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Health Overview and Scrutiny Panel

Thursday, 3rd September, 2020
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Virtual meeting

This meeting is open to the public

Members

Councillor Bogle (Chair)
Councillor White (Vice-Chair)
Councillor Laurent
Councillor Professor Margetts
Councillor Noon
Councillor Payne
Councillor Vaughan

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PUBLIC INFORMATION

ROLE OF HEALTH OVERVIEW SCRUTINY PANEL (TERMS OF REFERENCE)

The Health Overview and Scrutiny Panel's responsibilities and terms of reference are set out within Part 3 of the Council's Constitution: Responsibility for Functions

The general role and terms of reference for the Overview and Scrutiny Management Committee, together with those for all Scrutiny Panels, are set out in Part 2 (Article 6) of the Council's Constitution, and their particular roles are set out in Part 4 (Overview and Scrutiny Procedure Rules of the Constitution.

MOBILE TELEPHONES: - Please switch your mobile telephones to silent whilst in the meeting.

USE OF SOCIAL MEDIA: - The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting. By entering the meeting room you are consenting to being recorded and to the use of those images and recordings for broadcasting and or/training purposes. The meeting may be recorded by the press or members of the public.
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Details of the Council's Guidance on the recording of meetings is available on the Council's website.

PUBLIC REPRESENTATIONS
At the discretion of the Chair, members of the public may address the meeting on any report included on the agenda in which they have a relevant interest. Any member of the public wishing to address the meeting should advise the Democratic Support Officer (DSO) whose contact details are on the front sheet of the agenda.

SMOKING POLICY – the Council operates a no-smoking policy in all civic buildings.

Southampton: Corporate Plan 2020-2025 sets out the four key outcomes:

- Communities, culture & homes - Celebrating the diversity of cultures within Southampton; enhancing our cultural and historical offer and using these to help transform our communities.
- Green City - Providing a sustainable, clean, healthy and safe environment for everyone. Nurturing green spaces and embracing our waterfront.
- Place shaping - Delivering a city for future generations. Using data, insight and vision to meet the current and future needs of the city.
- Wellbeing - Start well, live well, age well, die well; working with other partners and other services to make sure that customers get the right help at the right time

CONDUCT OF MEETING

BUSINESS TO BE DISCUSSED
Only those items listed on the attached agenda may be considered at this meeting.

RULES OF PROCEDURE
The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

QUORUM
The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

DISCLOSURE OF INTERESTS

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Pecuniary Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PECUNIARY INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.

(ii) Sponsorship

Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.

(iv) Any beneficial interest in land which is within the area of Southampton.

(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.

(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.

(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

(a) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or

(b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

OTHER INTERESTS

A Member must regard himself or herself as having an, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

- Any body to which they have been appointed or nominated by Southampton City Council
- Any public authority or body exercising functions of a public nature
- Any body directed to charitable purposes
- Any body whose principal purpose includes the influence of public opinion or policy

PRINCIPLES OF DECISION MAKING

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the “rationality” or “taking leave of your senses” principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, ‘live now, pay later’ and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

DATES OF MEETINGS: MUNICIPAL YEAR 2019/2020

2020	2021
2 July	4 March
25 August	22 April
22 October	
17 December	

AGENDA

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Panel made in accordance with Council Procedure Rule 4.3.

2 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

3 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

4 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

5 STATEMENT FROM THE CHAIR

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING) (Pages 1 - 2)

To approve and sign as a correct record the minutes of the meeting held on 2 July 2020 and to deal with any matters arising, attached.

7 COVID-19: RECOVERY PLAN OVERVIEW (Pages 3 - 18)

Report providing an overview of the recovery and restoration activity underway in the Southampton and South West Hampshire system following the COVID-19 outbreak.

8 SOUTHERN HEALTH NHS FOUNDATION TRUST - WILLOW WARD PROPOSAL AND CQC UPDATE (Pages 19 - 40)

Report of the Chair of the Panel requesting that the HOSP consider proposals to close Willow Ward, and the Trust's CQC inspection update.

9 THE EMERGING PICTURE - COVID 19 AND HEALTH INEQUALITIES IN SOUTHAMPTON (Pages 41 - 54)

Report of the Interim Director of Public Health enabling the Panel to discuss the emerging picture with regards to Covid-19 and health inequalities in Southampton.

10 CCG REFORM IN HAMPSHIRE AND ISLE OF WIGHT (Pages 55 - 60)

Report of the Chair of the Panel recommending that the Panel consider developing a response to the proposals to reform CCGs in Hampshire and the Isle of Wight.

Tuesday, 25 August 2020 Service Director – Legal and Business Operations

SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 2 JULY 2020

Present: Councillors Bogle, Laurent, Professor Margetts, Noon, Payne, Vaughan and White

1. **ELECTION OF CHAIR AND VICE-CHAIR**

RESOLVED that:

(i) Councillor Bogle be elected as Chair for the Municipal Year 2020-2021;and
(ii) Councillor White be elected as Vice-Chair for the Municipal Year 2020-2021.

2. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED: that the minutes for the Panel meeting on 27 February 2020 be approved and signed as a correct record.

3. **HAMPSHIRE AND ISLE OF WIGHT NHS RESPONSE TO COVID-19**

The Panel considered and noted the report of the Chief Executive Officer, Hampshire and Isle of Wight Integrated Care System, providing the Panel with an overview of the response of health and care services in Hampshire and the Isle of Wight to the outbreak of Covid-19.

Maggie MacIsaac (Chief Executive Officer, Hampshire and Isle of Wight Integrated Care System, and Accountable Officer, NHS Southampton CCG) Cllr Fielker (Cabinet Member for Health & Adults, SCC) Grainne Siggins (Executive Director Wellbeing - Health & Care, SCC), James Rimmer (Managing Director, NHS Southampton City CCG), Dr Mark Kelsey (Chair, NHS Southampton City CCG), Dr Debbie Chase (Interim Director of Public Health, SCC) and Stephanie Ramsey (Director of Quality and Integration, Integrated Commissioning Unit) were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of points including:

- Whether the pandemic demonstrated the value in having health and care systems in place that can operate at a pan-county scale as well as having a focussed place response;
- The strategy for looking after and growing the health and care workforce;
- Unmet need for health and care created by the pandemic, including how to encourage patients back into the health system that may have been fearful of attending clinics because of concerns over the pandemic;
- The value of integrated commissioning across the NHS and local authorities, this is not a feature across Hampshire; and
- Conserving and developing the good practice and positive service changes implemented during the pandemic through both co-operation within the system and the use of technology.

4. **COVID-19: OVERVIEW OF THE HEALTH AND CARE RESPONSE IN SOUTHAMPTON**

The Panel considered the report of the Managing Director, NHS Southampton City CCG, and the Executive Director - Wellbeing (Health and Adults), Southampton City Council, outlining the health and care response to Covid-19 in Southampton.

Maggie MacIsaac (Chief Executive Officer, Hampshire and Isle of Wight Integrated Care System, and Accountable Officer, NHS Southampton CCG) Cllr Fielker (Cabinet Member for Health & Adults, SCC) Grainne Siggins (Executive Director Wellbeing - Health & Care, SCC), James Rimmer (Managing Director, NHS Southampton City CCG), Dr Mark Kelsey (Chair, NHS Southampton City CCG), Dr Debbie Chase (Interim Director of Public Health, SCC) and Stephanie Ramsey (Director of Quality and Integration, Integrated Commissioning Unit) were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of points including:

- The current position within the City in regard to infection rates and the supply of PPE;
- The sustainability of the local system to deal with the current and any future crisis;
- How the system was planning to address the backlog of cases and address inequalities within the system that had been exacerbated by the pandemic; and
- The preparations within the local health system for the onset of winter, flu and the potential for a second wave of the pandemic.

RESOLVED that the Panel are provided with an overview of the current waiting lists for NHS Services in Southampton, and how long people are having to wait for services.

Recovery Plan overview

August 2020 to March 2021

Southampton and South West Hampshire System

Restoration and Recovery at the Integrated Care System (Hampshire and Isle of Wight) level

The Access to Services Restoration Programme has been set up in the recognition that the focus of restoration activity and decisions are rightly taken by individual organisations and local systems. The focus of the pan-HIOW programme is therefore proposed to be:

- ensure consistency of decisions, including a set of principles that all partners own and apply;
- provide the modelling capability to support decision making;
- share learning regarding best practice and identify unwarranted variation that could be addressed to improve outcomes for local people;
- manage the prioritisation and allocation of locally / nationally / regionally available capital and revenue to support restoration and track impact;
- support collaboration and mutual aid to address collective challenges;
- ensure consistency of plans against the long term transformation ambitions for Hampshire and Isle of Wight;
- ensure the NHS in Hampshire and Isle of Wight can account for its progress in restoring access to services;
- to create a clear and coherent plan for restoration, and to use this as a means of strong communications to patients, carers, staff, partners, stakeholders and local citizens.

HIOW 7 principles for Restoration (Renewal and Recovery) are:

1. **Safe**: Patient and staff safety is paramount. Our restoration plans will be founded on the identification and mitigation of risks;
2. **Forward Looking**: We will lock-in beneficial changes and not restore by default to pre-Covid service models
3. **Outcome-focused**: Our purpose is to maximise outcomes for local people. This means ensuring we identify and care for patients requiring time-critical treatment which, if not provided immediately, will lead to patient harm
4. **Subsidiarity**: Individual organisations and local systems will lead the development and delivery of plans for restoring services guided by a common co-produced set of principles and approaches;
5. **Strategic**: We will ensure, where possible, our approaches are in line with our strategic ambitions as set out in the Hampshire and Isle of Wight Strategic Delivery Plan
6. **Prepared**: We will at all times retain sufficient aggregate capacity across HIOW to respond to demand.
7. **Aligned**: All partners in HIOW are committed to ensuring a common approach to planning restoration

Key Workstreams

Workstream

1. **Urgent and Emergency Care**
2. **Critical Services**
3. **Community Services: Home First**
4. **Planned Care**
5. **Mental Health Services**
6. **Primary Care**
7. **Children and Family Services**

1) Urgent and emergency care (UHS)

Where we are now

- A&E attendances dropped to below 50% during the first covid peak.
- Demand has been rising and likely to be back to pre-covid levels by the end of September 2020.
- Positively, major attendances have returned to previous levels and minors remains low due to this work being diverted to Urgent Treatment Centres (in Southampton this is run by Care UK and located in Royal South Hants Hospital) – work is ongoing to try and sustain this trend.

Rate limiting factors

- **Workforce** – Staff fatigue and potential shortages owing to build up of leave and social isolating.
- **Estates –** Physical space within the department has always been a constraint. Also required to consider social distancing requirements and infection control measures.
- **Time –** Need for urgent decisions on capital in order to complete in a timely way. The department would struggle to implement estate changes during periods of peak demand.
- **Affordability –** Funding of additional capacity is required, as well as needing to eliminate the growth in backlog since covid.

Proposal - Increasing capacity and flow (current and future state post restoration)

- Continue the streaming of patients into covid and non-covid pathways.
- £9m funding approved to start to re-develop the Emergency Department and move towards the concept of an Emergency Care Village
- Need for further funding to complete concept
- Independent sector capacity to support the elective programme is essential as non-elective activity will require all the available bed capacity within the acute hospital.

The ask

- **Investment/re-configuration** needed to support the building and staffing of additional beds.
- **Capital costs identified**, need to identify revenue
- **System support to reduce demand on acute services** by:
  - Delivering positive schemes to reduce ED attendances
  - Driving forward on admission avoidance schemes.
  - Maximising the out of hospital response (i.e. by increasing flow into discharge pathways.
  - Supporting mental health (both children and adults) patients in the community to avoid ED attendance.

2) Critical services (UHS)

Where we are now

- Hampshire and Isle of Wight has a lower per capita number of critical care beds than most other regions in UK.
- Currently have a **deficit of 30%** for adult critical care beds in the region.
- Learning from the first wave means there is much better understanding of which patients are most likely to benefit from critical care treatment.
- Need to create further permanent and surge beds, as well as potential need to support specialised commissioning in the South West.

Rate limiting factors

- **Workforce** – staff fatigue and potential shortages owing to build up of leave and social isolating.
- **Equipment –** Potential challenges in procuring the equipment needed because of national shortages. Access to PPE remains challenging.
- **Time –** Need for decisions on capital in order to complete in a timely way. Backlog of elective surgery and limited Independent sector capacity for critical care could impact recovery timescales.
- **Affordability –** Ongoing revenue costs for the system.

Proposal - Increasing capacity and flow
(current and future state post restoration)

- Proposal to create an additional 20 permanent critical care beds at UHS.
- Proposal to create 50 additional surge beds at UHS.
- Potential ask to create a further 25-35 beds to support excess demand in Hampshire and the Isle of Wight and specialist commissioning from the South West.
- Robust plans in place to deliver by the end of the financial year. However, no funding identified

The ask

- **Investment/re-configuration** needed to support the building and staffing of additional beds
- Capital costs of **£36m** identified, plus recurrent revenue costs.

3) Community Services: Home First (Solent NHS Trust)

Where we are now?

In 2019/20, 32,378 patients aged 65+ are admitted for a non-elective admission; the top five reasons for admission include unspecified chest pain or abdominal pain, chest pain, precordial pain, syncope and collapse

At the start of the pandemic we actively strengthened our admissions avoidance / early supported discharge teams to support the patient flow in the city and to care for people in their own homes in order to free up capacity in the hospital.

Sembal house Hub brought together a range of partners across the city to meet daily and work collaboratively to ensure support for proactive, preventative care to meet the needs of the population outside of the hospital.

Rate limiting factors

- Historic barriers between organisations, including funding allocation.
- Capacity within the system.
- Providers individual resilience to COVID and the impact on their businesses.
- Workforce and specialist skills / training required.

Proposal - Increasing capacity and flow
(current and future state post restoration)

- 'One Team - a shared identified resource across each Primary Care Network - working collaboratively to provide integrated, proactive care.'
- 'Home First' – rapid response, where ever possible Admission Avoidance /Reduction in Length of Stay
- Growing out of hospital capability and reducing bedded capacity in the hospital to support reshaping of services in the city and allow the provision of more care to individuals at home , including care homes
- Increasing people's independence will reduce reliance on long term social care and therefore free up resource to reinvest in preventative services and activities

The ask

- 'Home First' the first consideration when clinically appropriate.
- Strengthened community resource to ensure robust services in place to avoid admissions and to ensure timely discharge.
- Capacity to meet increased demand.
- Integrated proactive and reactive care, meeting the objectives of the NHS Long Term Plan.

6

4) Planned care (UHS and independent sector)

Where we are now

- Covid has significantly impacted the amount of acute activity delivered in Q1 (compared to 19/20):
  - 24,000 fewer outpatient first appointments
  - 3,000 fewer elective inpatients and 9,000 less day cases
- Secondary care providers have remained open to referrals and activity has been rising every week since the initial drop in late March/April.
- The overall waiting list has reduced, however, the number of long waiters is increasing and >52 week waiters have risen from 40 in March to 368 in May and > 1,000 in July
- 2ww cancer referrals dropped by up to 60% during the first covid peak. Cancer services have recovered well and there is a full work programme in place.

Rate limiting factors

- With measures theatres will return to c. 80% productivity and clinics to c.85%.
- 'Do not attend' rates have surprisingly reduced over the COVID peak
- People, space and funding are all rate limiting factors for the elective re-start

Proposal - Increasing capacity and flow (current and future state post restoration)

- Plan to review 5 specialities - Orthopaedics, Urology, ENT, Dermatology, Ophthalmology and Endoscopy - and make recommendations for change, which will inform local workstreams. Working across Hampshire and Isle of Wight to build an expanded capacity model.
- There is robust clinical prioritisation in place
- Maximise pathways in the outpatient setting by focussing on; 1) universal triage (including advice and guidance and consultant to consultant referrals), 2) digital transformation (increasing non face to face), and 3) pathway transformation (focussing on key pathways working with clinical teams to improve productivity and outcomes for patients).
- Fully utilise available independent sector capacity to support the elective programme.
- Detailed and robust plans for the recovery of Diagnostics and Cancer.

The ask

- Working across Hampshire and Isle of Wight to build an expanded capacity model; with capital we could create new theatres and wards in current shell of building within 2020/21.
- Investment in community capacity to ensure we do not have the normal 'winter' slow-down in elective care.
- Investment in acute capacity, such as theatre space and ophthalmology capability.
- Maximising the use of the independent sector is vital.

