

# Health Overview and Scrutiny Panel

## DOCUMENTS FOR THE MEMBERS ROOM

Thursday, 2nd July, 2020  
at 6.00 pm

MEMBERS ROOM DOCUMENTS ATTACHED TO THE  
LISTED REPORTS

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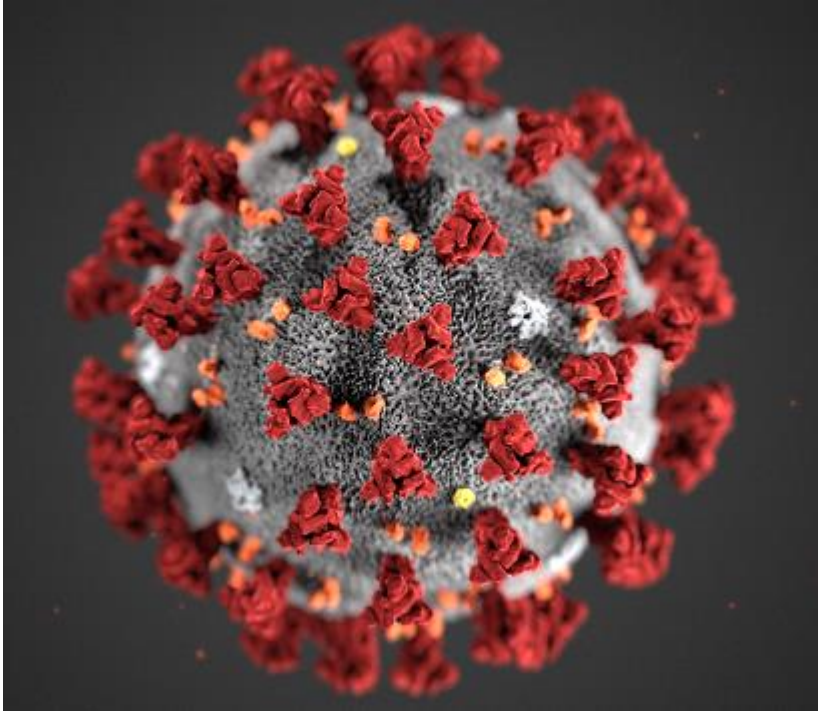
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# MEMBERS ROOM DOCUMENTS

8 **COVID-19: OVERVIEW OF THE HEALTH AND CARE RESPONSE IN SOUTHAMPTON** (Pages 1 - 30)

Wednesday, 24 June 2020

SERVICE DIRECTOR, LEGAL AND GOVERNANCE



**Solent NHS Trust  
response to Covid -19,  
plans for restore and  
recovery approaches -  
update for  
Southampton HOSP  
June 2020**

## Background - Preparation for Pandemic

As the COVID-19 pandemic approached in early March 2020, at Solent NHS Trust we made sure we were ready to deal with challenges that the national modelling indicated were coming.

Our **Emergency Planning Response** plans were stood up and we moved into command and control arrangements with an early establishment of an internal **Gold Command** structure which included support tools such as a business intelligence dashboard, which included a whole Trust bed stock management tool, PPE stock control trackers and workforce availability models.

**Building on our 2017 Winter contingency plans** – we have an established methodology for a risk based approach to curtailment of services to create additional capacity and capability in the event of crises, which we adapted for use in this instance.

We conducted an **early and rapid refresh of Business Continuity Plans** - based on potential staff absence rates of 20%, 30% and 50% (completed just before crises struck).

