The impact of Covid-19 upon NHS services in Derbyshire

Improvement and Scrutiny Committee – Health
Derbyshire County Council

23 November 2020

Overview of current position

- Derbyshire was escalated to Tier 2 on 31 October 2020 followed by national lockdown from 5 November
- Nationally we are in wave 2 of the pandemic.
- NHS nationally is at EPRR Level 4 (Emergency Preparedness Resilience and Response).
- CCG is at Level 3 currently but awaiting national guidance.
- Health and social care system under increasing pressure due to the convergence of significantly accelerated COVID-19 demand and winter which we must balance with restoration and recovery plans.

Examples of trends across the pandemic

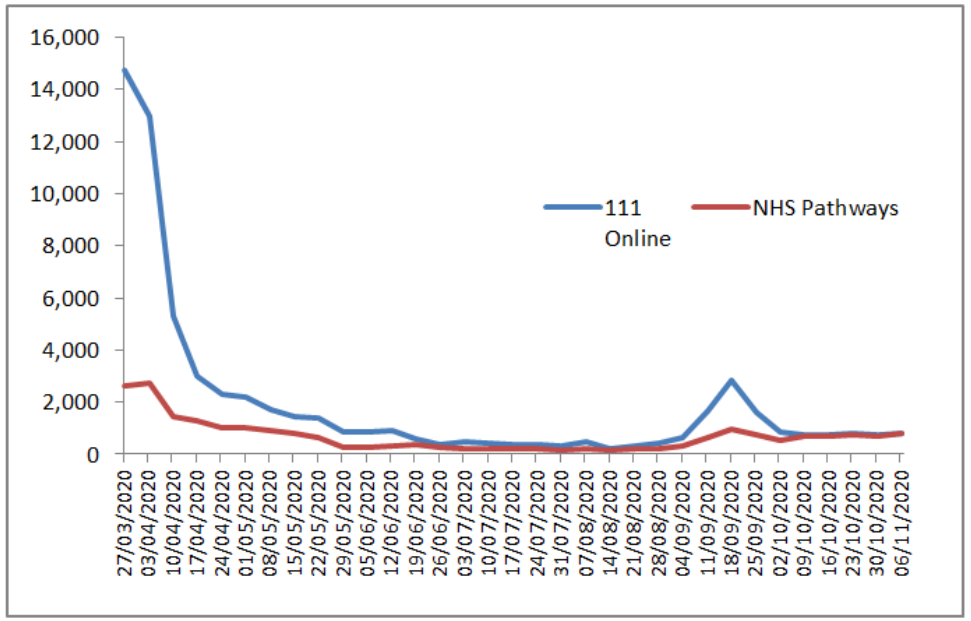
Please note that latest figures provided are subject to validation .

Covid-19 incidence – NHS 111

At the beginning of the COVID-19 Pandemic the 111 service experienced a high demand, resulting in the weekly publication of activity for the service in terms of these calls. As this table & graph show, the initial demand had reduced but peaked again during September, reaching similar levels to those experienced in April. Although now reduced the numbers are still high.

Week Ending	111 Online	NHS Pathways
27/03/2020	14,716	2,627
03/04/2020	12,989	2,728
10/04/2020	5,303	1,462
17/04/2020	2,978	1,294
24/04/2020	2,297	1,011
01/05/2020	2,194	997
08/05/2020	1,706	922
15/05/2020	1,445	813
22/05/2020	1,374	644
29/05/2020	865	242
05/06/2020	866	260
12/06/2020	934	324
19/06/2020	589	384
26/06/2020	371	248
03/07/2020	457	220
10/07/2020	423	202

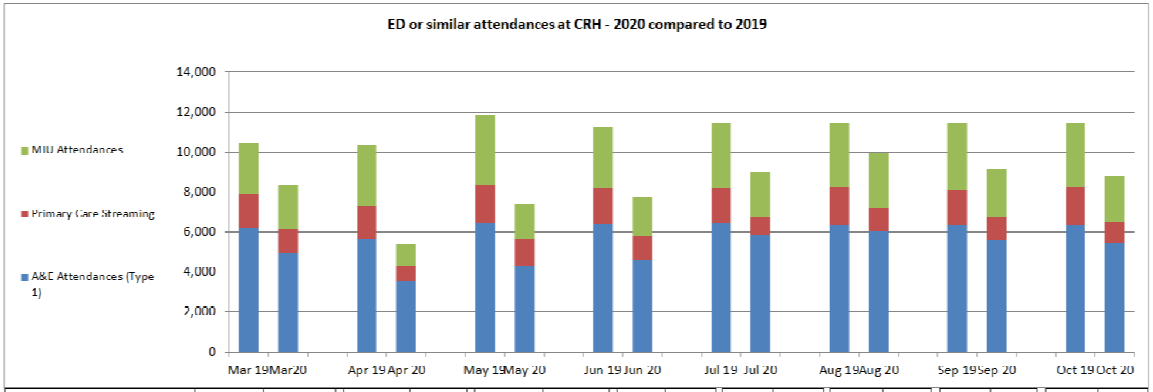
Week Ending	111 Online	NHS Pathways
17/07/2020	360	201
24/07/2020	396	186
31/07/2020	324	155
07/08/2020	457	218
14/08/2020	217	185
21/08/2020	338	229
28/08/2020	441	238
04/09/2020	625	317
11/09/2020	1,662	641
18/09/2020	2,843	965
25/09/2020	1,624	763
02/10/2020	855	558
09/10/2020	764	696
16/10/2020	747	685
23/10/2020	800	762
30/10/2020	761	701
06/11/2020	782	788



