ADULTS AND HEALTH SELECT COMMITTEE

19 JANUARY 2021

Surrey Heartlands Health and Care Partnership COVID-19 Recovery Programme – Update

Purpose of report: To update the Select Committee on Surrey Heartlands' Recovery Programme

Introduction:

1. The COVID-19 pandemic has been an enormous challenge and a period of significant change for health and care services. In Surrey Heartlands, our Recovery Programme aims to meet the patient and citizen need arising from the pandemic. In order to achieve this in a sustainable way, we will need to reset to a new model of care and achieve financial sustainability.

2. Our Recovery Programme runs in parallel with other COVID-related work, such as the Mass Vaccination Programme, Testing and our Local People Plan. This related work is not covered in this update.

Update following the writing of this paper

3. This paper was written in late December 2020 and represents the situation at that point in time. Due to the nature of the COVID pandemic and the progression of usual 'winter pressures' on health and care, the pressures on services can change rapidly. Rather than re-writing the paper to account for changes since the initial draft, the following paragraphs provide an update on changes relevant to the Select Committee's discussion, bridging the gap between the time of writing and the final submission on 5 January. A verbal update will also be provided at the meeting.

4. Due to dramatically rising cases of Covid-19 across the South East in recent weeks (with the new national lockdown announced on 4th January), including Surrey, we have been working collaboratively as a system to put measures in place that will enable us to prioritise how we provide care to those who are most critically ill. This is not a decision we have taken lightly but we must focus our efforts on those who need the most urgent and life-saving care including those with Covid-19. The following new measures have been put in place:

5. Opening up additional beds without our acute and community hospitals including additional beds at the NHS Seacole Centre

6. Prioritising urgent and cancer care over non-urgent care – postponing many routine planned elective procedures and non-urgent operations

7. Moving to virtual (telephone/online) appointments for many outpatient services to reduce numbers of people travelling to hospitals

8. Working together as a system across health and social care to discharge people from hospital as soon as they are well enough to leave, with the right support and package of care

9. Working with our independent sector partners to identify any additional bed capacity and any clinical staff that could be redeployed

10. Temporarily suspending home birth services due to ongoing pressures on the ambulance service as they are unable to guarantee a timely ambulance response to women choosing a home birth should they experience an emergency.

Overview of the Recovery Programme

11. The Surrey Heartlands Recovery programme has an overarching Statement of ambition, supported by our Recovery priorities:

Fig 1[1] Statement of Ambition

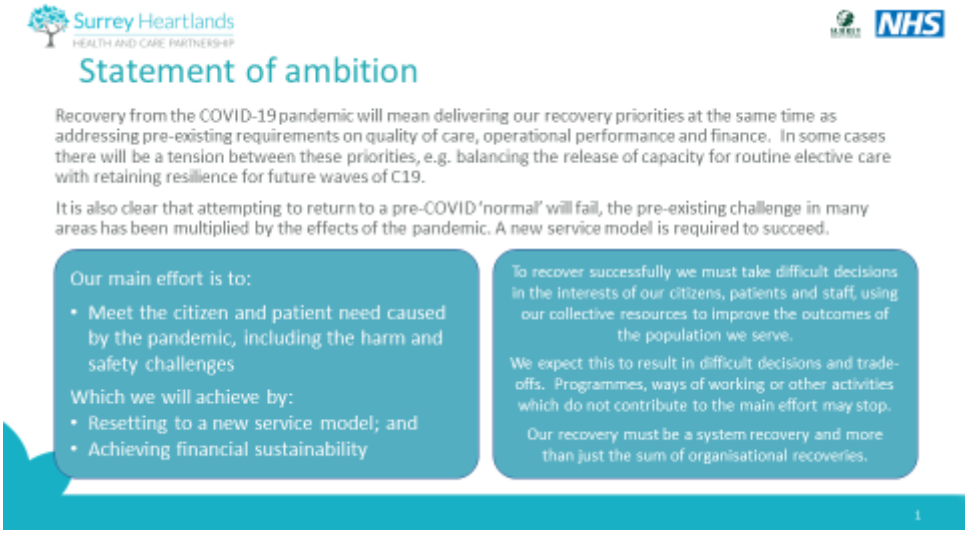
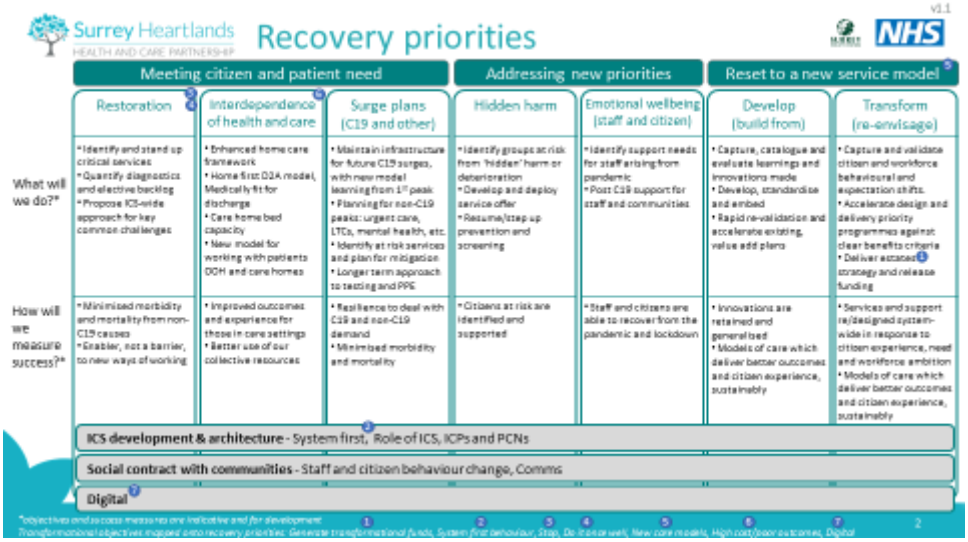