To prepare our people for what was expected to come, we took measures to:

- Redeploy staff internally where activities reduced or ceased to focus on areas of increased capacity requirements
- Recruit additional staff to our Bank – retirees and returners
- We instigated an upskilling, side-skilling and retraining programmes – for returners and redeployed staff, and
- Increased flexibility on working patterns, annual leave and workplace

# Procurement and Commercial

- **Equipment and PPE:**
  - Established three PPE hubs at main Solent sites
  - Volunteers identified to support distribution of PPE
  - PPE stock monitoring processes established
  - Processes in place for out of hours access to PPE
  - Equipment ordering, monitoring, reporting and logistics implemented for additional community bed capacity
- **Single Directory of Services** established on SolNet, updated daily with service changes approved through QIA
- Processes implemented to ensure **commissioners and other stakeholders have latest information about service changes** approved through QIA
- Arrangements in place for staff access to **hotels and patient transport via taxi**, where needed

# Quality

- **Mini-Quality Impact Assessment (QIA) process**
  - implemented for Solent services (inc. corporate functions) – with and linkage to wider system QIA for more complex schemes
  - Centralised commercial capture of service adjustments
  - Linkage to Recovery programme
- **Ethics Committee**
  - Established with Non-Executive Director membership
  - Reporting into Quality Review Group, Assurance Committee and onto Trust Board
- **Safe Staffing reviews** with Chief Nurse
- All changes to staffing models have been taken through QIA process and signed off by Chief Nurse
- Chief Nurse safe staffing discussions with Band 7 & 8A clinical managers/matron's
- Staffing models for new clinical areas reviewed and signed off by Chief Nurse
- Emergency staffing guidance in development for teams
- All changes to skill mix and ward establishments reviewed by Chief Nurse and Chief Medical Officer in line with QIA process



# Operational Service Delivery

On 19<sup>th</sup> March 2020, we received guidance from NHSE/NHSI setting out National Guidelines for Prioritisation for Community Services in preparation for the Covid-19 pandemic. Broadly, this guidance set out the following requirements:

- Support the immediate discharge of patients from acute and community beds and ensure patients cared for at home receive urgent care when they need it
- By default, use digital technology to provide advice and support to patients wherever possible
- Prioritise support for high-risk individuals who were advised to self-isolate for 12 weeks
- Apply the principles of mutual aid with health & social care partners, as decided through the local resilience forum

A detailed checklist of all key services was provided together with a recommendation of what action was recommended (cease – reduce – amend – continue)

*Guidance was to apply from 19th March to at least 31st July 2020*

# Operational Service Delivery in Practice

There was a requirement to review all of our services and reduce, cease or move the work according to the national guidance:

- **Group work was required to cease for patient and staff safety**
  - *This was the case for services such as Pulmonary Rehab, COPD, Diabetes and Cardiac Rehab. Due to the social distancing rules and the potential impact on these vulnerable patients, it was deemed unsafe to have them congregate in a room for these activities. Telephone contact has been maintained with these patients to allow them to share any concerns and to help them feel more supported.*
- **There were less face to face appointments (assessments & follow up) and more use of technology including remote video consultations, telephone appointments and remote patient monitoring**
  - *Teams such as Bladder & Bowel, CAMHS Psychiatry, Tissue Viability, MSK services, TB, Stoma, Diabetes, COPD & Cardiac moved to telephone or video appointments to reduce the risks to both patients and staff. Where face to face is necessary, appropriate PPE is worn by staff and all safety precautions are followed.*
- **Non-urgent, routine work was paused to release capacity in anticipation for the COVID demand, some activity was unable to continue.**
  - *Vocational Rehab was ceased to allow the staff to focus on more urgent tasks, School Nursing and School Aged Immunisations were unable to continue when the schools were closed although arrangements are in place to maintain support for vulnerable children. Routine referrals for CAMHS were paused although urgent ones are still being seen*





## Operational Service Delivery in Practice (cont.)

- **Services prioritised those patients of highest risk and worked in collaboration with other providers in partnership working to respond to the required changes in service delivery or who helped take on some of the essential but lower level work to release higher skilled capacity where it was needed.**
  - *Across the city and including Solent, GP surgeries aligned themselves to deliver a hot & cold hub in each locality to minimise the risks to patients and staff. Community Nursing reviewed its entire case load and enlisted the support for the less complex work from Solent Medical Services (SMS) for tasks such as phlebotomy and insulin administration.*
  - *We have had effective joint working with Southampton Primary Care Ltd (SPCL) and Countess Mountbatten Hospice (CMH) to support the Palliative Care Pathway*
- **Some staff were moved from their usual roles and redeployed to support the COVID demand preparations as some key areas were strengthened to support the drive for admissions avoidance and earlier discharge of patients from hospital.**
  - *Crisis Response (formerly Urgent Response) staffing was strengthened with additional resource to increase their ability to prevent admission and facilitate early supported discharge at greater scale.*
  - *Solent's community beds were increased by the repurposing of the Adelaide Health Centre into an inpatient ward with the potential capacity of 72 beds in the event of a surge.*
  - *The Palliative Care pathway has been strengthened to ensure a robust service delivery in collaboration with SPCL & CMH.*



