City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Health and Care System Executive Board to the meeting of Health and Social Care Overview and Scrutiny Committee to be held on 18 August 2020

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Subject:

Health and Care system update

Summary statement:

The challenge posed by Covid 19 has amplified the health needs of our population and the inequalities between people. It has also highlighted the existing strengths and weaknesses of our health and care system, and shown us how we need to be in the next phase in order to meet the needs of our people. In summary we have learnt;

- Our health, care and wider system relationships established over years have come into their own
- Our differences where we had them have been set aside
- We've all 'mucked in' if a job needed doing
- We've done some great things and we have some things we would do better given time and hindsight

In short we achieve better results for people when we **Act As One**

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Portfolio:

Healthy People and Places

Overview & Scrutiny Area:

Health and Social Care

1. SUMMARY

The challenge posed by Covid 19 has amplified the health needs of our population and the inequalities between people. It has also highlighted the existing strengths and weaknesses of our health and care system, and shown us how we need to be in the next phase in order to meet the needs of our people. In summary we have learnt;

- Our health, care and wider system relationships established over years have come into their own
- Our differences where we had them have been set aside
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In short we achieve better results for people when we **Act As One**

At the time of writing we remain in a fast changing situation with regard to the level of Covid 19 infection in the District and the control measures which this necessitates. As a result the recovery plans of the local health and care system may need to adapt at short notice.

2. BACKGROUND

One of the collaborations that has served us well during the height of the pandemic, and which we will now embed in our system for the long term is the Covid Scientific Advisory Group. Based on collaboration between all the analytical, intelligence and research assets of our local system, C-SAG has acted like a local 'SAGE' informing system decision making with analysis of data and primary research undertaken with local families. For example a study of 1000 local families identified that:

- 24% live with someone in vulnerable category, 29% in Pakistani families
- 22% lived in over crowded homes and 7% had no outdoor space
- 38% reported that they are just about getting by or finding it difficult to manage
- 23% reported that food often didn't last and they couldn't afford more.
- 24% are doing more physical activity, but 48% are doing less (57% of Pakistani heritage, and 68% of people who are struggling financially).

3. REPORT ISSUES

3.1 Prior to the pandemic we knew that we could not continue as we were. Demand grew, supply was limited by several factors, and inequalities were prevalent. Covid has impacted significantly on need, demand and supply – and continues to do so. We must put safety first, which means only addressing demand in the old ways is not viable. Therefore our strategy is to **Act As One.**

While Covid has amplified the needs and inequalities of our society, these were known to us before. So it follows that our strategy is fundamentally still the right response, but our tactics will need to adapt to new circumstances. The Basics are:

- Make sure every part of our system works together as effectively as possible – this is our Act as One approach – and includes embedding the transformational learning from Covid

- Push hard the left shift of resource and emphasis towards prevention – optimising supply alone will never meet demand – we need to find better ways of avoiding and addressing needs arising

