Nottingham and Nottinghamshire
Clinical Commissioning Group

**Changes to services to support the Covid-19 response**
**Update report for Health Overview and Scrutiny Committee**

Dear Colleagues,

Further to the briefing paper issued to the Health Overview and Scrutiny Committee in June, this paper and the appendices provide an update on the service changes included in the earlier brief.

As informed in June, as commissioners of local health services the CCG have been working closely with NHS Providers and other bodies in our response to Covid-19. Part of this work involved making changes to local services to manage the increased demand on services.

Some of these changes were mandated nationally, for example reducing face-to-face appointments and postponing the provision of some non-urgent services. Other changes were made by the local system, in response to locally specific circumstances.

At the time of the first brief the degree of pressure on the system and the rapid pace of response required to protect the safety and welfare of patients and staff meant that it was not always possible to notify the Local Authority of changes that, in normal times, you would be consulted on. In the main, changes have/had been made by providers to manage workforce and operational pressures and to maintain patient safety. These changes were not at necessarily at the request of the CCG.

The June briefing contained a full list of all service changes that have been made in response to the Covid-19 pandemic and Appendix 1 includes an update on the current status of those services.

A number of services have now restored or partially restored and there is an on-going system Recovery Cell that is charged with managing the return of services. Some services will restore to pre-Covid delivery and some will need more time or will not restore to pre-Covid as the service may have transformed in a positive way and the system may wish to keep some of this transformation. The latter will include changes that have been made that are aligned to the ambitions in the NHS Long Term Plan and have made a positive impact on health outcomes.

There are two areas, the urgent care pathway and reconfiguration of acute stroke services at Nottingham University Hospitals, where the service change during COVID-19 was based on strong clinical cases and as such are looking to be retained. Details of these proposals are included within Appendix 2 and 3 of this report, and will be the focus of the presentation to the meeting.

We want to reassure you that we maintain the stance that any service, temporary or permanent, made in response to Covid-19 will be done so with the safety and care of patients at the centre of our decision-making.

Any significant service changes that it is proposed to retain will be subject to the usual procedures, including public consultation and consultation with the Local Authority.

For more information please contact;

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**Appendix 1** **Restoration of Services**

Normal services resumed | Services operating differently | Services still not operational

**Children and Young People's Services**

| Description of Change | Update September 2020 | Status |
|---|---|---|
| Integrated Community Children and Young People's Healthcare Programme:<br><br>Routine reviews of respiratory conditions delayed except for at risk patients; routine referrals delayed; therapy services delivered by video conferencing or phone. | All nursing and therapy services have been reinstated to all children and young people (routine and urgent).<br><br>Face-to-face appointments are encouraged but choice of digital appointment is given to families. | |
| NUH out of hospital community paediatric services stopped except clinical priority services; child protection medicals; phone advice and urgent referrals. | Community paediatric clinics have been restored.<br>**Community Paediatrics & Neurodisability Service**<br>During the early stages of COVID, the service converted existing face to face clinics to virtual clinics and introduced twice weekly face to face rapid access clinics to see patients who could not be managed by telephone. A phased reinstatement of face to face provision is taking place, though this has been dependent on availability of accommodation in health centres, which have been utilised as COVID response centres.<br><br>The safeguarding and SARC element retained its face to face service with additional safety measures in line with COVID guidance.<br><br>**Children in Care Service**<br>Face to face clinics resumed from 15.07.20. Due to restrictions prior to this, there is a backlog in children requiring the physical component of their Initial Health Assessment. A funding case has been developed to increase clinic capacity to ensure these are undertaken in a timely manner. | |
| Rainbows Children's Hospice:<br><br>Respite Short Breaks suspended; family support services by video and phone; adult day care suspended. | Respite and young adult day care: These services will not be recommencing at Rainbows this year due to the continued requirement for social distancing and shielding of the extremely clinically vulnerable (see RCPCH guidance).<br><br>Family Support Services: Family Support Services have continued virtually using e-mail, video conferencing & telephone. Rainbows report that they currently make up to 80 contacts per day with children, young people and families.<br><br>Further information: Rainbows Hospice has been | |

