Leicestershire County Council

LECESTERSHIRE, LEICESTER AND RUTLAND HEALTH OVERVIEW AND SCRUTINY COMMITTEE – FRIDAY 3 JULY 2020

QUESTIONS SUBMITTED UNDER STANDING ORDER 34

The following questions are to be put to the Chairman of the Health Overview and Scrutiny Committee.

1. Question by Mrs Jean Burbridge

Did out breaks of Covid-19 occur in Care Homes in LLR to which patients with Covid had been discharged from UHL?

Reply by the Chairman:

The three Councils across LLR have worked closely with UHL and LPT to implement Government Guidance to ensure the safe and timely discharge of patients from hospital. Where appropriate, this has included ensuring that patients recovering from Covid can be discharged on a long or short term basis to care homes. Since March 2020 around a third of care homes in LLR have had a Covid outbreak although a lessor number in Rutland. This means that it is inevitable that some homes with outbreaks also admitted people discharged from hospital. Some of these infections are likely to be linked to these discharged patients, but others will have been as a result of community infection, often through asymptomatic care staff which has been shown through national and international research to be significant. In this respect Leicester, Leicestershire and Rutland is no different to other parts of the region and lower than the all England average

The number of new infections in care homes has declined significantly, and the number of new outbreaks has been very low in the last 2 weeks.

2. Question by Mrs Jean Burbridge:

From what date were patients tested for the Coronavirus before being discharged from Hospitals to Care Homes?

Reply by the Chairman:

I have received the following answer to the question from University Hospitals of Leicester NHS Trust:

> "National COVID-19 hospital discharge service requirements were first published on 19th March – these set out the actions to be taken

immediately to enhance discharge arrangements. There was no mandate to test patients being discharged to care homes.

At this time most patients were discharged to care homes with no test unless;

- they had been symptomatic, as the directive at this time was to test only symptomatic patients;
- the receiving care home refused to take the patient without a test result.

The "Admission and Care of Residents during COVID-19 Incident in Care Home" guidelines were published on the 2nd April highlighting the need for care homes to isolate patients – this included no details regarding additional testing prior to discharge.

The UHL approach to the guidance was to share with care homes our view that, 'Hospitals are a high risk environment and there is a case for considering isolation in a care home on admission from secondary care. Trusted Assessors and Discharge Co-ordinators will be able to support care homes with the most up to date information on the individual patients and relevant guidance.' In other words our advice to care homes was to be cautious and isolate patients discharged from hospital.

The "Coronavirus (COVID-19): Adult Social Care Action Plan" was published on the 15th April and for the first time the need to test patients prior to discharge to a care home was recommended. With the Government stating *"we can now confirm we will move to institute a policy of testing all residents prior to admission to care homes. This will begin with all those being discharged from hospital"*

The guidance was very clear stating that '*where a test result is still awaited, the patient will be discharged and pending the result, isolated in the same way as a COVID-positive patient will be'*

Thus from the 15th April – all care home discharges have been tested. The test is requested up to 48 hours prior to discharge, as per the guidance, and we continue to advise all care homes to isolate patients for 14 days from the date of the test."

3. **Question by Mrs Jean Burbridge:**

How many physical real extra beds in community hospitals or community buildings were prepared by Leicester Partnership Trust?: A paper presented by LPT to City Council states that 222 could be expanded to 350. LPT made a video showing the preparations of 36 extra beds at the end of April for Loughborough Hospital. Were these beds used? Which other hospitals had the extra beds? What will happen to these beds?

Reply by the Chairman:

I have sought information from Leicestershire Partnership NHS Trust (LPT) on the question and received the following response from LPT:

> "In April 2020, the Trust approved a plan to increase community bed capacity in order to accommodate an expected surge in the number of patients requiring in-patient rehabilitation as a consequence of catching Covid-19.
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> The plan to expand our beds included the conversion of 75 Independent Sector (private hospital) beds into rehabilitation beds. From mid April 2020 onwards, 33 of the 75 beds were converted and 6 were in use at any one time. These beds are no longer being used for rehabilitation purposes and have reverted back to their original use.
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> In our community hospitals, three wards (53 beds) were refurbished and made ready to accommodate rehabilitation patients. Two of the wards are located at Loughborough community hospital (Charnwood and Gracedieu ward) and one at Coalville community hospital (ward 4). During April, the Trust opened the wards at Loughborough community hospital to ensure additional capacity was available to respond to an expected surge of patients over the Easter period. The expected surge did not materialise and the wards were not required to accommodate any patients. On 1 May 2020 a decision was made to stand the wards down.
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> The refurbished wards in our community hospitals will enable the Trust to respond to any future wave of the virus, in addition to any bed pressures that the winter months may bring."

4. Question by Mrs Jean Burbridge

I am concerned that a massive reduction in hospital outpatient appointments is forecast in "Covid 19 Restoration and Recovery " (UHL Board meeting paper) and that the projected number of 'virtual' (phone/video) outpatient appointments is too high (70%). It looks as though the local NHS has already made a decision about Digital First implementation without consulting the public. The survey referred to with response from 1400 people was a set of questions on people's experiences during the pandemic and being ONLINE by its very medium will contain bias. Can the UHL Trust assure us that proper formal consultation will take place on these matters and that it will seek evidence that the proposals will not break Equality principles?