5) Mental Health (Southern Health - adults, Solent - children, Steps to Wellbeing - IAPT)

Where we are now

Secondary Care Mental Health Provision (provided by Southern Health NHS Foundation Trust):

- 24/7 MH Triage arrangements in place (NHS111) and psychiatric liaison within University Hospital Southampton NHS Foundation Trust . Mental health patients with only high risk and urgent referrals seen through April and early May. Patients supported remotely through digital platforms.
- The Lighthouse mobilised to be virtual, maintaining access 4pm-midnight 7 days per week. Supported 202 virtual visits during April. Supported over 600 virtual visits during April-June with 130 unique contacts.
- Reduction in mental health related ED attendances at UHS by 40% during Apr – now increasing and at 80% of usual expected levels
- Initial Reduction in referrals to community mental health teams resulting in a reduction in community caseload, this has now been replaced by high demand for urgent referrals
- Greater use of digital technology for assessment, psychological treatments and patient care
- Pilots to try virtual GP referral meetings
- Increase in presentations from people not previously known to services or who haven't accessed secondary care support for a number of years

IAPT (known in Southampton as 'Steps to Wellbeing', provided by Dorset Healthcare NHS Foundation Trust):

- Increased use of digital technologies based on national guidance during lockdown
- Reduction in referral by 50% during April – now increasing and at 85% of usual levels in Southampton, awaiting June data for West Hampshire
- Working towards restoring face to face appointments, and will identify those who cannot access telephone or online treatment options

Primary care:

- General Practice has seen an initial reduction in contact from people presentencing with emotional wellbeing and mental health needs, anecdotally across all sectors there appears to be a recovery of presentations to pre-Covid levels

Proposal - Increasing capacity and flow (current and future state post restoration)

- Delivery of NHS Long Term Plan for Mental Health to improve local services and meet national targets and to transform services to provide quality and timely mental health care, and tackle inequalities in access, experience and outcome
- Explore opportunities for accelerated integration through Primary Care Network development bringing together primary care, IAPT, secondary care mental health services and voluntary sector

Rate limiting factors

- **Demand –** surge in referrals relating to emotional and mental health – anxiety, depression, trauma – anecdotally this is already impacting on capacity in primary care and secondary care
- **Workforce** – staff fatigue and potential shortages owing to build up of leave and social isolating
- **Digital solutions evaluation -** understand patient and carer experience and impact on recovery
- **Estate suitability** – for delivering face to face contact and interventions whilst maintaining required social distancing
- **Primary care -** ability to resume and confidence in people accessing secondary care for emotional and mental health needs

The ask

- **Investment needed to support crisis capacity (psychiatric liaison, crisis resolution home treatment) and additional core community mental health capacity** at primary care and secondary care to tackle assessment and treatment waiting lists
- **Investment needed to substantially improve IAPT access** in West Hampshire
- **Whole system approach to early intervention** and promotion of mental health **–** use of trauma informed approaches
- **Real time surveillance** metrics to assess mental health surge/increase in demand to respond to changing presentation/demand profile

6) Primary care (GP services)

Where we are now

- As of May 2020, GP appointments were 37% lower than May 2019.
- Remote appointments (e.g. telephone / eConsult) equated to 20% of activity in Feb 2020, increasing to 51% in May 2020.
- 100% of general practices are open and operating a total triage model to support the management of patients remotely where possible. All practices operating telephone, online and video consultations.
- Restoration of primary care activity is in line with infection control guidance and suggested prioritisation (see next slide). 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. Ability to flex and consolidate in response to changes in capacity and demand.

Rate limiting factors

- **Workforce** – Staff fatigue and potential shortages owing to build up of leave and social isolating.
- **Equipment –** Potential challenges in procuring the equipment needed because of national shortages. Access to PPE remains challenging.
- **Complexity –** Many urgent patients have avoided accessing healthcare for many months, meaning when they present they are often more complex and take longer to treat. Post covid patients are also more time intensive with increasing needs such as oxygen saturation monitoring.
- **Affordability –** Ongoing revenue costs for the system of delivering additional support to care homes, and additional costs incurred to meet new infection control measures etc. Need for non-recurrent investment to enhance resilience over the winter period

Proposal - Increasing capacity and flow (current and future state post restoration)

- Restoration of primary care activity with more people accessing primary care, including those at highest risk of harm. Supported by clear messaging to the public on how to access care.
- Continued focus on prevention and self-management – empowering people to take control of their own health and well-being. Delivery of immunisation and screening programmes.
- Virtual triage and care delivery: Retain and expand digital technology support in line with digital road map. Ensure optimised use by primary care through deployment of training and support packages (national and local).
- Enhanced shared decision making through strengthened collaborative working (including referral support / A&G) ensuring right place, first time

The ask

- Delivery of the 2020/21 flu immunisation programme in collaboration with local partners
- Continued development of PCNs, PCN leadership and the implementation of the DES specifications including recruitment to additional roles in collaboration with system partners
- Further development of Integrated Care Teams and ‘one team approach’
- Non-recurrent funding to increase resilience over winter

7) Children & Family Services (UHS - acute care; Solent NHS Trust – community)

Where we are now

Secondary Care provision (UHS):

- Reduction in under 18 yr old non-elective admissions by 67% during Apr-20 compared to Apr-19
- Reduction in UHS ED under 18 yr old attendances by 50% during Apr-20 – now increasing
- Reduction in UHS under 18 yr old elective inpatient admissions by 75% during Apr-20
- Reduction in Southampton Children and Adolescent Mental Health Service (CAMHS; provided by Solent NHS Trust) routine referrals by 72% in Apr-20 compared to Feb-20 – now increasing and in June at 60% of expected levels
- Increase in young people presenting at UHS ED in crisis – 51 in June compared to previous peak of 28 in January this year

Community provision (Solent NHS Trust):

- Reduced community provision based on national guidance during lockdown, although business critical provision maintained
- Pause in routine CAMHS referrals and diversion of resource to 7 day a week crisis response – now stepping down crisis response to 5 days a week and routine referrals restored
- 24/7 children and young people triage arrangements in place (NHS111) and No Limits supporting in ED, working with NHS 111
- Increased children's community nursing service to 7 days a week and COAST (children's outreach and support team) rapid home nursing support via NHS 111 for suspected COVID cases
- Greater use of digital technology for assessment and patient care
- Cessation of school provision has impacted on opportunities for face to face contact and school immunisation programmes
- Reduced opportunities for face to face contact during lockdown have raised safeguarding concerns Primary Care

Proposal - Increasing capacity and flow (current and future state post restoration)

- Development of Integrated Urgent Care (ICU) pathways with acute and community providers
- Increase early intervention for emotional and mental health adopting system wide approach
- Development of Paediatric psychiatric liaison and multiagency crisis support provision to respond to increasing numbers of young people presenting at ED in crisis
- Explore alternative models for care of children with long term conditions

Rate limiting factors

- **Demand –** surge in referrals relating to children and young people's emotional and mental health – anxiety, depression, trauma – already impacting on capacity – if not addressed will result in significant waiting lists and waiting times over coming months
- **Workforce** – staff fatigue and potential shortages owing to build up of leave and social isolating
- **Schools –** if not all children return to school in September, this will impact on ability for services to work with children in schools, e.g. special school nursing, therapies, school immunisation programme
- **Lack of end-to-end IT** infrastructure for medical records reduces speed of decision making and treatment plans between acute, community and primary care
- Access to the appropriate **PPE** for parents, carers and non-NHS staff

The ask

- **Investment/re-configuration** needed to support the development of IUC
- **Investment needed to deliver psychiatric liaison, community crisis capacity and additional core CAMHS capacity** to tackle assessment and treatment waiting lists
- **Whole system approach to early intervention and promotion of mental health –** use of trauma informed approaches
- **Support to create end-to-end IT connectivity solution**
- **Live data** to support realistic trajectories for restoration and whole system solutions (increased waiting lists and times)

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		SOUTHERN HEALTH NHS FOUNDATION TRUST– WILLOW WARD PROPOSAL AND CQC UPDATE		
DATE OF DECISION:		3 SEPTEMBER 2020		
REPORT OF:		CHAIR OF THE HEALTH OVERVIEW AND SCRUTINY PANEL		
CONTACT DETAILS				
AUTHOR:	**Title:**	**Scrutiny Manager**	**Tel:**	**023 8083 3886**
	Name:	**Mark Pirnie**		
	E-mail	**Mark.pirnie@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY		
None.		
BRIEF SUMMARY		
At the request of the Chair, briefings related to a proposal to close Willow Ward, a ward based at the Tom Rudd Unit, Moorgreen Hospital in West End, for adults with learning disability whose behaviour challenges services, and an update on Southern Health's Care Quality Commission (CQC) inspection have been attached for the Panel to consider.		
RECOMMENDATIONS:		
	(i)	That the Panel consider the attached briefing paper, Appendix 1, on Southern Health NHS Foundation Trust's proposal to close Willow Ward, and replace it with an 'enhanced intensive support' community service, and discuss the issues with the invited representatives from Southern Health NHS Foundation Trust.
	(ii)	That the Panel consider the attached update on Southern Health NHS Foundation Trust's CQC inspection and discuss the issues with the invited representatives from Southern Health NHS Foundation Trust.
REASONS FOR REPORT RECOMMENDATIONS		
1.	To enable the Panel to scrutinise the proposals.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	No alternative options have been considered.	
DETAIL (Including consultation carried out)		
	Willow Ward Proposal	
3.	In July 2020 the Panel were informed of a proposal by Southern Health NHS Foundation Trust to close Willow Ward, a ward for adults with learning disability whose behaviour challenges services, and replace it with an 'enhanced intensive support' community service. The ward is based at Moorgreen Hospital in West End.	

4.	Attached as Appendix 1 is a briefing paper from the NHS Trust outlining the proposals and the rationale behind them. The Panel are asked to consider the proposal with the invited representatives from Southern Health NHS Foundation Trust.
	CQC Inspection
5.	On 23 January 2020, the CQC published their comprehensive report into Southern Health NHS Foundation Trust. The Panel have not had the opportunity to consider the inspection report up to now.
6.	Attached as Appendix 2 is a briefing paper from the NHS Trust providing the Panel with an overview of the key findings from the inspection, as well as the planned improvement plan to respond to the report's findings.
7.	The Panel are requested to consider the briefing paper and discuss the CQC findings and improvement plan with the invited representatives from Southern Health.
RESOURCE IMPLICATIONS	
Capital/Revenue	
8.	Not applicable
Property/Other	
9.	Not applicable.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
10.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.
Other Legal Implications:	
11.	None
RISK MANAGEMENT IMPLICATIONS	
12.	Outlined in the briefing papers attached.
POLICY FRAMEWORK IMPLICATIONS	
13.	None.

KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	**ALL**
SUPPORTING DOCUMENTATION	
Appendices	
1.	Briefing Paper – Willow Ward
2.	Briefing Paper – CQC Inspection update
3.	CQC Quality Improvement Plan

Documents In Members' Rooms

1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out?		**No**
Data Protection Impact Assessment		
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?		**No**
Other Background Documents **Other Background documents available for inspection at:**		
Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	**N/A**	

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Southern Health
NHS Foundation Trust

07 2020
Media and Communications Team

Briefing note:

Proposal to close Willow Ward and replace with 'enhanced intensive support' community service

Overview

The current inpatient model provided by Willow Ward - based at the Tom Rudd Unit, Moorgreen Hospital in Southampton - no longer reflects the national ambitions for the assessment and treatment of people with learning disability who present with challenging behaviours. Nationally, there is a drive to replace inpatient facilities like Willow Ward with a community-based model for the long-term benefit of this small group of patients with very complex learning disability. This is the right thing to do to improve care.

With this in mind, our commissioners in West Hampshire CCG and Southampton City CCG have articulated their tentative support to develop a community based model of Enhanced Intensive Support (EIS) which will incorporate assessment and treatment for people in their own homes. This would replace Willow Ward, the current inpatient facility for Hampshire and Southampton. There is acknowledgement that access to inpatient beds may still be required for those very few people whose needs cannot be met in the community, but this will be increasingly rare as the EIS would offer an enhanced level of intensive community support.

This paper details the current model, and the financial and practical challenges the inpatient service faces. It sets out a timetable for the proposed changes, and the implications for patients and for the workforce currently employed on Willow Ward, who would be redeployed into other settings.

There is an agreed consensus that Willow Ward is no longer viable to provide a safe, cost effective and modern service. It is, therefore, our proposal to close the ward from the end of September 2020 in order to develop and redeploy staff to a new community EIS service - improving care for this small, complex patient group.

Background

Willow Ward has been open since June 2012 and provides multi-disciplinary, evidence-based assessment and treatment for adults with learning disability whose behaviour challenges services. These behaviours should be significant (e.g. impact on the person's health, their safety, or the safety of others, and their quality of life) and should be a result of a learning disability rather than an underlying mental illness or personality disorder. Patients often present with a range of complex needs, alongside challenging behaviour, which may include physical health needs, communication needs, epilepsy and autistic spectrum disorders.

Willow Ward is a referral based, non-emergency service and its assessment and treatment provision includes:

- applied behaviour analysis/functional analysis
- complex communication assessment and profiling
- sensory integration/processing assessment and intervention
- complex assessment of motor and processing skills

- physical and mental health assessment and review
- person centred active support
- the creation of a positive behaviour support plan
- a placement needs profile
- periodic service reviews to support continuous quality monitoring.

The service is provided by a multi-disciplinary team, consisting of consultant psychiatry, clinical psychology, occupational therapy, speech & language therapy, registered learning disability nurses, registered mental health nurses and health care support workers.

The ward provides 6 beds set out across 4 single bedrooms (with access to shared lounge and kitchen facilities), as well as 2 'flats', with independent lounges and some facilities for meal preparation. The flats were originally designed to support patients with transition into and out of the ward. There are two enclosed gardens, an occupational therapy kitchen and a sensory integration suite.

The ward is provided within Moorgreen Hospital and remains the only inpatient facility on site, with all other services provided only during office hours. (These other services include children's services, adult mental health services, older person's mental health services and training services). Willow Ward is an isolated unit as it has no neighbouring clinical inpatient services able to offer support, leaving the ward clinically isolated, particularly out of office hours and at weekends.

There has been a reduction in the demand for beds on Willow Ward over recent years, and currently there are just two patients in Willow Ward (a third was recently discharged into the community with a robust package of care on 29 June 2020).

Planned Changes

The publication of the NHS Long Term Plan in January 2019 has provided a challenge in relation to the long term viability of inpatient provision for people with a learning disability, with NHS England committing to: *"transforming care (which) will mean that fewer people will need to go into hospital for their care. This means that we can close hundreds of hospital beds across England. To do this we are making sure that services in the community are much better."* Source: www.england.nhs.uk/learning-disabilities/care/

Moreover: NHS England is committed to:
- a reduction of inpatient admissions by more than 50% within the next 5 years
- increased investment in community support, reducing inpatient admissions
- care in the community should become more personalised and closer to home, with fewer people being subjected to preventable inpatient admissions
- by March 2023/24, inpatient provision should reduce to less than half of 2015 levels (on a like-for-like basis and taking into account population growth)
- for every one million adults, there should be no more than 30 adults with a learning disability and autism cared for in an inpatient unit
- every local health system is expected to have a 7-day specialist multi-disciplinary service and crisis care. Source: www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf

Therefore there is a national and commissioning-led move to close such facilities as Willow Ward and replace them with robust community-based alternatives. This is as a result of an evidence-led approach to care being more beneficial to patients when conducted in their own homes, rather than in an inpatient facility, as care can be more personalised, less restrictive and more responsive to their needs.

Currently, Willow Ward beds are commissioned on a spot purchase basis, with the flat rate per bed intended to cover the OBD (occupied bed days) rate, the multi-disciplinary team (MDT) and one-to-one support for each

patient. For patients with more complex needs, additional support is sought on an individual basis via agreement with commissioners (and is mainly provided by NHSP and agency staffing, thereby providing a challenge with continuity of care).

A significant cost pressure occurs when the ward is unable to fill all of its beds, irrespective of rationale, e.g. if it would be clinically unsafe to do so or the required staffing levels needed to increase above those agreed with commissioners. This is because the MDT funding is provided within the OBD rate charged, therefore it is significantly impacted if occupancy falls below 100% or patient need indicates that increased input is necessary. This puts significant pressure on NHS finances – whereas a community-based service can have more inherent flexibility built into the model to ease this pressure and see NHS resources spent more effectively and more beneficially on patient care.

There are also pressures on any onward moves for inpatients, as they are influenced by a number of factors including the complexity of a patient's needs, their requirements for adapted or specialised environments and whether any day time space is suitable to meet their needs. As a result, the patients currently on Willow Ward have been subject to delayed transfers of care, and the concern is that they start to view Willow Ward as a home, rather than its intended purpose, which is a hospital.

This said, similar to the patient who was discharged on 29 June 2020, the two remaining patients now have robust discharge plans in place, which will see them both discharged by 30 September 2020. The commissioners, and the clinical team at Willow Ward, have worked together to identify suitable providers, and each will be moving into their own home, with a skilled workforce supporting them. The providers in each case have been/are working with the ward to ensure the safe transition of each patient to their new home.

The current commissioner of the two remaining beds, West Hampshire Clinical Commissioning Group is aware of, and supportive of, the intention to close the ward once all patients are safely discharged.

There is a strong rationale that a 6-bed inpatient unit for this patient group is no longer needed. Willow Ward has been under-occupied for more than 18 months and it is agreed that those remaining patients on the unit should have been discharged to more beneficial community care some time ago and that their delayed discharges could have been reduced had an Enhanced Intensive Support (EIS) service been operational earlier.

To summarise, the biggest challenges currently facing Willow Ward are:

- Environmental factors (Willow Ward is isolated, situated in a remote site, away from any hospital infrastructure, and with no access to wider inpatient services. This creates a risk, particularly out of office hours, when access to support is not available).
- Whilst this is not an issue with the two remaining patients, in the past there have been inappropriate placements onto the ward. This saw increasingly high levels of acuity and dependency with some patients. This impacted on staffing numbers and, due to the isolation of the ward, the availability of staff who could be drawn in to meet increased demand was not there. As a result, there has historically been a high reliance on costly agency staff to meet the additional needs of the ward. (By comparison, an EIS team would have more inbuilt staffing flexibility than an inpatient facility).
- Financial challenges (heightened in December 2019, following the discharge of two Dorset CCG patients). Willow Ward is a spot purchased service, and the critical level of staffing is constant regardless of numbers of occupied beds. The costs related to the building itself also remain constant, regardless of the numbers of patients on the ward, and these fixed building costs would be better invested in delivering an enhanced community-based service.