## Provision of Additional Capacity

In order to prepare for the predicted surge in COVID 19 patients, the Trust stepped up to the challenge in both the Royal South Hants Hospital (RSH) and the Adelaide Health Centre (AHC).

**RSH wards (Fanshawe & Lower Brambles)**, which usually provide a step down rehab facility, were set up to be ready to take those patients who would usually be in an acute setting but who could safely be discharged from UHS but still need oxygen as all Solent beds at the RSH have a piped oxygen supply. This increased the Level 1 (sub acute) bedded capacity in the city

**AHC** has been repurposed into bedded wards which could take up to 72 patients in the event of a surge. These would be for patients who are well enough to leave hospital but not quite ready to go home.

The anticipated surge did not arrive as expected which is great news. We have taken the opportunity this created, using the additional beds created at AHC, to temporarily close Lower Brambles ward (until August) in order to conduct some much needed infrastructure repair and refurbishment to enhance future patient experience and in particular implement improved infection prevention and control in that ward.

# Adelaide – Ready for Patients



Solent  
NHS Trust

Page 9



## Recovery & Restoration

As part of our overall COVID-19 response, in the second week of the crises we started to think about our recovery planning.

There is a delicate balance between how we safely turn services back on at the same time as maintaining the agility to flex up & down depending on COVID-19 demands as lockdown restrictions are lifted, in particular cogniscent of the risk of a second wave .

We have framed our thinking through the lens of:

Workforce

Infrastructure – Estates, IT and equipment

Training

Stock (inc. PPE)

And we challenged ourselves to think about:

*Culture and behaviours – the good, the bad and the ugly*

*New ways of working – especially technology as a people change programme*

*What has gone so well that we must keep doing it, grow it, share it etc.*

*What things do we definitely need to go back to – will they look the same as before or different*

*What have we stopped doing and would never go back to*



# Recovery programme – Trust workstreams:

## Learning and governance:

- Programme governance
- Clinical leadership, governance, safety and ethics
- Corporate governance
- Learning and research

## Service delivery:

- Patient needs, outcomes and experience
- Commissioned activity
- Service remodelling and transformation
- Capacity and demand
- Safe staffing

## Workforce and OD:

- Occupational health and wellbeing
- Leadership resilience
- Workforce deployment and team dynamics
- Learning and development
- Culture and behaviours
- Volunteers, returning staff, students and community support

## Relationships and strategy:

- System change and integration
- Patient communications
- Staff communications
- Stakeholder management
- Media
- Community engagement

## Enablers:

- Commercial and procurement
- Communications
- Estates and FM
- Finance
- IT & IG
- Medicines' Management
- People services and OH
- Performance and patient systems

# Learning

## Learning

- Ongoing live evaluation and mixed methodologies
- Series of ongoing evaluations that will feed into overarching report
- Weekly summary of key themes presented to Ethics Committee and to Trust executives
- Urgent issues escalated to Gold Command
- Summaries shared via our website, via comms and social media for the Trust

### Summary of learning aims:

1. Capture **what has happened and what went well or not so well**. Findings used to inform ongoing learning and change (findings recorded to identify similar reoccurrences and share learning)
2. **Listen to the experiences of our staff and our patients** to adjust and respond accordingly
3. **Recognize good practice and good ideas, we share it and we say thank you** - where things are better, we make sure we know how and why so that we can continue with this when we return to more normal practice
4. **Pay constant attention to all of our patients** - think about how services may need to adjust to meet different needs the crisis continues. Including those affected by COVID -19, and those that have not be affected, but still need our care
5. Where we **develop new services or approaches to care**, we look for the best evidence to inform decisions and continuously measure impact.
6. **Ongoing learning methodology then informs our recovery.**