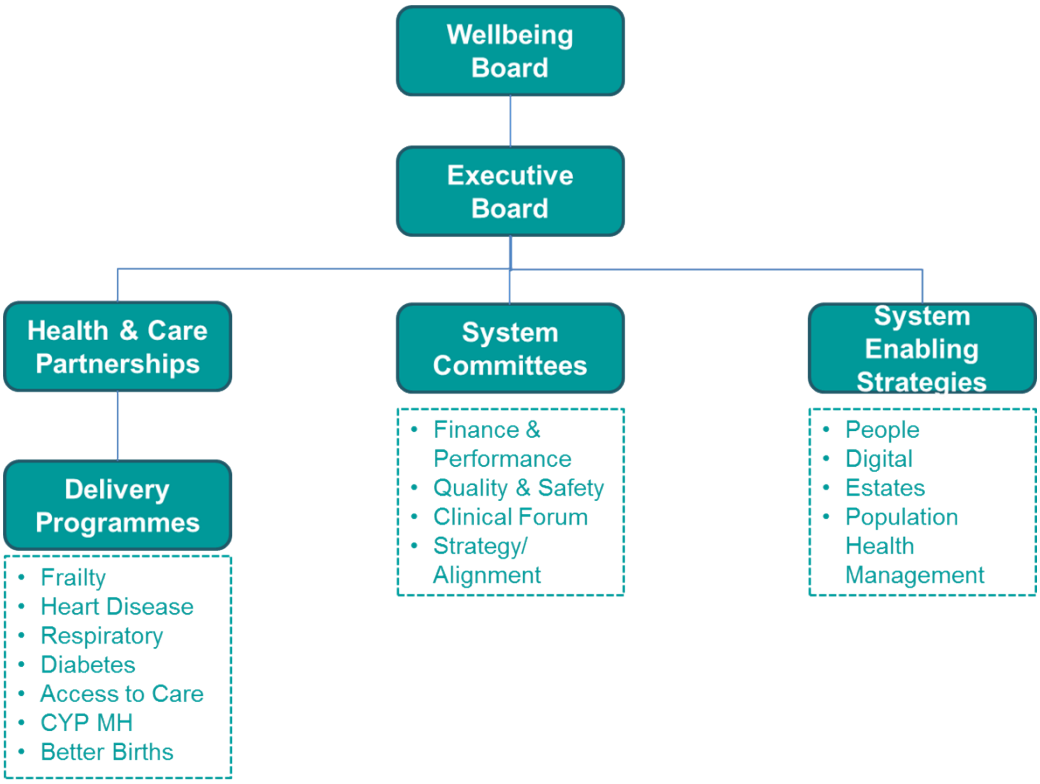
- Use of Population Health Management approach to guide everything we do – the way we prioritise use of services, and the way we target prevention to address inequalities

3.2 Act As One

We have observed in our teams; amazing innovation, collaboration, determination to do the right thing and put people first; and the power of agile working together when we have a shared goal. We want to make this the way we work together all the time

- Clinically and Community led change. Starts with empowering people, informed by clinical forum – drive the left shift at every point on pathway
- Build back better– apply COVID learning and find opportunities to sustain changes, where appropriate in order to address inequalities. Maintain agility and pace in change to sustain momentum.
- System by default – collaborate to be more than the sum of the parts – do the right thing for the person first – resolve organisational consequences second, and do this as a system. Impact on one is responsibility of all
- Bureaucracy light – what can we stop or do once?
- Integration - Service design that enables integration. Clarity of ask of enablers. Optimise through joined up governance
- COVID ready = Safety first – hot/ cold separation/ care for shielded people

3.3 Our Act As One governance arrangements



3.4 Our priorities for recovery

- Clinically led prioritisation – urgency and impact on outcome
- Wellbeing of shielded population and those with multiple long term conditions
- Wellbeing of vulnerable children and adults
- Prioritise prevention – e.g. vaccinations and immunisations
- Target inequality – people are experiencing higher levels of deprivation – currently considering how to operationalise this in prioritisation.
- Single place based approach to demand and capacity management, to make best use of all facilities and capacity wherever they are in Bradford District and Craven – e.g. some may be located in primary care, some in the independent Sector and some in local NHS hospitals. All should be used together in order to minimise waits for people.
- Use digital platforms to underpin transformation (Shared clinical records, patient portals, communication tools)

3.5 Our capacity and finance challenge

Local Government has had to meet additional costs related to the impact of Covid (beyond the £30.5m received from Government). Revenues have also reduced. In spite of this CBMDC has made an additional investment of £6m to support vulnerable people.

The CBMDC year end deficit could be as much as £60.7m. In the short term this will be covered through the use of reserves. In the longer term it is expected that there will be a continued impact on both need and income.

The Voluntary & Community Sector has experienced a significant impact, driven by high demand and reduced income from trading.

NHS organisations have planned around a base case before any national NHS financial support which would lead to a deficit of £90m for the health system as a whole at year end.