Due to the long-term national plans for a more community-based package of care for this small patient group, Willow Ward has recently closed to new admissions. This presents a significant cost pressure and as the remaining patients are discharged, this pressure will increase.

This said, Southern Health's Community Learning Disability Service, including the existing Intensive Support Team (IST), continues to work proactively with patients, their families, carers and providers to respond to any crises in the community in order to prevent the need for admission. This work would continue after the proposed closure of Willow Ward and until the commencement of a potential new community-based EIS team – in order to ensure the best possible care in any interim period.

Southern Health, and senior commissioners within West Hampshire CCG and Southampton City CCG, have agreed their commitment to a new model of care which supports people with a learning disability whose behaviour challenges services. A proposal paper detailing the new Enhanced Intensive Support Service has already been submitted to commissioners, and costings for the new service are now being progressed. Subject to the funding for the new service being approved, a detailed business case will be prepared and submitted to commissioners for approval.

The next steps are to develop a Project Initiation Document, including a Standard Operating Procedure, for the new service. This will be developed in partnership with members of Willow Ward's multi-disciplinary team (some of whom have split posts with the existing Intensive Support Team) as these staff members will play a vital role in the design of the new model. It is hoped that formal agreement for the first stage of this work will be made by the end of July 2020 and a project plan will then be developed, with clear timescales for when the new EIS service can commence.

In essence, the new EIS service would expand on the current IST community model to create an enhanced intensive support service in the community. The role of this EIS team would be to deliver flexible, high intensity, personalised care to people experiencing behavioural or mental health crises within their own home environments. The intent would be for expert clinical staff to work alongside patients' regular support networks, enabling them to develop resilience in coping with behavioural challenges being presented. The EIS service would be a flexible, needs-led service, operating extended hours where required.

In addition, the EIS team would be working to ensure the discharge, and repatriation of people in out of area beds, providing in-reach into other hospital settings, working with commissioners and supporting care providers in the development of packages of care to meet individual needs in the community. This is work identified by CCGs as part of the new commissioning model for Learning Disability Services in Southern Health.

Due to the work involved in establishing this new service, it is likely that there will be a planned delay between the proposed closure of Willow Ward and a new community-based model being finalised and implemented. As a result, there will be a risk that a very small number of people with a learning disability who require assessment and treatment may need to be admitted to an inpatient unit out of area although, as mentioned above, this will be mitigated by our community teams and IST working to prevent the need for any admissions. In Hampshire and Southampton, the Dynamic Support Register, held by the CCGs, has oversight of people who are at risk of hospital admission, and is supported by all partners working in the Learning Disability sector.

In the event that an individual with learning disabilities deteriorates, so that there is at risk of admission to hospital, there already exists a joint protocol (between Hampshire and Southampton local authorities, CCGs and Southern Health) to ensure the least restrictive option is applied. The Blue Light Toolkit or Local Area Emergency Protocol, is a process for drawing together commissioners, along with health and social care providers, to respond to crises related to the care of people with a learning disability. Every effort is made to avoid admission, including increasing levels of support in the short term, along with increased interventions by the Community Learning Disability Team and IST. If admission is ultimately required, the Community Learning Disability Team, IST, and social care departments will work with the responsible CCG to facilitate an admission to an appropriate bed. Beds may be situated within existing mainstream NHS provision, or in specialist Learning Disability provision. The CCGs work with a number of providers, and are able to identify available beds across the region to best fit a patient's needs.

When?

We propose closing Willow Ward at the end of September 2020, although this is subject to further consultation with our patient groups/families and agreement from organisations such as our commissioners and the local overview and scrutiny committee.

Engagement Activity & Next Steps

Patients and Families/Carers

Southern Health is involved in a detailed review of its Learning Disability Services, which involves consultation with service users and carers/families. This review covers all learning disability services including the Challenging Behaviour pathway, of which Willow Ward and IST are integral parts. Within the proposed commissioning model for the Learning Disability service, there is an emphasis on modernising the service to provide early intervention to service users, to prevent hospital admission, and also to work with inpatient settings to ensure timely, safe discharge for individuals back into the community.

The proposal for the closure of Willow Ward will be discussed at the next Programme Board meeting, planned for 16 July 2020. The Programme Board includes carer and service user representatives, along with representation from other key stakeholders from across the county.

In addition to this, we are writing to the families of the two remaining Willow Ward patients and the recently discharged patient to gather their views on the planned closure of the unit and its replacement with a new EIS community service. Whilst it would be hard to gather feedback from the patients themselves, due to the complexity and profound nature of their learning disabilities, we are keen to discuss the proposals with their families who advocate on their behalf. This feedback should be available by the end of August.

Wider Stakeholders

As the care provided at Willow Ward is so specific/niche for a very small cohort of people with a learning disability and challenging behaviours, wide-scale consultation is not necessarily the most appropriate method of gathering opinion. Instead, we plan to write to local groups/organisations whose specific purpose is learning disability/patient advocacy, to ensure their understanding of the complex patient group and their interest in advocating for their best possible care.

As a result, letters with contact details for further information, are planned for:

- Hampshire Learning Disability Partnership Board (with links to the LIGs – local implementation groups)
- Southampton Learning Disability Partnership Board
- Healthwatch Southampton
- Healthwatch Hampshire
- Health and Wellbeing Board (Council)

Staff

Staff have been kept informed of the plans in relation to Willow Ward through regular informal communication in recent months. Additionally, a more formal consultation is now taking place from 6 July to 7 September 2020 to gather views.

As part of this we are asking staff about the impact of the potential divestment of Willow Ward - to establish how the 26 staff (made up mainly of health care support workers, nurses, psychologists and allied health professionals like speech and language therapists and occupational therapists) would be redeployed if Willow Ward were to cease as a standalone service. The goal is to secure all staff suitable alternative employment and wherever possible to avoid redundancies.

Staff are aware that there is a commitment from West Hampshire CCG and Southampton City CCG to support the design of an Enhanced Intensive Support service, which will provide community-based assessment and

treatment for people with a learning disability, who present with severe challenging behaviour, and who may have been admitted to a unit such as Willow Ward. We anticipate that this proposed new model would provide opportunities for staff to apply to redeploy again and work in this EIS service once operational. In effect, we would be moving our highly skilled staff team and utilising their expert skills in the new community-based model, in line with national guidance.

Any questions?

If you have any questions, please contact Celia Scott-Molloy, Head of Operations, Learning Disability Services on 07901 624514 or email: celia.scott-molloy@southernhealth.nhs.uk.

Southern Health
NHS Foundation Trust

08 2020
Communications and Engagement Team

Briefing note:
Southern Health's recent CQC Report and planned actions

Overview
On 23 January 2020, the Care Quality Commission (CQC) published their comprehensive report into Southern Health NHS Foundation Trust. A summary of the key findings from the inspection, as well as the planned improvement plan to respond to the report's findings, is contained in this briefing paper.

The 2020 CQC Report
We are pleased to confirm that the CQC rated the Trust overall as '**Good**'.

The inspection took place in October 2019 and looked at the quality of four core services:
- acute wards for adults of working age and psychiatric intensive care units (PICUs)
- child and adolescent mental health wards
- wards for older people with mental health problems
- mental health crisis services and health-based places of safety.

The CQC also looked specifically at management and leadership of the Trust.

The 'Good' rating demonstrates the significant progress made at the Trust since the previous CQC report of October 2018 (when we were rated as 'requires improvement'). It reflects the quality of care provided by the staff at Southern Health and their commitment to provide the best possible services to our patients, services users and their families. The report shows that over 90% of Trust services are now rated as good or outstanding, reflecting the continued progress in improving services and care.

Comments from the CQC report include:
"*Staff treated patients with compassion and kindness. The privacy and dignity of patients was respected and embedded in the work of staff. Staff understood the individual needs of patients. Patients were supported by staff to understand and manage their care, treatment or condition. Staff put patients at the centre of everything they did*."

"*Staff actively involved families and carers of patients in their care appropriately."*

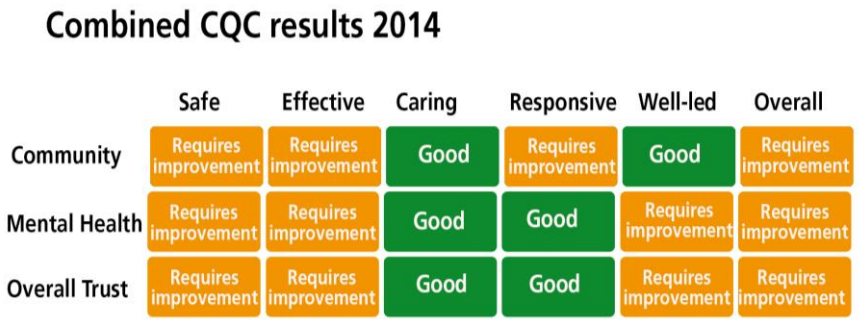
"The board had taken significant steps to improve the culture across the trust and staff felt valued. There was a real focus on doing what was best for people, both staff, patients and carers with a real commitment to the delivery of good quality patient care at every level. Staff at all levels of the trust were proud to work there and morale amongst staff was good."

Karen Bennett-Wilson, the CQC's Head of Hospital Inspection for the South, also added: *"At Southern Health, our inspectors found a really strong patient-centred culture with staff committed to keeping*

their people safe and encouraging them to be independent. Patients' needs came first, and staff worked hard to deliver the best possible care with compassion and respect. Inspectors saw many areas of good practice, with care delivered by compassionate and knowledgeable staff. Several teams led by example with a continuous focus on quality improvement. The trust did face some challenges and there are still some areas of improvement required but there has been a significant improvement in the services at this trust. Staff, patients and the leadership team should be proud of the work done so far."

<u>CQC ratings summary table</u>

Below is a visual demonstration of the progress made against the different CQC domains since the CQC's 2014 report on Southern Health.



On the next page are the current Trust CQC summary rating tables which show ratings for each domain (safe, effective, caring, responsive, well-led, and overall) against each core service. The arrows represent the changes in rating since 2018 for the core services inspected in October 2019:

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community health services for children and young people	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community health inpatient services	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community end of life care	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community urgent care service	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Overall*	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good ↑ Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Good ↑ Feb 2020	Good ↑ Feb 2020
Long-stay or rehabilitation mental health wards for working age adults	Good Oct 2018	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Outstanding Oct 2018	Outstanding Oct 2018
Forensic inpatient or secure wards	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Child and adolescent mental health wards	Good ↑ Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Good ↑ Feb 2020	Good ↑ Feb 2020
Wards for older people with mental health problems	Requires improvement →← Feb 2020	Requires improvement →← Feb 2020	Good →← Feb 2020	Good ↑↑ Feb 2020	Requires improvement →← Feb 2020	Requires improvement →← Feb 2020
Wards for people with a learning disability or autism	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Outstanding Oct 2018	Good Oct 2018	Outstanding Oct 2018
Community-based mental health services for adults of working age	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Mental health crisis services and health-based places of safety	Good →← Feb 2020	Requires improvement →← Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Requires improvement →← Feb 2020	Requires improvement →← Feb 2020
Community-based mental health services for older people	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community mental health services for people with a learning disability or autism	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Overall	Good ↑ Feb 2020	Requires improvement →← Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Good ↑ Feb 2020	Good ↑ Feb 2020

As well as lots of positive feedback, the latest CQC report has given us a valuable insight into the areas where we still must improve to ensure all of our services receive at least a good rating. We have been looking closely at the report and have now developed a quality improvement plan (QIP) for the coming months (see attached abridged version of our QIP 2020).

In this latest report, the CQC report has outlined:

- 8 actions the Trust 'must' take in order to comply with its legal obligations
- And 15 actions the Trust 'should' take to comply with a minor breach that did not justify regulatory action, to avoid breaching a legal requirement in the future or to improve services.

Compare this to the significantly higher 20 'must' actions, 74 'should' actions (and 7 'requirement notices') in the previous 2018 report – all of which were completed as part of a previous QIP.

The Quality Improvement Plan

The Quality Improvement Plan has taken the CQC's 23 actions and assigned staff to lead a programme of improvements against each of these. The planned improvements are outlined in the attached document, which was submitted to the CQC in February 2020.

In order to effectively address these issues, the Trust has once again introduced a themed approach to the management of the plan with a focus on quality improvement methodologies and the outcomes we want to achieve to improve patient care and experience. The actions are grouped into seven overarching themes with identified executive/theme leads and action owners and mapped to existing reporting structures.

The seven themes are:

- Workforce
- Patient Safety
- Patient Experience
- Privacy and Dignity
- Mental Health Legislation
- Records Management
- Operational

This Trust-wide Quality Improvement Plan has executive-level ownership for each theme, and it is hoped that the themed approach will ensure staff and stakeholders better understand the improvements required and how progress is being made against each theme.

Monitoring of progress and initial validation of the evidence to record an action as 'complete-unvalidated' will take place at the relevant workstream reporting meeting. Final validation that there is sufficient evidence to record an action as complete will take place at a monthly evidence review panel chaired by the Director of Nursing.

Progress dashboards and exception reports provide an update for the action plan with a summary of completed actions and any risks to actions not being completed within the deadlines identified. Exception reports will be submitted to the Trust Executive Committee (weekly) and to the Quality and Safety Committee, with a summary presented to Trust Board.

Recent CQC Inspections
The CQC undertook an unannounced focused inspection of Austen House, Child & Adolescent Mental Health Service (CAMHS) unit on 5 August 2020. Initial feedback was positive and the Trust are currently reviewing the draft report for factual accuracy. The final report should be published by CQC by the beginning of September 2020.

In Conclusion
This latest inspection is the next step towards Southern Health working to becoming an outstanding Trust. We would be very happy to further update the HOSP later this year on progress against the CQC Quality Improvement Plan.

Any questions?
If you have any questions or would like further information, please contact:

- Quality Improvement Plan 2018 - Briony Cooper, Programme Lead: on 023 8087 4009 or via email: qualityPMO@southernhealth.nhs.uk

- CQC Inspections - Tracey McKenzie, Head of Quality Assurance (interim): on 023 8087 4288 or via email: qualityPMO@southernhealth.nhs.uk

Ends

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Quality Improvement Plan for: CQC Inspection Recommendations - January 2020

Version: 0.1
Produced by: Briony Cooper, Programme Manager
Approved by: Paula Hull, Director of Nursing & Allied Health Professionals 17.02.20