# What have we learned?

## Workforce

- Highly motivated & engaged staff, low sickness and a real willing to flex and work differently to meet the needs of the patients and the necessary changes to service delivery
- Challenges in maintaining the momentum over the longer duration; risks of burnout, fatigue and concern over patients long term outcomes as a result of the changes in service provision over this period

## System Relationships

- True multi-disciplinary / multi-provider engagement at all levels. True collaboration across the system. Removal of traditional barriers and bureaucracy.
- Engagement across Primary, Community and Secondary Care providers, as well as Social Care and the Voluntary Sector

## Technology

- Use of telephone and video consultations to enable contact to continue with patients in lockdown. Well received by patients and their families
- Use of tablets on the inpatient wards to maintain patient contact with their families when visitors were not permitted to visit.
- Creation of video & YouTube content to support advice and treatment plans
- Zoom & Microsoft Teams has enabled an element of group work



## Priorities for Restoration

### Community – Solent - Adults

- ❖ Our Inpatient rehab offer (older persons/general rehabilitation and our specialist rehabilitation units) remain operational; key in supporting the system and impacted by any increasing activity (elective and non-elective) in the acutes, of particular note is the impact of covid on the rehab requirements that we are seeing, and lack of rehabilitation occurring in acute settings pre-discharge, which may impact on Length of Stay.
- ❖ Our home based Rehab offer - the community rehab service has continued in a combined role with urgent response. It will need to address the long term rehab needs of people with COVID disease and will have an important part to play in averting admissions as we move into the winter period.
- ❖ Community nursing and palliative care – services continue to operate, offering support to house bound patients and supporting care homes and hotels. Community nursing is a key supporting service that will need to be considered when restarting activity in primary or secondary care. The service is operating a reduced service provision due to the national guidance, and will return to normal provision in a phased approach in line with national guidance, and PPE availability. The service has diverted its resources to deliver palliative care to patients dying of COVID related disease in collaboration with SPCL
- ❖ Urgent Response services continue to support rapid discharge to home and other settings from the acute trusts; supporting patients to remain at home. Similarly to community nursing, this service is operating a reduced service provision and will return to normal provision in a phased approach in line with national guidance. There will be a need to remain fully operational at an enhanced level to support the enhanced care needed to facilitate rapid discharge from UHS including oxygen therapy in some, extended rehabilitation for many.
- ❖ Specialist Community Services (Diabetes, Cardiac, Respiratory, Tissue Viability and Neuro) have continued to operate, though with reduced provision, which will ramp up similar to our other community services.
- ❖ Our MSK, Podiatry, Pain and Rheumatology services have continued to operate throughout the pandemic; all service offers could be expanded to incorporate increased face to face assessments, dependent on national guidance, staffing and PPE availability.





## Priorities for Restoration

Community – Solent – Childrens Services

- ❖ Key priority is CAMHS, urgent and priority referrals including DSH rota.
- ❖ There are interdependencies with UHS, i2i, Hampshire CAMHS.
- ❖ Health Visiting – New birth visits
- ❖ Public health Nursing, Wellbeing and child protection contacts in Schools – key, but very dependent on how and when schools reopen
- ❖ Coast 111 Service for the Southampton area; Extended hours over the weekend and an integrated 111 service

## Next Steps – Planning for the Future

What will we do?

- Understand how we can fully resume services alongside Covid and remain agile enough to respond in the event of a second wave
- Harness the exceptional system collaboration and use of technology to meet the changing needs of the population in the future
- Ensure that we support our workforce to maintain their engagement and resilience; helping them adapt to the new ways of working and accommodating those with additional needs or protected characteristics
- Continue to work with our patients and service users to co produce the blueprint for the 'new normal' health and social care provision in the city.