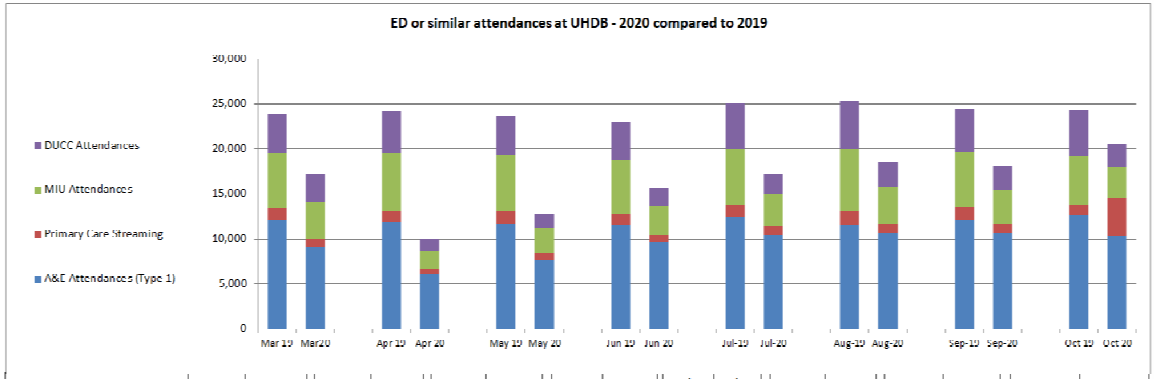
- *These count the number of contacts with potential COVID-19 symptoms reported by members of the public to NHS Pathways through NHS 111 or 999 and 111 online - not based on the outcomes of tests for coronavirus.*
- *111 Online: Online assessments in 111 online which have received a potential COVID-19 final disposition.*
- *NHS Pathways: The number of NHS Pathways triages through 111 and 999 which have received a potential COVID-19 final disposition.*

A&E demand

The overall volume of presentations to both EDs has increased since the April 2020 low, in October we saw around 82% of what we would have 'expected' based on a like-for-like analysis.



	Mar 19	Mar20	Apr 19	Apr 20	May 19	May 20	Jun 19	Jun 20	Jul 19	Jul 20	Aug 19	Aug 20	Sep 19	Sep 20	Oct 19	Oct 20
A&E Attendances (Type 1)	6,229	4,960	5,678	3,545	6,451	4,322	6368	4634	6481	5865	6,349	6033	6,334	5600	6,349	5478
Primary Care Streaming	1,661	1,176	1,629	754	1,878	1,362	1818	1195	1711	933	1,920	1150	1,771	1161	1,920	1031
MIU Attendances	2,540	2,250	3,058	1,099	3,535	1,728	3043	1967	3290	2174	3,220	2766	3,366	2355	3,220	2294
Total Attendances	**10,430**	**8,386**	**10,365**	**5,398**	**11,864**	**7,412**	**11229**	**7796**	**11482**	**8972**	**11489**	**9949**	**11471**	**9116**	**11489**	**8803**