Fig 2: Recovery priorities

[1] NB: all graphs, tables and pictures are **repeated in Appendix 2** to ensure that they are readable by those not reviewing papers electronically



12. Both the Statement of ambition and Recovery priorities were developed following a review of our strategic direction – including the Surrey Health and Wellbeing Strategy and our local response to the NHS Long Term Plan – in the light of COVID-19. They aim to balance the immediate needs of restoring and maintaining services with the longer term need to learn the lessons of COVID and embed the positive work which has happened through our response to the challenges it has presented.

13. The Recovery priorities are largely delivered through dedicated workstreams, although the overlay with existing structures in health and social care means there is a strong link with 'Business as usual' which ensures our work is joined up. For example:

- Our Restoration Group brings together a range of partners from across health and care to co-ordinate our system response to collective challenges such as addressing the backlog of patients awaiting diagnosis and treatment following the first wave; and
- Our Equalities and Health Inequalities workstream has leaders from across relevant services, including public health, acute, children's, mental health and primary care services, to provide joined-up leadership.

A summary of the leadership for each of our workstreams is included in Appendix 2.

Restoration of services following the first wave

Returning to pre-COVID levels of service

14. In addition to the COVID patients who needed treatment, the first wave of the pandemic created other significant pressures on health services, in particular:

- Reduction in capacity due to a number of factors, including infection prevention and control requirements (e.g. fewer beds to maintain distance, enhanced cleaning between procedures) and workforce absence due to illness and self-isolation;
- Increased backlog of patients waiting for diagnosis and treatment, due to the need to temporarily cease or reduce services;
- Patient reluctance to engage with health services, e.g. due to fear of infection or uncertainty over digital services; and
- Effect on mental health and emotional wellbeing (see section below).

15. In September we agreed a plan for restoring services to pre-COVID levels with the health regulators, NHS England and NHS Improvement. This had a particular focus on increasing capacity for key services to a level where we can reduce the backlog of patients waiting for treatment.

16. At the time of writing, we are successfully delivering planned levels of activity across the majority of services and delivering 125% of pre-COVID levels of endoscopies. Progress in addressing the backlog of patients waiting for diagnosis and treatment is discussed below and additional information about our plan is provided in Appendix 2 under "Returning to pre-COVID levels of service: Additional information".

17. Digital solutions have been a key part of continuing to deliver primary care, although face-to-face appointments continue to be an important part of general practice, especially for patients or conditions which cannot easily be assessed remotely.

18. Data shows that although GP appointments decreased immediately after lockdown, they rapidly increased between May and June with an increasing proportion of appointments being conducted by video or telephone.

