Rotherham Metropolitan Borough Council

BRIEFING	TO:	Health Select Commission
	DATE:	3 September 2020
	LEAD OFFICER:	Katherine Harclerode Governance Advisor, Assistant Chief Executive's Directorate 01709 254352
	TITLE:	Outcomes of Workshop on Covid-19 – Response and Recovery (16 July 2020)

1. Background

1.1 **Present**: Cllrs Keenan (Chair), Albiston, Andrews, Bird, Cooksey, R Elliott, Jarvis, Short, Vjestica and Walsh

1.2 **Apologies**: Cllrs Ellis, Roche and John Turner

1.3 **Attendees**: Ian Atkinson - Rotherham Clinical Commissioning Group (RCCG)
Jacqueline Wiltschinsky – Public Health, RMBC
Michael Wright - The Rotherham Foundation Trust (TRFT)

1.4 **Purpose of the session**

1) To seek assurances regarding current activity in response to the Covid-19 pandemic and preparedness for any second wave.

2) To consider and comment on plans and activity for the recovery or re-set from the pandemic.

1.5 **Information**

A presentation set the context through a reminder of the time frame of key measures introduced by the Government in response to the pandemic. It also covered the signs and symptoms of Covid-19, what people should do if they had a positive test result and the guidance on self-isolation. An overview of the current position in Rotherham provided headline and comparative data. Details of the commencement of an enhanced testing strategy to prevent further transmission of infection were outlined.

Two short briefing papers summarised the changes that had been required across TRFT Acute and Community Services and to General Practice in Rotherham since the announcement of the level four national emergency in relation to Covid-19.

A third briefing in a similar vein from Rotherham Doncaster and South Humber NHS Trust has been shared with the Health Select Commission (HSC) and will inform a separate workshop on mental health in September.

Issues raised specifically in relation to children and young people's mental health and the impact of Covid-19 have been responded to in a short paper. This will be linked in with work by Improving Lives and to the update to HSC in December on the Mental Health Trailblazer pilot in schools and Child and Adolescent Mental Health Services.

2. Key Issues	
2.1	The situation in Rotherham, as across South Yorkshire, was one of higher infection rates than in other parts of the country at the time of the workshop, but partners had a good overview and closely monitored the data in order to be able to respond to any outbreaks or clusters and to identify any potential surge in infections. The Local Outbreak Engagement Board and the Health Protection Board were up and running and the Outbreak Control Plan had been peer reviewed, agreed and published, supported by a communications plan.
2.2	As infection rates were not reducing as quickly as partners would like to see, Public Health England and national leaders had given permission to use enhanced testing across South Yorkshire, making testing available to everyone, including testing residents without symptoms. The aim was to identify new cases earlier and to accelerate the decline in new cases. The key message was for the need to self-isolate even if people had no symptoms if they had a positive test result. Enhanced testing would be carried out in centres at Herringthorpe Stadium car park and the ex-bus depot on Midland Road and would concentrate on five areas: – Testing contacts of identified cases – Making testing as easily accessible as possible – Offering asymptomatic testing – Providing wider scale testing in workplaces with more than one case – Continue with other testing programmes (care homes etc)
2.3	The pandemic has led to significant changes in primary care and at Rotherham Hospital as partners had to adapt swiftly to meet the urgent demands of the Covid-19 pandemic. Models of delivery of care needed to be changed to ensure the safety of both patients and staff. In Rotherham this has been facilitated by the excellent place-based relationships and good partnership working, developed over several years. Good relationships also existed between the CCG and the 30 practices, which had been helpful when changes started to be made to managing patient care.
2.4	National direction set out specific requirements for hospitals, with TRFT instructed to: • Discharge all medically fit patients • Cancel all non-urgent operations from mid-April • Free up community and intermediate care beds • Suspend elements of community to allow for resource to be focused on the Covid-19 pandemic response
2.5	In primary care four main areas of activity are undertaken in general practice: • Urgent response • Chronic disease and long-term condition management • Immunisation and vaccination • Ongoing planned care around routine follow up In the early stages the CCG and GPs were asked to work on the urgent response around Covid-19 but they also tried to continue with the second and where possible with the third area of activity, especially for new-born babies and young children.
2.6	Several initiatives put in place by necessity in response to the pandemic have worked very well and the learning from these will inform future services and ways of delivering care. A number of the changes made during the peak of Covid-19 will continue on a temporary basis and others may become permanent. However, as the local system was

