COVID - 19

Leicester, Leicestershire and Rutland NHS Response

Report to Leicester, Leicestershire and Rutland Joint Health Overview and Scrutiny Committee

1. Introduction

1.1 The initial phase of the NHS response to COVID - 19 commenced on 30th January with the declaration of a Level 4 National Incident. Following the World Health Organisation's declaration of a global pandemic on 12 March, on 17th March, the NHS initiated what has been described by NHS England and Improvement as the fastest and most far reaching repurposing of NHS services, staffing and capacity in its 72-year history.

1.2 This response has been unprecedented and necessary to deal with is one of the biggest international challenges faced in a generation. In Leicester, Leicestershire and Rutland (LLR) the total number of confirmed cases stood at 2,451 as at 24th June. Sadly 772 LLR residents have lost their lives, either in LLR hospitals or elsewhere.

1.3 The need to adapt and respond to the COVID - 19 epidemic has permeated all aspects of NHS services. As this paper highlights, to control the spread of the virus and protect patients, we have had to temporarily redesign how some services are accessed and provided or, in some cases, pause services in the interests of protecting patients and staff, to focus on the anticipated demand to support COVID – 19 cases.

1.4 Overall, the NHS in LLR has coped well under intense pressure as we went through the peak period during April. All patients who needed intensive treatment and support received the care they needed.

1.5 We need to learn lessons, with partners, on from is that the NHS has coped well in response to COVID – 19. In partnership with other agencies in LLR through the joint response arrangements established to manage the incident, the NHS has coped well, notwithstanding the tragic loss of life.

1.6 The hard work and commitment of NHS staff and key workers in other agencies has been instrumental and should also be acknowledged. They have worked through the most challenging of periods with such high levels of dedication, professionalism and commitment to look after the people of Leicester, Leicestershire and Rutland.

1.7 We should also acknowledge the role of the public in the positive response to social distancing guidance which has also helped to protect the NHS.

1.8 This paper describes the NHS response to COVID - 19 in LLR. It provides details of the arrangements for managing the incident, the actions taken and the priorities going forward as we enter the recovery phase.

2. Initial Phase

Planning arrangements

2.1 NHS organisations began preparations for managing COVID - 19 in January 2020, setting up a Health Economy Tactical Coordination group (HETCG) to coordinate the health response in LLR.

2.2 On 24th March, the COVID–19 outbreak was declared a Level 4 national emergency and in response a Major Incident was declared locally. NHS arrangements were integrated within the LLR Local Resilience Forum (LRF) governance and incident management structure under the strategic leadership of Leicestershire Police.

2.3 Within the LLR NHS the Health Economy Strategic Control Group (HESCG) has overall responsibility for the multi-agency management of the incident and to establish the policy and strategic framework within which lower tier command and coordinating groups work. Representatives on the HESCG are senior leaders within the NHS and other organisations including Local Authorities. It is chaired by the Chief Executive of the three LLR CCGs and the CEOs of other NHS organisations are also members.

2.4 The Health Economy Tactical Co-ordination Group (HETCG) is responsible for:

- Coordinating the preparation for, response to, and recovery from any outbreak of COVID - 19;
- Implementing the direction and guidance received from the HESCG, LLR CCGs, NHS England and Improvement Incident Management Centre; and
- Ensuring close partnership working with multi-agency partners through the LRF Tactical Coordination Group and the HESCG.

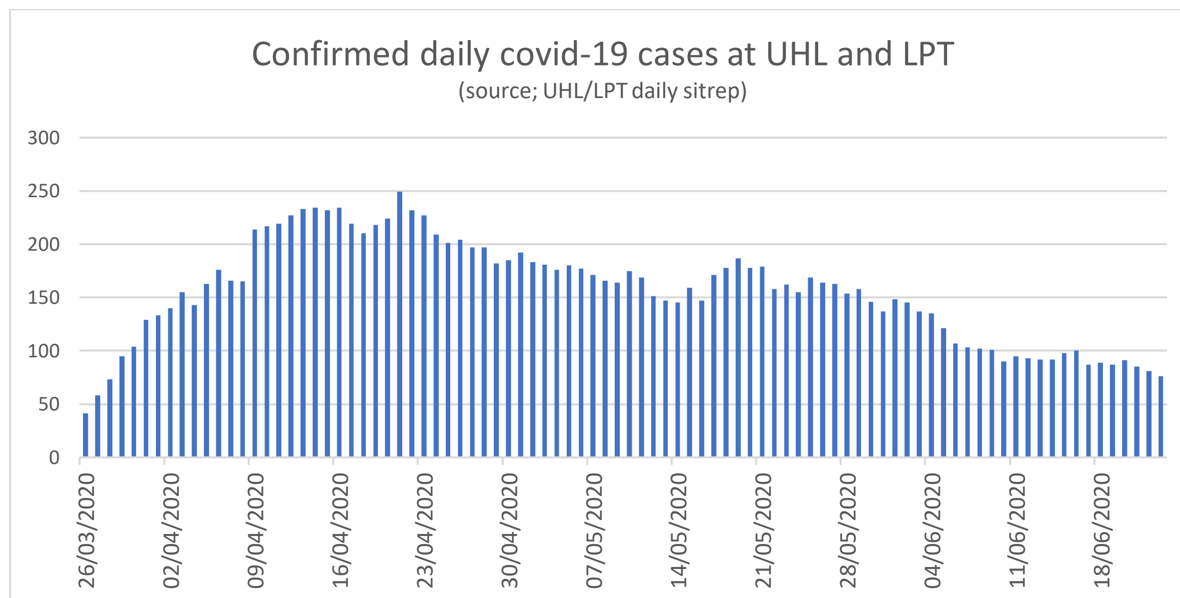
2.5 Supporting the HETCG are 13 tactical cells, each leading the operational response for an organisation or function/activity perspective. The governance structure is at Appendix 1

2.6 Daily situation reports (Sitreps) and tactical cell updates/escalations are discussed at HETCG conference calls. This ensures visibility across the NHS and social care system and ensures any cross - organisational responses can be actioned. The Daily Sitrep covers:

- Capacity at University Hospitals Leicester and Leicestershire Partnership NHS Trust
- ITU/HDU and other bed capacity
- Mortuary capacity
- workforce absences/impact and resilience/wellbeing
- PPE availability/supplies
- Primary care capacity/service levels
- Deaths, suspected and confirmed cases of Covid
- Care home and community resilience and well-being

The latest daily Sitrep up to 24 June is given at **Appendix 2**

2.7 The table below shows the number of confirmed daily cases in UHL and LPT. As can be seen the number of daily cases peaked from 9th April to 26th April when was regularly between 200 and 250 patients.



2.8 The actions we took as a system and the efforts of colleagues directly providing care ensured we maintained capacity and were not overwhelmed.

<u>Actions taken by the local NHS partnership</u>

2.9 Action taken by NHS organisations in the initial phase focussed on increasing capacity to prioritise care for COVID -19 patients and ensure guidance on infection prevention and control was strictly followed. This involved redesigning some services to ensure they could be delivered safely, protecting patients and staff through reductions in face to face contacts and consultations - including stepping up the use of technology, and suspending some elective services.

2.10 It should also be noted that despite these changes the NHS remained open to patients with non-COVID related emergencies or urgent care needs because of the measures being taken to separate COVID and non – COVID patients. For example, using online or telephone consultations (see examples below).

2.11 Specific examples of the actions taken include:

- Increasing critical care capacity in UHL. Critical care beds increased from 50 to 150, with the potential to create around 300 beds.

- Temporary changes to LRI's Adult's and Children's Emergency Departments at UHL. Now split into two separate areas: Blue department - for patients without symptoms of COVID - 19 and The Red Department - for patients with symptoms of COVID – 19.

- All non-urgent elective activity paused at UHL. When clinical necessary and appropriate some non - face to face appointments were held.

- Health and social care working jointly to implement effective arrangements to ensure clinically fit patients can be safely discharged from hospital settings.