UIN	Must/ Should actions	Core service	CQC recommendation *from the Inspection Report*	Regulation breached	Cause of breach/issue raised by CQC	Theme	Trust Action **Process:** *actions to be taken/processes to be put in place to meet the recommendation.* **Outcome:** *expected improvement for patients/carers/staff following implementation of process actions.*	Evidence to show completion	Responsible lead(s)	Executive Accountability	Completion date
1.a	MUST	Wards for older people with mental health problems	The trust MUST ensure that all patients have access to a clinical psychologist and psychological therapies to meet their needs.	9 HSCA (RA) 2014: Person Centred Care	Patients on five of the seven wards had limited access to a clinical psychologist and psychological therapies. Two wards had recruited a psychologist for two days per week, but others had no provision and nursing staff told us that they didn't have the skills to deliver any psychological therapies.	Workforce	PROCESS: 1. To agree revised structure chart for clinical psychology/psychological therapies staffing in OPMH across all divisions to include community/inpatient posts. This will include a plan for the remaining 3 organic wards. 2. Meet with Clinical Director of Portsmouth and South East division to discuss establishment of 8b clinical psychologist post. 3. Secure the required funding for these posts and recruit into them. 4. Introduce the Comprehend Cope and Connect (CCC) psychological formulation model to include training for all staff. OUTCOME: 1. Patients on all OPMH wards will have access to psychological therapies. 2. All appropriate patients will have a CCC formulation – will be recorded within RIO accessible to all staff and a copy offered to patient and can be shared with carer with consent.	PROCESS: 1. Structure chart for clinical psychology/psychological therapies 2. Establishment of new 8b post 3. Funding in place 4. Staff trained in CCC model OUTCOME: 1. Recruitment to psychology posts 2. Audit of CCC formulation	Hazel Nicholls Trust Director Psychological Therapies Ros Butters-Moule Consultant Clinical Psychologist	Dr Karl Marlowe Medical Director	PROCESS: August 2020 OUTCOME: December 2020
1.b	MUST	Wards for older people with mental health problems	The trust MUST ensure female lounges are not used by male patients and are available for female patients to use throughout day.	10 HSCA (RA) 2014: Dignity and Respect	Female patients did not always have a female-only designated area as the female-only lounges were accessed by male patients. The female only lounges were often used for other activities and meetings. We saw male patients wander into female lounges. One was a frequent user of the female lounge because he wanted to use exercise equipment in the room.	Privacy and Dignity	PROCESS: Divisions to review their local operating procedures for female only lounges and that staff are clear about maintaining female only lounges and that these are not used as dual purpose areas. OUTCOME: There will be access to gender specific areas across all inpatient sites.	PROCESS: Divisions to confirm action complete plus provide their local operating procedures. OUTCOME: Peer review / ward accreditation visits	Anne Middleton Divisional Director of Nursing & Allied Health Professionals (Southampton) Ben Goodwin Divisional Director of Nursing & Allied Health Professionals (South & West) Julia Lake Divisional Director of Nursing & Allied Health Professionals (Portsmouth & South East) Liz Taylor Divisional Director of Nursing & Allied Health Professionals (Mid & North)	Paula Hull Director of Nursing & Allied Health Professionals	PROCESS: May 2020 OUTCOME: July 2020
1.c	MUST	Wards for older people with mental health problems	The trust MUST ensure that staff record their decision-making when carrying out mental capacity assessments and ensure staff have a sound understanding of the Mental Capacity Act 2005.	11 HSCA (RA) 2014: Need for Consent	Staff across the services had limited understanding about the use of Mental Capacity Act. The service did not have a procedure for monitoring the use of the Mental Capacity Act and recording of mental capacity assessments was minimal and variable within the patient records.	Mental Health Legislation	PROCESS: 1. To appoint a Mental Health Legislation Manager for the Trust to lead on implementation of the Mental Capacity Act, including implementation of the Liberty Protection Safeguards scheme. 2. To review the current policy, guidance, training, supervision, and recording arrangements. 3. To roll out the new Mental Capacity Act training across divisions to provide staff with the skills and knowledge about the core responsibilities and provisions of the Mental Capacity Act. 4. Divisions to have procedures in place to ensure training is completed, mental capacity assessments are completed and that the Mental Capacity Act is followed. OUTCOME: Staff are skilled and confident in all areas of mental capacity and are able to appropriately evidence and record their practice	PROCESS: 1. Manager in post 2. Updated policy, guidance, training, supervision and recording arrangements 3. Training programme 4. Numbers of staff trained/divisional procedures OUTCOME: Mental Capacity Act Audit	Anne Middleton Divisional Director of Nursing & Allied Health Professionals (Southampton) Ben Goodwin Divisional Director of Nursing & Allied Health Professionals (South & West) Julia Lake Divisional Director of Nursing & Allied Health Professionals (Portsmouth & South East) Liz Taylor Divisional Director of Nursing & Allied Health Professionals (Mid & North) Eliot Smith Named Professional for Safeguarding	Paula Hull Director of Nursing & Allied Health Professionals	PROCESS: August 2020 OUTCOME: MCA Audit - tbc (new MH Manager to design and carry out audit)
1.d	MUST	Wards for older people with mental health problems	The trust MUST ensure there is a patient alarm system on all older person's wards which enables patients and visitors to alert staff to their need for urgent support.	12 HSCA (RA) 2014: Safe Care and Treatment	Patients on Beaulieu ward were unable to access a nurse call alarm from their bedroom areas so could not call for help from their bedrooms in an emergency. Staff told us these had been removed during refurbishment	Patient Safety	Divisional Director of Nursing confirms that all patient bedroom areas have nurse call alarms and that patients are able to call for help from their bedrooms in an emergency.	PROCESS: N/A OUTCOME: N/A	Anne Middleton Divisional Director of Nursing & Allied Health Professionals (Southampton) Sharon Harwood Area Matron	Heather Mitchell Director of Strategy & Infrastructure Transformation	PROCESS: OUTCOME:

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1.e	MUST	Wards for older people with mental health problems	The trust MUST ensure consistency in the disposal of clinical waste in line with their policy on handling and disposal of healthcare waste, to prevent a breach of the Hazardous Waste Regulations 2005. The trust must ensure that the carpet on Beechwood ward is suitable and meets infection control standards.	12 HSCA (RA) 2014: Safe Care and Treatment	Staff did not protect patients from infection control issues when disposing of clinical waste. Staff did not work in line with the trust policy on handling and disposal of healthcare waste. The management of infectious waste was not consistent across all wards. We saw paper bin liners in the bins that were designed for clinical waste and on some wards, it was not clear how this waste was being managed safely. The use of paper bin liners was not in line with the trust's policy. There was a carpet on Beechwood ward that posed an infection control risk. Staff had escalated this, but this had not been addressed.	Patient Safety	PROCESS: 1. To review and update SH NCP 47 Handling Disposal of Healthcare Waste Policy to reflect current practice. 2. To complete compliance checks that wards comply with updated Waste Policy. 3. To replace carpet on Beechwood ward. OUTCOME: Patients are cared for in environments which meet infection control standards.	PROCESS: 1. updated policy in place 2. compliance checks on wards 3. replacement flooring OUTCOME: Infection control and prevention team visit to wards to confirm wards meet IPC standards	Liz Taylor Divisional Director of Nursing & Allied Health Professionals (Mid & North) Cris Spring Area Matron Sally Banbery Contracts and Project Manager Tracy England Contracts Manager Jacky Hunt Lead Nurse Infection Control and Prevention	Paula Hull Director of Nursing & Allied Health Professionals	PROCESS: September 2020 OUTCOME: October 2020
1.f	MUST	Mental health crisis services and health based places of safety	The trust MUST ensure that all patients in the crisis service have a holistic, person-centred care and crisis plan within their records. Records must be clear, up-to-date and information recorded consistently in the electronic record.	9 HSCA (RA) 2014: Person Centred Care	Across the service records were not always clear, up-to-date and easily available to all staff providing care, with staff recording information inconsistently in different parts of the electronic record. Some paper records for patients in the health-based places of safety contained recording gaps. Staff working for the crisis teams still did not consistently develop and record holistic, recovery-oriented care and crisis plans informed by a comprehensive assessment and in collaboration with families and carers. Staff working for the mental health crisis teams worked with patients and families and carers to gather information but did not always develop individual care plans and update them when needed. Care plan recording was inconsistent, and when plans were produced they were not always personalised and holistic.	Records Management	PROCESS: 1. Identify teams who require additional support to complete holistic personalised up to date care plans and ensure support and additional training is provided to those teams. 2. Review documentation in place currently and revise in collaboration with staff, patients and carers. OUTCOME: Patients are involved in developing care plans which describe their needs and wants.	PROCESS: 1. Divisions to confirm completion of action 2. Audit care plans OUTCOME: Feedback from service users / carers	Anne Middleton Divisional Director of Nursing & Allied Health Professionals (Southampton) Ben Goodwin Divisional Director of Nursing & Allied Health Professionals (South and West) Julia Lake Divisional Director of Nursing & Allied Health Professionals (Portsmouth and East) Liz Taylor Divisional Director of Nursing & Allied Health Professionals (Mid and North) Sally-Ann Jones Patient Safety Specialist	Paula Hull Director of Nursing & Allied Health Professionals	PROCESS: June 2020 OUTCOME: September 2020
1.g	MUST	Mental health crisis services and health based places of safety	The Trust MUST ensure that the physical environment of the health-based places of safety are fit for purpose and meet the requirements of the Mental Health Act Code of Practice.	15 CQC (Registration) 2009: Notifications - notice of changes	The physical environment of the health-based places of safety did not fully meet the requirements of the Mental Health Act Code of Practice. For example, two of the three suites did not have a clock (this is important so that people brought into the suites know how long they have been there). There was no toilet door at the Antelope House suite and in the Elmleigh suite the toilet had no walls or door for privacy	Mental Health Legislation	PROCESS: 1. Divisions to complete compliance checks of the health-based places of safety with regard to the Mental Health Act Code of Practice. 2. Divisions to take corrective actions to address any areas of non -compliance. 3. The Trust Section 136 Suite Forum will monitor progress with this action. 4. The Trust Section 136 Suite Forum will report progress updates and escalation of issues to the relevant Trust meeting. OUTCOME: Patients are kept safe and their privacy and dignity are respected while in the places of safety. Trust Places of Safety will be compliant with the Mental Health Act Code of Practice.	PROCESS: 1. Compliance checks per division 2. Actions to address non-compliance 3. Minutes of 136 Suite Forum x 3 4. Reports OUTCOME: Patient feedback Compliance checks	Zaid Alabbasi Divisional Medical Director (Southampton) Sarah Olley Divisional Director of Operations (Southampton) Nicky MacDonald Divisional Director of Operations (Mid and North) Nicky Adamson-Young Divisional Director of Operations (Portsmouth and East) Beth Ford User Involvement Facilitator for Mental Health services	Grant Macdonald Chief Operating Officer	PROCESS: August 2020 OUTCOME: October 2020
1.h	MUST	Mental health crisis services and health based places of safety	The trust MUST ensure it meets its legal obligations in the health-based places of safety.	17 HSCA (RA) 2014: Good Governance	Leaders did not have assurance that the trust was meeting its legal obligation to ensure people did not stay in the health-based places of safety for longer than 24 hours or have an extension granted by an approved person because staff were not consistently completing the required hourly checks. There were no systems in place to ensure staff entered correct entry times, completed the hourly checks or to ensure staff would escalate appropriately so action could be taken if people had been in the health-based places of safety nearing the 24-hour period.	Mental Health Legislation	PROCESS: 1. Divisions to review local procedures for health-based places of safety and amend where required to ensure there are systems in place to support entry of correct admission times, completion of hourly checks and escalation processes. 2. Front-line staff to advise and design above systems and check these systems work in practice using 'plan, do, study, act (PDSA) cycle. 3. The Trust Section 136 Suite Forum to review the Trust escalation protocol against proposals from the divisions. 4. The Trust Section 136 Suite Forum to develop training materials and deliver training on the legal obligations and protocols to 136 suite staff. OUTCOME: Patients do not stay in health-based places of safety for longer than 24 hours or if required have an approved extension, where breaches do occur, the Trust will ensure its protocols expedite the discharge of the patient from the PoS to an appropriate ward and that the patient will remain cared for in the least restrictive manner.	PROCESS: 1. Divisional standard operating procedures 2. Checks that standard operating procedures are effective 3. Minutes of 136 Suite Forum 4. Training programme/numbers of staff trained OUTCOME: Performance data for 136 Suites Training and Systems will be in place to support staff with complying with the Pan Hampshire Section 136 Policy and Protocol.	Zaid Alabbasi Divisional Medical Director (Southampton) Sarah Olley Director of Operations (Southampton) Laura Rothery Director of Operations (South and West) Nicky MacDonald Director of Operations (Mid and North) Nicky Adamson-Young Director of Operations (Portsmouth and East)	Paula Hull Director of Nursing & Allied Health Professionals	PROCESS: October 2020 OUTCOME: December 2020

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2.a	SHOULD	Wards for older people with mental health problems	The trust SHOULD ensure that patients privacy maintained on Elmwood ward.	Not applicable	On Elmwood ward it could be possible to see into patients' bedrooms from a meeting room used by staff on the first floor of the building. This could compromise the privacy of patients.	Privacy and Dignity	PROCESS: **Trust has contacted CQC to request further information to clarify this recommendation as Trust is unable to replicate.** OUTCOME:	PROCESS: OUTCOME:	Liz Taylor Divisional Director of Nursing & Allied Health Professionals (Mid and North) Richard Ilsey Head of Nursing & Allied Health Professionals	Paula Hull Director of Nursing & Allied Health Professionals	PROCESS: OUTCOME:
2.b	SHOULD	Wards for older people with mental health problems	The trust SHOULD ensure patients can make phone calls in private.	Not applicable	Patients could not always make a phone call in private, unless they had their own bedroom and a mobile phone. On Beechwood ward staff said patients could make a call from the staff office.	Privacy and Dignity	PROCESS: Divisions to have local procedures in place to enable patients to make phone calls in private and test these procedures are effective. OUTCOME: Patients are able to make phone calls in private.	PROCESS: Local procedures in place. Divisions to test effectiveness of procedures OUTCOME: Feedback from service user audits	Anne Middleton Divisional Director of Nursing & Allied Health Professionals (Southampton) Ben Goodwin Divisional Director of Nursing & Allied Health Professionals (South and West) Julia Lake Divisional Director of Nursing & Allied Health Professionals (Portsmouth and East) Liz Taylor Divisional Director of Nursing & Allied Health Professionals (Mid and North) Beth Ford User Involvement Facilitator for Mental Health services	Paula Hull Director of Nursing & Allied Health Professionals	PROCESS: June 2020 OUTCOME: August 2020
2.c	SHOULD	Wards for older people with mental health problems	The trust SHOULD ensure staff know about plans for the eradication of dormitory accommodation	Not applicable	Some patients had to sleep in dormitories. While the trust had plans to eradicate dormitories in the future staff had little knowledge of what the plans were and when this might happen.	Privacy and Dignity	PROCESS: To develop and implement communication strategy to ensure that staff are kept up to date with the future plans to eradicate dormitory accommodation. OUTCOME: Staff are aware of the plans to eradicate dormitory accommodation.	PROCESS: Communication updates OUTCOME: Minutes of divisional governance meetings	Julia Lake Divisional Director of Nursing & Allied Health Professionals (Portsmouth and East) Nicky Adamson-Young Divisional Director of Operations (Portsmouth and East)	Grant Macdonald Chief Operating Officer	PROCESS: May 2020 OUTCOME: July 2020
2.d	SHOULD	Wards for older people with mental health problems	The trust SHOULD ensure all care plans are patient centred and that patients are given a copy of their care plan should they want it.	Not applicable	Care records were not always person centred, up to date or regularly reviewed. Of the 22 care records that we reviewed, we found nine that were not person centred.	Records Management	PROCESS: 1. Identify teams who require additional support to complete holistic personalised up to date care plans and ensure support and additional training is provided to those teams. 2. Review documentation in place currently and revise in collaboration with staff, patients and carers. OUTCOME: Patients are involved in developing care plans which describe their needs and wants.	PROCESS: 1. Divisions to confirm completion of action 2. Revised documentation OUTCOME: Audit care plans	Anne Middleton Divisional Director of Nursing & Allied Health Professionals (Southampton) Ben Goodwin Divisional Director of Nursing & Allied Health Professionals (South and West) Julia Lake Divisional Director of Nursing & Allied Health Professionals (Portsmouth and East) Liz Taylor Divisional Director of Nursing & Allied Health Professionals (Mid and North) Sally-Ann Jones Patient Safety Specialist	Paula Hull Director of Nursing & Allied Health Professionals	PROCESS: June 2020 OUTCOME: September 2020
2.e	SHOULD	Mental health crisis services and health based places of safety	The trust SHOULD ensure that staff are confident and able to assess and record capacity assessments and best interest decisions for patients who might have impaired mental capacity.	Not applicable	Staff in the crisis teams did not always record that they had considered a patient's capacity to consent to treatment or did not record whether patients had capacity in the patient electronic records. It was therefore not clear to all looking at the records whether a patient had capacity or not to make a particular decision or when best interest decisions had been made.	Mental Health Legislation	PROCESS: See 1c - same actions OUTCOME: See 1c - same outcomes	PROCESS: OUTCOME:	Anne Middleton Divisional Director of Nursing & Allied Health Professionals (Southampton) Ben Goodwin Divisional Director of Nursing & Allied Health Professionals (South and West) Julia Lake Divisional Director of Nursing & Allied Health Professionals (Portsmouth and East) Liz Taylor Divisional Director of Nursing & Allied Health Professionals (Mid and North) Eliot Smith Named Professional for Safeguarding	Paula Hull Director of Nursing & Allied Health Professionals	PROCESS: August 2020 OUTCOME: MCA Audit - tbc (new MH Manager to design and carry out audit)