Assuming receipt of Month 1-4 support regarding Covid, and delivery of elective activity within existing capacity the net year end position would be a deficit of £51m. However this would deliver a level of activity which would be insufficient to meet the needs of our population, and would result in longer waits for treatment.

Plans have been developed to accelerate the level of elective activity which the system could undertake, but this is conditional upon receipt of additional funding, which would be used to make premises and ways of working as Covid-safe as possible. However initial work on these plans has shown that this would require a considerable level of investment of circa £92m to breakeven at year end.

Even with this additional investment we will not get to full capacity and deliver as much elective treatment as we did last year. Activity levels would be assisted by our new ways of working, but would still remain below that which is required to meet demand.

This highlights that the direction of travel to reduce referrals into hospitals is even more essential than was recognised prior to Covid.

SYSTEM	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Outpatient attendances	59%	67%	69%	67%	68%	77%	60%	69%	81%
Elective Spells	47%	46%	47%	47%	47%	52%	44%	50%	70%
Non-Elective Spells (excluding covid patients)	62%	56%	66%	68%	79%	89%	85%	90%	119%
Average number of available G&A beds (As per A&E SitRep)	86%	81%	81%	81%	96%	96%	97%	97%	97%
Average number of available Adult Critical Care beds(as per A&E SitRep)	100%	101%	175%	175%	176%	100%	100%	100%	100%
Diagnostic tests or procedures	57%	65%	73%	68%	71%	78%	66%	75%	93%

AHFT	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Outpatient attendances	48%	65%	67%	72%	72%	73%	76%	75%	69%
Elective Spells	54%	55%	65%	65%	65%	65%	65%	65%	65%
Non-Elective Spells (excluding covid patients)	71%	72%	75%	75%	82%	81%	95%	95%	95%
Average number of available G&A beds (As per A&E SitRep)	100%	102%	102%	101%	100%	97%	94%	98%	100%
Average number of available Adult Critical Care beds(as per A&E SitRep)	100%	100%	100%	100%	100%	100%	100%	100%	100%
Diagnostic tests or procedures	70%	70%	70%	80%	80%	80%	85%	85%	85%

BTHFT	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Outpatient attendances	63%	67%	69%	67%	68%	77%	60%	69%	81%
Elective Spells	42%	46%	47%	47%	47%	52%	44%	50%	70%
Non-Elective Spells (excluding covid patients)	58%	56%	66%	68%	79%	89%	85%	90%	119%
Average number of available G&A beds (As per A&E SitRep)	80%	81%	81%	81%	96%	96%	97%	97%	97%
Average number of available Adult Critical Care beds(as per A&E SitRep)	100%	101%	175%	175%	176%	100%	100%	100%	100%
Diagnostic tests or procedures	52%	65%	73%	68%	71%	78%	66%	75%	93%

3.6.1 Managing Demand

GP referrals restarted as of the 1st July. They will go via GP Assist which is a form of triage which advises if a referral is appropriate.

Expansion of e-consult and advice and guidance.

