27/08/20
Health & Adult Care Scrutiny Committee
Thursday 10th September 2020

DEVON SYSTEM COVID-19 RESPONSE

Recommendation: that the Health & Adult Care Scrutiny Committee review this document

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DEVON SYSTEM COVID-19 RESPONSE

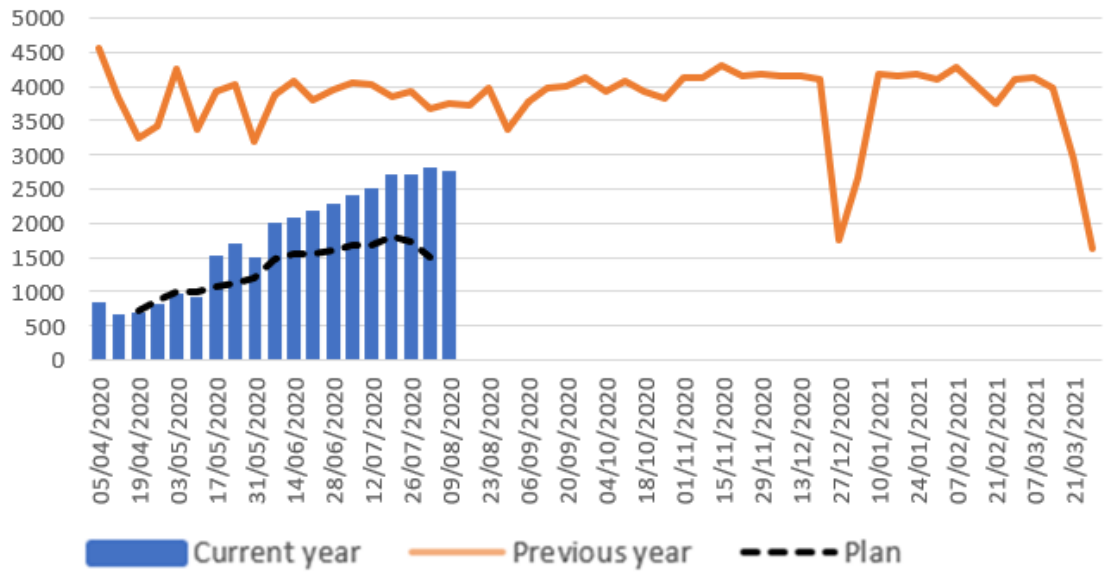
INTRODUCTION

The purpose of this paper is to build on the paper presented to the standing overview committee in July 2020 regarding Restoration and Transformation planning, focusing on further areas of good practice and innovative work undertaken during the COVID-19 pandemic response. The paper will also give an overview of Winter planning 20/21 identifying the actions the CCG and STP system need to take to fulfil national and NHSE/I winter planning requirements;

There is much to celebrate in the way organisations within the Devon system have worked together as a single system team through the COVID-19 response, showing commitment and flexibility in working to deliver the best for our local population.

ACTIVITY AND PERFORMANCE

In terms of activity, the South West recommenced elective activity faster than any other region and, within the South West, Devon has consistently over-achieved against Phase 2 plans for elective inpatient and day case activity. In the latest two weeks (ending 2nd and 9th August 2020), system information shows that STP elective activity levels were at 76% and 73.7% of 2019/20 levels - against a national Phase 3 ambition of 70% in August. This puts the system in a good position to achieve the 80% aim in September. The graph below shows the combined elective inpatient and day case weekly activity against planned levels and 2019/20 activity: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The Devon system has maintained performance against key Cancer targets throughout the COVID-19 pandemic response, improving both 62-day and two week wait performance between February and June, despite the significant reduction in capacity. As of June 2020, the CCG met the two week wait 93% target, achieving 93.07%, which is also higher than the England average of 92.5%. Whilst in relation to the 62 day urgent referral to treatment standard Devon did not achieve the target of 85% in June, again we exceeded the England average of 75.2%, with performance of 76.74%. This can be attributed in some part to the way in which Devon used available Independent Sector capacity and it has been recognised that Devon has led the way in maximising capacity available in the independent sector to provide additional space and services to support cancer and priority surgery.

Importantly, Devon has lost the fewest beds of any system in the South West due to infection control, losing just 5% of beds, compared to an average for the region of 10%.

In terms of COVID-19 infection rates, Devon has 157.9 cases per 100,000 (lowest ranked in SW and second lowest out of 150 or so upper tier/unitary authorities nationally). The South West is still the lowest region at 247.3 cases per 100,000 which compares to 490.0 per 100,000 nationally.

