Agenda Item 8

Leicestershire Partnership NHS Trust

University Hospitals of Leicester NHS Trust

Caring at its best

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

LEICESTERSHIRE, LEICESTER AND RUTLAND HEALTH OVERVIEW AND SCRUTINY COMMITTEE – 23 SEPTEMBER 2020

UPDATE ON COVID - 19

LEICESTER, LEICESTERSHIRE AND RUTLAND NHS RESPONSE

Introduction

1. Members will be aware that a detailed joint update from the three CCGs, University Hospitals Leicester NHS Trust (UHL) and Leicestershire Partnership NHS Trust (LPT) was provided to the Committee at its 3 July 2020 meeting.

2. The report described the extensive actions taken in the local NHS to ensure we were prepared to respond to the anticipated pressures including pausing or adapting some services and taking action to increase capacity within the local NHS.

3. The paper also set out details of action being taken to recover and restore non-COVID services.

4. Part 1 of this paper provides members with an update on specific topics as requested by them. These are: PPE, winter pressures, Student Nurse 2017 intake and Cancer performance and Part 2, details of the Phase 3 response, announced on 31 July 2020.

Part 1

Cancer metrics (Appendix 1)

5. The Covid-19 pandemic meant that UHL resources that would usually be used for cancer diagnostics and treatment were required to respond to the challenges presented by coronavirus. The priority for UHL was to keep patients safe, balancing the risk of covid-19 against the urgency of investigations and surgery. The reduction in capacity required many tumour sites to amend their

pathways following national, regional and/or specialist society protocols and guidelines when available. In some cases this facilitated and/or expedited service transformation already proposed or planned. To ensure governance and Trust oversight, all changes were reviewed at a cancer governance cell that met weekly. In addition, as specified by national guidance, all patients awaiting treatment were categorised with regards to the urgency of proposed treatment and the allocation of surgical resources was made based on this categorisation.

6. For some patients, demographic or underlying health status meant that the risks of treatment outweighed the potential benefit of diagnostic or treatment procedures for cancer. Other patients chose to avoid attendance at hospital. The latter was responded to by the use of virtual consultations which became the preferred method of communication with all patients and between staff whenever possible. The capacity and demand issue was partly mitigated by the fact that, in the community, patients were not presenting with symptoms to their GP and 2-week-wait referrals decreased. As per national guidance, patients fulfilling the criteria for 2-week-wait referral for potential cancer were referred by the GP even if they were unsuitable to progress through the pathway due to the implications of Covid-19 but were safety netted within UHL.

7. During peak-COVID, there were delays to treatment and diagnostics and we ensured that every patient had a contact so we could keep in touch and support patients when they needed it. We have also implemented a robust harm review process which will ensure that every patient who was delayed as a result of COVID (where National guidance was not followed), and for every patient treated over 62 days, an MDT harm review (physical harm) is completed.

8. UHL capitalised on changes that were required as a result of COVID which were made at a faster pace than we have seen previously; as such we have seen a faster recovery of cancer performance and in most areas we are ranked well against our peers and nationally. We have more to do to improve performance against the 31 day surgery target which has been slow to recover due to surgery capacity which has decreased due to PPE and down-time required between cases; and also to recover screening (bowel and breast) as the programmes were halted nationally during the pandemic and re-started in August.

9. Referrals are now back at pre-pandemic numbers and the backlog of patients (those waiting over 62 days) is also at pre-pandemic levels and continuing to fall.

PPE

10. National monitoring of PPE supplies has indicated there are no significant concerns with availability. As a result, following discussions with Local Resilience Forums (LRF), local authority representatives and procurement teams regarding emergency PPE supplies the Department of Health and Social Care (DHSC) will be terminating the current emergency supply channel of PPE to LRFs via the Ministry of Housing, Communities and Local Government (MHCLG) by 12th September.

11. To facilitate this transition the PPE portal (that supported small domiciliary and residential CQC registered providers with free PPE to support the Covid response) has been extended to support a wider cross section of the health and social care system and further work is being undertaken to widen its remit. (more details below on the PPE Portal) .

12. The LRF for Leicester, Leicestershire and Rutland made the decision that it wanted to retain responsibility for the administration of free emergency PPE and has put into place new arrangements to ensure that services not supported by the PPE portal, will continue to have access to essential items. Information has been circulated across the three local authority areas and is now live.

13. Work is now in train to ascertain the level of stock required to ensure the on-going supply via the Department of Health and Social Care (DHSC).