3.6.2 Non-elective care

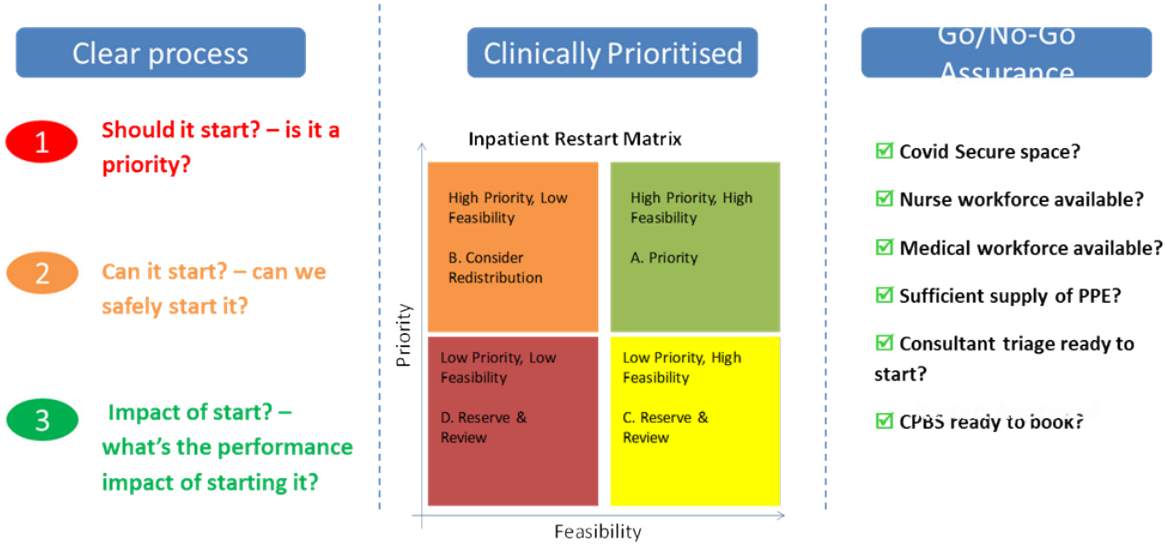
A&E – assume capital investment is available to address capacity constraints as a result of infection control and social distancing measures

Increased Same Day Emergency Care

If demand exceeded current Critical Care capacity, escalation would occur and other activity would be paused

3.6.3 Elective Activity

Elective activity has been prioritised according to National Guidance and procedures classified using London Clinical Prioritisation methodology



Constraints: Theatre activity, Lost inpatient bed base from creating covid medical bed capacity and through Infection Prevention and Control/ social distancing arrangements, theatre staffing, social distancing in out patient waiting areas

3.6.4 Independent Sector

Independent Sector capacity (Yorkshire Clinic and Optegra) have both been contracted nationally and have mainly been focused on cancer, endoscopy, and Yorkshire Eye has been doing urgent eye work. Primary care has also supported the system e.g. with ultrasound where available.

Current assumption on elective activity includes Independent Sector activity only where agreed and in place to date - additional community-based capacity is being considered as part of system demand management

3.6.5 Backlog & unmet need

AHFT: 8,000 patients on an incomplete RTT pathway, 3,500 diagnostics patients and approximately 32,000 Outpatients requiring to be rebooked and seen

BTHFT: circa 20,000 on an incomplete RTT pathway & 3,500 diagnostics patients

3.6.6 Winter

System winter planning will focus on:

- Managing demand through Admission Avoidance
- Improving Patient Flow and Facilitating Discharge
- Reducing Length of Stay

- Managing bed capacity (acute, community and care home capacity)
- Will reflect learning from Covid system work

And

- Social distancing, Infection prevention, PPE and Zoning - operational impact will be circa 30% productivity (on all points of delivery)
- Testing assumed to continue and grown in scale and timeliness - alongside considered impact of test and trace.
- Consideration given to impact on workforce of prolonged acute phase, annual leave period and longer term impact on staff
- Occupancy – maximum set to support hot/cold environment and the most efficient flow possible of patient groups

We are currently planning for a wide-range of scenarios – including preparation for demand of up to 120% of levels in previous years. Within this planning we're considering and preparing for the potential of a second peak of Covid. This requires us to ensure that both hospital and community bed capacity is available if needed; and to focus on options to bolster out of hospital care, which makes a significant contribution to the effective management of demand.

To deliver our plan we must focus on our people and how we support them through winter following a challenging first part of the year. Availability of workforce will need to be a key consideration in preparation for winter. HR Directors monitor key workforce resilience measures fortnightly.

Flu campaign (staff and general population) will be a key component of planning. Work is underway on this.

