs. During Covid 19 meetings with wider leadership teams have been more timely and efficient. Then it is a question of investing savings in the right places.
The panel wishes to thank Nicky Adamson-Young for her report and to place on record its thanks to all NHS Southern Health Foundation Trust staff for their excellent dedication and work during the current Coronavirus pandemic.

RESOLVED that the report be noted and that

- **The panel's thanks and appreciation of the work of the NHS Southern Heath Foundation Trust be put on record**
- **A report be brought to a future meeting showing how halted services have resumed.**

28. Update from Public Health (AI 6)

Helen Atkinson, Interim Director of Public Health, read out a deputation from Mr Mike Dobson before introducing her report. Deputations are not minuted but can be viewed on the council's website at:

https://democracy.portsmouth.gov.uk/ieListDocuments.aspx?CId=151&MId=4453&Ver=4

Ms Atkinson joined Public Health in February as the Interim Director. She thanked the team for their hard work in maintaining services by delivering them differently, for example, our substance misuse clients received support by Zoom and telephone. However, health checks had to stop in line with national policy.

Sixty homeless people currently living in hotels have been successfully screened for TB and blood borne viruses (BBV) thanks to Portsmouth Hospital Trust (PHT) and Public Health (PH) staff. As smoking is not allowed in rooms work has been done to support residents to stop smoking via a vaping project. 72 residents have engaged with the service, 16 of whom have set a quit date. Usually stop smoking services are difficult for this group to access.

Ms Atkinson has recently taken over the role of chair of the Air Quality Board. The focus is to prioritise health outcomes in terms of air quality equally to environment outcomes. Dr Jonathan Lake of Sunnyside Practice, representing Pompey Street Space and other GPs, is also joining the Board from the next meeting.

The Portsmouth Covid 19 local outbreak plan (a government requirement) is on the council's website with a resident focused summary. Staff had about three weeks to draw up local outbreak plans. It is a partnership plan including QA, Solent NHS, the CCG, the police, port, schools and the council which sets out how we will mitigate coming out of lockdown against the risk of increased infection. Portsmouth is in the bottom tenth of local authorities for infection rates per 100,000. Ms Atkinson thanked residents for their compliance during a challenging time when many are facing extreme financial pressures.

In response to questions from members Ms Atkinson clarified

Any increase in opiate misuse is worrying. The Society of St James (SSJ) have worked hard over a difficult period to support their service users. The homeless population has high numbers of opiate misuers but while they are in the hotels SSJ are trying to provide services to reduce the impact of substance misuse while maintaining social distancing. Lack of contact with people misusing alcohol, which has probably increased during lockdown, is a concern though SSJ provides telephone support and contact numbers to encourage people to seek help and support.

Evidence is that vaping is less harmful than smoking and there is no evidence it produces secondhand smoke; the vapour produced contains nicotine not carcinogenics. This is Public Health England advice and vaping is part of our treatment offer. The impact of COVID-19 is worse when there is lung damage so this is another reason to stop smoking. It is well known that smokers are likely to have an increased risk of mental health issues so GPs and providers encourage people, including those with learning disabilities, to stop or to not start smoking. Although smoking used to be seen as a distraction it relieved the nicotine craving rather than stress. There are multiple national and local campaigns to stop smoking. Approaches from healthcare providers and brief intervention from specialists are very effective and there is a lot of training for NHS colleagues for this type of work. The NHS had a huge smoking culture but it is different now with smoke-free premises. Smoking is the leading cause of health inequalities and early death, sometimes by up to 20 years in some populations. Public Health would like to move to a no smoking society.

"Real time surveillance" with reference to suicide prevention means that all local authorities have to have a suicide prevention strategy. Public Health works with the Coroner reviews to consider lessons learnt from each suicide but does not routinely publish data and there are agreements with local media not to publish too much information so as not to glamorise suicide. Some suicides are of people not been known to mental health services. All are tragic.

The National Test and Trace Service has 25,000 call handlers for the routine and non-complex cases (level 3), supported by 3,000 health protection specialists. Tier 1 Local test and trace is done by the local health protection team and they expanded four times their usual capacity to cope with the work.

Up to three weeks ago Public Health was only receiving pillar 1 (acute hospital) testing data. The week before the Leicester lockdown a data sharing agreement was signed allowing access to pillar 2 (community) testing data daily and granular data (postcodes, age, sex) weekly. Public Health hope to obtain ethnicity data as BAME residents are more at risk from COVID- 19 complications. Going forward LA PH will have more local control of testing. Most of the over 65 and dementia care homes were tested by the 6 June deadline; going forward residents will be tested monthly and staff weekly. A couple of areas have been piloted for testing domiciliary care workers. Rough sleepers in hotels will be tested as part of a national pilot. There is more testing capability now and everyone can get a home test. There was criticism around the speed of testing but this has improved. The panel suggested that data sharing agreements should be available in advance to prevent delays.

With regard to changing habits and behaviour, at the start of lockdown there was an increase in walking and cycling but it is now back to pre-lockdown levels. Public Health want to get the NHS involved with the Air Quality Board and active travel programme. According to the Royal College of Physicians a tenth of journeys are connected with health, either working, visiting or accessing services. Digital innovation opportunities could replace some of these journeys. Public Health has to look at opportunities to change behaviour as it does not have control over the infrastructure. Currently COVID- 19 means that public transport is not a popular solution.

With regard to child obesity a high percentage of children, mainly children of keyworkers, are at school. All schools now have some children attending. One positive point is that more families have been seen exercising together during COVID-19. Dominique Le Touze, Public Health Consultant, updated the panel. Public Health was charged with producing an action plan to combat higher than average rates of child obesity. One action was a "super zone" pilot, a concept developed in London, in the Charles Dickens ward; the pilot aligns community work, local government policy and the voluntary sector to focus on drivers of obesity, for example, lack of access to healthy food. A big workstream was planned focusing on Arundel Court Primary School; it was paused in the week of lockdown but it is hoped to re-launch in September 2021.

Work around physical activity is much broader and Public Health works closely with transport and planning to make incidental travel (journeys to the shops and work) accessible to all. The Emergency Transport Plan aims to enable social distancing and more cycle lanes; part of the plan is to close streets around schools at pick-up and drop-off times to reduce accidents and improve air quality.

The Panel wishes to thank Helen Atkinson, Interim Director of Public Health, for her report and to place on record its thanks to all Public Health staff for their excellent dedication and work during the current Coronavirus pandemic.

RESOLVED that the update be noted and that:

- **The panel's thanks and appreciation of the work of all Public Health staff be put on record**

- **A report be brought to the next meeting giving updates on workstreams.**

Post-meeting note
Minutes of the Air Quality Board are not published because it is a Programme Board where technical details of delivery of the programme are discussed. Much of the content of the discussions are confidential, for example, latest updates from government or the financial situation, so as with other programme boards that exist across the organisation the minutes are not published. Formal updates are reported through Traffic & Transport and Environment & Climate Change Committees and then any items for formal decision are taken to Cabinet.

29. Update from Adult Social Care (AI 7)

Andy Biddle, Assistant Director of Adult Social Care, introduced the report. The move towards business as usual is staggered as Covid 19 will be around for some time. One positive aspect has been joint working across Portsmouth to successfully support residents and providers. Another positive initiative expedited by Covid 19 is the new social work duty response team, who take calls directly from the public and professionals. The team includes colleagues from the Multi Agency Safeguarding Hub and has been incredibly successful as queries can be resolved straightaway. The team is continually learning from the initiative.

There are regular fortnightly meetings with domiciliary, weekly meetings with residential care providers and catch-ups every two to three weeks with day care and supported living providers.

Adult Social Care (ASC) has been able to give providers a financial guarantee, funded by the government, to maintain financial stability. It is a minimum income guarantee based on figures three months prior to Covid 19. If they fall below this level ASC will top it up. Provider failure would be less of a shock in Portsmouth as most providers are small but it is still a real risk.

The new dementia Extra Care facility on the Edinburgh House site is still on track despite some cost issues needing to be resolved. The integrated localities pilot is moving forward virtually as most staff are not based in offices for the time being. A domiciliary and technical provider have been identified for the domiciliary care intervention and need to be brought together. The pilot needs testing in a wider market and the operating system needs to be able to support the work.

Future plans are predicated on what ASC can afford alongside meeting statutory duties but despite expected winter pressures and increased numbers, some of whom will have Covid 19 related needs, ASC is in a better situation than previously thanks to partnership working. More people are being cared for at home, even during Covid 19. The change from Deprivation

of Liberty Safeguards to Liberty Protection Safeguards will be significant as it changes the way people lacking capacity are treated.

ASC would like to maintain the step-down unit in Harry Sotnick House long-term so people can make decisions about their future while they are there rather than in hospital.

The panel wishes to thank Andy Biddle, Assistant Director of Adult Social Care, for his report and to place on record its thanks to all the Adult Social Care staff for their excellent dedication and work during the current Coronavirus pandemic.

RESOLVED that the report be noted and that the panel's thanks and appreciation of the work of all Adult Social Care staff be put on record

30. Update from NHS England on dental practices (AI 8)

The panel noted the update from NHS England on the procurement of dental services in Portsmouth.

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

The formal meeting endedat 4.05 pm.

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Councillor Chris Attwell
Chair

Portsmouth Hospitals University NHS Trust

Portsmouth City Council Health Overview and Scrutiny Panel
17 September 2020

Portsmouth Hospitals University NHS Trust update

Portsmouth Hospitals University NHS Trust (PHU) is updating the Health Overview and Scrutiny Panel on the following items of interest:

- NHS 111 early mover
- Trust response to COVID-19

1. NHS 111 first early mover

1.1 Introduction

This paper provides an update on implementation of a new initiative that provides an additional, more convenient way for patients in Portsmouth and South East Hampshire (PSEH) to access urgent care via an enhanced NHS 111 service.

1.2 Background

The COVID-19 pandemic has had a significant impact on the delivery of NHS services and on the ways in which our communities choose to access healthcare. Patients have accessed NHS care in different ways locally, choosing to seek alternatives to presenting at the Queen Alexandra Hospital (QAH) Emergency Department (ED), including contacting NHS 111, their GP, or their local Minor Injuries Unit, Urgent Treatment Centre or other services.

The period of restricted movement introduced in the UK to help reduce the spread of COVID-19 led to a sharp reduction in patients attending Emergency Departments including at QAH, and an increase in patients instead contacting NHS 111 in the first instance.

However during the course of the past weeks and months there has been an increase in patients attending EDs locally and across other parts of the country.

On 30th June 2020, Stephen Powis, Medical Director of NHS England and NHS Improvement, announced at the Health and Social Care Select Committee that Portsmouth would be one of two areas to pilot a “call first” approach before attending their local Emergency Department (ED).

An ambition that all systems will have implemented a minimum specification of the clinical model by December 2020 was set out at the NHS England and NHS Improvement Board Meeting in Common held on 28 July 2020.

Portsmouth University Hospitals NHS Trust (PHU), South Central Ambulance Service NHS Trust (SCAS), Primary Care Alliances, out-of-hours providers and local Clinical Commissioning Groups continue to work in partnership to provide this additional, more convenient way for patient to access urgent care at Queen Alexandra Hospital (QAH) in Portsmouth.

1.3 Enhanced access to urgent care

Working with our partners, we continue to support patients in our communities to access the clinical service they need, the first time. In-line with national guidance, if a patient in Portsmouth and South East Hampshire needs medical help and it is not a life-threatening emergency, they are encouraged to call 111 first. If the patient’s condition is not assessed as being a medical emergency but they are advised to attend the ED at QAH, their health advisor will book them a time slot to attend where clinically appropriate. Their advisor can also direct the patient to a more appropriate NHS service depending on their needs, such as:

- Their GP practice
- A local pharmacy
- St Mary’s Urgent Treatment Centre in Portsmouth
- Petersfield Community Hospital Minor Injuries Unit
- Gosport War Memorial Hospital Minor Injuries Unit

Working with our partners, as of 2 September, more than 1,120 patients have attended a booked time slot at the ED at QAH. The ED remains open at all times and anyone experiencing a medical emergency can still attend the department or call 999.

The safety of our patients remains our highest priority and this initiative helps us to keep our patients safe with social distancing in our Emergency Department, while supporting patients to access the right care, the first time, in a more convenient way.

1.4 Clinical Assessment Service

This initiative is supported by a Clinical Assessment Service (CAS) which is run by local GPs who receive details from NHS 111 of patients in Portsmouth and South East Hampshire who may be better cared for in areas other than the ED at QAH.

The support of the CAS has been instrumental in providing timely triage for patients, in turn reducing the numbers of patients requiring ED or ambulance services and directing patients to more appropriate services for their needs. This had included giving self management advice, signposting to local pharmacies, redirecting patients to Minor Injuries Units or Urgent Treatment Centres or booking patients back in to primary care where appropriate.

1.5 Full system test days

Four test days have now been held to robustly test the full clinical model. During these test periods, patients attending the ED have been directed to one of six iPads, or a telephone if they prefer, which have been installed at the front door to the department, to contact NHS 111 where appropriate.

All patients who walk in to the ED continue to be assessed in a timely way and receive emergency care and treatment, should this be required.

1.6 Next steps

Findings from the four full system test days are currently being evaluated. Final recommendations on the clinical model are due to be presented to the Project Board in September.

Further updates will be provided to members as the initiative develops.

2. Trust response to COVID-19

2.1 Introduction

This paper provides an update on our response to the COVID-19 pandemic, which remains a priority for the organisation and has a significant influence on our planning for the months ahead.

Local prevalence of COVID-19 has reduced in-line with the national picture. We continue to implement all national guidance as we monitor and respond to emerging evidence about COVID-19, prevalence of the virus and impact. Regular Gold command meetings are ongoing and continue to support our clinically-led decision making.

We continue to work closely with organisations across the Hampshire and Isle of Wight Local Resilience Forum on a co-ordinated response to the pandemic and with our partners on plans to support restoration and recovery.

2.2 Risk assessments and support for our staff

We continue to take action to support colleagues identified as being at higher risk from COVID-19.

In-line with initial national guidelines we have carried out risk assessments for groups of staff or individuals who are at higher risk due to pregnancy, age or underlying health conditions.

Mark Cubbon, Chief Executive, has written to all staff from ethnic minority communities to explain support offered by the Trust and has met with colleagues via our Race Equality Network and across the organisation to understand concerns. Following these discussions and in-line with national guidance requirements, colleagues from ethnic minority communities were asked to complete a work health assessment with their manager.

Additional support is being provided to help any remaining members of staff to complete their assessments.

As we continue our focus on supporting the health, safety and wellbeing of colleagues we have extended risk assessments for all colleagues who have not been assessed to date, to date, to understand whether there are additional staff who may be vulnerable to the virus and recommend where further action is needed.

2.3 Health and wellbeing support

We have a range of support available for all our staff covering emotional, social, financial and physical wellbeing. Our staff support line and manager support line continue to be open daily to provide advice, guidance and access to professional occupational health support and welfare services.

Colleagues raised the need for a more suitable multi-faith prayer room and we have created an additional, bigger prayer room with an accompanying wash and change room. We asked colleagues about the support they would find most helpful and are prioritising short and longer term counselling and practical support such as additional locker space, outside benches, cycle storage and a fruit and vegetable stall. We continue to monitor the uptake of the services on offer and modify the support in response to feedback we receive.

2.4 Testing

We have continued to support the national testing strategy, providing antigen swab testing for patients, staff and their families. Our testing programme supports the track and trace strategy to identify individual incidences of infection. Anonymised results from the nationwide testing programme also provide information on the prevalence of COVID19 in different regions of the country and help better understand how the disease spreads.

At the end of May, we also began antibody blood tests for individuals across the Trust and for our healthcare system partners. The blood test demonstrates that someone has developed antibodies as a result of having COVID-19 in the past. In-line with national expectations, all staff have been offered an antibody test and 82% have taken up the offer.

We are recruiting healthcare workers to the national SIREN study, which will help establish whether antibodies indicate immunity to COVID-19.

2.5 Clinical research trials

The Trust is taking part in a number of COVID-19 clinical trials, providing the opportunity for patients to participate and increasing the potential to develop treatments that benefit patients quickly. The RECOVERY trial is testing a range of potential treatments for COVID-19. The REMAP-CAP trial for critically ill patients with community acquired pneumonia uses an innovative trial design to evaluate multiple interventions simultaneously.

In June we saw the announcement of the first positive results from the RECOVERY clinical trial, with the steroid Dexamethasone shown to reduce deaths by one third in ventilated COVID-19 patients and by one fifth in patients requiring oxygen. Our PHT team recruited 117 patients to the trial, giving our patients the opportunity for new treatments and making us the seventh largest contributor of the 176 UK recruiting sites. We have now incorporated the treatment into the clinical care of our patients.

2.6 Support from colleagues, local communities and partners

Throughout the pandemic, the entire workforce across our organisation have been exceptional, changing shift patterns and working practices, undertaking additional training and redeployment, working from home and introducing essential new processes and procedures. Our volunteers continue to support patients, their families and loved ones, while playing an essential part of our work every day. We are extremely grateful for the continued support for our staff from our local communities.

Our thanks go to our local communities for their positive response to the national lockdown measures, a crucial factor in preventing transmission of the virus in Portsmouth and South East Hampshire.

Local co-operation between health and social care partners is also a fundamental part of our collective response to the virus. We appreciate the increased levels of support and collaboration that our partners have provided and this will continue to be key in the months ahead.

2.7 Phase Three Plan

Throughout the COVID-19 pandemic we have prioritised the delivery of urgent and cancer work. We achieved all of our waiting time targets for the diagnosis and treatment of cancer in June and have a plan in place to safely increase the volume of elective activity based on clinical need. We continue to prioritise urgent and cancer services for our patients while increasing capacity for routine elective patients, maintaining patient safety and following all national guidance to reduce the risk of COVID-19 transmission.

In this third phase of COVID-19 our priorities include safely increasing our capacity for non-COVID-related health services in-line with our plan, while preparing for winter and maintaining our preparedness for additional COVID-19 patients and potential local outbreaks of the virus. We have contributed to the development of the local outbreak plans created by Portsmouth City Council and its partners, and by Hampshire County Council, and continue to work closely with our partners on plans to support restoration and recovery.

Our plan also includes arrangements for supporting the extended flu immunisation programme and the potential impact of EU exit and continued support for individuals and team across the organisation.

We have appointed a Director of Recovery to lead this complex piece of work across all four divisions and corporate areas of the Trust until March 2021.

ENDS

HIOW NHS Response to Covid-19
Update Briefing for HIOW Overview and Scrutiny Committees/Panels
September 2020

1. Introduction

Following the briefing provided in July 2020, this paper provides an update on the impact to date of the pandemic; the health element of the Hampshire and Isle of Wight Local Resilience Forum response to Covid-19; and the NHS restoration and recovery work including seeking the views of key stakeholders and local people.

The paper also provides details of planning work being undertaken across Hampshire and the Isle of Wight (HIOW) for winter and a potential second wave of Covid-19.

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

Up to 27 August, 2020 there have been 330,368 lab-confirmed cases in the UK with 41,477 deaths of people who had a positive test result and died within 28 days. The numbers of confirmed cases and deaths across Hampshire and the Isle of Wight have been as below:

- Total lab-confirmed cases and rates by unitary authority area:
  - Hampshire 5,302 (383.5 rate)
  - Southampton 1,008 (399.2 rate)
  - Portsmouth 541 (251.7 rate)
  - Isle of Wight 431 (304.0 rate)

  (Rates per 100,000 resident population) Source: Public Health England Data)
- Number of deaths as reported by Trusts:
  - Hampshire Hospitals NHS Foundation Trust – 161
  - Isle of Wight NHS Trust – 39
  - Portsmouth Hospitals NHS Trust – 229
  - Solent NHS Trust – 2
  - Southern Health NHS Foundation Trust – 17
  - University Hospital Southampton NHS Foundation Trust – 198

  Source: NHS England Data up to 4pm 27 August (announced 28 August, 2020)

Across HIOW staff sickness averaged 4.74% in June and 3.85% in July with 2.1% and 1.3% respectively related to Covid-19. We have provided support to our staff in a number of ways with mental health and wellbeing programmes and bespoke support is in place for all staff groups. This support is being provided on an ongoing basis to support the impact on staff from responding to the incident.