	still responding to the pandemic at the time of the workshop, it was difficult to provide specific details of timescales for decisions on key changes to pathways of care.
3. Key Points Discussed	
3.1	**Local Picture** Rotherham had 1,909 confirmed Covid-19 cases (cumulative at 12 July), which is 721.3 per 100,000 population and 275 deaths. The data showed that older people and males experienced worse outcomes from the coronavirus. Rotherham had no particular hotspots but was seeing infections among the working age population, which would be monitored. There could be a future focus on communities, geographical or of interest, for example if high transmission rates were seen through the data or if any clusters emerged. Also, possibly there could be a focus on houses of multiple occupation or areas with high density population. Members asked about other data on specific groups, such as disabled people or people from Black, Asian and Minority Ethnic (BAME) communities. There was some evidence at national level that BAME people were more at risk, but this was not really coming through in Rotherham. Track and Trace data was not detailed regarding BAME communities as it recorded postcodes rather than ethnicity. As at 12 July 2020, TRFT had treated 620 Covid-19 positive inpatients, with 389 having recovered and been discharged. Sadly, there had been 194 deaths. The pandemic had created unprecedented demand for high dependency care and at its peak TRFT were treating 70 Covid-19 positive patients, this figure had reduced to less than 20 who remained in acute beds.
3.2	**GPs** **a) Triage, Appointments and Consultations** Patient management and how they access primary care had really changed with “total triage”. Patient triage had already been in place via the Rotherham Health App by utilising the symptom checker and booking a telephone slot if it had determined an appointment was required. 10% of the population had the App downloaded but for patients without access to technology, a similar process was used where a patient would be telephone triaged to determine whether advice or a telephone slot was required. All GP’s were operating telephone appointments, with many using video consultation via the Rotherham Health App, which had been especially useful. Any promotion that Members could do in this regard would be welcome. Face to face appointments had been minimised unless absolutely necessary, with relevant Personal Protective Equipment (PPE) but were starting to increase in number again. Feedback from patients had been positive, advising that where telephone or video appointments were required these had been on the same day. A new primary care consultation service for suspected Covid-19 positive patients with primary care needs went live at the former walk-in centre at Rotherham Community Health Centre on 31 March. In another example of partnership working, this involved Rotherham Hospital releasing the site and deploying outpatient services to alternative sites, to enable patients to be treated in a separate site from those without symptoms. This had been effective in managing patient flow and keeping people safe. The service moved to Whiston medical centre on 15 June as TRFT required the building again to re-set services and is planned to remain in place until March 2021, which would also assist with resilience for winter or a possible surge in the pandemic.

Extended access to GPs encompasses core hours, 6-8pm on weekdays and the weekend hubs. Virtually overnight with lockdown a massive decrease in use ensued and this funding was used for the paramedic home visiting service (see below) and seven-day per week “hot site”, thus extended hours could still be provided if needed.

b) Home Visiting
A new service commenced on 16 April with four paramedics/advanced care practitioners undertaking ‘hot’ and ‘cold’ (“hot” - possible Covid positive and “cold” - routine) visiting on behalf of all practices across Rotherham and supporting care homes. The provider is a private paramedic service with fully trained paramedics capable of providing advanced care and is being piloted to the end of March 2021, using money from the national allocation. It started with two paramedics seeing on average 20 patients per day and then four on rota up to 30. It could be flexed again in the event of a surge between Covid possible and non-Covid patients and assists with winter preparations.

This service reduces the numbers of healthcare professionals going into patients’ homes and being at risk, reduces demand on practices and creates safe pathways. It has met with positive feedback from patients.

Ongoing debate occurs at national and local level about home visits, as many could be by paramedics or Advanced Nurse Practitioners and would not always need to be a GP as there was always the ability to go through 999 if urgent or to link back to senior decision makers. Potentially this service could be expanded further as traditionally all 30 GPs undertake their own home visits, so it would be a new model to have a borough-wide approach managed through a central point, which could be more efficient and effective in how patients are supported. Learning would come through the pilot.

Arrangements had also been agreed with the community team to reduce interactions in patient homes e.g. checking with the Care Co-ordination Centre at TRFT to establish if anyone else was due to visit the patient.

c) Care Homes
Almost 80% of care home patients in Rotherham already had an aligned GP providing regular ‘ward rounds’ enabling proactive care. This was extended in June to 100% of care home patients (registered with the CQC) having equal access to these arrangements in line with the national direction. This enables multi-disciplinary team and digital interaction with the care home around patient care and patient management.

d) Practice Capacity
Daily situation reporting (SitRep) from practices was working well. In addition to enabling system support, it informed the Directory of Service at 111 so if a practice had staffing issues and was struggling with capacity it would show on the national system. All GPs vary in size and number of staff, with more fragility and risk for some smaller practices and a possible impact on 2000 patients if one had to close. All practices had remained open but for some it had proved difficult to manage flow through, due to estate constraints, therefore remote triage was better. There has been no need to shift the patient list from one practice to another on a short-term basis but a process was there. Learning from this will be applied for winter.

