Public Document Pack

Hampshire County Council

NOTICE OF MEETING

Meeting	Health and Adult Social Care Select Committee
Date and Time	Monday, 14th September, 2020 at 10.00 am
Place	Virtual Teams Meeting - Microsoft Teams
Enquiries to	members.services@hants.gov.uk

John Coughlan CBE
Chief Executive
The Castle, Winchester SO23 8UJ

FILMING AND BROADCAST NOTIFICATION
This meeting is being held remotely and will be recorded and broadcast live via the County Council's website.

AGENDA

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

2. DECLARATIONS OF INTEREST

All Members who believe they have a Disclosable Pecuniary Interest in any matter to be considered at the meeting must declare that interest and, having regard to the circumstances described in Part 3 Paragraph 1.5 of the County Council's Members' Code of Conduct, leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with Paragraph 1.6 of the Code. Furthermore all Members with a Non-Pecuniary interest in a matter being considered at the meeting should consider whether such interest should be declared, and having regard to Part 5, Paragraph 2 of the Code, consider whether it is appropriate to leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with the Code.

3. MINUTES OF PREVIOUS MEETING (Pages 5 - 18)

To confirm the minutes of the previous meeting

4. DEPUTATIONS

To receive any deputations notified under Standing Order 12.

5. CHAIRMAN'S ANNOUNCEMENTS

To receive any announcements the Chairman may wish to make.

6. PUBLIC HEALTH COVID-19 UPDATE

To receive a Public Health overview update on Covid progression and monitoring including; current status; future modelling/second wave planning; Local Outbreak Control Plan. (*to follow*)

7. ADULT SOCIAL CARE COVID-19 UPDATE (Pages 19 - 38)

To receive an update on the Adult Social Care aspects of the pandemic including regarding support for those in the Shielding category, Care Homes, and Service Recovery.

8. NHS HAMPSHIRE AND ISLE OF WIGHT COVID-19 UPDATE (Pages 39 - 66)

To receive an update on the NHS Hampshire and Isle of Wight system approach to COVID including second wave/winter planning and recovery.

Including updates from the following Trusts:

a. Hampshire Hospitals NHS Foundation Trust
b. University Hospitals Southampton NHS Foundation Trust
c. Portsmouth Hospitals University NHS Trust

9. PROPOSALS TO VARY SERVICES (Pages 67 - 100)

To consider the report of the Director of Transformation and Governance on proposals from the NHS or providers of health services to vary or develop health services in the area of the Committee.

Items for Action

a) Southern Health NHS Foundation Trust: Proposed Closure of Willow Ward (inpatient unit for adults with learning disability and challenging behaviour)

Items for Monitoring

b) Southern Health NHS Foundation Trust: Out of Area Beds Update

Written only updates:

c) Andover Hospital Minor Injuries Unit (Hampshire Hospitals Foundation Trust and commissioners)
d) Orthopaedic Trauma Modernisation Pilot (Hampshire Hospitals Foundation Trust and commissioners)
e) Integrated Primary Care Access Service (Clinical Commissioning Group Partnership)

10. ISSUES RELATING TO THE PLANNING AND/OR OPERATION OF HEALTH SERVICES (Pages 101 - 186)

To consider a report of the Director of Transformation and Governance on issues brought to the attention of the Committee which impact upon the planning, provision and/or operation of health services within Hampshire, or the Hampshire population.

a. Hampshire Hospitals Foundation Trust – Care Quality Commission latest report (published in April 2020)
b. Clinical Commissioning Group Reform in Hampshire and the Isle of Wight

11. WORK PROGRAMME (Pages 187 - 200)

To consider and approve the Health and Adult Social Care Select Committee Work Programme.

ABOUT THIS AGENDA:

On request, this agenda can be provided in alternative versions (such as large print, Braille or audio) and in alternative languages.

ABOUT THIS MEETING:

The press and public are welcome to observe the public sessions of the meeting via the webcast.

AT A MEETING of the Health and Adult Social Care Select Committee of HAMPSHIRE COUNTY COUNCIL held virtually on Monday, 6th July, 2020

Chairman:
* Councillor Roger Huxstep

* Councillor David Keast
* Councillor Martin Boiles
* Councillor Ann Briggs
Councillor Adam Carew
* Councillor Fran Carpenter
Councillor Tonia Craig
* Councillor Rod Cooper
* Councillor Alan Dowden
* Councillor Jane Frankum
* Councillor David Harrison
* Councillor Pal Hayre
* Councillor Neville Penman
* Councillor Mike Thornton
Councillor Rhydian Vaughan MBE
* Councillor Michael White
Councillor Graham Burgess
* Councillor Lance Quantrill
* Councillor Dominic Hiscock
Councillor Martin Tod

*Present

Co-opted members
Councillor Trevor Cartwright MBE, Councillor Alison Finlay and Councillor Diane Andrews

Also present at the invitation of the Chairman: Councillor Liz Fairhurst, Executive Member for Adult Social Care and Health, and Councillor Judith Grajewski, Executive Member for Public Health.

200. **APOLOGIES FOR ABSENCE**

Apologies were received from Councillors Adam Carew, Tonia Craig, and Rhydian Vaughan.

201. **DECLARATIONS OF INTEREST**

All Members who believe they have a Disclosable Pecuniary Interest in any matter to be considered at the meeting must declare that interest and, having regard to the circumstances described in Part 3 Paragraph 1.5 of the County Council's Members' Code of Conduct, leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with Paragraph 1.6 of the Code. Furthermore all Members with a Non-Pecuniary interest in a matter being considered at the meeting should consider whether such interest should be declared, and having regard to Part 5, Paragraph 2 of the Code, consider whether it is appropriate to leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with the Code.

Councillor Dominic Hiscock noted that his wife is a consultant radiologist at University Hospital Southampton.

202. **MINUTES OF PREVIOUS MEETING**

The minutes were agreed with the revision of a typo “do not” on page 11 of the minutes in the Agenda Pack.

203. **DEPUTATIONS**

The Committee did not receive any deputations.

204. **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman made the following announcements:

- The Chairman noted that Cllr Rosemary Reynolds had stepped down from her position as a co-opted Member on the HASC and wished her the best.

- The Chairman welcomed Cllr Rod Cooper replacing Cllr Marge Harvey on the HASC who was elected as Vice-chairman of Hampshire County Council for 2020/21.

- The Chairman congratulated the NHS on its 72nd anniversary.

205. **PROPOSALS TO VARY SERVICES**

a. Modernising our Hospitals and Health Infrastructure Programme - Hampshire Hospitals Foundation Trust

Representatives from the Hampshire Hospitals Foundation Trust outlined accelerated plans for modernizing services with £5 million received from the Health Infrastructure Programme (HIP). This funding is a catalyst for much needed and multifaceted changes in primary care, mental health, a new midwife unit, ambulance services, to the meet the changes and challenges of the growing population.

Building improvements come at significant cost and have been identified to be on the plan. These changes, implemented in close collaboration with partners, will allow for the provision of services closer to home and benefit patients and staff in terms of wellbeing, flexible for future needs, and even in addressing pandemics.

Engagement has continued through June and July alongside considering various sites which will be reviewed in September with stakeholders and a pre-consultation business case for approvals with formal consultation to follow.

The clinical vision and focus are for the right care in the right place at n the right time and the capacity to care for people using digital technology and innovation with support to access services quickly to maintain their health. Centralized emergency services for offering the best care and outcomes with an outstanding,

brilliant staff who can be retained and providing high quality innovative care with a focus on research and training.

Covid has accelerated working in new ways and connecting services for the better. The joining up of services and users needs to be an equal partnership in this journey. Slick, efficient, and first-class services will help patients feel they are in control of their lives again with the support of health care partners and adults' services. There is a need to ensure that the new ways and technologies adopted will develop and nurture the right relationships in providing care and services.

Currently consultations are at a midway point with staff and public using video meetings and new ways of engagement. It has been possible to reach more residents and to run daily meetings with different parts of the geography and various groups and partner organisations in north and mid-Hampshire.

In response to questions, Members heard:

While some services will be digital, a location hub is necessary for clinical services. Similar endeavours around the country are being looked at for examples as this is a long-term opportunity to make significant improvements. With regards to the development of diagnostic services post-Covid, they may be helpful in general practices and community care locations. However, the picture is evolving, with each aspect of diagnostics being considered, alongside innovations to meet a national need for diagnostic hubs.

In terms of timelines, this project is different from previous ones undertaken in that it is a government led initiative and plan, where current infrastructure is no longer fit for purpose. A lot has been learned from previous endeavours and with the integration of health and social care the collaboration and partnership has deepened. Rethinking delivery of all services within the accelerated plan and milestones will be critical.

Clinical conversations with all neighbouring Trusts are taking place to understand priorities and impact. There will not be gaps in secondary care services and active engagement and consultations will continue to be progressed.

Conflicting Information Technology (IT) systems and handover remain a challenge, however there will be a significant component looking at communication, digital and analogue. Recognizing the variety of IT systems and working to reduce error by limiting duplication and consistently using "My Medical Record" for example will allow for patients, carers, service providers, and care homes to have digital collaboration for care and medical plans. Covid has positively affected digital innovation in having to quickly develop non-face-to-face care. The County Council will be involved in collaboration and integration in every work stream in this process.

The condition of the current estates requires urgent improvements and the backlog of maintenance is due to the limited budget allocation and lack of capital. This is a strategic opportunity for change and the new hospital should

see residents through approximately 5 decades. Clinical and capacity-based modelling, changes in services, and the impact of digital technology will be considered, and capital requirements narrowed down accordingly in the business case.

The hospital is currently well-staffed and retaining them will be key. Staff often work in difficult circumstances and Covid has highlighted those challenges. Combined nurse banks are easing options for working in different locations. Focusing on patient wellbeing, but also staff wellbeing and meeting their needs is critical.

Training for agency staff is in place and work is being done with the University of Winchester and University of Southampton nursing programmes to expand training offers and an opportunity to increase numbers. Physician's Assistants (PAs) are a different part of the work force and hold high science degrees to be able to support nurses and doctors. All staff members from porters to administration will be trained and be able to rotate across areas in exciting new roles in the community, without taking staff from other partners.

RESOLVED -

That the Health and Adult Social Care Select Committee:

a. Noted the report, engagement plan, and current challenges as well as any recorded issues addressed and/or resolved,
b. Requested a further update in November 2020

b. Building Better Emergency Care Programme – Portsmouth Hospitals Trust

Representatives from the Portsmouth Hospitals Foundation Trust outlined a capital project for the redevelopment of the Emergency Department. A strategic outline case has been submitted and there are no service changes planned but the HASC will be kept informed as the programme evolves. There is a proposed site on campus and anticipated timelines at present.

Members requested that their thanks be conveyed to the Trust for their efforts and service during the pandemic.

RESOLVED -

That the Health and Adult Social Care Select Committee:

a. Noted the report, engagement plan, and current challenges as well as any recorded issues addressed and/or resolved,
b. Requested a further update in November 2020

206. **HAMPSHIRE AND ISLE OF WIGHT COVID-19 SYSTEM APPROACH OVERVIEW**

Representatives from Hampshire and Isle of Wight (HIOW) organizations provided an overview of service changes and highlighted developments during the pandemic.

Members heard that healthcare organizations and staff appreciated the “thanks” they had received and have been working hard with colleagues in Social Care, Police, and Fire. All have been grateful for the public’s help in adjusting how they accessed services. Residents adapting quickly and following the guidance has been key.

The pandemic has been a major incident and one that has been ongoing for a long period of time. The aim has been to prepare and plan for the reasonable worst case scenario whilst hoping for the best. Capacity has been provided where needed and managed in new ways. Changes that have been on the list for years, took place in 2-3 weeks. It was imperative to maintain critical services and restore them, e.g. carefully rescheduling operations, considering PPE and social distancing needs. Patients were quite anxious initially to come into the hospital, but the hope is that there has been a shift in thinking and they now feel safer returning.

In order to exit the lockdown safely and prevent a second outbreak, the guidance and safety measures need to be followed. While numbers have dropped, Covid is still active.

Different agencies have been working well together in unifying understanding and action. Covid outbreaks have been less clear and building urgency in communities has been critical. Maintaining critical services in the priority areas of support have been key, including protecting the vulnerable and keeping them safe and maintain public order.

Work must continue in that perspective and with effective precautions. Careful plans are now being put into place for a new normal while watching out for the next wave. The reasonable worst case is still on everyone’s minds and they are ready for quick and critical fact-based decisions even with scant information but in the right context.

The real thing is often never quite like the exercise and Covid has had a life changing impact. However, it has been a privilege to come together with colleagues and organizations focused on issues as one team while maintaining the sovereignty of each team.

Upon clinical reflection, there have been about 2 million people affected including those who have been tested and those whom providers suspect may have been infected. There are high numbers of patients in some areas, fewer in others. There has been a fairly uniform experience overall with anxieties about outbreaks and hotspots. Approximately 5-10k residents have died naturally and 1400 of those of Covid in Hampshire and Isle of Wight. Many were elderly and frail so there has been some crossover in those areas.

Hospital resiliency was maintained, and capacity was always available against anticipated numbers. This is a tribute to the integrated work that goes on with partners and the community response.

While there has been some alarm about care homes, work with social care and care home colleagues continues alongside the restoration of critical and then elective services. Acute care has actually increased and back to 67% of non-critical care and finding new ways of working.

In response to questions, Members heard:

The numbers are based on people who have tested positive and the total mortality rate is between 0.05-1%.

Lessons learned continues to be ongoing in terms of managing 111 calls and wait times, helping residents who are avoiding care and procedures for fear of Covid, and cancer patients missing treatments, among others.

Due to the pace and knowing very little at the beginning in terms of how it affected people, 111 did struggle but extra staff were allocated relatively quickly to help cope. Plans are in place to be able to manage this winter, regardless of a second wave.

With more knowledge and understanding of the disease, it is clear now how hospitals need to work and the mechanisms needed to cope better. There is no complacency in planning ahead for the future. While there were frustrations, difficulties, and uncertainty initially, the focus now is genuinely working out how best to deal with the backlog and move forwards. There is critical evaluation of how things worked and sharing between acute Trusts with a huge amount of learning and more responsive services.

Initially, there were challenges with district nurses visiting care homes and residents, but they were back in action very rapidly.

There was an amazing response for returners as well and they were able to quickly join services.

In terms of certifying deaths, there were different processes in place, and this would need to be taken back to report on further details at the next HASC meeting.

There has been local anxiety about the route of discharge into care homes, but only a handful of cases have been identified where transmission occurred in this way. Infections have been minimized as much as possible with robust testing in place.

Using agency staff has been critical but there has been national media attention in this being a potential vector. Work is being undertaken currently to better understand and address the issue.

The HIOW Local Resiliency Forum (LRF) has been grateful for public order and confidence. Work is being done in surrounding LRF areas and across borders nationally and locally. There has been a top-down led response from No 10 with policies filtering through the system.

It is not possible to police a way out of this nor those kinds of resources available. One can imagine how communities would response to being policed in that way. If people take risks or act inappropriately against safety recommendations, they must be reminded of the focus and this is incumbent on everyone. Liaison is in place across borders with impact assessments and continued learning with all partners. The system of LRF is designed for this within the local context of operation.

Mental health during lockdown is a worry especially for those suffering from mental health issues who would generally use centres but could not access these services. Many services could not act without GP referrals or were overburdened. A central number for help would be useful. A joined-up approach is being followed but details can be brought back to the HASC to provide reassurance regarding the provision and access of services.

In terms of community care and the suspension and impact on some services, the details have to be brought back to the HASC in the future, as some service suspensions were done at the height of the pandemic and are now being reinstated.

Members acknowledged that the plan is a living document and expressed their gratitude for the many endeavours to fight this pandemic and save lives.

RESOLVED -

That the Health and Adult Social Care Select Committee:

a. Noted this briefing and consider the next steps outlined in Section 13.
b. Noted the Trust specific written updates.
c. Requested an update in 9 months' time.

The committee had no further questions regarding Trust-specific updates.

The Chairman called a 10-minute break at this time.
Cllrs Thornton and Cooper left at this time.

207. **PUBLIC HEALTH COVID-19 OVERVIEW, IMPACT ON HEALTH AND WELLBEING, AND OUTBREAK CONTROL PLANS**

The Director of Public Health provided an overview of the Outbreak Control Plan. Members heard that data is being evaluated from the very beginning in terms of who is receiving it, how it is being measured it, and with 3358 people having been diagnosed as of 8th June.

Testing developments are being scaled up via NHS and with additional providers from the private sector and military. Initially, it was unclear who would be tested, but there is more clarity now. The mortality rate is actually closer to 1%.

Understanding the impact on health and wellbeing from a national perspective as well as the effects of delays, death, and disease will be critical. Mental health issues and the bereavement process will be looked at in LRF work across Hampshire including managing worries, issues, and accessing the support needed.

The Health Protection Board and a Member led Board are being set up to defend against future outbreaks. There have not been pandemics at this scale in recent history and work is progressing with partners to provide assurance for issues across borders and manage those for Hampshire. Further clarity is pending on the remit of the new funding to ensure the right structures are in place to manage risks.

There will be more local ownership of testing, underpinned by local data rather than nationally led sites. More results at the local geography level will help audit potential outbreaks while providing support for vulnerable residents and continued collaboration with partners and local leadership.

In response to questions, Members heard:

With regard to PPE the early days were in common with rest of country in terms of being unprepared and having a “just in time” approach but is now ready for a potential second wave or a new pandemic. There is sufficient capacity and stock for the future. LRF support is in place as well as mechanisms to support care and NHS sectors with help from Public Health.

The current evidence is that young and school age children are less affected by the virus. Children being low spreaders and using consistent bubbles will help protect the staff. Good ventilation and height difference will help in some cases, but teachers will need protection. Testing for the bubble along with the staff will only be undertaken if there are symptomatic cases.

Rebuilding public confidence in returning to hospitals will be critical. Close collaboration is continuing with NHS and work taken forward to support and mitigate any new outbreaks. Hospitals are conducting pre-admission tests and ensuring Covid wards are kept separate, has had a remarkable effect in preventing cross contamination and providing protection.

Upper tier local authorities now have a plan in place and while there will be updates, a link to the plans on the website will be circulated via email following the meeting.
Mental health and wellbeing issues and the ongoing low-level anxieties. There are some not shielding who are still not wanting to go out. It has been identified as issue to better understand prevalence and the wellbeing plan picks up on this.

Organisations have been grateful for residents who have taken initiative in creating face masks and PPE. The County Council has passed along needs for

organisations, but it is important to highlight that any PPE needs to be the right standard and to be careful with the terminology.

With regards to children going back to school, there are a lot of anxious parents and some schools may have challenges in safely accommodating the population within limited space. Guidance comes out regularly and work continues with Children's Services to ensure staff and students are safe. The bubbles are going to be larger going forwards but kept separate for protection.

Currently deaths and the number of cases are levelling off in Hampshire and being monitored on a daily basis. All deaths are tragedies for loved ones, and work continues to prevent spreading. There is a need to really understand the excess deaths over the longer term and considering many indicators to ensure nothing is being missed. While remaining vigilant of symptoms is important, it cannot be depended on alone.

Members thanked the Director and the Public Health department for their hard work and efforts.

RESOLVED -

That the Health and Adult Social Care Select Committee:

a. Noted the Context of COVID-19.
b. Noted the impact on Health and Wellbeing and the need to monitor outcomes and take work forward to tackle the impact reviewing service development plans.
c. Noted the Outbreak Control Plans now in place.

208. **ADULTS' HEALTH AND CARE RESPONSE AND RECOVERY**

The Director of Adults' Health and Care provided an overview on welfare response and arrangements overseen by the Local Resilience Forum.

Members heard that the response has been supported by partners with close collaboration between HCC, 4000 volunteers, the Voluntary Care Sector (VCS), NHS, districts, and boroughs sharing best practices, collaboration, learning, coordinating the response. Being a large County Council with 11 districts and boroughs, this required swift and concerted efforts.

A significant number of vulnerable people were helped alongside older adults and existing service users. HCC care services and independent providers used a two-pronged approach to provide support with a comprehensive communication strategy and social media advertising leading to 13 thousand vulnerable residents reaching out.

Services were provided through local response centres served by district and borough councils, offering additional food boxes due to restrictions or in the early days including residents who were not entitled but still experiencing hardship. The links between districts and food banks have been key, easing and oiling the collaborative relationships around operations.

With partial easing of arrangements for the shielded including food boxes is expected to end soon, people will need support to rebuild their independence, access provisions and also manage anxieties. There is a need to reinstate services for service users that were ceased due to necessary social distancing. Increase in the emergency provision of mental health concerns and care for the vulnerable will be important to recovery.

A special focus will remain on those groups hard to reach in Hampshire including supporting domestic abuse victims, rough sleepers, and those with substance abuse issues. There is a need to flex quickly and ensure business continuity as much as possible, such as moving to virtual work to ensure statutory services continue but also taking steps to restore services for those that are paused. In line with Outbreak Control Planning, this is an opportunity to develop a recovery plan based on lessons learned and considering significant workforce aspects. Unparalleled developments of the pandemic led to a continuous improvement plan. Reflective sessions have been planned to look back over what has happened before looking forwards.

In response to questions, Members heard:

While there were some initial local challenges or lack of coordination, volunteers have made an incredible impact and food banks were generously helped by grocery stores.

The government shared information about those vulnerable but this came through in parts across several weeks leading to challenges in coordination for response across a challenging geography. Grassroots parish and district work and Facebook groups were encouraged but there was a need to introduce consistency, safety, and contend with significant data sharing restrictions. Not all shielded residents were registered or had not consented to sharing information. It remains a massive testament to the volunteers of whom there were more than there was demand.

Relationship managers were introduced for all districts and boroughs. In terms of local response, there was spontaneous volunteering and working with partners but over a few weeks, there was a need to ensure that the formal voluntary sector was able to put safeguards in place to ensure safety across the mobilization. Both formal and informal partners, the faith community, Good Neighbours, and many other organizations provided critical support. For those residents without access to online resources, text, radio, media, briefings for councils were used for a full range of support.

There were difficulties for a large number of people who were not on the list and off the radar. In the end, volunteers made a difference with a quick response and it is important to not lose those names. Adding to the list incrementally, from 19,000 to 53,000+, services and response had to be sorted out quickly and increased over time. Not all clinically vulnerable residents needed support and the list was diligently reviewed to contact those who might need support. While there was the risk of duplication at the national level, it was necessary to provide that vital safety net.

Members commended the Hants Helpline, the Director and Department on this mammoth task and on the collaboration between district, borough, and parish councils.

These services ran at a significant cost to the County Council, but equally to district and borough councils, and especially the VCS sector with their loss of income. The Chancellor is due to make a statement later this week.

Grassroots effort ran almost like military but there were some cases where they simply did not have the experience or ability to help, and the helpline was incredibly valuable. Voluntary groups will have a challenge in weening people off and releasing the people they are currently supporting. Triage is provided in the helpline calls and residents are directed to simpler VCS responses or for complex needs, referred through to the Adult Health & Care welfare team for a social work-oriented response. It has worked well, and slowly the focus will be on moving everyone on in a caring and safe way to the levels of independence they previously had. There have been anxieties around this, but work will continue with a strength-based approach with the VCS and relationship managers.

Members thanked all those involved in these efforts to support Hampshire residents.

RESOLVED -

That the Health and Adult Social Care Select Committee:

a. Noted the work that has taken place to date by Adults' Health and Care, public and voluntary sector organisations, and their partners in Hampshire to support the needs of its most vulnerable citizens and the wider community.
b. Was assured by the systems that have been put in place across Hampshire, as set out in this report, to support the county's most vulnerable residents as well as the wider community during the Covid-19 pandemic.
c. Notes actions currently underway to support moves toward recovery of services, system and processes across Adults' Health and Care.
d. Further updates to be received at successive HASC meetings while the pandemic is in progress, including the Recovery Plan.

209. **CARE HOME SUPPORT OFFER AND UPDATE**

The Director of Adults' Health and Care provided an update on the Care Home Support Offer and echoed the Chairman's sentiments in celebrating the NHS and highlighted that it is an anniversary of the foundations of social care as well.

Members heard there has been an impact across all communities and staff in social care. While there has been immense humanity, dedication, and skill evident in the sector, it is important to highlight that it is still in response mode and the pandemic is still very much active in communities.

Across the 500 care homes in Hampshire, 449 deaths have been noted positive for Covid-19. There are annual, seasonal, and monthly variations in the data and there has been a review of excess deaths in care homes. While Covid-19 positive many be noted on the death certificate, it may not be the primary cause of death. National testing reports from acute hospitals did not start taking place until mid-April and there may have been a larger Covid factor that was not captured at the national level until mid-July. There is uncertainty for providers and an impact on financial sustainability, that has led to supporting the wider care sector.

Cllr Hiscock left at this time.

Care homes received emergency PPE until regularized supply was put into place and it was difficult to know with initial guidance, which PPE was for where and when. There is a need for ongoing testing, with updates and reports from sector providers. Staffing suffered from absences which was a key factor as the needs remained the same, with an increase in the overall costs to care homes. There are a significant number of empty beds at the moment and with an impact in their income and bottom line, despite the hard work.

Announcements have been made by government regarding the national fund to support infection prevention and control in the care home sector. Area CCGs, the CQC, and Healthwatch sit on the Board, among others, meeting weekly to provide support. The goal has been to get this funding out to providers as soon as possible and slightly in advance of work that had to be done. Positively, all audits that have been undertaken, reflected that they had complied with the grant conditions and within permissible spends e.g. it was not for void beds or PPE. Every care home provider has received this support based on the number of beds. Work is being undertaken to learn lessons at pace but in a way that is sensitive to the needs of individuals and families, to better understand the transmission and learn those lessons rapidly.

In response to questions, Members heard:

Additional resources have been allotted for service surcharges being applied.

Testing prior to discharge has been ongoing but data can only be reported from 15th April onwards. In terms of preparing for the anticipated surge at acute hospitals, some 25,000 patients were discharged rapidly from acute hospital settings from March to create capacity into many settings. Agency staff appear across all health and social care sectors so cannot be the only vector. Further work remains and reviews are being commissioned for greater insight, in rapid time to better understand the factors in transmissions and outbreaks but there are real complexities to consider.

Care homes did lock down quickly and there was a phenomenal effort with many approaches and the staff quarantined for weeks if not months in order to provide care. Inevitably, staff moved within care providers but within same group of homes. Active work has continued with providers to ensure those coming in from hospital settings were isolated or quarantined before returning to the care home setting.

A lot of work is being undertaken from a national perspective to support care homes for learning and early insights. Collectively across the wider sector there is a need to delve deeply to understanding the recent impact. There will be inquiring and learning reviews for the County Council but also other partners to understand what has happened across Hampshire. The link to the Care Home Support Plan has been included and further updates will follow.
Members thanked those involved for their Herculean efforts and tireless work.

The Executive Members for Adult Social Care and Health and Public Health thanked and praised the departments' leadership, care homes, NHS, and county council for their tremendous work in uncharted waters during a trying and very difficult time.

RESOLVED -

That the Health and Adult Social Care Select Committee:

a. Was assured by the work underway to support the care home sector through the development of a care home plan and notes the contents of this report.
b. Recognised the impacts upon the care home and wider social care sector and thank all those staff working across the sector for the humanity, compassion and care shown throughout their responses to Covid-19.
c. Receives further updates at future meetings on continuing work to support the care sector.
d. Requested further updates at successive HASC meetings while the pandemic is in progress, including regarding the Care Home Support Plan.

210. **WORK PROGRAMME**

The Director of Transformation and Governance presented the Committee's work programme.

RESOLVED -

That the Health and Adult Social Care Select Committee:

a. That the Committee's work programme be approved, subject to any amendments agreed at this meeting.
b. That a Covid-19 Working Group be set up to consider the issues and help prioritise those that come to the full HASC.

The meeting closed at 2:10pm.

Chairman,

This page is intentionally left blank

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date:	14 September 2020
Title:	Adult Social Care COVID-19 Update
Report From:	Director of Adults' Health and Care

Contact name: Graham Allen

Tel: 03707 795574 **Email:** Graham.allen@hants.gov.uk

Purpose of this Report

1. This report provides an update on the COVID-19 response and support provided across the county of Hampshire by Adults' Health and Care, working with all key partners. The three main areas explored in the report are:
    - the support that has been provided to vulnerable residents and people supported by adult social care services during the pandemic,
    - the moves toward recovery of our services and usual support services, and
    - an update on the impacts and the work being undertaken to support the whole care home sector across Hampshire.
2. This report is intended to supplement the update provided to the Health and Adult Social Care Select Committee by the Director of Adults' Health and Care on 6 July 2020.