- In Leicestershire Partnership NHS Trust action was taken to increase community hospital in-patient capacity by up to 70% for step down patients and end of life care, including the phased introduction of 75 Independent sector beds and up to an extra 72 beds on additional LPT wards. Overall community beds could increase from 222 to around 350. More temporary changes are being undertaken in community inpatient facilities to establish additional capacity to meet any further COVID-19 related surge and create Covid secure wards

- Temporary changes to mental health services including: a new Mental Health Urgent Care Hub to assess urgent mental health patients to reduce demand at the emergency department at LRI; a Mental Health Central Access Point providing a24hour 7 day phone support for the public, including those who have not used mental health services before; and a new community based mental health rehabilitation offer to support people with longer term mental health illness outside of an inpatient setting

- Introduction of remote triage in GP practices (via telephone or online) and option of video or online consultations. This has enabled practices to continue to meet the needs of their patients and provide non-COVID - 19 related care, whilst reducing the risk of infection by minimising face to face contact. Currently all patients are remotely triaged and offered either telephone or video consultations and 65% are offered an online consultation.

- Around 800 patients with heart failure or the lung condition COPD have benefitted from the use of telehealth by Leicestershire Partnership NHS Trust, enabling them to remotely monitor their condition and connect to a team of specialist nurses for a video consultation.

- Video/virtual outpatient appointments at UHL piloting video consultations in areas as broad as haematology, dermatology and general surgery. The Trust also set up a virtual Diabetes clinic experience to enable video consultations and care and support to continue. In May, over 900 online consultations were held.

- Reducing the number of sites providing urgent care to minimise the movement of patients and consolidate clinical staff. All out of hours face to face consultations delivered from Loughborough Urgent Care centre and the creation of 'hot hubs' at Loughborough Urgent Care Centre, Oadby and New Parks health centre to see COVID - 19 symptomatic patients: and

- The restriction of visiting arrangements which we fully acknowledge was deeply upsetting for relatives and friends unable to visit their loved ones. Alternative

arrangements were put in place for example the use of iPad to allow video calls to relatives on wards, and messaging/card services.

3. System Recovery

Ongoing incident management

3.1 At the time of writing the UK Government has just declared that the COVID - 19 Alert level has been reduced from level 4 to level 3. NHS England and Improvement has, however, determined that the NHS remains at level 4 for the purpose of ongoing management of the response.

3.2 We are retaining our arrangements for incident management, ensuring the NHS is in a strong position to respond to changes in the prevalence of COVID - 19 and the impact on NHS services. The joint working, particularly between health and social care, has supported more holistic approaches to decision – making, enabling rapid action to be taken to resolve problems, and in many cases creative solutions to long-standing challenges.

3.3 We need to continue to be fully aware of the potential impact of the measures to ease lockdown and will be working closely with local authority colleagues as they develop outbreak plans. Close working with public health colleagues is essential to understand the prevalence of Covid -19 and the potential for ‘local hotspots.

3.4. This will include surge exercises to test the system ability to manage different scenarios over the coming months; this will need to consider the likely phased approach to social distancing and any potential peaks in COVID - 19 cases going forward together with normal surge planning events such as winter flu and bad weather.

3.5 Underpinning everything as we go forward will be infection, prevention and control (IPC); NHS England and improvement have made explicit the aim that no patient or staff member should catch COVID - 19 NHS healthcare facilities.

3.6 Like the general population, the NHS will be operating in a world with Covid -19 for the foreseeable future.

3.7 For patients there are now requirements when attending hospital sites to wear face coverings. Visiting restrictions remain in place, but we will review them. NHS Trusts fully acknowledge the difficulties and distress this has caused but we need to continue to protect patients and the public.

3.8 All sites are undertaking risk assessments and audits to ensure they meet the rigorous standards for infection control and social distancing.

3.9 Some of the changes introduced to support our response to Covid – 19 will remain in place where necessary to protect patients and staff.

Infection prevention and control (IPC)

3.10 NHS organisations must ensure the consistent application of Public Health England PHE/NHS IPC guidance. This includes separating/’cohorting’ COVID

and non COVID patients. Any services restored will have to be assessed against the new guidance to ensure a safe restart.

3.11 The safety of patients and staff is paramount, and this may lead to some difficult decisions being made about services in the short term. For example, the recent decision to temporarily suspend inpatient facilities at Fielding Palmer Hospital following a review of infection, prevention and control was taken to protect patients and staff.

PPE

3.12 In LLR NHS we faced some challenges with the availability of PPE as was the case nationally. At times stocks of items ran low and it took some time before the supply process worked effectively.

3.13 Mutual aid within the NHS in LLR and with neighbouring Trusts in other areas resolved the situation when necessary but was clearly not sustainable. Once the national supply chain was working effectively, including a central portal for ordering, the situation has largely been resolved but maintaining vigilance on stocks and supplies is essential going forward. We continue to monitor stocks through the daily sitreps.

Care homes

3.14 The joint working arrangements between health and social care has ensured robust support is available to care homes.

3.15 During the earlier stages of the outbreak it should be acknowledge that there were some significant challenges facing care homes: discharge of patients without a negative COVID test, the availability of appropriate isolation facilities for caring for COVID - 19 infected patients, clinical support, shortages of PPE and resilience of staff and impact of staff sickness on capacity all impacted on care homes.

3.16 To support care homes, health and social care have now established processes for the safe discharge of patients to care homes and support arrangements to ensure resilience in homes in response to staff shortages, for example. Training on Infection Prevention and Control and clinical leads to support care homes are also now in place.

3.17 The joint working between health and social care to support care homes will continue as will ongoing monitoring of care home resilience.

Testing and tracing

3.18 The test and tracing service ensures that people who develop symptoms of (COVID-19) can be tested to find out if they have the virus, and also includes targeted asymptomatic testing of NHS and social care staff and care home residents.

3.19 It also helps trace close recent contacts of anyone who tests positive and, if necessary, notifies them that they must self-isolate at home to help stop the spread of the virus.

3.20 Tests are carried out at the testing centre set up at Birstall Park and Ride and through Mobile Testing Units (MTUs), visiting various sites around Leicester, Leicestershire and Rutland. There have been visits to 9 mobile testing sites across LLR and further sites are being identified. UHL staff can also have the test at UHL.

3.21 The Birstall site has carried out 28,946 tests from 30th April to 21st June, whilst the MTUs have carried out 8,775 tests during the same period. From the 27th April to 21st June 1,728 staff have been tested for suspected COVID-19.

3.22 Whether symptomatic or not, all non - elective patients are given the test at the point of admission and elective patients are tested within 72 hours of being admitted.

3.23 We are at the beginning of the antibody testing programme to determine if someone has had COVID-19. The prioritisation and rollout plan for antibody testing is in line with national guidance and is currently available for NHS staff in UHL and LPT and primary care. There is an allocation of 1000 tests per day to cover these groups of staff and almost 12,248 UHL and LPT staff had been tested for antibodies to 21st June. On average 433 tests are carried out

3.24 We are working on extending antibody testing to the wider LRF partnership, including whole care home testing and considering options for home swabbing for surgery patients isolating for 14 days prior to surgery.

3.25 It should be noted that having an antibody test will only inform a person they have had COVID-19 and does not change the advice to self – isolate if they are in close contact with someone who has tested positive for COVID-19. There is currently no guarantee that having contracted COVID-19 a person is immune from future infection with COVID-19.

Service recovery and restoration

3.26 As stated above, our focus in the initial response was the need to deal with COVID - 19 related patients, and the action we took, including the cancellation of non-elective treatments and procedures, reflects this.

3.27 Within the next phase we will be seeking a ‘safe re-start’ of services stood down or reduced during the initial phase. We have a comprehensive picture and understanding of the impact on services and where waiting lists have a significant backlog.

3.28 Our **aim** is that no patients or staff will catch COVID - 19 in our hospitals and both patients and staff must have confidence in the local NHS. The following are six key areas of action and priorities:

3.29 Meeting patient needs

- Covid treatment capacity: maintaining critical care infrastructure (workforce, estates, supply, medicines) that enables readiness for future covid demand, and managing the separation of COVID and non-COVID patients.