We have also successfully supported a further 49 returners to work in both health and social care since July, with 493 in total now in place, along with 990 second and third year students to work on the frontline, as reported in July.

3. HIOW NHS response to Covid-19

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

As detailed in the July briefing, a number of temporary changes to NHS services were made as part of the response. The majority of these were implemented in direct response to requirements of national guidance with a smaller number made locally to enable the NHS to focus on the response to the major incident.

The changes made were changes in method of access; changes in location of services; reductions in service; and suspensions or increases in service. Changes determined locally were done so to embed social distancing; manage staffing pressures; increase (bed) capacity; support flow/ discharge; manage demand; prepare for redeployment of staff to other roles and/ or protect staff and patients.

Services are steadily being restored taking into account both the requirements of national guidance (Third phase of NHS response to Covid-19 which is available NHS England's website) and the service benefits realised through the changes made.

Progress to date includes:

Prevention
Health visiting and school nursing:

- Almost all nurses are back from redeployment to other services (only 0.4% FTE have not returned)
- Mandated checks: These were offered remotely (phone or video conferencing) during lockdown with very high levels of coverage maintained. Face-to-face contacts started to be offered incrementally from mid-June with a focus on the first three mandated checks (antenatal, new birth, 6-8 weeks)
- Digital offer: Maintaining access during social distancing. In Hampshire, ChatHealth, an anonymous texting advice service, has seen increased demand in 0-5 years service. Roll out of 11-19 year old service was been brought forward from August to June. Many service users have said they prefer using digital channels e.g. DNA rates for mandated checks very low during lockdown, fathers able to join from work, anonymity of ChatHealth. Digital part of new service specifications and implementation has been accelerated
- School nurses helped head teachers with Covid-19 related safeguarding and mental health prior to end of term.

Sexual Health:

- Most staff have returned from redeployment to other services
- Some return of face-to-face support
- From mid-June service users could return to clinic to have bloods taken
- From June onwards some face-to-face appointments have been provided for warts / skin conditions / long-acting reversible contraception (LARC) / vaccinations.

Substance misuse:

- Increase in referrals, especially alcohol related. Sessional workers have been employed to meet increased demand
- Face-to-face appointments are being initiated for high risk and vulnerable users

- Service user feedback positive on video and phone support and remote arrangement of rapid prescribing.

Primary Care

Primary care services have remained open throughout the pandemic but the way in which services are delivered has changed:

- All of the HIOW general practices are open and operating a total triage model to support the management of patients remotely where possible. All practices are operating telephone and online consultations
- Strengthened working with NHS 111, with NHS 111 able to directly 'book' patients into a practice work list for follow-up
- Continued provision of essential face-to-face services (including home visits) through designation of hot and cold sites (or zoning) and teams to minimise the spread of infection
- All sites designated as 'hot' sites have reviewed their situation in order to implement practice zoning or home visits for Covid-19 patients
- 72,000 shielded and vulnerable patients contacted to ensure ongoing care and support plans are in place and needs met via multidisciplinary teams (MDTs). This has involved significant joint working with local authorities, voluntary and community networks
- 100% alignment of 629 HIOW care homes with Primary Care Networks (PCNs) with **a** named clinical lead, weekly virtual MDTs and medication support in place. Strengthened collaborative working and provision of support in conjunction with local authorities including infection control, PPE (personal protective equipment), testing, workforce and clinical input
- Greater shared decision making through strengthened referral support, advice and guidance in collaboration with secondary care clinicians
- Daily resilience monitoring to enable rapid enactment of resilience plans at Primary Care Network (PCN) / Integrated Care Partnership (ICP) level, including mutual aid.

Community Care

The response to Covid-19 saw the system achieve greatly reduced lengths of stay in acute trusts and community hospital rehabilitation centres, with vastly improved discharge rates. Increasing numbers of people are now being supported in their own homes. This has been achieved through:

- Implementing seven day single points of access for community teams in all acute trusts
- Strong system and partnership working to optimise the rapid transfer of people from the acute hospitals who could be managed in the community
- A 'Home First' approach supported by integrated intermediate care models
- Community mental health access aligned to supporting physical health needs
- Community diagnostics and a rapid step-up of community rehabilitation capacity
- An accelerated digital capability
- Strong collaborative working between community services and local authorities to enact national discharge guidelines
- Collaborative commissioning between community services and local authorities to provide additional care at home and bed based support to enable discharges
- Continuing to provide telephone and video consultations with face-to-face appointments provided where required
- Support and education groups meeting virtually where possible
- Enabling patient visiting at inpatient units whilst maintaining social distancing.

Planned Care

HIOW hospitals have remained open to referrals with day and inpatient cases rising every week since the end of May. Work is underway to increase activity levels in line with national requirements.

Treatment levels in cancer services are now back to pre-Covid-19 levels. The focus is now on addressing those elements of service that were not achieving cancer standards pre-Covid-19:

- Two week wait cancer referrals dropped during the first Covid-19 peak but are now beginning to improve
- Cancer screening programmes are resuming, focusing on people already invited and high risk patients.

Patient visiting has been enabled at inpatient units whilst maintaining social distancing.

Mental Health

The vast majority of mental health services continued to operate throughout the lockdown period, but there were changes to how these were provided to ensure people could continue to access services. Progress to date to restore services includes:

- Continuing to provide increased specialist capacity within NHS 111 with safe haven and crisis support services available
- Providing telephone and video consultations in services as appropriate with high risk patients seen face-to-face where possible
- Proactively contacting and supporting current patients
- Triaging delayed non urgent referrals
- Serious mental illness and learning disability annual health checks resuming
- Group psychological interventions being providing digitally
- Older People's Mental Health Memory Assessment Service restarting in July
- Early Intervention Psychosis: Physical health monitoring resuming in June and seeing greater uptake
- Improving Access to Psychological Therapies (IAPT) services working towards restoring face-to-face appointments and identifying those who cannot access telephone or online treatment options to ensure they can receive therapy options
- Enabling patient visiting at inpatient units whilst maintaining social distancing.

Urgent and Emergency Care

Through the Covid-19 period, Emergency Department (ED) performance has improved and been maintained. As attendances increase recovery plans include maintaining improvements. These include:

- Sustaining reductions in delays to discharge from hospital
- NHS 111 First pilot in Portsmouth and south east Hampshire which is underway and will be rolled out to other areas as directed by NHS England/NHS Improvement nationally
- Continuing to directly admit patients to appropriate wards rather than all being directly conveyed through Emergency Departments
- Continuing telephone and video consultations for urgent Rapid Assessments
- Maximising the benefits of the Clinical Assessment Service model for both category three and four conveyances via NHS 111 and 999.

4. HIOW NHS restoration plans

In addition to the progress to date outlined in section three, a number of actions are being planned for the restoration of services as part of the third phase of the NHS response to Covid-19.

These include:

Prevention

- Increasing face-to-face appointments
- Restarting NHS annual health checks
- Using video-sharing social networking services for sexual health promotion

Primary Care

- Fully restore all services
- Retain and expand digital technology support to ensure optimised use for total triage and care delivery
- Delivery of annual flu vaccination programme
- Strengthen access to primary mental health care
- Further development of Integrated Care Teams
- Implementation of social prescribing in each Primary Care Network (PCN)
- Implementation of shared care record
- The development of estate plans
- Full implementation of Enhanced Health in Care Homes

Community Care

- Further detailed work on the demand and capacity and to determine priorities

Planned Care

- Review five specialities and make recommendations for change. Based on clinical risk and length of wait these are Orthopaedics, Urology, ENT, Dermatology, Ophthalmology and Endoscopy
- Maximise new pathways including advice and guidance, triage systems and straight to test and 'digital first'
- Create a HIOW diagnostic imaging network to support providers and facilitate at-scale working where beneficial
- Maximise the utilisation of available independent sector capacity
- Take a 'system waiting list' approach to ensure that patients are treated in priority order

Mental Health

- Commitment to deliver IAPT service to 25% of the prevalent population and access to services to meet surge in demand for psychological support
- Increase support for complicated grief based on 10 to 20% of the bereaved population experiencing this
- Accelerate development of integration through PCN development bringing together primary care, IAPT, secondary care mental health services and voluntary sector
- Support the Child and Adolescent Mental Health Service (CAMHS) to deliver 20% additionality including appropriate support in acute hospitals
- Maintain children and young people specific crisis line
- Support continued growth in 24/7 all age mental health NHS 111 triage service
- Continue to develop community perinatal services
- Continue phased approach to delivering psychiatric liaison

- Deliver physical health checks to at least 60% of people on the serious mental health registers
- Complete rehabilitation and re-ablement review in Hampshire
- Target and support practices with low Dementia diagnosis rates
- Assess impact of the increase of drug and alcohol use and impact on co-occurring substance use and mental health.

5. NHS England and NHS Improvement commissioned services

NHS England and NHS Improvement South East commission a number of local services and implemented changes in direct response to national guidance.

- **Pharmacy services**
  Pharmacies remain busy providing essential services for patients whilst adhering to social distancing measures.

  Whilst all pharmacies are open, some are operating to different hours to ensure they are able to catch up and to clean.

- **Dentistry services**
  General dental and orthodontic practices were able to reopen from 8 June for a gradual resumption of face-to-face care. The exact timing for each practice varied depending on the personal protective equipment (PPE) they were able to put in place and their ability to staff the practice, for example, some practice staff may still have been shielding.

  There are strict protocols for both practices and Urgent Dental Care Hubs which are still operational. It is important that dental practices continue to adhere to strict infection prevention control and social distancing measures so whilst practices are open, they are not able to treat as many patients per day as they could previously.

  All dental practices in the South East providing NHS services are now able to provide face-to-face care. Practices are providing different types of treatment and should minimise treatment involving Aerosol Generating Procedures (AGPs) (such as fillings, root treatment, crown preparation, scale and polish) due to the ongoing risk this poses to the dental team and patients.

  Practices that cannot provide AGPs or face-to-face management can continue to refer patients to one of the Urgent Dental Care Hubs which were put in place during lockdown, where this is clinically appropriate. Additional Urgent Dental Care hubs have been put in place and there are now 69 in operation across the South East.

  Patients who have an urgent dental need should continue to contact their dentist in normal working hours who will assess their need and advise on the most appropriate course of treatment which may be remote or face-to-face. Where patients do not have a regular dentist they can obtain details of dental practices from NHS.uk website or the Wessex Dental Advisory Service.

- **Optometry services**
  High street optometry practices are now providing face-to-face routine patient appointments. However, infection control and social distancing measures mean that the number of patients who can be sight tested during testing sessions is reduced.

- **Immunisation and screening services**
  Flu planning is underway as we prepare for the vaccination season. GP practices continue to be open and their staff are already putting plans in place to be able to safely administer the flu vaccine for patients. This may be done differently to how it has been done in the past. They are currently exploring options such as booked appointments only, in line with the current government advice; potential drive-through vaccine clinics at key venues; home visits to elderly and vulnerable patients where required; and holding small drop-in sessions at local venues.

A public campaign to drive awareness of the importance of getting vaccinated will begin during September. GP surgeries will use websites and their other communication channels to inform their patients how to get the flu vaccine. Health and social care workers will shortly be invited to have their flu vaccine.

A national campaign will be running shortly to encourage people to take up appointments for screening and immunisation services.

6. Winter and potential Covid-19 second wave planning

Planning for the management of winter 2020/21 is ongoing. The planning also covers the arrangements for responding to second wave/future spikes of Covid-19, working with the local authority Covid-19 Health Protection Boards, and a potential 'No Deal' EU Exit as well as supporting the extended flu immunisation programme. This work takes into account the maintenance of key service provision for urgent non-Covid-19 care. This includes managing issues such as testing arrangements, PPE (personal protective equipment) supplies, and staffing

The main principle that underpins our winter planning is forward planning and anticipation. It will ensure that health and care provision is optimised to meet demand, and that simple and effective systems and processes are in place to manage surges of demand on system capacity. Taking this approach will support us to ensure that we will be able to continue to restore and recover services during the winter period.

7. Seeking the views of local communities

It is key that we seek the views of our stakeholders, partners and local communities as we develop our restoration and recovery plans both within local systems but also across HIOW.To support this we are:

- Working with our Local Resilience Forum partners to track engagement work being undertaken by partners and other agencies to develop a bank of insight
- Seeking the views of the HIOW NHS Citizens Panel on their use and experience of NHS digitial solutions during the pandemic. The survey was completed by 661 people. Highlights from the results are:
  - As might be expected, Covid-19 has increased respondents propensity to do things online, including communicating with family and friends, shopping, banking and managing utilities. Those at high risk of Covid-19 are more likely to be doing some of these things for the first time
  - In terms of using digital channels for health there is a mixed picture. Some things, such as ordering a repeat prescription or using an interactive symptom checker have increased in usage whereas others such as booking a GP appointment have decreased. This might be a reflection of a general avoidance of face-to-face

contact and worry about overburdening the NHS, rather than not wanting to use digital channels
    - Positively, nearly one in ten respondents had an online GP appointment for the first time and 8% used the NHS App
    - Most respondents using digital health channels for the first time had confidence in using them again with the exception of using an interactive symptom checker and accessing mental health or counselling support online
    - Personal interaction appears to be key to a 'very good' experience, with in person, telephone and face-to-face online appointments being higher rated than email or live chat. Telephone is considered good or very good by 78% of respondents and this is the channel that most respondents would consider using in the future for non urgent health and care appointments
- Working with local authority partners to include health based questions in their citizens surveys – the surveys for two of the unitary authorities have now closed and the responses are being analysed. Some of the district and borough surveys are currently still open for responses
- Starting to seek the views of patients who have used the NHS 111 First Service to understand their experience
- Supporting primary care access and resilience during winter 2020/21 including:
    - Working with our local Primary Care Networks to support them to engage with local communities, including developing a toolkit
    - Working with Age Concern Hampshire to develop a Carers Panel who we will work with as 'critical friends' to help identify some of the key concerns that patients and people in the community have, particularly carers and the people they look after
    - Aligning activities to Healthwatch Hampshire, for example, investigating how we can link to their PCN Collaboration Project's 'Working in partnership with people and communities' workstream.

We are also investigating how we can collaborate more effectively with our upper and lower tier partners, directly (with Hampshire County Council Representatives) and indirectly, for example through the Local Resilience Forum.

In addition, NHS England is determining if there are opportunities to carry out engagement programmes on a regional footprint for common areas, for example mental health and primary care.

8. Recommendation

The Committee is asked to note this update briefing.

Hampshire and Isle of Wight
Partnership of Clinical Commissioning Groups

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PO17 6AR

Cllr Chris Attwell
Chair
Portsmouth Health Overview & Scrutiny Panel
Member Services
Civic Offices
Portsmouth PO1 2AL

Friday 4th September 2020

Dear Cllr Attwell,

Hampshire Partnership of Clinical Commissioning Groups: Update for Portsmouth Health Overview and Scrutiny Panel September 2020

This letter is provided, as requested, to update you and the members of the Portsmouth Health Overview and Scrutiny Panel on the work of the Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups (Fareham and Gosport, South Eastern Hampshire, North Hampshire and the Isle of Wight CCGs) and, in particular, the work that we do in the Portsmouth and South Eastern Hampshire area.

We have provided updates on a couple of items as requested but would be happy to provide further clarification if it is required. We are always happy to facilitate direct discussions if there are particular issues which are of interest.

1 How the Partnership operates

As you know, CCGs are changing the way they work and we recently wrote to update you as changes are planned to both what CCGs do, and how they do it.

Our aim is to overcome the complexity and fragmentation in the current commissioning arrangements, reduce duplication and to refresh the way CCGs work, so that together we can better support the health and care system in Hampshire and the Isle of Wight to improve population health outcomes and to improve the quality and performance of health and care services.

Our view is that the best way to deliver high quality sustainable care is through collaboration. In future we see the overwhelming majority of the work we do to be about understanding need, and planning and transforming services through collaboration with partners, through the Integrated Care System we are building together.

Our experience of working together during COVID-19 has demonstrated the benefits of doing things once, where there is a strong case for and demonstrable impact of doing so. Through a blend of working at scale and at place we hope to achieve the best possible outcomes.

In order to accelerate change, the Boards of six CCGs (North Hampshire CCG, West Hampshire CCG, South Eastern Hampshire CCG, Fareham & Gosport CCG, Isle of Wight CCG and Southampton City CCG) are developing a business case to merge, and create one new CCG for Hampshire, Southampton and Isle of Wight from April 2021.

The merged CCG will be organised with the flexibility to maintain a strong local focus as well as achieving the benefits of working at scale. There will be local teams with a local budget, responsibility for the local population and high levels of local decision-making authority, enabling the important work with primary care, local government and provider alliances to be effective.

Coming together as one organisation will allow us to build a more efficient and effective operating model, make better use of our resources for local residents, avoid duplication and achieve economies of scale.

Having a single Executive and a Hampshire, Southampton and Isle of Wight focus, will enable the new CCG to also streamline and simplify decision making for pan-system issues. The aim is to establish this new way of working by the Autumn in shadow form, aligned with the establishment of the ICS.

As you will be aware, Portsmouth CCG plans to remain a separate statutory body, delegating functions to Portsmouth City Council (to continue the Health and Care Portsmouth integrated approach) and to the Hampshire and Isle of Wight strategic commissioning function. We will of course continue to work closely with Portsmouth to enable us to speak as one voice across Hampshire and the Isle of Wight.

We would welcome your views and feedback on the proposals, which we will incorporate into our ongoing design.

2 Responding to COVID-19

Following the briefing provided in July 2020, we have attached a paper to this letter that provides an update on the impact to date of the pandemic; the health element of the Hampshire and Isle of Wight Local Resilience Forum response to Covid-19; and the NHS restoration and recovery work including seeking the views of key stakeholders and local people.

The paper also provides details of planning work being undertaken across Hampshire and the Isle of Wight (HIOW) for winter and a potential second wave of COVID-19.

3 Primary care update

a) Integrated Primary Care Service

The Integrated Primary Care Access Service (IPCAS) is provided by the Southern Hampshire Primary Care Alliance across Fareham, Gosport and south east Hampshire.

It was developed to bring together two services: the pilot GP Extended Access Service and the GP Out of Hours Service. The current contract runs until 2021 when Primary Care Networks will become responsible for providing extended access to their patients.

The combined IPCAS service has, since June 2019, enabled patients to be seen out of hours at a primary care hub of their choice, or choose to book a routine appointment at a hub at the weekend or in the evening if it suits them better. Appointments can be arranged through their surgery or by calling 111 when their surgery is closed.

The impact of the COVID-19 pandemic, although challenging, has accelerated the pace of change and transformed the way in which primary care services are delivered, and this includes the way the IPCAS service operates.

Primary care services have remained open throughout the pandemic but the way in which services are delivered has fundamentally changed -to ensure patient safety, implement infection, prevention and control measures effectively, and ensure patients are cared for in the most appropriate setting.

This accelerated pace of change has led to new models of delivery supported through strong clinical leadership, greater partnership working and digital technology, including:

- Practices operating **a total triage model**, whereby patients are triaged either by phone or online to determine whether a follow-up face to face appointment, home visit or follow up phone or online contact is required.
- Strengthened working with **NHS 111**, with NHS 111 able to directly 'book' patients into a practice.
- Continued provision of **essential face-to-face** services (including home visits) through designation of 'hot' and 'cold' sites and teams to minimise the spread of infection. Hot and cold is essentially the separation of care for those with suspected COVID-19 and those not.
- Greater use of **Electronic Repeat Dispensing (ERD)** to reduce footfall within practices.

It was extremely important to ensure all primary care services operated in this way and therefore the IPCAS service was also aligned to this model.