14. The stock is currently being held at a central location and the picking and onward distribution/collection of any orders is being facilitated. There is also a ring-fenced supply being held to support any response to a second wave or local spike in infection that may warrant additional PPE provision.

15. We have no concerns regarding current stock levels, but these are continuously monitored and reported to the LRF PPE Group. The system was established when the MHCLG required weekly Delta returns and will be maintained going forward to mitigate any risk.

PPE Portal

16. The DHSC has partnered with eBay, Clipper Logistics and Royal Mail to develop this service, with orders managed in line with Public Health England (PHE) guidance and wider availability from the NHS Supply Chain's central PPE logistic operations. It went live to this widened cohort on 1st September 2020.

17. The PPE portal is an emergency top-up system and the expectation is that services will continue to use their business-as-usual and wholesaler routes to access PPE and should only use the PPE portal for additional PPE if needed.

18. The PPE Portal can be used by the following services. Each category of service has a weekly order limit:

    - GPs
    - residential social care providers
    - domiciliary social care providers
    - pharmacies
    - dentists
    - orthodontists
    - optometrists
    - children's care homes and secure homes
    - children's residential special schools

19. Turnaround of orders is within a 48 to 72 hours depending on when orders are received. All PPE ordered from the portal is free of charge.

LRF Buffer Stock

20. We have received additional PPE which we have 'ring-fenced' as a buffer stock, to provide resilience in the case of a local spike or a temporary disruption to one of our usual supply routes. Arrangements are in place to replenish the buffer stock quickly if necessary.

LRF PPE Supply

21. The current supply route via the Ministry of Housing, Communities and Local Government (MHCLG) into LRFs will end by the 12th September and will be replaced by a similar arrangement managed by the DHSC. However, this LRF stock can only be allocated to service providers not eligible for the Portal (see above) and to provide the full Covid-19 PPE requirement, above business as usual (BUA) use. This second point is a change to current provision and will need further work with LRF partners to implement.

22. In support of this change the DHSC has asked LRFs to provide detailed modelling, demand/forecast information and logistics - drop-off/delivery points and storage capacity and this is being progressed through the LRF PPE Group.

23. The following is a list of eligible service providers:

    - Local authorities (including children and adult social care workers);
    - Mental health community care;
    - Personal assistants;
    - Domestic violence refuges;
    - Rough sleeping services;
    - All education (and childcare) services – including special schools.

24. There is a recognition however, that the range of services that have been using the current emergency stock will not have access to the PPE Portal. The DHSC seems comfortable for the LRF and LAs to make a judgement but have asked that such services should:

    - provide a health and social care service;
    - have a clinical need for the PPE;
    - use PPE in line with clinical guidance.

25. The PPE supplied via this route will be provided free of charge by DHSC until 31 March 2021.

Local Authority PPE and PPE support

26. Each local authority has arrangements in place to support its own services and the wider health and social care market. The arrangements that each authority

has or has had in place vary, but reflects the difficulty that has been faced in finding PPE that is safe and meets the required quality standards. Price has also been a significant issue across all provision.

27. The introduction of new guidance and its interpretation has also been a challenge, but has also led to significant collaborative/partnership working.

28. A good example concerns aerosol generating procedures (AGPs) where local authorities, procurement teams, trading standards, CCGs, NHS Commissioning and the Fire Service came together to support a FFP3 Fit testing programme (using LRF stock) for staff undertaking these procedures for adults and children. These staff and personal assistants work in nursing and care homes, in the community supporting people/children on personal health budgets and in special schools. Further work is now underway to establish a sustainable model going forward.

Winter Planning

29. Health and social care organisations plan for seasonal pressures on an annual basis, particularly focussing on the period between November - March, when seasonal illness predictably leads to an increase in presentations to health care, attendances at Emergency Departments and admissions to hospital as well as having an impact on the workforce as a result of increased sickness levels. This year, winter planning is being impacted by our escalated response to COVID-19.

30. Winter planning for 2020/21 brings with it added complexities, due to:

- the likelihood of further outbreaks of COVID-19
- an expected increase in non-elective activity pressures due to seasonal illness
- reduced capacity as a result of cohorting patients and staff, and enhanced infection prevention and control requirements
- the need to restore elective activity and deal with a growing back log of routine and planned care

31. Winter planning is being overseen by the LLR Urgent and Emergency Care (UEC) Cell, which is part of the Health Economy Tactical Command arrangements for the COVID incident. The Cell has absorbed some of the functions of the former Accident and Emergency Delivery Board, and includes senior representatives from all health and social care organisations in LLR.