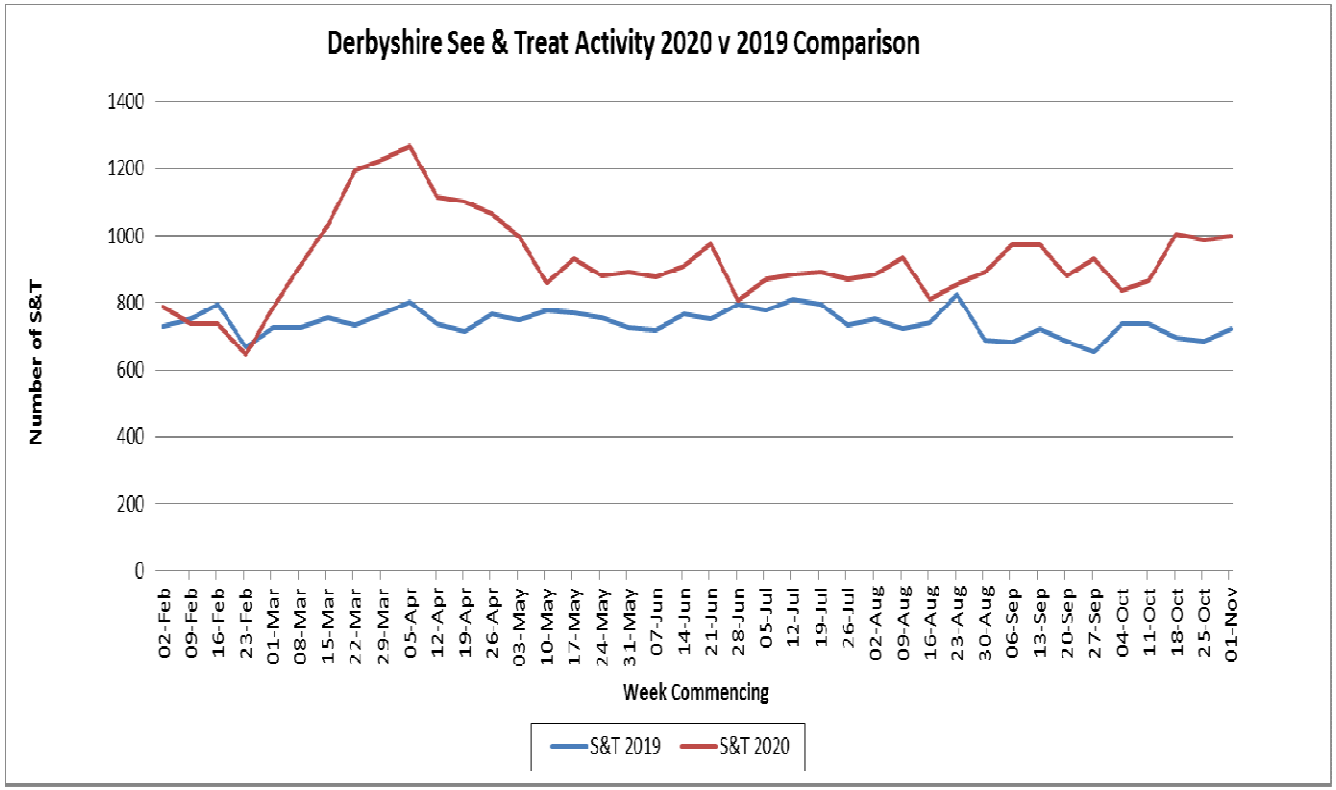


	Mar 19	Mar20	Apr 19	Apr 20	May 19	May 20	Jun 19	Jun 20	Jul-19	Jul-20	Aug-19	Aug-20	Sep-19	Sep-20	Oct 19	Oct 20
A&E Attendances (Type 1)	12,129	9,094	11,823	6,213	11,761	7,682	11,540	9,710	12,447	10461	11,586	10684	12,130	1066/	12,644	10385
Primary Care Streaming	1,319	939	1,302	495	1,344	689	1,222	699	1,369	969	1,498	1012	1,356	944	1,123	4167
MIU Attendances	6,109	4,075	6,431	2,027	6,248	2,973	6,060	3,177	6,170	3539	6,881	4013	6,195	3776	5,490	3390
DUCC Attendances	4,343	3,094	4,580	1,256	4,276	1,532	4,140	2,073	5,084	2284	5,281	2836	4,792	2710	4,981	2559
Total Attendances	**23,900**	**17,202**	**24,136**	**9,991**	**23,629**	**12,876**	**22,962**	**15,659**	**25,070**	**17,253**	**25,246**	**18,545**	**24,473**	**18,097**	**24,238**	**20,501**

March – October 2020 A&E attendance volumes vs. 'Expected'

	CRH	UHDB	Total
March	80%	73%	75%
April	52%	42%	45%
May	62%	55%	58%
June	69%	68%	69%
July	78%	69%	72%
August	87%	73%	78%
September	79%	74%	76%
October	77%	85%	82%