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| | supporting the NHS with step down capacity to free up acute Paediatric beds; this will continue throughout winter, as capacity allows.<br><br>From May, an Emergency Support Services in the home for families most in need has been provided (ensuring compliance with PPE guidance); this service supports 21 families per week.<br><br>From June, the organisation began to provide Emergency Stays in the Hospice for families that are in need of enhanced support or where the children and young people cannot be cared for in the home due to family illness. | |

| **Mental Health Services** | | |
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| **Description of Change** | **Update September 2020** | **Status** |
| Open access all age 24/7 crisis line set up. | The crisis line is continuing. Further capacity is provided by a mental health helpline provided by Turning Point. | |
| Reduction or suspension of face-to-face contact and increased use of phone and video consultations and online resources for the following: Crisis Teams; Local Mental Health teams; Community Mental Health Teams; CAMHS; Kooth; Sharp; Harmless project. | All commissioned services are continuing to provide phone and video consultations with face- to- face contact when required. A number of services have continued to provide a face- to- face service for example crisis resolution and home treatment teams. | |
| Temporary use of Haven House crisis house as a step down unit to support discharge (change now reversed). | Haven House is continuing to operate as a crisis house. | |
| Recovery College services suspended and staff deployed to other areas. | The Recovery College is providing services remotely. | |
| CAMHS support to schools via in-reach. | CAMHS are continuing to provide support to schools and a number of Mental Health Support Teams in Schools are going to be operational from September/October. | |
| Alexander House locked rehabilitation service designated as an isolation unit, with patients transferred to the Orion Unit at Highbury Hospital. | This change is no longer in place - Alexander House is operating as a locked rehabilitation service and the Orion Unit as an Assessment and Treatment Unit | |
| **Planned Care** | | |
| Block Contracts established with Independent Sector (IS) providers to create additional bed capacity. | NHSE/I maintain the responsibility for the contracts with the independent sector, however these have moved on to allow the NHS to access capacity required but also to allow more routine services to restart. All NHS patients seen within the IS will still be | |

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| | treated in clinical priority alongside the provision within the NHS Providers, however this next phase of the agreement in place will allow some of the services that were suspended to re-start.<br><br>The IS will also be using some capacity to restore their own private services. | |
| Move from face-to-face to virtual clinics for outpatient services where appropriate. | The use of non-face to face is a desire within the NHS Long Term Plan and therefore work is ongoing with providers to establish the correct level of virtual appointments. The ambition will be to achieve as high a percentage of non face-to-face as possible whilst still seeing those patients that need to be seen or wish to be seen. | |
| Postponement of all non-urgent elective operations. | There is an increasing amount of routine elective work being undertaken. The guidance from NHSE/I is that providers should be planning to return to 90% of pre-Covid levels of elective activity by October and 100% of outpatient activity in the same period. | |
| Suspension of community non-obstetric ultrasound service. | All non-obstetric ultrasound service providers have self-assured that they meet the requirements for Infection Prevention and Control and that they have robust access to the required Personal Protective Equipment, and on this basis they have been instructed to re-start services. | |
| NUH suspended faecal sample testing. | All pathology services at NUH are now fully operational. | |
| Sherwood Forest Hospitals (SFH) suspension of termination of pregnancy service – service to recommence from 9 June (community service continued). | The service recommenced as intended. | |
| Temporary suspension of home births service by SFH and Nottingham University Hospitals (NUH) - NUH have since re-established a restricted home births service. | The temporary suspension was very short this option is now available should patients choose. | |
| **Community Services** | | |
| Community Orthoptics service suspended all non-essential face-to-face services and increased use of video and phone consultation. | The Community Orthoptics service has now started to resume delivery of face to face clinics. Appropriate infection control measures have been put in place, but these will reduce the number of appointments available at each clinic. Virtual appointments continue where appropriate. | |
| Community diabetes nursing teams suspended clinics and education courses. | • Clinics have all been reinstated – virtual clinics and face to face clinics where clinically needed.<br>• Consultant clinics also have recommenced at the beginning of September.<br>• Virtual education courses have recommenced. | |
| Face-to-face community rehabilitation suspended, except for patients who have had recent elective surgery; fractures or | All redeployed staff returned to substantive roles. Face-to-face visits have recommenced. | |