32. The winter plan for 2020/2021 is an integral part of the Health Economy's Phase 3 response to COVID, setting out how we will respond to winter pressures while also managing the restoration of services and dealing with the ongoing presence of COVID infections within the community and health and social care services.

33. Key risks for winter are:

- Increasing attendances at ED, causing overcrowding, capacity issues and poor flow;
- Ambulance handover delays as a result of the high levels of activity or lack of beds to admit patients from ED, resulting in slow ambulance response times and unseen patient risk in the community;
- Pressures on emergency medicine beds and slow flow, causing outliers, elective and cancer cancellations and patients waiting for beds in ED, with the associated performance and safety impact that creates;
- Staffing gaps compromising patient care.

34. Plans for winter pressures are being developed in conjunction with plans for the next phase of the COVID pandemic, and form part of a single plan for how the LLR system will manage the restoration of routine activity alongside the management of winter pressures and the additional pressures arising from COVID.

35. We have developed a LLR surveillance group which monitors a range of metrics in real time including COVID infection rates and both COVID and non-COVID related activity levels, in order to establish the level of pressure that the system is under and assess the likelihood that increases in COVID activity will put pressure on the system's ability to maintain levels of care. The alert level recommended by this group informs actions across the system and is updated weekly, or more often if intelligence indicates that COVID levels are rising rapidly in any part of the LLR system.

36. We will maintain existing, effective methods of managing the urgent care system and responding to different levels of pressure on a day to day basis. This includes daily system calls to review the escalation level in both individual organisations and the system and to agree any actions to de-escalate from higher levels of response and to provide cross system support to maintain effective flow. The UEC cell maintains senior oversight of system actions to respond to pressures and maintain performance and patient safety, meeting weekly.

37. The system surge and resilience plan has been refreshed for winter, to reflect additional triggers related to COVID outbreaks and to incorporate additional surge capacity and actions to maximise system capacity and resilience that have been developed by system partners. This reflects the learning from the first phase of the pandemic about additional COVID related actions as well as having a stronger focus on actions in the wider system to maintain flow.

38. The draft winter plan includes a number of initiatives to increase capacity and manage demand effectively to mitigate the risks above. They include:

- Increasing capacity for urgent telephone and face to face contacts to restore the range of service locations previously in place before COVID. During the emergency response to COVID in March and April, a number of sites were temporarily closed in response to the dramatic reduction in face to face activity. In addition, access arrangements were made in sites

offering walk in access to put in place triage and COVID screening (including calls to NHS 111) before patients were seen face to face. This is to ensure that we are identifying and keeping separate those patients with suspected or confirmed COVID, to protect other people from risk.

- It is proposed to continue to deliver separate 'hot' clinics for patients who have either confirmed or suspected COVID and need to be seen urgently, in addition to the existing urgent care sites across LLR. The model of delivery is currently being reviewed and may change from the current two sites in LLR (Loughborough Urgent Care Centre and New Parks Clinic) to a more dispersed model over the autumn and as we go into winter.

- Strengthening the service delivered through NHS 111 to make sure that patients are seen in the right place at the right time, aiming to reduce unnecessary attendance and crowding in emergency departments and other site. A separate report on this has been provided to JHOSC.

- More support for care homes and East Midlands Ambulance Service crews responding to patients in care homes, with on call specialist consultant advice to agree the right approach to care and to keep patients in their place of residence wherever possible.

- Investment to increase capacity in the Home First service, to recruit more community nurses, therapists and social care staff. This will support us in speedier discharge of patients, meeting new discharge guidance requirements, and avoiding admissions where patients can be kept at home with increased support through a crisis.

- Increasing bed capacity in University Hospitals of Leicester to care for the expected numbers of additional admissions over winter. An additional 75 winter beds are planned.

- Availability of 36 'surge' beds in Leicestershire Partnership Trust which could be opened in case of a significant second COVID surge, or unmanageable winter pressures, conditional on staffing.

- Work with the three Universities in LLR to communicate the right access routes to healthcare to students including access to testing, encouraging GP registration and promoting wellbeing and mental health.

- Plans for flu vaccinations. Health and social care partners plan a large scale flu vaccination campaign each year, which is more important than ever this year as we need to minimise the impact of influenza alongside COVID. The flu vaccine remains one of the best defences available against flu however the delivery of this year's programme is going to be more challenging because of the impact of COVID-19. This includes flu vaccinations taking longer because of the need to observe social distancing rules and the need for clinicians to change personal protective equipment (PPE). The expansion of the programme to an increased number of eligible groups such as people over 50 years, despite the plans for phased approach, also creates practical challenges around vaccine supply and storage. This year we are aiming for 75% coverage of at risk

groups and 100% offer of the vaccine to front line health and social care workers. The vaccination will be delivered by GP practices, pharmacies and by health care providers to their front line staff.