Ambulance activity

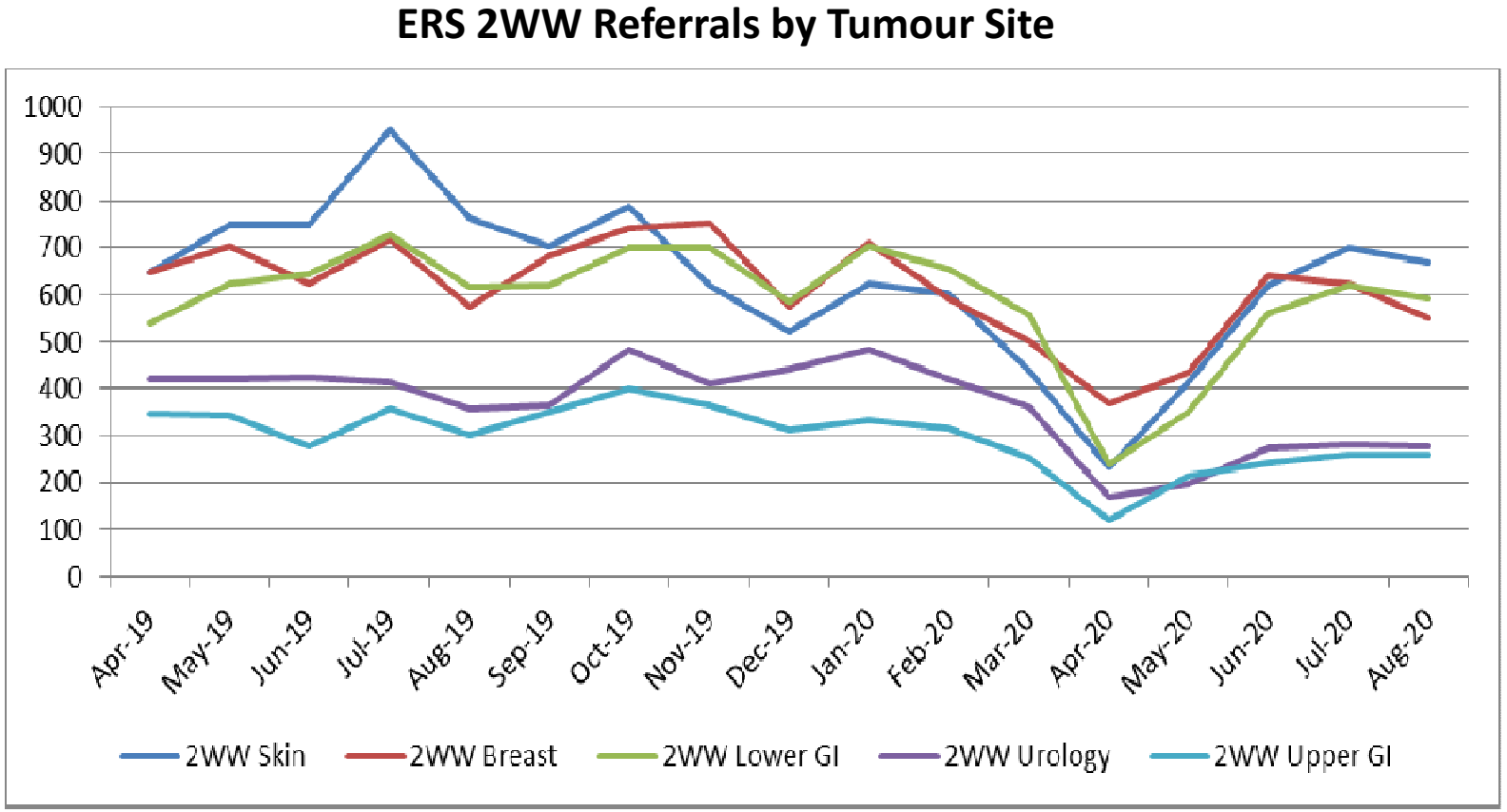


See & Treat saw a steady increase at the beginning of March before peaking at 1268 on WC 05/04/20, a 50% increase on pre-COVID levels. Since then, activity has declined but currently remains above the pre-COVID level.

Work is ongoing to safely reduce avoidable conveyances as part of a national programme.