Recommendations

3. That the Health and Adult Social Care Select Committee notes the work that has taken place to date by Adults' Health and Care, public and voluntary sector organisations and their partners in Hampshire to support the needs of its most vulnerable citizens and the wider community.
4. That the Health and Adult Social Care Select Committee is assured by the systems that have been put in place across Hampshire, as set out in this report, to support the county's most vulnerable residents as well as the wider community during the COVID-19 pandemic.
5. That the Health and Adult Social Care Select Committee recognises the impacts upon the care home sector and wider social care sector but is assured by the work underway to support the care home sector.
6. That the Health and Adult Social Care Select Committee notes actions taken and currently underway to support moves toward recovery of services,

systems and processes across Adults' Health and Care and receives further updates at future meetings.

Executive Summary

7. This report outlines the extensive work undertaken in Hampshire throughout the COVID-19 pandemic by providing details of the response by Adults' Health and Care and the different organisations who have come together, working with us, to meet the needs of people in Hampshire, particularly the most vulnerable. An update is also provided on the work being undertaken with the care home sector, in response to the impacts experienced, both from excess deaths and wider business continuity issues, through to the remarkable and resilient recovery the sector is valiantly undertaking.

8. Measures that have been identified and are being taken to support the recovery of a range of directly delivered services across Adults' Health and Care as the current response phase to the pandemic subsides are also included.

9. The approach to partnership working across Hampshire around the wider community recovery as well as the planning for outbreak control are also outlined within this report.

Contextual information

10. The coronavirus pandemic has had a pervasive impact on all aspects of life across all our communities and upon the Adult Social Care sector. The impact of the illness has caused significant distress for a larger proportion of the population than was known to Adults' Health and Care before the crisis; including those deemed to be at higher risk and vulnerable to COVID-19 impacts through a range of clinical and other reasons.

11. New demands on the existing health and social care system have been experienced and have led to unprecedented challenges. For example, increasing requirements around swift hospital discharge with a need for the creation of extra capacity in 'out of hospital' settings to enable anticipated acute hospital capacity to be available. In many situations this has increased complexity of need which services have had to manage.

12. Necessary requirements around social distancing have led to social isolation and this is especially challenging for those with dementia, learning disabilities, mental health problems or autism and is also very difficult for their carers. Some services, such as day services, had to be stopped in their original form to comply with social distancing, although many are starting to re-open albeit with significantly reduced capacity. Significant stress and family distress has been experienced by many individuals and families. It is important to recognise these consequences and also to pay tribute to the many organisations and individuals who have sought to maintain support, in the most challenging of circumstances.

13. Adults' Health and Care have operated in response to COVID-19 on a number of levels; service specific responses within our usual operating frameworks to meet the requisite adult social services duties, working with

NHS partners to ensure sufficient 'surge' capacity was created and supported in the event of reasonable 'worst case' scenario planning for **"**wave 1" of the COVID-19 pandemic, creating a broad 'welfare' response across the county of Hampshire with district / borough councils and the voluntary / community sector, providing support to the whole of the regulated care sector at a Hampshire County Council level, operating and leading elements of response as part of the COVID-19 response and now, stabilising and recovering service provision.

Aspects of the Response phase

Adults' Health and Care departmental response

14. Adults' Health and Care, along with all other Hampshire County Council departments, moved quickly to ensure continuity and safety of its services and support to the circa 20,000 people receiving social care support in Hampshire.

15. An internal 'Bronze' operational response structure was established within the department to manage and oversee all aspects of our response to the pandemic. This reported to the departmental management team and linked with Hampshire County Council's Silver and Gold operational command structure and, where necessary, operated with partners across local and national government and the health and social care economy.

16. Usual Adult Social Care services were adapted in light of the social-distancing and lockdown across all activities. This saw the cessation of many services in their usual form, ranging from the suspension of day services and respite services, ensuring our 'front door' services such as the Contact, Assessment and Resolution Team (CART) could operate remotely (whilst maintaining full service coverage), through to establishing new ways of supporting people discharged from hospital settings.

17. It is also vitally important to confirm that all usual services that safeguard individuals have been maintained during our COVID-19 response, safeguarding, mental capacity and mental health assessments, as well as deprivation of liberty safeguards. We have continued to work relentlessly with Police and other partners regarding domestic abuse and other key service areas. Arrangements have also been put in place to monitor our compliance with our duties under the Care Act 2014. Whilst delegated approval was provided by Cabinet to enable Care Act Easements (in light of Coronavirus Act legislation), it is important to underline that we have maintained close scrutiny of our capacity across all service areas and have not needed to enact and, therefore, move away from some key duties under the Care Act 2014. This is a testimony to the operational resilience of Adult Social Care services and the dedication of all staff. However, it is important to also recognise the strain and stress; personal, emotional, physical and financial this effort has put upon all our staff and those of our responding partner agencies.

Welfare response across Hampshire to vulnerable / shielded residents

18. The Director of Adults' Health and Care chaired the welfare response for Hampshire and the Isle of Wight Local Resilience Forum (LRF), supporting and co-ordinating work across all local authorities, the voluntary and community sector, faith communities and wider statutory partners (Hampshire Constabulary, Hampshire Fire and Rescue, NHS partners, etc). The LRF has the role to co-ordinate responses, disseminate learning, escalate issues and provide mutual aid in responding to civil emergencies: this has been a particular high risk area throughout the COVID-19 pandemic given the need to protect the most vulnerable and support them through shielding and maintaining essential safety in a variety of settings.

19. A welfare team was formed in March 2020 from Adults' Health and Care staff, as well as officers from across the County Council. Colleagues took on additional roles and extended 'normal' weekly working from five to seven days in order to make welfare calls and respond to requests being received. This team was stepped down at the end of July in line with the national government decision to pause shielding (see sections 40-47).

20. As part of the Hampshire County Council area response, a Helpline called Hantshelp4vulnerable was established and widely advertised where call advisers triage contacts from vulnerable people who are seeking help. Callers were:

- provided with information and signposting including, where appropriate, to the NHS;
- referred to Local Response Centres (LRCs), operated by each of the district and borough councils, where they were connected to local support, usually provided by an army of well-organised and well-supported volunteers, to access food, prescription collection and other forms of support;
- referred to the County Council's Adults' Health and Care Welfare Team where more complex or urgent needs and personal care requirements were identified.

21. Contact with those residents who were shielding has been via email, SMS, phone and face to face visits. Since the end of March over 32,000 calls have been made or received by the Hantshelp4vulnerable phone line.

22. Hantshelp4vulnerable call line and our Adults' Health and Care welfare team. Other people identified as needing to shield have registered with the national programme and have either identified no support required or accessed specific support issues available through the national shielding programme; food deliveries, medication collections, etc. The number of shielded residents not directly requiring any support or support provided by Hampshire County Council and our partners was approximately 30,000.

23. The Hantshelp4vulnerable phone line became an invaluable asset as a result of an extensive media campaign. This has enabled Hampshire County Council to reach beyond the Clinically Extremely Vulnerable and Clinically Vulnerable group and into the broader vulnerable population. There have been 6,106 referrals to district / borough council run LRCs for support, as

well as several hundred referrals to Citizens Advice for information. This has been alongside 7,000 Hampshire residents who have received central government food parcels. It should be noted some people have been in receipt of support through both schemes, given some of the inadequacies and limitations of the national shielding programme offer.

23. As a result of the referrals and work we have undertaken through the Hantshelp4vulnerable arrangements we have seen 71 new support plans funded by Adults' Health and Care, people with previously unidentified eligible social care needs.

24. Adults' Health and Care proactively made contact with the 7,000 people receiving central government food parcels as part of a "Get Going Again" strategy started at the beginning of July. This was a piece of proactive work designed to move people, without specific social care needs back to more independent arrangements for food and medication and to arrange continued volunteer support where required. Only 27 people so far have required additional support to their existing arrangements. This underlines the quality of support provided through 'lockdown' and the importance of the "Get Going Again" campaign.

25. The Department has received very positive feedback on the welfare response from Hampshire residents throughout the duration of COVID-19. The public have not only been grateful for direct support from volunteers with food, medication, befriending, emotional wellbeing and financial hardship support but also, for the welfare checks themselves. For example; "Mr X has been isolating for three months due to a cancer diagnosis. He says he hasn't laughed in all that time and my call gave him someone to laugh with. Mr X is feeling unmotivated and isolated and he was really grateful to talk about goal setting and being referred to the check and chat service" and "Thanked us all for caring and for our empathy, it is much appreciated and most helpful".

Role of the Borough and District Councils and Local Response Centres

26. There are 11 Borough and District Councils across Hampshire. Each of these councils set up LRCs which brought together local council and voluntary sector professionals (via local Council for Voluntary Services organisations) with volunteers to co-ordinate support at a neighbourhood level. They have been working closely with local supermarkets and charities, including foodbanks as well as with parish and town councils.

27. Borough and District Councils, along with the CVS (Council for Voluntary Services) organisations, have been able to use their extensive local community contacts and knowledge to ensure that the response within local communities has been as effective as possible.

28. A scaled-down LRC and CVS structure will be retained alongside the Hantshelp4vulnerable arrangements until the end of March 2021. It is an aspect of our collective continuity planning that these response structures could be stood up again, if required in the future.

Role of the Voluntary Sector and volunteer capacity

29. Hampshire CVS Network is an alliance of nine charity infrastructure organisations who work together to help Hampshire's charities, community groups and social enterprises to succeed and flourish. During the pandemic it has played a significant role in co-ordinating the response of the voluntary sector to help mitigate the impacts of the pandemic on local communities as well as providing support for voluntary organisations.

30. Hampshire saw a significant response in terms of people volunteering to help their local communities during this time. Around 4,000 volunteers signed up to new and existing frontline projects supporting vulnerable people across Hampshire. This meant that on some occasions there were more volunteers available than work for them to do. It has also meant that there was less of a pull on the NHS volunteers that were recruited by central government. It is important to recognise and thank the tireless work of voluntary sector partners and volunteers, perhaps this more than anything else underlines the uniqueness of community spirit and cohesion that exists across our communities.

31. The County Council's Insight and Engagement Unit has recently carried out a study around volunteering in Hampshire, designed to inform and support the recovery phase of COVID-19 and maximise the availability and skill sets of volunteers. A multi-agency working group focused on volunteers and volunteering has been established as part of the wider community recovery programme. Much of its initial focus will be on responding to the key issues highlighted by the survey, encouraging people returning to volunteering to do so safely and retaining those who had volunteered for the first time. Some of the key findings of the study were:

    - Many younger people had got involved for the first time bringing new skills (eg. IT) however, they had different and changing demands on their time so needed more flexible opportunities
    - There were time-limited opportunities for some e.g. children returning to school
    - There was a need to avoid the view that the crisis was over; many people needing continued support were now less supported and at risk of being adversely affected by the lockdown experience
    - Some of the pop-up organisations were stepping back and people needed to be offered attractive local alternatives to remain active in volunteering
    - A locally organised experience is preferable to signing up to a national or county-wide scheme and messaging from all points of enquiry should direct people accordingly, this underlines the importance of place
    - There is a need to thank and celebrate volunteers
    - There is a need to communicate clearly where more volunteers are needed.

Food Supply

32. One of the key priorities for the welfare response in Hampshire was to ensure that those people who were isolating or shielding had sufficient food and other basic items. The LRCs were instrumental in ensuring that people had food, as well as medicines and other basic supplies, delivered to them by volunteers where required. There has been a significant draw upon local resources to maintain food banks and to access on-line and supermarket direct deliveries. Initially, this was a major pressure, but from June 2020 onwards additional supermarket slots started to become available and some of the national mechanisms, through the shielding programme, enabled direct 'local' referrals to priority slots. This has helped significantly in the period leading up to and since the ending of the national shielding programme on 31 July.

Impact of COVID-19 on Mental Health

33. The mental health and emotional wellbeing of the population during the pandemic is a widely reported issue and cause for concern. A range of initiatives have been implemented alongside other statutory and voluntary sector partners in view of social distancing measures and the closure of key services. Hampshire Mental Health Well Being Centres are now remotely accessible and continue to offer a service to those in need. The Hantshelp4vulnerable helpline has been strengthened by a dedicated advice line staffed by Solent MIND assisting people including carers feeling anxious in isolation. Specialist mental health support has been set up to provide advice and guidance to homeless accommodation schemes.

34. As part of the wider community recovery programme a multi-agency Mental Health and Wellbeing Recovery Board has been established (see paragraph 58).

Impact of COVID 19 on People in Caring Roles

35. People who care for family members or others have generally been disproportionately impacted by the consequences of social distancing, isolation and shielding. Since the outbreak of the pandemic, carers' organisations, including Andover Mind, Carers Together, Hampshire Young Carers Alliance and Princess Royal Trust for Carers have responded to support both carers and the wider community in Hampshire. They have extended the opening times of their helplines and have adapted and widened their service offerings to provide listening services, virtual peer groups for carers, making welfare calls to carers and running online workshops for carers, as well as making their services available to people who are self-isolating or shielding. Such organisations continue to innovate and offer extended services as referrals to them continue to increase. Additional support has been provided by Adults' Health and Care through the provision of a dedicated carers support role, hosted by Carers Together.

36. Operational teams continue to monitor the situation for families to ensure that individuals with disabilities and older people continue to have their needs met and that carers are supported. Additionally, the County Council

has set up a weekly carers sub-group as part of its formal response to dealing with the pandemic consisting of carers, representatives from carers organisations in Hampshire and operational staff from the County Council's Adults' Health and Care department. This arrangement is paying significant dividends in ensuring pro-active responses and support to those requiring assistance and enabling co-ordination of the available capacity.

Domestic Abuse

37. Support and advice continue to be available in Hampshire for people if they, or someone they know, is experiencing domestic violence or abuse or is struggling to control their behaviour. This is provided by Hampshire Domestic Abuse Service and other methods including Facebook messenger. This work and network of support has been developed closely with partners across Hampshire County Council and with Hampshire Constabulary and other partners.

Rough sleepers

38. Significant effort has been made in collaboration across the relevant housing authorities (district / borough councils) to meet the Government requirement that all homeless people living in Hampshire should be offered accommodation and move off the streets. The District and Borough Councils continue to offer accommodation to homeless people who may not previously have been considered priority need but may now be considered vulnerable in the context of COVID-19 taking into account their age and underlying health conditions. However, as hotels and B&Bs have opened up to local visitors, finding appropriate emergency accommodation for all rough sleepers has become increasingly challenging due to the complexity of support needs of many of these people**.**

39. As part of the outbreak control planning work, there is a focus on the challenges of managing an outbreak within homeless hostels and the County Council is actively supporting and collaborating with District and Borough Councils to identify contingency accommodation that could be used in this scenario. Extensive contingency work has also been undertaken by staff in Adults' Health and Care, working with Public Health and housing colleagues, on outbreak management arrangements in homeless hostels and other facilities – as part of the local outbreak plan high risk settings approach.

The pausing of shielding

40. From 31 July support provided through the national programme was paused for those people who have been shielding because they were regarded as Clinically Extremely Vulnerable or Clinically Vulnerable . The central provision of food parcels also stopped from this date.

41. Some 53,200 Hampshire residents who have been shielding have either confirmed to us or the national programme that they have appropriate support arrangements in place, with a small number of local residents

requiring additional support to complete their return to more independent living. Overall, since the announcements relating to the easing of shielding arrangements were made there has been extremely positive progress in contacting all those people who had been receiving support in order to confirm potential ongoing needs, a task made no easier given the inaccuracies of contact details we had initially received through the national programme.

42. Our complementary communications campaign "It's OK to…" has been designed with engagement from District / Borough Council partners to support the wider vulnerable group with the risks and barriers to independence caused by COVID-19, taking account of the fact that some people have not been outside of their home for some time. It has also been shared with other Local Resilience Forum partners, such as the Clinical Commissioning Groups (CCGs) and Southern Health Foundation Trust (SHFT).

43. The "It's OK to…" campaign has started and is initially targeting those that have been shielding with 15,000 emails already sent followed by 30,000 letters. The campaign is focusing on the following elements:

- Learning how technology can help you.
- Staying active.
- Getting out and about safely.
- Reconnecting with others safely.
- Looking after yourself.

44. Future areas of focus by the campaign will include Mental Health and the financial impact of COVID-19.

45. Independence packs have been developed with the involvement of Hampshire County Council's Public Health team and the community of partners supporting shielding / vulnerable residents. These are also being distributed via call centres and through LRCs.

46. The digital elements of the campaign started on 2 August with comprehensive information published on the County Council's website.

47. The "It's OK to…" campaign logo is shown below:

Adults' Health and Care Recovery

48. In June, Adults' Health and Care carried out a "Stop/Start model" exercise to capture what was stopped or started during the Response to COVID-19, and the related proposed Recovery action. These Stop/Start models are now built into Recovery plans for each service area and provide a baseline reference in the case of a future COVID-19 peak with the agility to 'switch back on' Response if necessary.

49. Assistant Directors within Adults' Health and Care are responsible for the development and delivery of detailed Recovery plans for their service areas, as part of an established and robust Adults' Health and Care Recovery governance framework. Any plans which have a potential financial, reputational, legal or department-wide implication are escalated to the Adults' Health and Care Recovery Executive Group for decision, to the Departmental Management Team if necessary and then to Hampshire County Council Gold. The department's governance approach links in closely with the corporate Gold / Silver / Bronze Response structure, the Hampshire County Council Recovery Group, as well as the Public Health and local/national Recovery planning.

50. Significant progress is being made in a number of areas as part of the department's gradual recovery of its services. An example is the provision of day services, both directly provided (HCC Care) and commissioned, which was stopped in response to COVID-19. All HCC Care day services for Younger Adults have now re-opened, with HCC Care day services for Older Adults due to re-open through September. Some 28 external day services for Younger Adults have now opened that Adults' Health and Care commission places at, with more due to open in the next month. As at the end of August, over 400 younger adults with disabilities have returned to some form of day service provision, from a cohort of 1,140. A further 220 younger adults are scheduled to return in the next month. It is hoped more capacity can be available in due course, however, guidance on social distancing and staying safe will inevitably be a rate-limiting factor for some time yet. The re-start of commissioned day services for Older Adults remains a challenge we are working hard with providers to resolve. It is also important to note that although people are returning to day services, many are not receiving the same levels of service as they did prior to COVID-19. We expect capacity in Younger Adults services to be <50% of that pre-COVID-19.

51. Arrangements are progressing as the department transitions smoothly from the Response phase to Recovery. This will entail the 'closure' of the weekly Bronze Response Group and its related sub-groups, with a seamless transfer of ongoing activity to existing Recovery governance forums. Arrangements are being put in place to clearly identify roles and responsibilities should there be a future COVID-19 local / national outbreak, necessitating the efficient reinstatement of Bronze and related Response activity. In this scenario, the Adults' Health and Care Recovery Executive Group would switch swiftly and seamlessly into the Adults' Health and Care Response Executive Group. That Group will have oversight of the

department's Response, while day to day Response activity will be led by Bronze in line with the County Council's established Command and Control procedures.

Community Recovery and Outbreak Planning

52. One of the key recovery workstreams is the Community recovery and Outbreak Control Planning.

53. Our District and Borough Council partners as well as our colleagues in the voluntary sector are involved in the stabilisation and recovery planning around community welfare, with three district Chief Executives actively engaged in our ongoing welfare planning. It has been agreed, in principle, that a skeleton LRC and VCS structure will be retained alongside the Hantshelp4vulnerable arrangements and an internal Hampshire County Council welfare team (based in CART) until the end of March 2021. This structure will not only enable support for shielded / vulnerable residents if required, but also support potential outbreak control planning should residents be required to self-isolate and require volunteer support. For example, we have recently extended the service to support those returning from holiday who may need support with essential supplies so that they can effectively self-isolate.

54. A Welfare Recovery and Stabilisation group has been established consisting of representatives from across the County Council, including Customer Insight and Engagement, Adults' Health and Care and Public Health, the VCS organisations (represented by Community First), District and Borough Councils (represented by Hart District Council), the CCGs and Citizens Advice. Colleagues from Winchester City Council are also part of the group in their lead role for homelessness and high-risk settings.

55. The focus of the group to date has been contingency and capacity planning for possible future lockdowns or local restriction scenarios. Working groups have been established to develop process and procedures around outbreak control planning as well as communications for the wider community recovery.

56. The next priorities for the group are to plan for four outbreak scenarios: no change to current situation; increased infections and tightening of restrictions; full lockdown measures and district / local lockdown.

57. A draft memorandum of understanding for COVID-19 outbreak control is also under development by the group. It will cover the roles and responsibilities of all partners, including the County, District / Borough Councils, NHS and VCS organisations in order to ensure the response to any future potential outbreak is as well planned and co-ordinated as our collective response to the first-wave. It will include (but is not limited to) the identification of risks and development of mitigating actions with respect to the following areas:

- Data management and management of the shielding list
- Food supply
- Pharmacy delivery

- Voluntary transport
- LRC capacity and finance
- VCS capacity and finance
- Hardship
- Homelessness
- Communications
- Social care response
- Hantshelp4vulnerable and welfare response
- Personal Protective Equipment (PPE) supply for the voluntary sector.

58. Also included in the scope of the Community Recovery, there is a separate Mental Health and Wellbeing Recovery Board chaired by the Director of Public Health for Hampshire and is a collaboration across Hampshire County Council, VCS and SHFT. This forms part of the system-wide Mental Health and Wellbeing Recovery LRF Cell led by SHFT. All psycho-social support work sits with the Mental Health and Wellbeing Recovery Board.

Workforce Recovery

59. The strategic objectives of the Adults' Health and Care Workforce Recovery workstream are:

- **Wellbeing Support**

  Build on the departmental and corporate wellbeing offer to ensure there is support available given the experience of staff working during the pandemic.

- **Change Support**

  Identify how the service can capture / capitalise upon the flexibility and resilience demonstrated by staff during COVID-19 and embed new ways of working.

- **Working Differently Interface**

  Reconcile Working Differently with the COVID-19 response, particularly the impact on the original flexible working principles e.g. drop-in centres and office hubs.

- **HR-Focused Activity**

  a) Re-invigorate Value Based Recruitment in the context of new remote / virtual recruitment processes.

  b) Ensure managers are equipped with the tools and the skills to ensure productivity and quality are maintained.

60. A diagnostic tool was developed with senior leaders to understand the main issues and concerns regarding staff welfare within each service area, and how this varies across the Department, to inform the ongoing staff support offer. Findings from the Staff Wellbeing survey and service area Stop/Start models were fed into this exercise.

61. The Adults' Health and Care Staff Wellbeing Hub was set up at the beginning of the COVID-19 emergency and continues to operate with

support from Adults' Health and Care Learning & Development resource. Plans for the Staff Wellbeing Hub in the longer-term are under consideration by the departmental management team. As part of the staff wellbeing offer, Connect 5 is being carefully considered to support staff mental health, particularly in response to COVID-19. It is also recognised that focus upon teambuilding, in a post-Covid world will be significant in the context of Recovery and staff wellbeing.

62. In terms of recruitment and training of staff, planning continues to further support virtual recruitment and Values Based conversations in the longer-term. Virtual training is now in place for all identified essential training across the department, and work to restart critical face to face training is nearing completion.

63. Learning lessons will be undertaken at various levels to examine good practice, areas of learning and the degree of compliance with national and local policy, guidance and directives.

64. Two targeted COVID-19 Learning Reviews commissioned by the Care Governance Board are now underway within the department, focusing on HCC Care and Management of the Provider Market. In addition, the Lessons Learned workstream is undertaking the following activities to feed back into the department's strategy:

- Scenario-based sessions with Bronze Group members
- Surveys and reviews of key teams and services
- Reflective sessions – e.g. use of PPE
- Participation in system wide reviews – e.g. hospital discharge arrangements
- A review led by the Hampshire Safeguarding Adults Board on health and care sector impacts and learning
- Regional and national reviews and inquiries.

Care sector impacts

65. As stated in the previous report received by this Committee the impacts upon families and staff caring for individuals in care home settings have been significant and the effects upon the care home sector have featured regularly in national news reports. Approximately 40% of care homes in Hampshire have seen positive cases of COVID-19, either for their residents or their staff.

66. Much information has begun to be available providing insights into the impacts on the sector and the potential causes of such a significant and virulent transmission within the care home sector nationally. At this point in time it remains the case that there is probably no single cause and effect, but clearly the devastating impacts of such a novel, new disease were not understood and mitigation measures not communicated at an international or national level until the consequences were being profoundly felt.

67. Some recent reports include the Stirling University report, which highlights a range of likely contributory factors but does not conclusively evidence the root cause, as the data available is judged to be inadequate. However, it

highlights factors such as the transfer of patients from hospital who were not tested early on in the pandemic, the erratic testing strategy for care home staff, particularly the lack of testing of asymptomatic staff and residents, and links between care home characteristics and outbreaks.

68. Equally, it is likely that some of the knock-on effect of COVID-19 restrictions (such as isolating residents and stopping visits to residents) may also have contributed to excess deaths – as highlighted in the Lancet. Adelina Comas-Herrera of the LSE points out that even if the majority of this year's excess deaths in care homes are not directly attributable to COVID-19, that does not mean they are not a consequence of the pandemic. “Isolating residents may mitigate the spread of the virus, but it is associated with morbidity of its own. Care homes are built for communal living and staffed accordingly. The lack of supervision places isolated residents at increased risk of injury, particularly from falls, and their mental health might suffer. People with dementia often stop eating if they are depressed, which can hasten death. Besides, it is no small task to persuade people with dementia to stay in their rooms and maintain physical distancing. No-one wants to see care-givers resort to restraining or sedating residents.” Care home visiting has been in place, cautiously and within the available guidelines for some weeks now. However, incidences of an outbreak, either for staff or residents, will continue to prompt changes to local visiting regimes. Furthermore, reviews have been commissioned about the experiences of the care home sector in Hampshire, both for the directly provided HCC Care homes and across the wider sector. At the time of writing this report findings are not available but will be brought before this Committee once they are.

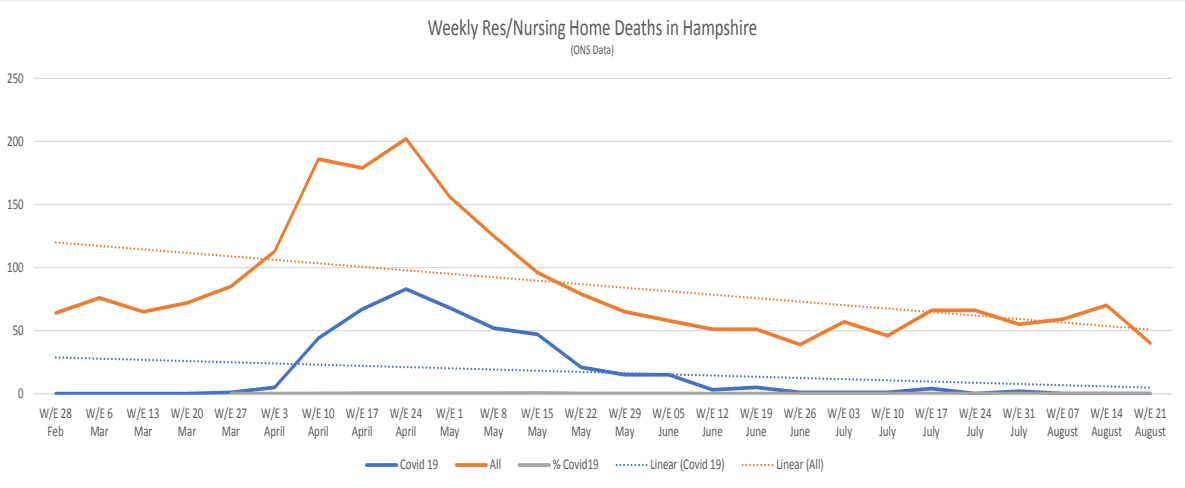
69. Overall, and in light of academic studies beginning to be published - in Hampshire, a total 2,299[1] people have died in care home settings in the period between the week ending 28 February 2020 and the week ending 14 August 2020. Appendix 1 provides a regional comparator of care home deaths per 1,000 beds – Hampshire shown in red.