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| those with acute and complex needs. | | |
| Neuro rehabilitation - Chatsworth Unit patients discharged to community provision and inpatient function temporarily closed to admissions. | The Chatsworth unit remains temporarily closed, with all patients being managed within the community neuro rehabilitation service. Any patients requiring access to the service (previously delivered within Chatsworth unit) will access the community service via the discharge to assess pathway. | |
| Community podiatry and podiatric surgery services suspended, except for high risk patients. | **Podiatry** - Community clinics being reinstated with social distancing measures. A phased approach has been taken due to access to estates.<br><br>**Podiatric Surgery** – Procedures have now recommenced. | |
| Community services provided by Primary Integrated Community Services (PICS) suspended all non-essential face-to-face interventions. | • Clinics have restarted seeing urgent and longest waits.<br>• Clinics are now split equally between face-to-face and telephone. This is now expected to be the new norm.<br>• Within community gynaecology, the provider is working with NUH to identify consultant capacity to address backlog of routine patients. | |
| Community MSK groups suspended. | MSK groups recommenced virtually and plans to offer face to face being mobilised for patients unable to access virtual support. | |
| Community specialist nursing service suspended. | • Face to face appointments have recommenced following clinical prioritisation.<br>• Alternatively virtual support being offered. | |
| Changes to community pain management services, including suspension of face-to-face consultations; greater use of video and phone consultations and suspension of steroid injections. | • Face to face appointments have recommenced following clinical prioritisation.<br>• Alternatively virtual support being offered.<br>• Steroid injections have recommenced. | |

**Appendix 2**

**Proposed retention of service changes implemented during Covid-19**

**Future urgent care pathways**

## 1. Introduction

Nottingham and Nottinghamshire CCG remain committed to delivering the Long Term Plan for Urgent Care with Integrated Care System (ICS) partners. System partners have very recently joined together to produce a clinical services strategy for urgent care, which alongside emerging national guidance will help to shape the future of urgent care commissioning.

The current pandemic and the challenges it has provided health and social care services with has brought with it an opportunity (and the necessity) to look at the local urgent care pathway in a different way.

In order to ensure services can operate safely while social distancing remains in place and the further pressures due to winter and second phase COVID-19, NHS England/Improvement are asking all commissioners and systems to implement the NHS 111 First initiative.

## 2. Alignment with Long Term Plan and Integrated Urgent Care pathway

In Nottingham and Nottinghamshire this new national drive aligns well with the local ICS plans for delivering the long term plan for urgent care, the outcome of the clinical services strategy review and the work that was already under way to transform the Integrated Urgent Care pathway. All of this work is being over seen by a new Right Place First Time Cell which is well attended by all stakeholders.

## 3. NHS 111 First

NHS 111 First aims to ensure patients receive the service they need first time by:

- encouraging the use of NHS 111 or the local GP practice as the first places to go when experiencing a health issue that is not immediately life threatening
- A move away from going to a physical location as the first choice to access healthcare
- Embracing remote assessment and the technology which supports it
- Preventing hospital acquired infection by ensuring patients do not need to congregate in Emergency Department (ED) waiting rooms
- Allowing 111 to book patients directly into appointments or time slots in a service that is right for them

By the 1st December 2020 all areas have been asked to:

- Transfer 20% of unheralded (those that currently arrive at ED having not sought advice from another service) ED attendances to the 111 services
- Ensure an increased number of dispositions are available on the Directory of Services for 111 providers, with a focus on secondary care pathways including, Same Day Emergency Care, Assessment Units & Hot Clinics
- Provide a clear pathway for those patients that contact 111 and require an ED attendance to be booked into a time slot
- Develop a clear communication and engagement strategy
- Complete structured evaluation

The ICS is in the fortunate place of already having key components of the new urgent care pathway in place, including a clinical assessment service (CAS) which supports the 111 provider to ensure patients are seen by the right person first time.
The Nottingham plan was approved by the National team on the 19th October and a soft launch commenced on the 26th October 2020.