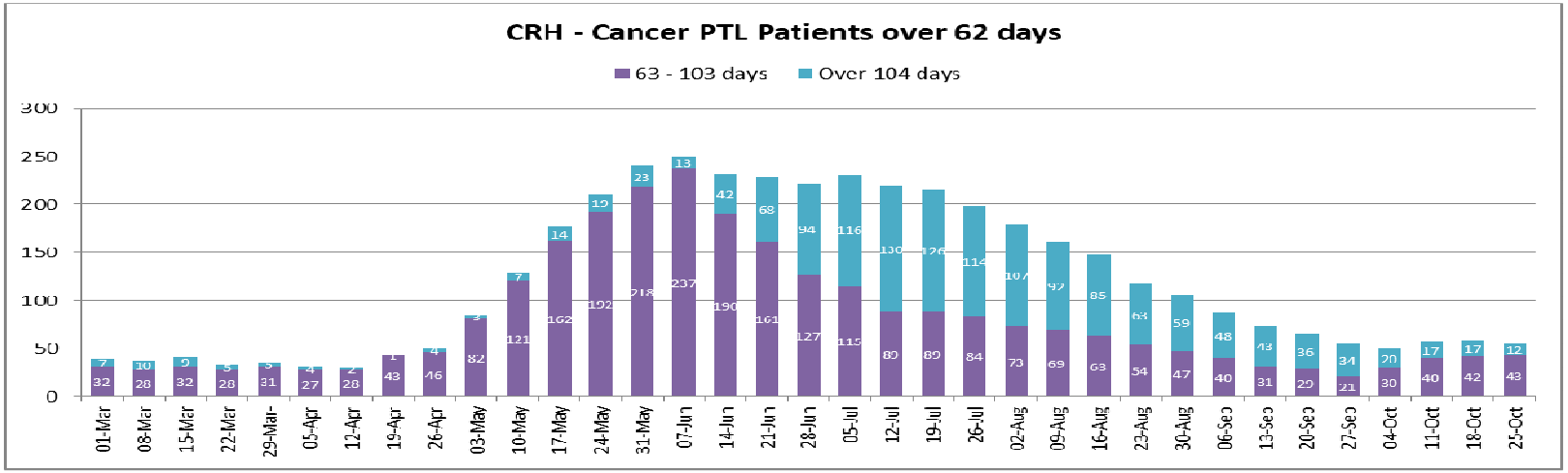
2 week wait referrals

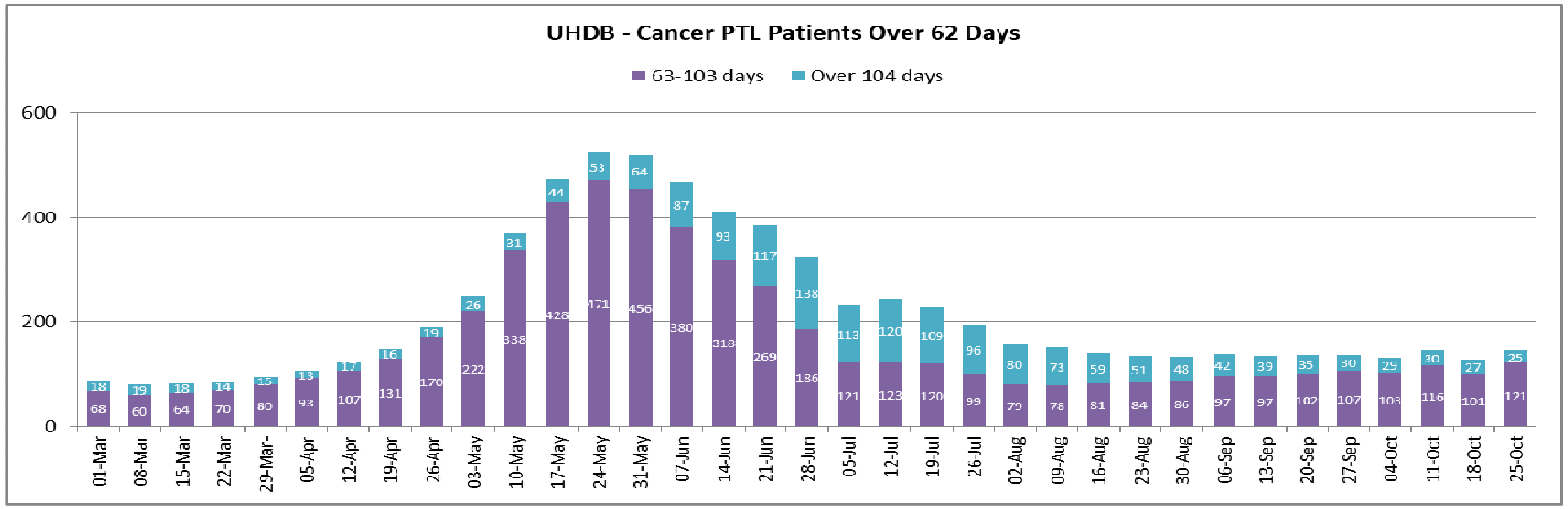
The graph below indicates the number of DDCCG ERS 2WW referrals by tumour site from April 2019 to August 2020. The top tumour sites by number of referrals are included in this chart:
Skin, Breast, Lower GI, Urology and Upper GI.



Cancer waiting times

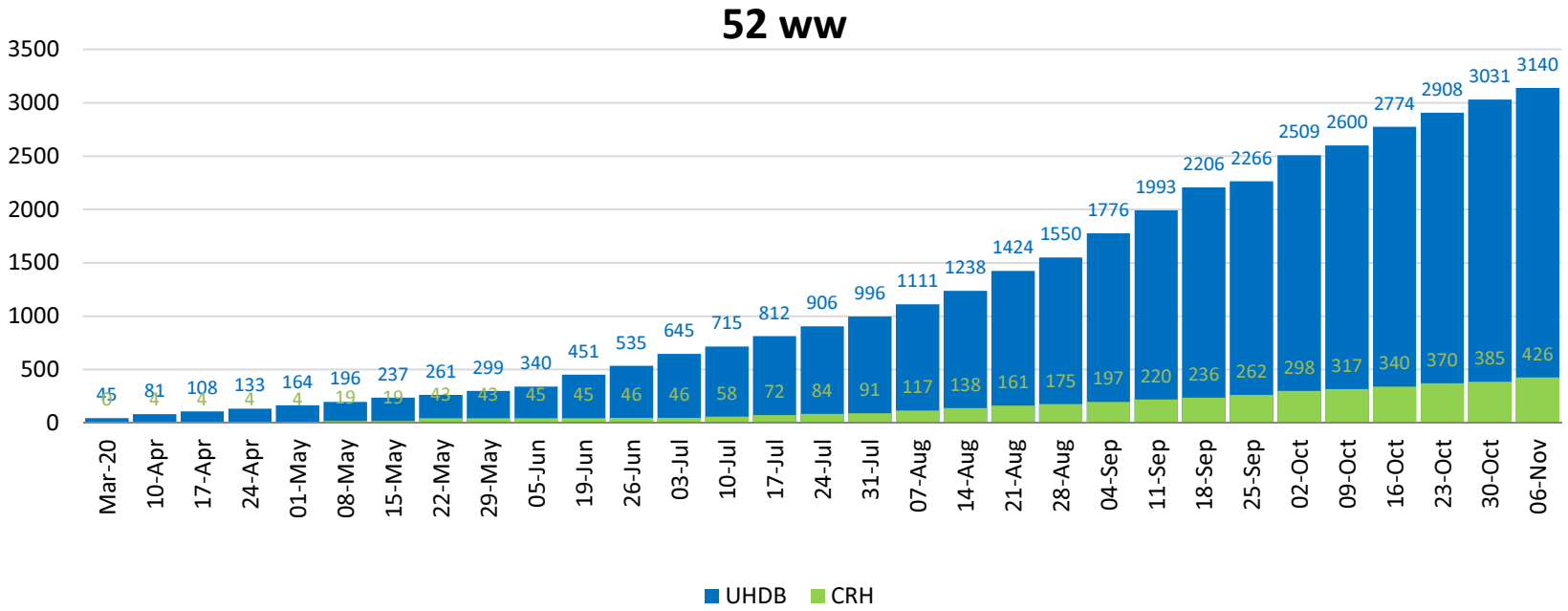
Whilst the long wait (62+ day) position is still slightly higher than at the beginning of the pandemic the situation is improving.