70. Of these deaths 469 people had COVID-19 recorded as the cause of death on their death certificate. Of this total number of 2,299 recorded care home deaths approximately 800 (including those with a cause of death identified as COVID-19) are considered to be excess, that is to say above the expected average number of deaths in the corresponding period over the previous 5 years.

71. Figure 1, below, shows the progression of care home deaths during the period 28 February to 21 August.

1 These figures are taken from the most recent release from ONS which is available here; https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregisteredweeklyinenglandandwalesprovisional/weekending14august2020

Figure 1 – Care home deaths in Hampshire 28/2/20 – 21/8/20



72. In addition to the high numbers of excess deaths providers of care homes and other social care support providers also saw other significant impacts upon their provision; staff absence through self-isolation, increased pressures and costs in securing PPE and other essential supplies, uncertainty over guidance being issued / followed, as well as a massive reduction in their income base where residents tragically died.

73. In response to these pressures Hampshire County Council (and Hampshire CCG Partnership) moved swiftly to increase payments on commissioned care values, where acting as the commissioner of a service. From an Adults' Health and Care perspective additional commissioned care payments to care homes and providers of domiciliary care will amount to an additional £16m (additional payments up to September 2020).

74. Additionally and, in response to a requirement from the Secretary of State for Care a Care Home Support Plan covering a comprehensive series of key areas was rapidly developed through May 2020, working in partnership with Hampshire Care Association, Hampshire CCG Partnership and with the support of Healthwatch Hampshire and local Care Quality Commission (CQC) senior management. That action plan can be found here.

75. The submission of the action plan and accompanying information has led to the work being undertaken on Infection Prevention and Control being identified as an exemplar nationally, we are working with Department of Health and Social Care officials to produce case studies of our approach as part of a national toolkit.

76. Additionally, some £18.4m of financial support was made available to Hampshire County Council by Government in two tranches (in late May and early July) to provide additional financial support to the whole of the care home sector. Payments were made in May, prior to the national funding being received, and again in early July to the care home sector – this totals some £15m, with an additional £2m being provided to the domiciliary care sector, up to £0.5m to the day opportunities sector and the balance of

funding used to fund emergency supplies of PPE. A return to Government on the use and outcomes of the funding will be submitted at the end of September.

77. Positively, since the peak of the first wave of COVID-19 in March / April / May when care home occupancy fell overall to an unsustainably low level of circa 70% of available beds occupied, that has now risen to approximately 85% of available beds – as declared by all care home providers through care tracker data submissions. This is positive for many reasons, but most notably the financial resilience of providers can be on a stronger footing, meaning less residents at risk of being displaced through closures and secondly it underlines the confidence the public have in the sector. Again, it is important to recognise the compassion, professionalism and dedication of the whole sector in seeking to provide the highest quality care for residents (and their families).

78. Issues which remain challenging are the national testing programme for residents and staff. Whilst we have seen some progress being made to ensure regular testing becoming available across the care sector we are still several weeks from being confident that this is universally in place. This remains a vital element as we head into what will inevitably be a very challenging winter. The programme in place regarding local outbreak measures, including testing will be covered within the Director of Public Health update.

Conclusion

79. The response to the COVID-19 pandemic across all aspects of our services and communities has been significant. The impacts of the pandemic have been similarly significant and the consequences upon our communities and individuals profound. It will take some time for the full impacts of restrictions and the lockdown upon our communities to be known.

80. In line with Government's progress toward reducing the current restrictions, services and responses will be amended over the coming period, whilst monitoring the risk of a second wave, in line with the Local Outbreak Management Plan.

81. The care home sector whilst mortally wounded by the devasting impacts of COVID-19 has proven itself to be resilient, compassionate and imaginative as it continues to provide high quality care to residents. The work that is being undertaken across Hampshire County Council, Hampshire CCG Partnership and Hampshire Care Association is an excellent example of the collaborative effort that will continue to be required in the short, medium and longer term. All parties are fully committed to the approaches that have been instituted and collectively we stand ready to ensure any and all measures to maintain resident care are adopted, sector wide.

82. Whilst there is still much further work to be undertaken as we steadily move from response to recovery, and learning and analysis continues to be undertaken, it is hoped this overview provides the Health and Adult Social

Care Select Committee with a degree of assurance and confidence in the ongoing approach by Adults' Health and Care.

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	No
People in Hampshire live safe, healthy and independent lives:	Yes
People in Hampshire enjoy a rich and diverse environment:	No
People in Hampshire enjoy being part of strong, inclusive communities:	Yes

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. **Equality Duty**

The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

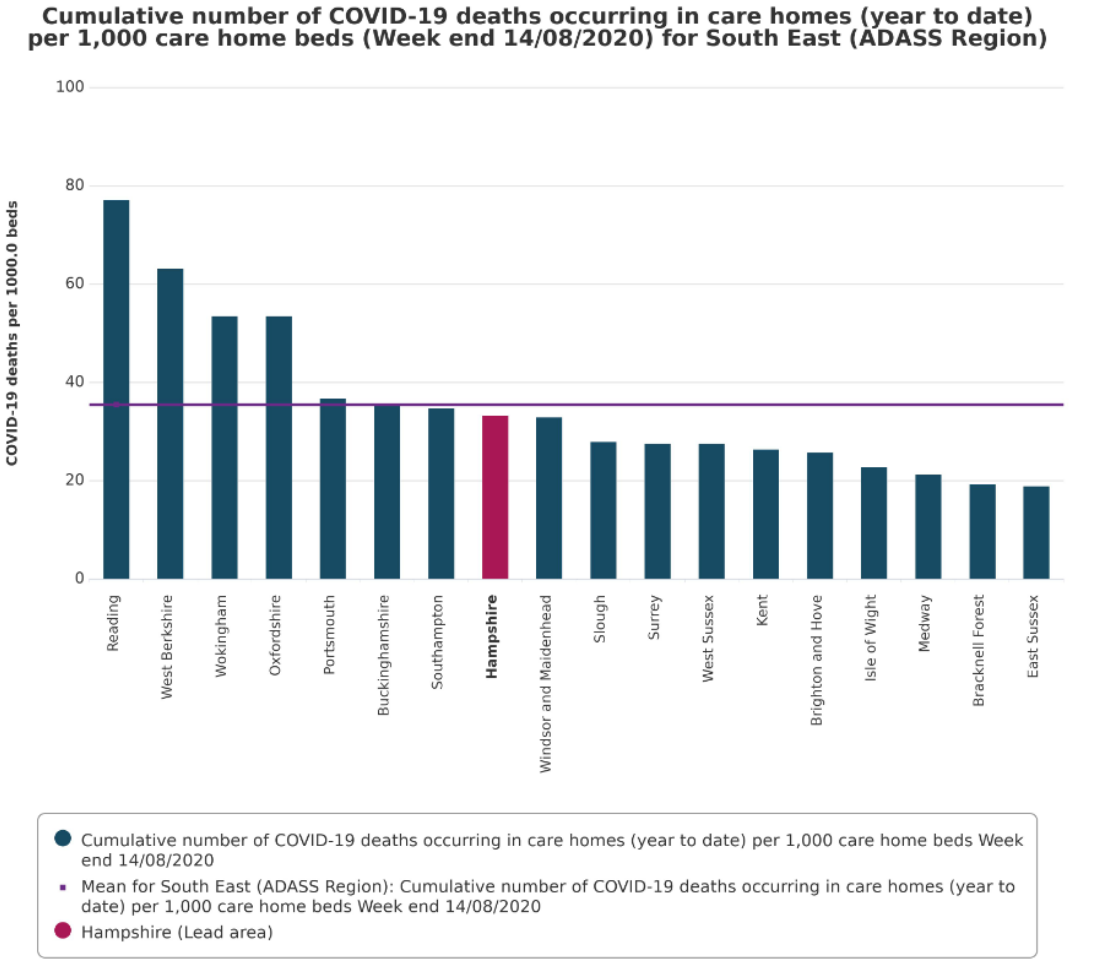
Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. **Equalities Impact Assessment:**

2.1 This paper is an update report, so Individual Equalities Impact Assessments have not been completed.

Appendix 1



Source:
Calculated by LG Inform

Powered by LG Inform

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date of Meeting:	14 September 2020
Report Title:	Hampshire and Isle of Wight NHS Covid-19 Response Update
Report From:	Hampshire and Isle of Wight Integrated Care System Southampton City, West Hampshire and Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups

Contact name: Members Services

Tel: 0370 779 0507 **Email:** members.services@hants.gov.uk

Summary and Purpose

1. Following the briefing provided in July 2020, the attached report (Appendix 1) provides an update on the impact to date of the pandemic; the health element of the Hampshire and Isle of Wight Local Resilience Forum response to Covid-19; and the NHS restoration and recovery work including seeking the views of key stakeholders and local people. The paper also provides details of planning work being undertaken across Hampshire and the Isle of Wight (HIOW) for winter and a potential second wave of Covid-19.

2. Also attached are updates provided by the following NHS Trusts:
   - Hampshire Hospitals NHS Foundation Trust (Appendix 2)
   - University Hospitals Southampton NHS Foundation Trust (Appendix 3)
   - Portsmouth Hospitals University NHS Trust (Appendix 4)

Recommendations

3. That the Health and Adult Social Care Select Committee:
   a) Note the system wide update
   b) Note the Trust specific updates provided
   c) Confirm the timing, format and themes for the next update

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	no
People in Hampshire live safe, healthy and independent lives:	yes
People in Hampshire enjoy a rich and diverse environment:	no
People in Hampshire enjoy being part of strong, inclusive communities:	no

Other Significant Links

Links to previous Member decisions:	
Title Hampshire and Isle of Wight Covid-19 System Approach Overview	Date 6 July 2020
Direct links to specific legislation or Government Directives	
Title	Date

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. Equality Duty

The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. Equalities Impact Assessment:

This is a covering report for items from the NHS that require the attention of the HASC. It does not therefore make any proposals which will impact on groups with protected characteristics.

This page is intentionally left blank

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

1. Introduction

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

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

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

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

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

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

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

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

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

3. HIOW NHS response to Covid-19

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

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

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

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

Progress to date includes:

Prevention
Health visiting and school nursing:

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

Sexual Health:

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

Substance misuse:

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

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

Primary Care

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

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

Community Care

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

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

Planned Care

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

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

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

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

Mental Health

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

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

Urgent and Emergency Care

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

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

4. HIOW NHS restoration plans

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

These include:

Prevention

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

Primary Care

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

Community Care

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

Planned Care

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

Mental Health

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

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

5. NHS England and NHS Improvement commissioned services

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

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

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

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

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

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

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

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

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

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

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

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

6. Winter and potential Covid-19 second wave planning

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

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

7. Seeking the views of local communities

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

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

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

8. Recommendation

The Committee is asked to note this update briefing.

Hampshire Hospitals
NHS Foundation Trust

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Services (Overview and Scrutiny) Committee
Meeting Date:	14 September 2020
Title:	Update from Hampshire Hospitals NHS Foundation Trust (HHFT) on the response to COVID-19
Report From:	Julie Dawes, Chief Nurse and Deputy Chief Executive Hampshire Hospitals NHS Foundation Trust

Contact name: Stuart Wersby, Trust EPRR Lead

Tel: 01256 313510 **Email:** Stuart.wersby@hhft.nhs.uk

1. PURPOSE

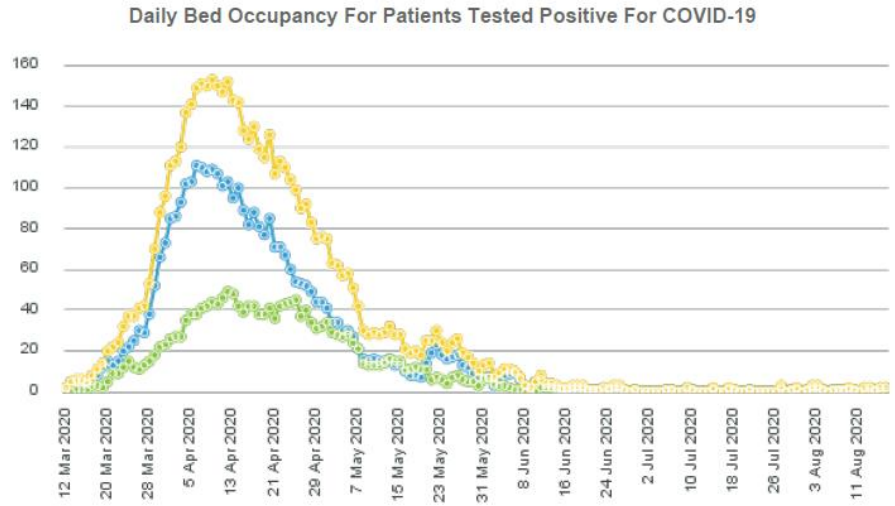
To provide an update to HASC on the response of Hampshire Hospitals NHS Foundation Trust to the COVID-19 epidemic.

2. IMPACT OF COVID-19 ON HAMPSHIRE HOSPITALS

2.1 Hampshire Hospitals Trust had its first positive COVID-19 patient on 10 March 2020 and as of 17 August 2020 has treated 612 COVID positive in-patients, 73 in critical care. Of the 612 COVID-19 patients 450 were discharged and sadly 162 passed away.

Hampshire Hospitals discharged its final patient from the first wave on 23 June 2020 and there have been no COVID-19 related admissions between this date and 17 August 2020.

The graph below shows the daily bed occupancy for COVID positive patients each day for Winchester (green line) Basingstoke (blue line) and total for Hampshire Hospitals.



2.2 Significant changes to the configuration of each of our hospitals estate has taken place in order to segregate hot (highly probable) and cold (low likelihood) COVID-19 patients as well as catering for elective diagnostic and surgical activity. Reconfiguration has included changes to the emergency departments, wards and radiology designed to minimise the risks to patients and staff. Whilst there have not been any positive COVID-19 inpatients for some time we continue to manage significant numbers of patients whose symptoms require them to be isolated and tested before they mix with non-symptomatic patients.

2.3 During the Emergency Response to COVID-19 it was necessary to suspend a number of services in order to focus staff and resources on the response to the epidemic. One of the services which were suspended was the Andover War Memorial Hospital Minor Injuries service which in the early stages of the epidemic was receiving minimal numbers of patients and for which segregation into hot and cold streams was impractical.

The unit currently remains closed, though plans are currently being developed to partially reopen a minor injuries service which can be delivered in a COVID-secure way.

3. RESTORATION OF ACTIVITY

3.1 In order to manage a significant increase in unplanned attendances and to safeguard our patients from the COVID-19 infection we had to significantly reduce our capacity for the management of elective outpatients, diagnostics and surgical activity.

During the peak of the COVID-19 epidemic we maintained emergency surgery on our primary sites and undertook urgent surgical activity primarily by the use of the independent hospital sector to reduce the risk of infection to these patients.
The majority of outpatient activity took place through virtual (telephone or video) consultations with only those who were urgent and unable to be managed in this way attending in person.

From the end of April the number of patients receiving care for COVID-19 related illness and the overall level of infection in the community dropped allowing us to commence a process of restoring our routine services.

3.2 During the peak of the COVID-19 epidemic there was a significant reduction in the number of emergency department attendances and associated unscheduled admissions. Since early May the number of admissions has steadily increased and Hampshire Hospitals are now dealing with as many patients as we were prior to the COVID-19. In order to minimise the risk of infection to patients within the emergency department and admitting wards, admissions are screened as hot (potential COVID-19 symptoms) or cold (no COVID-19 symptoms). This streaming arrangement is expected to continue for the foreseeable future and as a result increases the space and staff requirement for the emergency department and a reduction in the efficiency of capacity utilisation in receiving wards.

3.3 A significant amount of outpatient activity was able to continue during the peak of COVID-19 by switching face-to-face appointments to virtual consultations. The use of virtual outpatient appointments has been considered a positive innovation which has accelerated as a result of COVID-19 and been adopted as part of our ongoing model of care. There are some patients who, because of the nature of their referral, do require a face-to-face consultation and to meet these requirements physical clinics have been reintroduced with measures in place to support social distancing including a review of the environment and restrictions on the number of face-to-face appointment sessions forming each of those clinics.

3.4 Prior to COVID-19 balancing the demand for diagnostic procedures with the available capacity was at time challenging particularly within CT and MRI imaging modalities. The impact of COVID-19 has been that the number of patients awaiting non-critical diagnostic procedures has increased and the need to adhere to additional COVID-19 prevention related processes has reduced the volume of procedures possible through each scanner. A number of initiatives are now in place or planned to support the projected level of demand;

- An increase in the number of MRI sessions offered through an increased use of portable units.
- Plans to introduce a medium-term portable CT scanner in Andover as part of the Department for Health provision at this site with the added benefit of being a lower infection risk as it is not used for treating COVID-19 patients.
- The use of self-contained portable vanguard endoscopy units on the Basingstoke and Winchester sites as well as an increase in the number of sessions on the Andover site.

3.5 Surgical activity has, since early in the COVID-19 response been prioritised by clinical need. The National 4 stage priority levels (1a - Emergency 24 hrs, 1b - Emergency 72hrs, 2 - Elective 4 weeks, 3 - Elective 3 months and 4 - Elective that can be deferred) have been used along with a clinical prioritisation panel to ensure that the most critical of procedures have been prioritised to continue by using ring fenced

capacity on our primary sites and through the use of capacity within the independent sector.

Priority 1a→3 activity has in the main continued throughout the response to COVID-19. A reduction in capacity has led to more limited priority 4 activity that otherwise would have been undertaken. Additional COVID-19 prevention related processes which include the segregation of theatres and wards used for pre-screened and isolated patients as well as enhanced cleaning between patients has led to a reduction in the effective capacity and the number of procedures which can be delivered in each session.

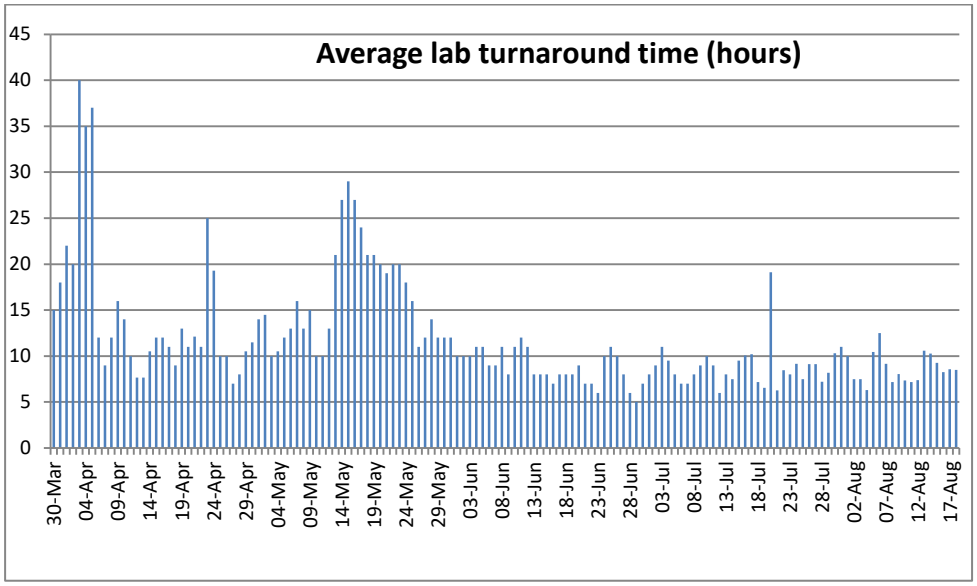
As part of the restoration processes further assessment and stratification is being undertaken to ensure that patients within the priority level 4 category are treated in line with their clinical need. Work is also being undertaken to ensure that theatres are utilised in as efficient a way as practicable maximising the number of procedures which can be undertaken in the current environment.

3.6 In order to minimise the disruption to our patients we have worked closely with independent sector hospitals, primarily BMI Hampshire Clinic (Basingstoke) and BMI Sarum Road (Winchester). Independent hospitals have provided extra capacity in a setting which was not treating COVID-19 patients. In addition to the provision of surgical capacity we have used Sarum Road for the delivery of chemotherapy treatment and have used Hampshire Clinic for the delivery of diagnostic procedures including endoscopy.

4. TESTING, RESEARCH AND INNOVATION

4.1 Hampshire Hospitals understands the importance of innovation and research to improve the response to COVID-19 and remains engaged with a number of trials including the Siren surveillance study testing asymptomatic staff and the use of various rapid diagnostic techniques both in the hospital and community environment.

4.2 Early into the response to COVID-19 it became apparent that testing would be a critical component in the management of the infection and the microbiology team at HHFT worked hard to develop a testing capability using existing PCR technology in a novel way. Between 26 January and 18 August 2020 the microbiology team have undertaken 21,442 tests of staff, patients and partner organisation staff of which COVID-19 was detected on 1,486 occasions. Through ongoing innovation and significant changes to increase the operating capacity of the lab it has been possible to drive down the turnaround time to less than 10 hours which improves the decision making for potential COVID-19 patients and reduces the disruption to staffing.



4.3 In addition to testing for the presence of the COVID-19 vaccine we have since the start of June been able to offer antibody testing to staff and patients though Portsmouth Hospitals University NHS Trust. Between 2 June 2020 and 16 August 2020 3,866 staff members have been tested of which 581 (15%) had antibodies detected and 2,588 patients have been tested of which 163 (6%) had antibodies detected.

4.4 Building on some of the innovative testing methods developed by the Hampshire Hospitals Microbiology Team a Cabinet Office sponsored trial of "Lab in a van" service where a van based mobile laboratory accompanied by a testing team could be deployed away from the hospital site providing rapid testing and results.
The trial applied the mobile lab methodology to the testing of care homes as well as a rapid "front of house" near patient testing model close to the emergency department.

4.5 To improve decision making for patients attending our Basingstoke and Winchester hospitals over the winter period, and anticipating the potential for a second wave of COVID-19 we are developing plans to place near patient testing for COVID-19, Flu and other respiratory conditions on a 24-hour-per-day basis. The microbiological testing will be achieved by providing a satellite microbiology lab providing a service to the Winchester site and a POD based lab outside the emergency department in Basingstoke. It is expected that the introduction of near patient testing will allow informed decisions about how and where a patient is treated before they leave the emergency departments.

5. STAFF WELFARE AND SUPPORT

5.1 At the start of the COVID-19 epidemic the government introduced a process of shielding for the most vulnerable members of society (including members of staff) and a significant amount of work was undertaken redeploying at-risk staff to appropriate environments.

As more information about the risk to particular groups of staff was understood Hampshire Hospitals assessments were extended to all members of staff who were from BAME backgrounds over 55, all staff over 60, all male staff, all pregnant staff and all staff with underlying conditions which they considered might be impacted by COVID-19.

Risk assessments were used as the basis of discussions between staff members and their line managers with a range of control measures depending upon the outcome of the assessment.

Due to the reduced incidence of COVID-19 in the community the hospital control measures for at-risk staff are currently relaxed with pre-defined triggers in place for reinstating them if and as the prevalence increases.

5.2 A dedicated team was established early in the response to COVID-19 to support members of staff displaying COVID-19 symptoms and to facilitate their testing and, where required advice and support. This services remains in place and has now been broadened to support the screening of pre-operative or pre-treatment patients.

5.3 Early in the response to COVID-19 welfare rooms and spaces were established on each of the Hampshire Hospitals sites in order that members of staff had the ability to take some time to unwind away from the clinical environment. Since mid-July we have been supported by "Project Wingman" a group of airline crew from every UK airline in order to support these spaces and help deliver a "first class lounge" experience.

6. On-Going Risk and Preparation for Potential of a Second Wave

6.1 Whilst over the past few months, the focus of the Trust has been the restoration of services; the risk of a second wave remains a significant threat. As such, the Trust has been mindful to maintain its ability and capability to escalate its COVID-19 response should it be required.

6.2 It was clear, early in the preparation and response to COVID-19 that the virus impacted a proportion of patients severely, resulting in them requiring intensive care treatment. In order to respond to the increasing demand it was necessary to deploy nursing and medical staff to these areas. In order to maintain resilience for any second wave (or other event requiring escalation to critical care capacity) the Trust has developed a Critical Care Academy. This academy teaches both theoretical and practical critical care skills to enable nurses to learn and maintain competencies so that they can rapidly redeploy to support the critical care of patients. As of 6 August 2020 the Critical Care Academy has trained 154 additional nurses with critical care skills.

6.3 Whilst the intensity of the COVID-19 response has reduced over recent months, in line with the ongoing National Level 3 (Regional) Major Incident, the Trust has maintained its response structure with oversight by an executive led strategic team which meets weekly and an established Incident Coordination Centre / single point of contact for the coordination of information and requests. Plans are in place for the wider re-escalation of command and control arrangements should the intensity of operations require it over the coming weeks or months.

7. RECOMMENDATION

That this report is noted by the Committee.

This page is intentionally left blank

Committee:	Health and Adult Social Services (Overview and Scrutiny) Committee
Meeting date:	
Title:	Update from University Hospitals Southampton NHS Foundation Trust (UHS) on the response to Wave 1 of COVID-19
Report From:	Duncan Linning-Karp, Director of Operations

1. Purpose

1.1 To provide an update to HASC on the response of UHS to the COVID-19 first wave and to provide an update on plans for winter and a potential second wave.

2. Preparedness for COVID-19

2.1 The COVID-19 pandemic has had a real impact on the whole of the NHS. It led to the reduction of a significant amount of 'business as usual' activity and the cancellation of many patients. It also led to some positive changes that happened far faster than in normal times, for example a huge increase in the number of virtual pathways and consultations.

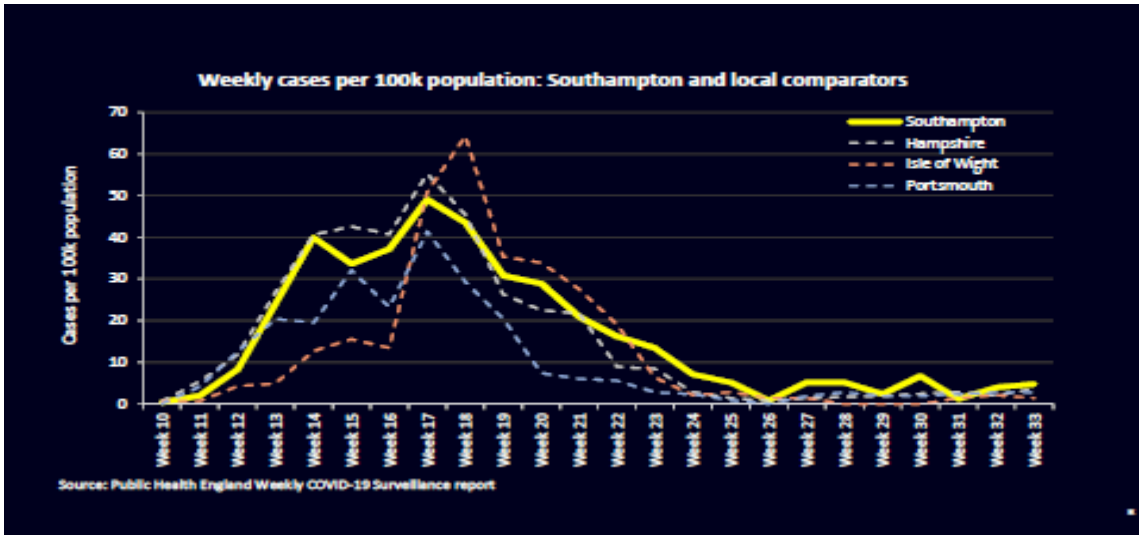
2.2 It also led to a great deal of change and reconfiguration, with staff being asked to work in different ways at short notice. This was undoubtedly difficult and the pandemic has had a significant effect on individuals and teams. However, the dedication, commitment, team work and flexibility of staff across all staff groups was, and remains, exemplary.

2.3 Prior to the pandemic the Trust had a well-developed pandemic plan, revised with the learning from the last H1N1 pandemic.

2.4 The Trust started to plan for a potential pandemic in early January, with a daily drumbeat of meetings involving clinical, operational and infectious disease colleagues, chaired by the Medical Director of Chief Operating Officer.

2.5 UHS quickly developed plans to move a significant amount of elective operating to the private sector, scale back non-COVID-19 related activity to support the predicted influx of COVID-19 + patients and scale up critical care capacity. The Trust had the ability to support over 120 ventilated patients (double the usual capacity) and plans to increase Level 1 COVID+ beds as the need arose.

2.6 The peak locally was lower than predicted but still significant:



3. Impact of COVID-19

3.1 During the first wave of the pandemic the hospital reconfigured its services and pathways several times to reflect changing guidance and the fact that the number of COVID-19 patients remained lower than predicted.