- Re-starting non-covid urgent care, cancer, screening, and immunisations, identifying the highest risk services that have had the most impact in terms of population health. This includes recovering service waiting lists and delayed referrals.

- Services have been prioritised including cancer, maternity, cardiovascular disease, heart attacks and strokes, mental health. **Appendix 3** shows the impact of COVID - 19 at UHL on the level of activity in A&E, outpatient attendances, emergency admissions and referrals by GPs for April to mid - June this year compared with last year. We are working as a system to understand the impact of the fall in activity and addressing the backlog. **Appendix 3e** shows the percentage and number of people waiting at various intervals in weeks. There has clearly been an increase in the number and length of time people are waiting and the system is building a complete picture of the impact of this as an anticipated increase in GP referrals takes place.

- Addressing new priorities: the impact of COVID - 19 on public health including identifying additional needs due to the pandemic and considering health inequalities. This specifically includes responding to the clear evidence to have emerged on the disproportionate impact of COVID - 19 on the BAME community. We also anticipate increased demand for mental health services and support due to the economic consequences of COVID -19 such as increased unemployment for example.

- Staff capacity and wellbeing: including capitalising on new ways of working, considering staffing ratios and moving the current expanded workforce to a sustainable footing.

- Working jointly with LRF partners through the Health and Wellbeing Board (HWB) local resources for staff have been developed. The national resources (wellbeing apps) and support for resilience and counselling.

- We must also ensure we work closely with our BAME colleagues within the NHS workforce to ensure we understand their concerns and respond to them. BAME colleagues must have the reassurance and confidence to feel safe carrying out their work. A programme of risk assessments and listening exercises has been undertaken and through the HWB specific resources have been developed for BAME staff.

3.30 Re-set to a new NHS

- We need to retain acute, primary and community service innovations in future models of care. We are cataloguing the service delivery and clinical pathway changes that have worked to assess these in terms of retaining to share and develop further. This is to support the creation of a ‘new norm’ in the NHS. (Please see below for more on service changes). In response to COVID -19 we have innovated and delivered significant change in a short timescale. Many of these changes, where they demonstrate benefits to patients and are clinically and financially viable should be retained.

- We need consider the impact of services in the light of the long term and strategy for health services in LLR. A clinically led set of service expectations to support and underpin the future development of services have been agreed. We will be engaging on staff, public and other stakeholders to seek views and feedback on these.

4. Review of LLR wide service changes

4.1 As stated above, some service changes have been made in response to COVID -19. We have established a baseline of the service changes and are now reviewing each change to determine whether the service should now be returned to its previous state, continued for a further temporary period, or if steps should now be taken to 'lock in' the benefits of these changes by making them permanent.

4.2 Using an NHSE Impact Assessment Tool (IAT) services are being categorised as 'restore' or 'recover'. The IAT, assesses each change for patient safety, clinical effectiveness, and patient outcomes. Where there are no clearly identifiable benefits the change is not viable, and the service will be restored to its pre-COVID position.

4.3 If the IAT identifies benefits and the service change is viable for consideration as a permanent change a further review is required to ensure it aligns with the long-term plan for health services in LLR.

4.4 The IAT process includes the need to engage with stakeholders, specifically OSCs, Healthwatch and the Care Quality Commission and will follow the NHS *Planning, assuring and delivering service change process.* We will also ensure we engage with local people and consult on service changes where applicable.

5. Public and patient engagement and communication

5.1 We will continue to support public health messaging on social distancing, symptom awareness and hygiene. We are working closely with our partners in the LRF agencies to work jointly on public information. We are also ensuring the public is aware of changes to services and how to access them.

5.2 Public confidence in the safety of services is essential. There is national and local concern that some people did not use NHS services because of concerns about safety as well as not wishing to burden a hard-pressed NHS. To encourage patients, we will publicise and make patients aware of the measures being taken to protect them when they use NHS services as well as ensure they know the NHS is open to meet their needs. Patients will also be made aware of the actions they need to take including the new arrangements for wearing face coverings.

5.3 We will continue to issue a regular stakeholder bulletin to highlight developments related to COVID - 19. We are also working closely with community radio stations to target specific communities including BAME audiences. This includes providing messages in different languages. We will also continue to work through

our network of voluntary and community organisations and our Citizen's Panel to communicate and ask for feedback on people's experiences of services.

5.4 We have carried out, with Healthwatch, an online survey of people's experience of primary care and community services. Over 1400 people responded. We are currently analysing these results and will publish them shortly. The insight gained will help us carrying out the service reviews referred to above.

5.5. We would like to acknowledge the positive response of the public to keeping the NHS safe. Social distancing messages have been adhered to, but we fully understand that for many people, particularly those shielding, this has been incredibly difficult.

5.6 The #ClapforCarers has been fantastic and welcomed by the NHS. The show of support from the public has been motivating and heart-warming.

Conclusion

Covid – 19 has been unprecedented. It has had a profound and distressing impact on many in our community. It has also deeply impacted those providing care and support to people who have been ill with the virus. It is important we acknowledge that.

Notwithstanding this the NHS in LLR coped well, in partnership with social care and other agencies. Whilst incredibly challenging at times, the NHS was not overwhelmed.

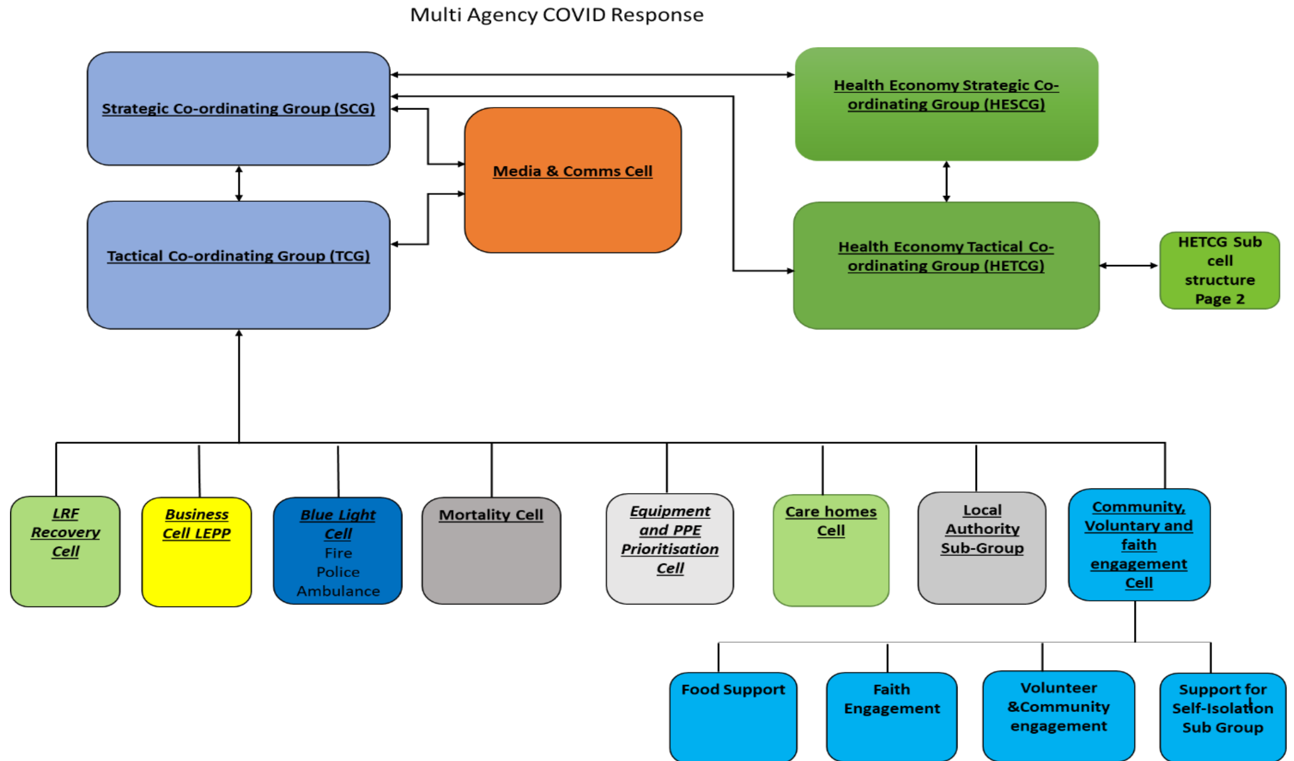
The dedication and commitment of everyone in NHS and our partners should also be acknowledged.