22 06 2020

Media and Communications Team

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## Briefing note:

# Southern Health's response to coronavirus epidemic: update 4

### Introduction

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

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

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

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

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

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

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### Overview of Service Changes

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

#### OUR VALUES



### **Within our community services:**

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

### **Within our inpatient services:**

- All wards across the Trust saw an improvement in flow, an increase in bed capacity (empty beds) and a reduction to zero in the number of out of area beds being used.
- Within our community hospitals, we achieved significantly increased capacity, daily board rounds, early discharge, rehab outreach, and created 'hot and cold' beds for the management of coronavirus patients.
- Within our AMH/OPMH (adult and older people's mental health) units, we worked to achieve a reduction in admissions (with an increased number of patients being managed in the community).
- Beechwood ward at Parklands Hospital in Basingstoke was converted into a Covid19 ward (for adult/older people with mental health issues who require physical health care for Covid19).
- We also implemented restrictions to patients' leave (i.e. section 17), as per national guidance.
- Physical health training and support was put in place for mental health wards.
- Increased infections control training and support across all inpatient services was also quickly established.
- On Tuesday 24 March, we took the difficult but necessary decision to close our wards to visitors with immediate effect. This is being continually reviewed as lockdown measures ease.
- From 10 April until 11 May, Ford Ward (a 15 bedded rehabilitation unit based at Fordingbridge Hospital) was temporarily closed to admissions and merged with Romsey Hospital to support the clinical need for patients requiring a Covid19 recovery ward. This enabled us to reinforce our staffing (which had been affected by sickness and enforced isolation) to meet the increased physical and psychological needs of patients and their families.

- For a short period of time, Beaulieu Ward (an OPMH ward based at Western Hospital in Southampton) was also temporarily closed to admissions – this was as a result of 3 staff (all asymptomatic) and 4 patients testing positive for Covid19 from 28 May. The decision to temporarily close was due to the fact that all new admissions require patients to be isolated for 14 days, which was not possible since the isolation area was full. During the closure, the number of patients who were Covid19 positive rose to 6 and the number of staff self-isolating whilst awaiting test results rose to 5. A comprehensive strategy was in place to manage this limited outbreak which included developing ‘hot’ and ‘cold’ areas and revised procedures to ensure all staff were fully informed regarding area management, PPE and safe IPC working practices. Beaulieu Ward reopened on Monday 22 June and the temporary closure had no impact on bed availability as we had typically had around 60 unoccupied OPMH beds within the Trust during the period it was closed.

#### **Elective treatments:**

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

#### **Workforce:**

- Our recruitment processes for staff and volunteers was reduced from weeks to days, and was delivered 7 days a week thanks to the efforts of our HR team.
- We adopted a flexible approach to the redeployment of available staff - including MSK staff to work in community and inpatient services, health visitors and school nursing teams to support PPE hubs and community testing, and volunteers and corporate staff to deliver supplies, food and donations to wards and teams.
- Home working for non-essential services and shielded staff was quickly adopted.
- There has been a significant increase in the staff wellbeing support offer that we have at Southern Health - and more than 1000 staff have accessed the new pages detailing this support on our staff intranet.
- We have in place a staff risk review process, which was developed to protect/shield BAME, pregnant and other higher risk staff.
- We appointed a number of 3<sup>rd</sup> year students, returning retirees and also redeployed all corporate ex clinical staff - some to neighbouring Trusts’ ITUs (intensive therapy units).
- We worked hard to train new staff and current staff in various new skills, with a shift to a 7 day training service and bespoke delivery (both online and safely face-to-face)

- Our media and communications team began working 7 days a week, delivering daily messages and updates and introducing a new Staff Connect mobile phone app (which already has 2500 staff users) – particularly useful for those staff who are not desk-based (i.e. on wards and in the community). The team also organised weekly Facebook Live sessions which have been hosted on our intranet and also on a new internal Southern Health Facebook Group (which has more than 1000 active staff).
- In terms of our work with staff unions, the chair of our Staff Side has been part of our daily Gold Command calls and part of our daily workforce briefings. Additional JCNC and LNC meetings have also been held.