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2.f	SHOULD	Mental health crisis services and health based places of safety	The trust SHOULD ensure that patients have access to physical health checks within the crisis service.	Not applicable	Staff were not consistently completing and recording physical health checks for patients in the crisis teams	Patient Safety	PROCESS: 1. Divisions to review and confirm that procedures for physical health checks are in place, with access to necessary equipment and that staff understand and follow 'non contact' physical health observations where appropriate. 2. Divisions to monitor performance that physical health checks are completed appropriately. OUTCOME: Patients have appropriate physical health checks and are safe in our care.	PROCESS: 1. Divisional procedures 2. Performance data OUTCOME: Clinical audit and/or peer review	Anne Middleton Divisional Director of Nursing & Allied Health Professionals (Southampton) Ben Goodwin Divisional Director of Nursing & Allied Health Professionals (South and West) Julia Lake Divisional Director of Nursing & Allied Health Professionals (Portsmouth and East) Liz Taylor Divisional Director of Nursing & Allied Health Professionals (Mid and North)	Paula Hull Director of Nursing & Allied Health Professionals	PROCESS: June 2020 OUTCOME: September 2020
2.g	SHOULD	Mental health crisis services and health based places of safety	The trust SHOULD ensure that there is clear senior oversight of the service, particularly the health-based places of safety.	Not applicable	Due to recent changes in the way crisis services and health-based places of safety suites were managed both managers and staff of the services unclear who the senior manager was who held responsibility for the service.	Workforce	PROCESS: 1. The Trust Section 136 Suite Forum and Divisions to review Section 136 Protocols for ambiguities or unclear instructions. 2. Ambiguities or unclear instructions in protocols to be resolved as a single standard document or divisional protocols to implement the new Trust protocol. OUTCOME: The Pan Hampshire Section 136 Escalation Protocol will be clear for each Division in terms of responsibilities and instructions for escalation. Staff will understand the lines of responsibility and oversight for the service including the health-based places of safety.	PROCESS: 1. minutes of meetings 2. Trust 136 Suite protocol/divisional protocols OUTCOME: Peer review/accreditation visits	Zaid Alabbasi Divisional Medical Director (Southampton) Sarah Olley Divisional Director of Operations (Southampton) Nicky MacDonald Divisional Director of Operations (North and Mid) Nicky Adamson-Young Divisional Director of Operations (Portsmouth and East)	Grant Macdonald Chief Operating Officer	PROCESS: June 2020 OUTCOME: August 2020
2.h	SHOULD	Acute wards for adults of working age and psychiatric intensive care units	The trust SHOULD ensure that the furniture at Hawthorns 1 and 2 is fit for purpose.	Not applicable	Staff on Hawthorn 1 and 2 told us that the furniture was not fit for purpose as it an infection control risk. Although a capitol bid had been put to the board to replace it this had been unsuccessful as the trust had other immediate priorities that it needed to fund.	Patient Safety	PROCESS: To order new furniture for the ward which is fit for purpose and does not pose an infection control risk. OUTCOME: Patients are kept safe and have a positive experience on the ward.	PROCESS: Furniture in place OUTCOME: Infection Prevention and Control team visit to ward to confirm ward meets IPC standards	Liz Taylor Divisional Director of Nursing & Allied Health Professionals (Mid and North) Richard Ilsey Head of Nursing & Allied Health Professionals	Paula Hull Director of Nursing & Allied Health Professionals	PROCESS: February 2020 OUTCOME: May 2020
2.i	SHOULD	Acute wards for adults of working age and psychiatric intensive care units	The trust SHOULD ensure that any maintenance work is completed in a timely manner.	Not applicable	Staff said it was it was difficult to get maintenance work done in a timely manner. For example, the washing machine on Saxon ward had been broken for some time and despite reporting this it had not been fixed.	Operational	PROCESS: 1. Estates team to signpost team leads to the new tableau reports on the status of requested maintenance works, enabling them to track and monitor individual works requests. (These include works to be completed by Bellrock/Lift contract.) 2. Estates team to track performance on completion of maintenance works via tableau reports and identify and resolve outstanding works. OUTCOME: 1. Staff are able to track individual requests on tableau and understand estimated completion dates. 2. Increased oversight of maintenance works will drive timely completion.	PROCESS: 1. communication re signposting 2. Tableau reports on maintenance performance /minutes of Estates MOM x 3 OUTCOME: 1. number of staff accessing tableau reports 2. Tableau reports on maintenance performance /minutes of Estates MOM x 3	Andy Mosley Associate Director of Estate Services Tracey England Contract Manager	Heather Mitchell Director of Strategy & Infrastructure Transformation	PROCESS: May 2020 OUTCOME: July 2020
2.j	SHOULD	Acute wards for adults of working age and psychiatric intensive care units	The trust SHOULD ensure that the staff are able to observe and communicate with patients in all areas of Hawthorns 2 seclusion room appropriately whilst maintaining the dignity of patients.	Not applicable	It was difficult for staff to observe or communicate with a patient in the seclusion room at Hawthorns 2 when they were using the toilet facilities. Staff had raised this as a potential risk issue, but this had not been addressed by the trust. Staff made every effort to manage patients safely and there had not been any incidents.	Patient Safety	PROCESS: To install an intercom system enabling staff to communicate with patient in seclusion room in Hawthorns 2 at all times. OUTCOME: Patients are kept safe and potential risks are minimised in the seclusion room in Hawthorns 2..	PROCESS: Intercom system in place OUTCOME: Staff feedback that potential risk eliminated	Liz Taylor Divisional Director of Nursing & Allied Health Professionals (Mid and North) Richard Ilsey Head of Nursing & Allied Health Professionals	Paula Hull Director of Nursing & Allied Health Professionals	PROCESS: May 2020 OUTCOME: July 2020

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2.k	SHOULD	Acute wards for adults of working age and psychiatric intensive care units	The trust SHOULD ensure it continues work to ensure female patients requiring psychiatric intensive care beds are accommodated as close to home as possible.	Not applicable	There were no female PICU beds within the trust, so staff needed to refer out of area if a bed was needed. There had been a small number of occasions when patients admitted to Elmleigh ward had needed to be secluded in the health based place of safety suite while they waited for a PICU bed.	Patient Safety	PROCESS: To address issue of no female PICU beds within Trust. OUTCOME: Female patients are cared for as close to home as possible.	PROCESS: Plan in place OUTCOME: Data on PICU beds/out of area beds	Sarah Olley Divisional Director of Operations (Southampton) Nicky MacDonald Divisional Director of Operations (Mid and North) Nicky Adamson-Young Divisional Director of Operations (Portsmouth and East)	Grant Macdonald Chief Operating Officer	PROCESS: July 2020 OUTCOME: September 2020
2.l	SHOULD	Child and adolescent mental health wards	The trust SHOULD ensure there are enough activities for young people throughout the week.	Not applicable	Young people and staff told us young people did not have enough to do when they were not at school Young people and staff at Bluebird House told us there were not enough activities, especially at weekends on Stewart ward.	Patient Experience	PROCESS: 1. Map what activities are available and collate feedback from young people as to why they perceive there is not much activity available out of school hours to understand the scope of the issues. 2. We will map the process for identifying needs and interests related to activities and how we support patients to choose activities. This will include using the Model of Creative Ability (MOCA). Information will then be detailed in every young person's assessment and we will understand and document their needs and wishes clearly. 3. We will develop a profile page on activities for all young people and a personal activity plan for each individual which covers all of their waking hours. 4. The Ward Managers across CAMHS will develop a consistent OpenRiO template for recording shifts which will include activities offered and undertaken by each patient. The Ward Managers will also devise the MDT template so that the nursing report to MDT includes a breakdown of activity by each young person for review at the MDT meeting. The use will be reviewed after one month of implementation. OUTCOME: Young people across CAMHS will be given every opportunity to access activities outside of school hours which are appropriate, meet their needs and that they enjoy. We will be able to evidence the activities offered and undertaken as well as the support offered to help a young person increase their activity levels.	PROCESS: 1. Map of activities and feedback from young people. 2. Process map developed as to how we identify needs and interests with results detailed in every young person's assessment. 3. Evaluate that profile pages and personal activity plans in place. 4. OpenRiO template for general progress notes are in place. MDT template in place. Both templates evaluated for effectiveness. OUTCOME: Activities clearly documented as to what is available and records of activities offered and undertaken for each individual patient.	John Stagg Divisional Director of Nursing & Allied Health Professionals (Specialist Services) Karen Dixon Head of Nursing & Allied Health Professionals	Paula Hull Director of Nursing & Allied Health Professionals	PROCESS: June 2020 OUTCOME: August 2020
2.m	SHOULD	Child and adolescent mental health wards	The trust SHOULD ensure that all staff receive regular supervision.	Not applicable	Some staff on Stewart ward did not always receive regular supervision and supervision was sometimes cancelled	Workforce	PROCESS: 1. The Practice Educators and the Clinical Improvement Lead at Bluebird House will implement a session on supervision within the Band 6 development programme. 2. The Practice Educators will roll out the dates for supervision training for the next 12 months and ensure that they are on LEaD for staff to book on to the sessions. This will include the "Having Difficult Conversations" elements of the training. 3. We will have booked all staff onto this training over the next 12 months. 4. We will implement the system used at Leigh House across all CAMHS services so that it is consistent for all services - Reflective practice - Ward Supervision - Management supervision - Peer support supervision - Safeguarding supervision - Individual Clinical supervision - Same formats for recording 5. All Appraisals will be regarded as the 12th Management Supervision and will set the objective for clinical supervision being a mandatory requirement to work within the service. It will be mandated into everyone's appraisal that they will attend a minimum of 8 clinical supervision sessions per year as well as their management supervision. 6. We will monitor supervision for all staff of all disciplines through the CAMHS Operational Meetings on a monthly basis. OUTCOME: Staff will access all appropriate forms of supervision on a regular basis and it will be integral to role and work undertaken. Supervision compliance will be at a minimum of 95% by 30.11.20.	PROCESS: 1. Band 6 development programme will include supervision 2. Dates for supervision training on LEaD 3. Staff booked onto supervision training 4. Leigh House system in place in all CAHMS sites 5. Appraisal data 6. minutes of CAHMS Operational meetings x 3 OUTCOME: Supervision data	John Stagg Divisional Director of Nursing & Allied Health Professionals (Specialist Services) Karen Dixon Head of Nursing & Allied Health Professionals	Paula Hull Director of Nursing & Allied Health Professionals	PROCESS: August 2020 OUTCOME: November 2020
2.n	SHOULD	Child and adolescent mental health wards	The trust SHOULD review its procedures for booking carers and families visits to young people on Hill ward to ensure they run smoothly.	Not applicable	Two carers of young people on Hill ward said their visits were shortened or cancelled and one arrived for a visit and was told it was not booked. In forensic service visits need to be booked due to security issues.	Patient Experience	PROCESS: 1. Review the policy/ procedures for booking visits / facilitating visits on secure CAMHS wards. 2. Develop a process for centralised booking and pilot it with involvement from Reception and Administration staff – then roll out for secure CAMHS. OUTCOME: Visits to secure services will have an appropriate and monitored booking system that reduces the risk of visits being arranged inappropriately, cancelled or delayed as much as possible. Cancelled visits will be the exception with clear evidence as to why it was appropriate to cancel or change a visit.	PROCESS: 1. Updated policy/procedure 2. Process for centralised booking system across CAMHS OUTCOME: Visits are appropriately planned with the number of cancelled visits and appropriate rationale for cancellations documented	John Stagg Divisional Director of Nursing & Allied Health Professionals (Specialist Services) Karen Dixon Head of Nursing & Allied Health Professionals	Paula Hull Director of Nursing & Allied Health Professionals	PROCESS: June 2020 OUTCOME: August 2020

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2.o	SHOULD	Child and adolescent mental health wards	The trust SHOULD continue to address the staff morale issues at Bluebird House and should provide support regarding forthcoming changes.	Not applicable	Staff morale was varied at Bluebird House and some staff said they were stressed about forthcoming moves	Workforce	PROCESS: 1. Clinical Improvement Lead will become the project manager for the Quality Improvement (QI) project with supervision from Head of Nursing & AHPs. Head of Nursing & AHPs will review cultural survey and the staff survey results and bring this into the QI project plan. 2. The division will make sure that the actions and the plan from the QI project is fully supported and the Head of Nursing & AHPs will take overall responsibility. 3. Develop a communication strategy in each service/ unit – this should include a newsletter, update meeting, staff meetings. 4. Communication box in nursing office and staff rooms. 5. Quarterly listening groups set up for all staff facilitated by a matron from another area. 6. A "You Said/ We Did" communication on a quarterly basis (minimum) devised at the CAMHS Operational Meeting and delivered by the Head of Nursing & AHPs. OUTCOME: Staff will have various means of communicating information on a two way basis which will be managed through the CAMHS Operational Meeting which will look to evaluate the morale of staff on an ongoing basis.	PROCESS: 1. QI project plan 2. QI project plan progress updates 3. Communication strategies in place 4. Communication boxes in place 5. Listening groups 6. 'You said, we did' quarterly communication OUTCOME: Minutes of CAMHS Operational meeting x 3	John Stagg Divisional Director of Nursing & Allied Health Professionals (Specialist Services) Karen Dixon Head of Nursing & Allied Health Professionals	Paula Hull Director of Nursing & Allied Health Professionals	PROCESS: May 2020 OUTCOME: July 2020

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		THE EMERGING PICTURE - COVID-19 AND HEALTH INEQUALITIES IN SOUTHAMPTON		
DATE OF DECISION:		3 SEPTEMBER 2020		
REPORT OF:		INTERIM DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Kate Lees**	Tel:	
	E-mail:	Locum Consultant in Public Health		
Director	**Name:**	**Debbie Chase**	Tel:	023 8083 3694
	E-mail:	Interim Director of Public Health		

STATEMENT OF CONFIDENTIALITY
N/A

BRIEF SUMMARY

Southampton experienced significant health inequalities before Covid-19. There is evidence to show that Covid-19 is exacerbating health inequalities through a variety of mechanisms. Some groups are at much higher risk of either being infected by, or severe outcomes from the virus; there have been changes in the use of and access to health services over the course of the pandemic to date; there is emerging evidence to show the measures taken to control the spread of the virus have had unequal socioeconomic impacts, and it is anticipated this may continue.

This paper provides an initial analysis of the impact of Covid-19 on health inequalities in Southampton. Detailed analysis is limited to data of those who have had a positive test for coronavirus and deaths from Covid-19. Further analysis is required once data and capacity is available, to understand the full impact of Covid-19 on health inequalities in the city, and inform action planning to mitigate this impact.

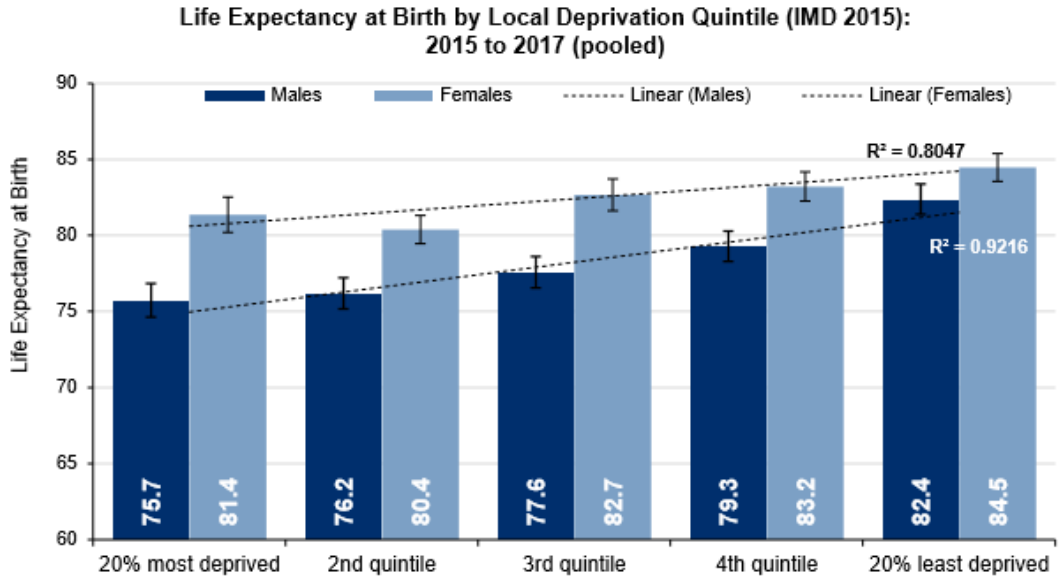
There are a range of evidence-based interventions for reducing health inequalities, which take a lifecourse and place-based approach. Evidence shows that a focus on the wider determinants of health will have the maximum population impact. These approaches require a 'whole-system' approach. The Health and Wellbeing Board has recognised they are well-placed to lead this approach to reduce health inequalities and improve health outcomes for the city.

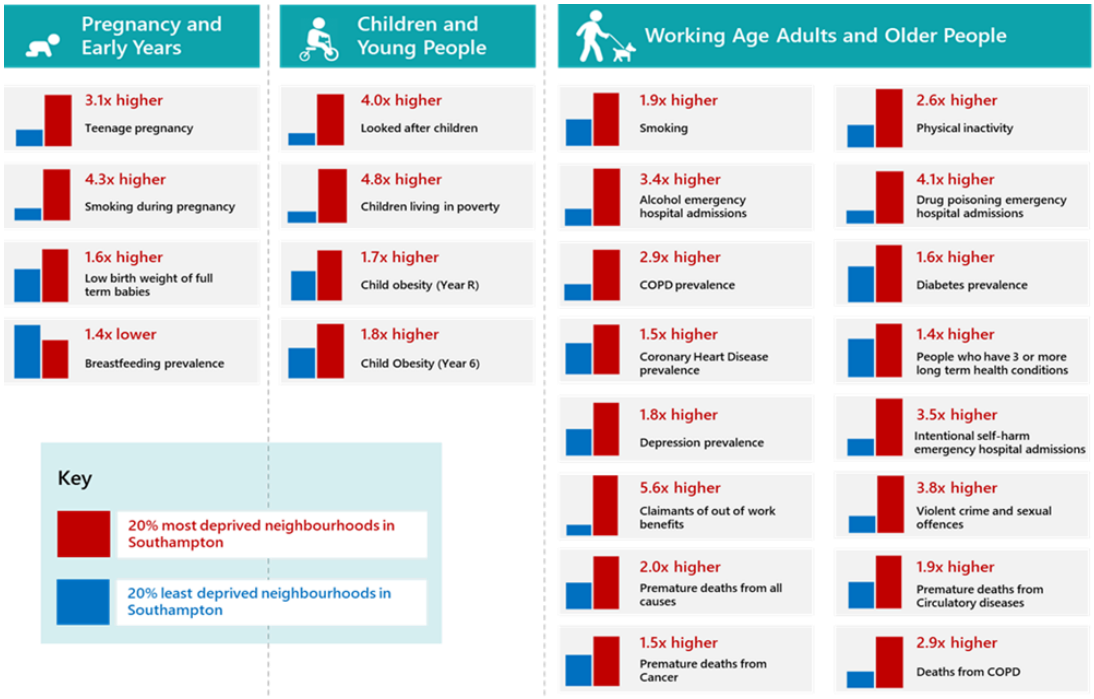
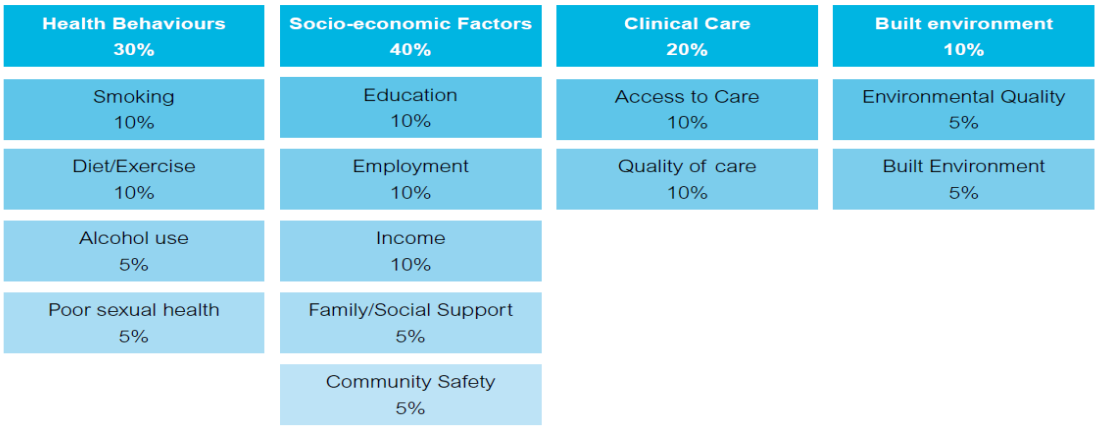
RECOMMENDATIONS:		
	(i)	That the Panel note, discuss and debate the content of this report.