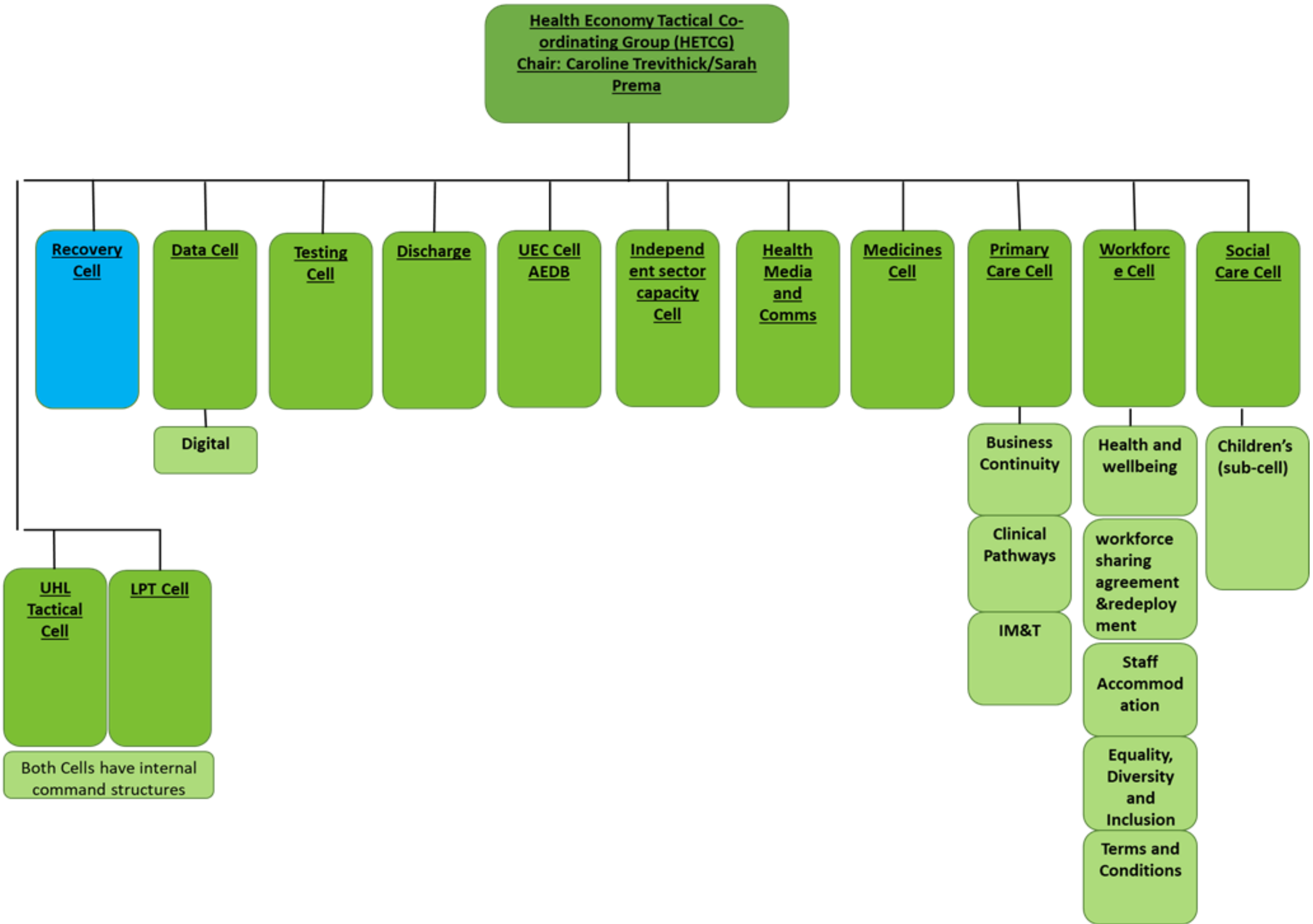
Through effective joint planning and governance, decisions, many of which have led to innovative solutions to longstanding challenges, were taken quickly. It is essential we keep what has worked well where there are demonstrable benefits and improvements to previous service models.

It is also essential that whilst there is currently no vaccine or treatment in place COVID – 19 remains with us so we must continue to be vigilante to the ongoing threat it poses. The response to the outbreak provides us with the infrastructure to do this.

Incident Management Structure

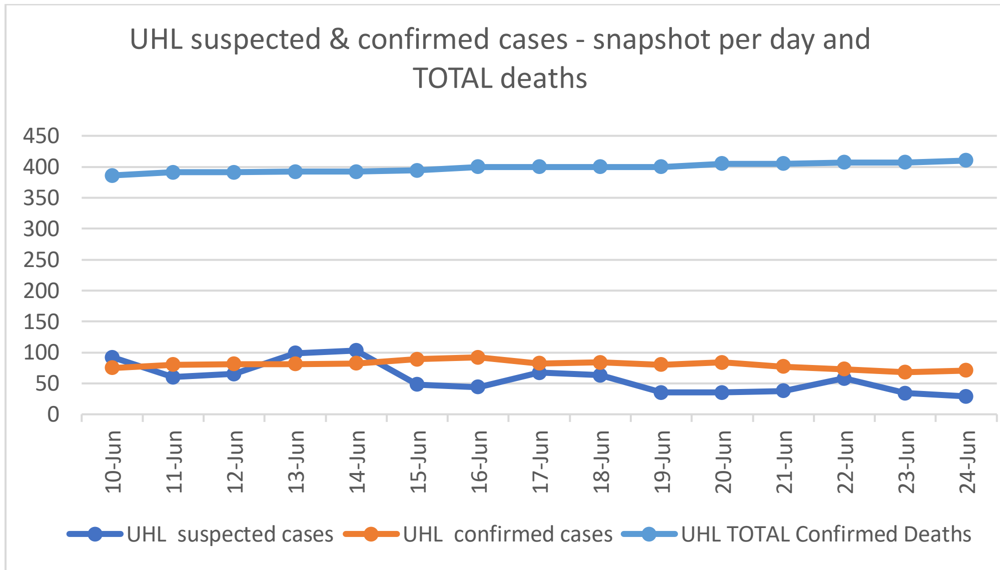
Appendix 1

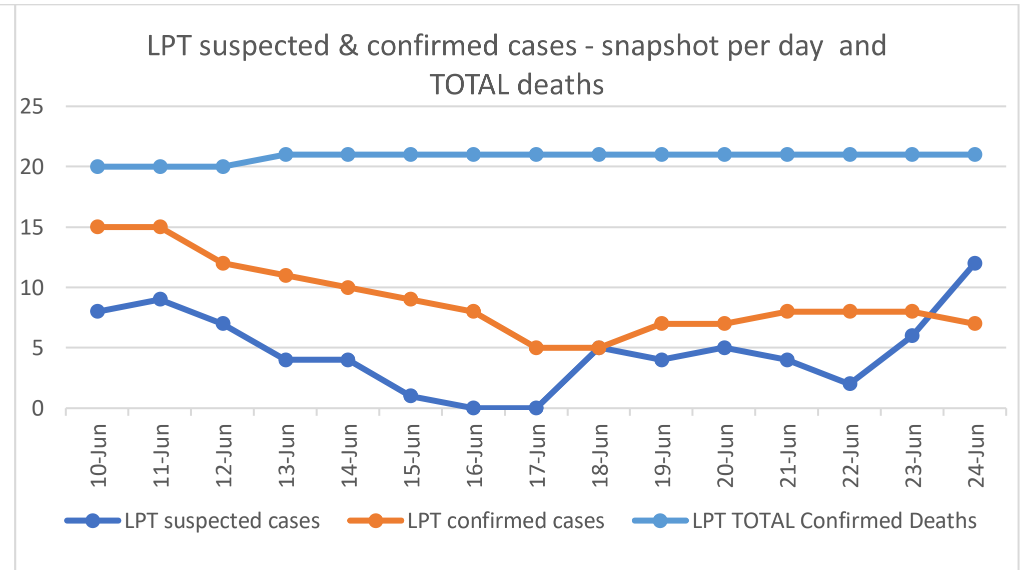



Health Economy Tactical Co-ordinating Group (HETCG) Chair: Caroline Trevithick/Sarah Prema
Recovery Cell
Data Cell
Digital
Testing Cell
Discharge
UEC Cell AEDB
Independent sector capacity Cell
Health Media and Comms
Medicines Cell
Primary Care Cell
Business Continuity
Clinical Pathways
IM&T
Workforce Cell
Health and wellbeing
workforce sharing agreement &redeployment
Staff Accommodation
Equality, Diversity and Inclusion
Terms and Conditions
Social Care Cell
Children's (sub-cell)
UHL Tactical Cell
LPT Cell
Both Cells have internal command structures