3.2 Patients arriving at hospital were streamed, separating those with symptoms potentially of COVID-19 and those who did not have symptoms associated with COVID-19. Admissions were streamed into 3 different types of ward; those for COVID-19 positive patients, those who had tested negative for COVID-19 but where there was a strong clinical presumption of COVID-19, and those who had tested negative for COVID-19. Where possible, splits between specialities were also preserved.

3.3 Urgent and emergency surgery was maintained through COVID-19, both by retaining some (primarily emergency and cancer) operating on site and through significant use of the Independent Sector (IS). UHS has used the Spire, the Independent Sector Treatment Centre and the Nuffield for a combination of outpatient activity, diagnostics and elective operating. This has allowed us to continue treating patients throughout the first wave of the pandemic.

3.4 UHS also moved to seeing a significant number of outpatients virtually.

3.5 To protect patients, chemotherapy was moved offsite to the Spire.

3.6 There was a significant effect on the Trust's workforce, with over 10% being required to shield, although that number has reduced significantly through a combination of risk assessments and creating COVID-secure areas of the Trust where both the patients and staff have been tested.

3.7 A significant number of staff were moved to support increased ICU capacity. These staff have now largely returned to their usual workplaces.

3.8 In early May the Trust started to scale back up elective services as the peak appeared to have passed and was less severe locally than modelling had predicted. The Trust went from 35% of elective activity in April (compared to the same month the previous year) to 68% in July, with plans to increase further.

4. Restoration and Recovery

4.1 NHSE/I wrote to Trusts in July outlining their expectations around restoration of the elective programme. The deadline for final submission is September the 17th and like other organisations UHS is currently working through detailed plans.

4.2 Restoration is complicated by the need to socially distance, which reduces the number of patients who can be seen particularly in some outpatient areas. Furthermore, requirements for Personal Protective Equipment (PPE) in some theatre and ward areas has reduced the number of patients who can be seen in some theatres and diagnostic areas. The need (now changed) for all patients to self-isolate for 14 days prior to surgery led to the Trust being unable to re-book in the event of last minute cancellations. This further reduced throughput.

5. UHS has continued to make use of the Independent Sector and plans to do so for the foreseeable future.

6. Preparation for a Second Wave and Winter

6.1 While the Trust has focused on restoring elective activity, it has also been planning for a potential second wave of COVID-19, as well as planning for the usual winter pressures.

6.2 Currently prevalence of COVID-19 locally is low, with an estimate of 4.75 cases per 100,000 in Southampton (as of 19/8). This has allowed the Trust to restart more elective activity and bring more staff back to work, in line with infection control guidance. However, there are robust plans to flex both activity and staffing if and when we see an increase in the number of cases and hospital admissions locally.

6.3 Winter planning is happening at a system level across South West Hampshire, focusing on the learning from last year. There remains a significant pressure on reducing the number of Medically Fit for Discharge patients in acute beds; further focus on this is required.

6.4 The Trust has received a significant investment (£9m) to support expanding the Emergency Department and creating the start of an Emergency Care Village.

6.5 The Trust has also invested in an additional ward, which will be open in November, and creating more side rooms to aid isolation of patients with infections.

6.6 The Trust continues to run bi-weekly incident management meetings to plan plan for further phases of COVID-19.

6.7 With strong clinical leadership and thanks in no small part to the commitment and dedication of our staff, we have robust plans for the next 6-12 months. However, there is clearly a great deal of uncertainty about the likelihood, timing and size of a potential second wave, as well as the more usual winter pressures.

Hampshire County Council Health and Adult Social Care Select Committee
14 September 2020

Portsmouth Hospitals University NHS Trust response to COVID-19

1 Introduction

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

Local prevalence of COVID-19 has reduced in-line with the national picture. We continue to implement all national guidance as we monitor and respond to emerging evidence about COVID-19, prevalence of the virus and impact. Regular Gold command meetings are ongoing and continue to support our clinically-led decision making. We continue to work closely with organisations across the Hampshire and Isle of Wight Local Resilience Forum on a co-ordinated response to the pandemic and with our partners on plans to support restoration and recovery.

1.2 Risk assessments and support for our staff

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

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

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

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

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

1.3 Health and wellbeing support

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

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

1.4 Testing

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

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

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

1.5 Clinical research trials

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

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

1.6 Support from colleagues, local communities and partners

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

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

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

2. Phase Three Plan

Throughout the COVID-19 pandemic we have prioritised the delivery of urgent and cancer work. We achieved all of our waiting time targets for the diagnosis and treatment of cancer in

June and have a plan in place to safely increase the volume of elective activity based on clinical need.

We continue to prioritise urgent and cancer services for our patients while increasing capacity for routine elective patients, maintaining patient safety and following all national guidance to reduce the risk of COVID-19 transmission.

In this third phase of COVID-19 our priorities include safely increasing our capacity for non-COVID-related health services in-line with our plan, while preparing for winter and maintaining our preparedness for additional COVID-19 patients and potential local outbreaks of the virus. We have contributed to the development of the local outbreak plans created by Portsmouth City Council and its partners, and by Hampshire County Council, and continue to work closely with our partners on plans to support restoration and recovery. Our plan also includes arrangements for supporting the extended flu immunisation programme and the potential impact of EU exit and continued support for individuals and team across the organisation.

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

ENDS

This page is intentionally left blank

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date of Meeting:	14 September 2020
Report Title:	Proposals to Develop or Vary Services
Report From:	Director of Transformation & Governance

Contact name: Members Services

Tel: 0370 779 0507 **Email:** members.services@hants.gov.uk

Purpose

1. The purpose of this report is to alert Members to proposals from the NHS or providers of health services to vary or develop health services provided to people living in the area of the Committee. At this meeting the Committee is receiving updates on the following topics:

   a) Southern Health NHS Foundation Trust: Proposed Closure of Willow Ward (inpatient unit for adults with learning disability and challenging behaviour)

   b) Southern Health NHS Foundation Trust: Out of Area Beds Update

   c) Hampshire Hospitals NHS Foundation Trust and commissioners: Andover Hospital Minor Injuries Unit Update

   d) Hampshire Hospitals NHS Foundation Trust and commissioners: Orthopaedic Trauma Modernisation Pilot Update

   e) Clinical Commissioning Group Partnership: Integrated Primary Care Access Service Update

Recommendations

2. Summary of recommendations (the recommendations for each topic are also given under the relevant section below):

3. *Southern Health NHS Foundation Trust: Proposed Closure of Willow Ward*

That the Committee:

a) Consider whether the proposed ward closure constitutes a substantial change and whether the engagement undertaken is appropriate.

b) Consider whether to support the proposed closure of Willow Ward and replacement with a community-based service as in the interest of service users and the local health system.

c) Consider whether to request a further update.

4. *Southern Health NHS Foundation Trust: Out of Area Beds Update*

That the Committee:

a) Note the update and welcome the reduction in use of out of area beds.

b) Note the intention to explore increasing inhouse bed capacity to reduce reliance on other providers, and request a further update when progress has been made in this regard.

5. *Hampshire Hospitals NHS Foundation Trust and commissioners: Andover Hospital Minor Injuries Unit Update*

That the Committee:

a) Note the update including the planned re-opening of a minor injuries service in Andover from 1 October 2020.

b) Request a further update in Spring 2021 regarding plans for a more sustainable minor injuries model for the Andover area.

6. *Hampshire Hospitals NHS Foundation Trust and commissioners: Orthopaedic Trauma Modernisation Pilot Update*

That the Committee:

a) Note the update.

b) Consider whether to request a further update.

7. *Clinical Commissioning Group Partnership: Integrated Primary Care Access Service Update*

That the Committee:

a) Note the update.

b) Consider whether to request a further update in Spring 2021 regarding longer term plans for these services.

Summary

8. Proposals that are considered to be substantial in nature will be subject to formal public consultation. The nature and scope of this consultation should be discussed with the Committee at the earliest opportunity.

9. The response of the Committee will take account of the Framework for Assessing Substantial Change and Variation in Health Services (version agreed at January 2018 meeting). This places particular emphasis on the duties imposed on the NHS by Sections 242 and 244 of the Health and Social Care Act 2006, includes new responsibilities set out under the Health and Social Care Act 2012, and takes account of key criteria for service reconfiguration identified by the Department of Health.

10. This Report is presented to the Committee in three parts:

a. *Items for information:* these alert the Committee to forthcoming proposals from the NHS to vary or change services. This provides the Committee with an opportunity to determine if the proposal would be considered substantial and assess the need to establish formal joint arrangements

b. *Items for action:* these set out the actions required by the Committee to respond to proposals from the NHS or providers of health services to substantially change or vary health services.

c. *Items for monitoring:* these allow for the monitoring of outcomes from substantial changes proposed to the local health service agreed by the Committee.

11. This report and recommendations provide members with an opportunity to influence and improve the delivery of health services in Hampshire, and to support health and social care integration, and therefore assist in the delivery of the Joint Health and Wellbeing Strategy and Corporate Strategy aim that people in Hampshire live safe, healthy and independent lives.

Items for Information

12. **Southern Health NHS Foundation Trust: Proposed Closure of Willow Ward**

Context

13. Willow Ward is a six bed unit which has been open since June 2012 and provides multi-disciplinary, evidence based assessment and treatment for adults with learning disability whose behaviour challenges services. There has been a reduction in the demand for beds on Willow Ward over recent years, and the Trust is now proposing to close the ward and replace it with a community-based service. A letter to stakeholders and a briefing note on the proposal have been provided, see appendix 1.

Recommendations

14. That the Committee:

d) Consider whether the proposed ward closure constitutes a substantial change and whether the engagement undertaken is appropriate.

e) Consider whether to support the proposed closure of Willow Ward and replacement with a community-based service as in the interest of service users and the local health system.

f) Consider whether to request a further update.

Items for Monitoring

15. Southern Health NHS Foundation Trust: Out of Area Beds Update

Context

16. In July 2019 Southern Health informed the HASC of their plans to tackle use of Out of Area Beds. An update on implementation of the new model was last received in January 2020. A further update was requested and has been provided, see appendix 2. The update indicates use of Out of Area beds is much reduced compared to last year.

Recommendations

17. That the Committee:

c) Note the update and welcome the reduction in use of out of area beds.

d) Note the intention to explore increasing inhouse bed capacity to reduce reliance on other providers, and request a further update when progress has been made in this regard.

18. **Hampshire Hospitals NHS Foundation Trust and commissioners: Andover Hospital Minor Injuries Unit Update**

Context

19. The HASC last received an update at the January 2020 meeting. Since then the service has been suspended due to the Covid-19 pandemic. A report providing an update has been provided, see appendix 3. This covers plans to restore a minor injuries service at Andover War Memorial Hospital from October 2020 and developments to offer a more sustainable model of urgent care in Andover from April 2021.

Recommendations

20. That the Committee:

c) Note the update including the planned re-opening of a minor injuries service in Andover from 1 October 2020.

d) Request a further update in Spring 2021 regarding plans for a more sustainable minor injuries model for the Andover area.

21. **Hampshire Hospitals NHS Foundation Trust and commissioners: Orthopaedic Trauma Modernisation Pilot Update**

Context

22. In September 2019 the Trust informed the HASC of their plans to centralise all trauma services to Basingstoke and North Hampshire Hospital. This was implemented from December 2019 and the HASC last received an update at the March 2020 meeting. Since then the service has been impacted by the Covid-19 pandemic. A report providing an update has been provided, see appendix 4.

Recommendations

23. That the Committee:

c) Note the update.

d) Consider whether to request a further update.

24. **Clinical Commissioning Group Partnership: Integrated Primary Care Access Service Update**

Context

25. In July 2019 commissioners informed the HASC of their plans to bring together two services across Fareham, Gosport and south east Hampshire: the GP Extended Access Service, which was a pilot, and the GP Out of Hours Service. These were delivered by two separate providers with differing access points for local people. The HASC last received an update at the January 2020 meeting. Since then the service has been impacted by the Covid-19 pandemic. A report providing an update has been provided, see appendix 5.

Recommendations

26. That the Committee:

a) Note the update.

b) Consider whether to request a further update in Spring 2021 regarding longer term plans for these services.

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	no
People in Hampshire live safe, healthy and independent lives:	yes
People in Hampshire enjoy a rich and diverse environment:	no
People in Hampshire enjoy being part of strong, inclusive communities:	no

Other Significant Links

Links to previous Member decisions:	
Title	Date
Direct links to specific legislation or Government Directives	
Title	Date

Section 100 D - Local Government Act 1972 - background documents	
The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)	
Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. **Equality Duty**

The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. **Equalities Impact Assessment:**

This is a covering report which appends reports under consideration by the Committee, therefore this section is not applicable to this covering report. The Committee will request appropriate impact assessments to be undertaken should this be relevant for any topic that the Committee is reviewing.

Southern Health
NHS Foundation Trust

Celia Scott-Molloy
Head of Operations
Learning Disability Services
Southern Health NHS Foundation Trust
Specialist Services Division
Room 41, The Elms
Tatchbury Mount
Calmore, Totton
S040 2RZ

02380 87 4462
07901 624514

Email: Celia.scott-molloy@southernhealth.nhs.uk
PID: celia.scott-molloy@nhs.net

9 July 2020

Dear Colleague

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

I wanted to write to you about a proposal to close our inpatient unit Willow Ward - based at the Tom Rudd Unit, Moorgreen Hospital in Southampton – and replace it with a community-based service for the long-term benefit of a small group of patients with very complex learning disabilities.

Inpatient facilities such as Willow Ward no longer reflect the national ambitions for the assessment and treatment of people with a learning disability who present with challenging behaviours. Instead, there is a national drive to replace them with community-based models to improve care.

The planned community based model to replaced Willow Ward would be an Enhanced Intensive Support (EIS) for assessment and treatment for people in their own homes across Hampshire and Southampton.

There is an agreed consensus that Willow Ward is no longer viable to provide a safe, cost effective and modern service and we are therefore proposing to close the ward from the end of September 2020 in order to develop and redeploy staff to a new community EIS service.

About Willow Ward
Willow Ward is a six bed unit which 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 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.

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

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.

Planned Changes
There is a national and commissioning-led move to close facilities like 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.

Willow Ward also has a number of challenges:

- There are significant cost pressures when the ward is unable to fill all six of its beds. Staffing levels are constant, as are the costs related to the building itself, regardless of the numbers of patients on the ward. (A community-based service would 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 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.
- Willow Ward is isolated, situated on 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. As a result, there has historically been a high reliance on costly agency staff to meet the additional needs of the ward. (By comparison, a community team would have more inbuilt staffing flexibility.)

In terms of Willow Ward's two remaining patients, they 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.

There is a strong rationale that a six 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.

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 Intensive Support Team 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.

Risks

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.

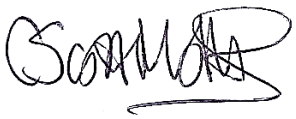
Every effort is made to avoid admission, including increasing levels of support in the short term, along with increased interventions by the Community Learning Disability Team and IST. If admission is ultimately required, the Community Learning Disability Team, IST, and social care departments will work 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.

Your Feedback
Once you have had the opportunity to digest these proposals, I would be happy to answer any questions you may have about the plans or to arrange a meeting to discuss them in more detail. I can be contacted on 07901 624514. I would also be keen to find out your thoughts to these proposals and would welcome your feedback via email to: ceila.scott-molloy@southernhealth.nhs.uk.

Please note, these proposed changes are dependent upon further consultation with our service users and their families, our health overview scrutiny committees, other local stakeholders and of course our staff. (We anticipate that our highly skilled staff team at Willow Ward would redeploy to the new community-based service, in line with national guidance.) Therefore the timings for any changes are yet to be confirmed, however, as mentioned earlier in the letter, it would be our intention to close Willow Ward in the autumn if we have agreement to do so.

Kind regards.

Yours faithfully



Celia Scott-Molloy
Head of Operations, Learning Disability Services

This page is intentionally left blank

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.

Out of area mental health placements

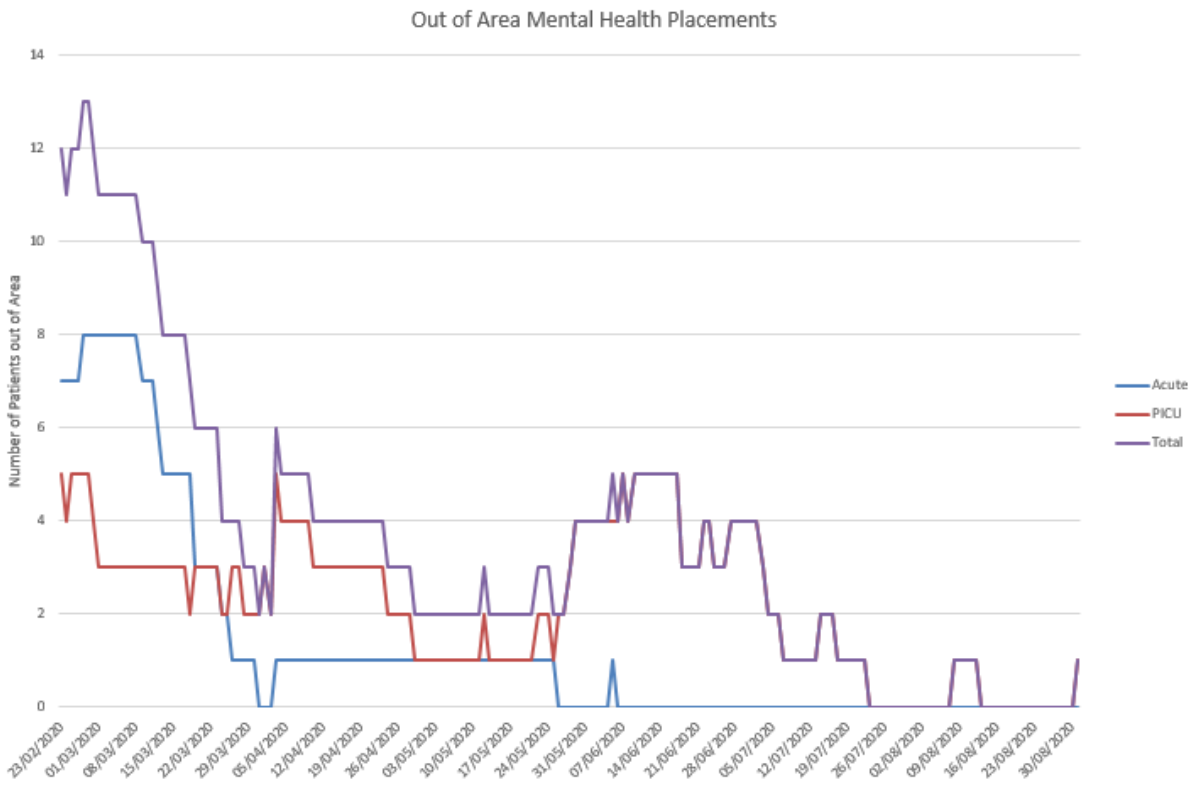
Background and summary

A key priority for Southern Health is to ensure that people who need admission to a mental health hospital are able to access this care close to home. This enables greater continuity of care and makes it more straightforward for family and loved ones to remain in contact with patients, which is such an important part of recovery.

The Trust has been working in recent years to ensure that all patients within its catchment areas who need an admission are supported in a Southern Health hospital, or at least within the borders of Hampshire. Details of the ways the Trust has been doing this are outlined in previous HASC updates, most recently in February 2020. In summary this has involved a different way of managing access to beds (more frontline ownership of bed management) combined with rigorous daily monitoring and increased communication with patients and professionals at out-of-area sites.

Encouragingly, since February the Trust has continued to make significant and sustainable progress towards reducing 'out of area' mental health placements. As at the end of August there was a single patient placed out of area, with zero patients out of area on 25 days during August. This compares to over 80 patients placed out of area during a peak in 2019.

Data



Notes:

'Acute' refers to general psychiatric admissions. 'PICU' refers to Psychiatric Intensive Care admissions – which are for patients who require more intensive support. Southern Health also contracts up to 17 acute beds to Marchwood Priory and up to 6 female PICU beds to Thornford Park. In both cases, the Trust has demonstrated effective joint care and discharge planning, effective sharing of patient records, and access for relations, and as such these beds are not counted as 'out of area' according to NHS England criteria.

Next steps

Whilst the progress outlined above is very positive for patients, families and NHS finances, it is important that this is maintained and sustained. After careful assessment of the demand for mental health beds and our capacity to deliver, there is a case for additional mental health beds within our services. We are now exploring the feasibility of opening additional beds within our existing hospitals in order to provide this, with the ultimate aim of eliminating out of area placements in all but the most extraordinary circumstances. This will reduce our reliance on our current partnerships with Marchwood Priory and Thornford Park. Creating extra capacity will also help to ensure the most therapeutic environment for patients and enable services to flex to meet peaks in demand.

A final, but very important point to make is that the Trust will always find a bed for patients who are assessed to need one – even if this involves placing a patient further from home than is ideal. Patient safety is the most important priority at all times.

For further information please do not hesitate to get in touch:
communications@southernhealth.nhs.uk

Report to Health and Adult Social Care Select Committee: Andover Minor Injury Service

1. Purpose

1.1 Further to the Andover minor injuries discussion at this committee in January 2020, and the temporary closure of the service due to the COVID-19 pandemic, this report has been provided to update the committee on:

- plans to restore a minor injuries/illness healthcare offer from October 2020 at the Andover War Memorial Hospital site
- progress to design and implement a sustainable model of access to urgent care within Andover from 1 April 2021

2. Context

2.1 In January 2020 the Health and Adult Social Care Select Committee (HASC) received confirmation that both market testing and co-production had concluded that it was not feasible to provide a service offer in Andover to meet the enhanced national UTC standards within available resources. Instead;

- existing services would continue as currently commissioned until April 2021 and during this period consideration would be given to how the three existing urgent care services could better align with wider service developments
- engagement with Andover and Rural PCNs, local stakeholders and patients would take place during this period; ensuring the needs of staff and patients are understood and incorporated within a sustainable model of access to Andover patients to be implemented from 1 April 2021

2.2 Responding to the COVID-19 pandemic, Hampshire Hospitals Foundation Trust (HHFT) made the necessary decision to close the Andover Minor Injuries Unit from Monday 6 April 2020. The need to account for social distancing, and the additional challenges of maintaining effective infection control, meant that some reorganisation of services was required. In this context, with the need to safely and effectively staff the two Emergency Departments at Basingstoke and Winchester, it was necessary to redeploy staff from Andover to support colleagues working in the Emergency Departments. At the time of writing this report, the Minor Injuries Unit remains closed.

3. Restoration of Andover Minor Injuries Unit

3.1 Although the initial peak of the COVID pandemic has passed, the impact of the virus on the way that services are accessed, and provided, remains in place. In particular, across the two HHFT acute hospital sites there remains the need to operate separate hot and cold emergency departments. The existing Andover MIU workforce pool has been critical to enable these departments to operate safely, and a significant proportion of this workforce is still required to safely operate these services.

3.2 The continued need to pull on this workforce to support the provision of hot and cold departments means it is not possible to re-open the Andover MIU in its previous form. However, the considerable benefit to the local population, and the wider health system, of re-establishing some form of service offer from the site is well recognised.

3.3 Commissioners and healthcare partners have therefore been working together to restore a service offer at the Andover site. The service offer is focussed upon meeting the key identified needs of the local population whilst balancing the demands on the workforce from elsewhere in the local healthcare system to ensure the safe and quality delivery of services.

3.4 From 1 October 2020, HHFT will provide a Minor Injury Clinic from the Andover MIU site Monday-Friday 8-6pm delivering minor injury services to the local population including treatment of lacerations, access to X-ray and minor fractures. This service will be accessed via 111, where patients will be able to directly book into the next available slot.

3.5 Access to the Minor Injury Clinic will be in line with National 111 developments to reduce hospital acquired COVID infections through eliminating waiting rooms and asking the public to call '111 First' before accessing urgent care. This will also enable patients to book into Primary Care, Accident & Emergency Department and other urgent care services where appropriate ensuring patients receive the right treatment at the right time.

3.6. This clinic will be operating at reduced capacity due to staff resources needing to be deployed to Basingstoke and Winchester Emergency Departments. However, this will be continually reviewed as we better understand how the national '111 First' campaign changes access patterns across urgent care as a result of patients being successfully navigated to the right service.

4. Future Andover Healthcare Model

4.1 In line with the commitment given to this committee in January 2020, arrangements to extend existing service provision were made and commissioners have been working with healthcare partners to design a sustainable access model to urgent care services in Andover.

4.2 This timeline has enabled commissioners to consider how existing provision can better align with wider service developments, but importantly, also incorporate the significant changes in which patients now access services, and the delivery methods of services as a result of the COVID-19 pandemic. For example, ensuring no-one is required to queue in a waiting room if this can be avoided through a booked timeslot.

4.3 A task and finish group is operational to develop the future model and includes membership from commissioners, Hampshire Hospitals, Mid Hampshire Healthcare and Primary Care. The group has developed the following future service principles in line with the vision presented in January:

- The service will provide an integrated access hub for the treatment of secondary and primary care minor injuries, operating during core hours 7 days a week. Access to the minor injuries clinic will be via NHS 111.

- Improved access and extended hours will be provided on site for the Andover locality in its totality. This offer will include routine and same day urgent appointments with a GP, Practice Nurse appointments such as Diabetic and Asthma reviews and cervical screening,

and Healthcare Assistant appointments such as wound care, ear irrigation and NHS health checks.

- Individuals accessing the service will have their needs remotely assessed whenever possible, and then booked directly into an appropriate appointment slot. This will ensure patients do not need to queue unnecessarily in a physical waiting room environment.

- The service will remain under review to ensure any further integration opportunities with Primary Care Network services/developments; such as the emerging MsK pathway within the locality, GP direct access to diagnostics and the delivery of primary care enhanced services are fully explored and incorporated wherever feasible.

- Commissioners and providers will continue to identify further opportunities to develop and improve healthcare provision at the Hospital site. An example of this has been the recent successful bid by Hampshire Hospitals for a CT scanner to be added to the diagnostic facilities in Andover.

4.4 Engaging with the local population

4.4.1 Prior to any formal decisions being made, and to ensure the future service offer is reflective of the needs of the local population, we plan to engage with our Andover patients.

4.4.2 As above, the continued need to utilise the existing Andover MIU workforce elsewhere as part of the Trust's COVID-19 response means the service will not be restored in its exact previous form. Instead, an alternative delivery model will be deployed that supports the longer term vision for the service, providing a valuable opportunity to test potential future service delivery options.

4.4.3 Robust evaluation of the service deployed from 1 October 2020 provides an opportunity to explore how the service is working, how it is being experienced by patients, and whether it meets the expectations of those who use it. In turn that feedback can inform decisions about the longer-term future of the service.

4.4.4 Between October - December 2020 people using the reinstated minor injuries clinic will be asked to give feedback on their experience, to help us understand its strengths, and any shortcomings, and to generate intelligence regarding how people are making decisions about where they access same-day healthcare.

4.4.5 At the same time, alongside this direct engagement activity, other sources of information (e.g. complaints, compliments, incidents, and activity and performance data) will be analysed, to help identify whether there are issues to address in terms of service quality, or accessibility.

4.4.6 The above will help inform the completion of the Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) to ensure the service offer does not directly or indirectly discriminate against any population groups, and delivery is having a positive impact on quality. Should these assessments identify any accessibility or quality concerns, further targeted engagement activity may be conducted to ensure any potential solutions or mitigating actions are well informed.

4.4.7 A report setting out the themes arising from this engagement period, and how this intelligence has informed the development of urgent care services in Andover, will be made publicly available in January 2021.

5. Next Steps

5.1 Communicate to patients, public and key stakeholders the restored service offer during September 2020.

5.2 Implement restored service and commence robust evaluation, including engagement activities with patients accessing the service.

5.3 Conduct robust evaluation and formalise longer term Andover Urgent Care services offer. The local ambition is to formalise service arrangements on the site from 1 April 2021, however this date may be subject to change dependent upon; feedback obtained via our local engagement activities, findings from our evaluation of the restored service offer, and any considerable local Andover Primary Care Network developments.

5.4 The Health and Adult Social Care Select Committee is asked to:

- Note the plans to restore service provision in Andover from 1 October 2020.
- Review and comment on the progress to date, and future plans to develop a sustainable model of access to urgent care within Andover.