Planning for non-elective demand associated with Winter will need to be done alongside the continued restart of planned activity. Bradford Teaching and Airedale working together on plans, this includes maximising available physical and workforce capacity in the system (including the independent sector)

3.6.7 Mental Health

In mental health this is not about stepping up services but rather the return to normal levels of activity, and widespread application of digital enabled delivery models. All pathways to MH services have remained open and unchanged through COVID. Adaptations have been made to service delivery to ensure people have had continued contact and access at the most appropriate level.

Additionally during Covid we have seen a significantly increased demand and acuity in VCS mental health services
We have undertaken communications campaigns to advertise that pathways are open and to encourage early access and referral. We have undertaken initiatives to prevent escalation and Emergency Department attendances. E.g. MH 1 Car/Street Triage with WY Police and LA.

The key thing for mental health providers is the unknown element of the medium to long term impact of Covid on our communities from a mental wellbeing/trauma perspective

- Pressure on inpatient mental health services is particularly high especially psychosis and mood disorders. Unprecedented levels of acuity = increased PICU activity and use of s136.
- First Response Service Call volumes relatively unchanged however peaks times have altered (weekday evenings). Whilst call numbers remain unchanged we have seen a doubling of referrals from police and relatives and triple in terms of self referrals, offset by the drastic reduction in referrals from GPs.
- Intensive Home Treatment Team Caseload sizes normal, number of red cases higher than usual. Partly acuity but also partly about how lockdown changes how we view risk e.g. less opportunity for additional support networks, less face to face etc.
- Older Peoples Mental Health Dementia Assessment Unit continues to have low occupancy. Changes to care home and family support is being mapped as a model for on-going delivery.
- CAMHS Referral rates returning to usual levels. Activity rates show ~75% increase in terms of appointments and contacts. In part enabled by enhanced use of technology. We remain focussed on vulnerable children as major focus of both CAMHS and 0-19 service.
- IAPT Referral rates increasing however not yet back to usual levels. Recovery rates continue to improve (all above 50%). Demonstrates effectiveness of the current digital offer.
- Learning Disabilities: No significant change to activity levels. Teams continue to offer blended approach digital and face to face. No requests for admission to ATU showing effective management of risk

3.6.8 Workforce

Strategic Workforce priorities

- Supporting system transformation programmes
- Maintaining workforce health and wellbeing
- Improve the diversity of our workforce with a focus on BAME leadership

The wellbeing of our Workforce

In summary aiming to review the work established during the covid emergency response phase and build a sustainable model that supports both the health and the care sector workforce requirements:

- System wide offer developed by the Bradford District and Craven Health and Wellbeing KIT Group. The group pulled together the top picks of existing national, regional and local health and wellbeing offers (evidence based and best practice offers and developed a 'front door' to health and wellbeing for all health and care staff on the West Yorkshire & Harrogate Health and Care Partnership web site: https://www.wyhpartnership.co.uk/our-priorities/coronavirus-covid-19-information-and-resources/new-workforce-health-and-wellbeing
- The initial focus was on self-care and prevention of longer-term mental health needs arising. The next phase is building on this and recognises the need for offers that will

provide medium to longer term support.

- Additional wrap around support for Care Homes has been provided through a psychological helpline provided by BDCFT
- Support for care homes has initially focused on supply of staff, training and wellbeing support. Will now add a focus on restarting workforce development
- Flu campaign for staff – system approach – intention for 100% staff have vaccine
- Medium term aim to support the training needs for the care sector, plan to enable as much training as possible to be online and accessible to all via shared platform.
- Focus on the diversity of our workforce and engaging with BAME networks to shape our approach to diversity across workforce with focus on leadership

Workforce Supply

National Bring Back staff campaigns. Initially focused on supply into 111 and directly into NHS Trusts. Then opened up to include the independent care sector. This involved matching supply with demand using the care sector capacity tracker. A Care Sector Resilience group still meets regularly alongside a nursing task and finish group.

A system wide casual staff bank has been established through Skills House, which provides flexible, trained staffing for the care sector, deployed in ways which maximise infection control.