Elective waiting times

The effect of the pandemic on the waiting list position has been significant. Across both Providers the unvalidated data is showing that we have 3,566 patients waiting over 52 weeks for their substantive treatment. About 40% of these waits sit within the T&O service line.



The 5 specialties with the largest numbers waiting over 52 weeks at UHDB are Trauma and Orthopaedics, Opthalmology, General Surgery, Spinal Surgery, and Hand Surgery.

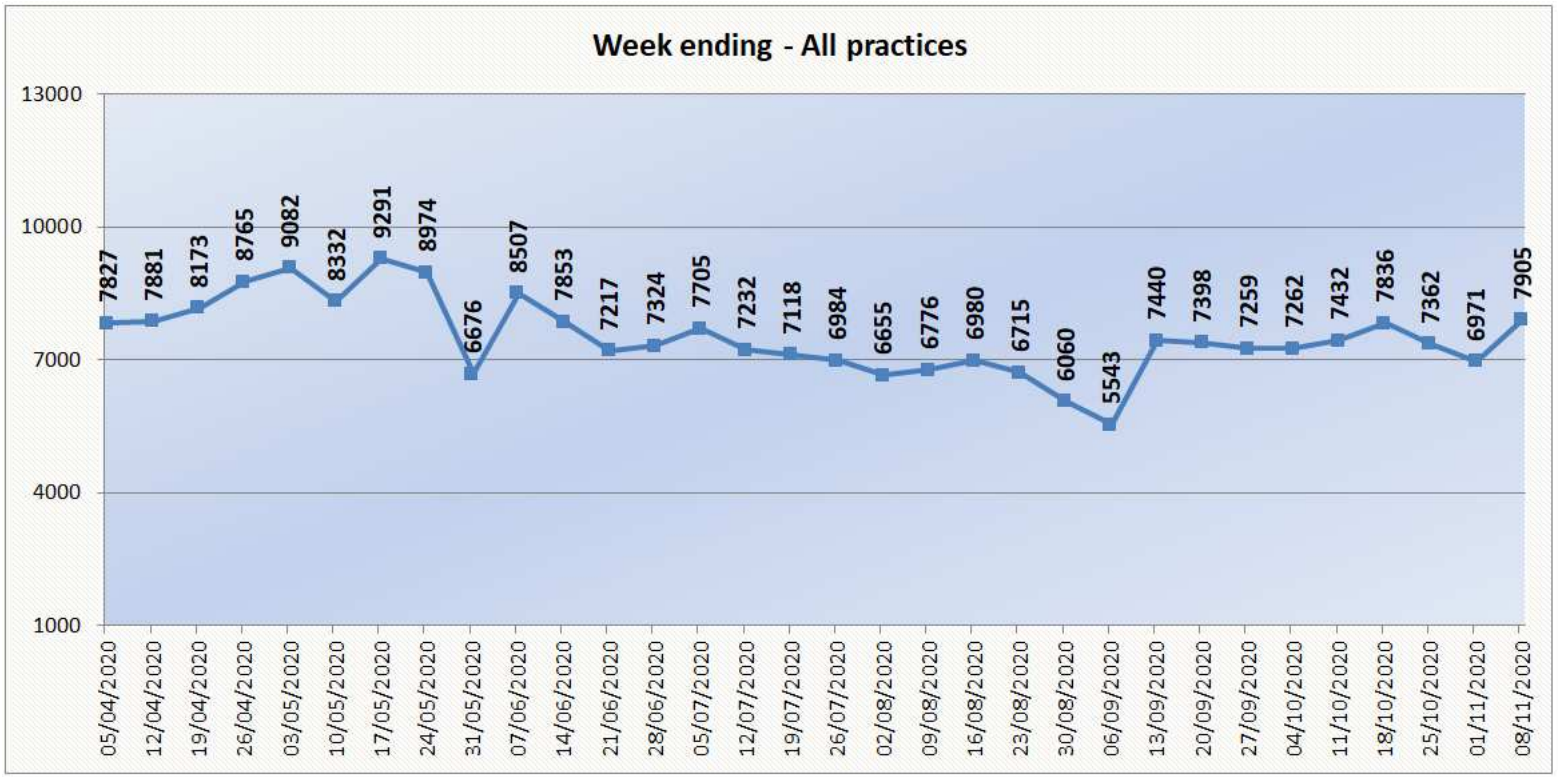
The charts here are showing validated data at the end of each respective month in relation to the number of patients who had been waiting over 52 weeks at that time.