e) Recovery and Re-set
The focus was on the primary care re-set now with new national guidance to comply with and getting all primary care services back on where possible. The next six weeks would focus on robust flu planning and ensuring patients who are high risk, vulnerable, over 65

3.3	and children would be vaccinated in a timely way in the next few weeks. (See 3.9 for more on vaccination under winter planning). **Rotherham Hospital** **a) Access to the Hospital** TRFT closed visiting (in line with national guidance) from early March but put measures in place to ensure inpatients could remain in contact with family and carers e.g. ipads in critical care and communication advisors going around the trust. Few complaints had been received. **b) Critical Care** For TRFT a major learning point had been in respect of critical care as the hospital had moved from a small, eight-bed unit to a larger space with 50 beds to meet the demand within the system and staff deployed accordingly to support the additional need within critical care. In order to enhance capacity, intense work had taken place to introduce new supplies of oxygen into the hospital and additional ventilators obtained, which had been sufficient for the peak. The thinking was now to move away from the larger critical care unit and patients had returned to the pre-existing smaller unit, freeing up beds that were needed as admissions increased again. **c) Urgent and Emergency Care** Access to the Urgent and Emergency Care Centre (UECC) had changed significantly with patients being triaged at the front door to screen for possible Covid-19. At the height of the pandemic low numbers of patients were attending the Urgent Care centre, falling from often 300 patients per day to 120/130 but confidence was returning and numbers increasing again. Concerns had been raised with Members by residents about other family members not being able to stay with the patient, even if the patient did not speak English, which had led to some reluctance to go to the UECC or to stay in hospital. At present it was still preferable for family members not to attend with the patient at UECC unless they were critically ill, a minor or had dementia. The hospital appreciated the difficulties but had access to phone interpretation services. **d) Community and Outpatient Activity** Both services had changed the way in which they worked to meet the demands of Covid-19 and this would be likely to continue. Many community services had moved to remote ways of working, only accessing individual homes where necessary. As with general practice, for people needing outpatient care more video and telephone support were made available. **e) Staffing – Capacity and Support** TRFT staff were praised for their commitment and bravery in responding to the pandemic and caring for patients, whilst working within some challenging environments. The number of staff self-isolating or shielding was tracked and monitored daily and the overall sickness absence (excluding Covid-related) was down, which was positive. After the tremendous efforts by staff, they needed some downtime and were being encouraged to take leave for their own wellbeing. A contact centre was set up and available for staff to talk about any conditions and could also offer support. Some of the funds from charitable donations had been invested in resilience training, which could be cascaded across the organisation. Support and occupational health were also available. Regular walks round the hospital from the executive team took place providing a visible presence. Morale was good and staff positive.

f) Recovery and Re-set

Whilst still responding to Covid-19, TRFT were focusing on re-establishing services, aspiring to 90% for March, with particular attention on ensuring cancer patients received timely care. Private sector use had helped for trauma and orthopaedics, urology, general surgery and accommodation. MRI and CT scans had been carried out in the private sector but the Trust was enhancing their internal capacity and a mobile MRI unit and CT scan in a box had been procured to help catch up. Further analysis would be necessary to understand the position on waiting lists for planned care.

Anecdotally Members had heard concerns from residents regarding cancer diagnosis and asked how the Trust was working to get cancer treatment and testing back up again. They asked if there were concerns over the cancer diagnosis rate in Rotherham. Scan results were pretty much business as usual and the Trust were unaware of any issues but if there were specific cases these could be discussed after the meeting. Members were asked to be mindful in their communities as one of the key challenges was late presentation of patients accessing health care services because of being fearful of Covid-19. People needed to be encouraged to go early so they were not presenting late in the pathways, at primary care in the first instance. Member support with messages would be extremely helpful.

3.4

Embedding New Ways

In starting to think about the re-set, Members inquired whether the lessons learned and new techniques might influence long-term ways of working and potentially be more robust, efficient and effective in both primary and secondary care. For the hospital there was learning from the use of technology for communication with patients where possible, and work with partners. Endoscopy and gastro-intestinal bleeds for on call patients had been handled by Sheffield in the evenings which seemed to work well and there was an arrangement with Barnsley. Private sector use had been invaluable and would continue to help TRFT get back on track.

One clear benefit of telephone and video consultation was the elimination of sitting and waiting for an appointment in a surgery waiting room, potentially exposed to illnesses from other patients, plus the time to travel there and back. Although this had arisen out of necessity Members wondered to what extent it would become the norm. Utilisation of digital means was on the national agenda for primary care due to the demands on the workforce but had been exacerbated by Covid-19 in both primary and secondary care, so a return to the previous model was unlikely. Engagement through the CCG with the Patient Participation Groups and individual patients showed it did represent a culture change but feedback had been positive from patients with co-morbidity or managing long term conditions. Further dialogue was needed and it was important to get the right balance and the right people being seen face-to-face.