Workforce Deployment and Resilience

A Memorandum of Understanding has been developed and agreed between all local NHS trusts, the Council, Bradford University and General Practices. This enables staff of one organisation to work safely and flexibly across the whole system, to meet people's needs.

A Mutual Aid scheme for the care sector has been developed, and is currently being tested before any final decision to implement.

A tele-medicine 'super rota' was established at pace to provide medical support and advice into Care Homes via the Airedale Telemed Hub. This improved timely access to a wide range of clinical support, dramatically reducing the need for unsettling hospital attendances. This arrangement has been extended until October and will be reviewed in line with changing needs.

Workforce Development

Majority of essential training and development has moved to virtual/on line or via selective socially distanced programmes

Programmes have been established to meet specific needs eg rapid delivery of Infection Prevention Control train the trainer's programmes into Care Homes.

Non-essential training and development was paused to allow focus on service delivery. Some programmes now being restarted where possible and appropriate

4. FINANCIAL & RESOURCE APPRAISAL

Incorporated into section above

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

- The on-going heightened presence of Covid19 infection in our District, and the control measures which this necessitates, must be balanced with the need to accelerate the diagnosis and treatment of non-covid healthcare needs; in order to avoid delays in treatment leading to poorer outcomes.
- Workforce is tired and needs time to recover
- Lack of public confidence in accessing healthcare
- Need to restart alongside the presence of COVID 19 and related productivity implications: hot and cold zones, testing, cleaning, PPE donning / doffing etc
- Limited community capacity for longer term rehab/ re-ablement for people recovering from Covid19.
- Sector viability in Care Sector and VCS both at tipping point

	Risk	Response
1	There may be insufficient PPE to keep staff safe and treat all patients	Availability of PPE is one of the Go/No go safety questions before re-starting any additional elective/ routine activity. Implement daily tracking and control of PPE stock and availability
2	Significantly reduced capacity to assess and treat people due to reduced productivity (bed spacing/ PPE use etc)	A 2 x weekly clinical prioritisation process is in place to ensure surgical; capacity is prioritised for patents whose disease progression is time sensitive, rather than just by time waiting . Work in partnership with ISP to make best use of physical capacity. Implement advice and guidance services to provide specialist advice and minimise the need for referral to secondary care.
3	There may be insufficient staff available to restart elective activity as well as manage acute demand	Availability of staffing is one of the Go/No Go safety questions before re-starting any additional elective/ routine activity. Prioritise activity based on clinical urgency to make best use of staffing resource. Work in partnership with independent sector providers to make best use of all available staffing capacity Consider flexible deployment of staff across the system and within organisations Development of surgical hubs to coordinate specialist resource .
4	Impact of covid control measures on new operating model reduce our productivity more than anticipated, resulting in less activity/ longer waits/ worse outcomes, and reduced confidence in system.	Planning accuracy – closer 30% than 10%. Accelerate shared estate/ operating models
5	Public fears (& reluctance re testing and isolation requirements) increase DNAs, reduce activity levels, worsen outcomes	Targeted community communications and engagement. Demonstrate safe environments
6	Continued reduction in covid reduces sense of urgency to change – lose momentum – tired people tempted to go back to 'old ways'	Communicate the reality, maintain agile and empowered ethos. Reinforce progress with comms. Widespread engagement in change