Excerpts from Daily Sitrep (up to 22nd June)

Appendix 2a





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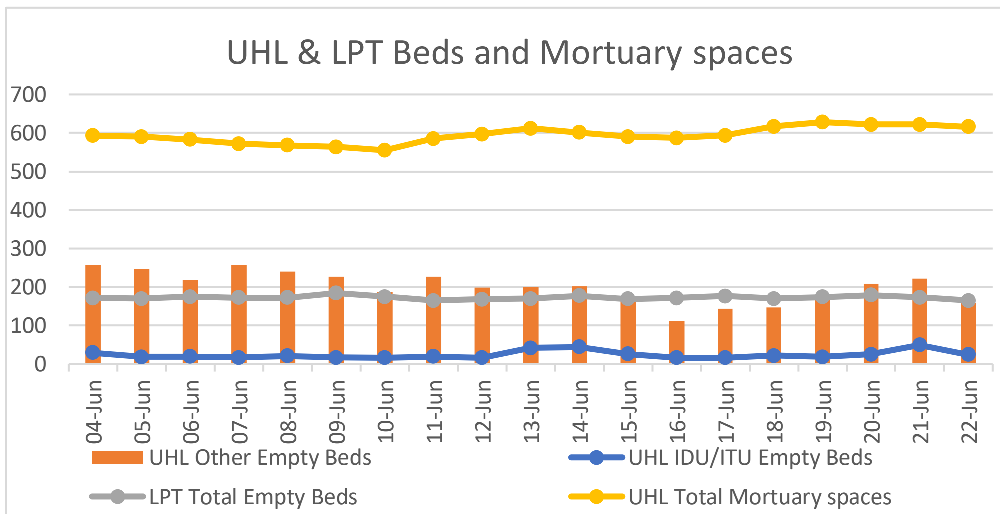
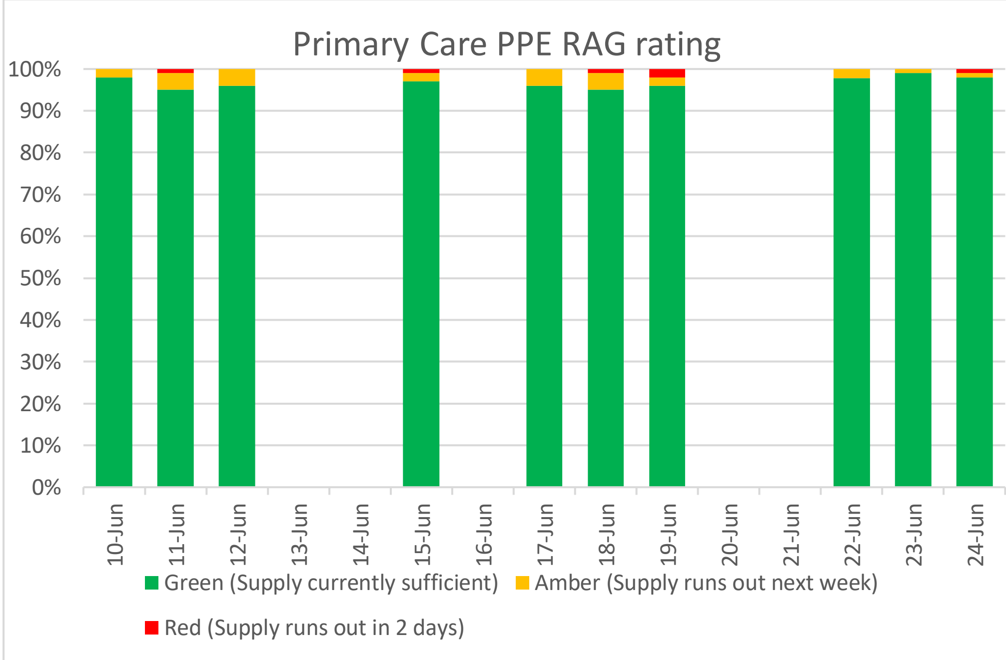
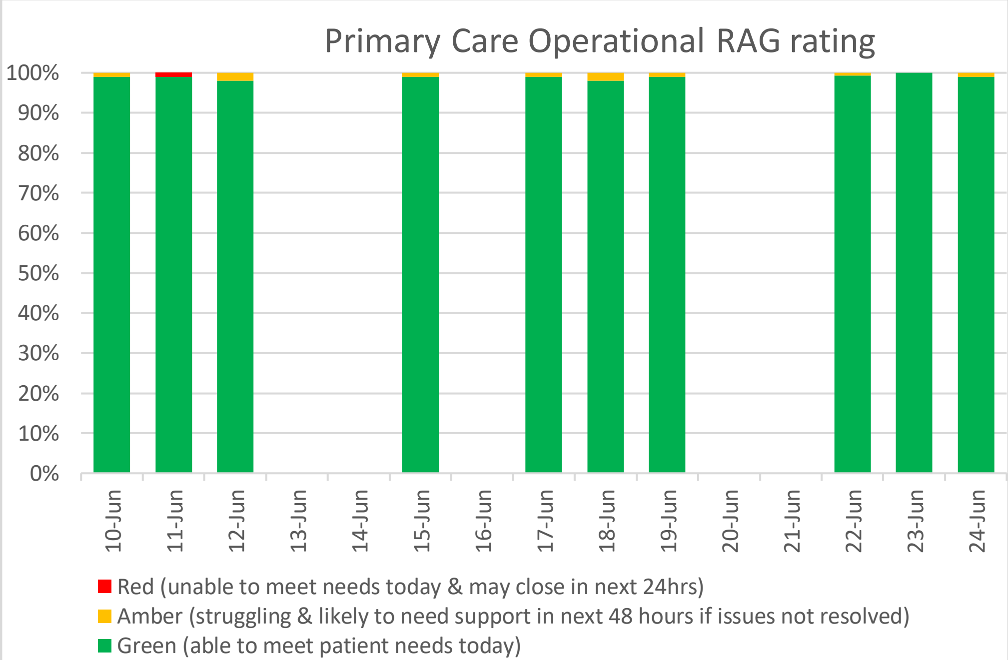