PHASE 2 RECOVERY – HIGHLIGHTS

1. Greater use of digital technology and innovative solutions to care and wellbeing services, including significant increase in virtual outpatient and general practice appointments. Before the outbreak, around 80 per cent of GP appointments were carried out face-to-face – now it is the opposite, with about 90 per cent of patients seen first online.

2. Local patients are embracing new technology, with more than 13,000 video consultations in Devon between April and May 2020 - among the highest of any area in the country

3. Nightingale Hospital Exeter is now providing safe and fast diagnostic testing for the peninsula for a range of conditions: CT scanning services commenced last month and nearly 200 patients have so far been seen. Ultrasound services started week commencing 10/8/20 and 100 patients have been scanned so far. It is anticipated that 2,000 ultrasound scans will be undertaken in the next 12 weeks, which will clear the non-obstetric ultrasound backlog. Almost 100 echocardiography tests have been completed since the service started last week.

4. The CCG has continued to work closely with care homes and out of hospital providers, alongside local authority colleagues. A regular webinar has provided information and shared experiences on key topics. These have been planned using feedback from the care sector. We recently published a set of system agreed principles for health and care professionals visiting care homes. The Academic Health Science Network (AHSN) is working with us to support the rollout of RESTORE2, a digital tool which will enable care homes and primary care to have early identification of deteriorating individuals. Infection, prevention and control training has been offered to all care homes across Devon and continues with domiciliary and supported living providers included.

5. In a pioneering approach to target groups who are digitally excluded, an informative newspaper was delivered to more than 300,000 homes across Devon as an essential guide to services and next steps in the continuing efforts against COVID-19. The publication was jointly commissioned by NHS Devon Clinical Commissioning Group, Devon and Cornwall Police and Crime Commissioner's Office and Devon County Council - https://tinyurl.com/y2bl4hfa (*use this link to view the paper*)

6. The need for stringent infection prevention and control (IPC) measures had a significant impact on diagnostic activity as we moved into Phase 2, doubling the time taken for CT, MRI and non-obstetric ultrasound scans (NOUS) from 15 minutes to 30 minutes, halving productivity. As the weeks have progressed, teams have worked to improve productivity whilst maintaining the same strict infection control processes and have reduced the time per scan to 20 minutes, aiming to return to 15 minute slots shortly. Given the significant constraints on diagnostic capacity in Devon, this is an important development.

7. Throughout the COVID-19 pandemic response DRSS has continued to provide referral management services, albeit contingency based, and since February 2020 has processed 99,261 routine, urgent and 2WW referrals.

8. Additionally, DRSS has supported the system in several ways;

    - Contacted over 1,500 local businesses and companies and collected over 55,000 assorted items of PPE equipment and clothing
    - Supported Devon Doctors by speaking to over 37,000 patients waiting on the Devon Dental Waiting list
    - Supported 10 GP Practices with shielding support, having made 2,000 outbound patient calls and receiving 200 inbound calls
    - Co-ordinated around 2,300 antibody tests referrals (CCG staff and GP practices - approx. 17 000 staff eligible for antibody testing within Devon/East Cornwall).

9. Launch of the first Ethical Framework and Guidance on the treatment of critically ill patients in a future pandemic like Coronavirus. The CCG linked up remotely with local community members as well as key professional groups to agree vital guidance for frontline clinicians, patients and their families and carers in a pandemic situation where health systems are at risk of being overwhelmed.

PHASE 3 - WHAT IS HAPPENING NOW?

Some of the steps we are taking to restore services include:

1. Identifying the most clinically urgent cancer patients for surgery, including use of the independent sector.

2. Reviewing all surgery lists, prioritising patients and reintroducing surgery and outpatients' services incrementally.

3. GP referrals to hospitals beginning to return to pre-pandemic levels over time, while continuing to focus on high-risk patients.

4. Continue to maintain increased community services capacity to support discharges, support care homes and predominantly support young patients and those patients with respiratory conditions or learning disabilities. Also ensuring that appropriate services and support is in place for those people who have been in hospital with COVID-19 and are now in recovery.