### 3.1 Key deliverables

Key deliverables and changes to the current pathway locally which are being mobilised at pace include:

- 111 being able to access our local community urgent response services (services that respond in under 2 hours)
- An increase in direct bookings (from 111 and the CAS) into the urgent treatment centres (UTCs) and primary care appointments
- Diverting more low acuity ambulance activity through the CAS and to alternative services
- Increasing the number of 111 ED dispositions that are reviewed by the CAS and diverted to alternative services
- Facilitating direct booking from 111/CAS into ED slots, same day emergency care appointments and speciality clinics at the acute hospitals
- Ensure unheralded patients attending ED are safely triaged/streamed to an alternative service including Same Day Emergency Care services, primary care and Urgent Treatment Centre(s)
- Developing a communications strategy aligned to the national messages in preparation for go live

### 3.2 Benefits

The key benefits of these changes include:

- A clear message to patients that 111 is their entry point to urgent care, which will reduce confusion
- Patients receive the care they need first time
- A reduction in the number of patients waiting in Emergency Departments which will reduce the associated risks to the public and allow the departments to operate more effectively
- Patients are seen at a time and location that is appropriate for their needs
- Appointment slots and transfer of patient information allows the Acute Trusts the opportunities to match demand to capacity more effectively
- Pathway developed to enable 111 to refer to community 2 hour urgent response services

The development of 111 First builds on the successful transition to digital and telephone based services that were well received and utilised by our citizens during the Covid pandemic. It provides incentives for the public to use 111 rather than walk in service as it provides access to a booked appointment with community services, GP, Urgent treatment centres and the emergency department.

### 3.3 Stakeholder Engagement

Commissioners are utilising the opportunities that COVID-19 has provided to engage with the public around how they have accessed urgent and emergency care services during the pandemic and their thoughts on accessing healthcare in the future. As part of this programme of work the public are being asked to feedback their thoughts on how and where they access services which will help to shape commissioning decisions that relate to the 111 First workstream and the integrated urgent care pathway as a whole. Early results from a survey of a representative sample of our population of over 2,000 people indicate that the public are supportive of remote consultations with considerable acceptance of remote consultation for a number of possible scenarios including a “concern about a potential infection” (61%); “concern about minor physical illness or injury” (67%); “concern about your emotional wellbeing” (58%) and; “advice on an ongoing physical problem or condition” (64%). Further research is scheduled to explore access to emergency services and 111 in more depth.

A common theme from feedback to date has been concerns raised around the implications for primary care, therefore the commissioning team are proactively approaching the Local Medical Committee to ensure that messages to GP colleagues are aligned and there is clinical support for the models being proposed.

## 4. Relocation of the primary care element of the Urgent Treatment Unit (UTU) at Queen's Medical Centre (QMC) to Platform 1, Upper Parliament Street

### 4.1 Background and Context

As part of the response to the COVID-19 pandemic, the primary care element of the UTU delivered by NEMs was re-located from QMC to Platform 1, Upper Parliament Street in March 2020. The basis for this move was the requirement to introduce social distancing in the Emergency Department to minimise the risk of COVID infection spread in addition to the predicted increase in demand for acute services as a direct result of the rise in COVID cases.

### 4.2 Current Service Delivery

Since the relocation of the service, activity has significantly reduced from 80-90 patients seen per day to 20-30 patients seen per day. However, this is in the context of an overall reduction in patients using **face to face** urgent care services as demonstrated in the table below.

Table to show average daily number of patients using urgent care services pre and during COVID

| **Services** | **Attends Pre Covid (Feb 2020)** | **Attends During Covid (July 2020)** |
|---|---|---|
| All A&E Activity;<br>• NUH ED<br>• SFH ED<br>• London Road UTC<br>• Newark UTC | Average 1184 attends per day. | Average 936 attends per day |
| NUH ED – Type 1 ED activity (all patients through the main NUH ED) | 514 | 427 |
| All A&E attendance in the Greater Nottingham area<br><br>(Includes NUH ED, eye Casualty, UTC and NEMs in ED/Platform 1) | 744 | 580 |

The UTU service continues to operate 24/7 and accept patients streamed from NUH ED. NUH and NEMs regularly review the patients streamed to ensure they are appropriate and streaming is done safely. To date, no significant incidents have been raised.