Trauma & Orthopaedics Transformation
HASC - Position Paper - September 2020

1. Purpose

Further to the discussion at this committee in March 2020 this report has been provided to give the committee a status update on the trauma and orthopaedic services transformation programme, with particular reference to the impact COVID-19 has had on the delivery of these services.

2. Context

2.1 Implementation to Date

On 3 December 2019, the Trust implemented its plans to centralise all trauma services to Basingstoke and North Hampshire Hospital. The plan supported all patients requiring inpatient procedures, or treatments relating to trauma or non-elective conditions, who were previously admitted to the Royal Hampshire County Hospital, being redirected to Basingstoke and North Hampshire Hospital.

Further to this, from 3 January 2020, all hip and knee arthroplasty was centralised to the Royal Hampshire County Hospital.

2.2 The COVID effect

In response to the COVID-19 pandemic, the Trust was required to make significant changes to services to enable the safe treatment and management of patients. This response has had the following impact upon the Trauma and Orthopaedic (T&O) programme; and has made the evaluation of success difficult in lieu of these changes.

a) Staffing

Staffing the T&O medical rotas and wards has been challenging due to staff self-isolation, the shielding of staff, and the need to redeploy staff to support other areas in the hospital such as the Emergency Departments and Critical Care. For a significant period the Foundation Year doctors from T&O were also unavailable to the service as they were re-directed to support COVID.

b) Dedicated Inpatient Care

From early March to August in order to support the safe segmentation of COVID positive patients, it was not possible to treat T&O patients on a dedicated ward with the specialist clinical and nursing teams.

Both of the dedicated wards for planned orthopedic surgeries, and the Firs transition unit, were repurposed to care for other patient groups, and these arrangements remain in place.

As a result the Trust is currently managing with a reduction of 25% in its trauma bed stock that has been supported by the successful delivery of reduced length of stay.

c) Theatres

Elective theatres closed in the last week of March; the department would normally run 52 elective theatre lists a week. Elective procedures have now restarted however in significantly reduced numbers; two all day theatres are operational against the modelled need for all day theatres seven days per week with a further two additional lists. Productivity within these two days is also hindered due to the increased infection control requirements needing to be taken.

Whilst there was a short-lived dip in trauma demand at the start of the pandemic, demand has now returned to pre-COVID levels (135 trauma theatre cases in the last four weeks, compared to 146 in the same period in 2019), and plans are being continually assessed to increase elective work as part of 'Phase 3 recovery'.

d) Out patients

Outpatient facilities at both acute hospital sites were moved to accommodate other pressing hospital demands, and in conjunction with infection control requirements, clinic capacity was reduced from 16-20 patients per clinic to six face to face appointments per clinic. To support the management of the service during this period the majority of appointments have been converted to telephone appointments, apart from urgent trauma reviews. This has enabled the service to bring forward plans to offer appointments via digital means, providing greater flexibility for patients to have appointments without the need to attend hospital.

3. Transformation Objectives

a) Improve patient experience and outcomes (measured via patients surveys)

The completion of patient surveys has demonstrated that the assessment and treatment of patients is 'good' or 'very good' with one poor experience reported that is being investigated. Patient feedback to date has shown the care being provided is of a high quality, and whilst there were initial concerns raised about travel, parking and transport, no formal complaints have been made.

b) Improve 30 day mortality and increasing best practice tariff following #NOF

To date there has been no reduction in the total number of deaths related to fracture neck or femur.

Ortho-geriatric input is key to delivering positive improvements, unfortunately two Orthogeriatric Consultants left their roles in December 2019. This enabled the service to test an alternative service model, with this aspect of the service covered by two newly appointed nurse practitioners and one staff grade doctor. They have now also introduced a full-time locum consultant and have advertised another vacancy.

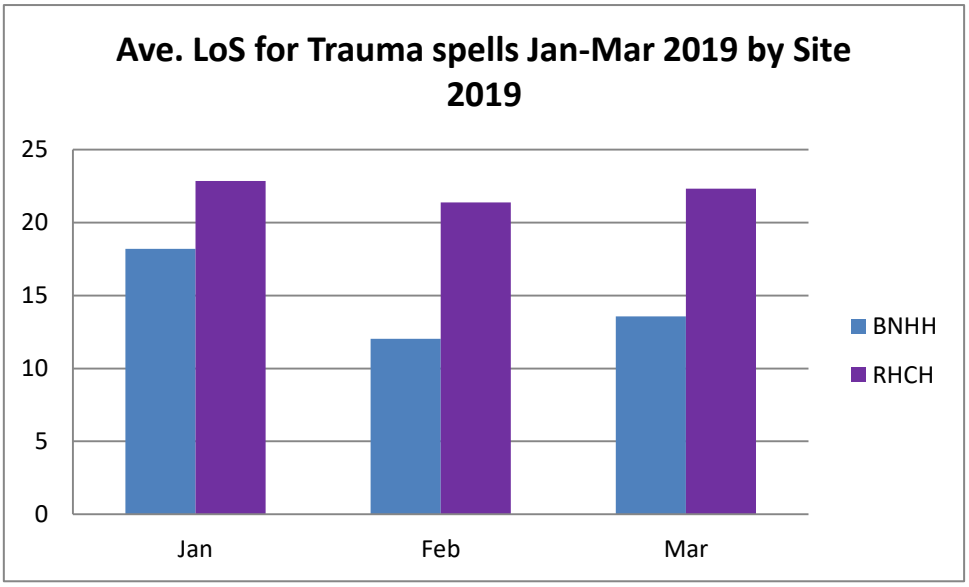
Any deaths that happen are rigorously reviewed, audited and reported within a robust governance structure in place lead by specialist clinicians.

c) Increase elective theatre productivity

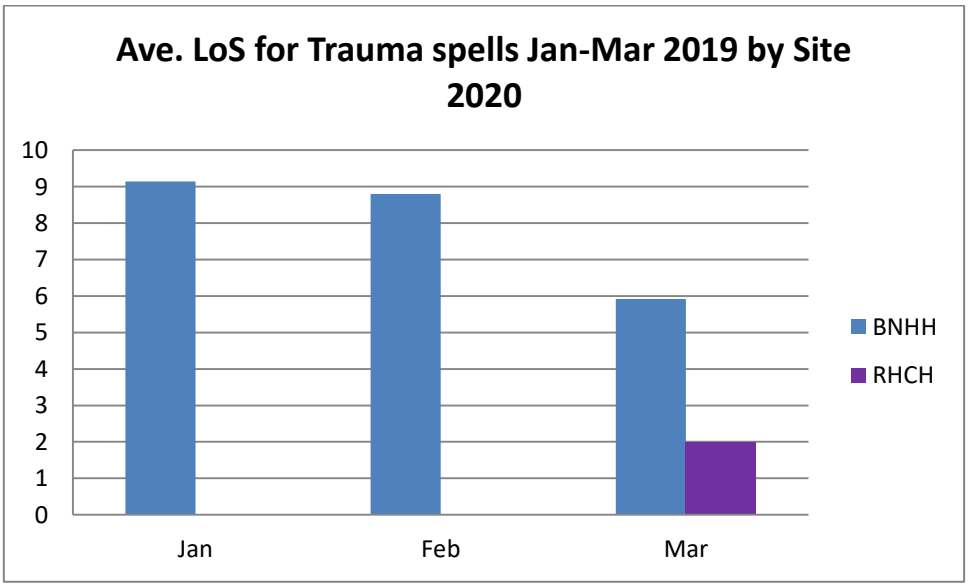
The transformation programme has successfully delivered increased elective theatre productivity. Unlike previous years, planned surgeries continued throughout the winter period, with the Trust being one of a few that maintained this service provision amidst the seasonal pressures. Furthermore, the ring-fenced theatre capacity in Winchester allowed upper and lower limb surgeons from Basingstoke to maintain their surgeries from Winchester.

d) Establish dedicated transition facilities

Prior to the repurposing of the unit, the introduction of the transition facility (The Firs) had a very positive affect on the Length of Stay (LOS) and improving the outcomes for patients.



This graph shows the average length of stay for trauma per site in 2019 - on average, over 20 days in Winchester and over 13 days in Basingstoke



This graph shows the average length of stay reductions for trauma patients from the date of transformation, January 2020.

This data shows our length of stay reduced from 18 days to 8 days when compared with the same three months in 2019 (both RHCH and BNHH).

e) Improve compliance with a "Seven Day Services"

The programme has successfully delivered a centralised seven day service for trauma patients at Basingstoke from midnight 3 December 2019. A full day of trauma theatre is scheduled each day including weekends, and fully supported with consultants, registrars, surgical assistants and junior doctors.

f) A service to promote training, development and promote staff retention

Staff morale is a very high priority at the Trust. Significant planning went into preparing the service model ensuring the displacement of very few staff and no staff members were forced to move site. Doctors who worked across sites were given support with time and mileage for travel and other staff groups were provided with initial support throughout the transition.

Whilst careful consideration has been given to ensure the morale of staff, there were actual and anecdotal concerns from individuals and staffing groups that needed to be investigated and responded to. During February, independent staff engagement walk and talk, workshops, team meetings and surveys took place.

Over 85 surveys were competed and just over 20 staff attended the workshops, mainly admin staff and one consultant. The survey completions provided a broad spectrum of feedback which should be considered in the context of:

- Change and people at work
- Organisational history
- A chance to share
- Opting in
- The method mix

In response to this feedback the following actions have been taken:

- Agree a business as usual model for cross site working
- Update Trust policies to support the new model
- Engagement workstreams to be established early with future transformation programmes
- Shared learning to be easily accessible to all staff

g) Phase 3 - create capacity to repatriate elective activity subcontracted to private providers

In lieu of the effects of COVID-19 this phase has not yet commenced.

4. Next Steps

The next stage for T&O is as follows:

- Agree COVID restoration plans and work across sites to deliver
- Identify the impact restoration will have on the service
- Monitor performance and activity levels
- Review job planning (revised Autumn 2020)
- Engage with BMA to move from test to Business as Usual phase
- Engage with other local health providers, such as UHS, CCG, SCAS to formalise long term model
- Agree when Phase 3 will progress

Committee:	Health and Adult Social Care Select Committee
Date of Meeting:	14th September 2020
Report Title:	Integrated Primary Care Access Service update
Report From:	Keeley Ellis, Locality Director, Primary Care on behalf of **Sara Tiller** Managing Director – Fareham and Gosport and South Eastern Hampshire **Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups**

Integrated Primary Care Access Service - update

1. PURPOSE

This paper provides an update on the development of the Integrated Primary Care Access Service (IPCAS) provided by the Southern Hampshire Primary Care Alliance across Fareham, Gosport and south east Hampshire.

The IPCAS service was developed to bring together two services: the GP Extended Access Service, which was a pilot, and the GP Out of Hours Service. These were delivered by two separate providers with differing access points for local people. The contract runs until 2021 when Primary Care Networks will become responsible for providing extended access to their patients.

This has previously been well documented and discussed and therefore the aim of this paper is to provide an update to the Committee on the paper submitted for the meeting in January 2020, especially given the impact on local services as a result of the pandemic.

During the summer in 2019 the CCGs and Primary Care Alliance worked together to seek the views of local people about the services, hubs, travel, and their preference for accessing the service. Following feedback the service model was determined as summarised in the table below:

	Site	Opening times
Patients ring their practice to book an appointment (both routine and urgent) or NHS111 when their practice is closed for an urgent appointment	Fareham Community Hospital	• Mon to Fri 6.30pm to 10.30pm
	Forton Medical Centre, Gosport	• Tues and Thurs 6.30pm to 10.30pm (for urgent appointments) • Sat and Sun 8am to 10.30pm
	Portchester Health Centre	• Sat and Sun 8am to 10.30pm
	Chase Community Hospital	• Fri 6.30pm to 10.30pm
	Swan Surgery, Petersfield	• Tues and Thurs 6.30pm to 10.30pm • Sat and Sun 8am to 10.30pm
	Waterlooville Health Centre	• Mon, Wed and Fri 6.30pm to 10.30pm • Sat and Sun 8am to 10.30pm

2. IMPACT OF COVID-19

The impact of the COVID-19 pandemic, although challenging, has accelerated the pace of change and transformed the way in which primary care services are delivered, this includes the way the IPCAS service operates. There has been a further breakdown of traditional roles and boundaries, with strong collaborative working with NHS 111, community and mental health services, secondary care and the voluntary sector to deliver the best outcomes for our population during the pandemic.

Primary care services have remained open throughout the pandemic but the way in which services are delivered has fundamentally changed -to ensure patient safety, implement infection, prevention and control measures effectively, and ensure patients are cared for in the most appropriate setting. This was accompanied by national guidance from NHS England on how primary care services should be delivered during the pandemic: https://www.england.nhs.uk/coronavirus/primary-care/general-practice/

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

- 100% of general practices open are operating **a total triage model** to support the management of patients remotely where possible. This means operating a model where all patients requiring GP care are assessed either on the phone or via an electronic system (eConsult) to determine the best option for their care. All practices operate telephone and online consultations.

- Strengthened working with **NHS 111**, with NHS 111 able to directly 'book' patients into a practice.

- Continued provision of **essential face-to-face** services (including home visits) through designation of 'hot' and 'cold' sites and teams to minimise the spread of infection. Hot and cold is essentially the separation of care for those with suspected COVID-19 and those not.

- Greater use of **Electronic Repeat Dispensing (ERD)** to reduce footfall within practices.

This has meant a significant change for patients in how services are accessed and used, but has meant that primary care and general practice could continue to operate and provide essential services during this very challenging time.

A 'Frequently Asked Questions' (FAQ) document was created to support patients in understanding these changes, and this is provided as Appendix A

3. CHANGES TO LOCAL DELIVERY

Several 'hot' sites were set up across our two CCG areas to ensure there was safe separation in the way services were delivered for patients, with these hot hub sites providing care for those patients with suspected COVID-19. 'Cold' sites were then identified within the remaining general practice facilities to provide services to those who also needed care but didn't have suspected COVID-19.

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

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

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

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

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

During the first wave of the pandemic the service model was adjusted to also allow patients to be booked into a video consultation, reducing the need for patients to travel and reduce the risk of infection.

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

4. LONGER-TERM SERVICE PROVISION AND NEXT STEPS

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

As referenced previously the IPCAS contract runs until March 2021. NHS England has now confirmed that Primary Care Networks will become responsible for providing extended access to their patients and therefore this currently integrated service may be split again as follows:

- the GP Extended Access Service provided by Primary Care Networks
- the GP Out of Hours Service provided by a Primary Care Provider Organisation

The Primary Care Alliance and CCGs are working together to develop the longer-term model further taking into account the views of local people, the lessons from running the service to date and aligning the service to the wider vision for urgent care services in Portsmouth and South East Hampshire.

This work will now be extended to Primary Care Networks given they will now be responsible for delivering elements of this service.

All service providers, as well as the CCG will need to take into account how we can effectively develop these services but also robustly ensure we recognise the vast feedback we have collectively received to date. Some of this will include:

- Consolidating the number of sites to ensure GP cover is in place in order to reduce the number of cancelled clinics and enable the service to increase its use of Advanced Nurse Practitioners (ANP) and Practice Nurses (PNs) under the supervision and support of GPs
- Introducing a new employment model to ensure that clinicians are available to work the least popular shifts
- Providing a transport service for patients who need to be seen urgently but are unable to travel to a hub
- Introducing telephone/online consultations for patients who are happy to receive the support they need in this way meaning they do not need to travel to a hub.

5. RECOMMENDATION

It is recommended that the Committee notes the vast changes as a result of COVID-19, and recognises the proposed next steps to engage local people on the intended service changes as a result of the NHS England mandate for Primary Care Networks to deliver elements of this service.

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

Appendix One: FAQ document

GP appointments and bookings

The way we access GP services has changed. Below are some frequently asked questions that may help you understand these changes:

Why can't I walk into my GP practice?

The coronavirus (Covid-19) pandemic has forced us all to work differently to help slow down the spread of the virus. All healthcare settings are taking special measures to protect you, the public and their staff. GP practices are working as hard as ever, but differently.

Where possible we want to avoid people having to wait inside a waiting room together, as we know this increases the risk of the virus spreading. Like hospitals and dentists, we have also had to change how we offer our services to you.

If you do need to come in, then we can ensure there are a minimal number of people in the practice, we can maintain social distancing and keep patients and staff safe.

How do I get an appointment?

The easiest and most effective method is to use e-Consult through the practice website, or you can telephone. You will then be contacted by a clinician to talk through your symptoms either over the phone, via email, or if needed and you have the available technology, through a video consultation.

Why can't I book a face-to-face appointment?

We have adapted the way in which you can get an appointment quickly and safely. Most patient's health concerns can be managed over the phone or via video consultation. This is why we are providing you with either an initial phone call or video consultation to decide what would be the best way to help. If we can support you without needing you to come into the practice then we reduce the need for you to travel, and reduce the risk of the virus spreading.

If you do need a face-to-face appointment, you will be invited to attend the practice. If we can ensure there are a minimal number of people in the practice, we can maintain social distancing and keep patients and staff safe.

What is e-Consult?

You can access e-Consult via the practice website. It lets patients consult with their own NHS GP online by completing a quick form which is reviewed by the practice. After reviewing your query, you will then be directed toward the most appropriate help. This might be some advice on self-help, pharmacy advice, an appointment with one of the practice clinical team or another service. Your data is secure at all times – including during a video consultation or telephone call.

What if I do not have access to a smartphone or web camera?

While technology has evolved and supports us all in many different ways in our day-to-day lives, we appreciate not everyone will have access to a smartphone or web camera for a video consultation.

We can still talk to you on your mobile phone or landline.

Will I need to wear a face mask if I come into my practice for an appointment?

To help limit the spread of the virus, we are asking for all patients aged 12 and over to wear a face covering when they come the practice. This doesn't have to be a face mask, but a cloth covering which covers your mouth and nose while allowing you to breathe comfortably. It can be as simple as a scarf or bandana that ties behind the head. You can find additional information by visiting https://www.gov.uk/government/publications/how-to-wear-and-make-a-cloth-face-covering/how-to-wear-and-make-a-cloth-face-covering

How do I get a repeat prescription?

For practices to fill in according to its practice policy.

How do I cancel or move a booked appointment?

For practices to fill in according to its practice policy.

How do I see a GP during the evening and weekends?

For evening and weekend access to GPs please either visit 111.nhs.uk or call NHS 111.

What if I am not registered with a GP practice?

You can call any GP surgery to get emergency treatment for up to 14 days if you are not registered with a GP or are away from home.

If your treatment will last longer than 14 days, you'll have to register as a temporary or permanent resident. You can find more information about this via www.nhs.uk and search 'how to register with a GP practice'.

If you are a resident in the area and need to register with a practice, then it's best to look at practices where your home falls within its geographical boundaries. You can check a GP practice boundary by visiting their website.

Once you have selected which practice you would like to register with, make contact with them either by calling or visiting their website.

You will be asked to fill out a registration form and once it is completed and returned, NHS England will transfer your medical records to your new practice. They will also write to you to confirm your registration with your chosen practice.

What do I do if I think I have coronavirus (Covid-19)?

The main symptoms of coronavirus are:

- high temperature – this means you feel hot to touch on your chest or back
- new, continuous cough – this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours (if you usually have a cough, it may be worse than usual)
- loss or change to your sense of smell or taste – this means you've noticed you cannot smell or taste anything, or things smell or taste different to normal

If you are experiencing one or more of these symptoms then DO NOT visit your GP practice. You should visit 111.nhs.uk/covid-19 or call NHS 111 if you cannot get help online.

You must self-isolate for seven days from when your symptoms started. Anyone you live with, or in your support bubble, who does not have symptoms must self-isolate for 14 days from when the first person started having symptoms.

You must also ask for a test as soon as you start showing symptoms. You can do this online – visit www.nhs.uk/ask-for-a-coronavirus-test

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date of Meeting:	14 September 2020
Report Title:	Issues Relating to the Planning, Provision and/or Operation of Health Services
Report From:	Director of Transformation and Governance

Contact name: Members Services

Tel: 0370 779 0507 **Email:** members.services@hants.gov.uk

Summary and Purpose

1. This report provides Members with information about the issues brought to the attention of the Committee which impact upon the planning, provision and/or operation of health services within Hampshire, or the Hampshire population.

2. Where appropriate comments have been included and copies of briefings or other information attached. Where scrutiny identifies that the issue raised for the Committee's attention will result in a variation to a health service, this topic will be considered as part of the 'Proposals to Vary Health Services' report.

3. New issues raised with the Committee, and those that are subject to on-going reporting, are set out in Table One of this report.

4. Issues covered in this report:

   a. Hampshire Hospitals NHS Foundation Trust – Care Quality Commission latest report (published in April 2020)

   b. Clinical Commissioning Group Reform in Hampshire and the Isle of Wight

Recommendations

5. Summary of recommendations: (the recommendations for each topic are also given under the relevant section in the table below)

6. *Hampshire Hospitals NHS Foundation Trust CQC Inspection*

   That Members:
   a. Note the outcomes of the most recent inspection.
   b. Consider when to seek an update on any improvement actions.

7. *Clinical Commissioning Group Reform in Hampshire and the Isle of Wight*

That Members:

a. Note the plans to merge outlined.
b. Request a future update with further detail on how these changes impact the development of an Integrated Care System (ICS) for the Hampshire area.

Table 1

Topic	Relevant Bodies	Action Taken	Comment
Care Quality Commission (CQC) Inspection - Hampshire Hospitals NHS Foundation Trust	Hampshire Hospitals NHS Foundation Trust CCGs and partner organisations CQC	The HASC monitors CQC inspection outcomes and improvement actions regularly.	The Trust were last inspected in January/February 2020 and the report published April 2020. The Trust received an overall rating of 'Good' and have provided a summary of the outcomes (see Appendix 1). The full CQC report is also appended at Appendix 2.
Recommendations: That Members: c. Note the outcomes of the most recent inspection. d. Consider when to seek an update on any improvement actions.			
Topic	**Relevant Bodies**	**Action Taken**	**Comment**
Clinical Commissioning Group Reform in Hampshire and the Isle of Wight	Hampshire CCGs	The HASC has been maintaining an overview of changes in how NHS commissioning is organised	The HASC have received a letter indicating that 6 of the CCGs covering the Hampshire and Isle of Wight area are planning to merge. Members will note however that this does not include the Portsmouth CCG or the CCG for North East Hampshire and

Topic	Relevant Bodies	Action Taken	Comment
			Farnham. (see Appendix 3)

Recommendations:

That Members:

c. Note the plans to merge outlined.
d. Request a future update with further detail on how these changes impact the development of an Integrated Care System (ICS) for the Hampshire area.

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	no
People in Hampshire live safe, healthy and independent lives:	yes
People in Hampshire enjoy a rich and diverse environment:	no
People in Hampshire enjoy being part of strong, inclusive communities:	no

Other Significant Links

Links to previous Member decisions:	
Title	Date
Direct links to specific legislation or Government Directives	
Title	Date

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. Equality Duty

The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. Equalities Impact Assessment:

This is a covering report for items from the NHS that require the attention of the HASC. It does not therefore make any proposals which will impact on groups with protected characteristics.

This page is intentionally left blank

NHS
Hampshire Hospitals
NHS Foundation Trust

Hampshire Hospitals CQC report April 2020 and progress to date

Julie Dawes - Chief Nurse
Sarah Mussett - Programme Lead for Quality

Andover War Memorial Hospital
Basingstoke and North Hampshire Hospital
Royal Hampshire County Hospital

Hampshire Hospitals
NHS Foundation Trust

Trust rating at Previous Inspection

	Safe	Effective	Caring	Responsive	Well-Led
CQC	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement

NHS
Hampshire Hospitals
NHS Foundation Trust

Trust rating after January 2020 inspection

	Safe	Effective	Caring	Responsive	Well-Led
CQC	Good	Good	Outstanding	Good	Good

Andover War Memorial Hospital
Basingstoke and North Hampshire Hospital
Royal Hampshire County Hospital

Hampshire Hospitals
NHS Foundation Trust

What did CQC say……Outstanding practice:

Prostate gland surgery - same day discharge and quicker recovery

One of three services in the country - Peritoneal Malignancy Unit - competency programme

Andover War Memorial Hospital
Basingstoke and North Hampshire Hospital
Royal Hampshire County Hospital

Hampshire Hospitals NHS Foundation Trust

What did CQC say……Areas for Improvement:

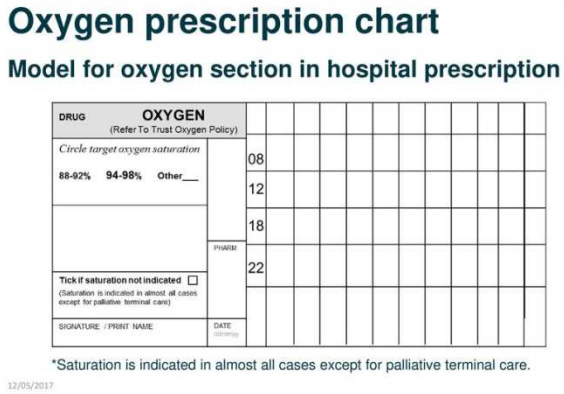
- **1 Must do** - The service must have clear processes for checking expiration dates, storing medication and recording fridge temperatures
- **30 Should do's - 10 themes below:**

Medicine management	**Patient risk assessment/check list**	**Nursing & Medical staffing**	**Estates issues**	**Audit**
Training	**Consent and patient information**	**Responsive**	**Well led**	**Use of resources**

	10 August 2020
Overdue	0
At risk/partially met	11
On track	58
Complete	29
Total number of actions	98

Medicine management progress

- Fridge temperature monitoring system
- Expiry date stickers
- Medicine security & storage audits
- Medicine management training
- Oxygen prescribing
- Accurate process to record medicine related stationary
- Revised process for monitoring the use of patient group directives



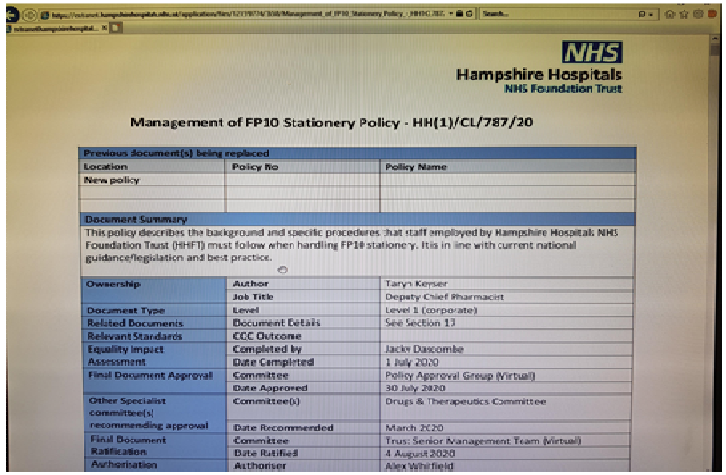
Oxygen prescription chart

Model for oxygen section in hospital prescription charts

DRUG	OXYGEN (Refer To Trust Oxygen Policy)													
Circle target oxygen saturation 88-92% 94-98% Other___		08												
		12												
		18												
	PHARM	22												
Tick if saturation not indicated ☐ (Saturation is indicated in almost all cases except for palliative terminal care)														
SIGNATURE / PRINT NAME	DATE													

*Saturation is indicated in almost all cases except for palliative terminal care.