- Preparing for mass COVID vaccinations. Although we do not yet have confirmation of when a vaccine will be made available, NHS systems have been asked to work up plans for COVID vaccination on the basis of this being available before Christmas. The COVID-19 pandemic poses a specific set of challenges to achieving high volume through-put when vaccination becomes available. NHS England and NHS Improvement are exploring options for delivery and further information will be made available as this becomes known.

- The system has developed a strengthened workforce plan in response to COVID which includes mutual aid between organisations and effective monitoring of the workforce situation across health and social care. The workforce group has developed plans to support care homes as a vital part of the health and care system

Student Nurse 2017 cohort

39. Mrs. A. Hack CC submitted a question to the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee meeting on 3 July 2020 regarding the Student Nurse 2017 cohort. The response from UHL was as follows:

    - Across UHL, we have approximately 100 finalist student nurses and midwives from the 2017 cohort who volunteered to become an aspirant nurse at the beginning of the COVID-19 outbreak in England. Some of the Aspirants are from other universities across England who have chosen to complete their training in Leicester to be nearer to their families during the pandemic. All Aspirant nurses are being paid a Band 4 salary.

    - We also have 80 x 3rd year finalist students who chose not to be an aspirant nurse or midwife but wanted to have an extended paid placement in UHL. They are being paid a Band 3 salary.

    - At the beginning of the COVID outbreak, Health Education England, (HEE) believed that the extended paid placement initiative would be for six months and this was communicated to universities and students. However in UHL we gave all of our students (and all the NHS Bring Back Scheme volunteers) a three month fixed term employment contract in UHL that would end on July 31st 2020. This was a pragmatic decision because of the unpredictable nature of COVID. It is always easier to have a shorter contract that can be extended rather than bringing a longer contract to an end with little notice to an individual (which may be the case elsewhere in the UK).

    - However, HEE announced on Friday 26th June that these paid placements could now continue for six months as per their original

decision. Locally, we will now extend contracts until the 31st August so as of the 1st September the students will revert back to full supernumerary status in order to complete their training. Our finalist students at DMU should complete their training on the 20th September and many have secured jobs in UHL so we will make sure they are supported to complete their programme in the best way possible.

- HEE and NHSI/E agreed that students who chose to continue their placements during the pandemic should have an NHS contract and be reimbursed for their time working on wards. This is because as an NHS employee students would benefit from the COVID legislation around statutory sick pay which would give them the same protection as existing NHS employees should they contract COVID whilst working in the NHS and as a result, become very ill (or in the worst case scenario, die as a result of COVID so, family becoming eligible to receive death in service payment). The salaries for students are being paid for by NHSI/E. Many students across the UK may have given up part-time employment thinking they would be receiving a band 4 salary for six months and this has caused distress to the students. This is not the case we believe, in LLR.

- However, when the contract ends on August 31st the students will no longer be an NHS employee or be remunerated for the remainder of their training (they should still receive their bursary) but they could still contract COVID but will be no longer eligible for benefits. So, we now await a decision from the Council of Deans who are working with NHSE/I, regulatory bodies, HEE and DoH to agree what needs to be in place that will support students appropriately. The final decision lies with the Department of Health and Social Care under the direction of the Secretary of State.

- In relation to the point about “we have 500 vacancies in UHL” and using our students to support this position, we actually have circa 400 RN vacancies in UHL but we cannot use our students as qualified nurses and the most important thing is that we support them to complete their training.

40. The updated position with regards to the student nurse 2017 cohort is as follows:

- All ‘paid’ placements came to an end on the 31st August. As of the 1st September 2020, students returned to ‘normalised’ unpaid placements and in the event of contracting COVID-19 will be covered by a new NHS and Social Care Coronavirus Life Assurance (England) Scheme. (Subject to confirmation that they contracted the virus whilst on placement)

- This scheme provides additional financial protection for frontline staff who are employed to deliver care for people and work in environments that carry an increased risk of contracting coronavirus (COVID-19). The scheme will deem

unpaid medical and other healthcare students eligible to claim from the scheme in the event that a student contracts COVID-19.

- As a Trust, we are working with the Universities to ensure our students are ready for their placement by continuing to provide additional infection prevention education and training, personal protective equipment (including individual respirator hoods if students have their placement in ITUs and theatres) and full supervision in the clinical areas.