#### **Wider support:**

- Infection control training and the provision of PPE Hubs for all Trust services were established - firstly in inpatient units, and including staff, patients and families.
- Significant additional requirements were effectively managed - including developing an internal supply chain and 8 local distribution hubs for 2.7million pieces of PPE, and the rapid purchase of 4,500 sets of uniform (scrubs, polo shirts and trousers for non-uniformed staff) and around 1,000 pieces of furniture and equipment for planned surge bedded capacity.
- Environments and workforce issues in care homes created capacity issues which led to an increase in support from Southern Health.
- Additional cleaning hours were introduced to all clinical areas and non-clinical essential areas.
- Establishing accommodation arrangements for staff and for service users.
- Identifying and supporting colleagues with innovative solutions for supply challenges.
- Maintaining strong financial controls and due diligence without compromising on pace and agility.
- Working with the IPC Team (infection prevention and control) and staff to support product requirements for changing guidance and new products coming safely into the organisation.
- Mobilising individuals from across the organisation to support on deliveries across the Trust's various sites.
- Supportive to other teams across Hampshire with mutual aid and shared best practice when required.
- Establishing a Trust-wide taxi service, e.g. to ensure staff were able to get to work.
- To aid capacity, there was a system-wide 'pause' in the NHS complaints process for three months (although complaints were still logged, triaged and acknowledged) – normal service resumes in July 2020.

#### **Digital solutions:**

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

## Governance:

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

## Changes to clinical guidance:

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

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

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## Key Points

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

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

otherwise a risk that people may wait too long to get help which could adversely affect their health.

- Whilst it is true that the methods for delivering care may have temporarily changed, the **vast majority of the care we provide is still available for people to access** - and we have been working hard to share this message with our patients to avoid any unnecessary negative consequences of service change.

## Key Learnings

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

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

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## Moving to Recovery

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

- our community health services will be supporting the increase in patients who have recovered from Covid19 and who, having been discharged from hospital, need ongoing health support
- we are stepping-up non-Covid19 urgent services as soon as possible over the next few weeks



- there is now a renewed focus on mental health services and providing support to people as the lockdown is set to ease
- we will begin to make decisions on whether we have further capacity for some routine non-urgent elective care.

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

We are also specifically looking at:

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

### **How we are planning for restoration and recovery**

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

- A review of patient caseloads is already underway.
- We are also reviewing all the work that we stopped doing and what the impact of that was.
- We are undertaking an evaluation of service changes from a patient and quality impact perspective.
- Where possible, we are starting to recommence services using a clinically led risk based approach.
- We are planning to increase capacity in mental health services, to manage the impact of social isolation and post Covid19 patients, including suicide risk.
- We are continuing to develop our care home response and our offer to PCNs (primary care networks) as part of a 'single team' approach and in relation to IIC (integrated intermediate care) plans.
- A rapid evaluation of all the digital innovations we've introduced since March has been implemented.

- We are continuing to support system analysis and modelling as well as internal demand and capacity modelling – particularly on unmet need and any post lockdown surge.
- We have met as a Board and are resetting our Trust’s operating plan in light of the pandemic.
- We are working with colleagues and partners to cement non clinical process and governance changes, with the aim of streamlining and removing red tape wherever possible and safe to do so. (This will include how we reflect service changes into contracts and commissioning decisions with our CCG/LA/NHSE colleagues).
- We are putting into place longer term support for our staff’s health and wellbeing (this includes individual risk assessments to safeguard staff based on age, gender, ethnicity and health vulnerabilities).