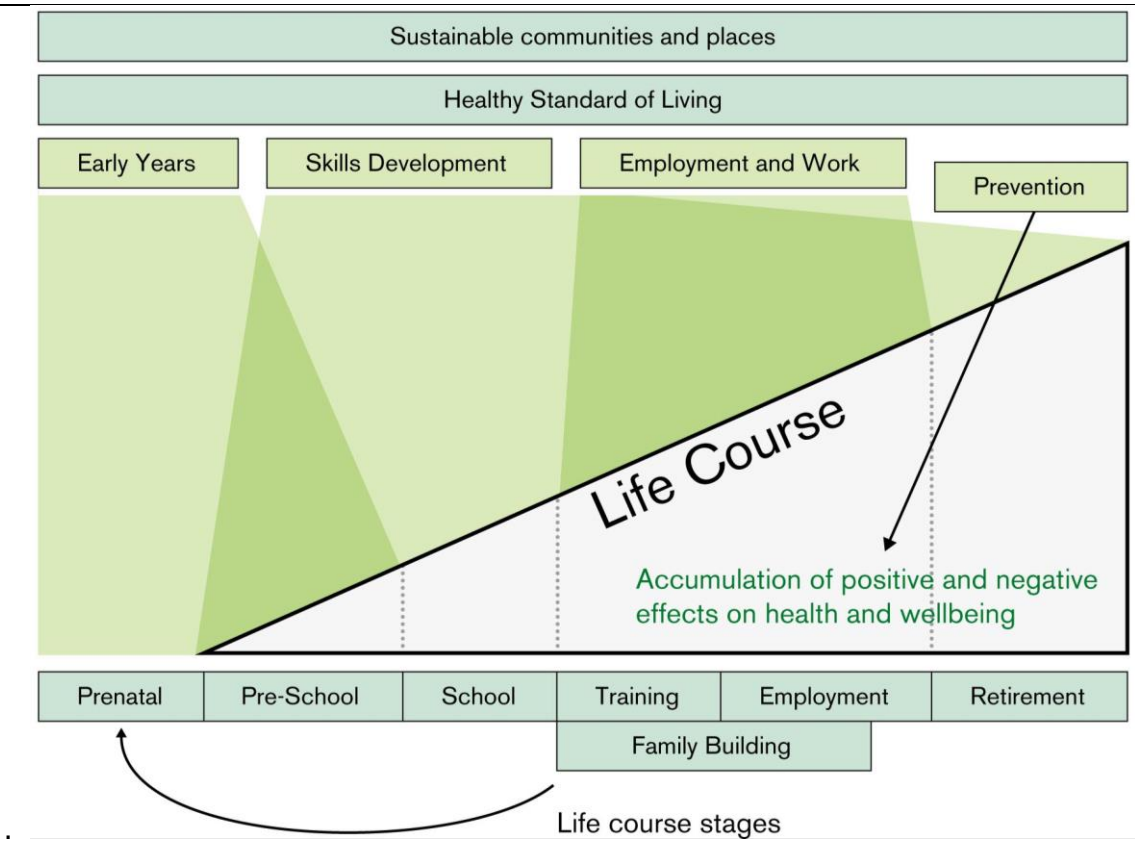
REASONS FOR REPORT RECOMMENDATIONS	
1.	To enable the Panel to discuss the emerging picture with regards to Covid-19 and health inequalities in Southampton.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	None

DETAIL (Including consultation carried out)	
	Background

3.	Health inequalities are defined as “differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact, because they result in people who are worst off experiencing poorer health and shorter lives.” (NICE, 2012)
4.	A major incident was declared by Hampshire and the Isle of Wight Local Resilience Forum in March 2019, in response to Covid 19, the disease caused by a novel coronavirus spreading in the community. The virus and measures put in pace to control its’ spread have had large and far-reaching impacts across society.
5.	It has become increasingly apparent over the course of the Covid-19 pandemic that impact from Covid-19 has not been experienced equally across society. Some quantitative evidence of this differential impact comes from international, national and local sources, whilst some evidence is developing. An exacerbation of health inequalities are anticipated based on this evidence and expert opinion about likely future impact.
	Health Inequalities in Southampton pre Covid-19
6.	Men living in the most deprived quintile in Southampton live on average 6.6 years less than those in the most affluent quintile. For women this difference is 3.1 years. The graph below shows a clear relationship between life expectancy and deprivation.  Sources: NHS Digital Primary Care Mortality Database, ONS Mid-Year Population Estimates & IMD (2015) People living in the most deprived quintiles in Southampton are almost twice as likely to die prematurely (under 75 years old) than those in the most affluent.
7.	People living in the most deprived quintile in Southampton are more likely to have long term health conditions compared to those in the most affluent quintile. For example, they are almost three times as likely to have COPD, over one and a half times more likely to have diabetes. Those in the most deprived quintile are 1.78 times more likely to have depression and 2.77 times more likely to have schizophrenia.[1]
8.	People living in the most deprived quintile in Southampton are 1.93 times more likely to smoke and 2.6 times more likely to be inactive and children 1.7 times more likely to have excess weight compared to those in the most affluent quintiles.[1]

9.	Southampton had significant health inequalities before the major incident in response to Covid-19. This difference was seen across a range of different health outcomes, as summarised in the infographic below. Health inequalities exist both in mortality and morbidity and across physical and mental health outcomes.[1] 
	The determinants of health
10.	Our health is affected by a wide range of factors as shown in the figure below. The biggest determinant of health is socio-economic factors, followed by health behaviours, then clinical care and the built environment. The socio-economic and environmental are referred to as the wider determinants of health.  **Source**: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute. Used in US to rank counties by health status
11.	The distribution of social, economic and environmental assets impacts differently on health outcomes across society and results in inequalities in health outcomes. This impact starts before birth and builds over the life-course, as the positive and negative impacts of the wider determinants of health accumulate over time.



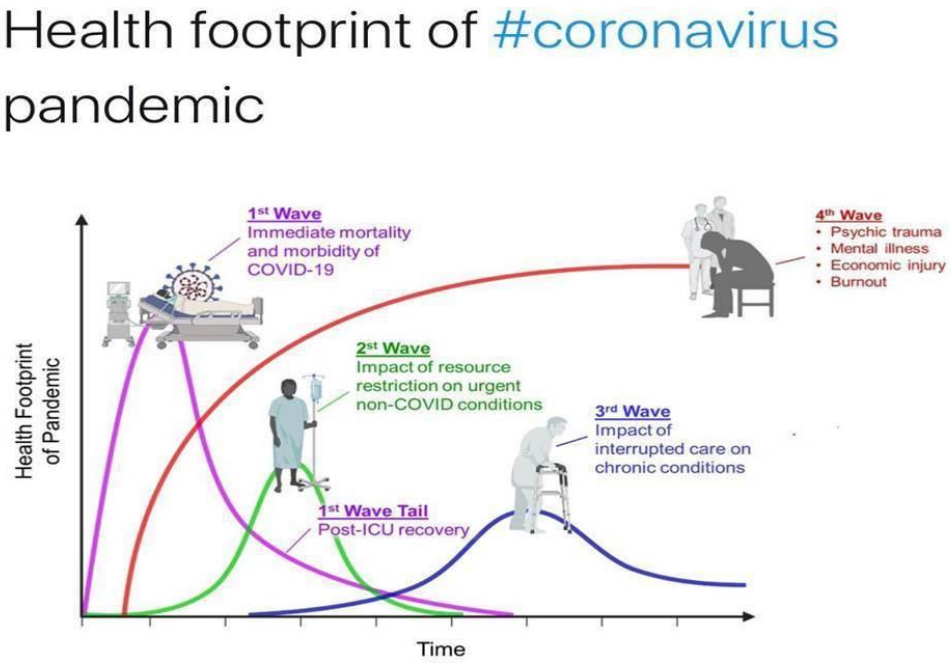
Marmot 'Fair Society, Healthy Lives' 2010.

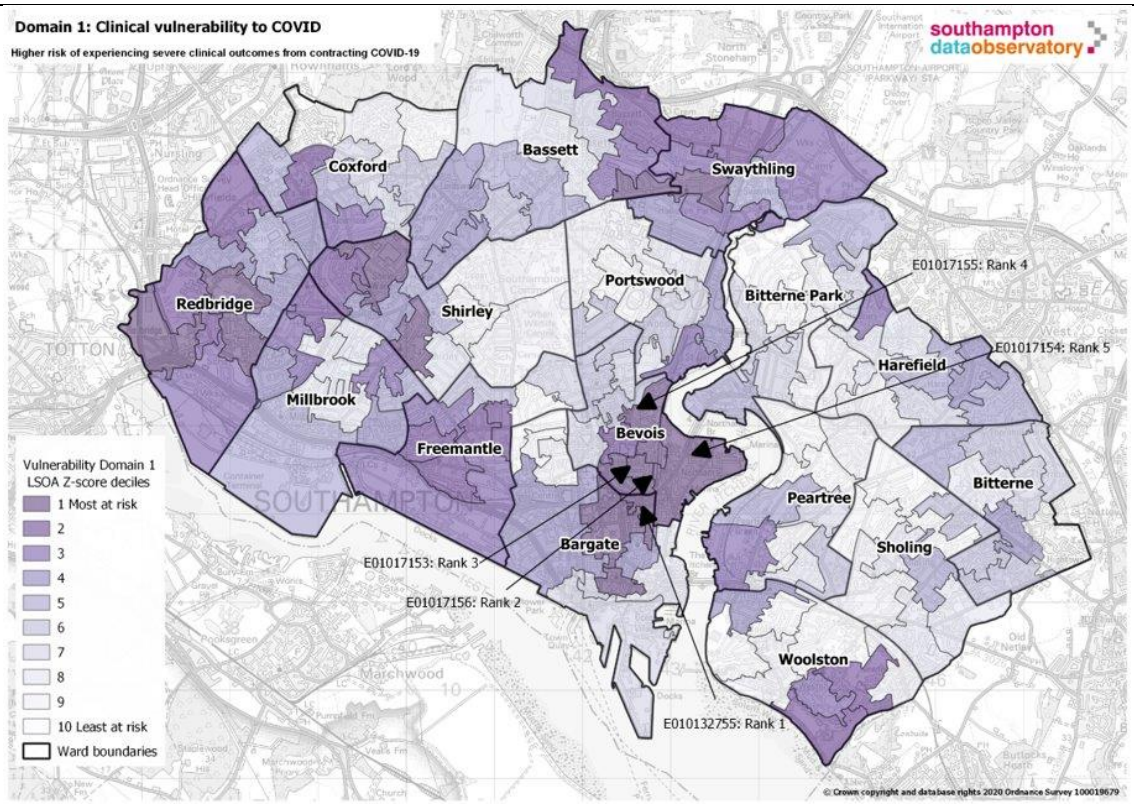
12. This evidence has informed the life-course approach to reducing health inequalities, which recognises that no one agency can implement any of these objectives on its own. Reducing health inequalities requires collaboration, partnership and collective action in many different spheres of activity.

13. The chart below shows the impact of actions taken across the life-course on health outcomes, health inequalities and both the speed of this impact and the strength of evidence for its effectiveness. Action on the best start in life, healthy schools and pupils, jobs and work, access to green space and leisure opportunities and health and spatial planning have the highest impact on health inequalities.

Area	Scale of problem in relation to public health	Strengths of evidence of actions	Impact on health	Speed of impact on health	Contribution to reducing inequalities
Best start in life	Highest	Highest	Highest	Longest	Highest
Healthy schools and pupils	Highest	Highest	Highest	Longer	Highest
Jobs and work	Highest	Highest	Highest	Quicker	Highest
Active and safe travel	High	High	High	Longer	Lower
Warmer and safer homes	Highest	Highest	High	Longer	High
Access to green spaces and leisure services	High	Highest	High	Longer	Highest
Strong communities, wellbeing and resilience	Highest	High	Highest	Longer	High
Public protection	High	High	High	Quicker	High
Health and spatial planning	Highest	High	Highest	Longest	Highest

9 http://www.kingsfund.org.uk/publications/improving-publics-health

	Impact of Covid-19 on health inequalities
14.	The health impacts of Covid-19 include the immediate impact of mortality and morbidity from Covid-19, followed by later impacts due to restricted care on both urgent and long-term conditions, and then longer-term impacts on mental health and poor health due to the economic impact of measures to control its spread. At this stage in the pandemic, we have some information about the immediate impact of Covid-19 related mortality and morbidity. However, information about the later impact of Covid-19 on the later stages outlined below is not yet available. 
15.	Covid-19 and the measures put in place to control its spread have been experienced differently across different parts of the community and differentially across the lifecourse[2]. This is expected to increase health inequalities. Differences in vulnerability to Covid-19 are presented below, followed by an analysis of cases and deaths by age, gender, ethnicity and deprivation quintile; then emerging evidence of the impact of the pandemic on the wider socioeconomic determinants of health.
16.	**Vulnerability to Covid-19** Vulnerability to Covid-19 varies with age, gender, comorbidities, excess weight, housing overcrowding, geography, occupation, ethnicity and deprivation. This vulnerability comprises of the risk of being infected with the virus, and a range of factors that increase the risk of severe outcomes from the disease once infected. Southampton's intelligence team have created vulnerability indices, considering; 1. clinical vulnerability to Covid-19 2. risks of contracting Covid-19 through work / living conditions and vulnerability to 3. negative impacts from Covid-19 related policies The maps of these vulnerability indices show that vulnerability to Covid-19 is distributed unevenly across the city. Some parts of Bevois, Bargate and Millbrook, followed by Woolston and Bitterne have high vulnerability to all 3 indices.