Supporting the mental health and wellbeing of NHS staff

41. Prior to COVID we had made good progress in respect of working collaboratively on Health and Wellbeing, including providing a comprehensive programme of events, for our people, centred around Mental Health First Aid.

42. During COVID the LLR system has worked effectively to support our people and their health and wellbeing working in collaboration with regional and national NHSI/E and Adult Social Care Health and Wellbeing Teams. Across the LLR system we are doing some amazing work to support staff Health and Wellbeing, enhanced by national NHSI/E and Adult Social Care Health and Wellbeing comprehensive offers. Working closely with system, regional and national partners, we are:

    - Highlighting areas of need where provision is variable, absent or needs scaling at a system level – many private sector organisations and charities have agreed support packages with the National Health and Wellbeing Team and as a system we are targeting those to the areas of greatest need and avoiding duplication

    - Supporting the development of a system-wide Health & Wellbeing Board best practice resource – together setting out what 'good' looks like in relation to restoration and recovery

    - Providing a conduit of original, innovative practice for scaling up at system, regional or national level - sharing some fantastic and inventive ways to support staff at this time and sharing the learning as quickly as possible

43. We send out fortnightly communications across LLR in sharing resources and best practice across the system, utilising internal communication channels.

44. Across social care we have specifically been targeting interventions across care homes and supporting the Personal Assistants (PA) workforce across the system. The PA workforce in LLR is estimated to be close to 10% of the Adult Social Care workforce, which itself is over 30,000 staff across LLR.

Where we want to be

45. We are totally committed to working together to improve the experience of our people across our system. Ultimately, we want to become the best place to

work for all: –one team that brings out the very best in each other. Wellbeing is our business and our priority - we will keep our staff safe and healthy and maintain safety of the population we serve

46. An action plan has been created including the flowing activities focussed on the health and wellbeing of staff:

- All organisations to identify a Well Being Guardian;
- Present a proposal for setting up a system wide Resilience Support Hub working with the regional HWB Team;
- Implement Health and Wellbeing conversation for all staff;
- Implement Health and Wellbeing Champions Network across the System with initial focus on Adult Social Care;
- Increase health and wellbeing education/awareness raising through provision of a range of system wide events and interventions;

Part 2: Phase 3 response to Covid - 19

47. The NHS and partners across LLR have continued to work effectively as part of the Leicestershire and Rutland Local Resilience Forum (LRF) and through the Strategic Co-ordination Group (SCG) in response to the Covid-19 outbreak.

48. Andy Williams, the Accountable Officer for the three CCGs, currently chairs the SCG which continues to meet regularly to set strategic direction, coordinate the complex response across the partners and prioritise resources.

49. The focus has entirely been on doing what is best for our patients and public and ultimately to save lives by working in partnership through the multi-agency response structure.

50. We have achieved this through our continued effort and effective collaboration and partnership working both within the NHS and with other public, private and voluntary sector organisations and also through sheer determination and hard work.

Phase 3 NHS response to COVID-19

51. At the end of July 2020 NHS England issued guidance on the next phase of COVID-19 recovery and restoration requirements. The letter is at Appendix 2.

52. The letter sets out the context for Phase 3: falling inpatient numbers but the continued prevalence of Covid -19 in the community meaning it is a continued threat. The incident level was reduced from Level 4 national command and control to Level 3 local management of the incident through the incident management structures described above.

53. The current concern over the rise in Covid-19 cases in the community means we must remain vigilante and in a high state of alert for the potential impact on NHS services.

54. The guidance requires all NHS systems to develop a Phase 3 recovery and restoration plan which sets out how we will meet the requirements based on the following priorities:

- Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter. As part of responding to this priority there is a focus on restoration of Cancer services. The letter explicitly states that systems must tackle unmet need and encourage people to come forward for referral for suspected cancer. Other services highlighted are primary care and community health services, mental health and learning disability and autism.

- Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally. Details of our winter planning are included above within this paper (Paras 24 – 33).

- Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

The letter at Appendix 2 provides full details of the action needed within each of the priority areas above.

55. An early draft of the Phase 3 plan for Leicester, Leicestershire and Rutland was submitted on 3 September 2020 and more work is currently underway to refine and finalise this for 21 September 2020.

56. Representatives of the LLR NHS will be happy to attend a meeting of the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee to discuss our Phase 3 plan in more detail once this has been approved by the NHS England.

Appendices
Appendix 1 – Presentation slides on Cancer
Appendix 2 – Letter from Sir Simon Stephens dated 31 July 2020
Appendix 3 – Summary of Phase 3 Covid Response National Guidance

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