19. To help overcome patient reluctance, we proactively engaged with patients to encourage take up of assessment and treatment, and contacted all planned care patients who have had their care disrupted.

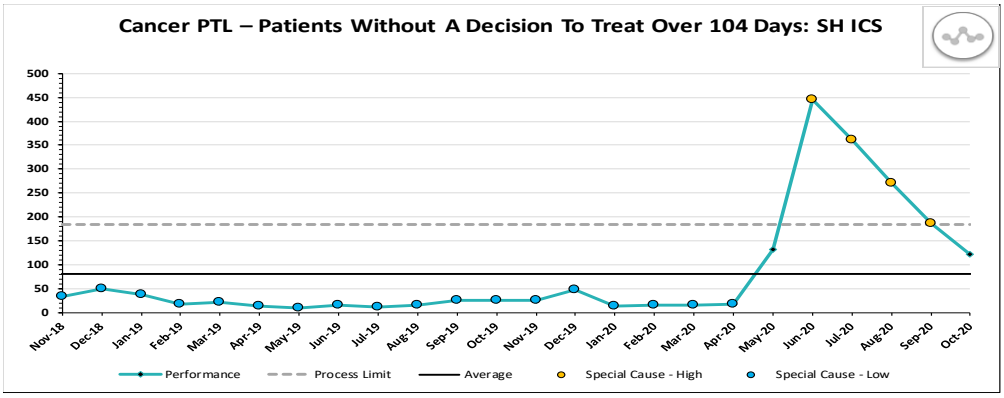
Addressing backlogs for diagnostics and treatment

20. Treating patients with long waits for diagnosis and treatment is a major priority for restoring services, in particular where longer waits are associated with higher clinical risk or poorer outcomes. We reviewed every 'long waiter' to assess their level of risk and proactively contacted them.

21. Patients on a cancer pathway are some of the highest clinical priorities. Cessation of diagnostics and treatments during the first wave led to a large

increase in the number of patients waiting longer for treatment, with upper and lower gastro-intestinal and urology being particular challenges. The graph below shows the number of patients waiting over 104 days for treatment, a key metric of long waits.

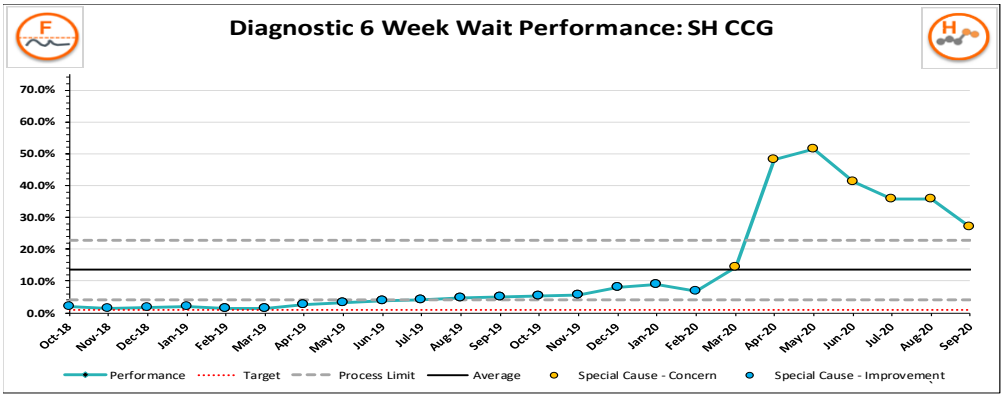
Fig 3: Cancer waiting list



22. Addressing this backlog of patients has been a top priority for Surrey Heartlands. Working with Surrey and Sussex Cancer Alliance, all our providers have placed significant effort into ensuring that patients are treated as soon as possible, with the result that the number of patients waiting has fallen steadily since July. Remaining patients largely have benign diagnoses, with some patients choosing to delay treatment until 2021 or on complex pathways.

23. Endoscopies (including Colonoscopy, Flexible sigmoidoscopy and Gastroscopy) are a key driver of long waits, in particular for patients with suspected cancer. Endoscopies are also particularly affected by COVID-related infection prevention and control protocols, making the return to pre-COVID levels particularly challenging. We have therefore placed significant focus on reducing waits for these critical procedures.