Excerpts from daily Sitrep

Appendix 2





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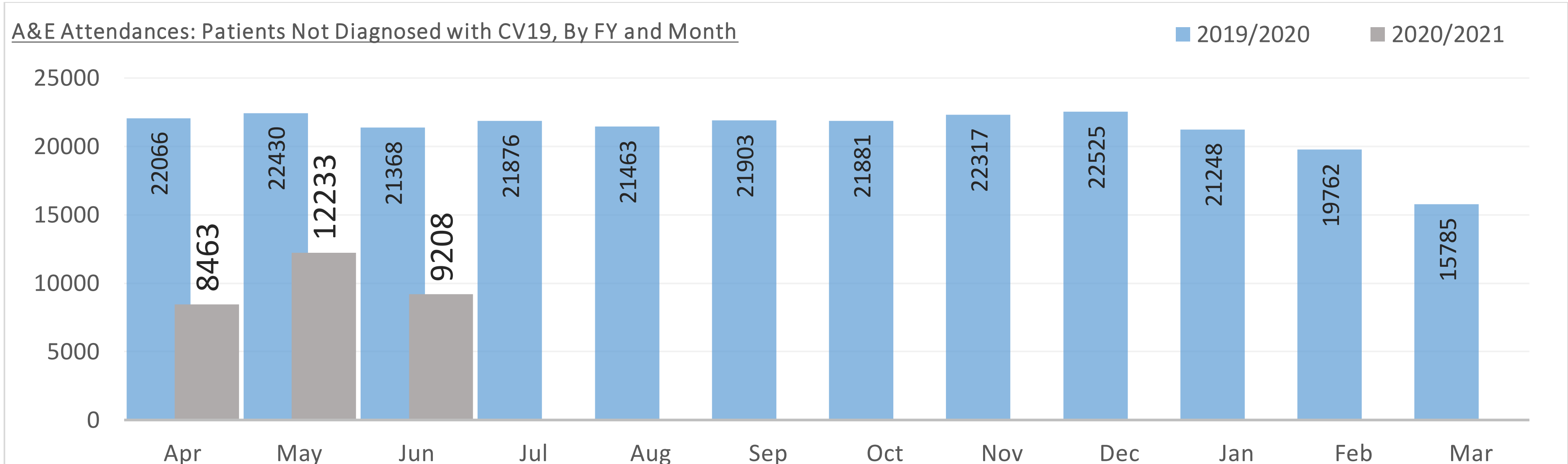
Impact of COVID-19 on UHL activity

Appendix 3



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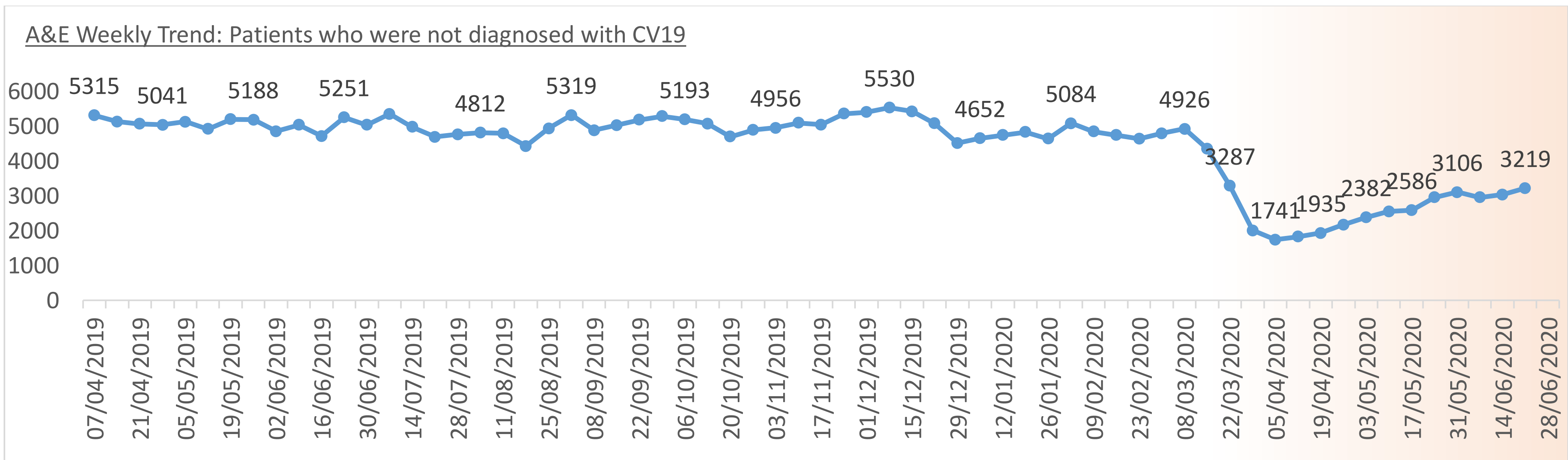

Appendix 3

GP Referrals: By FY and Month

2019/2020
2020/2021

18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0

15,271
4,824
15,632
6,520
15,141
5,785
16,991
15,005
15,556
16,893
14,420
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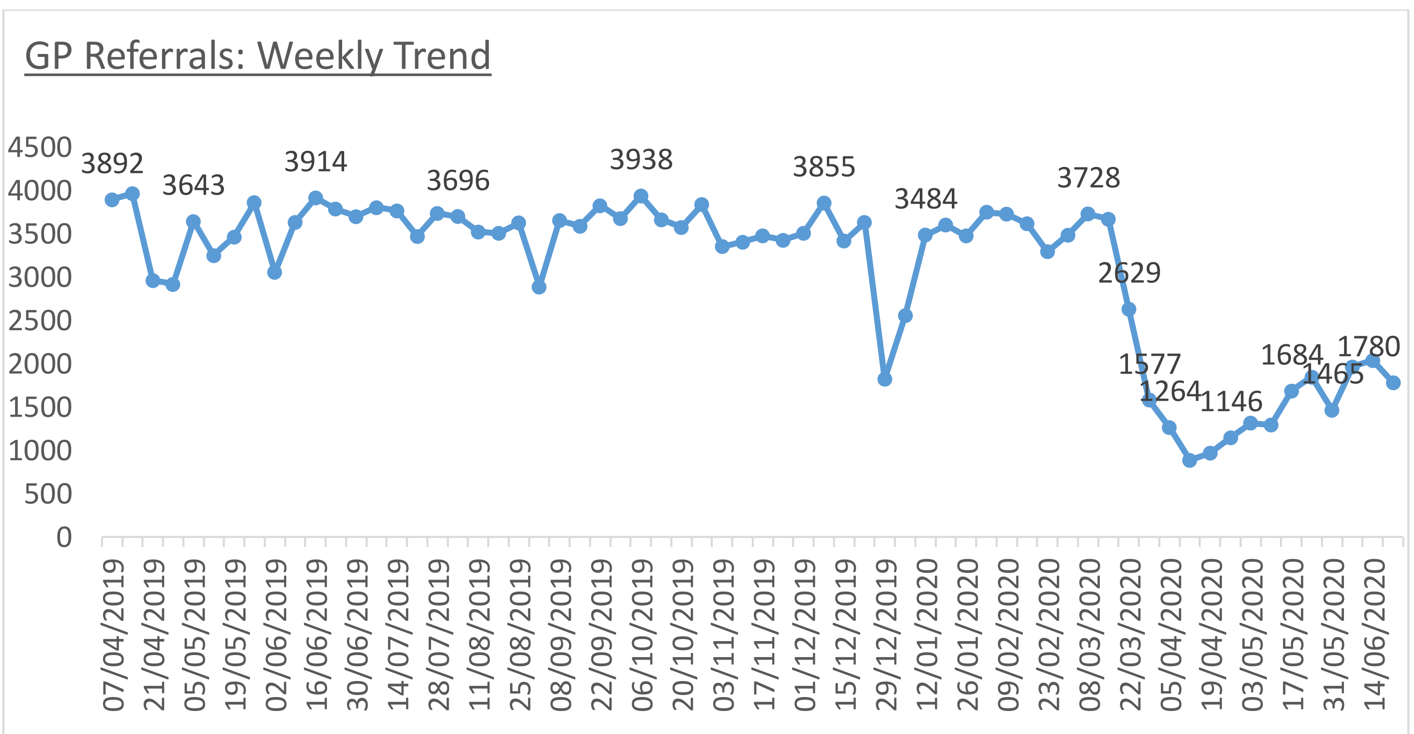