Domain 1: Clinical vulnerability to COVID
Higher risk of experiencing severe clinical outcomes from contracting COVID-19
southampton dataobservatory
Coxford
Bassett
Swaythling
Redbridge
Shirley
Portswood
Bitterne Park
Harefield
Millbrook
Freemantle
Bevois
Bitterne
Peartree
Bargate
Sholing
Woolston
E01017155: Rank 4
E01017154: Rank 5
E01017153: Rank 3
E01017156: Rank 2
E010132755: Rank 1
Vulnerability Domain 1
LSOA Z-score deciles
1 Most at risk
2
3
4
5
6
7
8
9
10 Least at risk
Ward boundaries
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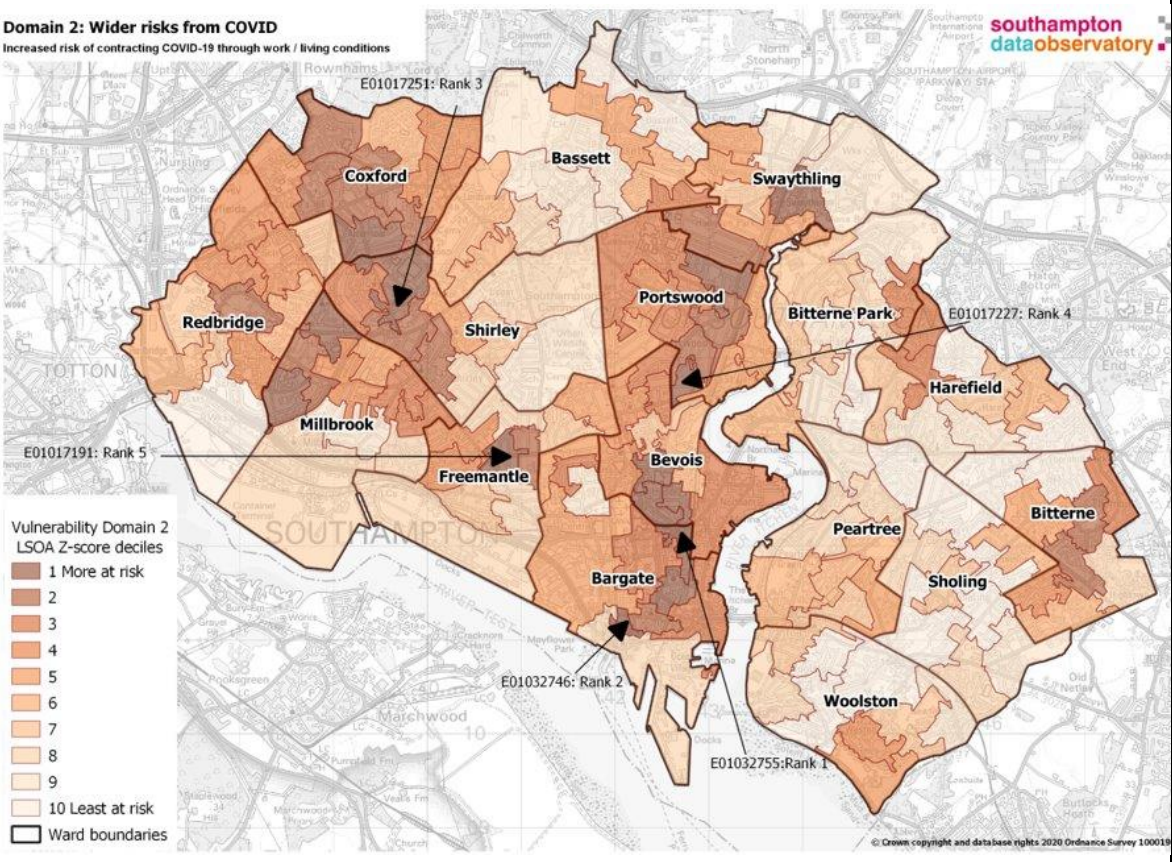
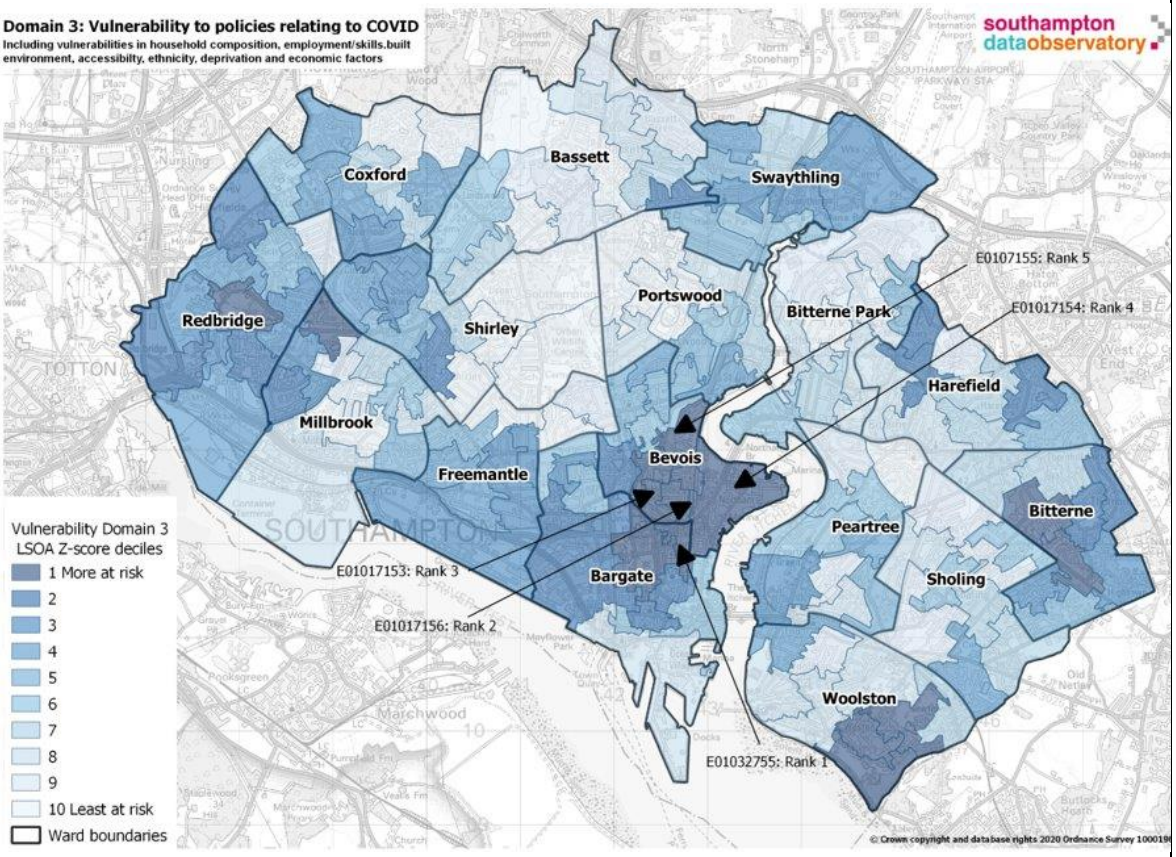

Domain 2: Wider risks from COVID
Increased risk of contracting COVID-19 through work / living conditions
southampton dataobservatory
E01017251: Rank 3
Coxford
Bassett
Swaythling
Portswood
Redbridge
Shirley
Bitterne Park
E01017227: Rank 4
Harefield
Millbrook
E01017191: Rank 5
Freemantle
Bevois
Bitterne
Peartree
Bargate
Sholing
E01032746: Rank 2
Woolston
E01032755:Rank 1
Vulnerability Domain 2
LSOA Z-score deciles
1 More at risk
2
3
4
5
6
7
8
9
10 Least at risk
Ward boundaries
© Crown copyright and database rights 2020 Ordnance Survey 100019



17. **Cases of Covid-19 by age and gender**

Southampton has had 958 confirmed cases of Covid-19 (as of 26th July 2020). Of the 950 people for which age and gender data are available, 44% are male and 56% female, with a median age of 50.

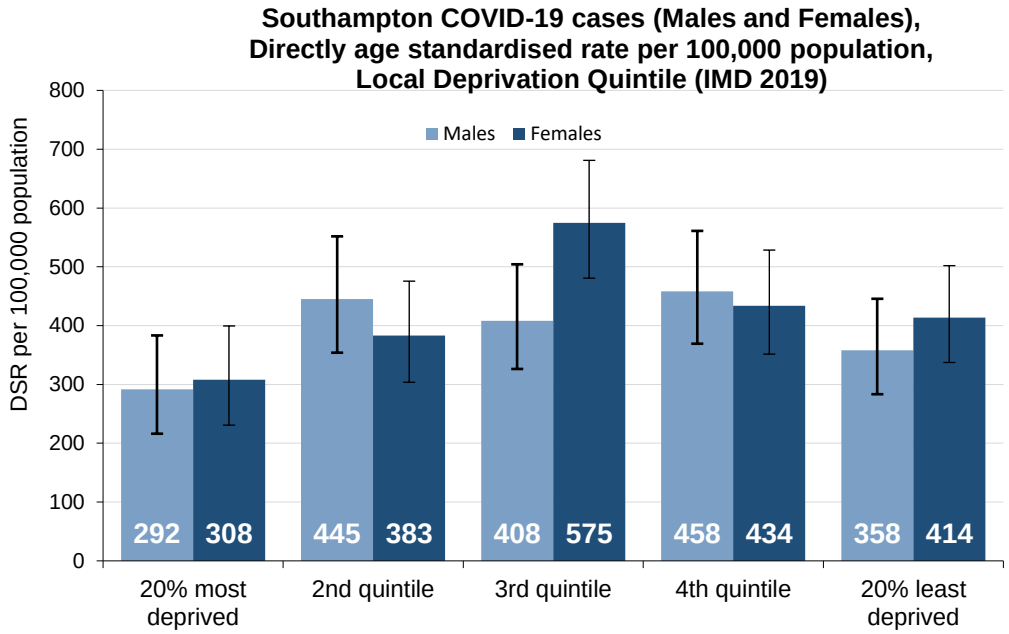
Males aged 80+ years had the most confirmed cases, followed by the 30-34 age group and those aged 45-49 years. Females aged 80+ years also had the highest number of confirmed cases, with those aged 25-29 years the second highest, followed by those aged 30-34 years. Males and females aged under 20 years had the lowest number of confirmed cases.

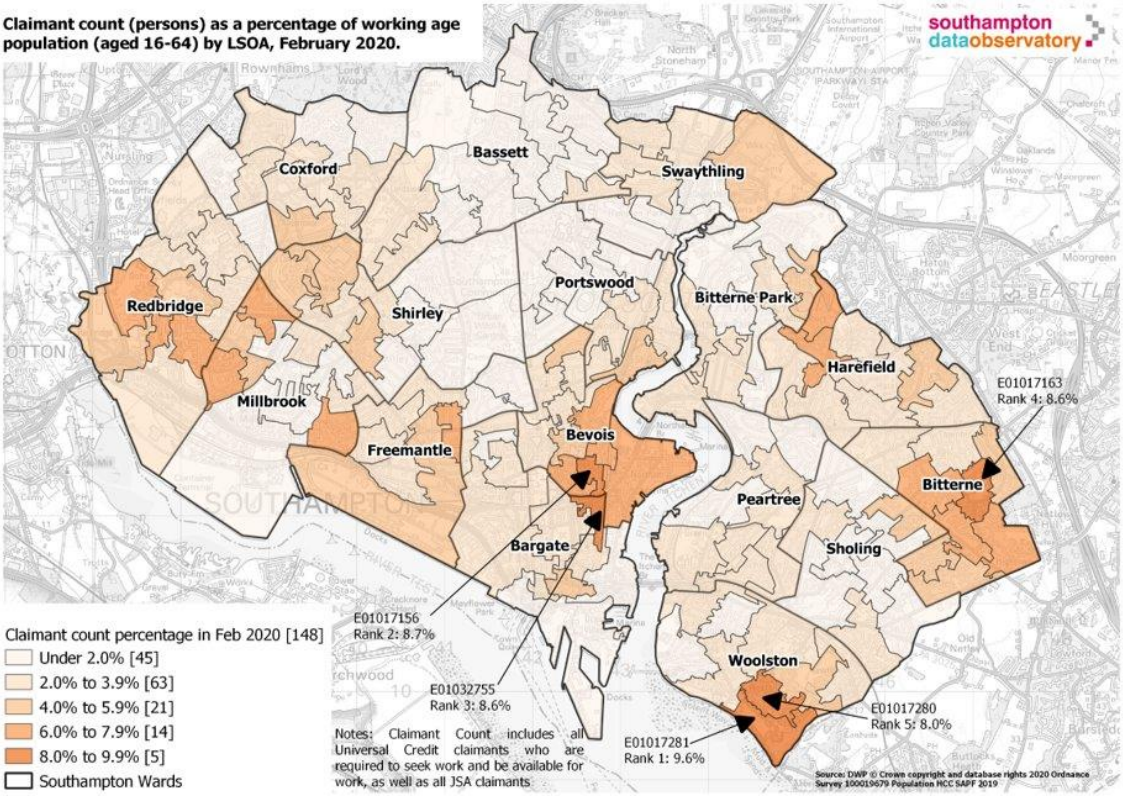
The percentage of confirmed cases in each age group were compared against the age structure of the resident population. This showed the percentage share of confirmed cases for males and females aged 80+ are higher compared to the resident population structure. Females aged 25-29 also have a higher percentage of confirmed cases compared to the resident population structure. Males and females aged under 25 years have a lower percentage share of confirmed cases compared to the resident population structure.

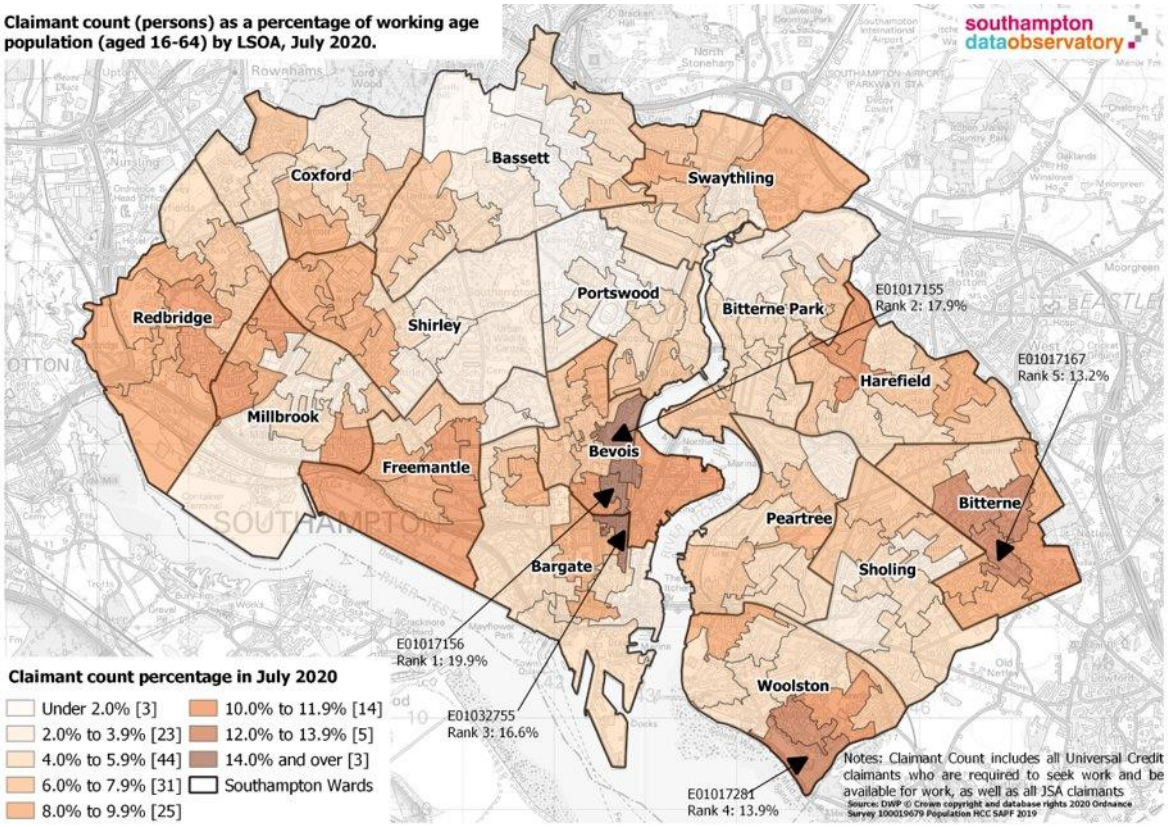
18. **Cases of Covid-19 by ethnicity**

Of the 783 cases of Covi-19 in Southampton for which ethnicity was recorded, 621 (79%) were recorded as White and 162 (21%) as Black, Asian and Minority Ethnic (BAME). This is in line with national findings, with BAME groups accounting for 22% of confirmed cases nationally (Public Health England Surveillance reports).

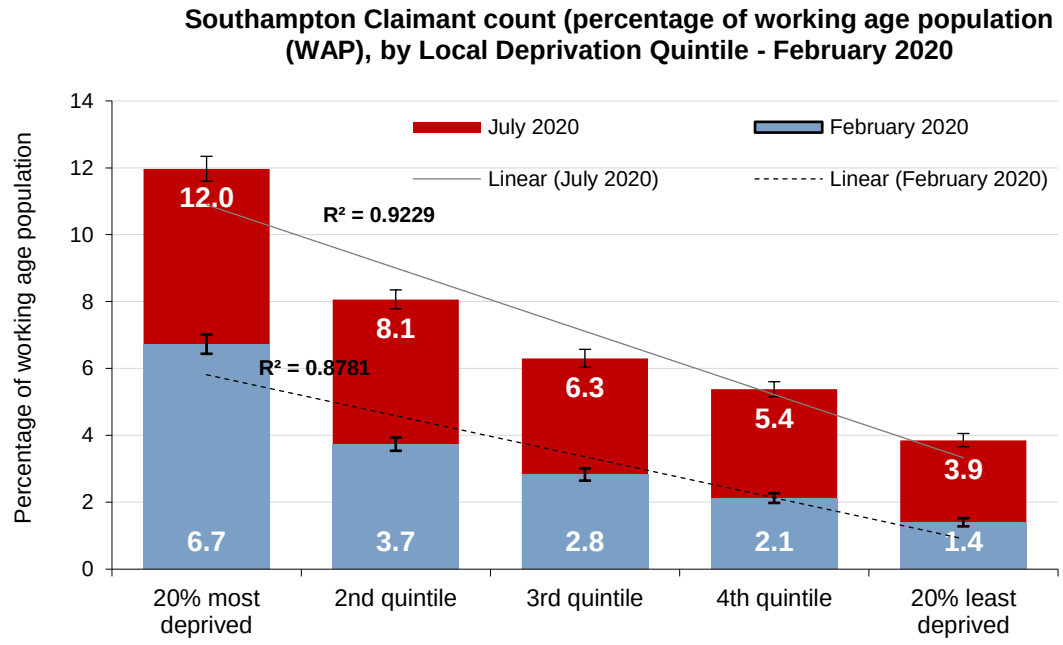
Analysis of the percentage breakdown of confirmed cases by ethnic group shows that Asian/Asian British residents have the highest percentage share (11% of cases) of confirmed cases among BAME groups. When comparing the percentage share of cases against the resident population, BAME groups have a higher

	percentage share of cases (21%) compared to the resident population structure (14% residents BAME).
19.	**Cases of Covid-19 by deprivation** The graph below shows there is no clear relationship between deprivation measured by Southampton deprivation quintile and Covid-19 cases recorded for Southampton residents.  Sources: PHE's Second Generation Surveillance System (SGSS), HCC SAPF 2019 and IMD (2019)
20.	**Covid-19 related deaths** Sadly, there were 163 Covid-19 related deaths in Southampton (as of 30th June 2020). Analysis shows that males account for 53% of these deaths and females 47%. The majority of Covid-19 related deaths occurred among those aged 70 and over, with deaths in this age group accounting for 83% of male and 90% female Covid-19 related deaths. There were very few deaths occurring among younger age groups, with no deaths occurring among those aged under 20 years. These findings are not surprising, and align with national evidence showing the risk of dying from Covid-19 strongly increases with age among other factors. Numbers are too small to draw any conclusions about Covid-19 related deaths by ethnicity in the city. The risk of death involving Covid-19 varies significantly with ethnicity. After accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British[2]. There is no clear relationship between deprivation and Covid-19 related deaths in Southampton.
21.	**Impact on the wider determinants of health** As outlined previously, the factors that affect our health most are the wider determinants of health, including socio-economic and environmental factors. The measures taken to prevent the spread of Covid-19, have had far-reaching impacts into many aspects of our lives. Some of this evidence is still emerging, however this report presents the quantitative data that is currently available on income;