Fig 4: Percentage of patients waiting longer than 6 weeks for Diagnostics



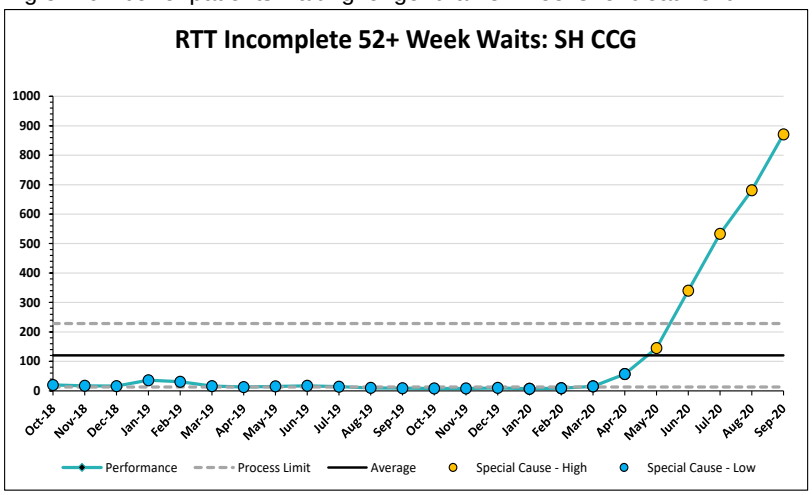
24. We have employed mutual aid across the system to ensure that patients are treated in order of priority not geography, with Royal Surrey able to use its additional endoscopy capacity to support the wider system. Early data shows that the amount of time patients are waiting for diagnostics has continued to

decrease. We are also developing a diagnostics strategy across Surrey Heartlands to drive medium and long term goals and further improve our services for patients.

25. In Surrey Heartlands we have been able to make extensive use of the independent sector to treat patients waiting for elective care. There is a potential risk to the availability of this capacity going forwards due to a change from national to local contracting on 1 January and national funding ending on 31 March 2021. Ensuring we can utilise all available capacity remains a key priority.

26. Despite best efforts across the system, the number of patients waiting over 52 weeks for treatment continues to increase. Although Surrey residents continue to have shorter waiting times than the majority of the country, we continue to aspire to no patients waiting longer than 52 weeks. The recent re-opening of Crawley Hospital, run by Surrey and Sussex Hospitals, will help us improve the trajectory.

Fig 5: Number of patients waiting longer than 52 weeks for treatment



27. Early data indicates that the trend shown in the graph above has continued through the autumn and, although there has been a levelling off of 52 week waiters in late November/December, increasing winter pressures are likely to place further pressure on elective care.

28. Patients are being treated in order of clinical priority, although large numbers of patients continue to choose to delay surgery (over 60 at Ashford & St Peter's alone). Patients who we have been unable to treat are those with benign conditions which, though important, have lower clinical risk associated with long waits.

29. During the first wave, health and care services nationally were unable to keep many services open. This winter we intend to keep all services running for as

long as we are safely able to do so in order to minimise the disruption to non-COVID patients.

Impact of the second wave of COVID cases

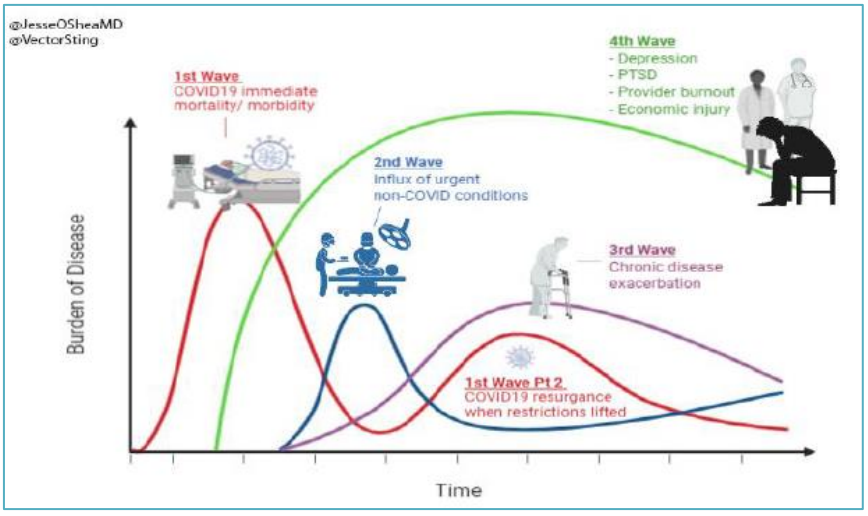
30. Through the early stages of the second wave, numbers of COVID patients in Intensive Therapy Units (ITUs) have remained at a manageable level. This is due to a number of factors, including lessons learned from the first wave and the availability of treatments and non-invasive ventilation now that the disease is better understood. However, the increased infection prevalence and the usual winter pressures expected, January is expected to be a particularly challenging period.