CCG Patients – Trend – 52 weeks								
	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
DDCCG	0	1	27	103	242	527	934	**1,519**

Provider Patients – Trend – 52 weeks								
	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
UHDB	0	0	45	138	298	580	1,011	**1,667**
CRH	0	0	0	4	17	53	117	**212**

The impact of Covid-19 on General Practice

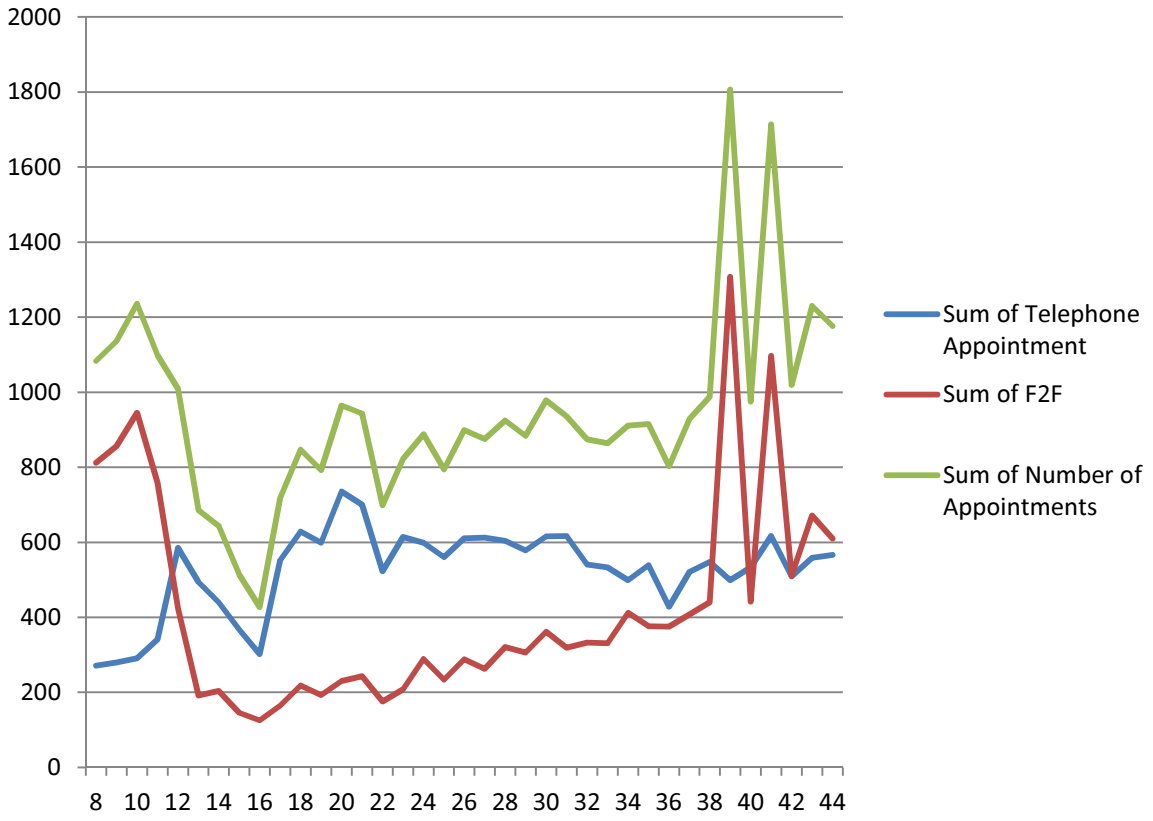
Covid-19 incidence - GP



COVID-19 related activity in general practice decreased during the summer months but is now back to June 2020 levels.

*The low activity for week ending 31/05/20 was due to missing a significant amount of activity on the 25th May Bank Holiday

Telephone appointments - GP



COVID-19: what did General Practice do?