As a result the sites of delivery were identified to align to the 'hot' service hubs set up across the patch so that the IPCAS service could focus on service provision that was absolutely critical and needed at this time (in line with national guidance). The sites identified were therefore:

Patients ring their practice to book an appointment (both routine and urgent) or NHS111 when their practice is closed for an urgent appointment	**Site**	**Opening times**
	Forton Medical Centre, Gosport	• Mon to Fri 6.30pm to 10.30pm • Sat and Sun 8am to 10.30pm
	Waterlooville Health Centre	• Mon to Fri 6.30pm to 10.30pm • Sat and Sun 8am to 10.30pm

NHS England determined nationally which services were vital to continue throughout the pandemic phase and therefore 'cold' sites were also aligned in the IPCAS service to day time delivery to ensure safety for patients, these were as follows:

	Site	Opening times
Patients ring their practice to book an appointment (both routine and urgent) or NHS111 when their practice is closed for an urgent appointment	Portchester Health Centre	• Mon to Fri 6.30pm to 10.30pm Sat and Sun 8am to 10.30pm
	Swan Surgery, Petersfield	• Mon to Fri 6.30pm to 9pm (from mid-September to increase to 10.30pm) • Sat and Sun 8am to 2pm

Given the likely pressure on services over the forthcoming winter period and the potential impact of any local outbreaks of COVID-19, it is proposed that this service model is continued until the IPCAS contract expires in March 2021.

There is a significant piece of work to be done to work with patients and the public to gain their views of the future of primary care services when the pandemic phase has passed. It is important that we use this as an opportunity to continue some of the innovations that have been introduced, but also ensure services respond to patient need.

All service providers, including primary care networks, as well as the CCG will need to take into account how we can effectively develop these services but also robustly ensure we recognise the vast feedback we have collectively received to date.

b) Stoke Road surgery/Willow

The impact of the COVID-19 pandemic on primary care means that the situation with Stoke Road surgery in Gosport, and the update we provided informally in mid-July, remains largely unchanged at this stage.

As previously described, the decision to reduce the opening times at Stoke Road to two days a week was taken in March due to a sudden reduction in GP workforce. This had an impact on the Willow Group being able to provide safe and effective services at the site on a daily basis, particularly given the difficulty experienced in recruiting and retaining GPs in the town, hence the decision that had to be made.

Clearly the ongoing pandemic, which followed within a matter of weeks of the decision, caused a broader review of the delivery of primary care services not just in Gosport but across the area. This led both to changes in the way appointments are delivered and other options that have added to the choice available for the way people can access care, and in terms of where people are referred if a face to face appointment was required.

These alternative arrangements remain in place for now but a broader piece of work is underway between the practice, the CCG, and other practices in the local primary care network that we hope will help steer the future for primary care in Gosport and the related estate on a longer term basis. This has included a recent workshop to identify how best we can support the development of the practice's strategy and this does include some further engagement work with the patients and public, which will be an important component in this approach.

The practice is engaging with its Patient Participation Group as things progress – and, in the meantime, it continues to support patients across the whole range of primary care services, including chronic disease reviews, phlebotomy, cancer screening, immunisations and wound care, and through a range of approaches, as it continues to take appropriate measures to protect staff and patients.

c) Emsworth Surgery move

Work is well under way to relocate Emsworth Surgery to its new home at the former Victoria Cottage Hospital in the town centre.

Contractors are currently on site as part of a £3.5m scheme to convert the building and although work had to be temporarily halted for a few weeks during the pandemic lockdown, progress is now restored and work is due to be completed early next year.

It is hoped that the new surgery could open its doors to its first patients in March 2021. For years GPs, staff and patients have struggled to cope on their cramped existing site a stone's throw away from the unused hospital.

The practice could not have coped much longer at its present site given that when it opened it catered for 2000 patients and that figure has grown to around 13000.

We are hoping that the new surgery, when open, will mean a positive outcome for those people who campaigned so strongly to keep the surgery in the heart of their community; for the GPs who wanted to provide modern and accessible premises with space to expand; and for patients as well.

4 The Clarence Unit – re-use of the former Woodcot nursing home

Based in Gosport, the Clarence Unit at Woodcot Lodge, has, since June, offered temporary 'step-down' accommodation, initially for up to 54 patients who no longer need acute care at Queen Alexandra Hospital but who are not yet ready to return to a care home or their own home. They are supported by a team of dedicated nurses, physiotherapists, occupational therapists, social workers and skilled care staff who will work with them to plan their rehabilitation, recovery and onward care arrangements.

It represents a unique collaboration between Hampshire County Council and local NHS partners, established rapidly during the coronavirus pandemic because of the increased need for facilities where people are able to isolate safely, and thus avoiding passing undue risk to other very hard pushed public and private care homes. This collaboration is an exciting new initiative and could, beyond the COVID-19 period, provide the blueprint for additional dedicated short-term nursing care facilities for the vulnerable across other hospital systems in Hampshire. It also complements work undertaken jointly between the NHS and Portsmouth City Council to establish a similar approach at Harry Sotnick House.

The approach provides the care and support patients need, in a safe environment, to help them recover and build up their strength after a stay in hospital.

It allows us to make best use of our combined health and social care skills and resources and so that we can provide care tailored to the need of each individual patient.

It is a positive example of what can be achieved by organisations working together effectively, at speed and with a shared purpose.

Around 75 patients have been admitted to the service at the time of writing, with an average length of stay of around 21 days. Stays can be up to a maximum of 28 days after which residents either return home, or will be transferred to the right longer term care setting.

Under current plans, the Clarence Unit is set to remain open until 31 March 2021, but this will be closely monitored and could become permanent, subject to demand levels and the availability of partner funding beyond 2020/21.

5 NHS 111 First programme

I understand that an update on progress with the NHS 111 First programme will be provided by our colleagues from Portsmouth Hospitals University NHS Trust at the meeting so I am not proposing to provide a detailed update here. However, as with the Clarence Unit development, the 111 First programme is another example of the Portsmouth and South Eastern Hampshire Health system working together to develop an enhanced service for local people in rapid time.

The programme is due to be in place across the country by the beginning of December and so the CCG partnership will be working with partners in other parts of Hampshire, Southampton and on the Isle of Wight to deliver schemes in these areas too.

6 Ongoing updates to the Panel

I trust that this update has been helpful. We would be happy to provide further updates as required and I also wanted to draw your attention to our two local annual reports which provide more information about the work of our two local CCGs over the past year. They can be found on our websites as follows:

Fareham and Gosport CCG: https://www.farehamandgosportccg.nhs.uk/about-us/information-about-us_2.htm

South Eastern Hampshire CCG: https://www.southeasternhampshireccg.nhs.uk/about-us/information-about-us_2.htm

Yours sincerely

Sara Tiller
Managing Director, Fareham and Gosport and South Eastern Hampshire CCGs
Hampshire and Isle of Wight Partnership of CCGs

Portsmouth CITY COUNCIL

Report to: Health Overview and Scrutiny Panel

Subject: COVID-19 Briefing

Date of meeting: 17th September 2020

Report from: Helen Atkinson - Director of Public Health

Report by: Helen Atkinson and Matt Gummerson

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1. Purpose of report

1.1 To brief the Health Overview and Scrutiny Panel (HOSP) meeting on the work led by public health on the Covid-19 response in Portsmouth, current plans in place, including current insight data, and the local governance arrangements in place for the current response for Test and Trace, Outbreak Plans and the Health Protection Board and Member Led Engagement Board.

2. Background

2.1. Public Health Leadership within the Portsmouth City Council corporate response and the HIOW Local Resilience Forum

Early in the pandemic response, we ensured that we were maintaining our statutory responsibilities and PH service delivery as well as supporting the council around specialist advice for preventing the spread of infection. This work included providing 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. PH set up a daily rota to reply to queries that came in from the HR team and other senior managers in the council via our generic emails address. PH also supported, via our Communications lead, much of the internal and external facing communication messages on our intranet and internet sites.

2.2. The three Directors of Public Health (DPHs) for Portsmouth, Southampton, Hampshire and the IOW have played a senior leadership role within the COVID-19 Local Resilience Forum (LRF) response as the local specialists for infectious disease pandemics. We have each taken a lead for specific areas of the response within the LRF. Simon Bryant (HIOW DPH) has led the work for preventing the spread of infection as the Strategic Coordinating Group (SCG) Deputy Chair and Chair of the Cross Border Outbreak Group; Debbie Chase (Southampton DPH) has led the work of the LRF Modelling and Intelligence Cell and Helen Atkinson (Portsmouth DPH) has led on the PH in-put to the Health and Social Care Cell, Chaired the Strategic Testing Operations Cell and specialist PH advice, including

the recovery timeline, to the Recovery Coordinating Group RCG) chaired by our Chief Executive, David Williams. The DPHs and their teams have worked closely together to ensure a networked response to COVID-19 across HIOW as well as taking a lead role in their individual local authority response.

2.3. The Public Health Team in Portsmouth City Council are core members of several of the groups and provide specialist in-put to the work of the LRF response to the pandemic. Please find below details of which groups we have been supporting:

- Helen Atkinson, DPH - Member of the Strategic Coordinating Group; the Recovery Coordinating Group, the Modelling cell, chairing the Recovery Intelligence Cell and the Strategic Testing Operations Cell and member of the Health and Social Care Cell.
- Fiona Wright, Consultant in Public Health (CPH) - The Tactical Coordinating Group (TCG); protecting our Most Vulnerable Residents group and co-chairing the Portsmouth Mental Health Alliance.
- Dominique Le Touze, CPH - The Portsmouth City Council GOLD Business Continuity Group and the Cross Border Outbreak Group.
- Matt Gummerson, Strategic Lead for Intelligence - The Recovery Coordinating Group, the Modelling and Intelligence Cell, GOLD Business Continuity Group and the Recovery Intelligence Cell.
- Alan Knobel, PH Development Manager - Covid-19 Homelessness work-stream and the PCC Homeless Management Group
- Cheryl Scott, PH Communications Lead - LRF Media Cell.

2.4. PH are also involved in regional and national work as members of the Association of Directors of Public Health (ADPH). To mention two examples of this work - the SE ADASS Recovery Reference Group and the DHSC Whole Care Home Testing Task and Finish Group.

The SE ADASS Recovery Reference Group was set up to support the work on recovery that all DPHs in the region are currently involved with. We are all looking at the evidence from other pandemics and current response from other parts of the world to identify opportunities for learning during recovery. To reduce duplication and save on scarce PH resource we are undertaking this work together across the South East. Emma Richards, Specialist Registrar in PH, and Matt Gummerson, Strategic Lead for PH Intelligence at PCC are taking the lead on the literature review work for the whole region. The aim of the group is to:-

- identify issues relating to whole population health and wellbeing for consideration in the recovery phase of COVID 19
- set out a whole systems approach to health and wellbeing recovery based on available evidence and learning from previous pandemics, disasters and emergencies
- collate / generate resources that PH teams can use to feed in to their local recovery plans/systems which will all be different

Whole Care Home Testing - in mid-May the Minister of State for Care, Helen Whately MP announced whole care home testing across the sector. In a letter to local Directors of Public Health and Directors of Adult Social Services, she asked them to lead work with local NHS providers and PHE Regional Directors to ensure that testing of staff and residents in care settings is joined up. This program, along with the Test and Trace program will allow us to get a better understanding of where our local community infection 'hot spots' and outbreaks are so that we can direct effective prevention measure to reduce the spread of infection.

2.5 Public Health Intelligence and COVID-19

Public Health Portsmouth has worked in partnership with colleagues across Hampshire and the Isle of Wight (HIOW) to develop a range of Covid-19 Intelligence products that are being used to inform the local response and recovery efforts.

Modelling - Coronavirus is a newly emergent virus and much remains to be understood about COVID-19 transmission dynamics. Its precise impact on individuals is not fully known. Through the Local Resilience Forum (LRF) Modelling Cell, we aim to distil the emerging evidence and try to infer from that to what it may mean for us and the impact on our area for capacity and demand planning.
Our model adopts a public health approach to modelling infectious diseases. It uses the epidemiological evidence that we know of COVID-19 and simulates infection spread through a population. Population age structure, density and household composition are strong determinants of how infection spreads, so every area is different. So far, our model has been successful in predicting COVID-19 rates for the LRF, and we continue to adapt the model as new evidence becomes available. We have modelled different scenarios in response to the relaxation of lockdown restrictions and identified potential early warning indicators in the local system that are published weekly for partners.

Portsmouth Gold Dashboard - As well as data and analysis at LRF level, we have produced a local dashboard for GOLD that highlights key information about the progression of COVID-19 in Portsmouth. An updated Dashboard (Appendix 1) is presented weekly to GOLD, summarising key data into charts covering:

- Infection rates for Portsmouth, HIOW authorities and comparators
- Epidemiological care of Portsmouth new cases
- Deaths in Portsmouth Hospitals NHS Trust from COVID-19
- Excess deaths each week in Portsmouth compared to previous weekly averages

Recovery timelines - Public Health Intelligence supports the LRF Recovery Coordinating Group through the Recovery Intelligence Cell. We provide advice and information on potential timelines and emerging challenges and opportunities for the next phases of the response to, and recovery from, COVID-19. This includes analysing national policy, local sector intelligence, and wider evidence on recovery.

A summary slide of the latest assumptions on Recovery timelines is attached as Appendix 2.

Additional information and analysis - We continue to respond to local demand for new information and analysis around COVID-19 e.g. working closely with Adult Social Care, Children, Schools and Families and the Clinical Commissioning Group to provide an intelligence-led approach to the challenges in the local health and care sector.

3. Next phase of the COVID-19 response including Test and Trace, local outbreak plans and local health protection and engagement boards.

3.1 On Friday 22nd May, national Government announced the requirement for Local Outbreak Control Plans (CoVid-19) to be developed to reduce local spread of infection and for the establishment of a Member-led Covid-19 Engagement Board for each upper tier Local Authority to communicate with the general public, supported by an Officer-led Health Protection Board connected into existing Local Resilience Forum command structures (PCC GOLD). A £300m funding offer to upper tier Local Authorities accompanied this announcement, though individual allocations.

3.2 Work is continuing within the national test and trace programme, which was launched on Tuesday 26th May. This has formed a central part of the government's Covid-19 recovery strategy. The primary objectives of the national test and trace programme, and our local programme including the requirements for outbreak plans, is to control the Covid-19 rate of reproduction (R), reduce the spread of infection and save lives. In doing so, we can help to return life to as normal as possible, for as many people as possible, in a way that is safe, protects our health and care systems and releases our economy.

3.3 Achieving these objectives will require a co-ordinated effort from local and national government, the NHS, GPs, businesses and employers, voluntary organisations and other community partners, and the public. Local planning and response will be an essential part of the Test and Trace service, and local government has a central role to play in the identification and management of infection and to develop and action their plans to reduce the spread of the virus in our populations.

3.4 Building on the statutory role of Directors of Public Health (DPHs) at the upper tier local authority level, and working with Public Health England's (PHE) local health protection teams (HPTs), local government have built on existing health protection plans to put in place measures to identify and contain outbreaks and protect the public's health. Local DPHs have responsibility for defining these measures and producing the plans, working through Covid-19 Health Protection Boards. They will be supported by and work in collaboration with Gold command emergency planning forums and the public-facing Board led by council members to communicate openly with the public.

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

4. Local Outbreak Plans

4.1 Government guidance required that local outbreak plans were centred on7 themes:

- Planning for local outbreaks in care homes and schools (e.g. defining monitoring arrangements, identifying potential scenarios and planning the required response).
- Identifying and planning how to manage other high-risk places, locations and communities of interest including sheltered housing, dormitories for migrant workers, transport access points (e.g., ports, airports), detained settings, rough sleepers etc. (e.g. defining preventative measures and outbreak management strategies).
- Identifying methods for local testing to ensure a swift response that is accessible to the entire population. This could include delivering tests to isolated individuals, establishing local pop-up sites or hosting mobile testing units at high-risk locations (e.g. defining how to prioritise and manage deployment).
- Assessing local and regional contact tracing and infection control capability in complex settings (e.g., Tier 1b) and the need for mutual aid (e.g. identifying specific local complex communities of interest and settings, developing assumptions to estimate demand, developing options to scale capacity if needed).
- Integrating national and local data and scenario planning through the Joint Biosecurity Centre Playbook (e.g., data management planning including data security, data requirements including NHS linkages).
- Supporting vulnerable local people to get help to self-isolate (e.g. encouraging neighbours to offer support, identifying relevant community groups, planning how to co-ordinate and deploy) and ensuring services meet the needs of diverse communities.
- Establishing governance structures led by existing Covid-19 Health Protection Boards and supported by existing Gold command forums and a new member-led Board to communicate with the public.

4.2 All upper tier local authorities were required to develop local outbreak control plans in June ahead of the roll out of further phases of the national infection control framework.

4.3 A National Outbreak Control Plans Advisory Board was be established, led by Tom Riordan, CEO Leeds City Council, now led by Dr Carolyn Wilkins OBE, CEO officer of Oldham. The Advisory Board has drawn on expertise from across local government and ensured the national Test and Trace programme has built on local capability, and shared best practice to inform future programme development. The local plans, linked with the work of the Joint Biosecurity Council, has been at the heart of the current phase of the response.

4.4 DPHs have led the development of Local Outbreak Plans and worked with PHE local HPTs to lead the work on contact tracing and managing outbreaks in complex settings and situations. HPTs have led at PHE regional centre level and DPHs have led within their Local Authorities. This is described as Level 1, which is delivered with partners at local levels. The management of local outbreaks is resource intensive work and so local authorities through the leadership of their DPHs and PHE have worked closely together to build capacity of both the local authority teams and the PHE local HPTs, which has been a key part of the Local Outbreak Control Planning.

5. Test and Trace - contact tracing

5.1 The national approach to contact tracing has been highly iterative and remains so, however, includes two main elements:

- **Covid 19 App:** This is an innovative, but largely untested approach to using technology to support people to identify when they are symptomatic, order swab tests, and send tailored and targeted alerts to other app users who have had close contact. Even when operational, this feature of the national model will be insufficient as a standalone approach due to limitations in terms of reach and functionality. The NHSX app will no longer go forward but government are working with Apple/Google to develop an App that will be in place by the autumn and is currently being piloted in Newham and the IOW.

- **National Contact Tracing Service (NCTS):** This incorporates a significant scaling up of the tried and tested contact tracing approach and has 3 tiers:

  Tier 3: A cohort (c.12, 000) of contact tracing call handlers based within a national call handling centre providing phone-based contact tracing (PBCT);
  Tier 2: A significantly increased cohort (c.3, 000) of trained contact tracing Specialists providing phone-based contact tracing (PBCT) recruited through a national recruitment approach;
  Tier 1b: A regionalised network, including sub-regional and localised delivery providing contact tracing, consequence management and support in relation to complex settings, cohorts and individuals / households.
  Tier 1a: A national co-ordinating function to lead on policy, data science, and quality assurance of the service.

5.2 Tier 1b will have 3 primary functions:

1. Complex Contact Tracing with:

- Potentially complex settings (for example: Special Schools, Homeless Accommodation; DV refuges; Police Stations; HMO's; Day Centre Provision; NHS Settings; Social Care settings; Statutory Service HQ's; residential children's homes)
- Potentially complex cohorts (for example: rough sleepers; faith communities, asylum seekers)

- Potentially complex individuals and households (for example: Clinically shielded; Learning Disability; diagnosed Mental Illness; Rough Sleepers; Victims of Domestic Abuse; complex social-economic circumstances)

2. Providing direct support to those identified through contact tracing for whom adherence to self-isolation measures may be challenging, including links into locality hub pathways for our shielded and vulnerable cohorts.

3. Consequence management as a result of managing an outbreak in a complex setting or within a complex cohort.

6. The role of the Local Resilience Forum

6.1 The Strategic Co-ordinating Group of the Local Resilience Forum has responsibility to agree and co-ordinate strategic actions by Category 1 and 2 responders for the purposes of the Civil Contingencies Act in managing demand on systems, infrastructures and services and protecting human life and welfare. The SCG has crucial capabilities in aligning and deploying the capabilities of a range of agencies at local level in supporting the prevention and control of transmission of COVID-19. An LRF may often cover multiple local authority areas and at a local level, the relationship between each local authority and the SCG needs to be agreed and understood by stakeholders. In this respect, the SCG will add value to co-ordination and oversight across larger geographical footprints. Local areas are best left to determine how these arrangements will work.