31. At the time of writing, we have started to see the first indicators that numbers of COVID patients are starting to place further strain on services. As a greater proportion of our bed base is taken up by COVID patients, particularly ITU beds, we will only be able to manage these patients by cancelling non-urgent elective surgeries. Even where physical capacity may exist, workforce constraints mean that additional COVID beds can only be staffed if non-COVID work is paused and staff redeployed.

Impact of COVID and lockdown on mental health and emotional wellbeing

32. We are now seeing a surge in mental health and emotional wellbeing issues. During lockdown there was an initial reduction in referrals, linked to closure of referring services, slow-down of referrals from primary care in particular and citizen behaviour change as people stayed away to protect the NHS. However, activity quickly recovered, reaching pre-COVID levels in September and has continued to increase.

Fig 6: Illustration of the progression of the burden of disease



33. In addition to increasing volumes, patients are presenting with a higher degree of acuity. We are seeing increases in:

    - Patients presenting in crisis who are not previously known to services (c.80% of cases presenting are patients in crisis, up from 37% last year) and greater use of Mental Health Act Emergency Powers;
    - Patients with autism presenting in inpatient services;
    - Welfare calls and more safeguarding referrals due to domestic abuse;
    - Children facing loneliness, self-harm and a significant increase in eating disorders.

34. Although the move to digital has enabled services to continue to be provided in primary care, it has created a significant barrier to people with Serious Mental Illness or Learning Disabilities accessing annual health checks, and has therefore exacerbated health inequalities.

35. Integrated working is key to our current and on-going response to COVID demand and to our recovery. Service offers brought online or expanded include General Practise integrated Mental Health Service (GPiMHS), bereavement support, virtual safe havens, crisis pathway, fast track workforce wellbeing support, virtual wellbeing hub offering access to third sector interventions.

36. Further information on our mental health recovery is provided in Appendix 1.

Building on changes made during our COVID response

37. The demands of responding to COVID have led to many changes in the way we work and deliver services. There is an opportunity to capture the value from these changes to ensure that our citizens, patients and staff benefit from them going forwards.

38. As mentioned above, mutual aid and shared clinical prioritisation of patients was a key factor in addressing the diagnostics backlog and this type of arrangement will be continued and developed as part of Surrey Heartlands Diagnostics Strategy and our response to the recent Richards Review[2].

[2] *"Diagnostics: Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England"* was undertaken by Professor Sir Mike Richards, former Chief Inspector of Hospitals, and reported in November 2020. Sir Mike was commissioned to undertake a review of NHS diagnostics capacity and recommends the need for a new diagnostics model, where more facilities are created in free standing locations away from main hospital sites, including on the high street and in retail locations, providing quicker and easier access to tests to a range of tests on the same day, supporting earlier diagnosis, greater convenience to patients and the drive to reduce health inequalities. We are currently assessing the implications of the Richards Review for Surrey Heartlands and how we can best implement its recommendations for the benefit of our patients and citizens.

Care sector

39. The first wave of COVID brought to the fore a number of existing issues with the way the health and care sectors have historically interacted. Practical changes implemented include:

    - Improved data collection in relation to COVID business continuity and capacity tracking via a new Capacity Tracker used by over 350 of our 370 care homes;
    - NHSmail uptake in care homes greatly increased, providing a secure means of transmitting personal records between partners and care home access to MS Teams for virtual MDTs; and
    - Enhanced healthcare support in care homes – 'Directed Enhanced Service' (DES) – providing a named clinical lead, weekly check in calls to care homes and development of MDT care home rounds.

40. General practice continues to deliver best practice support to care homes, including video consults, GP & paramedic visiting services & weekly check-ins with community providers.