5. Seeking to understand the potential mental health impact of the pandemic, providing ongoing support for high risk and urgent patients. Preparing for possible longer-term increases in demand for mental health services

6. Continued segregation of infected and non-infected patients across all services

7. Enhanced discharge planning to ensure timely, safe and appropriate discharges

8. Further support to care homes including identifying a clinical lead for each care home and setting up weekly virtual 'care home round' of residents needing clinical support and medication reviews

9. Enhanced psychological support for all NHS staff who need it

10. Putting in place mechanisms to ensure closer working between the NHS, local communities and partners to increase the scale and pace of progress in reducing health inequalities.

11. GP practices are starting to address the backlog of childhood immunisations and cervical screening, as well as flu planning through their Primary Care Network (PCN)

THINGS TO CONSIDER

We will keep a constant check on the development of the pandemic locally and be guided by the Local Outbreak Boards, we will remain fully prepared to go back to full COVID-19 provision if this is required, in line with national and regional guidance. As we restore our services, we need to ensure that:

1. We protect the long-term welfare of our staff to be able to treat the numbers of extra patients. Our staff have been absolutely fantastic in their response to the pandemic and affected in many different ways by COVID-19. We must support our staff to recover before we take too many steps forward in recovering our services.

2. Our stocks of Personal Protective Equipment (PPE) are able to match service provision to ensure services can commence and continue safely to protect staff and patients

3. We want to support patients to continue to use services in a different way. Data from August shows reductions of more than 14% in our accident and emergency departments' A&E attendances compared to last year's volumes, amounting to 56,000 fewer attendances. And while some of this may have been patients who perhaps might have been best to come to A&E but were deterred by the ongoing pandemic, we expect also that many patients with minor injuries or illness decided not to attend A&E and either

used an alternative service or self-care, which is a message we have been trying to send to the public for many years.

4. We start to understand the greater impact of the pandemic on the population, both for routine care and where there might be the potential for greater complications due to patients being treated later than would normally have happened.

5. We understand the knock-on implications for different sectors and services within health and social care, not least the secondary impact of operations on primary and community care services.

WINTER PLANNING 20/21.

The Phase 3 winter plan is required at a system level with the following key requirements:

1. Continue to follow good COVID-related practice to enable patients to access services safely and protect staff, including following Public Health England guidance on outbreaks and policies on testing, applying Infection Prevention and Control (IPC) guidance and ensuring staff and patients have access to personal protective equipment (PPE);

2. Sustaining current NHS staffing, beds and capacity, including ongoing use of independent sector capacity and the Nightingale hospital to support discharge;

3. Delivering an expanded flu vaccination programme for priority groups and NHS staff;

4. Maximising use of 'hear and treat' and 'see and treat' pathways for 999 demand to reduce conveyance to emergency departments; by which a patient receives care via the telephone or by attendance of a paramedic rather than attending the emergency department.

5. Continue to make full use of the NHS Volunteer Responders scheme;

6. Continue to work with local authorities on resilient social care services and facilitate discharge.

7. Ensure the public are aware of the range services available to them, across health and social care. A system-wide communications plan is being developed.

Furthermore in order to meet the requirement to restore service delivery in primary care and community services, there are a number of requirements around out of hospital services that will be key in our winter planning. These include:

- Continuing government funding of the Hospital Discharge scheme and a requirement for systems to fully embed Discharge to Assess processes from 1st September 2020;
- Building on the enhanced support being provided to care homes;
- Enhancement of community crisis response services.

The impact of these initiatives on patient flow will be articulated within the winter plan.

The Devon winter plan will also need to reflect learning from the winter of 2019/20 and from the COVID-19 pandemic response and link to the two Devon Local Outbreak Management Plans (LOMPs) developed by local Directors of Public Health. The plan must also reflect the additional infection prevention and control (IPC) requirements of the current environment:

Workforce resilience

- Frontline Health Care Workers (FHCW) flu vaccination plans;
- Provision of adequate personal protective equipment (PPE).

Patient/public prevention & safety

- Weekly testing for health & care staff visiting care homes;
- Effective discharges (eg: continue covid testing for patient being transferred to onward care setting);
- Additional IPC support for community & primary care through the additional Community Infection Management service roles (CIM's);
- Local system outbreak management plans in place;
- Maintaining covid secure areas during high demand;
- Plans for managing co-circulation of flu & covid-19;
- Plans for supporting patient/public flu programme across community settings.

In parallel, other system-wide elements of the plan are in the process of being developed, which will address the other key requirements, 999 'hear and treat' and 'see and treat' pathways and use of the Volunteer Responders scheme. Flu vaccination plans are being developed by the System Infection Prevention and Control (IPC) lead.

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