7. The role of the Integrated Care System (ICS)

7.1 Just as the Public Health “system within a system” is necessary to a strong Local Outbreak Plan, so the Capabilities of the whole system, including the ICS, will be crucial to preventing and managing Outbreaks. Both are necessary parts of a system. A good local Outbreak Plan will:

1. Have a clear role for the Strategic Co-ordinating Group in deploying and aligning multi-agency capabilities in furtherance of the Plan
2. Ensure that agencies play to their strengths and capabilities and do not try to do the roles of others with specific statutory responsibilities or more suited to a specific role
3. Ensure the capabilities needed from all agencies, from analysts and data specialists to clinicians, local authority, NHS, police and voluntary sector functions are harnessed for appropriate roles ranging from supporting those self-isolating to the use of legal powers where needed.
4. Ensure NHS infection control capabilities will deliver clinical leadership fully playing their part in supporting the leadership of the Director of Public Health in NHS and Care settings, and the ICS and NHS organisations will facilitate this

8. Terms of reference and membership of the Local Health Protection Board

8.1 The Local Health Protection Board is an operational group that is responsible for the ongoing implementation of the Local Outbreak Plan. This group includes:

Director of Public Health (PCC) - Chair

Assistant Director - Regulatory Services, PCC (and Deputy Chair)

Representative from PCC communications

Assistant Director - Adult Social Care (care homes a key focus of Local Outbreak Plans)

Deputy Director of Children, Families and Education - Education (schools a key focus of Local Outbreak Plans)

Emergency Planning and Resilience Representative

PHE - link to wider health protection structures

Housing (appropriate representation to pick up homeless and sheltered housing as both groups are a focus of the Local Outbreak Plans)

Culture and Leisure (link to high-risk locations or events)

The HIVE (Supporting local vulnerable people to self-isolate)

PCC finance (to support resource allocation)

CCG - Infection control specialism

Portsmouth Hospitals Trust

Solent NHS

Portsmouth University

Portsmouth Naval Base

8.2 The Board meets weekly to drive the development of the plan. There will be scope for extraordinary meetings if required.

9. Terms of reference and membership of the Local Engagement Board

9.1 The Local Engagement Board provides strategic oversight for the Health Protection Board and the development and delivery of the Local Outbreak Plan. Guidance states this oversight is provided through the Health and Wellbeing Board, in its statutory role as bringing local system partners together. In Portsmouth, the Local Engagement Board is established as a sub-committee of the Health and Wellbeing Board, as the full board has a wide membership and only meets quarterly. A sub-committee has a focused membership and is more responsive to immediate need of the Health Protection Board.

9.2 It is recommended that the membership of the Board is balanced to be composed half of elected members, and half of other membership, with the elected membership representing political proportionality. Therefore the membership is:

Cabinet Member for Health, Care and Wellbeing (PCC) - Chair

Five elected members (1 Liberal Democrat, 2 Conservatives, 1 Labour and 1 Progressive Portsmouth Party)

Director of Public Health

Accountable Officer (PCCG)

Healthwatch

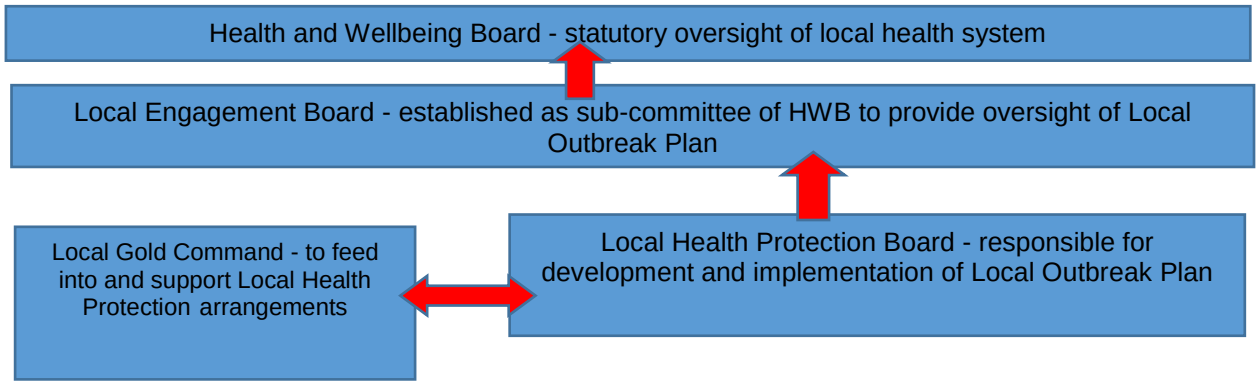
The Hive

Two additional members drawn from Business and Education

9.3 The Local Engagement Board sub-committee was established formally through the Health and Wellbeing Board meeting on 17th June, and meets monthly. There will be scope for extraordinary meetings if required.

10. Summary structure

10.1 In summary, the reporting structure can be summarised as below:



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Portsmouth Covid-19 Intelligence Summary

04.09.20

Overview

1. Infections
   - Case Rate per 100,000 population: HIOW Local Authorities and comparators
   - Epidemiological curve: Portsmouth new cases (3 day average)
   - HIOW infections by UTLA (spark lines)
   - Weekly rates per 100,000

2. Deaths
   - New deaths in Hospital (3 day overage): Portsmouth Hospitals
   - Extra deaths occurring in 2020 in Portsmouth (LA) compared to average of corresponding week by week of death

Please read – important caveats

This presentation includes data derived from a dashboard owned by the Hampshire & Isle of Wight LRF for the purpose of emergency planning and response, and data made available to local Directors of Public Health that is not in the public domain.

The dashboard is marked ***official sensitive*** and has been developed for the purpose of planning and responding to CoVid19 in Hampshire and IOW (including the unitary authorities of Southampton and Portsmouth) known hereon as HIOW. Data and information in this product has been processed under the COVID-19 Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

https://www.gov.uk/government/publications/coronavirus-covid-19-notification-of-data-controllers-to-share-information?utm_source=d05aa30e-95d2-48e3-93e0-0a696c35bd3c&utm_medium=email&utm_campaign=govuk-notifications&utm_content=immediate

The information and data in this product should only be used, processed and shared for a Covid-19 Purpose and solely for that COVID-19 purpose. A Covid-19 Purpose includes but is not limited to the following:

> Understanding Covid-19 and risks to public health, trends in Covid-19 and such risks, and controlling and preventing the spread of Covid-19 and such risks;

> Monitoring and managing the response to Covid-19 by health and social care bodies and the Government including providing information to the public about Covid-19 and its effectiveness and information about capacity, medicines, equipment, supplies, services and the workforce within the health services and adult social care services;

> Identifying and understanding information about patients or potential patients with or at risk of Covid-19, information about incidents of patient exposure to Covid-19 and the management of patients with or at risk of Covid-19 including: locating, contacting, screening, flagging and monitoring such patients and collecting information about and providing services in relation to testing, diagnosis, self-isolation, fitness to work, treatment, medical and social interventions and recovery from Covid-19;

> Understanding information about patient access to health services and adult social care services and the need for wider care of patients and vulnerable groups as a direct or indirect result of Covid-19 and the availability and capacity of those services or that care;

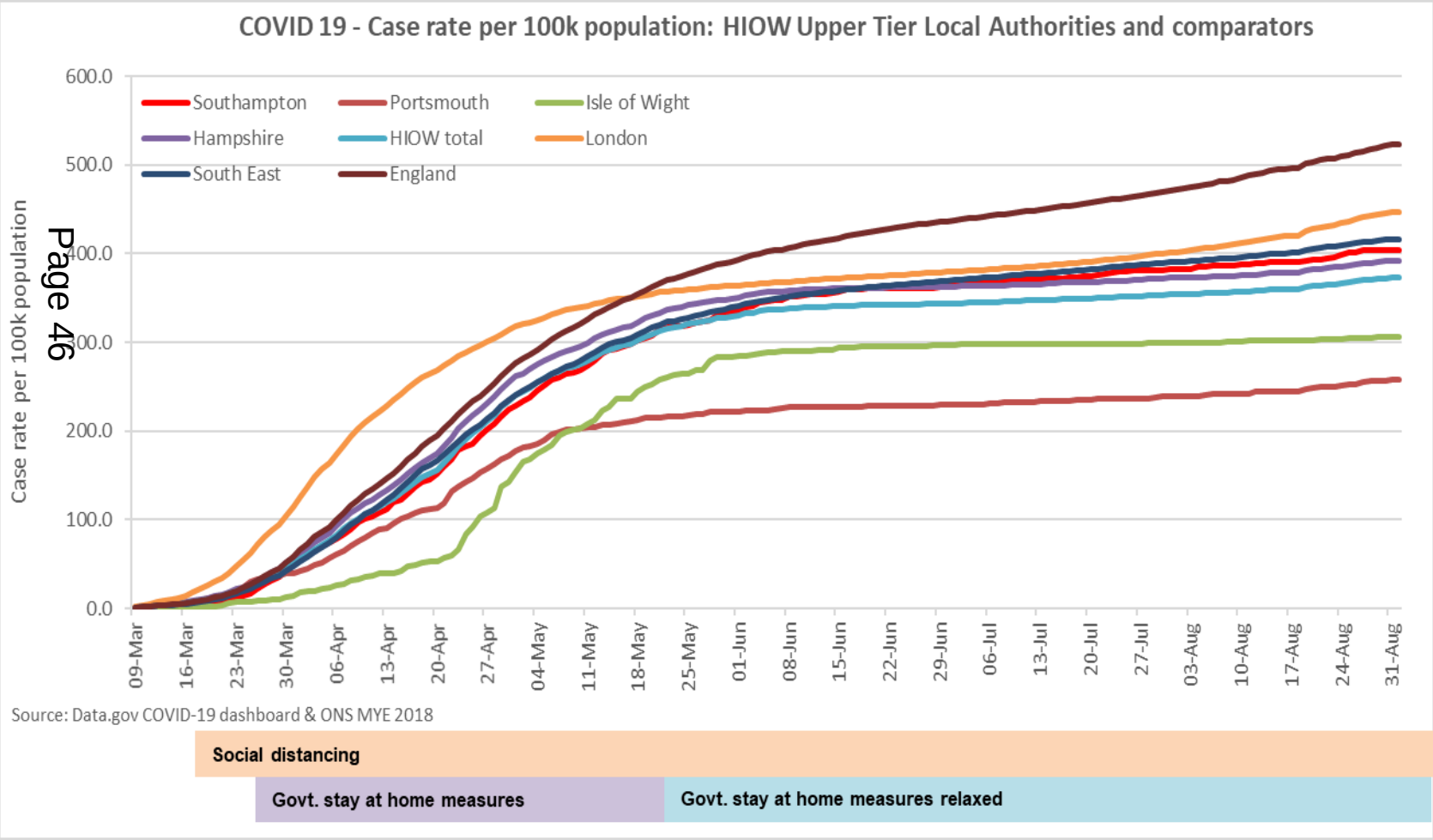
> Delivering services to patients, clinicians, the health services and adult social care services workforce and the public about and in connection with Covid-19, including the provision of information, fit notes and the provision of health care and adult social care services; and

> Research and planning in relation to Covid-19.

Advice should be sought from the appropriate Public Health team member before this information is shared into the public domain; it does not contain patient identifiable data, but it does contain sensitive information and data which requires explanation and contextualisation.

1.1 Infections

Case rate per 100,000 population: HIOW Local Authorities and comparators, Pillar 1 and Pillar 2 tests



The rate of infections in Portsmouth has plateaued since early June.

It remains below the rates for Southampton, Hampshire and England as a whole, and with inclusion of Pillar 2 tests is now below IOW too.

The chart shows the crude rate of confirmed cases (cumulative) per 10,000 population for HIOW Local Authorities and comparators.

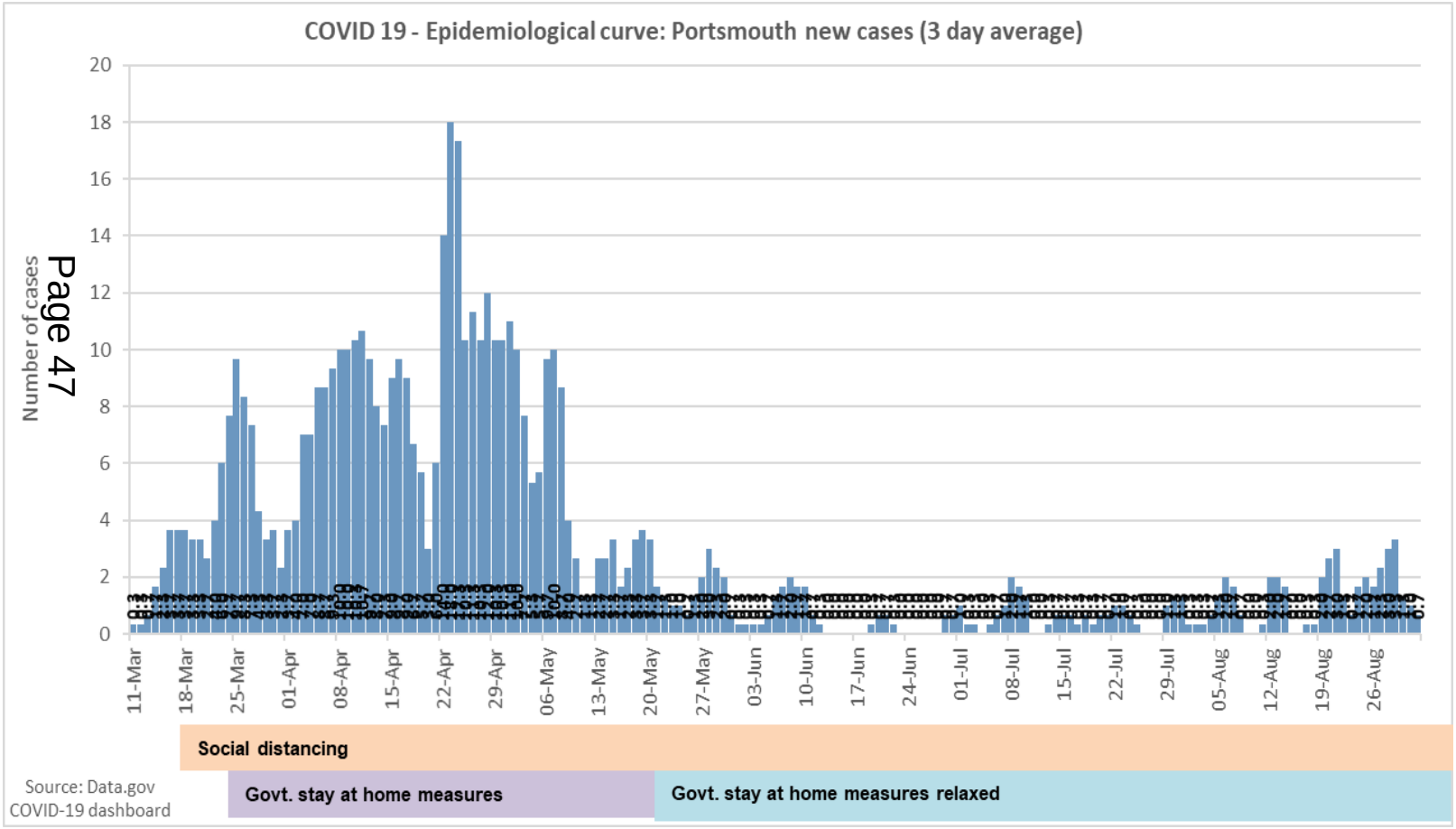
Data on confirmed cases is from https://coronavirus.data.gov.uk/, data as of 03.09.20 and population data is from ONS (mid year estimates 2018).

Case numbers are subject to revisions, especially most recent numbers.

Isle of Wight has implemented track and trace from 07/05.

1.2 Infections

Epidemiological curve: Portsmouth new cases (3 day average), Pillar 1 and Pillar 2 tests



There have been 16 new infections in Portsmouth recorded (Pillar 1 and Pillar 2) in the past week. 558 total pillar 1 and pillar 2 positive test cases.

The number of new infections peaked on 22nd April.

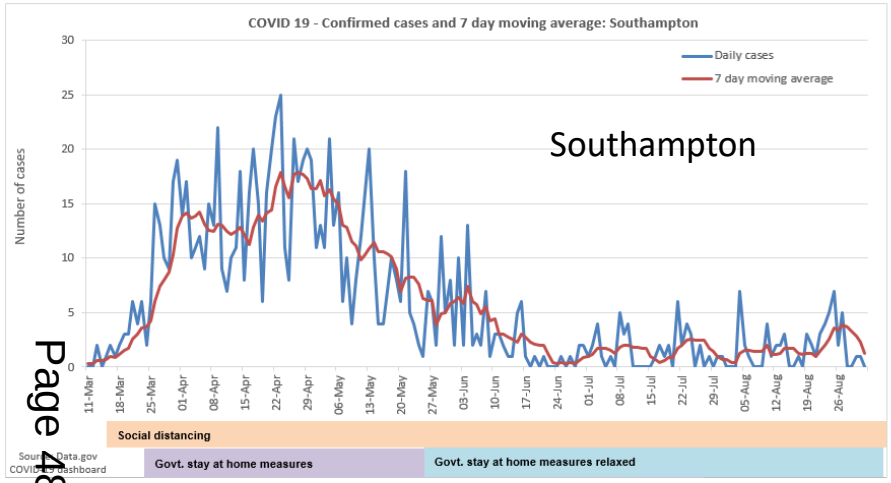
The chart shows the epidemiological curve of new cases (3 day average) in the area that is selected from the dropdown.

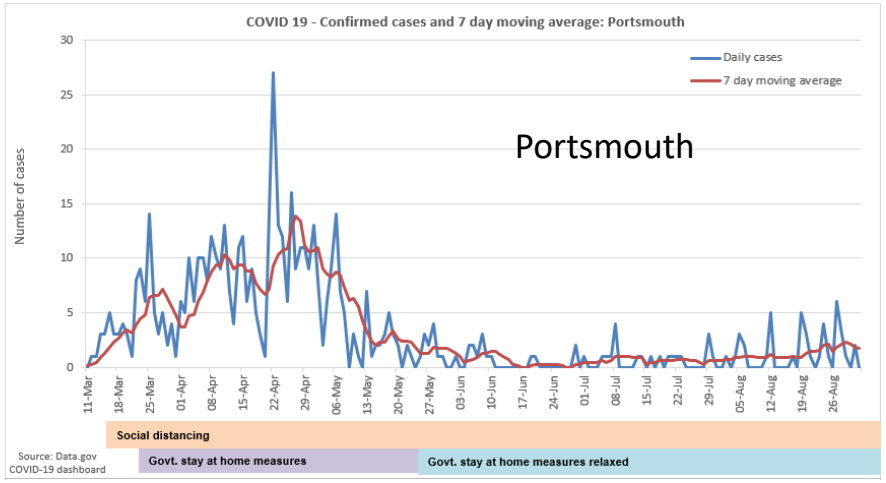
Data is from https://coronavirus.data.gov.uk/, data as of 03.09.20

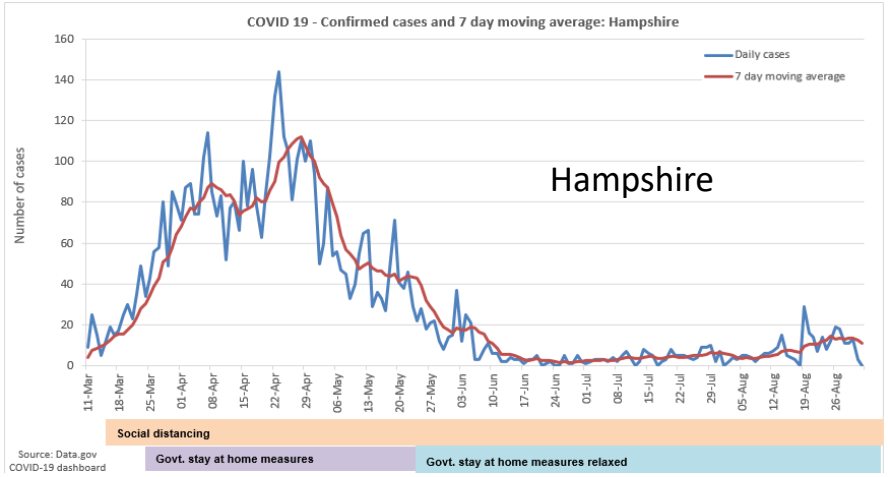
Case numbers are subject to revisions, especially most recent numbers.