41. Over 1,800 people were discharged from hospital through the 'discharge to assess' model employed during the first phase of the pandemic. This has been supported by coordinated purchasing across health and social care through a central placements team which was able to source 166 beds on a block basis and many more spot placements. 94% of people had a bed or placement available within 2hrs of referral.

42. Learning the lessons from these temporary protocols, a revised discharge to assess model, Home First, has been implemented from September. This improves both citizen/patient experience and improves outcomes by ensuring that care is provided in the best setting, as well as releasing capacity in acute hospitals.

Move to digital first in primary and secondary care

43. Before the pandemic, Surrey Heartlands had ambitious plans to reduce face-to-face outpatient appointments by 70% over 5 years. The move to virtual appointments during our COVID response, whether online or telephone, has greatly accelerated the roll out of these plans as well as increasing acceptance among staff and patients of new ways of working.

44. Before lockdown, telephone and video consultations made up only a very small proportion of total consultations. During lockdown we were able to quickly roll out and scale up services to ensure that patients had access to care wherever possible.

45. Although face-to-face appointments have resumed where needed, for example where particular patients or conditions cannot be assessed remotely, video and telephone consultations have now become a normal part of patient care, with acute trusts currently providing between 40% and 50% of consultations remotely. A full review into virtual consultations is required in order to facilitate effective patient care across multiple pathways and organisations.

46. Further digital tools such as Consultant Connect – providing GPs with access to specialist consultants – are enabling us to close down more cases in general practice without referral to secondary care, resulting in quicker and more convenient care for patients and more efficient use of health resources.

Fig 7: Changing how we worked – a rapid shift to digital

47. This move towards digital has also meant an accompanying increase in our digital inclusion work. There is the potential for digital exclusion to exacerbate existing health inequalities, and in Surrey there is an overwhelming correlation between social exclusion and digital exclusion, linked to areas of greater deprivation and the communities that live in these areas.

48. Tech to Connect is a project to provide technology and support in using technology and virtual groups to reduce feelings of loneliness and isolation in people with care and support needs. Tech to Connect specifically addresses both those who do not have, or are unable to afford, a device and those who are unable to get out and about because of health needs, caring responsibilities, disabilities or other significant barriers.

49. We also recognise that not everyone can or wants to engage digitally and we plan to carry out further research and engagement to understand barriers to digital.

50. As part of our move towards remote consultation, it has become clear that many patients prefer telephone to video, and we have adjusted our response accordingly. Our 'Think 111 First' programme, part of a national programme to ensure patients are seen in the most clinically appropriate setting, similarly uses telephone as a core entry point to NHS services.

Fig 8: Digital inclusion next steps

Updates from Recovery workstreams

51. We have 8 dedicated workstreams, each focused on delivering our Recovery priorities:

i. Restoration – focusing on restoring services, as discussed above;

ii. Interdependence of Health and Care (now closed, see below);

iii. Surge – system management of peak demand in areas such as critical care and flu vaccination;

iv. Equalities and Health Inequalities (formerly Hidden Harm, see below);

v. Emotional Wellbeing – as discussed above;

vi. Develop and Transform – driving projects which help us reset to a new model of service and financial sustainability;

vii. Digital – including digital inclusion;

viii. ICS Development and Architecture – ensuring our partnership is set up as an effective enabler of our shared objectives.

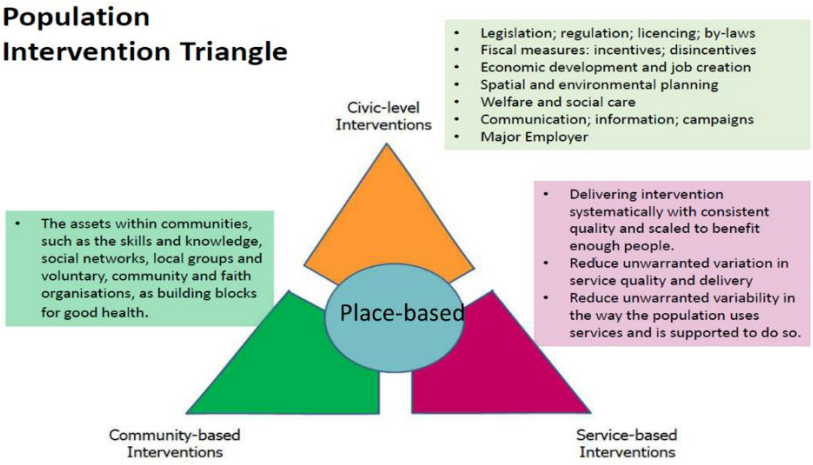
52. Much of the work of these workstreams is covered earlier in this report. Other highlights we would like to draw to the attention of the Select Committee are as follows.