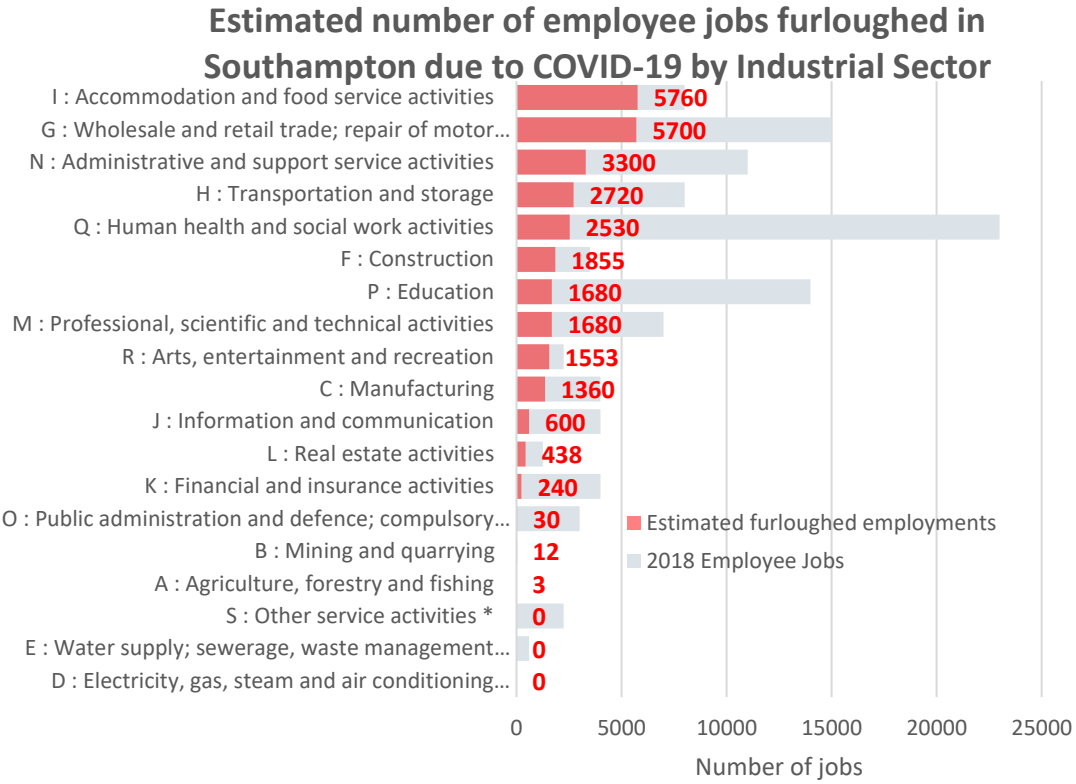
	employment and some anecdotal evidence on social impacts for vulnerable communities.
22.	**Income - benefit claimants and debt** The figures below show the percentage of people eligible for work (aged 16 to 64) claiming universal Credit by ward before lockdown in February, compared to the most recent figures for July. This shows that the proportion of people eligible for work who are claiming benefits has increased substantially over this time. Area with the highest proportion of claimants were in Bargate, Bevois, Bitterne and Woolston before lockdown, and these wards continue to be the wards with the highest proportion, despite increasing claimants overall. Voluntary services across the city have reported increased concerns from their service users about debt.[5] 



23. The figure below shows claimant count by local deprivation quintile in February compared to July. The increase for claimant counts over time was greatest for the 20% most deprived areas, and there is a relationship between deprivation and increase in claimant count. This suggests inequalities in income are widening across the city.



Source: DWP and ONS

24.	**Employment** An analysis of jobs at risk in Southampton, based on data on furloughed workers shows that up to 23,000 jobs in the city may be at risk. The largest industrial sectors affected were accommodation and food services and wholesale and retail industries. Many workers in these industries are young and earnings lower than average, suggesting that these groups may be disproportionally affected by potential job losses.  *These figures have been estimated based on HMRC Coronavirus Job Retention Scheme registrations for the South East up to 30th June. These figures have been applied to the local industrial profile to estimate the number of jobs at risk due to COVID-19.* ** Data not available*
25.	**Social impacts** Nationally and locally there were reports of an increase in the severity and amount of reported domestic abuse over the course of lockdown; an increase in child on parent abuse; a reduction in reports to child safeguarding indicating potential 'stored up' neglect and abuse and an increase in demand for mental and emotional support.[5]
26.	**Children and young people** Child poverty is already an issue in the city, and this is expected to be exacerbated by job losses. Those now newly eligible for free school meals may mean more children and families will face food insecurity and digital exclusion is a concern where children and young people are unable to access the equipment and don't have Wi-Fi. There is emerging anecdotal evidence of the negative impact of Covid-19 on the mental health of young people.[5]
27.	**BAME communities** Nationally BAME groups are over-represented in those occupations more likely to be exposed to those with Covid-19 whilst doing their job, and over a third of these occupations had a median pay lower than the median UK hourly pay.[3] Locally,

	BAME communities in the city have expressed concerns with temporary and poorly paid jobs, including zero-hour contracts; children's education and home-schooling; and digital exclusion affecting a range of issues including education, access to welfare and other health and support services.[5]
	Work to reduce health inequalities in the light of Covid-19
28.	In recognition of their statutory responsibilities to reduce health inequalities, Southampton Health and Wellbeing Board reviewed the evidence to date of the impact of Covid-19 on health inequalities at their meeting in June 2020. The Board: • agreed their leadership is essential for the whole system approach required to reduce health inequalities • committed to put health inequalities at the heart of plans to rebalance following Covid-19.
29.	Members of the Health and Wellbeing Board also recognised their individual organisational statutory responsibilities to reduce health inequalities. This includes: • Southampton City Council's statutory responsibility to improve the health and wellbeing of residents and to reduce health inequalities. • The NHS's commitment to strengthening its' contribution to reducing health inequalities through the NHS Long Term Plan. This has subsequently been strengthened through NHSE call to action on the third phase of NHS recovery from Covid-19.
30.	The Health and Wellbeing Strategy prioritises reducing inequalities in health outcomes. This is supported by the Health and Care Strategic Plan's goal to target health inequalities and confront deprivation which is being reviewed in the light of Covid-19.
31.	Southampton Covid-19 Outbreak Control Plan sets out how partners across the system will protect the health of the population through: • Preventing the spread of Covid-19 infection • Early identification and proactive management of local outbreaks • Co-ordination of capabilities across agencies and stakeholders • Maintaining the support of residents to follow public health advice, and supporting those that need additional help to enable them to do so • Assurance to the public and stakeholders that this Plan is being effectively delivered The Plan includes a focus on vulnerable people. An Equality and Safety Impact Assessment (ESIA) is currently underway to evaluate the Southampton Outbreak Control Plan in terms of reducing inequalities and will make recommendations for change.
	Provisional conclusions about the impact of Covid-19 on health inequalities
32.	Evidence suggests that Covid-19 and the measures put in place to reduce its spread have had a disproportionate impact on those already experiencing health inequalities in the city, therefore without mitigation health inequalities in the city are likely to be exacerbated.
33.	The measures put in place to reduce the spread of Covid-19 have already had an impact on the wider determinants of health. It is likely that the number of people in the city experiencing social and economic hardship will increase, with the risk of an associated negative impact on health outcomes.

RESOURCE IMPLICATIONS	
Capital/Revenue	
34.	None
Property/Other	
35.	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
36.	The Health and Wellbeing Board is a statutory board that aims to reduce health inequalities.
Other Legal Implications:	
37.	None
RISK MANAGEMENT IMPLICATIONS	
38.	None
POLICY FRAMEWORK IMPLICATIONS	
39.	None

KEY DECISION?	**Yes/No**
WARDS/COMMUNITIES AFFECTED:	N/A

SUPPORTING DOCUMENTATION

Appendices	
1.	N/A

Documents In Members' Rooms

1.	N/A
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**Yes/No***
** - ESIAs and DPIAs will be undertaken for any decision arising from actions proposed in the COVID-19 recovery plan as required.*	
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.	**Yes/No***
** - ESIAs and DPIAs will be undertaken for any decision arising from actions proposed in the COVID-19 recovery plan as required.*	
Other Background Documents **Other Background documents available for inspection at:** N/A	

Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	N/A	

Data Sources

1. Southampton data observatory. Health Inequalities https://data.southampton.gov.uk/health/health-inequalities/health-inequalities/health-inequalities.aspx
2. Public Health England. Disparities in the risk and outcomes from Covid-19. 2nd June 2020. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/889195/disparities_review.pdf
3. ONS. Coronavirus deaths by ethnic group. 7th May 2020. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020
4. ONS. Deaths involving Covid-19, England and Wales; deaths occurring in April 2020. 15th May 2020. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19englandandwales/deathsoccurringinapril2020
5. HIOW LRF, Protecting our Vulnerable Residents Group. Provisional Intelligence gathering to inform Community Impact Assessment.
6. Department for Work and Pensions (DWP). People on Universal Credit - Southampton, South East and England monthly trend: April 2019 to April 2020.

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		CCG REFORM IN HAMPSHIRE AND ISLE OF WIGHT		
DATE OF DECISION:		3 SEPTEMBER 2020		
REPORT OF:		CHAIR OF THE HEALTH OVERVIEW AND SCRUTINY PANEL		
CONTACT DETAILS				
AUTHOR:	**Title:**	**Scrutiny Manager**	Tel:	**023 8083 3866**
	Name:	**Mark Pirnie**		
	E-mail:	**Mark.pirnie@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
N/A

BRIEF SUMMARY
Attached as Appendix 1 is a letter to the Chair of the Panel from the Chair's of CCGs across Hampshire and the Isle of Wight. The letter identifies that 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 a new CCG for Hampshire, Southampton and Isle of Wight from April 2021. The CCG Governing Bodies are meeting on 24th September where a decision with regards to proceeding with the merger will be sought. The letter states that the views and feedback from the HOSP on the proposals would be welcome and will form an important part of the discussion at the 24 September meeting, and in the design of the proposed organisation. The Panel are asked to consider developing a response to the proposals for consideration at 24th September meeting of the CCGs, and to have a more detailed discussion on the developing proposals at the 22 October 2020 meeting of the HOSP.

RECOMMENDATIONS:		
	(i)	That the Panel consider developing a response to the proposals attached as Appendix 1 for consideration at 24 September meeting of the CCGs.
	(ii)	That the Panel include on the 22 October agenda an item on CCG reforms in Hampshire and Isle of Wight.

REASONS FOR REPORT RECOMMENDATIONS	
1.	To enable the Panel to provide feedback for consideration by the CCGs as they seek to develop new organisational arrangements.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	None

DETAIL (Including consultation carried out)	
	Background

3.	The proposal to merge 6 CCGs and create a new CCG for Hampshire, Southampton and Isle of Wight from April 2021 is outlined in the letter sent to the HOSP Chair, attached as Appendix 1.
4.	The letter identifies that feedback from the Southampton HOSP on the proposals would be welcome and would be considered at the CCG decision making meeting on 24 September 2020.
5.	The Panel are recommended to discuss the proposal with the invited representatives from NHS Southampton City CCG with a view to providing feedback for the 24 September meeting, and, having a more detailed conversation on the implications of the plans for Southampton, at the October meeting of the Panel.
RESOURCE IMPLICATIONS	
Capital/Revenue	
6.	None
Property/Other	
7.	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
8.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.
Other Legal Implications:	
9.	None
RISK MANAGEMENT IMPLICATIONS	
10.	None
POLICY FRAMEWORK IMPLICATIONS	
11.	None
KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	N/A
SUPPORTING DOCUMENTATION	
Appendices	
1.	Letter to Cllr Bogle about the proposed reforms of the CCGs in Hampshire and the Isle of Wight

Documents In Members' Rooms

1.	N/A
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**No**
Data Protection Impact Assessment	

Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.		**No**
Other Background Documents **Other Background documents available for inspection at:** N/A		
Title of Background Paper(s)	**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**	
1.	N/A	

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Councillor Sarah Bogle
Health Overview and Scrutiny Panel Chair
Southampton City Council
By email

Dear Councillor Bogle,

CCG REFORM IN HAMPSHIRE & ISLE OF WIGHT

As you know, CCGs are changing the way they work. We are writing to update you on our plans and to invite your observations and feedback.

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 & 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. Too often in the past – in part as consequence of the market environment - commissioning was undertaken remotely, separate from provision.

Whilst a small number of decisions, such as the award of contracts, need to be undertaken by CCGs independently, in future we see the overwhelming majority of the work to understand need, plan and transform services being undertaken collaboratively, with partners, through the Integrated Care System we are building together. This also provides the opportunity to divert resources from servicing contracts and transactional machinery towards service transformation and improvement activity. Whilst changes to structures will be needed, the most significant changes will be cultural – related to how we work and the way we behave.

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. 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.

That said, achieving the benefits of commissioning at scale will not be to the detriment of a local approach, which has been at the heart of some of our most successful service improvements in recent years. Our local teams working with our partners have a deep understanding of the communities they serve, their needs and the interventions that can make a real difference to their health and wellbeing. Through a blend of working at scale and at place we hope to achieve the best possible outcomes.

As we change the aim is for CCGs to:

a) **Increase the focus and support CCGs provide to primary care and to the development of primary care networks.** General practice is the cornerstone of the NHS and the first port of call for most people who seek health advice or treatment.

b) **Pursue deeper integration of health and care with council partners,** building on the arrangements and relationships already in place in Southampton, on the Isle of Wight and in Hampshire. The alignment and integration of the NHS and local government at a local level is key to our success in future. As well as maintaining our focus on communities and the places where people live and work, collaboration with local authorities provides the best opportunity to use our collective resources to make genuine impact on preventing ill health and reducing inequalities, to join up health and care delivery, and to improve people's independence, experience and quality of life.

c) **Better support providers to redesign and transform service delivery.** Providers, CCGs and Local Authorities are working increasingly closely together to redesign service delivery, co-ordinating and improving the delivery of services for the population they serve. For some services it makes most sense to build delivery alliances to plan, transform and co-ordinate service delivery in geographies based around acute hospital footprints. For other services it makes sense to plan and deliver transformation together at the scale of Hampshire & Isle of Wight, and beyond. Alongside our work to integrate health and care with local authorities, we will align CCG teams and resources with each delivery alliance, supporting them to redesign pathways and develop services. The solutions may be different in each part of Hampshire & Isle of Wight and we will work with providers through the Autumn on the detail.

d) **Create a single strategic commissioning function for the Hampshire & Isle of Wight ICS.** As providers, CCGs and Local Authorities we are designing the ICS together, including through our most recent events and conversations during July and August. The ICS will involve clinical, professional and managerial leaders from across the whole system in all of its work. As CCGs we will create a single 'strategic commissioning' function focussed on the Hampshire & Isle of Wight geography as a whole, to support and enable the ICS, accelerating the simplification of the planning, transformation and infrastructure in place at Hampshire & Isle of Wight level.

In order to accelerate change, changes to CCG organisational arrangements are planned.

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 a 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 described above to be effective. 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 plan 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 & Isle of Wight strategic commissioning function. At the same time, the Frimley Collaborative comprising East Berkshire, North East Hampshire and Farnham and Surrey Heath CCGs has stated its intention to proceed to a merger. We will of course continue to work closely with both Portsmouth and Frimley to enable us to speak as one voice across Hampshire and the Isle of Wight and continue to work together in the respective local health and care systems.

We would welcome your views and feedback on the proposals, which we will incorporate into our ongoing design. Your feedback will also form an important part of the discussion at CCG Governing Bodies on 24th September when agreement to proceed with the merger will be sought, and by NHS England at the end of September regarding the formal application to form the new CCG.

Should you have any queries or wish to discuss any of this in more detail we would be more than happy to do so. Please contact Sara.Bunting@nhs.net to arrange a convenient time.

Yours sincerely,

Dr Mark Kelsey Chair, Southampton City CCG	Dr Sarah Schofield Chair, West Hampshire CCG	Dr Michele Legg Chair, Isle of Wight CCG
Dr David Chilvers, Chair, South East Hampshire CCG	Dr Nicola Decker Chair, North Hampshire CCG	Dr Barbara Rushton Chair, Fareham & Gosport CCG