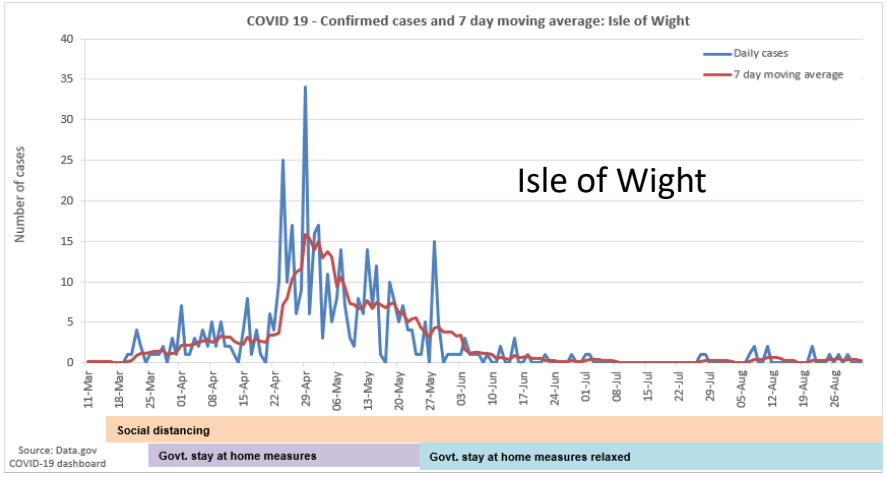
Publically available data.

1.3 Infections – spark lines for HIOW UTLAs









Portsmouth:
- 558 total cases
- 16 new cases in last 7 days

Southampton
- 1,022 total cases
- 7 new cases in last 7 days

Isle of Wight:
- 433 total cases
- 2 new cases in last 7 days

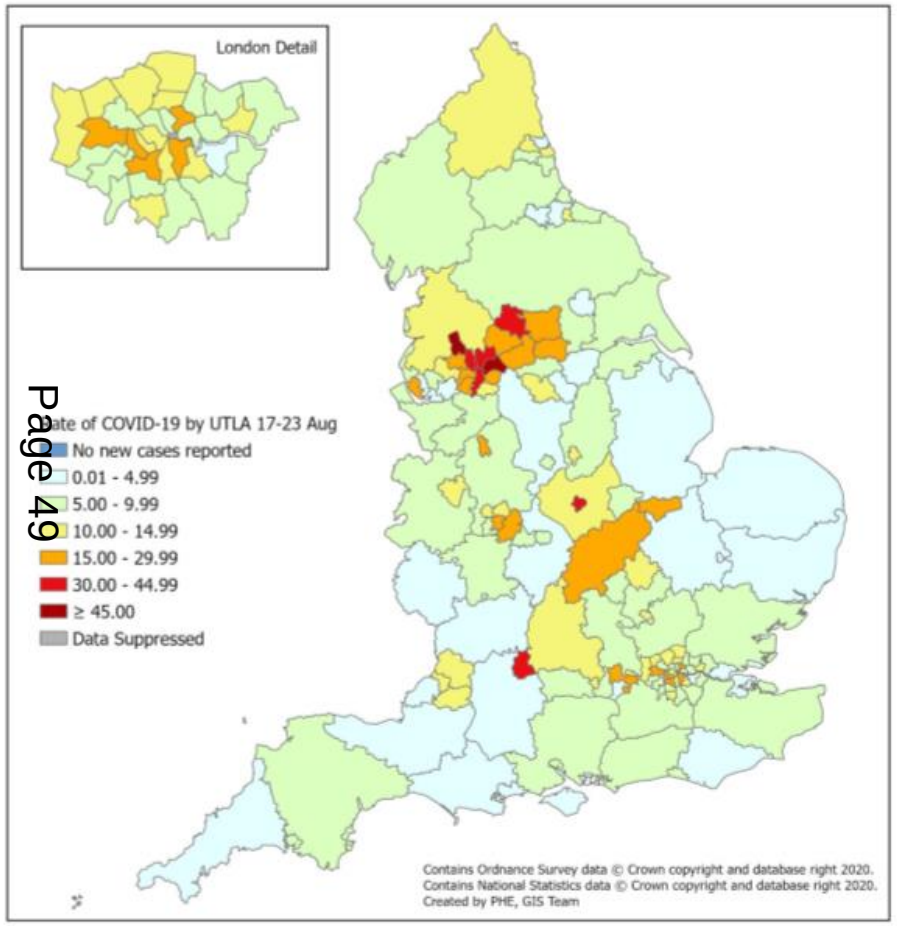
Hampshire
- 5,394 total cases
- 65 new cases in last 7 days

The chart shows the epidemiological curve of new cases (daily and 7 day average) for the Upper Tier Local Authorities in HIOW

Data is from https://coronavirus.data.gov.uk/, data as of 03.09.20

Case numbers are subject to revisions, especially most recent numbers.

1.4 Weekly rates of Covid-19 cases



Weekly rate of COVID-19 cases per 100,000 population tested under Pillar 1 and 2, by upper-tier local authority, England
(box shows enlarged maps of London area).

Based on week 34 (data between 17 and 23 August 2020).

UTLA name	Rate per 100,000 last 7 days
Isle of Wight	1.4
Hampshire	6.5
Portsmouth	**7.0**
Southampton	10.3
Swindon	38.3*
Leicester	42.2*
Blackburn	50.4*
Oldham	52.6*
South East	**7.4**
England	**12.8**

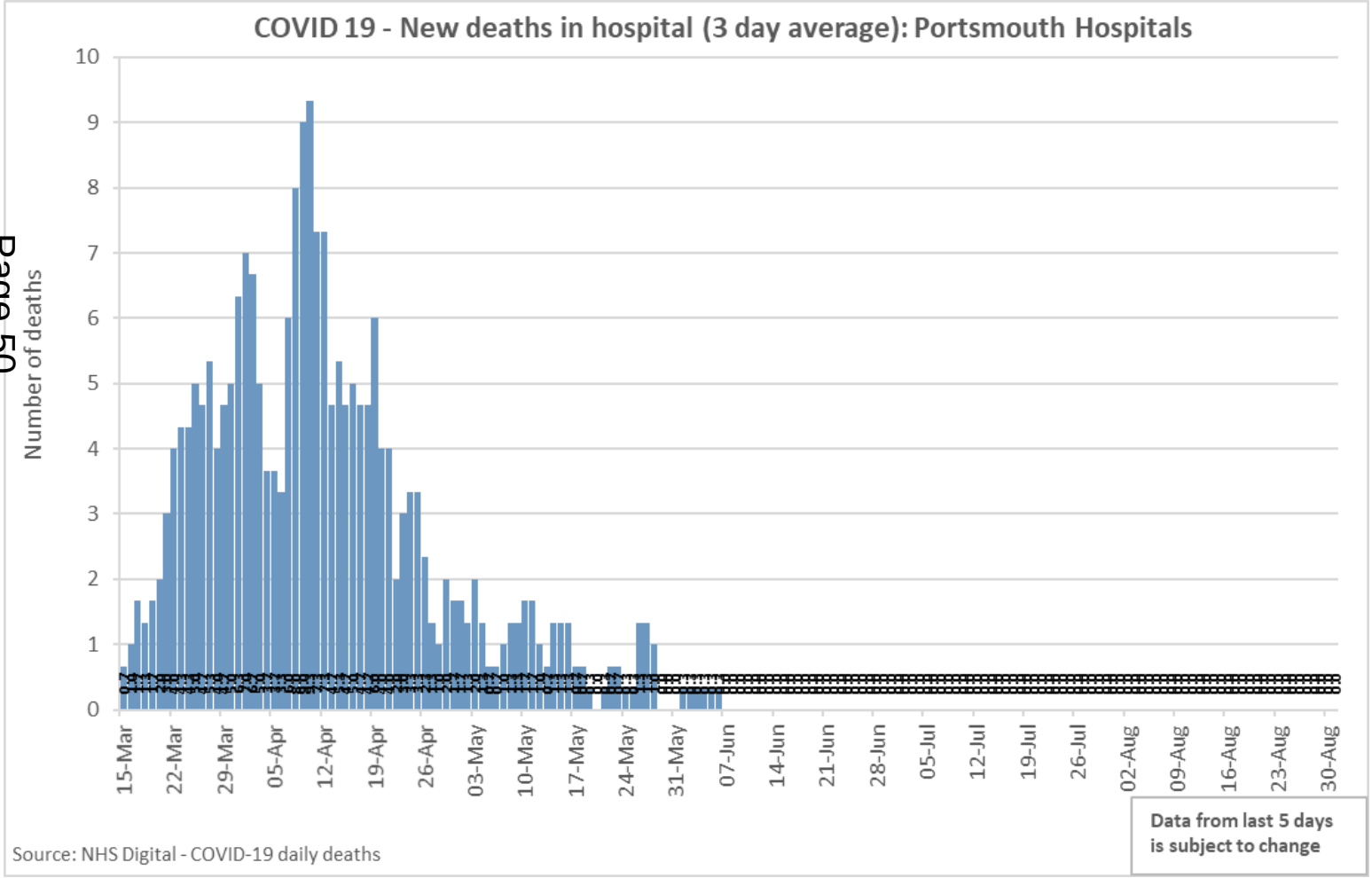
Weekly rate of COVID-19 cases per 100,000 population tested under Pillar 1 and 2, by UTLA, England, 22 Aug – 28 Aug (South East Daily Surveillance Report)

National reports available weekly at:
https://www.gov.uk/government/publications/national-covid-19-surveillance-reports

*Based on week 34 (data between 17 and 23 August 2020).

2.1 Deaths

New deaths in Hospital (3 day average): Portsmouth Hospitals



There have been 0 Covid-19 related deaths recorded at QA Hospital since the first week of June.

The number of Covid-19 related deaths at QA Hospital peaked on 11th April.

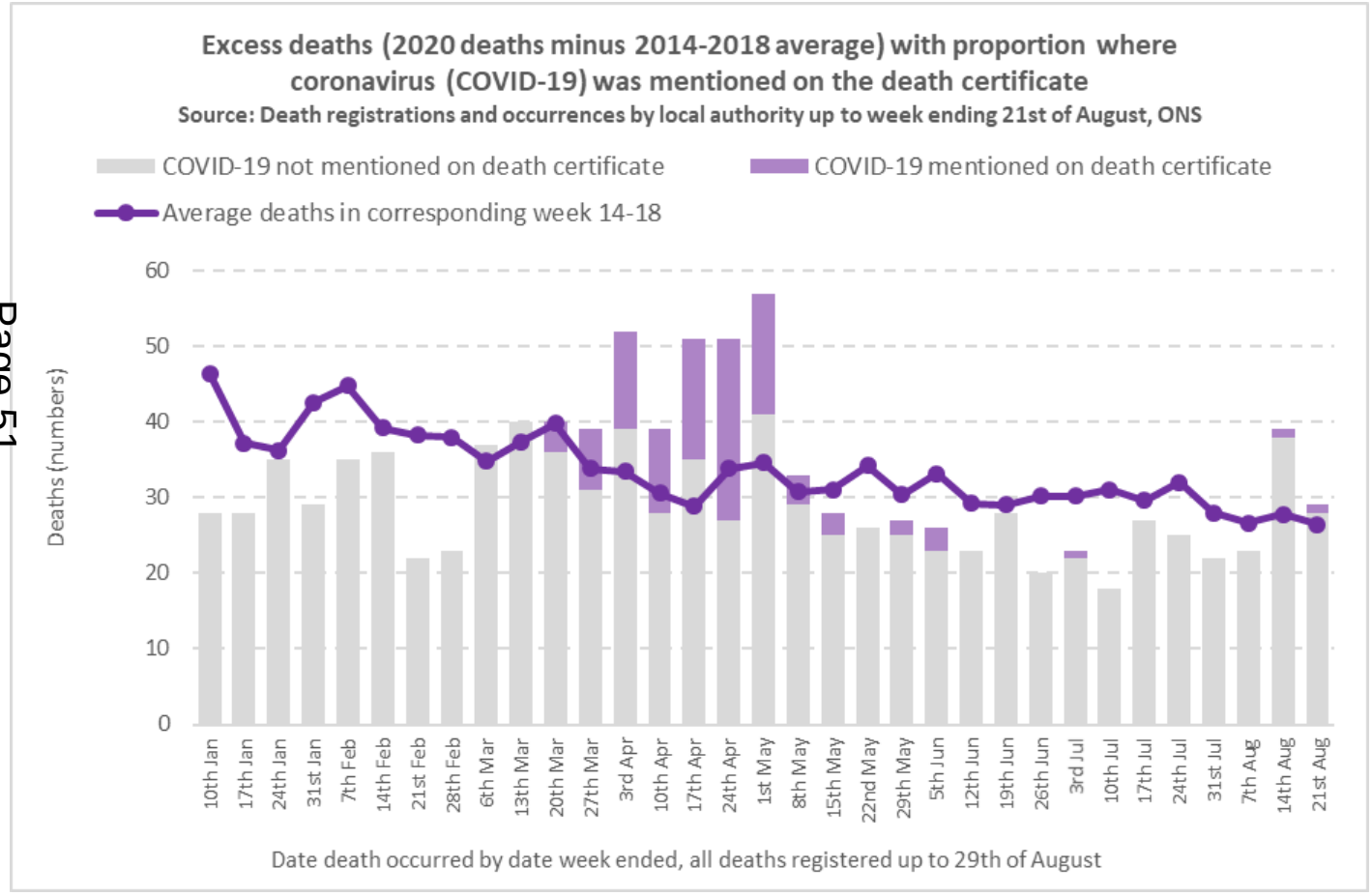
The chart shows the number of new deaths (3 day average) from COVID-19 at the trust selected from the dropdown - note this is not just exclusive to residents, but any patient who has died at hospital and had tested positive for COVID-19 at the time of death.

COVID-19 deaths that occur in the community or care home are not included in this figure. Totals by day are based on date of death.

Data is from NHS England COVID-19 daily deaths. Figures are subject to revisions, particularly for the most recent data, as more post-mortem tests are processed and data from them are validated.

2.2 Deaths

Excess deaths (2020 deaths minus 2014-2018 average) with proportion where coronavirus (COVID-19) was mentioned on the death certificate



The total number of deaths each week in Portsmouth was higher than in an average week for 5 weeks from the end of March to early May.

These excess deaths were mostly Covid-19 related.

Since week ending 15th May deaths have been below what was seen in previous years.

The chart shows the number of deaths by week of occurrence for the selected geography.

The number of deaths where COVID-19 was not mentioned on the death certificate are shown in pale grey.

The number of deaths where COVID-19 was mentioned on the death certificate are overlaid in purple.

The total number of deaths is shown by the total height of the bar.

The average number of deaths for the corresponding week of the relevant years are displayed as a dark purple line.

Numbers are subject to revisions, especially most recent numbers.

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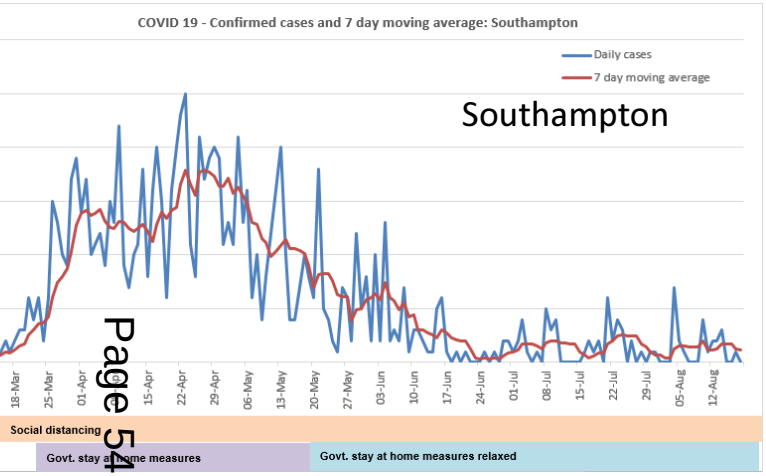
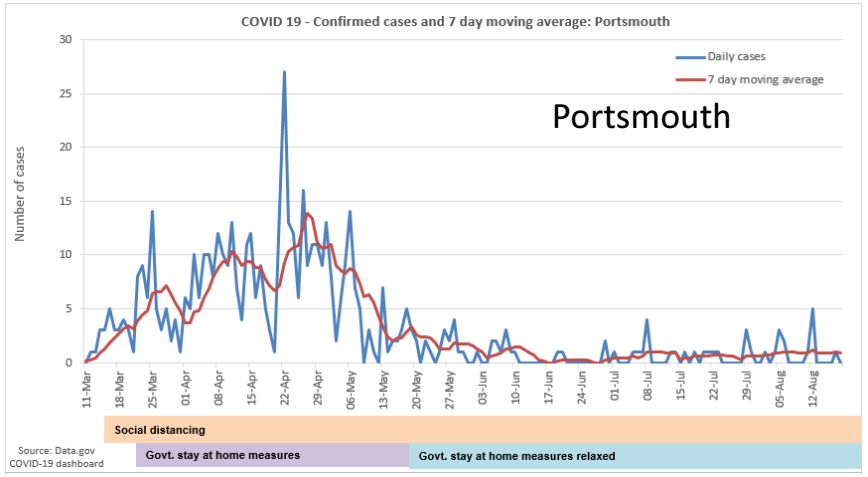
HIOW Recovery Picture

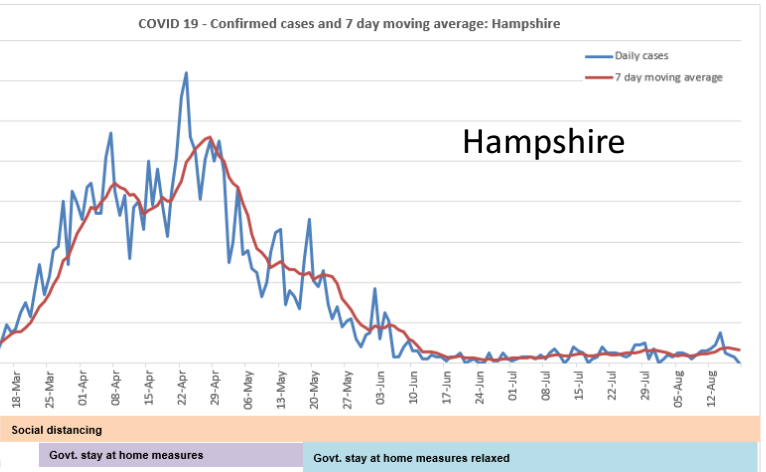
Modelling Update, Policy Analysis & Recovery Timeline

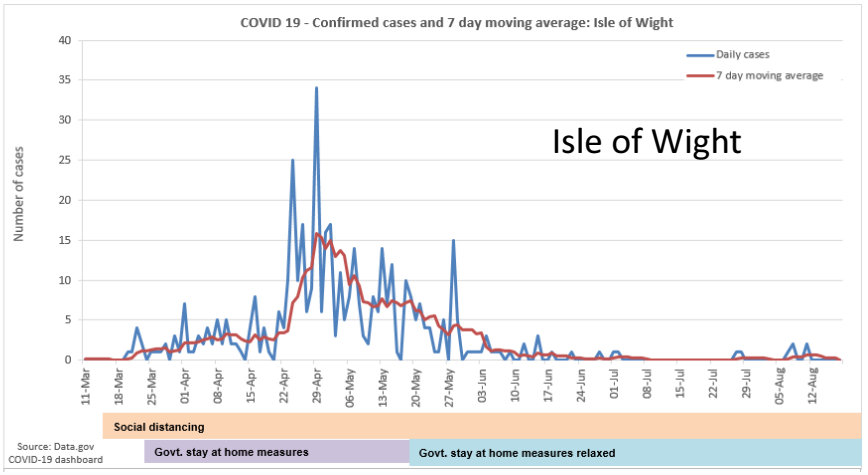
BEST ESTIMATES AS OF 26 AUGUST 2020

1.3 Infections – spark lines for HIOW UTLAs









Growth rate in South East:
-4% - 0%
Estimated Rt for South East:
0.8 – 1.0

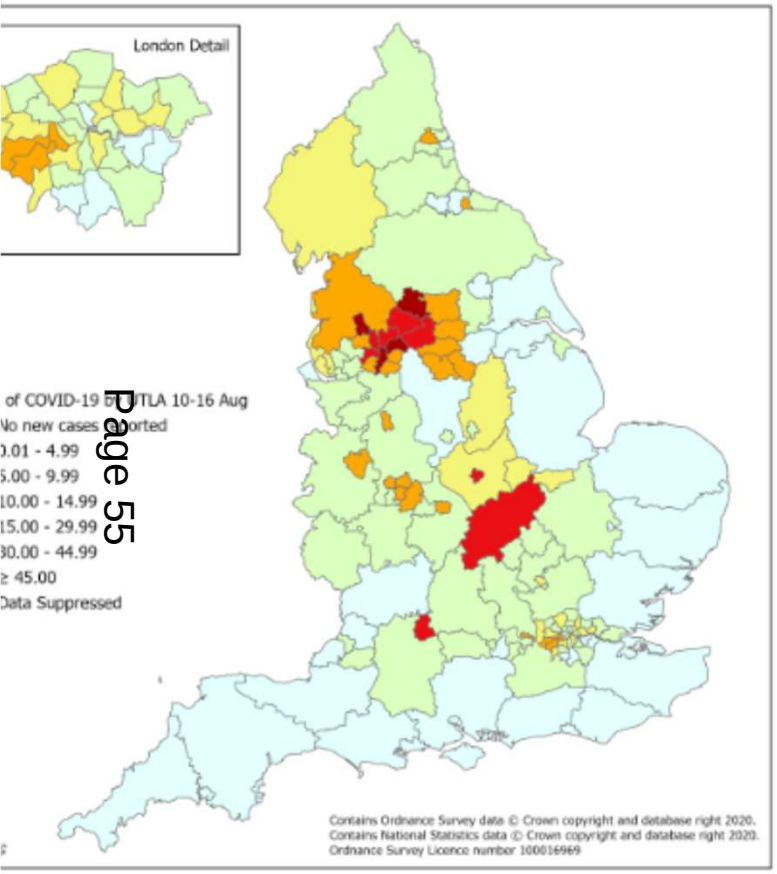
All 4 HIOW authorities remain low in terms of new cases: **70 new cases in last 7 days acros HIOW** (23.08.20)

The early warning dashboard (29/08/20) shows**:**

- ✓ Low numbers of new infections and hospital admissions
- ✓ Community-based respiratory indicators, NH Pathways and GP activity overall decreased or remained stable

Hampshire and the I
Local Resilience For

1.4 Weekly rates of Covid-19 cases



kly rate of COVID-19 cases per 100,000 population tested under
1 and 2, by upper-tier local authority, England
shows enlarged maps of London area).

d on week 33 (data between 10 and 16 August 2020).