12/05/2017



NHS Hampshire Hospitals NHS Foundation Trust

Management of FP10 Stationery Policy - HH(1)/CL/787/20

Previous document(s) being replaced		
Location	Policy No	Policy Name
New policy		
Document Summary		
This policy describes the background and specific procedures that staff employed by Hampshire Hospitals NHS Foundation Trust (HHFT) must follow when handling FP10 stationery. It is in line with current national guidance/legislation and best practice.		
Ownership	Author	Taryn Kenser
	Job Title	Deputy Chief Pharmacist
Document Type	Level	Level 1 (corporate)
Related Documents	Document Details	See Section 13
Relevant Standards	CCC Outcome	
Equality Impact Assessment	Completed by	Jacky Dascombe
	Date Completed	1 July 2020
Final Document Approval	Committee	Policy Approval Group (Virtual)
	Date Approved	30 July 2020
Other Specialist Committee(s) recommending approval	Committee(s)	Drugs & Therapeutics Committee
	Date Recommended	March 2020
Final Document Ratification	Committee	Trust Senior Management Team (Virtual)
	Date Ratified	4 August 2020
Authorisation	Authoriser	Alex Whitfield

Andover War Memorial Hospital
Basingstoke and North Hampshire Hospital
Royal Hampshire County Hospital

Patient risk assessments and checklists

- Reassessment of Venous Thromboembolism
- WHO safe surgical checklist - new Standardised Operating Procedure for out-patient procedures in theatres

- Improved recording of fluid and food through new e-charts
- Improved recording of cultural, social & religious needs

Staffing and training

Hampshire Hospitals NHS Foundation Trust

Focus on retention & recruiting for now and in the future:

- International Nurse recruitment
- HCA apprenticeships
- Turnover lowest for 3 years
- Health and Wellbeing focus
- 10 years of WOW awards

GREEN BRAIN
A different way of learning

Training - work to do:

- Mandatory Training rates highest for 3 years
  - much easier system
- MCA training - currently 59% Trust wide
- Safeguarding children training - level 2: 85% level 3: 40%

Andover War Memorial Hospital
Basingstoke and North Hampshire Hospital
Royal Hampshire County Hospital

Estates

Hampshire Hospitals
NHS Foundation Trust

Estate is aging but we are making improvements now and will have a new hospital by 2030

- ED - painting and decorating
- Signage improved to the ED
- Improvements to the plaster room
- Continue with the ward refurbishment programme

Andover War Memorial Hospital
Basingstoke and North Hampshire Hospital
Royal Hampshire County Hospital

Responsive

- Improved emergency flow - twice daily
  Sitrep calls, DOD team expanded - 7 days
  8-6:30pm on site
- Electronic bed management
- Daily ED analyser reports
- Review refer to send process
- Handover process being reviewed
- Teenage area being reviewed in both EDs

ED team won the RCEM national award for the best learning environment

Well Led

- Vision and strategy - Clinical services strategy, Restorative plans post COVID, new hospital strategy
- Oversight/visibility at Andover - new Q&A sessions
- Embed diversity - new EDI strategy, updating position on WRES, Inclusivity networks and champions groups
- Ensure all policies are up to date

Celebrating Black History Month

Andover War Memorial Hospital
Basingstoke and North Hampshire Hospital
Royal Hampshire County Hospital

NHS
Hampshire Hospitals
NHS Foundation Trust

Any questions?

Andover War Memorial Hospital
Basingstoke and North Hampshire Hospital
Royal Hampshire County Hospital

Hampshire Hospitals NHS Foundation Trust

Inspection report

Aldermaston Road
Basingstoke
Hampshire
RG24 9NA
Tel: 01256 473202
www.hampshirehospitals.nhs.uk

Date of inspection visit: 15 January to 12 February 2020
Date of publication: 07/04/2020

Ratings

Overall trust quality rating	**Good**
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Good**
Are resources used productively?	**Requires improvement**
Combined quality and resource rating	**Good**

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

Summary of findings

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

We award the Use of Resources rating based on an assessment carried out by NHS Improvement. Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

The Evidence appendix appears under the Reports tab on our website here: www.cqc.org.uk/provider/RN5/reports. A detailed Use of Resources report is available under the Inspection summary tab (www.cqc.org.uk/provider/RN5/inspection-summary).

Background to the trust

Hampshire Hospitals NHS Foundation Trust provides general hospital and some specialist services to a population of approximately 570,000 people across Hampshire and parts of west Berkshire, and to patients from much further afield for some specialist services. The population is predominantly rural, with urban areas in Basingstoke, Winchester, Andover, Eastleigh and Alton.

The trust holds contract with four clinical commissioning groups, North Hampshire, North East Hampshire and Farnham, West Hampshire and South Eastern Hampshire. Other stakeholders include Hampshire City Council, Southern Health NHS Foundation Trust, NHSI, NHSE, Healthwatch and other system providers. It works closely with the local university and military to support the local population.

Overall summary

Our rating of this trust improved since our last inspection. We rated it as Good 

What this trust does

The trust provides urgent and emergency care, medical care, surgery, critical care, maternity, gynaecology, end of life care, diagnostics, outpatients and services for children and young people at both its Basingstoke and Winchester sites. At Andover, the trust provides all the above services except for critical care, maternity, gynaecology and services for children and young people.

The trust also provides some specialist services to people across the UK and internationally. They are one of two centres in the UK treating pseudomyxoma peritonei (a rare form of abdominal cancer) and provide tertiary liver and colorectal cancer services as well as the haemophilia service.

Hampshire Hospitals NHS Foundation Trust provides services from three main sites:

- Basingstoke and North Hampshire Hospital (BNHH) in Basingstoke

Summary of findings

- Royal Hampshire County Hospital (RHCH) in Winchester
- Andover War Memorial Hospital

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse. We use information from previous inspections, engagement, notifications and information from staff, patients, stakeholders and the trust to decide what areas of the trust to inspect.

During this inspection we inspected three core services, the trust's use of resources and the trust's leadership. The core services we inspected were, urgent and emergency services, medical care (including older people's care) and surgery.

What we found

Overall trust

Our rating of the trust improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Summary of findings

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Are services safe?

Our rating of safe improved. We rated it as good because:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Generally, staff kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- The environment on the elderly care wards was dementia friendly.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- Despite high vacancy rates, the trust had enough staff using bank and agency. Staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

However:

- Although, mandatory training compliance rates had improved since our last inspection, they did not always meet the trust target.
- Staff had access to safeguarding training, however not everyone had completed this. Compliance rates for medical staff were particularly low.
- The service did not always have efficient systems and processes to safely prescribe, administer, record and store medicines. FP10 prescriptions were not always managed safely. In some areas, there was limited pharmacy oversight. Up to date patient group directive paperwork was not always available on the intranet
- On two surgical wards, emergency equipment was not consistently checked to ensure they were safe to use and in line with guidance.
- The urgent and emergency department at Basingstoke was tired in appearance. There was damage to the walls, chips in some wooden door frames and some chairs were dusty and torn.

Summary of findings

- The service did not always use the World Health Organisation Checklist for Safer Surgery.
- Signage was poor in the urgent and emergency department at Basingstoke.
- Seating in the main waiting room did not accommodate those who require a higher seat or for bariatric patients.
- The risk assessment for developing blood clots was not always recorded or completed in line with national guidance.
- Recording risk assessments in all notes where patients might have been at risk in the urgent and emergency department at Basingstoke.

Are services effective?

Our rating of effective improved. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

However:

- Staff did not body maps to record the location of transdermal patches
- Patient outcomes were variable and did not always meet expectations. National audits showed the hospital did not always meet national standards.
- Staff did not always keep up-to-date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff did not consistently record consent in patient records.
- Although, compliance rates for appraisals had improved since our last inspection, they did not always meet the trust target.
- Patients food and fluid records were not fully completed, and fasting processes were not always in line with national guidance.

Are services caring?

Our rating of caring improved. We rated it as outstanding because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Summary of findings

- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

However:

- Staff did not always record patient's personal, cultural, social and religious needs.

Are services responsive?

Our rating of responsive improved. We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

However:

- People could not always access services when they needed it and did not always receive the right care promptly.
- The service was restricted by the challenges faced with capacity and flow. Demand was outweighing capacity, and escalation areas were being used frequently.
- There were no information leaflets available in other languages or print sizes and no signs to advertise chaperones the urgent and emergency department in Basingstoke

Are services well-led?

Our rating of well-led improved. We rated it as good because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Summary of findings

- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

However:

- Minutes from mortality and morbidity meetings across the service were not standardised across the medicine division.
- The medicine division's quarterly performance report lacked detail in many areas such as the division's performance in audits.
- There was no formal process for staff and senior managers to discuss and manage risk, issues and performance. There was limited opportunities for wider learning within the surgical division.
- Senior oversight and visibility had improved since our last inspection at Andover but this still required building upon.
- Staff told us there was no vision or strategy for the development of the surgical service at Andover.

Use of resources

Our rating of stayed the same. We rated it as requires improvement because:

- The trust had seen a material increase in its unscheduled care activity which had impacted its ability to improve its productivity and it had not progressed significantly on the areas we had identified in our previous assessment in 2018.
- Although the trust showed some areas of good productivity, for example on pathology, imaging and procurement, it needed to further progress, on workforce productivity.
- The trust continued to be challenged to deliver against operational standards.
- The trust's financial performance had markedly deteriorated during 2019/20 and it still needed to finalise its financial recovery plan at the time of our assessment.

Combined quality and resource

Our rating of improved. We rated it as good because:

We award the Use of Resources rating based on an assessment carried out by NHS Improvement. Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Summary of findings

Outstanding practice

We found examples of outstanding practice in surgery.

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including one breach of legal requirement that the trust must put right. We found 30 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

Action we have taken

We issued requirement notices to the trust.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

- The service undertook a new procedure for enlarged prostate glands taking referrals from other NHS trusts. Patients were able to go home on the same day and recovery was much quicker than more invasive procedures to reduce the size of the prostate gland.
- Theatres had implemented innovated processes in response to incidents that had occurred. There was a safety protocol for the same administration of local anaesthetic blocks.
- Theatres used a colour coded tray system for medicines, to act as a visual prompt for staff.
- The surgical service hosted the Peritoneal Malignancy Unit. This was one of three services in the country providing this service.
- Staff completed a 20- week competency programme to care and support patients receiving care in the peritoneal malignancy ward to ensure they had the skills and competence to provide effective care.
- The service was taking part in the PICO project for peritoneal malignancy patients.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve

We told the trust that it must take action to bring services into line with one legal requirement. This action related to one service.

Summary of findings

In Medical Care:

- The trust must have clear processes for checking expiration dates, storing medication and recording fridge temperatures.

Action the trust SHOULD take to improve

Trustwide

- The trust should ensure all qualified nursing staff complete medicine management training.
- The trust should ensure all medical staff complete safeguarding children training

In Medical Care:

- The service should provide all necessary support for its staff to improve compliance for MCA/DoLS training for medical and nursing staff.
- The service should continue to review nursing staffing in the medical care wards and focus on recruitment and retention to ensure safe staffing levels can be consistently achieved across all wards.
- Staff should document patients personal, cultural, social and religious needs and how they may relate to their care needs as part of assessment processes.
- The service should continue to work to improve its performance in national clinical audits.

In Surgery:

- The service should ensure there is pharmacy oversight and support to wards and departments.
- The service should continue to embed diversity groups within the trust.
- The service should achieve its referral to treatment target for urology, ear nose and throat and ophthalmology.
- The service should ensure patients have their risk of developing a venous thromboembolism reassessed within 24 hours of admission.
- The service should ensure appraisal compliance meets the trust target.
- The service should consider training in quality improvement methods to support the service to enhance the service provided.
- Senior managers should consider how to strengthen governance process and the mechanisms for identifying and understanding of risk.
- Senior managers should consider how the day surgery unit can monitor and benchmark performance.
- The service should ensure there is effective governance and analyse of the risk for the anaesthetic medicines within the unit.
- The service should consider consistency with the World Health Organisation Safer Surgery Checklist.
- The service should consider a vision or strategy for the development of the service.
- The service should continue to improve senior oversight and visibility within the unit.
- The service should follow processes and procedures in line with the trust's medicines management policy
- The provider should review staff's access to up to date policies and procedures.
- The provider should act to meet the trust target of 90% for appraisals in all staff groups.

Summary of findings

- The provider should act to improve the completion of patients' food and fluid records and review their dietary care plans to meet the patients' needs safely.
- The provider should act and review the process for fasting pre-operatively in line with guidelines.

In Urgent and Emergency Services:

- Ensure qualified nurses complete training in the Mental Capacity Act.
- Ensure that there is an accurate process to record medicine related stationary and that this is monitored, including storing, recording and auditing the use of FP10 forms.
- Continue to review and improve care pathways to ensure patient care meets the standards set by the Royal College of Emergency Medicine.
- Continue to work with the rest of the hospital teams to meet the nationally agreed wait times for patients attending the emergency department.
- Ensure that patient directive paperwork on the trust intranet is the most recent and in date version.
- Ensure staff record if patients are at risk of developing blood clots in all notes.
- Review processes for monitoring the use of PGDs.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well-led at the trust improved. We rated well-led as good because:

- Executive leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The trust had appointed two non-executive directors with clinical backgrounds to strengthen independent clinical challenge at board level.
- The board of directors had a vision for what they wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on patient safety, sustainability of services and were aligned to local plans within the wider health economy.
- The board of directors and managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on a set of shared values that were embedded across the organisation.
- The service promoted equality and diversity in daily work and provided opportunities for career development. Staff of all levels across the trust reported that the trust's culture had improved since our last inspection.
- The trust had embedded Schwartz rounds across all three sites since our last inspection.
- There was a new governance structure in place and the board of directors recognised further work was required to strengthen and embed processes.

Summary of findings

- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- The quality of the board meeting minutes had improved since our last inspection.
- Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The board and senior staff expressed confidence in the quality of the data and welcomed challenge.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- There was a shift in the trust's approach to quality improvement (QI). The trust had a quality improvement (QI) strategy dated 2018-20, that identified the principles for QI and the trust had, since our last inspection, identified a preferred methodology that all projects used.
- Staff reported the taste for change within the trust and the need for training and knowledge development was high.

However:

- Not all the leadership team had the correct skills and experience for their role.
- Senior staff acknowledged that although they had visibility and actions in place for risk in relation to non-clinical trust infrastructure, actual solutions to were difficult to achieve due to time and funding restraints.
- There were still 300 nursing vacancies trust wide which was being managed using bank and agency staff and international recruitment.
- Some senior staff felt that the trust had become less focused on matters concerning the here and now in its desire and push for a new hospital.
- The guardian of safe working hours did not receive protected time for this role and had limited admin support
- Some staff during the core service inspection still reported a disconnect between ward and board. Some reported it was not always clear who was best placed to speak to as there had been so many changes within the leadership team and their portfolios.
- The self-assessment completed by sub-committees highlighted common themes for improvement such as enough time being given to each item to enable debate and decision making.
- At the time of our inspection, the review of the trust risk register was still in progress and more work was required to ensure all risks were reflective of current concerns.
- Managers did not monitor changes for potential impact on quality and sustainability as there was no process to review implementation of business cases.
- Only 58% of the trust's responses to complaints met the trust's timeliness targets.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ↑ Apr 2020	Good ↑ Apr 2020	Outstanding ↑ Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Royal Hampshire County Hospital	Good ↑ Apr 2020	Good ↑ Apr 2020	Outstanding →← Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020
Andover War Memorial Hospital	Good ↑ Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Good ↑ Apr 2020	Requires improvement →← Apr 2020	Good ↑ Apr 2020
Basingstoke and North Hampshire Hospital	Good ↑ Apr 2020	Good ↑ Apr 2020	Outstanding ↑↑ Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020
Overall trust	Good ↑ Apr 2020	Good ↑ Apr 2020	Outstanding ↑ Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020

Ratings for the trust are from combining ratings for hospitals. 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 Basingstoke and North Hampshire Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↑ Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020	Requires improvement →← Apr 2020	Good ↑↑ Apr 2020	Requires improvement ↑ Apr 2020
Medical care (including older people's care)	Good ↑ Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020
Surgery	Good ↑ Apr 2020	Good ↑ Apr 2020	Good →← Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020
Critical care	Good Nov 2015	Good Nov 2015	Outstanding Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
Maternity	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
Services for children and young people	Good Nov 2015	Good Nov 2015	Outstanding Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
End of life care	Good Nov 2015	Good Nov 2015	Outstanding Nov 2015	Outstanding Nov 2015	Outstanding Nov 2015	Outstanding Nov 2015
Outpatients	Good Nov 2015	Not rated	Outstanding Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
Overall*	Good ↑ Apr 2020	Good ↑ Apr 2020	Outstanding ↑↑ Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020

*Overall ratings for this hospital 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 Andover War Memorial Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017
Medical care (including older people's care)	Requires improvement Jun 2018	Good Jun 2018	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018
Surgery	Good ↑ Apr 2020	Good ↑ Apr 2020	Good →← Apr 2020	Good ↑ Apr 2020	Good ↑↑ Apr 2020	Good ↑ Apr 2020
Maternity	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
End of life care	Good Nov 2015	Good Nov 2015	Outstanding Nov 2015	Good Nov 2015	Outstanding Nov 2015	Outstanding Nov 2015
Outpatients	Good Nov 2015	Not rated	Good Nov 2015	Good Nov 2015	Requires improvement Nov 2015	Good Nov 2015
Overall*	Good ↑ Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Good ↑ Apr 2020	Requires improvement →← Apr 2020	Good ↑ Apr 2020

*Overall ratings for this hospital 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 Royal Hampshire County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑↑ Apr 2020	Good ↑ Apr 2020	Good →← Apr 2020	Requires improvement →← Apr 2020	Good ↑↑ Apr 2020	Good ↑↑ Apr 2020
Medical care (including older people's care)	Good ↑ Apr 2020	Good ↑ Apr 2020	Good →← Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020
Surgery	Good ↑ Apr 2020	Good ↑ Apr 2020	Good →← Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020
Critical care	Good Nov 2015	Good Nov 2015	Outstanding Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
Maternity	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
Services for children and young people	Good Nov 2015	Good Nov 2015	Outstanding Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
End of life care	Good Nov 2015	Good Nov 2015	Outstanding Nov 2015	Good Nov 2015	Outstanding Nov 2015	Outstanding Nov 2015
Outpatients	Requires improvement Nov 2015	Not rated	Outstanding Nov 2015	Good Nov 2015	Requires improvement Nov 2015	Requires improvement Nov 2015
Overall*	Good ↑ Apr 2020	Good ↑ Apr 2020	Outstanding →← Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020

*Overall ratings for this hospital 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.

Andover War Memorial Hospital

Charlton Road
Andover
Hampshire
SP10 3LB
Tel: 01264 358811
www.hampshirehospitals.nhs.uk

Key facts and figures

Hampshire Hospitals NHS Foundation Trust provides services from three main sites, Basingstoke and North Hampshire Hospital in Basingstoke, the Royal Hampshire County Hospital in Winchester, and Andover War Memorial Hospital.

Andover War Memorial Hospital (AWMH) provides community and hospital services including a minor injuries unit, outpatient clinics, diagnostic imaging, day surgery, rehabilitation and midwife led maternity services. The majority of services are commissioned by North and West Hampshire Clinical Commissioning Groups.

Summary of services at Andover War Memorial Hospital

Good ↑

Our rating of this service improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Summary of findings

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Staff had not received training in quality improvement methods.
- Governance processes and mechanisms for identifying and understanding of risk were not always robust.
- The day surgery unit did not benchmark its performance.
- The service did not consistently use the World Health Organisation Safer Surgery Checklist.
- Staff were not aware of the surgical division's vision or strategy.

Surgery

Good

Key facts and figures

Andover War Memorial Hospital (AWMH) is part of the Hampshire Hospitals NHS Foundation Trust. The hospital has a day surgery unit which provides minor elective surgical procedures, dermatology (skin), one-stop menstrual disorders clinic, one-stop flexible sigmoidoscopy service, cataract and minor eye surgery, urology, diagnostic and endoscopy.

Surgeries that require general anaesthetic are not carried out at this hospital.

The day surgery unit is a 10 -bedded unit with two operating theatres. The unit is open from 8am to 6pm Monday to Friday.

We inspected Andover War Memorial Hospital on 24 January 2020. We visited the day surgery unit, operating theatres and recovery area. We spoke with six patients one relative, and approximately 10 staff which included doctors and nurses.

We observed care and treatment patients were receiving and reviewed six patient records.

Before and after the inspection we reviewed performance information from and about the surgical care service.

Summary of this service

Our rating of this service improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well.
- Staff were trained to recognise and respond appropriately to signs of deteriorating health or medical emergencies.
- The service used systems and processes to safely prescribe, manage, record and store medicines and there was increased pharmacy support.
- Emergency equipment was available and checked to ensure it was fit for purpose and available when needed.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- The service managed patients' pain effectively and provided or offered pain relief regularly.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. Feedback from patients confirmed that staff treated them well and with kindness.
- The trust generally planned and provided services in a way that met the needs of local people.

However:

- We found medicines given for general anaesthesia which is not performed in the day surgery unit. There was no specialist equipment to support patients having general anaesthetics. There was a lack of risk assessments and governance detailing in what circumstances these would be used in an emergency.

Surgery

- There was a lack of overarching governance processes. There was no formal process for staff and senior managers to discuss and manage risk, issues and performance. Although staff had formal meetings and discussed learning, incidents and risks there was limited opportunities for wider learning within the surgical division.
- Although senior oversight and visibility had improved since our last inspection had improved, this still needed building upon, to ensure senior managers understood the service and the risks.
- The service used the World Health Organisation Checklist Safer Surgery Checklist for some procedures but not all, which could lead to confusion amongst staff.
- Although there was a trust strategy, staff were unaware of whether there would be any changes to the services in the future. There was no vision or strategy for the development of the service.
- Patients could not access the service when they needed it. Waiting times for treatment for ear, nose and throat and ophthalmology were not in line with good practice. However, it was not possible to tell how well the day surgery unit was performing as their data was included in the Royal Hampshire County hospital data.
- Staff had ideas of additional procedures could be performed within the unit which would alleviate capacity on the other two hospitals. However, these had not been developed and implemented. Staff felt this was because the focus of the senior leadership team was on the projects on the other two acute hospitals.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- Improvements had been made in the management of emergency procedures, resuscitation equipment, medicine management, management of deteriorating patients and mandatory training compliance.
- The service provided mandatory training in key skills to all staff. The data supplied showed that nursing staff had exceeded the trust training target.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff completed safeguarding training and the percentage of staff completing training exceeded the trust target.
- The service had suitable premises and systems were in place to ensure equipment was well looked after.
- The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff assessed risks to patients and monitored their safety, so they were supported to stay safe. Staff collected safety information and shared it with staff, patients and visitors.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- Assessments were in place to alert staff when a patient's condition deteriorated.
- The service planned for and practiced emergencies and staff understood their roles if one should happen.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

However:

Surgery

- The service used the World Health Organisation Checklist Safer Surgery Checklist for some procedures but not all, which could lead to confusion.
- We found medicines given for general anaesthesia which is not performed in the day surgery unit. There was no specialist equipment to support patients having general anaesthetics. There was a lack of risk assessments and governance detailing in what circumstances these would be used in an emergency.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- Staff had knowledge of how to apply the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff received training for the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards compliance exceeded the trust target.
- The outcomes of people's care and treatment were monitored regularly. Participation in local and national audits was limited due to the nature of the procedures undertaken within the unit. The results of any relevant audits were used effectively to improve quality and patient outcomes.
- Staff had access to and completed formal clinical supervision to identify staff development and training needs.
- The service made sure staff were competent for their roles. The management and support arrangements for staff had improved, such as appraisal, supervision and professional development. Appraisal rates for day surgery staff were above the trust target.
- Andover War Memorial hospital relied on Royal Hampshire County hospital for many additional services. This working relationship had improved to provide joined up care for patients.
- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- The service managed patients' pain effectively and provided or offered pain relief regularly.
- Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Is the service caring?

Good → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff communicated with patients and their relatives and provided information in a way that they could understand.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress. Staff ensured that patients privacy and dignity was maintained.

Surgery

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good because:

- The service was inclusive and took account of patients individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- Facilities and premises were appropriate for the services being delivered. Mixed sex breaches no longer occurred.
- Staff had improved the service to support people who had complex needs or people in vulnerable circumstances.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

However:

- Patients could not access the service when they needed it. Waiting times for treatment for ear, nose and throat and ophthalmology were not in line with good practice. However, it was not possible to tell how well the day surgery unit was performing as their data was included in the Royal Hampshire County hospital data. Staff and managers were aware of the challenges around treatment targets and were exploring how they could undertake additional procedures within the unit to help access to treatment times.
- Staff had ideas of additional procedures could be performed within the unit which would alleviate capacity on the other two hospitals. However, these had not been developed and implemented. Staff felt this was because the focus of the senior leadership team was on the projects on the other two acute hospitals.

Is the service well-led?

Good ↑↑

Our rating of well-led improved. We rated it as good because:

- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Leaders had the integrity, skills and abilities to run the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

However:

- There was a lack over overarching governance processes. There was no formal process for staff and senior managers to discuss and manage risk, issues and performance. Although staff had formal meetings and discussed learning, incidents and risks there was limited opportunities for wider learning within the surgical division.
- Although senior oversight and visibility had improved since our last inspection, this still required building upon, to ensure senior managers understood the service and the risks.
- Although there was a trust strategy, staff were unaware of whether there would be any changes to the services in the future. There was no vision or strategy for the development of the service.
- All staff were committed to continually learning and improving services. However, access to quality improvement methods and training was not available. Opportunities for innovation and participation in research were limited.

Areas for improvement

Actions the provider should take:

- The service should consider training in quality improvement methods to support the service to enhance the service provided.
- Senior managers should consider how to strengthen governance process and the mechanisms for identifying and understanding of risk.
- Senior managers should consider how the day surgery unit can monitor and benchmark performance.
- The service should ensure there is effective governance and analyse of the risk for the anaesthetic medicines within the unit.
- The service should consider consistency with the World Health Organisation Safer Surgery Checklist.
- The service should consider a vision or strategy for the development of the service.
- The service should continue to improve senior oversight and visibility within the unit.

Royal Hampshire County Hospital

Romsey Road
Winchester
Hampshire
SO22 5DG
Tel: 01962 863535
www.hampshirehospitals.nhs.uk

Key facts and figures

Hampshire Hospitals NHS Foundation Trust provides services from three main sites, Basingstoke and North Hampshire Hospital (BNHH) in Basingstoke, the Royal Hampshire County Hospital (RHCH) in Winchester, and Andover War Memorial Hospital (AWMH).

RHCH provide a full range of planned and emergency district general hospital services, including a 24-hour accident and emergency, general and specialist surgery, general medicine, intensive care, rehabilitation, chemotherapy, diagnostic services, maternity, neonatal, gynaecology, paediatric care and outpatient clinics.

RHCH pioneered the use of intraoperative radiotherapy for breast cancer treatment.

Summary of services at Royal Hampshire County Hospital

Good ↑

Our rating of services improved. We rated it them as good because:

- Generally the service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Summary of findings

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Mandatory training rates did not always meet the trust's target.
- Not all staff had completed training in the Mental Capacity Act/Deprivation of Liberty.
- Not all staff had completed a yearly appraisal.
- Safe staffing levels were not always achieved consistently across the hospital.
- Staff did not always work effectively to manage patient flow within the hospital.
- Not all areas had a dedicated pharmacist and medicines were not always managed well.
- Surgical patients did not have their risk of developing a venous thromboembolism reassessed within 24 hours of admission.
- The hospital did not achieve its referral to treatment target for urology, ear nose and throat and ophthalmology.

Urgent and emergency services

Good ↑↑

Key facts and figures

The emergency department at Royal Hampshire County Hospital (RHCH) forms part of the unscheduled care division. Front door services include three resuscitation bays, a dedicated emergency department paediatric area (EDPA), an emergency decision unit, 10 high care in-patient beds, six assessment trolleys and six chairs for medical assessment, along with 28 in-patient medical assessment beds.

Ambulatory emergency care and GP referrals can be seen in the newly appointed same day emergency care facility (SDEC) and the three newly created rapid assessment and treatment bays (RAT).

There were 129,773 attendances at Hampshire Hospitals NHS Foundation Trust from July 2018 to June 2019

We undertook an announced inspection of the urgent and emergency care services on the 15 and 16 January 2020.

We previously inspected this service in June 2018. At that time the service was rated inadequate overall, with safe, and well led rated as inadequate, effective and responsive requiring improvement and caring as good.

During this inspection we spoke with four patients and four relatives and carers. We spoke with approximately 24 members of staff including nurses, managers, health care support workers, doctors and reception staff. We observed care in the service and looked at 12 sets of patients' records.

Summary of this service

Our rating of this service improved. We rated it it as good because:

The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse. The service controlled infection risk and managed medicines well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents effectively and learned lessons from them. Staff collected safety information and used it to improve the service.

Staff provided good care and treatment, gave patients enough to eat and drink and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

The service planned care to meet the needs of local people, took account of patients' individual needs and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care and were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Urgent and emergency services

Is the service safe?

Good ↑↑

Our rating of safe improved. We rated it as good because:

- The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.
- Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, using bank and regular agency staff when required. Locum medical staff were given a full induction
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- Management of FP10 prescriptions and patient group directions were not monitored efficiently but generally the service used systems and processes to safely prescribe, administer, record and store medicines.
- The service did not have a designated area suitable for teenagers.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Urgent and emergency services

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

However:

- The service did not always meet standards required by the Royal College of Emergency Medicine for a number of national audits.
- The nursing staff did not meet the trust's target for training in the Mental Capacity Act (2005).