- Stayed open and moved the service **online**
  - Telephone triage and treatment
  - Virtual appointments
  - Face to face for those who need it most
- Practices worked together in their Primary Care Networks, to help each other and to set up **local hubs** to see patients with suspected Covid
- Set up a county wide **home visiting** service for people with Covid
- **Prioritised** those most at risk, or who most needed care: e.g. cancer referrals and people with long term conditions or at the end of their life
- Provided extra support to **care homes** including a weekly check in
- Directly contacted patients who needed to **shield**
- **Re-organised** sites so that they were Covid secure, and agreed and implemented new ways of working, with distancing & PPE
- Distributed **laptops** so staff could work from home if necessary
- Set up a **leadership team** to co-ordinate work county wide, with daily county wide calls and regular bulletins

The impact of Covid-19 on mental health

What happened in mental health?

COVID has resulted in an increase in mental ill health and has impacted in a variety of ways. There is a strong correlation with mental ill health and the following groups:

- Those with socio-economic challenges
- People with pre-existing poor mental health including learning disability and autism
- Children and young people where the family unit goes into crisis and normal circles of support via schools are removed

In addition:

- Activity linked to high acuity went up by 34% over the lockdown period
- Admissions due to psychosis increased significantly.

What happened in mental health?

- The use of psychiatric intensive care beds has increased and female occupancy in these beds has almost doubled

- There has been an increase in children and young people with emotional issues going into A&E

Work to help offset these issues includes:

- A 24/7 mental health helpline was introduced during the pandemic

- Mental health and wellbeing resource packages were developed and continue to be extensively promoted

- Increasing investment in mental health services in line with the Mental Health Investment Standard.

Recovery and restoration of services

Context

On 31st July 2020, Sir Simon Stevens and Amanda Pritchard, in a letter to all Health and Social Care Systems across England, detailed the objectives for the third phase of the NHS' response to Covid-19. In summary, the priorities of the next phase (Phase 3 - September 2020 to March 2021) are to:

1. Accelerate the return of non-Covid health services, making full use of the capacity available in the window of opportunity between now and winter;

2. Preparation for winter alongside Covid resurgence; and

3. Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including support for our staff, action on inequalities and prevention.

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Current position in key areas

The following are the key areas but it is important to note that these are based upon outputs and projections pre Wave 2 of the Covid-19 pandemic and the current escalation in hospitalisations and acuity levels in conjunction with winter will impact upon Quarter 4 delivery:

Primary care

- Practices are physically open for business and appointments are above previous years – September 2020 appointments were 6% higher than the same time last year.
- 50% of appointments were offered the same day or the next day (compared to 43% in September 19).
- 59% face to face (compared to 82% September19) with telephone making up the difference
- 30% increase in appointments in September compared to August

Current position in key areas

Other areas

- Elective activity – 80.9% against the plan 81%. Day case - 67.4% against plan for 68.4% (please note these are September figures).
- Slowing the growth in the number of patients waiting longer than 52 weeks for their treatment and aim to at least stabilise the position over the next 6 months.
- Developing the community capacity required to sustain discharge performance during the pandemic, during the winter.
- NHS 111 First programme underway to reduce ED attendance.
- Increasing investment in mental health services in line with the Mental Health Investment Standard.
- 24/7 mental health crisis helpline operational.

Learning from Wave 1

Examples of learning points

- A cohesive and collaborative system is vital
- Rapidly established, senior level escalation processes facilitate decision making and enacting change at pace.
- Mutual aid has been a critical factor in various scenarios.
- Constant communication with patients in a targeted way that resonates with them and answers concerns and reassures is critical.
- Protecting the workforce from infection is fundamental to system capacity.
- More clinical work can be done remotely than projected pre-pandemic.
- Digital capability and capacity is key to continuity for individual organisations and the system.
- Continuing to engage with public and patients through virtual channels is important to service change and future developments.

Financial impact of Covid-19 on the NHS in Derbyshire

Key background context

- Months 1-6 (H1)

- NHS Provider contracts block values
- Covid response expenditure was reclaimable
- This included hospital discharge programme (HDP) with CHC suspended
- Every NHS organisation's bottom line brought to break-even through "top-up" payments

- Months 7-12 (H2)

- Block values adjusted
- System control total
- System allocations include:
  - Baseline CCG allocation
  - Prospective Covid
  - Prospective top-up based on H1
  - Growth funding
- Expectation of break even
- Some Covid remains retrospective

Financial impact

- System broke even in H1
- H2 resource available c. £15m higher than H1

- Planned c. 5% increase in substantive staffing for recovery @ c. £30m
- Assumed c. £18m increase in CHC costs from H1 to H2
- Prescribing, Primary Care, non-NHS cost & volume expenditure uplift
- Net impact a planned £43m system deficit

- £25m mitigations identified including:
  - Planned substantive workforce not available
  - CHC assumptions overstated OR retrospectively claimable if they materialise
  - Allocations to come for flu; primary care
  - Options to control mental health investment expenditure

Longer term financial impact

- System control totals have accelerated collaborative working
- Removing barriers between NHS organisations created by the purchaser-provider split
- Underlying position no longer clear in absence of recurrent allocations
- System focus is therefore shifting to the cost of capacity to meet demand
- National focus on technical efficiency needs to be supplemented by local focus on allocative to embrace opportunities in wider determinants

Questions