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

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

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



Meet patient needs			Address new priorities		Re-set to a new NHS	
<b>Covid treatment capacity</b>	<b>Non-covid urgent care, cancer, screening and immunisations</b>	<b>Elective care</b>	<b>Public and mental health burden of pandemic response</b>	<b>Staff wellbeing and numbers</b>	<b>Primary and community care and innovation in models of care</b>	<b>New NHS landscape</b>
Maintain the critical care infrastructure to sustain readiness for future Covid demand	Identify the highest risk services; act now to minimise the risks as much as possible; develop plan for mitigating post-pandemic	Quantify the backlog; act now to slow growth in backlog as much as possible; develop the plan for clearing over time	Identify the highest risk services; act now to minimise the risks as much as possible; develop plan for mitigating post-pandemic; align with LTP	Catalogue the interventions now in place; identify additional actions now to support staff; develop the plan for recovery	Catalogue the innovations made; determine those to be retained; evaluate; plan for widespread adoption post pandemic	Catalogue the service and governance changes already made and which can still be made or accelerated; define ICS role
<b>Examples:</b>	<b>Examples:</b>	<b>Examples:</b>	<b>Examples:</b>	<b>Examples:</b>	<b>Examples:</b>	<b>Examples:</b>
Beds, equipment, supply chain, estate, workforce	Unexplained reduction in CVD presentations; reduced cancer diagnoses, low uptake of screening and immis	52 VWV increases; RTT backlog; repurpose & ?expand physical capacity to diagnose/treat; accelerate outpatient reform	Mental illness, domestic violence; harness positives such as greater air quality, vaccination acceptance	Staff support offer; delivering workforce manifesto commitments	Model for primary and community care; changes to discharge arrangements; lower UEC demand	Focus of ICPs and ICSs, future service configuration, financial architecture, link with local authorities, regulatory and oversight framework
<b>Securing long term capacity</b>						

## **When?**

Service changes took place with immediate effect and these were communicated to our overview and scrutiny committees (over the March-May period). As we now move into the recovery phase, we are keeping you updated of the measures we are taking to safely restore services. This will be a gradual, service-by-service process as teams undertake localised risk assessments and patient engagement to step up services.

## **Engagement Activity & Next Steps**

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

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

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

## **Any questions?**

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

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## Summary of UHS response to Covid-19

The response to the Covid-19 has seen exceptional changes in the nature of the operation of UHS.

Our Trust, patients and staff have all been impacted by Covid-19 and the actions necessary to respond appropriately to the pandemic. Below is a summary of the significant changes we have made across areas of our operations, how we have managed our changed workforce and supported those on the frontline of our response.

### Operational and clinical:

Within our services a wide range of detailed and complex operational and clinical changes have included:

- We reorganised our total bed base and structure of the hospital to ensure we had separate areas for Covid and non-Covid patients.
- Our first entire month of our response to COVID-19 was April where we saw the number of COVID-19 positive inpatients reach a maximum of 150 in ward beds and 30 in high care/intensive care beds.
- To support this, all of our clinical teams have reorganised the way they work to ensure more senior cover in the hospital during the period of the outbreak including many of our managerial colleagues changing their working weeks to ensure seven day cover is in place.
- The outbreak has been managed through an incident control centre which included daily incident meetings and a seven- day a week hub to manage our incident response.
- We expanded and reorganised all of our intensive care areas and created additional rotas, using staff from other areas of the Trust to cope with the expanded demand. The paediatric intensive care unit was moved to create additional COVID-19 critical care capacity.
- Throughout our response UHS has continued to prioritise urgent care including cancer treatments, urgent surgery and patients assessed as being at high risk. This has been delivered through our partnerships with independent providers across Southampton. Sites at The Spire Hospital, Nuffield and by Care UK at the Royal South Hants Hospital have all received UHS patients for a range of procedures and surgery allowing us to still deliver urgent treatment for the patients who need it most with emergency surgery continuing at the SGH site.
- A range of services have been transformed throughout our COVID-19 response in order to enable us to continue treating patients in innovative ways. We have more than tripled the number of outpatients we are seeing virtually either over the phone or via video consultations with just under 20,000 patients 'attending' their clinics in this way during April. This represents a huge investment in our digital infrastructure.
- Our eye unit has continued to receive patients for vital sight saving treatment by introducing a 'drive-through' style screening service to allow them to still attend their appointments.