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement  

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The service did not meet the nationally agreed wait times which meant that some patients did not receive their planned care in the right place. The hospital wide system did not have sufficient means to ensure patients did not linger in the emergency department.
- The staff in the emergency department coordinated care with other services and providers but were not always able to respond to patients needs in a timely way.
- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients did not always meet national standards.

However:

- The service planned and provided care in a way that met the needs of local people and the communities served.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Good ↑↑

Our rating of well-led improved. We rated it as good because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Areas for improvement

Action the provider should take to improve:

- Ensure mandatory training meets the trust's target for all areas, including nurse training in the mental capacity act.
- Review processes for monitoring the use of PGDs and PSD prescriptions.

Urgent and emergency services

- Continue to review and improve care pathways to ensure patient care meets the standards set by the Royal College of Emergency Medicine.
- Continue to work with the rest of the hospital teams to meet the nationally agreed wait times for patients attending the emergency department.

Medical care (including older people's care)

Good ↑

Key facts and figures

The medical care service at Hampshire Hospitals NHS Foundation Trust provides care and treatment for 10 specialties: cardiology, diabetes and endocrinology, elderly care and stroke, gastroenterology, endoscopy, respiratory, neurology and rheumatology.

There are 454 medical inpatient beds located across 20 wards or units. A ward breakdown by site can be viewed below:

Basingstoke and North Hampshire Hospital:

Ward/unit	Number of beds	Services provided
E1	**22**	**Gastroenterology and acute general medicine**
E2	**24**	**General medicine**
E3	**28**	**Respiratory and acute general medicine**
E4	**25**	**Diabetes, endocrinology and acute general medicine**
F1	**22**	**Acute elderly care**
F2	**18**	**Acute elderly care**
F3	**14**	**Acute elderly care**
Cardiac/CCU	**27**	**Inpatient cardiology**
Isolation ward	**7**	**General medicine**
Lyford unit	**4**	**Specialty specific day cases and infusions**
Overton ward	**25**	**Non-acute rehabilitation**
Acute assessment unit (AAU)	**14 beds 9 trolleys**	**Acute medical and frailty unit**
Total	**230 beds and 9 trolleys**	

Royal Hampshire County Hospital:

Ward/unit	Number of beds	Services provided
Clarke	**24**	**Inpatient cardiology and stroke**
Clifton	**26**	**Acute elderly care**
Freshfield	**26**	**Delayed transfer of care (DTOC) ward**

McGill	**40**	**Ambulatory care, acute medical and frailty unit**
Shawford	**27**	**Respiratory and acute general medicine**
Twyford	**24**	**Hyper acute stroke unit**
Victoria	**27**	**Gastroenterology and acute general medicine**
Wykeham	**22**	**Acute elderly care**
Total	**216 beds**	

*(*Source*: Routine Provider Information Request AC1 - Acute context)*

The trust had 46,878 medical admissions from July 2018 to June 2019. A breakdown of these admissions by type can be found below:

- Emergency admissions – 25,173 (53.7%)
- Elective (i.e. planned) – 402 (0.9%)
- Day cases – 21,303 (45.4%)

Admissions for the top three medical specialities were:

- Gastroenterology – 17,153
- General medicine – 14,802
- Cardiology – 3,071

(Source: Hospital Episode Statistics)

This report details our findings following our inspection of Royal Hampshire County Hospital.

During this inspection, we visited medical care ward areas, escalation areas, and the discharge lounge. We attended meetings including bed meetings, board rounds, and leadership and flow meetings.

Summary of this service

During our inspection we visited medical care ward areas, escalation areas, and the discharge lounge. We attended meetings including bed meetings, board rounds and leadership and flow meetings.

We spoke with approximately 42 staff. This included divisional leaders, medical staff, nursing staff, therapists, pharmacy staff, the discharge team, the site team, and speciality nursing and clinical leads.

We spoke with 13 patients and five relatives to discuss their experience of the care and treatment they received.

We reviewed 14 patient records to review record keeping and consider specific areas of care and treatment. We also analysed other information, including data and trust documents.

Our rating of this service improved. We rated it as good because:

Staff had training in key skills, understood how to protect patients from abuse, and managed safety well.

The service controlled infection risk well.

Medical care (including older people's care)

Staff assessed risks to patients, acted on them and kept good care records.

The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it.

Managers monitored the effectiveness of the service and made sure staff were competent.

Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.

Key services were available seven days a week.

Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.

Leaders ran services well using reliable information systems and supported staff to develop their skills.

Staff understood the service's vision and values, and how to apply them in their work.

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Good 

Our rating of safe improved. We rated it as good because:

- Compliance for nursing staff was very close to, or above, the trust targets in mandatory modules.
- Nursing staff had access to training specific for their role on how to recognise and report abuse and kept up to date with safeguarding training.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. The endoscopy service had reobtained their Joint Advisory Group accreditation.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- Nurse staffing remained a challenge and a known risk. There was a clear focus on recruitment and retention, with staffing numbers in the pipeline improving vacancy rates and the division being innovative with roles.

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

However:

- Although the service provided mandatory training in key skills to all staff, not all staff kept up to date with their mandatory training. Although compliance rates for medical staff were improving, they did not meet the trust target for any mandatory training modules.
- Medical staff had access to training specific for their role on how to recognise and report abuse, however compliance rates for safeguarding training for remained low.
- The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. There was a high vacancy rate of 31% for medical staffing and 27% for qualified nursing staff across the service.
- Medicines were not always stored correctly and recording of fridge temperatures was not done in line with trust policy.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements. The service had been accredited under relevant clinical accreditation schemes such as the Joint Advisory Group.
- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care. The addition of the Same Day Emergency Care (SDEC) unit complemented the services offered to patients.
- Staff gave patients practical support and advice to lead healthier lives.

- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

However:

- Staff did not use body maps to record the location of transdermal patches which meant an increased possibility of patches being placed in the same body area and causing irritation.
- Patient outcomes were variable and did not always meet expectations. National audits showed the hospital did not always met national standards.
- Staff did not always keep up-to-date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- The service sought to make sure staff were competent for their roles. However, not all staff groups achieved the trust's target for completion of yearly appraisals, though this was an improving picture compared to how the trust was performing at the last inspection.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Patients spoke positively about the care and treatment they received from all staff.
- Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Patients, families and carers were supported to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Good 

Our rating of responsive improved. We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Medical care (including older people's care)

- Flow continued to be a challenge for the trust, however, this was being better managed since our last inspection, with use of clear escalation processes and specific criteria for moving patients. Staff also felt there had been definite improvement with flow across the hospital with the introduction of the Same Day Emergency Care (SDEC) unit.
- Patients could access the service when they needed it and received the right care promptly.
- There was a clear improvement in the number patient moving wards at night, although out-of-hours moves remained a focus for the service.
- Discharge delays were reviewed regularly within the hospital and with stakeholders.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff

However:

- The service was restricted by the challenges faced with capacity and flow. Demand was outweighing capacity, and escalation areas were being used frequently.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff knew and understood the trust's visions and values and could tell us how that was being achieved.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.
- The service had an open culture where patients, their families and staff could raise concerns without fear. There was an effective multi-professional and collaborative culture within the division.
- Some told us they would feel confident to raise concerns or to make suggestions for improvement.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

However:

- Leaders did not always operate effective governance processes throughout the service. Minutes from mortality and morbidity meetings across the service were not standardised. This meant the ability to learn from these minutes was potentially not as effective.
- The division’s quarterly performance report lacked detail in many areas including, for example, when it referred to the audits undertaken by the division but did not provide detail on the division's performance in these audits. This raised questions about the reports ability to fulfil its stated aim of providing assurance to the quality and performance committee regarding the performance of the medical services division.

Areas for improvement

Action the provider must take to improve:

- The service must have clear processes for checking expiration dates, storing medication and recording fridge temperatures.

Action the provider should take to improve:

- Provide all necessary support for its staff to improve compliance for MCA/DoLS training for medical and nursing staff.
- Continue to review nursing staffing in the medical care wards and focus on recruitment and retention to ensure safe staffing levels can be consistently achieved across all wards.
- Continue to work to improve its performance in national clinical audits.

Surgery

Good ↑

Key facts and figures

Royal Hampshire County Hospital provides elective (planned) and non-elective (emergency) general surgery services in a range of specialities, including general surgery, orthopaedic, urology, ear nose and throat and vascular surgery. The Hospital provides care to people across Basingstoke, Winchester, Andover and surrounding areas in Hampshire and west Berkshire.

The service includes the Nightingale theatres with four theatres and one eye theatre, five surgical wards, a pre-assessment clinic, a same day emergency care unit, a treatment centre with 3 theatres that supports day case surgery.

Services across the trust were changed in December 2019. Royal Hampshire County Hospital no longer treats orthopaedic trauma patients but continues to provide elective orthopaedic surgery. In addition, at the time of the inspection there was no longer a surgical assessment unit and patients on Kemp Welch ward were not surgical patients.

The trust had 36,223 surgical admissions from July 2018 to June 2019. Of these, 10,620 (29.3%) were emergency admissions, 20,105 (55.5%) were day case, and the remaining 5,498 (15.2%) were elective.

We inspected Royal Hampshire County Hospital on 15 and 16 January 2020. We visited theatres, the pre-assessment unit, Wainwright ward, Bartlett ward, St Cross ward, the same day care unit and the treatment centre. We spoke with approximately 15 patients two relatives/visitors and over 30 members of staff that included all grades of nursing staff, healthcare assistants, domestic staff, surgeons, anaesthetists, junior doctors, therapists, a radiographer and managers.

We observed care and treatment patients were receiving and reviewed 16 patients' records.

Before and after the inspection we reviewed performance information from and about the surgical service.

Summary of this service

Our rating of this service improved. We rated it as good because:

The overall completion rate for mandatory training for nursing and medical staff at the hospital had improved since the last inspection to 89% which was almost equal to the trust target of 90%.

We saw improvements which showed that medicines were being stored and managed safely and in line with legislation. Medicine fridge temperatures were consistently monitored to ensure medicines remained safe and effective.

We saw improvements which showed equipment was used correctly and was maintained. We also saw that emergency equipment was consistently checked to ensure it was fit for purpose and available when needed.

Staff in the operating theatres and treatment centre followed the World Health Organisation Surgical Safety Checklist and five steps to safer surgery and monitored this to make sure this was completed accurately. We saw the fifth step (debrief) was now completed.

We saw improvements in the leadership, governance and culture which supported the delivery of high-quality person-centred care.

Surgery

The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well.

Staff assessed risks to patients, acted on them and kept good care records. This was an improvement from the last inspection when risk assessments were not consistently completed.

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. This was an improvement since our last inspection when patients privacy and dignity was not maintained. All patients that we spoke with during this inspection were very complimentary about the level of care they had received.

Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent.

The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.

The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

The service generally met national standards for care and treatment in key areas, such as length of hospital and in national audits.

There was not an individual strategy for the surgical division. However, the key strategic aims for surgery were incorporated into the trust's four high level strategic objectives.

However:

There was limited assurance that there was pharmacy oversight and support for wards and departments.

Level 2 adult safeguarding training compliance was below the trust target for both nurses and medical staff.

The service had not achieved its referral to treatment target for urology, ear nose and throat and ophthalmology. However, it was meeting the target for: trauma and orthopaedics and general surgery.

Patients did not have their risk of developing a venous thromboembolism reassessed within 24 hours of admission, this was not in line with national guidelines.

Appraisal rates were still below the trust target, but this was mainly due to the transition to the new online system.

The service promoted equality and diversity in daily work and provided opportunities for career development. However, trust diversity groups were in their infancy and still needed embedding.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- The overall completion rate for mandatory training for nursing and medical staff at the hospital had improved since the last inspection to 89% which was almost equal to the trust target of 90%.

Surgery

- We saw improvements which showed that medicines were being stored and managed safely and in line with legislation. Medicine fridge temperatures were consistently monitored to ensure medicines remained safe and effective.
- We saw improvements which showed equipment was used correctly and was maintained. We also saw that emergency equipment was consistently checked to ensure it was fit for purpose and available when needed.
- Staff in the operating theatres and treatment centre followed the World Health Organisation Surgical Safety Checklist and five steps to safer surgery and monitored this to make sure this was completed accurately. We saw the fifth step (debrief) was now completed.
- Although compliance with level two safeguarding training was below the trust target, staff understood how to protect patients from abuse.
- The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff managed clinical waste well.
- Staff assessed risks to patients, acted on them and kept good care records. This was an improvement from the last inspection when risk assessments were not consistently completed. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff to care for patients and keep them safe. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Substances subject to the Control of Substances Hazardous to Health regulations were stored securely to prevent harm.

However:

- There was limited assurance that there was pharmacy oversight and support for wards and departments.
- Level 2 adult safeguarding training compliance was below the trust target for both nurses and medical staff.

Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

- The service generally provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff fully completed food and fluid charts, and documented escalation and actions.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. Staff supported those unable to communicate using suitable assessment tools. and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. We saw improvements had been made in national audits since our last inspection.

Surgery

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Staff were very positive about the new online system which incorporated appraisals, mandatory training and wellbeing.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Doctors in training were very positive about the training they received and support from seniors.
- Staff gave patients practical support and advice to lead healthier lives, this started at the pre-assessment stage.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They monitored compliance of consent process to ensure they were in line with national guidelines. Staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

However:

- Patients did not have their risk of developing a venous thromboembolism reassessed within 24 hours of admission, this was not in line with national guidelines.
- Appraisal rates were still below the trust target, but this was mainly due to the transition to the new online system.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. This was an improvement since our last inspection when patients privacy and dignity was not always maintained.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. Feedback from patients and families was positive about the care they had received.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good because:

- A theatre improvement and productivity programme had helped to improve the utilisation in theatres. There were clear processes and oversight for theatre planning. Theatre utilisation had improved and the amount of cancelled operations due to non-clinical reasons had reduced. The number of non-clinical bed moves, including at night had reduced since our last inspection.

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. The investigation and closure of complaints was broadly in line with the trusts policy, this was an improvement since our last inspection.
- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers and teams within the trust.

However:

- The service had not achieved its referral to treatment target for urology, ear nose and throat and ophthalmology. However, it was meeting the target for: trauma and orthopaedics and general surgery. The service had comprehensive action plans to address the shortfalls in referral to treatment targets.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- The service had made improvements in a number of areas since our last inspection. The leaders had an approach to continually improve the quality of its services using relevant data and information.
- Governance process and communication between clinical matrons and the operational service managers had improved since our last inspection. Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- There was a transparent and open culture where staff escalated concerns, reported incidents and sought support from peers and seniors.
- There was a structured review and judgement process for mortality and morbidity meetings. This was an improvement since our last inspection when there was not a standard approach.
- There was not an individual strategy for the surgical division. However, the key strategic aims for surgery were incorporated into the trust's four high level strategic objectives.
- Patient and relative's views and concerns were sought, listened to and used to shape services.
- The service engaged, listened and involved staff and service users. The majority of staff felt respected, supported and valued and respected there was an active staff recognition scheme.
- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- Leaders could articulate their governance processes, which were structured. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Staff we spoke to were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. This was an improvement since our last inspection when innovation within the service was limited.
- The service promoted equality and diversity in daily work and provided opportunities for career development. However, trust diversity groups were in their infancy and still needed embedding.

Outstanding practice

The service undertook a new procedure for enlarged prostate glands taking referrals from other NHS trusts. The steam treatment, called Rezum, involved having steam injected at 1cm intervals, killing enough prostate tissue to shrink the enlarged prostate gland. Patients were able to go home on the same day and recovery was much quicker than more invasive procedures to reduce the size of the prostate gland.

Theatres had implemented innovated processes in response to incidents that had occurred. There was a safety protocol for the same administration of local anaesthetic blocks.

When anaesthetists prepared the medicines to inject for a local anaesthetic block they used a dedicated yellow tray to put the medicines in. Once prepared they put a yellow lid over the tray with stickers on saying stop before you block. Yellow is the national colour used to identify medicines for use in local anaesthetic blocks to identify they are not for intravenous administration (into a vein). The lid over the top of the tray meant they could not be picked up and administered into a vein in error. The lid was removed immediately before the medicines for the anaesthetic block were to be administered, the stickers reminded staff to check the intended site of the block before administration.

Theatres used a colour coded tray system for medicines, to act as a visual prompt for staff. Red trays contained emergency medicines, yellow trays contained local anaesthetic medicines and clear trays were for all other medicines.

Areas for improvement

Action the provider should take to improve:

- The service should ensure there is pharmacy oversight and support to wards and departments.
- The service should continue to embed diversity groups within the trust.
- The service should achieve its referral to treatment target for urology, ear nose and throat and ophthalmology.
- The service should ensure patients have their risk of developing a venous thromboembolism reassessed within 24 hours of admission.
- The service should ensure appraisal compliance meets the trust target.

Basingstoke and North Hampshire Hospital

Aldermaston Road
Basingstoke
Hampshire
RG24 9NA
Tel: 01256 473202
www.hampshirehospitals.nhs.uk

Key facts and figures

The trust provides services from three main sites, Basingstoke and North Hampshire Hospital (BNHH) in Basingstoke, the Royal Hampshire County Hospital (RHCH) in Winchester, and Andover War Memorial Hospital (AWMH).

BNHH provides a full range of planned and emergency district general hospital services, including a 24-hour accident and emergency, general and specialist surgery, general medicine, intensive care, rehabilitation, chemotherapy, diagnostic services, maternity, neonatal, gynaecology, paediatric care and outpatient clinics.

BNHH provide some specialist services to people across the UK and internationally. They are one of two centres in the UK treating pseudomyxoma peritonei (a rare form of abdominal cancer) and provide tertiary liver and colorectal cancer services as well as the haemophilia service.

Summary of services at Basingstoke and North Hampshire Hospital

Good ↑

Our rating of services improved. We rated it them as good because:

- Generally the service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients and acted on them. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Summary of findings

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Not all staff had completed training in the Mental Capacity Act/Deprivation of Liberty.
- Not all staff had completed a yearly appraisal.
- Medicines were not always managed well.
- Safe staffing levels were not always achieved consistently across the hospital.
- Surgical patients did not always have their food intake and fluid balance recorded. The pre-operative fasting process did not always follow best practice guidelines. They did not have their risk of developing a blood clot reassessed within 24 hours of admission.
- Medical patients did not always have their personal, cultural, social and religious needs recorded.
- Staff did not always work effectively to manage patient flow within the hospital.

Urgent and emergency services

Requires improvement 

Key facts and figures

Basingstoke and North Hampshire Hospital provides an emergency service through a Type 1 emergency department. Services include trauma and cardiology, an emergency decision unit, a dedicated paediatric department and same day medical assessment for ambulatory medical patients. Furthermore, there is a minor injuries service provided by emergency nurse practitioners.

Details of emergency departments and other urgent and emergency care services

- Basingstoke and North Hampshire Hospital – Emergency department and minor injuries unit
- Royal Hampshire County Hospital – Emergency department
- Andover War Memorial Hospital – Minor injuries unit

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Summary of this service

Our last inspection of Basingstoke and North Hampshire Hospital's emergency department was in June 2018. We followed this up with two unannounced focussed inspections in February and April 2019.

In February and April 2019, we visited the department and looked at issues raised in a warning notice under Section 29A that was issued in June 2018. We noted that the trust had made many improvements and this resulted in the conditions of the notice being removed in December 2019.

This inspection was unannounced. We looked at the environment, equipment and observed care. We reviewed 12 sets of patients notes and looked at information provided by the trust before and after the inspection. The inspection team spoke with 10 patients and relatives, 32 members of staff including consultants, junior doctors, nurses of several grades, health care support workers, managers, allied healthcare professionals, security and domestic staff and reception staff.

Our rating of this service improved. We rated it as requires improvement because:

- Overall, the department was tired in appearance, with some damage to plasterwork on walls. Storage cupboards were cluttered and untidy. In the main department, the main storage cupboard was small but fitted with shelving. The shelves were labelled but, in some cases, the items in boxes did not match the label.
- Nursing and medical staff did not keep up to date with all their mandatory, medicines management and safeguarding training.
- The department had challenges in medical staff vacancies. The medical staff did not match the planned number with a shortage of middle grade doctors.

Urgent and emergency services

- The service did not meet the nationally agreed wait times which meant that some patients did not receive their planned care in a timely way or in the right place. We noted there was limited pull from other wards to alleviate pressure for beds in emergency department, no proactive action plan to deliver more beds and there did not seem to be efficient use of the discharge lounge. Patients were treated on trolleys in the corridor in times of pressure, but this was noted to be managed by staff within the department.
- Management of medicines paperwork was not consistent. FP10 forms that patients were able to take to community pharmacies, were not always recorded when they were issued. Up to date patient group directive paperwork was not always available on the intranet. Prescriptions were completed online and on paper. Some medications were not routinely prescribed in the department and the patients possibly had to wait for a review before receiving their regular medication.

However:

- The service had enough staff to care for patients and keep them safe, using bank and locum staff. Staff were trained in key skills and understood how to protect patients from abuse. The service controlled infection risk well, staff assessed risks to patients, acted on them quickly. The service managed safety incidents effectively, learned and shared lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, supported patients in their pain relief when they needed it and meet their nutritional needs. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them in how to make decisions about their care, and had access to good information. Key services were available seven days a week, including x-rays, CT scans, access to psychiatric liaison and mental health services.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's values, and how to apply them in their work. Leaders planned to involve staff in the planning of future vision and strategy for the service. Staff felt respected, supported and valued. Staff and leaders were clear on how to meet the needs of patients receiving care and were clear about their roles and accountabilities. Leaders were committed to improving services continually and were clear in how they planned to achieve this.

Is the service safe?

Requires improvement 

Our rating of safe improved. We rated it as requires improvement because:

- Nursing and medical staff did not keep up-to-date with all their mandatory and safeguarding training.
- Overall, the department was tired in appearance. There was damage to walls that exposed concrete under the plasterwork as a result of door handles knocking into walls. There were chips in the wooden frames of doors and in the doors themselves. This provided an infection control risk as they could not be adequately cleaned as the surfaces were porous.

- Seating in the main waiting room was all the same height and size which meant there may not be seating available for those who require a higher seat or for bariatric patients.
- Chairs in the temporary waiting area in the corridor outside the plaster room were dusty and had tears in the seats.
- Signage in the emergency department and from the main hospital corridor was limited and unclear.
- Room 12 situated between the resus department and patients in the corridor, was not clearly visible.
- We saw the plaster room in the paediatric unit had plaster tools left out on surfaces.
- The medical staff did not match the planned number. Staff told us that there was a shortage of middle grade doctors.
- Assessments to record if patients were at risk of developing blood clots were not written in all notes where patients might have been at risk
- FP10 forms that patients were able to take to community pharmacies, were not always recorded when they were issued.
- Up to date patient group directive paperwork was not always available on the intranet.

However:

- The mandatory training was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and had systems to alert staff when they needed to update their training.
- Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities and dementia.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns and staff followed safe procedures for children visiting the unit. A safeguarding meeting was held with the trust safeguarding lead each month to discuss referrals and feedback on audits.
- The main department had suitable furnishings which were clean and well-maintained. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.
- Staff followed the restraint policy for patients who became distressed or were aggressive. The environment had been risk assessed for ligature points and rooms used by patients with mental health issues were designed to keep them safe.
- Staff followed infection control principles including the use of personal protective equipment (PPE). Staff disposed of clinical waste safely.
- Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. Staff used standard operating procedures to ensure patients were assessed and treated appropriately.
- The service included round the clock access to mental health liaison and arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. There were assessment rooms available for use by the children and adolescent's mental health team or as a quiet space for other patients.
- The trust used operational escalation level ratings (OPEL) to identify how busy the department was. The service had a process to escalate ambulance handovers if there were more than three patients waiting or if the handover was taking more than 15 minutes.

- Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The department manager could adjust staffing levels daily according to the needs of patients
- Managers limited their use of bank and agency staff and requested staff familiar with the service. All bank and agency staff had a full induction. The service always had a consultant on call during evenings and weekends.
- Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.
- Safety data was displayed on wards for staff and patients to see using an electronic board in majors.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.
- Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.
- Staff assessed patient's pain using a recognised tool and gave pain relief in line with individual needs and best practice.
- Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.
- The service participated in relevant national clinical audits.
- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.
- New staff told us they were part of a preceptorship programme and they were able to develop additional skills during the first year in post.
- Managers gave all new staff a full induction tailored to their role before they started work.
- The clinical educators supported the learning and development needs of staff.
- Staff worked across health care disciplines and with other agencies when required to care for patients.
- Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.
- The service had relevant information promoting healthy lifestyles and support on the unit.

However:

- We did not see that staff clearly and consistently recorded consent in the patients' records.

Is the service caring?

Good ↑

Our rating of caring improved. We rated it as good because:

Urgent and emergency services

- Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.
- Patients said staff treated them well and with kindness.
- A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey
- Staff followed policy to keep patient care and treatment confidential
- Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.
- Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.
- Patients gave positive feedback about the service. Staff could give examples of how they used patient feedback to improve the quality of care they provided.

Is the service responsive?

Requires improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The service had no information leaflets available in other languages or print sizes displayed in the department.
- We saw no signs in reception or on doors advertising chaperones were available
- We noted there was limited pull from other wards to alleviate pressure for beds in emergency department, proactive action plan to deliver more beds and there did not seem to be efficient use of the discharge lounge.
- The service did not meet the nationally agreed wait times which meant that some patients did not receive their planned care in a timely way or in the right place.

However:

- Facilities and premises were appropriate for the services being delivered.
- The service had systems to help care for patients in need of additional support or specialist intervention. Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.
- Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia.
- Managers and staff worked to make sure patients did not stay longer than they needed to. Staff worked to make sure that they started discharge planning as early as possible. This included those with complex mental health and social care needs. There was an out of hours GP service where patients could be assessed, treated and discharged without been seen in the main department.
- Patients, relatives and carers knew how to complain or raise concerns and staff understood the policy on complaints and knew how to handle them.

Urgent and emergency services

Is the service well-led?

Good ↑↑

Our rating of well-led improved. We rated it as good because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Areas for improvement

Action the provider should take to improve:

- Ensure qualified nurses complete training in the Mental Capacity Act.
- Ensure that there is an accurate process to record medicine related stationary and that this is monitored, including storing, recording and auditing the use of FP10 forms.
- Continue to review and improve care pathways to ensure patient care meets the standards set by the Royal College of Emergency Medicine.
- Continue to work with the rest of the hospital teams to meet the nationally agreed wait times for patients attending the emergency department.
- Ensure that patient directive paperwork on the trust intranet is the most recent and in date version.
- Ensure staff record if patients are at risk of developing blood clots in all notes.

Medical care (including older people's care)

Good ↑

Key facts and figures

The medical care service at Basingstoke and North Hampshire Hospital provides care for seven specialities: cardiology, diabetes and endocrinology, elderly care, endoscopy, gastroenterology and respiratory. Other medical care specialities including: stroke, neurology and rheumatology are based at the Royal Hampshire County Hospital.

The medical care service as Basingstoke and North Hampshire Hospital consists of 230 beds and nine trolleys. Hampshire Hospitals NHS Foundation Trust had 46,878 medical admissions from July 2018 to June 2019.

Admissions for the top three medical specialties were:

- Gastroenterology – 17,153
- General medicine – 14,802
- Cardiology – 3,071

We inspected the service as part of our routine inspection programme. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We inspected the whole core service and inspected using our five key questions.

We inspected the following ward areas:

- Acute assessment unit (AAU)- Acute medical and frailty unit
- Ward F1- Acute elderly care
- Ward F2- Acute elderly care
- Ward F3- Acute elderly care
- Ward E2- General medicine
- Ward E3- Respiratory and acute general medicine
- Coronary Care Unit (CCU)- Inpatient cardiology
- Overton Ward- Non-acute rehabilitation
- Lyford Unit- Specialty specific day cases and infusions

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- Spoke with 11 patients who were using the service and three relatives of patients using the service.
- Spoke with 41 staff including; clinical matrons, ward sisters, doctors, nurses, clinical nurse specialists, ward admin coordinators and patient flow coordinators.
- Observed multidisciplinary meetings, staffing meetings, safety huddles, staff interactions and care on the wards.
- Reviewed 13 patient records.