3.5

Personal Protective Equipment (PPE)

This had been more of a concern in the early days but all partners gave assurances that current stocks were adequate and work continued to ensure this, including for the winter and in the event of a second wave. It would become a national level issue depending on the timing, size and scale of any second wave. TRFT were part of a joint procurement cell for the longer term. The CCG had also commissioned additional PPE and an order had been approved for the winter on 15 July 2020. Joint work and sharing PPE across the system assisted where necessary. PPE availability for vaccinations would also be

3.6 included within this and would depend on the delivery models used.

Communications

Public Health were working closely with the Communications Team and the Director of Public Health and community leaders were helping with the communication of key messages around the pandemic. Members emphasised the importance of clear,

accurate communication with residents as there seemed to have been cases of conflicting information.

Acknowledging the likelihood that increasing the number of tests would result in an increase in the number of people testing positive, Members explored how this would be communicated as media coverage seemed to be based on a "league table" type approach to reporting numbers of cases in different locations. It was important that people were informed that we had more cases because of carrying out the extra testing, to provide some reassurance. Residents were also asking if Rotherham would be likely to have a local lockdown.

South Yorkshire along with Bradford and Kirklees would be in a similar position. The communications and how data was used would both be key as the data was confusing and the point in time would be changed to a seven-day week data collection period rather than one day. A watching brief would be maintained.

3.7

Track and Trace Programme

The Government was working to refine the programme to speed up reaching contacts to minimise onward transmission. Feedback had been given about the need for speedier test results. Granular detail was not received, only overall data but now postcodes of cases were available this could be mapped. The Army run the centres and do the swabs which were then sent to Public Health England laboratories.

3.8

Testing

It was confirmed that home tests were available for residents without symptoms, either through ringing NHS 119 or ordering one on-line (best option if people had access to the internet) because of the special dispensation for enhanced testing. As people were being told they needed to have symptoms this would be escalated to the Local Resilience Forum as a South Yorkshire wide issue.

Under the national testing programme, private sector nursing homes would test staff weekly and residents monthly. Tests were carried out at the hospital for staff and had been from early on, including the antibody tests. It had been the case throughout that people testing negative had returned to work swiftly.

3.9

Winter Planning and Flu Vaccination

NHS partners and social care were preparing for winter pressures, taking account of Covid-19 and seasonal influenza. Emergency planning scenarios had formed part of the planning, learning from what had been done in past winters and the first wave of the pandemic. The intention was to ensure a vaccination plan that could deliver at scale and ensure the highest level of population coverage.

Members sought assurances about the availability of sufficient flu vaccine and plans to roll out vaccination early. Under the traditional model, over 65s were vaccinated through their GP with 3000-4000 patients seen quickly over six weeks, usually on Saturdays and Sundays, possibly some evenings. This model would not be possible this year, therefore new models of delivery at scale for primary care were being explored to have an accessible service. Pharmacists also do vaccinations and could potentially vaccinate over 65s but dialogue would be needed with them on the practicalities of delivery bearing in mind throughput of patients and the one in, one out scenario at pharmacies.

NHS England notification via Public Health England regarding targets for flu was expected w/e 17 July 2020. Irrespective of the targets Rotherham aspired to higher levels of coverage as the right thing to do for Rotherham residents. The timing of vaccinations will be key and is usually September or October with the same risks for

3.10	Rotherham as elsewhere. Availability of the vaccine is crucial, especially if the plan is for higher numbers to be vaccinated over and above what has already been ordered. **Preparedness for Second Wave** Actions outlined above contribute to being ready to deal with a second wave, in the autumn/winter – close data monitoring, enhanced testing, winter planning, vaccination plans and embedding new models and ways of working. However, across the entire health and care system limiting factors are always present in terms of the winter and then early recovery of the services - the ability to work with the physical estate to manage patient flows and keep staff and patients safe; availability of staff at work; and availability of PPE.
4. Recommendations from the Workshop	
4.1	The Health Select Commission are asked to endorse the recommendations below that emerged from the workshop and to consider any additional ones they wish to make. • That the gratitude and thanks of the Health Select Commission to colleagues working at Rotherham Hospital and in primary care be formally recorded and fed back, commending them on their commitment and bravery in responding to the pandemic and caring for patients. • That the gratitude and thanks of health partners to colleagues working in care homes be formally recorded and fed back, in recognition of their hard work and care for residents during the pandemic. • That members of the Health Select Commission support the Council and partners through their communication with residents to help people understand the measures being taken and to reiterate the key messages and to encourage people with health needs to go to primary care in the first instance to ensure early presentation for diagnosis. • That members of the Health Select Commission encourage residents to download the Rotherham Health App if they are able to use the technology.