Reply by the Chairman:

University Hospitals of Leicester NHS Trust have provided me with the following assurance:

"The Chief Medical Officer for England has highlighted that we are likely to be living with COVID-19 and its implications for the foreseeable future. The safety of our population and patients is paramount and we are adapting all models of service provision, to ensure that our patients only need to travel to hospital for care they cannot safely receive elsewhere. Outpatients are no different, and the use of virtual technology allows us to maintain the vital services we offer to our patients, in a safe and timely manner. We are aware that virtual appointments will not be the appropriate option for all patients and therefore technology will be used in combination with appointments in our community hospitals, GP practices & traditional UHL sites. The approach to virtual technology will be flexible, meeting the needs of our patients, whilst maintaining their safety. All UHL & LLR transformation programmes are undertaken in collaboration with patient representatives and engagement/consultation will be a key pillar of the changes we make.

The NHS Long Term Plan (Released in January 2019), required all NHS providers to deliver 33% of the outpatient activity virtually and follow ups to only take place when clinically necessary. More recently to reduce the risk of infection and support the safe switch on of services NHSE/I have issued guidance stating that,

> "As far as practicable, video or telephone appointments should be offered by default for all outpatient activity without a procedure…"

It should be recognised that for years we have received feedback from patients regarding their frustration with regularly attending our hospitals for 15 minute appointments only to be told they are well and to return in six months. Roughly 30% of all new outpatient activity involves patients traveling to an acute hospital site to receive no ongoing treatment, following the initial appointment. COVID-19 has therefore shown that the original aim of 33% reduction in face to face consultations is at the lower end of what is possible and so we have chosen a stretching target of 70%. Of course there cannot be a one size fits all approach, not least because there are some services where 'face to face and hands on' is essential for diagnostic reasons; equally there are patients who are unable or unwilling to access care virtually BUT the idea that we will continue to ask hundreds of thousands of patients to travel into hospital in a COVID endemic world is counter intuitive when other options exist.

Finally and importantly a digital approach to outpatient activity allows the NHS to contribute to the ambitious national climate change and air quality targets, given that circa 5% of traffic on England's roads is NHS related."

The Committee ensures that it is consulted by NHS partners on all major transformation programmes and it is intended that the local response to the NHS Long Term Plan will be on the agenda for a Committee meeting later in the year.

5. Question by Mr Robert Ball

How in practice will UHL manage to 'juggle' between handling ordinary treatments and handling more Covid-19 patients if there is a resurgence of the Coronavirus?

Reply by the Chairman:

University Hospitals of Leicester NHS Trust has stated the following:

> "The Paper on Restoration and Recovery (part of the agenda pack for this 3 July 2020 meeting and the monthly updates in public at the UHL Trust Board https://www.leicestershospitals.nhs.uk/aboutus/our-structure-and-people/board-of-directors/board-meeting-dates/), cover this off in some detail. The summary is that we have managed to turn back on the majority of our services, (whilst still anticipating a second peak). However, it is important to recognise that although services are being restored it is not back to 'business as usual'. For example, a typically efficient theatre list pre-Covid might have seen our surgeons carry put 10 procedures in a session. Now, with the added infection risk posed by COVID, surgeons are working in full PPE, which is changed between patients; the theatre is deep cleaned between each patient and the air is completely exchanged. This means that in the 'new normal' we can only treat half the numbers of patients on a list."

The Committee will discuss this issue further as part of agenda item 7 at this meeting: Covid-19 Leicester, Leicestershire and Rutland NHS Response, and also at future Committee meetings.

6. Question by Mr Robert Ball

How many non-urgent operations were cancelled by UHL to stop hospitals being overwhelmed and provide space to treat Covid-19 patients? Also, assuming no resurgence of the Coronavirus, how long will it take to clear the backlog in operations, in months and years?

Reply by the Chairman:

University Hospitals of Leicester NHS Trust have provided the following information:

> "We postponed almost all of our non-urgent surgery in anticipation of the first peak of the pandemic and given the size of the Trust and the numbers of patients we routinely see, that amounts to some 13,000 patients who did not have their procedures. The numbers who were actually 'cancelled' is much smaller (700) but this is only because we generally book patients a few weeks in advance meaning that only a relative few had dates for their operations at the time we took down lists. There were two drivers for this; the first (and lesser) of the two was to create sufficient surge capacity in our bed base. The second (and more

> important) was to create sufficient surge capacity for patients requiring Intensive Care and other types of ventilation. This meant that we converted operating theatres into ICUs and diverted theatre staff to support the large number of ventilated patients we were caring for. With theatres and staff 'repurposed', non-urgent activity could not take place. (Though of course we continued urgent and emergency activity throughout).
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> As the briefing paper in the agenda pack for this 3 July 2020 meeting explains, we are now restoring / recovering services and aim to be at 75% capacity by early July. However, as the example above explains, being at 75% capacity does not equate to being able to run services at their previous levels of efficiency. All of which means that waiting times for non-urgent operations will be much longer than people have been used to. In terms of how long it will take to 'recover' to previous levels, for which we would mean waiting lists back to 'normal'… that is still a work in progress and also depends on what levels of new referrals we receive but a conservative estimate would be 12 months."

The Committee keeps a close eye on waiting times for operations and will monitor performance going forward in particular the impact of the Covid-19 cancellations.