Medical care (including older people's care)

Summary of this service

Our rating of this service improved. We rated it as good because:

- Staff had safeguarding training on how to recognise and report abuse, and staff knew how to apply it.
- The service managed infection risk well. The wards were visibly clean and free from clutter. Staff used recognised infection prevention methods.
- The environment and equipment were suitable for the service provided including; access to necessary emergency equipment.
- The service assessed and mitigated patient risks. Each patient had risk assessments completed in their care plans and detailed actions against each risk.
- Patient records were clear, up-to-date and reflected the care needs of the patient. Patient records were stored securely.
- The service investigated incidents and lessons learnt shared with staff.
- The service monitored its safety performance and sought to improve performance of the service.
- Managers worked collaboratively and responsively to ensure staffing levels kept patients safe.
- Patient care and treatment were based on national guidance and evidence-based practice. Staff monitored performance against national guidelines and best practice.
- The service ensured staff were competent for their role. Staff had access to training and had regular supervisions and appraisals.
- The service worked in multidisciplinary teams to improve patient care and staff could refer for specialist advice.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005. Staff could access advice from the mental health liaison service.
- Staff treated patients and those close to them with dignity, respect, compassion and kindness. Patients we spoke with commented that their privacy and dignity was respected.
- Staff showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.
- Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff sought specialist support from specialist teams for patients who required additional emotional support and care.
- Staff made sure patients and those close to them understood their care and treatment and supported patients to make informed decisions about their care.
- The service planned and provided a service which met the needs of the population.
- Staff treated complaints and concerns seriously; complaints were investigated, and lessons learnt were communicated to staff.
- Managers and staff worked hard to make sure that patients did not stay longer than they needed to. Managers and discharge teams in the hospital worked with agencies to facilitate discharge from the hospital.
- Managers were visible, approachable and had the skills and abilities to manage the service.

Medical care (including older people's care)

- Staff worked well as a team and had good morale. They felt respected and valued within their roles and worked hard to give good patient care.
- The service had effective governance processes to monitor performance and discuss learning. The service monitored risks, issues and performance effectively.
- The service was dedicated to quality improvement and innovation at all staff levels. Managers encouraged staff to improve the service.

However:

- Medicines were not always recorded and stored correctly.
- Compliance with mandatory training did not meet trust targets and this needed to improve.
- Medical staff compliance with safeguarding training did not meet trust targets and this needed to improve.
- Compliance with Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training did not meet trust targets and this needed to improve.
- The service should continue to review nursing staffing in the medical care wards.
- We did not see consideration of personal, cultural, social and religious needs of patients documented in their care plan and how they related to the patients' care needs. This meant staff may not be considering what is important to patients when planning care.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- Staff had safeguarding training on how to recognise and report abuse, and they knew how to apply it. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff knew who their safeguarding lead was and how to contact them if they needed advice.
- The service managed infection risk well. The areas we visited were visibly clean and free from clutter. Staff used infection prevention methods such as gloves and aprons and were bare below the elbows. The service safely managed substances hazardous to health and waste.
- The environment and equipment were suitable for the service provided to patients. Ward areas had access to necessary emergency equipment. All the equipment we checked had been tested and was in date. The environment on the elderly care wards was dementia friendly.
- The service assessed and mitigated their risks to patients. Each patient had risk assessments completed in their care plans, with detailed actions against each risk. Examples of risk assessments include; nursing assessment, pressure ulcer assessment, nutritional risk assessment, falls risk assessment.
- Patient records were clear, up-to-date and reflected care needs of the patient. Patient records were locked securely but easily accessible to staff when they needed them.
- The service managed incidents well and actions were taken to investigate them promptly. Where lessons were learnt, learning was fed back to staff. We saw learning from incidents on notice boards on the wards for staff and patients to view. Managers would feedback learning from incidents specific to their team during daily meetings.

Medical care (including older people's care)

- The service monitored its safety performance and sought to improve performance of the service.
- Staff on wards did not always match planned staffing levels, but gaps were filled using bank and agency staff. Managers worked collaboratively and responsively to ensure staffing levels kept patients safe.

However:

- Medicines were not always recorded and stored correctly. We found one insulin syringe that was out of date on the acute assessment unit. During our inspection we also saw one dose of a patient's morphine on the acute assessment unit not documented. We found two missing FP10 forms on the acute assessment unit. FP10 forms are used to prescribe medicines.
- The service should continue to review nursing staffing in the medical care wards and focus on recruitment and retention to ensure safe staffing levels can be consistently achieved across all wards.
- Compliance with mandatory training did not meet trust target, and this needed to improve.
- Medical staff had low compliance in meeting the trust target for safeguarding training completion, and this needed to improve.

Is the service effective?

Good 

Our rating of effective improved. We rated it as good because:

- Patient care and treatment were based on national guidance and evidence-based practice. Staff monitored performance against national guidelines. The medical division monitored performance against best practice and determined if they were fully, partially or non-compliant with NICE guidelines.
- Patients received adequate nutrition and hydration. Patients were supported in making food choices and their personal, religious, cultural and other needs were considered. Staff completed risk assessments for patients at risk of malnutrition.
- Patients received appropriate and timely pain relief.
- The service took part in national clinical audits and local audits to monitor and help drive improvement of the service. Where the outcome of audits required some improvement, we saw action plans to drive improvements.
- The service ensured staff were competent for their role. Staff had access to training and had regular supervisions and appraisals and there was a programme of mandatory training to ensure staff maintained essential skills
- The service worked in multidisciplinary teams for the benefit of patients. Staff could refer for specialist advice. For example, staff could refer using an e-referral system for specialist advice from the pain team, mental health liaison team and dementia team.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005. Staff knew how to support patients experiencing mental health illness. Staff could access advice from the mental health liaison service.

However:

- Staff had low compliance in meeting the trust target for Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training completion, and this needed to improve.

Medical care (including older people's care)

Is the service caring?

Good ↑

Our rating of caring improved. We rated it as good because:

- Staff treated patients and those close to them with dignity, respect, compassion and kindness. Patients we spoke with commented that their privacy and dignity was respected. Staff respected people's privacy and dignity whilst in distress
- Staff showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. During our visit staff showed a non-judgemental attitude.
- Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff sought specialist support from the dementia team, learning disabilities team and psychiatric liaison for patients who required additional emotional support and care. The hospital ran a 'dementia carers café' once a month to support relatives and carers of patients with dementia.
- Staff made sure patients and those close to them understood their care and treatment and supported patients to make informed decisions about their care. Staff told us they actively involved patients and those close to them in the design of their care plans. Staff considered patients and relatives wider circumstances and gave them options for care and discharge decisions. Staff had a meeting within 24 hours to discuss and agree the care plan.

However:

- We did not see consideration of personal, cultural, social and religious needs of patients documented in their care plan and how they related to the patients' care needs. This meant staff may not be considering what is important to patients when planning care.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good because:

- The service planned and provided a service which met the needs of the population. The facilities and premises were appropriate for the needs of the patients receiving care. The service had support from specialists to meet the needs of the patient.
- The service took account of patient's individual needs and preferences. Staff supported patients with mental health problems, learning disabilities and dementia and staff could access additional support services for advice and support with a patient's care plan.
- Staff treated complaints and concerns seriously, and staff told us they aimed to resolve complaints at the time. Complaints were investigated, and lessons learnt from complaints were communicated to staff regularly through team meetings.
- Managers and staff worked hard to make sure that patients did not stay longer than they needed to. Staff were proactive and discussed patient discharge at daily board meetings. Managers and discharge teams in the hospital worked with other agencies to facilitate discharge from the hospital.

Medical care (including older people's care)

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good because:

- Managers were visible, approachable and had skills and abilities to manage the service safely. However, staff commented that the senior leadership team were not always visible.
- Culture within the service was good, staff worked well as a team and had good morale. Managers were open; they encouraged people to raise concerns and staff felt secure raising issues. Staff felt respected and valued within their roles. Staff worked hard to give good patient care.
- The service had effective governance processes to monitor performance and discuss learning. Governance meeting minutes where comprehensive.
- The service monitored risks, issues and performance effectively. Senior leaders, managers and staff knew the service risks and actively acted to address them where they could.
- The service was dedicated to quality improvement and innovation at all staff levels. Managers encouraged staff to improve the service. We saw quality improvement projects taking part at ward level. For example, outside of F1 ward they had a notice board showing ongoing projects.

Areas for improvement

Action the provider must take to improve:

- The service must have clear processes for monitoring and storing FP10 prescription pads, checking expiration dates, recording and storing medicines and recording fridge temperatures.

Action the provider should take to improve:

- The service should provide all necessary support for its staff to improve compliance for Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training for medical and nursing staff.
- The service should continue to review nursing staffing in the medical care wards and focus on recruitment and retention to ensure safe staffing levels can be consistently achieved across all wards.
- Staff should document patients personal, cultural, social and religious needs and how they may relate to their care needs as part of assessment processes.
- The service should continue to work to improve its performance in national clinical audits.

Surgery

Good

Key facts and figures

The Basingstoke and North Hampshire Hospital provides a full range of planned and emergency services, including a 24-hour accident and emergency, general and specialist surgery, general medicine, trauma and orthopaedic, intensive care, rehabilitation, chemotherapy, diagnostic services, maternity, neonatal, gynaecology, paediatric care and outpatient clinics.

Basingstoke and North Hampshire Hospital (BNHH) provides some specialist services to people across the UK and internationally. They are one of two centres in the UK treating pseudomyxoma peritonei (a rare form of abdominal cancer) and provide tertiary liver and colorectal cancer services as well as the haemophilia service.

The trust runs a range of surgical services for inpatient and day case procedures including urology and peritoneal malignancy as well as services for hepatobiliary, upper gastrointestinal, colorectal, ENT, ophthalmology, orthopaedics, oncology, maxillofacial and oral surgery. Following national recommendations and local consultation, the trust changed its trauma and elective orthopaedic service, with elective surgery at Royal Hampshire County Hospital and trauma surgery at Basingstoke and North Hampshire Hospital.

Summary of this service

Basingstoke and North Hampshire Hospital

Basingstoke and North Hampshire Hospital hosts the Peritoneal Malignancy Unit for the treatment of pseudomyxoma (a rare form of abdominal cancer) which spreads cancerous cells to the lining of the abdominal cavity. Additionally, the hospital has a Diagnostic Treatment Centre (DTC), four endoscopy rooms, the Eye Day Care Unit (EDCU) with one eye theatre (local anaesthetic cases only) and a pre-assessment unit.

The trust had 36,223 surgical admissions from July 2018 to June 2019. Of these, 10,620 (29.3%) were emergency admissions, 20,105 (55.5%) were day case, and the remaining 5,498 (15.2%) were elective

We inspected this service using our comprehensive inspection methodology. We carried out this unannounced inspection (people did not know we were coming) on 15 and 16 January 2020.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

During this inspection we visited the following services--

- C2 – Liver and peritoneal malignancy ward
- C3 – Non- elective surgery ward
- C4 – Elective surgery ward
- Admission ward
- EDCU – Emergency day care unit
- D1 – Elective orthopaedic ward

Surgery

- D3 & D4 – orthopaedic/ trauma wards
- Diagnosis and Treatment Centre
- Eye day care unit

The inspection team spoke with 18 patients and their relatives, appropriately 24 members of staff including nurses, health care assistants, allied health care staff such as physiotherapists and pharmacist, doctors, receptionists, and domestic staff. We observed care and treatment and reviewed 14 patients' records. We also reviewed information, documents and data provided by the trust both before and after the inspection.

Our rating of this service improved. We rated it as good because:

The staff looked after the equipment well and infection control procedures were followed to minimise the risks of cross infection.

Incidents were reported, and these were investigated. Action plans were developed, and lessons learnt were shared widely to effect learning and practices changed.

The service used systems and processes to safely prescribe, administer, record and store medicines. Patients medicines were reviewed, and any changes were discussed with the consultants.

The service controlled infection risks well. Staff followed guidance used control measures to protect patients, and others from infection. They maintained equipment and the premises were visibly clean and used methods to identify clean equipment.

The service had policy and procedures which staff followed to recognise and respond to sepsis, a severe blood infection in line with national guidance which staff followed.

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. Staff supported those unable to communicate using suitable assessment tools. and gave additional pain relief to ease pain.

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

The service provided care and treatment based on national guidance and evidence-based practice.

There was effective multi-disciplinary working where staff of different roles such as dieticians and specialist nurses worked cohesively for the benefits of patients. They supported each other to provide good care.

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff supported patients to make informed decisions about their care and treatment. They followed guidance to gain their consent written and verbally.

Patients who lacked capacity or were suffering from mental ill health were effectively supported to make their decisions about their care. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 1983 and the Mental Capacity Act 2005.

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. Families were supported to remain with the patients during their treatment.

Surgery

The staff were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

The senior managers and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues. They developed and reviewed action plans to reduce and mitigate their impact

Services were available 24 hours a day, seven days a week to support timely patient scare. Arrangements were in place for out of hours services through their on- call service such as consultants, theatre staff and mental health services.

The senior managers and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues. They developed and reviewed action plans to reduce and mitigate their impact.

Leaders had the integrity, skills and abilities to run the service. They were visible and approachable in the service for patients and staff. They understood and managed the priorities and issues the service faced. Risks were managed, and strategy developed to mitigate risks.

However:

In surgery medical staff did not meet the trust's target for any of the mandatory training modules for which they were eligible, and this included safeguarding adults training.

Nursing staff compliance with safeguarding training was below the target as set by the trust.

On two of the surgical wards, emergency equipment was not consistently checked to ensure they were safe to use and in line with guidance.

The service did not always manage prescriptions forms (FP10) safely and there was a lack of oversight on their usage.

The system for storing oxygen cylinders was not safe as these were stored on the floor and may pose safety risks.

The food and fluid charts were not consistently completed to inform staff's practices and enabling them to support patients' dietary needs.

The service did not always follow fasting process prior to surgery in line with good practice guidelines.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- The service provided mandatory training in key skills to all staff. Nursing staff received and kept up-to-date with their mandatory training.
- Staff had training on how to recognise and report abuse, and they knew how to apply it. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service controlled infection risks well. Staff followed guidance used control measures to protect patients, and others from infection. They maintained equipment and the premises were visibly clean and used methods to identify clean equipment.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment and carried out daily safety checks of specialist equipment.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Surgery

- Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately.
- The service had policy and procedures in place to recognise and respond to Sepsis (severe blood infection) in line with national guidance which staff followed.
- Electronic records were easily accessible to staff and included multi- disciplinary records and blood results to ensure patients continued to receive safe and effective care.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- In surgery medical staff did not meet the trust's target for any of the mandatory training modules for which they were eligible, and this included safeguarding adults training.
- Nursing staff compliance with safeguarding training was below the target as set by the trust.
- In two of the wards, emergency equipment was not consistently checked to ensure they were safe to use and in line with guidance.
- The service did not always manage FP10 prescriptions safely and there was a lack of oversight on their usage.
- Patients food and fluid records were not fully completed and posed risks of patients not having their dietary needs met in a consistent way.
- Oxygen cylinders were not always stored safely as some were left on the floor.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance when providing care and audited at intervals.
- Patients undergoing elective surgery had a pre- assessment completed which was a process to identify patients' suitability for surgery.
- The service had access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health to provide them with appropriate care and support.
- Staff in the recovery followed their internal procedure and sought additional support to ensure patients were safe to be discharged to the wards.
- Staff supported patients to make informed decisions about their care and treatment. They followed guidance to gain their consent written and verbally.
- Patients who lacked who lacked or were suffering from mental ill health were effectively supported to make their decisions their care. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 1983 and the Mental Capacity Act 2005.

Surgery

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and provided support and development opportunities. All new staff received an induction tailored to their role before they started work.
- Staff of different disciplines worked together as a team to benefit patients. They supported each other to provide effective care.
- Services were available 24 hours a day, seven days a week to support timely patient scare. Arrangements were in place for out of hours services through their on-call service such as consultants, theatre staff and mental health services.

However:

- The service did not always manage patients' fasting process in line with practice guidelines.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff assessed patients emotional well- being and provided emotional support and made referrals when patients needed specialist help. This included appropriate referrals to other services as needed.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. Families were supported to remain with the patients during their treatment.
- The staff were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Patients could be referred to counsellors or psychology support if needed. Staff identified the need and accessed support for the patients.

Is the service responsive?

Good ➔

Our rating of responsive improved. We rated it as good because:

- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. Staff supported those unable to communicate their pain and used recognised tools to assess and treat pain.
- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- Patients could access the service when they needed it. Waiting times from referral to treatment and were mostly in line in line with national averages. Managers and staff worked together to make sure that they started discharge planning as early as possible.

Surgery

- The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff It was easy for people to give feedback and raise concerns about their care and treatment.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- Senior managers were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- Staff felt respected, supported and valued. Managers were focused on the needs of patients and promoted equality and diversity in daily work and provided opportunities for career development.
- The service had an open culture where patients, their families and staff could raise concerns without fear. Safety culture and staff morale had improved in theatres since our last inspection following the appointment of new managers.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.
- Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Senior managers and staff actively engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Outstanding practice

The surgical service hosted the Peritoneal Malignancy Unit which offered maximal tumour debulking and cytoreductions. This was one of three services in the country providing this service.

Staff completed a 20- week competency programme to care and support patients receiving care in the peritoneal malignancy ward to ensure they had the skills and competence to provide effective care.

The service was taking part in the PICO project for peritoneal malignancy patents. This was aimed to identify patients as potentially needing a PICO would have one placed prophylactically and they would be provided with information, and support in line with the pathway.

Areas for improvement

Action the provider should take to improve:

- The service should follow processes and procedures in line with the trust's medicines management policy.
- The provider should review staff's access to up to date policies and procedures.

Surgery

- The provider should act to meet the trust target of 90% for appraisals in all staff groups.
- The provider should act to improve the completion of patients' food and fluid records. and review their dietary care plans to meet the patients' needs safely.
- The provider should act and review the process for fasting pre- operatively in line with guidelines.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Our inspection team

Amanda Williams, Head of Hospitals South West, led the inspection.

The team included two inspection managers, 12 inspectors including specialist mental health and medicines inspectors, 15 specialist advisers, one executive reviewer, two assistant inspectors, one analyst and one inspection planner. Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.

This page is intentionally left blank

Councillor Roger Huxstep
Health and Adult Care Select Committee Chair
Hampshire County Council
By email

Dear Councillor Huxstep,

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

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select (Overview and Scrutiny) Committee (HASC)
Date of meeting:	14 September 2020
Report Title:	Work Programme
Report From:	Director of Transformation and Governance

Contact name: Members Services

Tel: 0370 779 0507 **Email:** members.services@hants.gov.uk

Purpose of Report

1. To consider the Committee's forthcoming work programme.

Recommendation

2. That Members consider and approve the work programme.

WORK PROGRAMME – HEALTH AND ADULT SOCIAL CARE SELECT OVERVIEW & SCRUTINY COMMITTEE

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	14 Sep 2020	22 Oct 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
Proposals to Vary Health Services in Hampshire - *to consider proposals from the NHS or providers of health services to vary health services provided to people living in the area of the Committee, and to subsequently monitor such variations. This includes those items determined to be a 'substantial' change in service.* **(SC) =** Agreed to be a substantial change by the HASC.									
Andover Hospital Minor Injuries Unit	Temporary variation of opening hours due to staff absence and vacancies.	Living Well Healthier Communities	Hampshire Hospitals NHS FT and West CCG	Last update Jan 2020, inc UTC developments (invite West CCG to joint present with HHFT). Next update due Sept 2020 – written only	**x**				
North and Mid Hampshire Clinical Services Review **(SC)**	Management of change and emerging pattern of services across sites.	Starting Well Living Well Ageing Well Healthier Communities	HHFT / West Hants CCG / North Hants CCG / NHS England	Monitoring proposals for future of hospital services in north and mid Hampshire since Jan 14. Status: last update Jan 2019. Retain on work prog for update if any changes proposed in future. Timing to be kept under review.	If any changes proposed, HASC to receive an update.				

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	14 Sep 2020	22 Oct 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
Spinal Surgery Service	Move of spinal surgery from PHT to UHS (from single clinician to team).	Living Well Ageing Well	PHT, UHS and Hampshire CCGs	Proposals considered July 2018. Determined not SC. Last Update March 2020 (UHS). Next update due Sept 2020 but deferred due to pandemic.		**x**			
Chase Community Hospital (Whitehill & Bordon Health and Wellbeing Hub Update)	Hampshire Hospitals NHS FT - Outpatient and X-ray services: Reprovision of services from alternative locations or by an alternative provider.	Living Well Ageing Well Healthier Communities	HHFT and Hampshire CCGs	Item considered at May 2018 meeting. Sept 2018 decision is substantial change, further update Nov 2018 meeting. Latest update March 2020. Further update timing tbc					
Mental Health Crisis Teams	Proposed changes to the Mental Health Crisis Teams.	Living Well Ageing Well Healthier Communities	Solent NHS and Southern Health for PSEH	Presented July 2019. Informed Nov 2019 of 9-12 month project delay. Update when work is resumed.		**x**			

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	14 Sep 2020	22 Oct 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
Integrated Primary Care Access Service	Providing extended access to GP services via GP offices and hubs.	Living Well Ageing Well Healthier Communities	Southern Hampshire Primary Care Alliance	Presented July 2019, last update January 2020. Requested update July 2020 -deferred due to pandemic. written only requested for Sept 2020.	**x**				
Beggarwood Surgery Closure	Alternate plan to closing, continuing to provide GP services with NHUC provider.	Living Well Ageing Well Healthier Communities	NH CCG NHUC	Presented September 2019, written update January 2020.					
Orthopaedic Trauma Modernization Pilot	Minor trauma still treated in Andover, Winchester and Basingstoke. An elective centre of excellence for large operations in Winchester.	Living Well Ageing Well Healthier Communities	HHFT	Presented September 2019, last update March 2020. Next update due Sept 2020 (written only)	**x**				

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	14 Sep 2020	22 Oct 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
Out of Area Beds and Divisional Bed Management System	Plan to tackle the Out Of Area (OOA) bed issue within the adult mental health services.	Living Well Ageing Well Healthier Communities	Southern Health NHS FT	Presented September 2019, update January 2020. Written update March 2020. Next update due Sept 2020.	**x**				
Modernising our Hospitals and Health Infrastructure Programme	To receive information about a new hospital being built as part of a long term, national rolling five-year programme of investment in health infrastructure.	Starting Well Living Well Ageing Well Healthier Communities Dying Well	HH FT and Hampshire CCGs	Presented July 2020 following informational briefings. Next update due Oct or Nov 2020		**x**	**x**		
Building Better Emergency Care Programme	To receive information on the PHT Emergency Department (ED) capital build.	Starting Well Living Well Ageing Well Healthier Communities	PHT and Hampshire CCGs	Presented in July 2020 following informational briefings. Next update due Nov 2020			**x**		

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	14 Sep 2020	22 Oct 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
Issues relating to the planning, provision and/or operation of health services – *to receive information on issues that may impact upon how health services are planned, provided or operated in the area of the Committee.*									
Care Quality Commission Inspections of NHS Trusts Serving the Population of Hampshire	To hear the final reports of the CQC, and any recommended actions for monitoring.	Starting Well Living Well Ageing Well Healthier Communities	Care Quality Commission	To await notification on inspection and contribute as necessary. PHT last reports received Nov 2019. New full report received Jan 2020, update March 2020. SHFT – latest update received Jan 2020, but new full report and update March 2020. HHFT last update heard in May 2019. New report and action plan expected in May 2020. Solent – latest full report received April 2019, written update on minor improvement areas	 **x**	 **x** **x**			

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	14 Sep 2020	22 Oct 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
				in November 2019. Frimley Health NHS FT inspection report published March 2019 and update provided July 2019. Further update March 2020. UHS FT inspected Spring 2019. Update provided July 2019. Further update March 2020.		**x** **x**			
Sustainability and Transformation Plans: One for Hampshire & IOW, Other for Frimley	Subject to ongoing scrutiny the strategic plans covering the Hampshire area.	Starting Well Living Well Ageing Well Healthier Communities	STPs	H&IOW initially considered Jan 17 and monitored July 17 and 18, Frimley March 17. System reform proposals Nov 2018. STP working group to undertake detailed scrutiny – updates to be considered through this. Last meeting in Dec 2019 and report to HASC April 2019.					

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	14 Sep 2020	22 Oct 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
				Last report alongside WG report in Oct 19. Final papers circulated Nov 2019 (minus Appendices D and I) Timing of next update tbc					
Pre-Decision Scrutiny – *to consider items due for decision by the relevant Executive Member, and scrutiny topics for further consideration on the work programme*									
Budget	To consider the revenue and capital programme budgets for the Adults' Health and Care department.	Starting Well Living Well Ageing Well Healthier Communities	HCC Adults' Health and Care (Adult Services and Public Health)	Considered annually in advance of Council in February (January) Transformation savings pre-scrutiny alternate years at Sept meeting. T21 at Sept 2019 and written response to concerns/queries.				x	
Integrated Intermediate Care	To consider the proposals relating to IIC prior to decision by the Executive Member.	Living Well Ageing Well	HCC AHC	Initial briefing on IIC Oct 2019, with pre-scrutiny of EM Decision due later (tbc)			**x**		

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	14 Sep 2020	22 Oct 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
Working Groups									
Sustainability and Transformation Partnership Working Group	To form a working group reviewing the STPs for Hampshire.	Starting Well Living Well Ageing Well Healthier Communities	STP leads All NHS organisations	Set up in 2017, met in 2018 and 2019. Report back to HASC Oct 19.	**Will meet as needed going forwards.**				
Update/Overview Items and Performance Monitoring									
Adult Safeguarding	Regular performance monitoring adult safeguarding in Hampshire.	Living Well Healthier Communities	Hampshire County Council Adult Services	For an annual update to come before the Committee. Last update Nov 2019. Timing 2020 best for Oct meeting. (from 2020 to combine with Hampshire Safeguarding Adults Board annual report, last received March 2020)		**x**			

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	14 Sep 2020	22 Oct 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
Public Health Updates	To undertake pre-decision scrutiny and policy review of areas relating to the Public Health portfolio.	Starting Well Living Well Ageing Well Healthier Communities	HCC Public Health	Substance misuse transformation update heard May 2018. 0-19 Nursing Procurement pre scrutiny Jan 2019. Hampshire Suicide audit and prevention strategy provided July 2019.					
Health and Wellbeing Board	To scrutinise the work of the Board.	Starting Well Living Well Ageing Well Healthier Communities	HCC AHC	Joint Health and Wellbeing Strategy refresh agreed by Board March 2019. Update on Strategy received in May 2019. Business plan update expected, timing tbc.			**x**		

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	14 Sep 2020	22 Oct 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
Public Health Covid-19 Overview and Impact on Health and Wellbeing and Outbreak Control Plans	To receive an overview on the three different aspects in relation to COVID-19.	Starting Well Living Well Ageing Well Healthier Communities Dying Well	HCC Public Health	First received July 2020. Updates to be received at each meeting until further notice	x	x			
Adults' Health and Care Response and Recovery	To receive an overview of the systems that have been put in place by Hampshire organizations, partners and voluntary sector.	Starting Well Living Well Ageing Well Healthier Communities	HCC AHC, Borough and District Councils, Hampshire Council for Voluntary Service Network, and voluntary sector	First received July 2020. Updates to be received at each meeting until further notice	x	x			

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	14 Sep 2020	22 Oct 2020	10 Nov 2020	11 Jan 2021	1 Mar 2021
Hampshire and Isle of Wight Covid-19 NHS System Approach Overview	To receive a report setting out the Hampshire and Isle of Wight Local Resilience Forum response	Starting Well Living Well Ageing Well Healthier Communities Dying Well	Hampshire and Isle of Wight Integrated Care System Southampton City, West Hampshire and Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups	First received July 2020. Updates to be received at each meeting until further notice	x	x			
Care Home Support Offer and Update	To receive an overview of the care home and care sector position and an update on the Care Home Support Plan.	Living Well Ageing Well Healthier Communities Dying Well	HCC Adults' Health and Care	First received July 2020. Updates to be received at each meeting until further notice	x				

*** Work program to be prioritized and updated accordingly to note items that can be written updates only.**

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	No
People in Hampshire live safe, healthy and independent lives:	Yes
People in Hampshire enjoy a rich and diverse environment:	No
People in Hampshire enjoy being part of strong, inclusive communities:	No

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. Equality Duty

The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. Equalities Impact Assessment:

This is a forward plan of topics under consideration by the Committee, therefore this section is not applicable to this report. The Committee will request appropriate impact assessments to be undertaken should this be relevant for any topic that the Committee is reviewing.