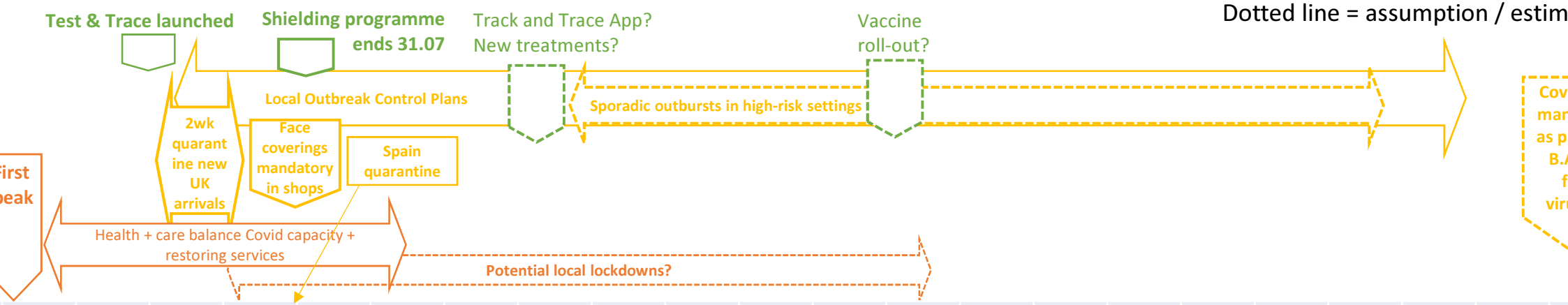
UTLA name	Rate per 100,000 last 7 days
Isle of Wight	1.4
Portsmouth	**2.8**
Hampshire	3.7
Southampton	4.8
Swindon	42.3
Leicester	44.8
Blackburn	75.9
Oldham	83.2
South East	**5.4**
England	**12.2**

Weekly rate of COVID-19 cases per 100,000 population tested under Pillar 1 and 2, by UTLA, England, week 33 10 Aug – 16 Aug

National reports available weekly at:
https://www.gov.uk/government/publications/national-covid-19-surveillance-reports

IOW Recovery Timeline – updated 29.07.20

Solid line = known
Dotted line = assumption / estim



Page 56

One - 13.05.20
el to work if can't work from home
d Secure guidelines for work-places
nited exercise, garden centres open
1 person outdoors with social distancing,

Two - 01.06.20
sed school return
door markets + car showrooms
ural/sporting events behind closed doors
o 6 people can meet outside
lded patients can meet 1 person outside
Two part Two 15.06.20, including:
-essential retail from if Covid secure
coverings mandatory on public transport

o Three - 04.07.20
cial distancing: 1m+ where 2m not possible
spitality, Hotels and Places of Worship: can re-open with mitigations
cial contact: two households can meet non-exclusively
ort, leisure and culture: able to restart with mitigations
r bridges: open to some countries with low Covid rates

Step Three, part 2 – end July
- Gyms, pools and personal care: able to re-open with mitigations
- Outdoor theatre performances can go ahead

All pupils return to school

Furlough scheme extended to end October, tapering from August

Courts open with mitigations, huge case backlog

Moderate gatherings <50 with restrictions

Large gatherings >50 with restrictions

nightclubs and live indoor events, open with restriction?

Business events/conferences

Return to normal business rate relief

Elections resume, distancing / postal votes encouraged

Job retention bonus

5% VAT for tourism and hospitality

No stamp duty of first £500k, Green Homes grants

Kickstarter jobs scheme

National Recovery picture (England)

1. Near-completion of exit from national lockdown
2. Bumps in road: quarantine, A Levels, intra-UK differences
3. GDP starting to bounce back
4. Return to school marks a critical new phase
5. Exhortation to return to the office
6. Furlough/Eat Out schemes winding down
7. Organisational reform: PHE, Devolution White Paper
8. Wave 2/Brexit planning
9. Local outbreak management/no return to national lockdown
10. Where does it leave us?

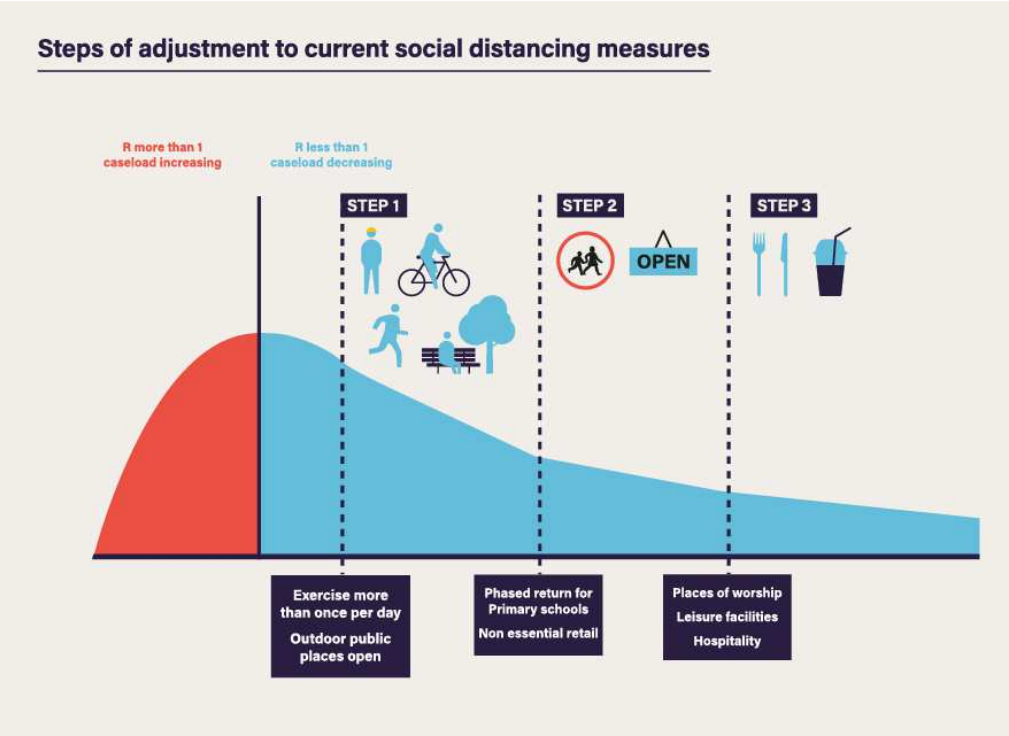
1. National lockdown: planned

Our plan to rebuild: The UK Government's COVID-19 recovery strategy' initially laid in Parliament 11 May 2020

- Step 1 (13 May) – easing of measures for outdoor exercise
- Step 2 (1 June) – reopening of non essential retail
- Step 3 (4 July) – reopening of hospitality

'Next chapter' presented to Parliament July 2020

- 1 August (delayed to 15 August) – reopening of leisure settings and enabling close contact services to resume
- 1 August – End of shielding
- 1 September – full time return to schools, nurseries and colleges for all children. Schools in Leicestershire returned on Weds 26 August.
- 1 October – bring back audiences in stadiums, and allow conferences and other business events



1. National lockdown: now

- Roadmap substantially complete
- Night clubs/similar still closed
- Still no gatherings over 30
- Still only two households indoors
- Step-by-step return for sport, theatre, leisure etc
- Local lockdowns, varying in scope and duration

1. National lockdown: endgame

"If prevalence remains around or below current levels into the autumn, we will bring back audiences in stadia, and allow conferences and other business events to recommence in a COVID-19 Secure way, from 1 October. This step will only take place once we have a reliable scientific understanding of the impact of reopening schools on the epidemic.

If prevalence falls very significantly, we will review the necessity for the outstanding measures and allow a more significant return to normality. This would start with removing the need to distance people, while retaining limited mitigations like face coverings and plastic screens in shops. Our ambition is that this may be possible by November at the earliest, however this would be contingent on a number of factors, including consideration of the specific challenges as we move into winter, as described above."

(Published in July)

HM Government

2. Bumps in the road

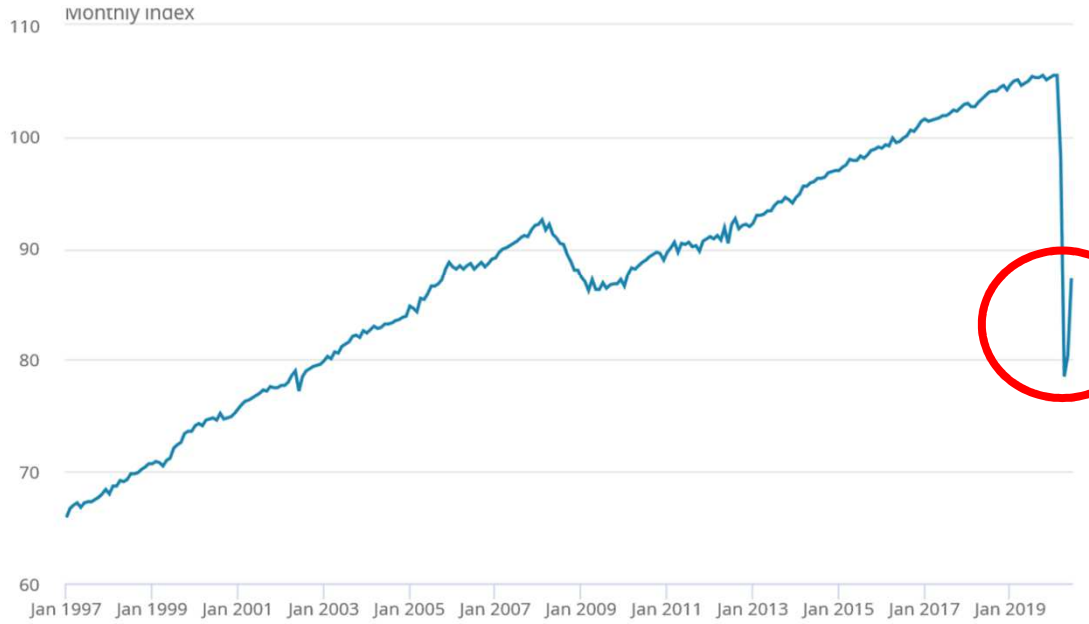
- Quarantine list changed at short notice: France, Croatia…
- Exam results policy change
- Different choices in Scotland, Wales, NI eg face coverings in secondary school
- Widespread disruption and confusion – but no good options
- “Led by the science/data/algorithm” not always enough

3. GDP ticking up again

- GDP growth:
  - -20% in April
  - +2.4% in June
  - +8.7% in June (9.2% in HIOW)
- Still 17% below February
- …but HIOW retail sales in July were 3% higher than February

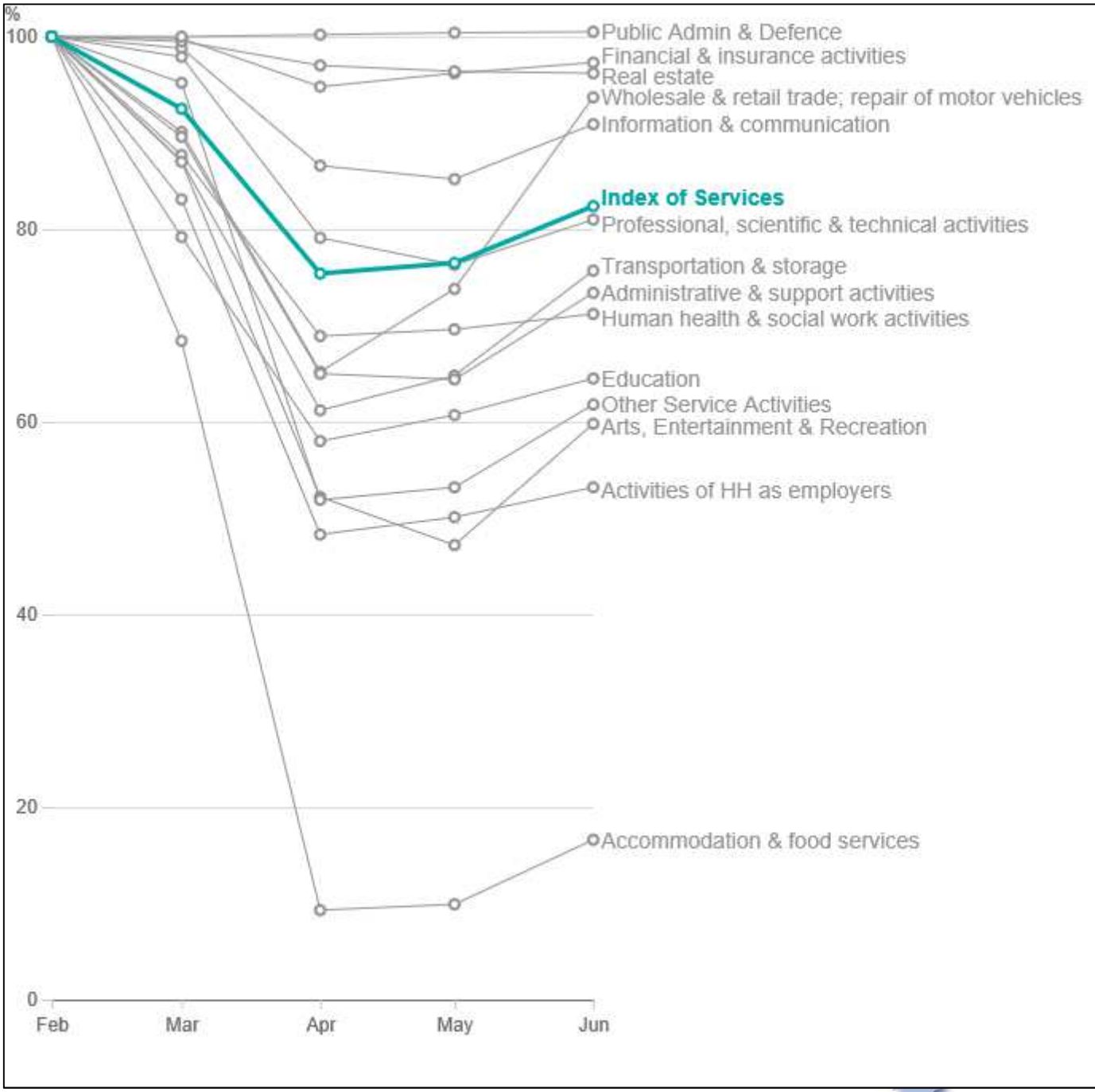
Figure 2: GDP grew by 8.7% in June 2020, but is still well below the levels seen in February 2020

Monthly index, January 1997 until June 2020



Source: Office for National Statistics – GDP monthly estimate

3. Uneven impact across economy



4. Return to school

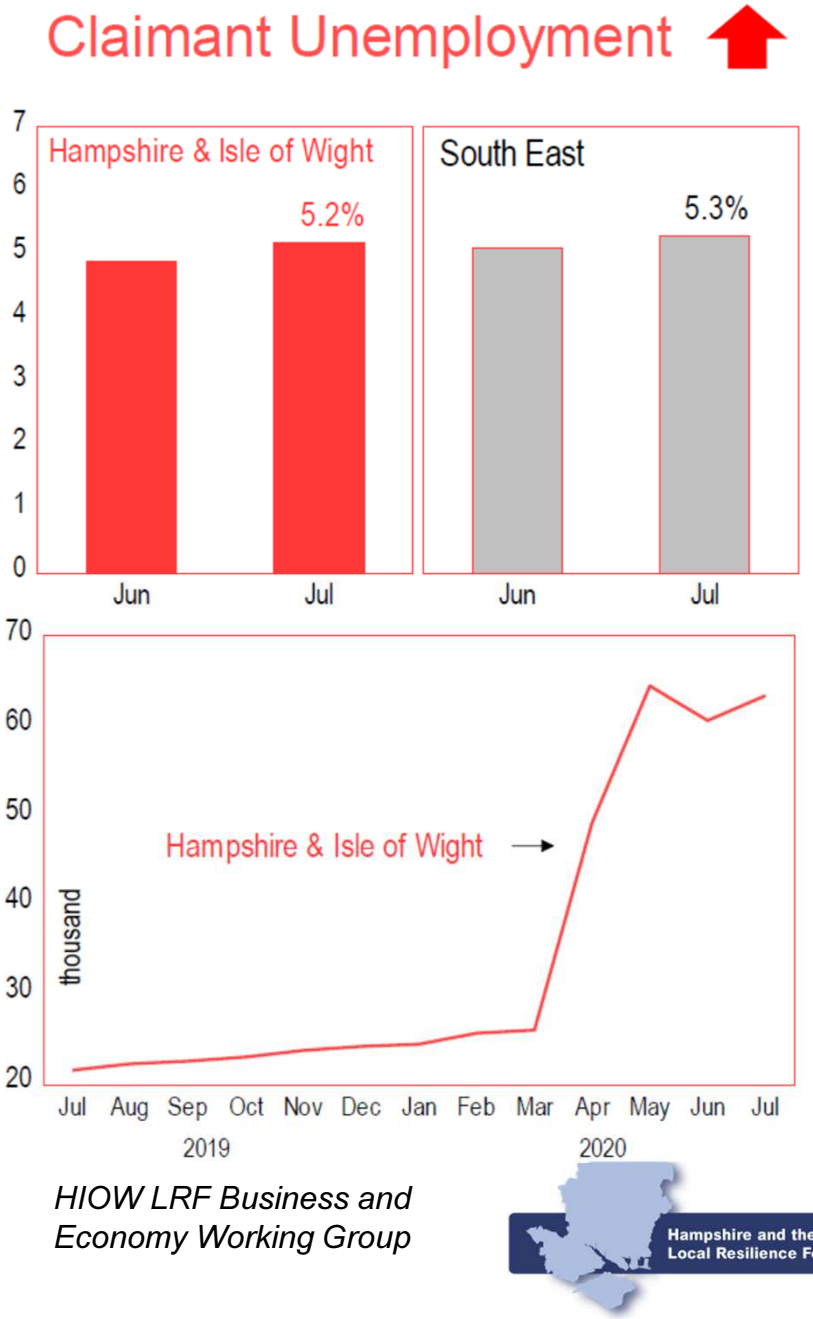
- The biggest test yet?
- Strongly supported by the Chief Medical Officer
- Impact:
  - Children's education and health
  - Particularly those going into Years 11 and 13
  - Teachers' safety
  - Working parents' ability to return to the office
  - Traffic and transport
- Failure will not be an option

5. Return to the office

- Visible impact on city centres as many people continue to work from home
- Unintended by-product of “work from home” and “avoid public transport” edicts
- Exhortation rather than legislation
- Home working is quite popular and employers can’t won’t enforce a return…potential Covid legacy?
- Opportunity for local action?