	Risk	Response
7	Care homes 'fill up again' rather than growing domiciliary care options – because market under developed/ staff supply limited – resulting in limited implementation of care sector strategy	Additional support for care sector transformation. Engagement of supplier base. Focus through Centre for Workforce Development
8	Insufficient community capacity for longer term rehab/ re-ablement for patient recovering form Covid19. Leading to longer LOS in hospital, which limits the capacity for increasing elective activity	Seacole rehab facility and diversion of community teams towards this requirement. Impacts on other service availability. Work with social care and voluntary services to help people receive reablement support at home and reduce reliance on long term care. Develop multi-skilled generic roles – ie care staff/ therapists who can work within a hospital or community setting and provide holistic care to people.
9	Restricted diagnostic capacity creates bottlenecks, hinders clinically led prioritisation, outcomes and experience deteriorate. Limits capacity for restoration of elective activity.	Use of IS and AQP, collective system approaches, capital bids for expansion of diagnostic capacity.
10	Risk of crowding in Emergency departments as attendances increase to pre-covid levels	Maintain separate red/ green ED assessment and treatment areas. Develop direct to specialty assessment pathways to minimise time in ED Focus on increasing medical or surgical assessment/ same day emergency care pathway limiting the waiting time for assessment and reducing the need for overnight stay. Expand facility for see and treat and focus staff on initial assessment. Use digital technology for advice and guidance/ triage Explore 'call before you walk' model
11	People with cancer may suffer harm due to delays in treatment or delays in accessing investigations	Continue pathway tracking and MTD regular review to identify risk of harm Identify innovations to implement a risk based triage of cancer referrals – eg FIT/ pinpoint. Prioritise capacity for early diagnosis. Prioritise capacity for treatment by clinical urgency Promotion of screening services / communications to local population on early warning signs of cancer.

6. LEGAL APPRAISAL

NOT APPLICABLE

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

Covid Scientific Advisory Group work (https://www.bradfordresearch.nhs.uk/c-sag/) highlighted disproportionate impact of Covid on BAME communities, older people, people living in poverty, and people with pre-existing long term conditions (both from Covid and control measures such as shielding)

Priorities for re-start and recovery include commitment to 'target inequality'. Currently considering how to operationalise –e.g. which aspects of inequality? how to reconcile with NHS freely available to all at point of need irrespective of personal characteristics

BAME workforce disproportionately impacted by Covid. All BAME staff offered risk assessment conversation with line manager to support safe working. All NHS organisations reporting completion of risk assessments until all reach 100% - includes staff not at work e.g. mat leave, shielding etc

7.2 SUSTAINABILITY IMPLICATIONS

Increased use of digital and telephone for service provision. Increased use of ‘advice and guidance’ from secondary care clinicians to primary care clinicians. these elements have been critical to maintaining access to care during Covid, and have contributed to a reduction in travel to access healthcare. This will have reduced the carbon footprint of healthcare locally.

Additionally, many health and care workers in supporting roles have been enabled to work from home, and meetings have largely moved on-line. This has further contributed to a reduction in the carbon footprint of the local health and care system. Much of these adapted ways of working will be sustained for the foreseeable future.

Some impact on economic activity associated with working from home. 27,000 people work in health and care in Bradford and Craven. the majority are engaged in care directly with people and therefore will have continued to travel to ‘work’. However a significant minority will no longer be utilising car parks, buying lunch, and making ad-hoc purchases in local shops. Some of this will be displaced – e.g. towards supermarkets and on-line retailers.

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

Included in section above

7.4 COMMUNITY SAFETY IMPLICATIONS

Local command structure has focused on ensuring Covid safety messages reach all communities. Use of social media, support of local community leaders remains critical part of ensuring messages reach all parts of our population. Will remain essential throughout recovery phase.

7.5 HUMAN RIGHTS ACT

NOT APPLICABLE

7.6 TRADE UNION

NOT APPLICABLE

7.7 WARD IMPLICATIONS

NOT APPLICABLE

7.8 AREA COMMITTEE ACTION PLAN IMPLICATIONS (for reports to Area Committees only)

NOT APPLICABLE

7.9 IMPLICATIONS FOR CORPORATE PARENTING

NOT APPLICABLE

7.10 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

NOT APPLICABLE

8. NOT FOR PUBLICATION DOCUMENTS

NONE

9. OPTIONS

NOT APPLICABLE

10. RECOMMENDATIONS

The Committee is invited to receive the report.

11. APPENDICES

NONE