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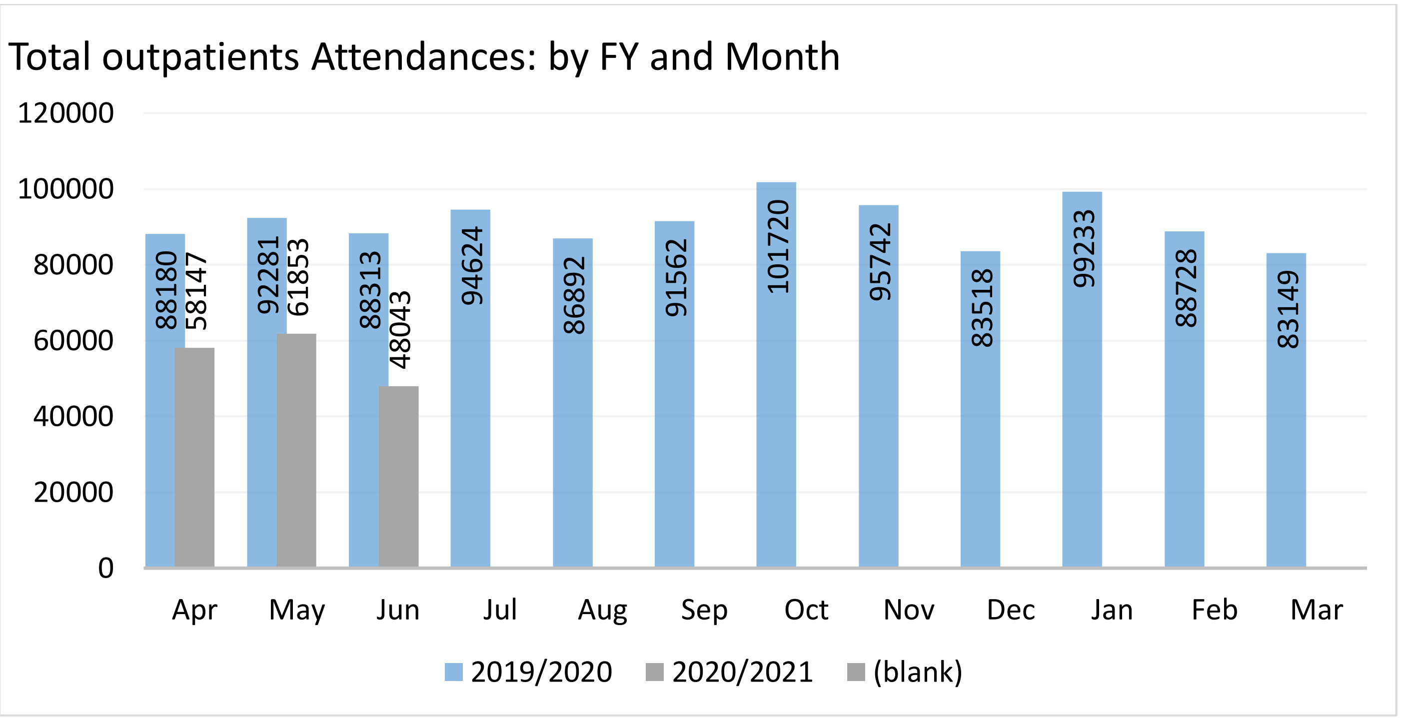
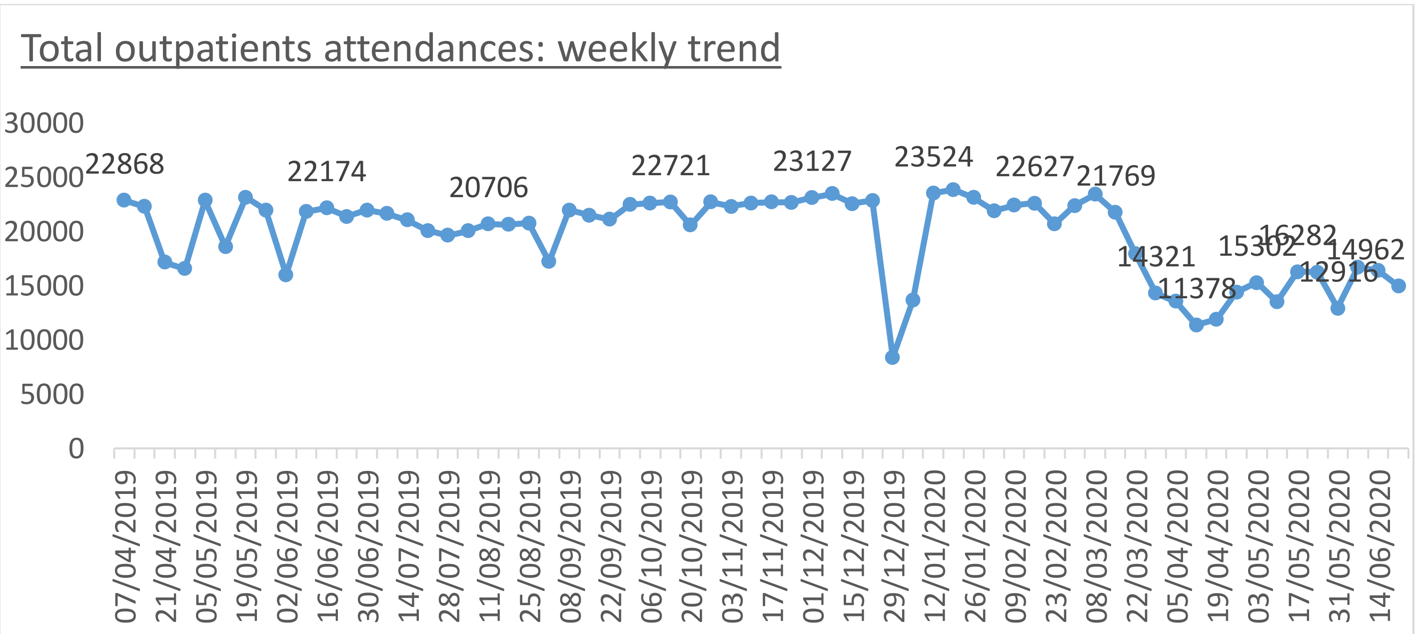
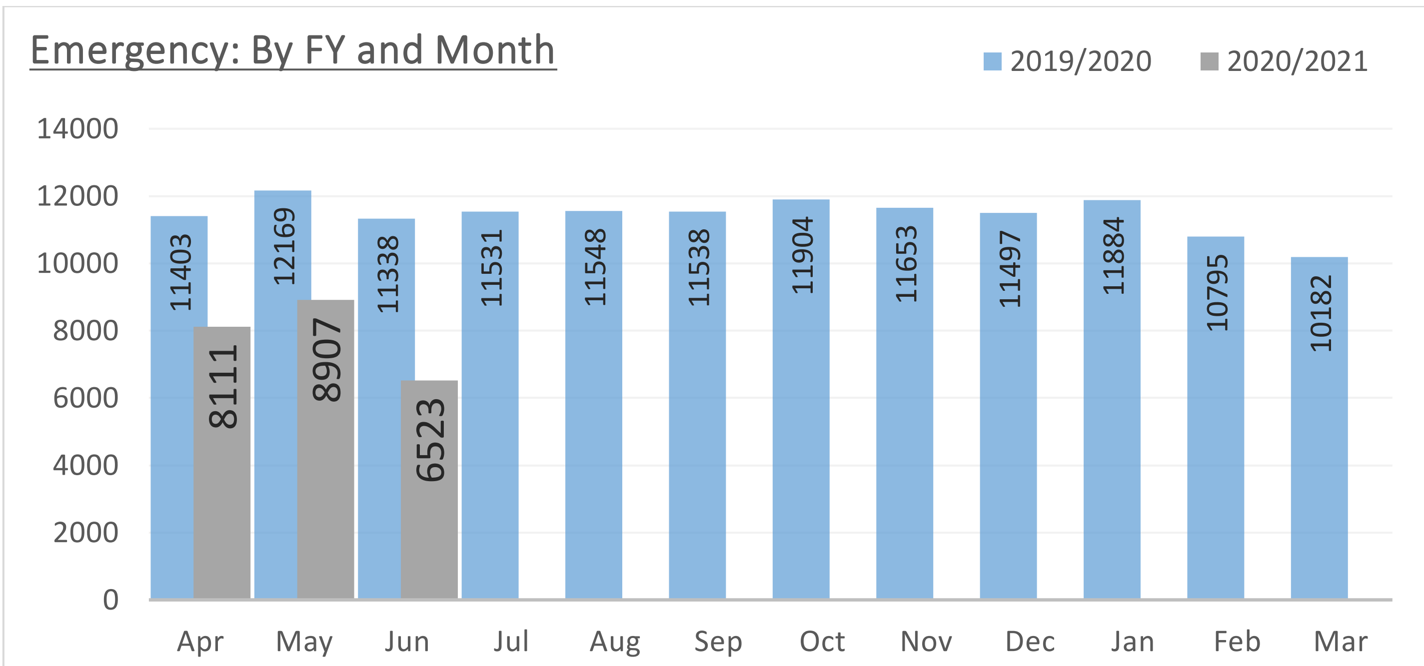
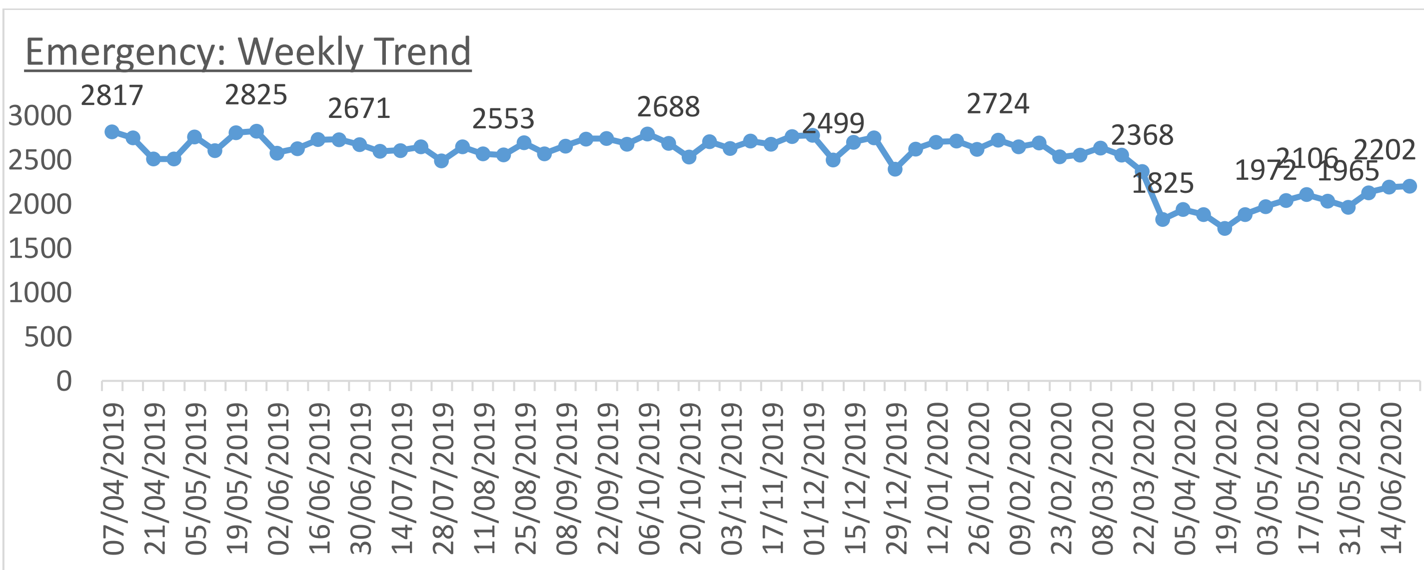