6. End of furlough etc.

- Job protection schemes end on 31 Oct
  - Govt will cover only 60% in October
- ~10m jobs claimed across UK as at 16/8
  - 5-6m still on furlough
  - 350,000 in HIOW (37% of total)
  - National cost £35.4bn
- Chancellor has said no extension
  - Potential for limited extension of furlough for certain sectors?
- OBR 2020 unemployment forecast: 8.8%
  - Rising to 10.1% in 2021
- Eat Out scheme: 35m meals as at 20/8
  - National cost £180m (~£5 per meal)



HIOW LRF Business and Economy Working Group

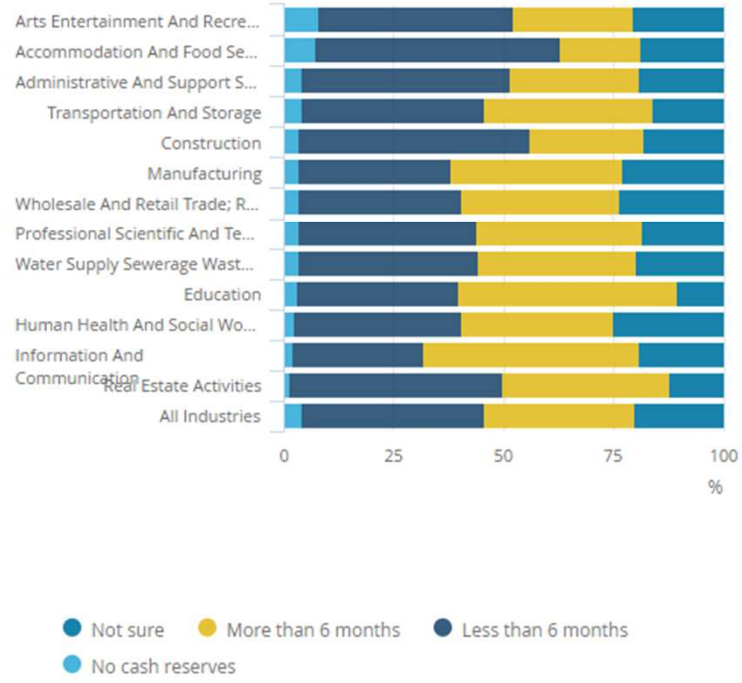
6. End of furlough: what next

What next for the economy?

- Building resilience (winter, local lockdowns, Brexit)
- Potential displacement of jobs and businesses
- Skills gaps as people are displaced across industries
- Responding to the ‘new’ consumer
  - Latte to the home?

Figure 11: The accommodation and food service activities sector had the highest percentage of businesses reporting they had no or less than six months’ cash reserves at 63%

Cash reserves, businesses that have not permanently stopped trading, broken down by industry, UK, 13 to 26 July 2020



ONS

6. End of furlough: new consumers?

McKinsey US

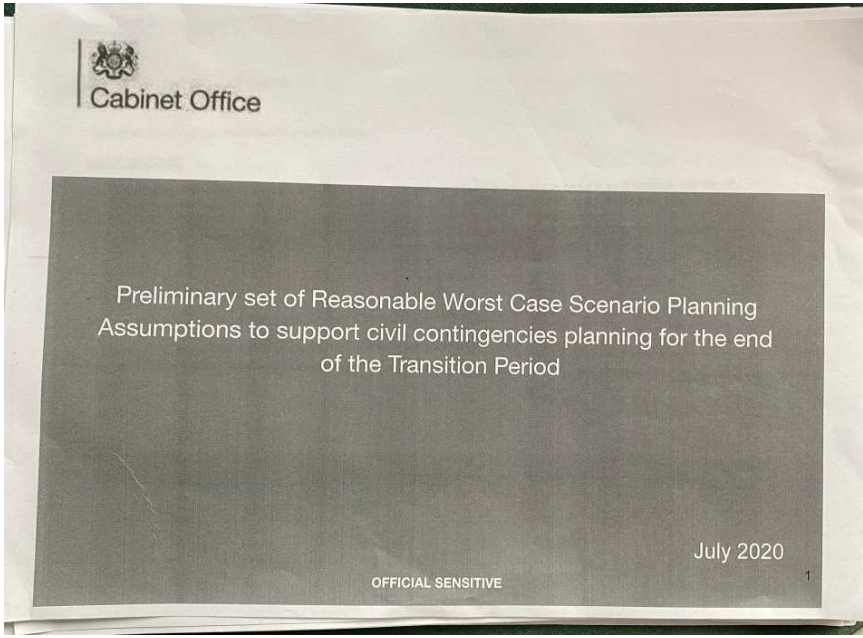
7. Organisational reform

- Government's recovery strategy confirms a "rapid re-engineering of government structures and institutions"
- Public Health England to merge into the National Institute for Health Protection
- Devolution White Paper in the autumn, likely to promote elected mayors and reorganisation of county/district councils
- Devolution package to include elements of pandemic response?
- The wrong time…or the perfect time?

Daily Mail

8. Wave 2/Brexit planning

- Timing of Wave 2, no-deal Brexit and annual flu pressures could all coincide
- UK/EU trade deal talks not progressing well; transition period ends 31 December
- Leaked document reveals reasonable worst case scenario:
  - Restrictions on trade in a no deal scenario alongside Covid-19, flu and floods could overwhelm NHS
  - Significant traffic queues at Dover and 45% reduction in cross-channel flow
  - Shortages of petrol, potential water rationing and power cuts
  - Shortages of food and medicine because of blocked channel crossings, leading to outbreak of animal diseases
  - Likely coordinated industrial action
  - Public disorder
  - One in 20 councils could become bankrupt, impacting social care


Cabinet Office

Preliminary set of Reasonable Worst Case Scenario Planning Assumptions to support civil contingencies planning for the end of the Transition Period

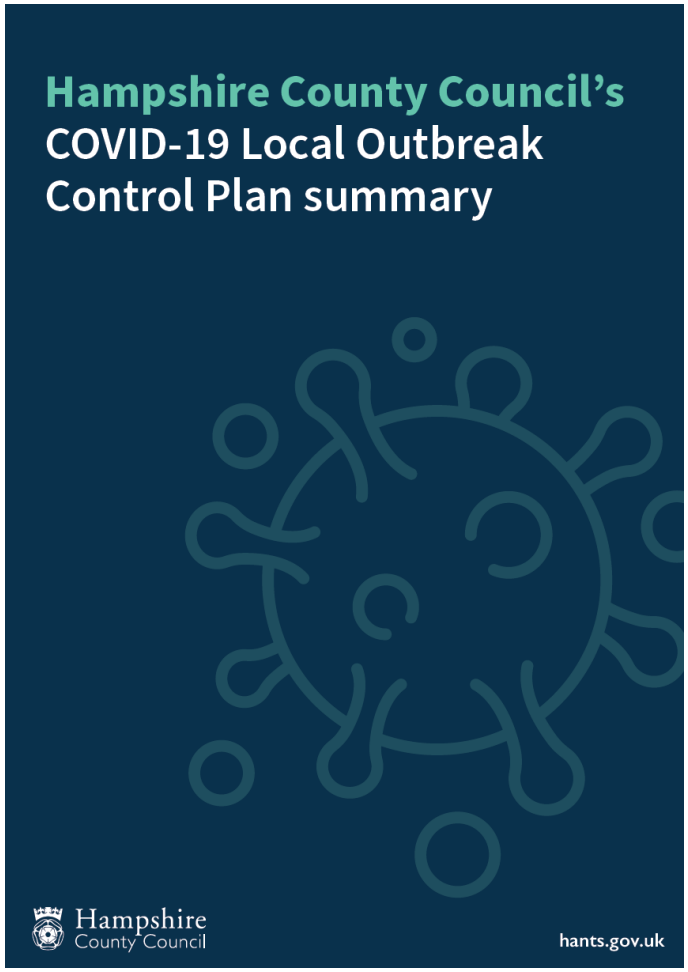
July 2020

OFFICIAL SENSITIVE

1

9. Local outbreak management

- Crystal clear strategy: no return to national lockdown, outbreaks to be managed locally
  - Leicester and Aberdeen now being eased out of lockdown
  - Others eg Birmingham at risk
- Contact tracing returned to councils
- Further powers being considered to allow wider powers to impose restrictions on leaving home, overnight stays, gatherings, travel and businesses
- Likely to carry on around the country for the life of the pandemic



10. Where does it leave us in HIOW?

Some thoughts…

1. Responsible for local outbreak management
2. Supporting return to school
3. Some scope to influence local economic recovery, return to offices, transport, high street
4. Critical to continue to work together on Wave 2/Brexit while navigating organisational reform
5. Community leadership and support during a difficult/uncertain time

Portsmouth Covid-19 Intelligence Summary

04.09.20

Overview

1. Infections
   - Case Rate per 100,000 population: HIOW Local Authorities and comparators
   - Epidemiological curve: Portsmouth new cases (3 day average)
   - HIOW infections by UTLA (spark lines)
   - Weekly rates per 100,000

2. Deaths
   - New deaths in Hospital (3 day overage): Portsmouth Hospitals
   - Extra deaths occurring in 2020 in Portsmouth (LA) compared to average of corresponding week by week of death

Please read – important caveats

This presentation includes data derived from a dashboard owned by the Hampshire & Isle of Wight LRF for the purpose of emergency planning and response, and data made available to local Directors of Public Health that is not in the public domain.

The dashboard is marked ***official sensitive*** and has been developed for the purpose of planning and responding to CoVid19 in Hampshire and IOW (including the unitary authorities of Southampton and Portsmouth) known hereon as HIOW. Data and information in this product has been processed under the COVID-19 Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

https://www.gov.uk/government/publications/coronavirus-covid-19-notification-of-data-controllers-to-share-information?utm_source=d05aa30e-95d2-48e3-93e0-0a696c35bd3c&utm_medium=email&utm_campaign=govuk-notifications&utm_content=immediate

The information and data in this product should only be used, processed and shared for a Covid-19 Purpose and solely for that COVID-19 purpose. A Covid-19 Purpose includes but is not limited to the following:

> Understanding Covid-19 and risks to public health, trends in Covid-19 and such risks, and controlling and preventing the spread of Covid-19 and such risks;

> Monitoring and managing the response to Covid-19 by health and social care bodies and the Government including providing information to the public about Covid-19 and its effectiveness and information about capacity, medicines, equipment, supplies, services and the workforce within the health services and adult social care services;

> Identifying and understanding information about patients or potential patients with or at risk of Covid-19, information about incidents of patient exposure to Covid-19 and the management of patients with or at risk of Covid-19 including: locating, contacting, screening, flagging and monitoring such patients and collecting information about and providing services in relation to testing, diagnosis, self-isolation, fitness to work, treatment, medical and social interventions and recovery from Covid-19;

> Understanding information about patient access to health services and adult social care services and the need for wider care of patients and vulnerable groups as a direct or indirect result of Covid-19 and the availability and capacity of those services or that care;

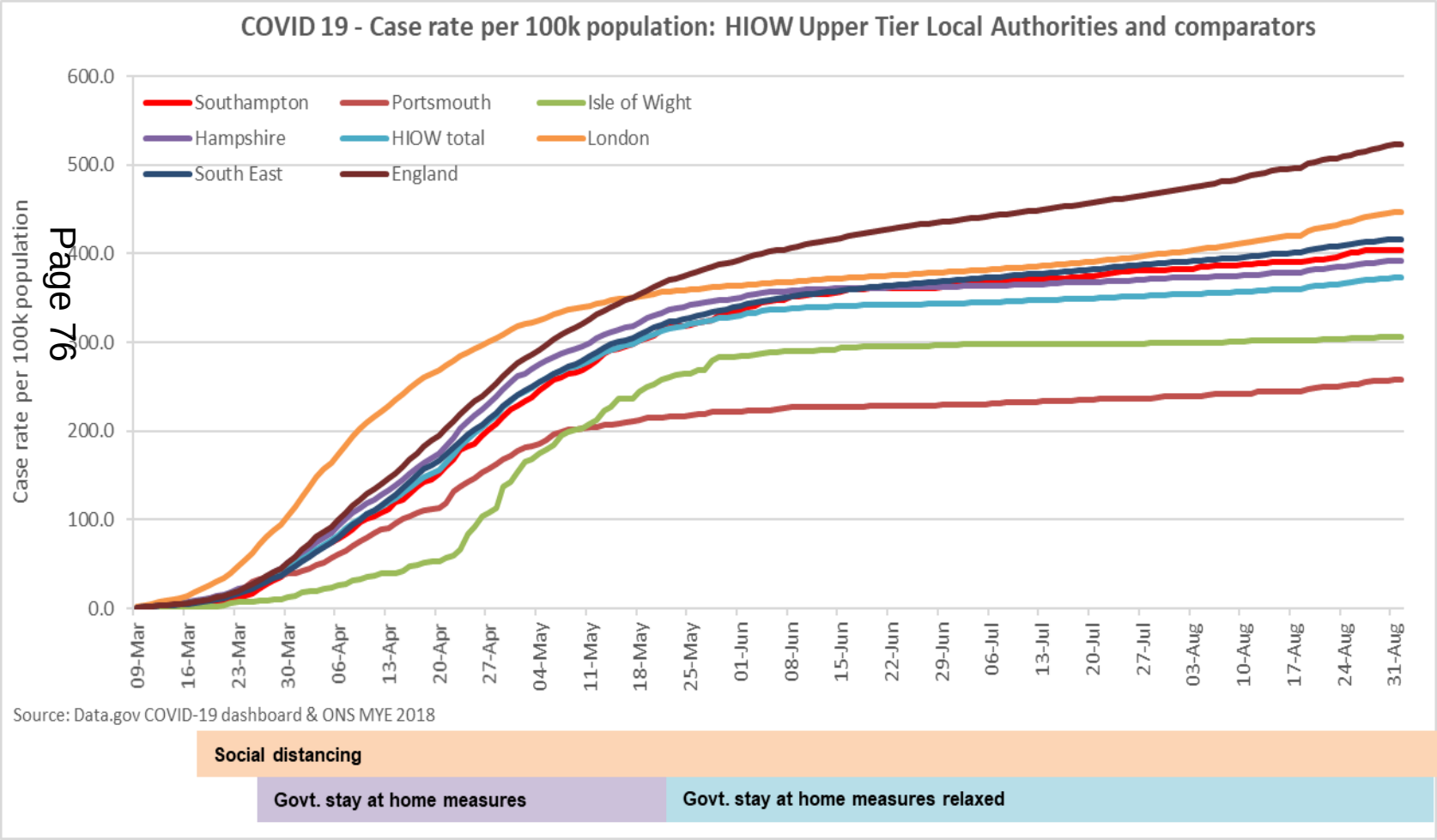
> Delivering services to patients, clinicians, the health services and adult social care services workforce and the public about and in connection with Covid-19, including the provision of information, fit notes and the provision of health care and adult social care services; and

> Research and planning in relation to Covid-19.

Advice should be sought from the appropriate Public Health team member before this information is shared into the public domain; it does not contain patient identifiable data, but it does contain sensitive information and data which requires explanation and contextualisation.

1.1 Infections

Case rate per 100,000 population: HIOW Local Authorities and comparators, Pillar 1 and Pillar 2 tests



The rate of infections in Portsmouth has plateaued since early June.

It remains below the rates for Southampton, Hampshire and England as a whole, and with inclusion of Pillar 2 tests is now below IOW too.

The chart shows the crude rate of confirmed cases (cumulative) per 10,000 population for HIOW Local Authorities and comparators.

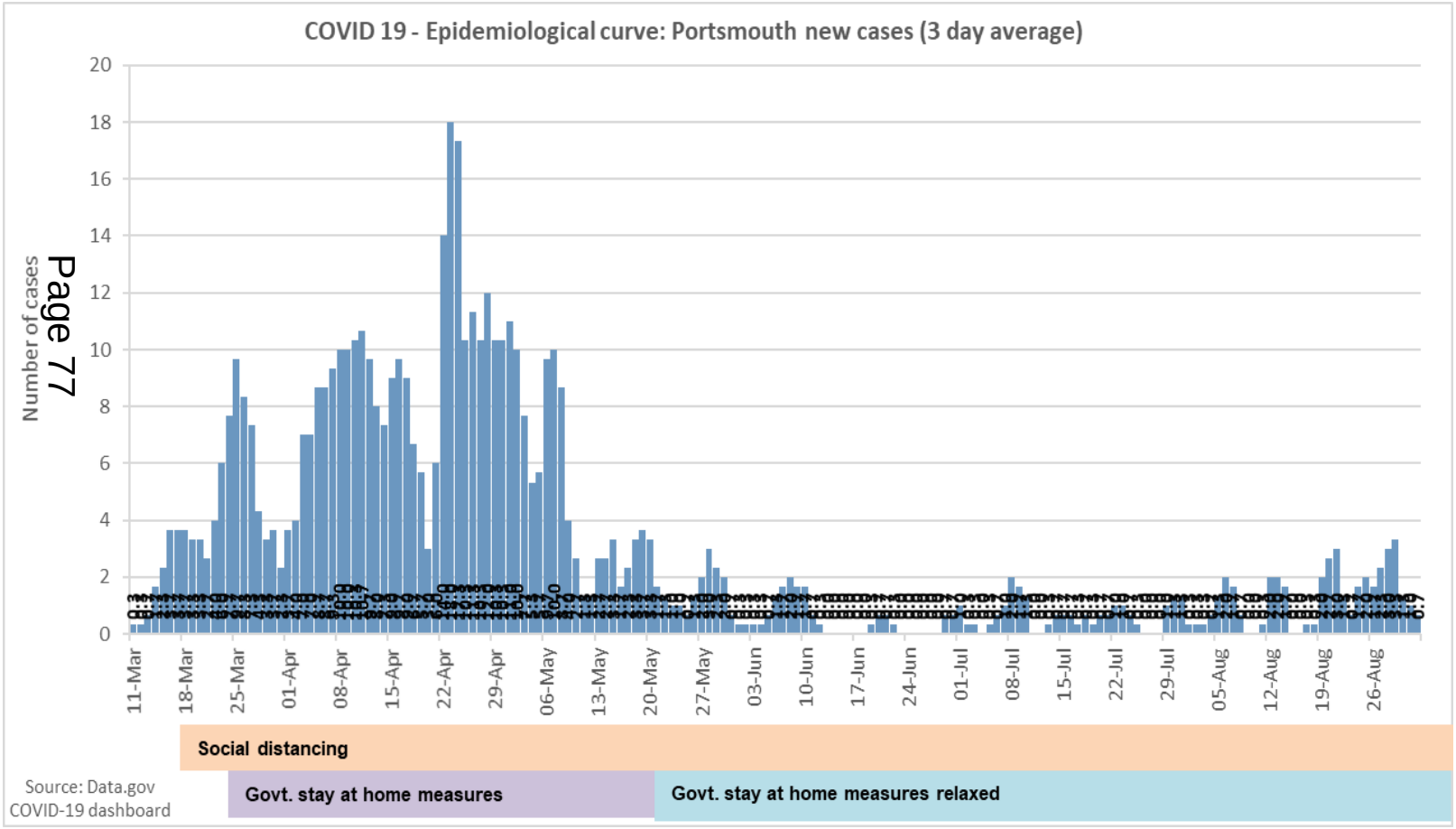
Data on confirmed cases is from https://coronavirus.data.gov.uk/, data as of 03.09.20 and population data is from ONS (mid year estimates 2018).