- Maternity services have established a dedicated support group for pregnant women to keep them updated on changes to guidance and provide reassurance.
- Testing laboratories increased capacity greatly from the start of the pandemic with the laboratory and pathology teams at UHS responsible for processing samples for the South of England.
- Our emergency department has been completely transformed to deal with patients presenting with and without Covid symptoms. This involved completely reorganising the department into separate and ring fenced areas.
- In addition those patients who have minor injuries are being redirected to urgent treatment centres in Southampton and Lymington.
- To manage Personal Protective Equipment supplies we created a separate team to ensure the hospital staff were supplied with appropriate equipment including daily deliveries to hubs across the hospital.
- Since March we have imposed visitor restrictions on UHS sites, in line with national guidance. This has meant that all but compassionate and carer visitation has been restricted. Since last month face masks have also been made compulsory around the site for visitors, staff and patients (where it does not impede treatment or care).

### **Patient support:**

- Our experience of care team has created a patient support hub, offering a number of ways for family and friends to stay in touch with their loved ones who are being cared for at UHS.
- They have relayed over 1000 messages from families to inpatients. These have been emails, photographs, and poems and the team has also received over 350 patient property drop-offs which have been delivered to patients on the wards and have introduced telephone and virtual interpreting as a standard practice.
- The team has produced over 30 pieces of COVID-19 specific patient information materials for a range of services.
- We are also supporting patients with learning disabilities through a range of virtual and online platforms including a forum dedicated to sharing support and advice.
- More information is available on the [UHS news feed](#) and [Trust Highlights](#) pages.

### **Workforce:**

- Our workforce has also been significantly reorganised with staff being redeployed due to their own health conditions whilst we have enabled more colleagues to work from home where they can continue to support patients who are not being seen face to face through online platforms.

- Staff testing has been rolled out to include both symptomatic and routine asymptomatic testing along with antibody testing. This piece of work is being expanded as we look towards building up our future capacity.
- A staff support and wellbeing workstream has overseen the creation of a staff helpline, dedicated staff areas for one-to-one support and help. Boost boxes containing donated gifts to wards and departments have been delivered in conjunction with Southampton Hospitals Charity which has led a wellbeing fundraising drive to fund a number of projects to support staff.
- Our BAME staff have been supported in the guidance that has been issued in response to how some communities have been disproportionately affected by COVID-19. Our One Voice network which represents staff from across these communities has been highly engaged with the development of our response.
- We are extremely proud of the response by our staff many of whom have significantly changed their working practices and work they do routinely to support our COVID-19 response.

## Research and innovation:

- UHS has been involved in a number of pioneering research trials in developing effective treatments for the virus including partnering with Oxford University in the recent RECOVERY trial which led to the availability of the drug Dexamethasone.
- We have also been involved in the city-wide pilot of a saliva test taking a key role in providing the secure data systems needed to handle participant results.
- UHS was also the first UK Hospital to use the PeRso hood which gives staff protection through a fabric hood equipped with a fan pack attached to a belt through which clean air is delivered.
- Researchers in Southampton are leading a study to find out how the virus affects adults and children who are more vulnerable to infections, have helped produce specific national guidance to parents and have been involved in a number of vaccine trials in partnership with other centres. More information can be found here on our [research pages here](#).

## Restoration and recovery:

We are now restoring services but this can only be achieved by adhering to strict infection prevention measures to enable us to have more of our patients who are in need of treatments back into hospital. Our goal is to be a hospital where there is zero transmission of COVID-19 within it and we have begun setting set out a number of measures in order to achieve that along with a community-focussed campaign. With the limitations that currently present we will continue to focus on those patients most at risk while we build up services and capacity.

We have made a good start and activity is starting up again so we are working hard to plan for the months ahead with the ever-present threat of a potential second wave. We are seeing increasing referrals now and presentations to our emergency department following a period where that did drop significantly through the initial months of the Covid response. We are restarting as much elective work as we can continuing to use the capacity at the local privately run hospitals and expanding the number of theatre lists at the SGH site. UHS is committed to making sure that patients that need us most are prioritised, focusing on infection free hospital sites and supporting colleagues either back to work where possible or finding suitable alternatives so they can continue to contribute to the quality of our care.