As a result of reduced demand for face to face services, NEMS have expanded their telephony based clinical assessment service (CAS) which offers remote consultations. To deliver this, NEMs have retrained staff and enabling home working in order to more effectively support the system during the pandemic.

This is aligned to the direction of travel for 111 First which encourages the use of remote consultations and a move away from physical locations as a first choice to access healthcare.

The overall aim for the NHS this winter is to preserve ED for emergencies only, moving away from co-located primary care streams in ED to treating patients in the most appropriate place including primary care, community and urgent treatment centres.

This means co-located primary care services over time will become less utilised as patients are offered advice and support by telephone or advised to attend alternatives, preserving emergency departments for those patients with conditions that need the level of service offered only by a hospital.

### 4.3 Future Intention for service delivery

As the COVID pandemic progresses, there is still the requirement for services to adhere to social distancing requirements to reduce nosocomial (hospital acquired) infection risk. This is the key ambition of the 111 First programme previously described which asks systems to triage or stream 'unheralded' (unknown to the system) patients to appropriate alternative services to reduce crowding in the department. NUH ED have identified the maximum number of patients who can be safely managed in the UTU estate at any one time is 50. In this context, as part of planning for the winter period, the Nottinghamshire system is reviewing future plans for the location of the primary care element of the UTU. We will continue to closely monitor attendances at all areas of the urgent care system and amend the service offers appropriately working with stakeholders.

This review is aligned to the 111 First programme timescales of roll out of new pathways by 1st December 2020.

**Appendix 3**

**Reconfiguration of stroke services in Nottingham and Nottinghamshire**

In July 2020 we informed you of a change to be implemented to reconfigure local acute stroke services so that we could manage the risk of Covid-19 infections among our patients and staff, as we progressed with restoring key NHS services.

To restore services safely, our providers needed to be able to treat patients with Covid-19 separately to those who are not infected. In Nottingham specifically, this meant creating additional capacity on Nottingham University Hospitals (NUH) NHS Trust City Campus site to create an additional admission assessment area. The only suitable area with direct access, which could be used as an additional assessment area, was the current Stroke Unit. The reconfiguration described in this briefing enabled this work to progress, while also being clinically beneficial for the treatment of stroke services and aligned to local, regional and national plans for stroke services.

Changes were made due to the urgency of local system restoration and recovery. The changes involved NUH centralising hyper acute stroke services at the Queens Medical Centre (QMC) site. This meant that the Hyper Acute Stroke Unit and the Acute Stroke Ward at the City Hospital campus moved to QMC. Stroke rehabilitation services at the City Hospital were enhanced and remain unaffected by these changes. Additional transport services for patients were made available between sites to facilitate the reconfiguration.

These changes mean that all urgent and immediate treatment for patients with a suspected stroke were centralised at QMC. This had two main benefits for the restoration and recovery of our services. Firstly, it enabled NUH to meet a national directive to reduce infection risk from Covid-19 by creating Covid and non-Covid admission assessment areas. Secondly, it created vital enhanced rehabilitation capacity on the City Hospital Campus for patients recovering from Covid-19 infection.

In addition to the impetus for these changes for the restoration and recovery of NHS services, there is a clear clinical case for the reconfiguration of stroke services and specifically for the centralisation of hyper acute stroke services. The change is aligned to regional and national stroke strategies and is a stated ambition of the local Clinical and Community Services Strategy review of stroke services. This review was underpinned by strong patient and public involvement with stroke survivors forming part of the work alongside staff and clinicians, and the Stroke Association supporting a number of patient engagement sessions.

Acute stroke services at NUH are currently a national outlier in two ways. Firstly, the hyper acute stroke service is not co-located with the emergency department. Currently 40% of strokes treated by NUH present at the Emergency Department at QMC and then require transfer to City Hospital. Secondly, it is not co-located with neurosurgical intervention and mechanical thrombectomy, which are required by a proportion of stroke patients.

Although aligned to national, regional and local plans for acute stroke services we informed you of this change as a temporary measure. There are plans to increase capacity at QMC for hyper acute stroke, which would enable this to become a permanent change.
However, that development would be subject to the usual procedures for service reconfigurations, including our requirement as the Commissioner to consult the Local Authority.