53. Our Interdependence of Health and Care workstream has been closed after its objectives were either completed or partially completed and transferred to BAU:

- Provision of comprehensive support to care homes over the course of the first phase of the COVID-19 pandemic – Achieved
- Development of training and education, including Infection Prevention & Control – Achieved
- Integration of health and social care to sustain a high quality discharge to assess model – Partially achieved and transition to BAU
- Targeted support to areas requiring additional support and reducing health inequalities – Achieved
- Enable a higher level of digital connectivity across the care sector – Partially achieved and transition to BAU

54. The Equalities and Health Inequalities workstream brings together various pieces of work addressing these key areas of Recovery. The workstream is using the evidence based Health Inequalities framework to bring system partners together in response to these needs.

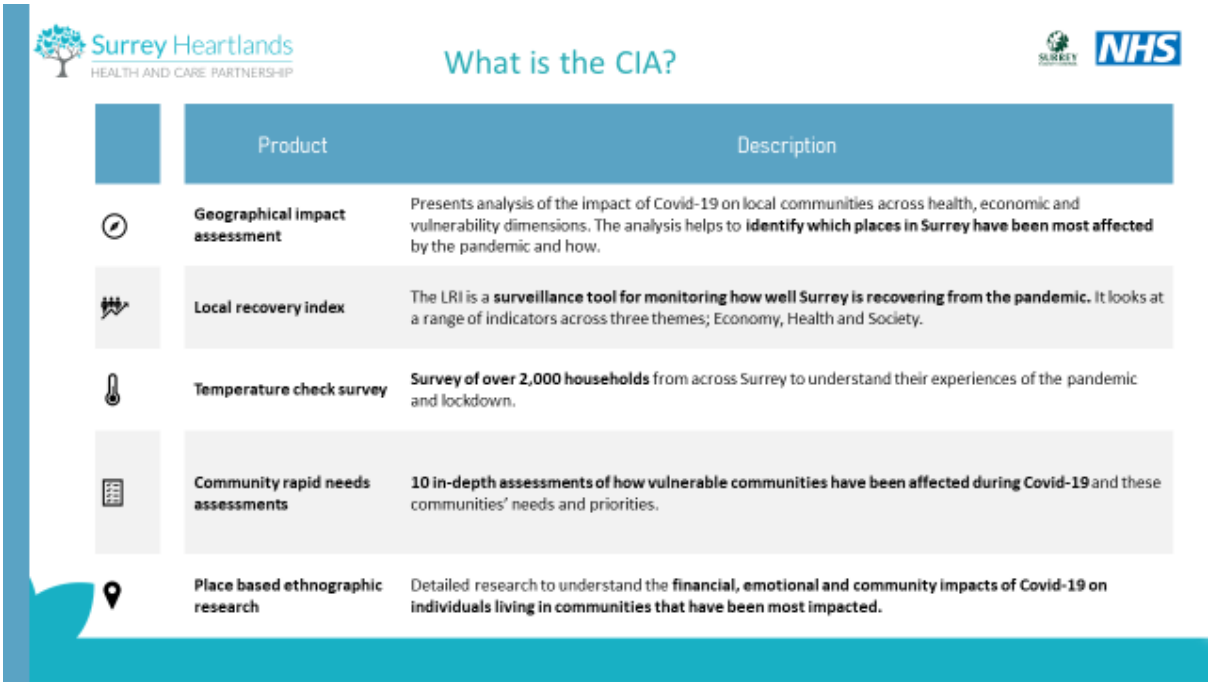
Fig 9: Population Intervention Triangle



55. Core objectives include a system-wide Health Inequalities strategy with a focus on COVID inequalities, identification of Health Indicators considering the findings of the Community Impact Assessment (CIA) and Rapid Needs Assessments (RNAs), and the development of a Health Inequalities dashboard.