Case numbers are subject to revisions, especially most recent numbers.

Isle of Wight has implemented track and trace from 07/05.

1.2 Infections

Epidemiological curve: Portsmouth new cases (3 day average), Pillar 1 and Pillar 2 tests



There have been 16 new infections in Portsmouth recorded (Pillar 1 and Pillar 2) in the past week. 558 total pillar 1 and pillar 2 positive test cases.

The number of new infections peaked on 22nd April.

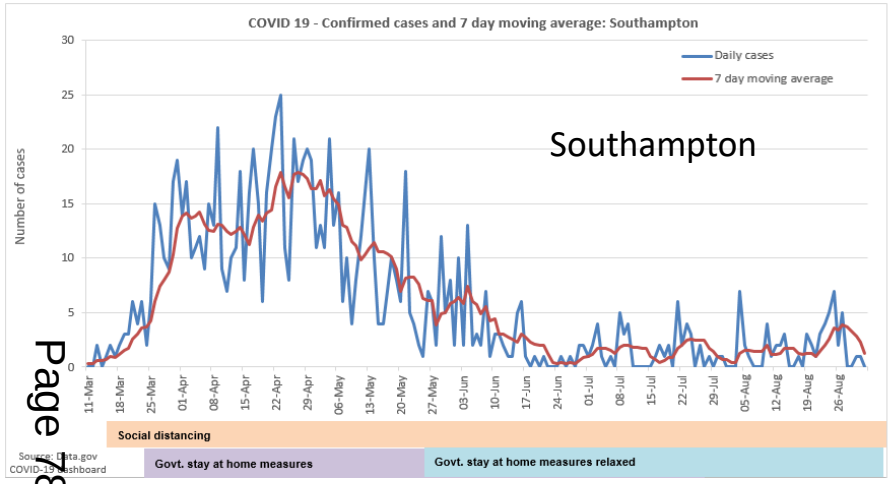
The chart shows the epidemiological curve of new cases (3 day average) in the area that is selected from the dropdown.

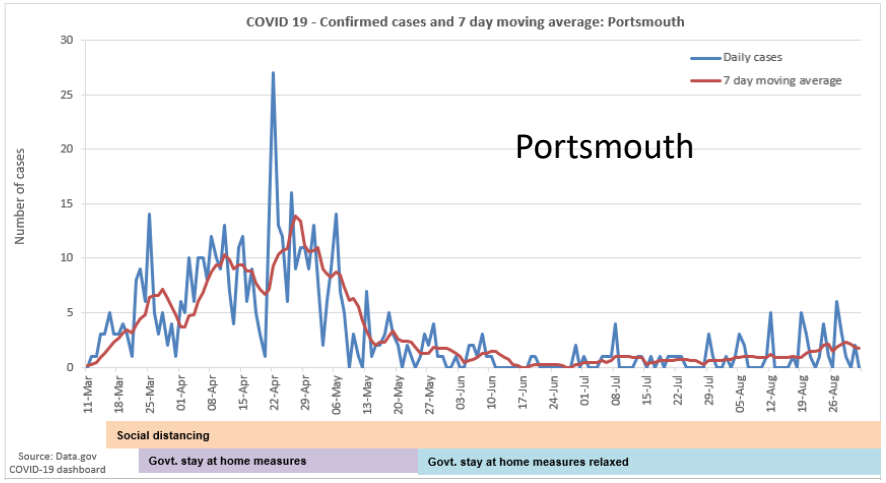
Data is from https://coronavirus.data.gov.uk/, data as of 03.09.20

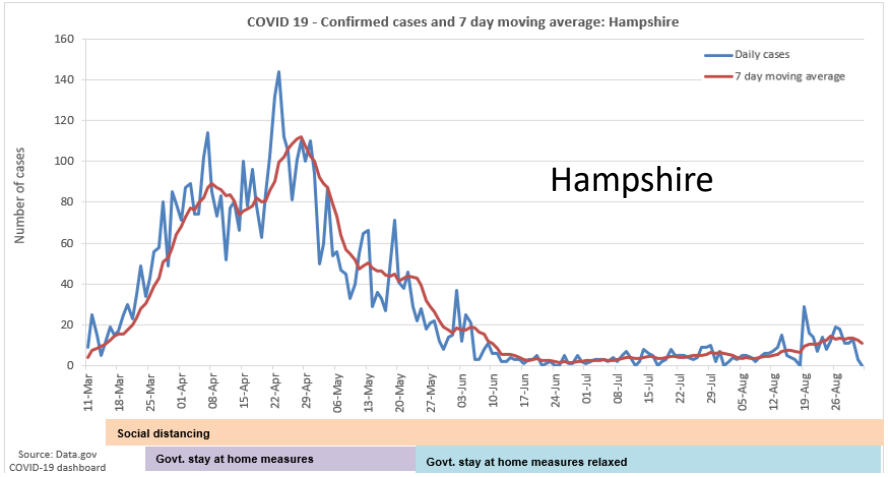
Case numbers are subject to revisions, especially most recent numbers.

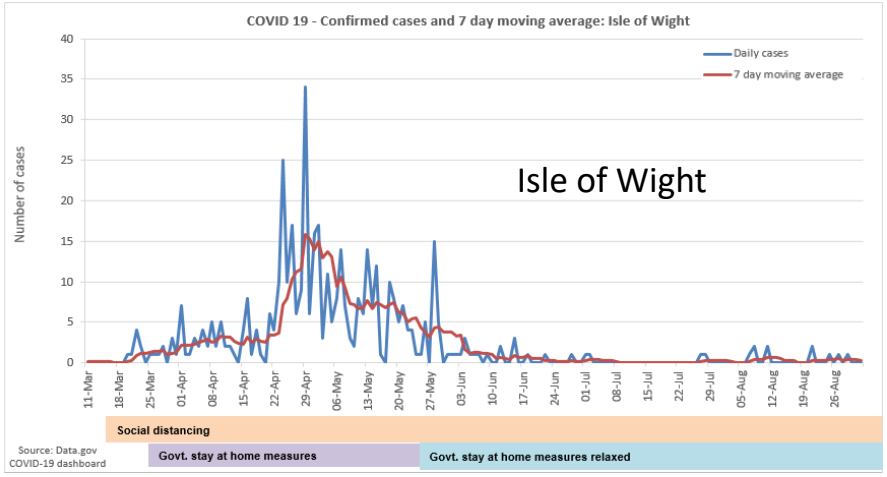
Publically available data.

1.3 Infections – spark lines for HIOW UTLAs









Portsmouth:
- 558 total cases
- 16 new cases in last 7 days

Southampton
- 1,022 total cases
- 7 new cases in last 7 days

Isle of Wight:
- 433 total cases
- 2 new cases in last 7 days

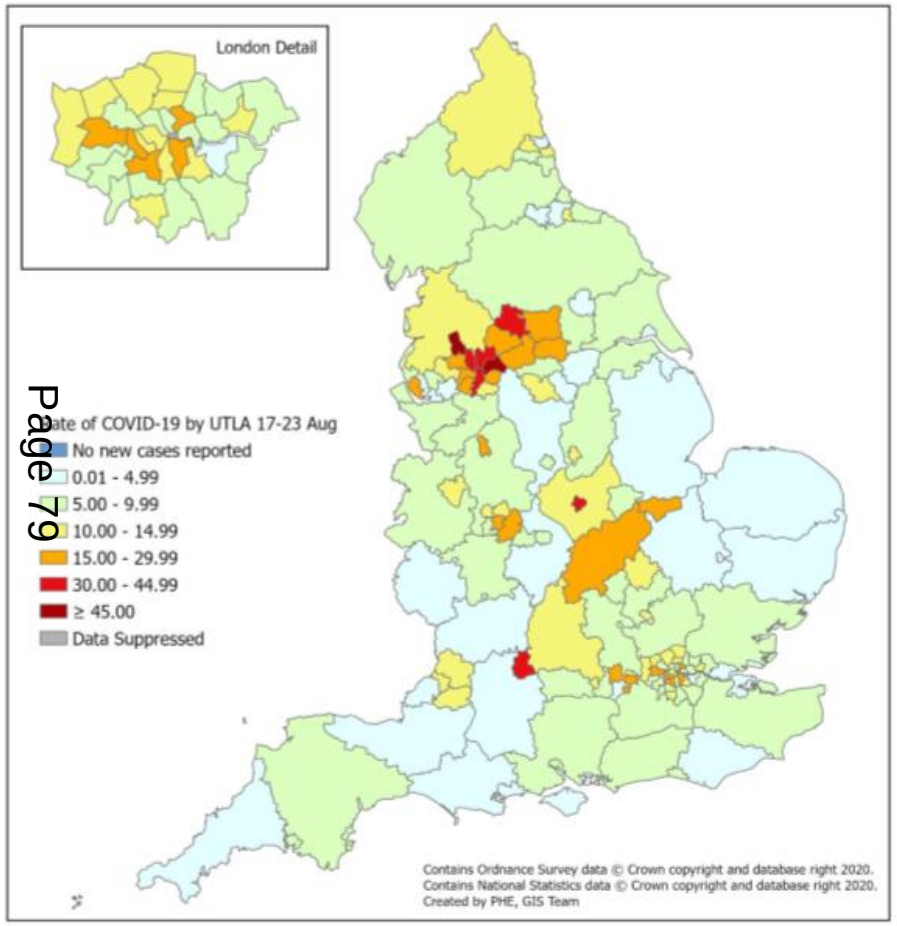
Hampshire
- 5,394 total cases
- 65 new cases in last 7 days

The chart shows the epidemiological curve of new cases (daily and 7 day average) for the Upper Tier Local Authorities in HIOW

Data is from https://coronavirus.data.gov.uk/, data as of 03.09.20

Case numbers are subject to revisions, especially most recent numbers.

1.4 Weekly rates of Covid-19 cases



Weekly rate of COVID-19 cases per 100,000 population tested under Pillar 1 and 2, by upper-tier local authority, England
(box shows enlarged maps of London area).

Based on week 34 (data between 17 and 23 August 2020).

UTLA name	Rate per 100,000 last 7 days
Isle of Wight	1.4
Hampshire	6.5
Portsmouth	**7.0**
Southampton	10.3
Swindon	38.3*
Leicester	42.2*
Blackburn	50.4*
Oldham	52.6*
South East	**7.4**
England	**12.8**

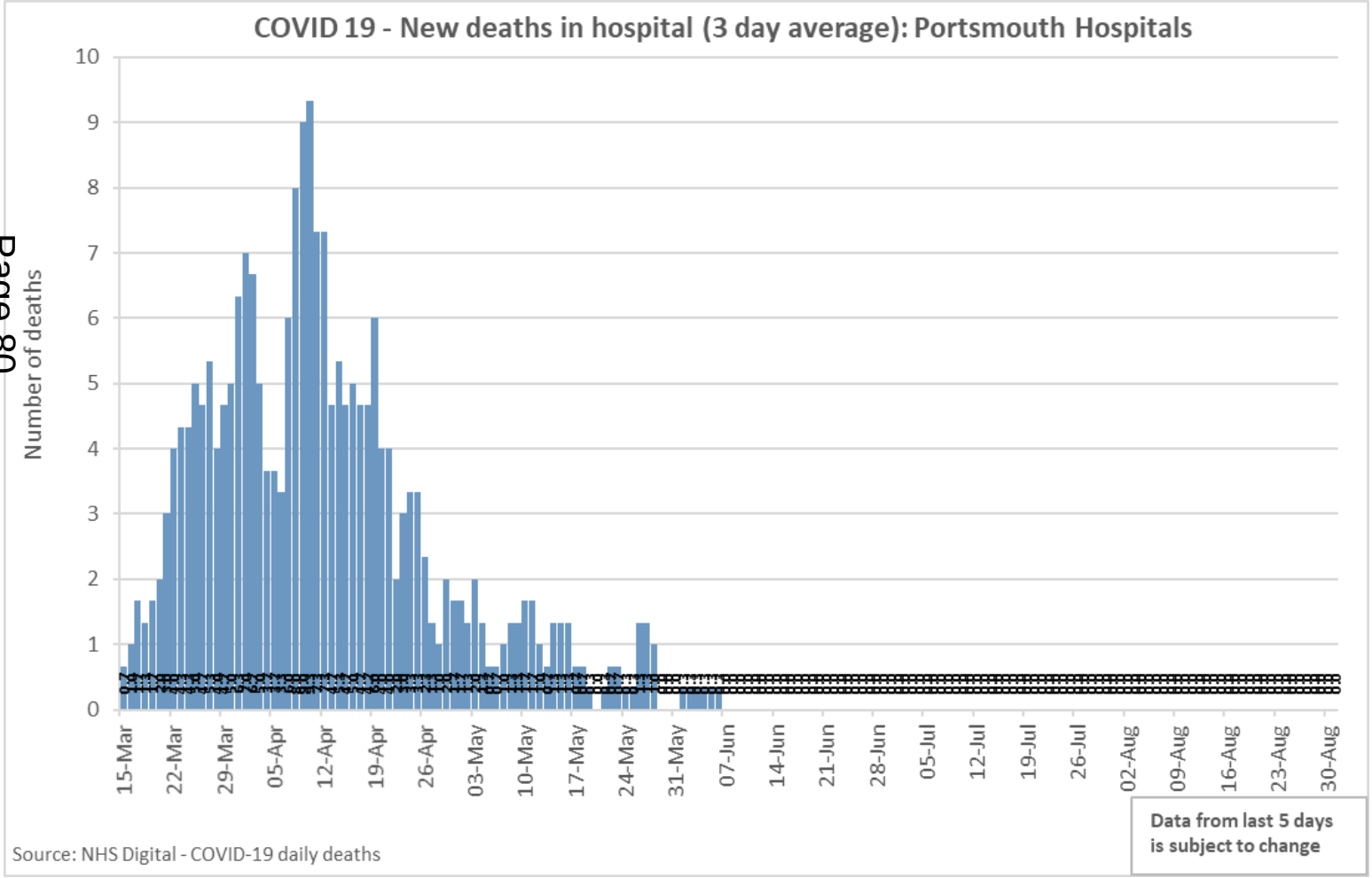
Weekly rate of COVID-19 cases per 100,000 population tested under Pillar 1 and 2, by UTLA, England, 22 Aug – 28 Aug (South East Daily Surveillance Report)

National reports available weekly at:
https://www.gov.uk/government/publications/national-covid-19-surveillance-reports

*Based on week 34 (data between 17 and 23 August 2020).

2.1 Deaths

New deaths in Hospital (3 day average): Portsmouth Hospitals



There have been 0 Covid-19 related deaths recorded at QA Hospital since the first week of June.

The number of Covid-19 related deaths at QA Hospital peaked on 11th April.

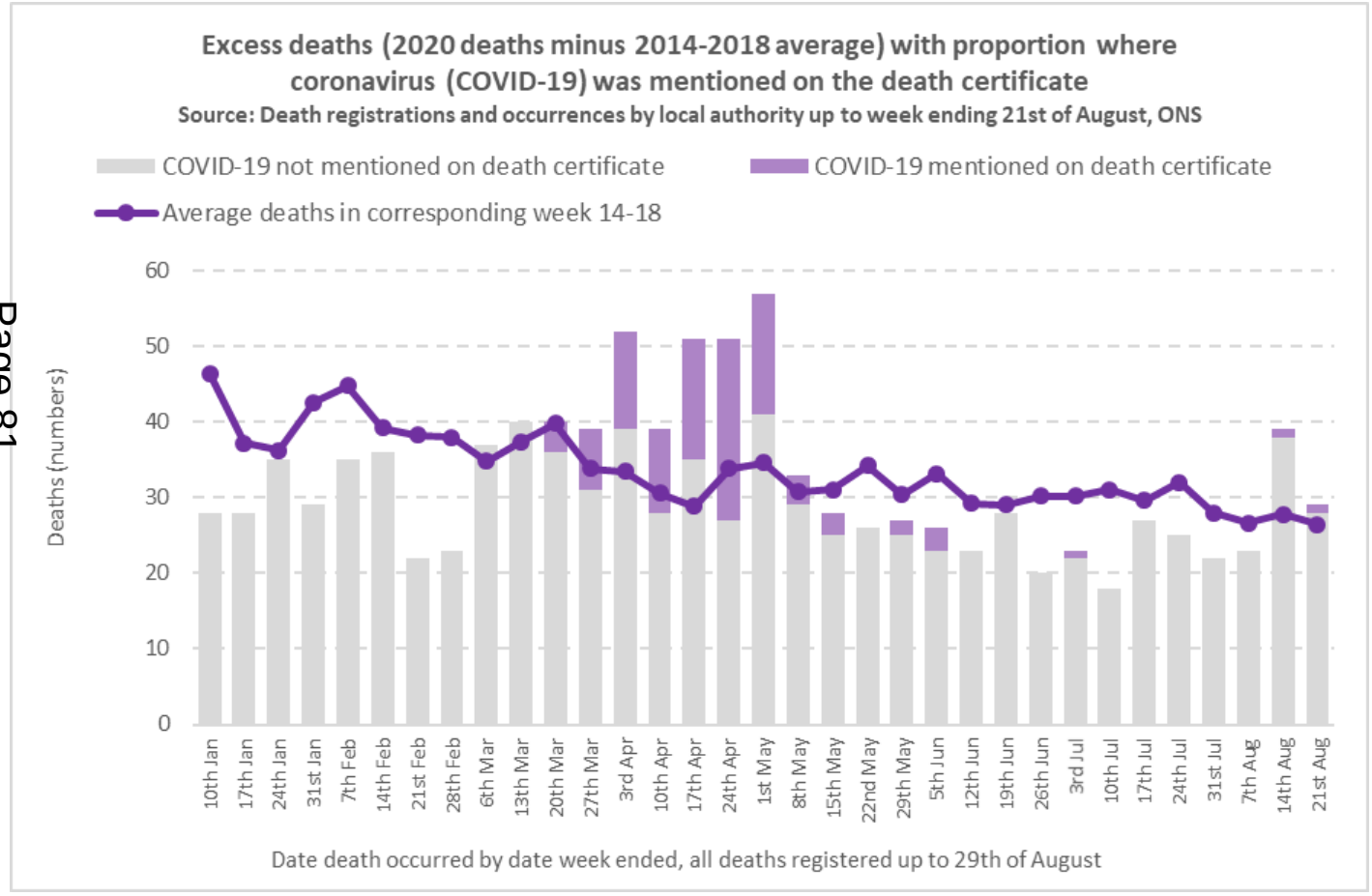
The chart shows the number of new deaths (3 day average) from COVID-19 at the trust selected from the dropdown - note this is not just exclusive to residents, but any patient who has died at hospital and had tested positive for COVID-19 at the time of death.

COVID-19 deaths that occur in the community or care home are not included in this figure. Totals by day are based on date of death.

Data is from NHS England COVID-19 daily deaths. Figures are subject to revisions, particularly for the most recent data, as more post-mortem tests are processed and data from them are validated.

2.2 Deaths

Excess deaths (2020 deaths minus 2014-2018 average) with proportion where coronavirus (COVID-19) was mentioned on the death certificate



The total number of deaths each week in Portsmouth was higher than in an average week for 5 weeks from the end of March to early May.

These excess deaths were mostly Covid-19 related.

Since week ending 15th May deaths have been below what was seen in previous years.

The chart shows the number of deaths by week of occurrence for the selected geography.

The number of deaths where COVID-19 was not mentioned on the death certificate are shown in pale grey.

The number of deaths where COVID-19 was mentioned on the death certificate are overlaid in purple.

The total number of deaths is shown by the total height of the bar.

The average number of deaths for the corresponding week of the relevant years are displayed as a dark purple line.

Numbers are subject to revisions, especially most recent numbers.

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