Staffordshire and Stoke-on-Trent NHS Response to COVID19

Staffordshire County Council
Corporate Scrutiny Committee

4th June 2020
### NHS System Representatives

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The COVID-19 pandemic has presented an immense challenge to health and social care in the UK with every part of the system being affected.

As directed by NHS England / Improvement this is being dealt with as a Level 4 major incident. This triggers national command and control approach across the NHS.

The Staffordshire Resilience Forum (SRF) declared a local system major incident in relation to the COVID19 pandemic on 25th March, establishing a local command and control approach (C3).

The Health and Care Tactical Group sits under this and brings together the health and care organisations.

The command and control approach provides the single point of access for the region, supports coordination across the system and facilitates two way information flow.

A number of workstreams have been established in response to COVID-19 in recognition of:

- Key programmes of work identified as required to support our response
- Areas where there is a Regional or National requirement for a single point of contact or an overarching approach and response
- Areas where there is an opportunity / need to have a consistent planning or delivery approach
Level 4 Major Incident - Suspension of business as usual

Key dates in the response:

17th March - Important and Urgent Next steps on NHS Response to COVID 19

28th March - ‘Reducing the Burden’ guidance issued to the NHS on managing the COVID 19 pandemic – changes to regulation, reporting performance management and assurance of systems

29th April - ‘Second Phase of NHS Response to COVID19’ – setting out restoration of essential services

Operational Changes as a result have included (not exhaustive):

• Suspension of some non essential services

• Reorganise patient flows across all settings into COVID19 and non-COVID19 areas to enable the safe continuation of essential services.

• Hospital Visiting – suspended / curtailed

• For primary care, community and mental health services, the main operating model has changed to move from face to face to digital or telephone to maintain infection prevention control, with the exception of those patients who need to attend ‘hot clinics’ and essential domiciliary visits
Headline Summary

Meeting the immediate COVID demand and managing the system capacity
- Critical care beds (surge and super surge)
- Ventilated, non invasive ventilation, oxygen and non oxygen bed segmentation
- Use of the Independent Sector to support local capacity
- Opening of Nightingale Hospital in Birmingham – Mobilising beds capacity locally
- Changes across primary care, community based care and mental health services
- The NHS stayed ‘open for business’ throughout
- Significant digital mobilisation and response across all sectors
- Support to care homes

Workforce
- Supporting staff self isolating or with symptoms
- Support for BAME colleagues
- ‘bring back’ scheme across NHS Partners
- Staff well being and mental health

Testing
- Availability of tests & use of them to support discharges and restoration of activity
- Reliability of tests
- Staff and patient testing
- Test and trace shift of emphasis

PPE
- Evolving guidance throughout the response
- Confidence in the supply chain

Admission and Discharge arrangements and guidance
- Secondary Care
- Care homes

Restoration and recovery
- 3 phases in the NHS response
- Recognising the burden of mental health issues caused by the pandemic
Modelling of Covid-19 positive patients in beds at UHN. For assurance, three predictive scenarios are shown. The assumptions are that the newly hospitalised patients will follow the same patterns as previously seen in terms of LoS and days before ITU admission.

- **Scenario 1;**
  Revised modelling shared regionally (14th April) shows levels of ITU need expected to be in excess of 40 beds however no second peak.

- **Scenario 2;**
  From the 1st of June the rate of growth of new infections has been modelled to match the rate seen pre lockdown (18th -25th March) second peak
  ITU - 20th June = 24
  Other beds - 18th June = 142

- **Scenario 3;**
  The growth in daily infections has been reduced to 60% of the growth seen pre lockdown (the gradient of the line is less steep)
  ITU - 20th June = 20
  Other beds - 17th June = 112

**Conclusion**
Both scenario 2 and scenario 3 fall well below the initial surge plan UHN prepared for based on the black NHSI planning line.
A more realistic view would be scenario 3 due to the fact some lockdown measures remain in place in June and awareness of social distancing is higher and more practiced than pre lockdown. Scenario three does not exceed the Blue Zone bed base of 130 beds.
Restoration and Recovery
Alignment to Staffordshire and Stoke-on-Trent Five Year Delivery Plan Ambitions

The five year delivery plan was based on the ambitions outlined in the Long Term Plan (LTP). The aims remain:

• To ensure that our population will have:
  o Access to **urgent and emergency care services** that are appropriate and deliver that care within the right setting
  o **Care integrated around the individual**, delivered as close to home as possible
  o **Integrated and efficient ways to deliver complex care** that are simple to navigate, with rapid access to specialists and diagnostics
  o **Enhanced primary care and community services**, aiming for continuity of care pathways, which appropriately include and value social care and the voluntary sector
  o Care within the community that provides integrated mental and physical health services.

• Delivery of a system architecture with a single system (ICS) with three emerging Integrated Care Providers (ICP).

Recovery and alignment to the system five year delivery plan will:
1. Recognise that the systems response to the pandemic has accelerated progress on a number of key programmes of work and sectors.
2. Capitalise from the learning and innovation that has taken place at the system, place and neighbourhood levels.
3. Capture and review changes made to service delivery, back office function etc and consider against our programmes and ambition.
4. Provide an opportunity for recovery planning to progress and embed our ICS, ICPs and organisation-based priorities.
3 Phases - Restoration, Recovery & Reset

- General agreement that we need to “re-set” our plans in the light of the changed circumstances brought about by the COVID-19 epidemic
- A rapid piece of work to assess both the restoration and recovery phases – restore essential services and understand the impact / catch up needed
- Undertaken by the cells with significant clinical leadership given the clinical risk elements (augmented where necessary) and by statutory organisations
- Need to maintain and sustain the level 4 major incident structures during this initial period
- Focus on working in a truly integrated manner and using restoration phase to deliver restored services to the local population
- Responding to the hidden demand and the harm that has been caused – mental health demand
- Essential that we built on the response and don’t revert back to how we used to work!
Rapid Appraisal and Change: 6 Week Task & Finish

In each geographical area:

Using the ICP footprint and resource to focus rapid review approach and develop agreed action plan to deliver restoration of non-covid19 urgent services

Each organisation and cell to propose what we should: STOP / START / KEEP / CHANGE

Informed by the evidence base and available analytics

- Urgent and routine surgery and care
- Cancer
- CVD, heart attacks and stroke
- Maternity
- Primary Care
- Community Services
- MH, LD & Autism Services
- Screening & Immunisations
- Digital solutions
Discussion and Questions