56. The CIA explores the health, social and economic impacts of COVID-19 among communities across Surrey, communities' priorities for recovery, and what support these communities might need in the event of another outbreak. It then aims to enable partners to provide targeted support to communities impacted by COVID-19 and to act preventatively to mitigate future risk and impacts.

Fig 10: Communities Impact Assessment



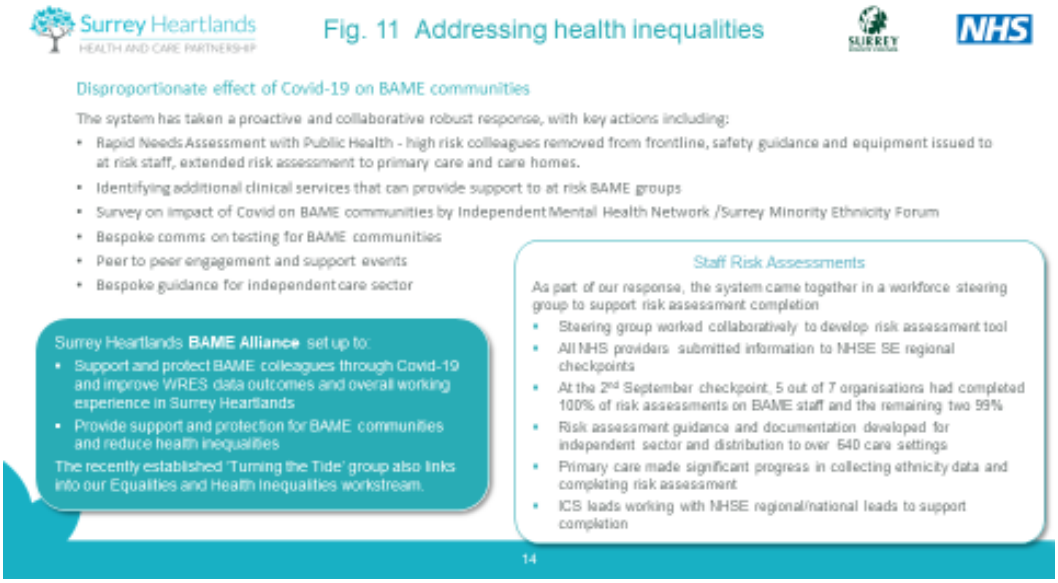
57. A core aspect of this, the Rapid Needs Assessments (RNAs) – as discussed at the September Health and Wellbeing Board, identified that:

- COVID-19 has had a disproportionate impact on certain groups within Surrey, including people from Black, Asian and minority ethnic (BAME) backgrounds, people experiencing domestic abuse, people with mental health conditions and those in residential care; and

- Across the spectrum of the RNAs, there were cross-cutting themes emerging, further emphasising support and resource needed for mental health, carers and vulnerable groups

58. Our Equalities and Health Inequalities work also links closely into key, related areas of work in Surrey Heartlands. For example, support for our BAME communities are core to the Local People Plan and our new 'Turning the Tide' Board.

Fig 11: Addressing Health Inequalities



Conclusions:

59. COVID-19 and lockdown have presented enormous challenges for health and care at every level. Our Recovery Programme in Surrey Heartlands is focused on meeting the citizen and patient need created by the pandemic and doing so in a way which captures the lessons and positive work from our COVID response.

60. Since the first wave we have taken significant steps to both restore services and to capture the valuable work accelerated and developed during the pandemic. Key examples include mutual aid on diagnostics, use of digital and the 'discharge to assess' model.

61. At the time of writing, we are experiencing a surge in demand across our services: COVID, non-COVID, physical and mental health, and care. Even as vaccines are rolled out, this unprecedented demand continues to place strain on our services. Given the fast-moving nature of these developments, a verbal update can be provided to the Committee as required.

Recommendations:

62. The Committee is asked to note the contents of this report and provide any comments on the Recovery Programme.

Next steps:

63. Surrey Heartlands Health and Care Partnership will continue to deliver the Recovery Programme, amending our approach for factors such the second and

any subsequent waves, vaccination roll out and any changes to the needs and priorities of our citizens and patients.

Report contact

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Appendix 1

Mental health update – as provided to the Recovery Co-ordination Group of the Local Resilience Forum on 14 December

Appendix 2

The graphs, tables and pictures included in the main report, in a clearer format for those printing the report, plus some additional information as referred to above in the main report.

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