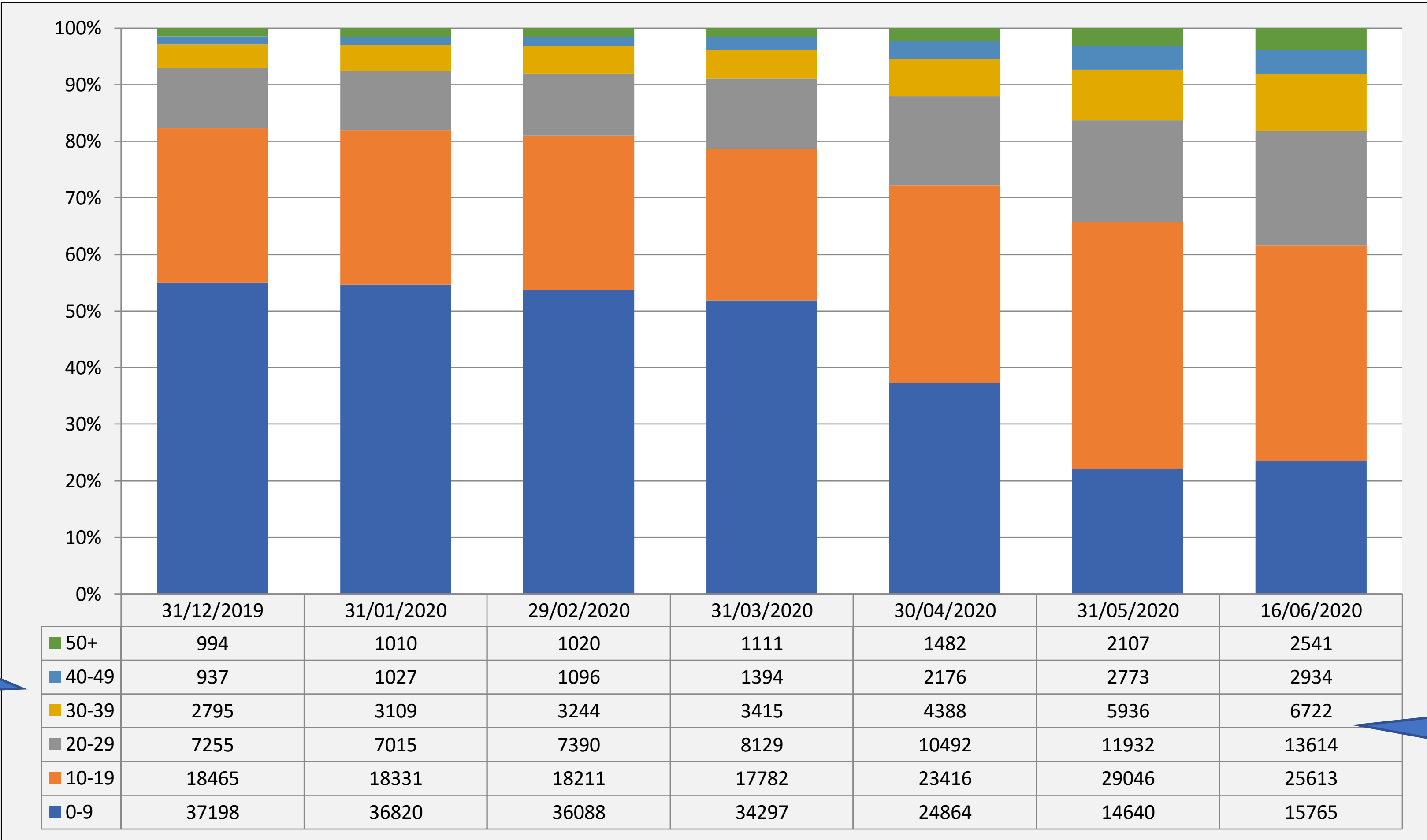
Appendix 3d





COVID – 19: IMPACT ON WAITING

Percentage/number of people waiting at weekly intervals



	31/12/2019	31/01/2020	29/02/2020	31/03/2020	30/04/2020	31/05/2020	16/06/2020
50+	994	1010	1020	1111	1482	2107	2541
40-49	937	1027	1096	1394	2176	2773	2934
30-39	2795	3109	3244	3415	4388	5936	6722
20-29	7255	7015	7390	8129	10492	11932	13614
10-19	18465	18331	18211	17782	23416	29046	25613
0-9	37198	36820	36088	34297	24864	14640	15765

Waiting time intervals (wks)

Number of people

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