Nottingham and Nottinghamshire CCG

Briefing for Health Scrutiny Committee (Nottinghamshire)

January 2022

The purpose of this document is to inform the Health Scrutiny Committee of the approach to decision-making and temporary service change in line with NHS England/Improvement declaring a level 4 national incident in December 2021 in recognition of the impact of both supporting the increase in the vaccination programme and preparing for a potentially significant increase in Covid-19 cases. A level 4 incident is the highest level of response supported by national level command and control.

Context

At the outset of the global pandemic in March 2020, under national direction, our hospitals responded to high numbers of patients with Covid-19 requiring urgent and complex care. Like all other health systems, non-urgent elective procedures ceased for a period under national direction and a number of temporary service changes were required. Our local health systems have since worked together across primary and secondary care to reduce waiting lists as part of our 'Elective Recovery' programme.

At the beginning of September 2021 through to late November 2021, local hospitals experienced high levels of attendances via A&E and urgent admissions to hospital with an increased number of discharge delays. The social care system was under extreme pressure at this time when home care was required to enable safe timely discharge home. This occurred earlier than the normal 'winter-pressures'. The system worked together to model the likely impact on bedded capacity and developed plans for additional home care and community beds to cope with increased demand over winter. However, the Omicron variant has had a significant impact across the wider health and social care system. Staff shortages due to self-isolation across health and social care have resulted in loss of capacity in acute, community and home care provision creating delays in discharge and urgent care flow through hospital. In addition, more patients have tested positive for Covid-19 which means hospitals and care homes have had to close beds to avoid cross infection.

NHS England wrote to all NHS providers and ICSs on 13th December[1] with clear priorities to prepare the NHS for the impact of the Omicron variant and Winter Pressures, and confirmed the move to level 4 on the national incident framework. This required systems to develop 'surge' and 'super surge' plans to:

- Significantly ramp up the vaccination programme, bringing forward the deadline to offer all adults the booster from 31st January to 31st December;
- Offer Covid-19 anti-viral treatment;
- Increase capacity in acute and community settings to support discharge home;
- Ensure patient safety in urgent care;

[1] C1487-letter-preparing-the-nhs-potential-impact-of-omicron-variant-and-other-winter-pressures-v4.pdf (england.nhs.uk)

- Support staff and maximise staff availability.

The Level 4 national incident declared by NHS England/Improvement on 4th November did not include specific direction to step down non-urgent treatment or services, instead this has been left for ICS level determination in line with the national priorities described above. A framework for prioritisation of community services has since been issued on 11th January 2022[2].

The ICS has responded to these priorities in order to provide safe care for those patients who need it most urgently and with the Local Resilience Forum (LRF) have ensured that all public facing services worked together to maximise system support.

The types of change likely to be required during this period include:

1. Short-term, temporary, full or partial closure of a service in advance to release a physical space or staff. For example, hospitals have plans to use outpatient areas with extra beds for patients needing urgent hospital admission. It may also be the case that staff will need to be transferred between services to support urgent care needs. These short-term changes are planned in advance and the CCG notified.
2. Short-term closure or change of services to respond to urgent clinical needs. This includes changes to wards to take urgent patients instead of patients receiving non urgent care. This is in response to increased pressures or staffing and all patients are prioritised by clinicians. Therefore, any change will typically need a rapid decision at an ICS level. The end date will remain under review dependant on demand, bed occupancy, staffing and any other risks.
3. Potential urgent service changes that may link to and potentially accelerate planned future service reconfigurations. There are none that are currently proposed during this phase of the pandemic.
4. Routine adjustments to scheduling of clinics and other services. These are operational decisions taken on a day to day basis prior to the pandemic in order to ensure smooth running of hospitals. These issues will be more frequent as the situation is exacerbated due to staff absence as a direct result of the Omicron variant. The CCG is routinely notified but smaller day to day operational decisions do not require ICS agreement.

The impact of Omicron has presented significant challenges during this winter period and the Health and Care system has worked well together with robust plans to offer safe care to all patients. However, the biggest impact has been on staffing and therefore the response and types of change required reflect this. Clinical and non-clinical staff have been redeployed from the CCG and other providers to address the urgent national and local priorities This has included significant scaling up of the vaccination programme and a joint focus on timely discharge.

A summary of small, temporary, changes already enacted is provided in Appendix 1. A more detailed briefing will be provided if there are any service changes that may influence or accelerate future service configurations.

[2] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/01/Community-Health-Services-Prioritisation-Framework-January-2022.pdf

The ICS has agreed a robust mechanism and decision-making framework with system partners across health and social care to inform proposed system changes which includes the temporary cessation or scaling down of some non-urgent services as described above.

The CCG continues to act within its statutory duties during this period. Section 23 of Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 specifically allows for no consultation on service change to take place when;

S 23 (2) *[the CCG] is satisfied that a decision has to be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff.*

S 23 (3) *In a case such as is referred to in paragraph (2), [the CCG] must notify the authority immediately of the decision taken and the reason why no consultation has taken place*

Any changes that may be considered for the longer term will be subject to the usual procedures for service reconfigurations, including our requirement as the Commissioner to consult the Local Authority.

The Nottingham and Nottinghamshire ICS decision making framework

During October and November, Chief Executive Officers (CEOs) and leaders across our health and social care system worked together to ensure that plans to manage winter pressures were robust. A number of triggers to inform system decision making were agreed. A draft framework linked to the existing urgent care process was developed (see Appendix 2). Progress and implementation have since been overseen by system CEOs, and the process has developed further to respond to the Level 4 incident. If a material temporary service change is required, then a detailed proposal is now made to the daily Health and Social Care Economy Tactical Coordinating Group (HSCETCG) attended by system CEOs and a system decision agreed with any additional timescales for review. All decisions are clinically overseen, and the impact on patients and public considered by the wider Health and Care system.

The CCG currently oversees all service changes and commissioning proposals via the Service Change Cell (SCC) with attendance from senior commissioners, GP clinical directors, finance leads, CCG quality leads and governance team. This informs next steps and CCG governance requirements to enable the CCG to fulfil its statutory duties.

If a temporary operational change is required that is not material, during this Level 4 incident response providers will report this to the SCC for consideration. SCC oversees all notifications and will refer any material changes to the HSCTECG if needed with further detail from providers.

Reporting to HSC

The system remains under significant pressure due to the Omicron variant and it is likely that a number of temporary service changes need to be rapidly made due to staffing and capacity constraints. We suggest that a monthly report is provided to HSC by way of an update by exception and restoration of services in due course. Specifically these updates will address

changes described in 1-3 from the list above in line with our approach at the outset of the Covid-19 pandemic.

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Nottingham and Nottinghamshire CCG

Appendix 1: Summary of temporary emergency service changes

Organisation Making Change	Description of change	Update	Status
NUH SFHT EMAS	Suspension of Home Births. Patient risk due to EMAS capacity to respond in the event of an emergency.	Remains suspended until EMAS capacity is available.	Weekly Review
SFHT	Phase 1 super surge plan. Create additional 8 bed spaces by moving the Discharge lounge to Clinic 6.	Confirmation that all new urgent cancer referrals and follow up patients via the clinic can be accommodated. Existing patients reviewed to either defer or offer virtual appointments.	Ongoing
SFHT	Phase 2 super surge plan. Create additional 10 bed spaces by repurposing the cardiac catheter lab to an emergency ward. Whilst there may be longer waits for some procedures this does not impact cancer patients or very long waits.	Remains in place due to current bed occupancy levels.	Ongoing
NUH	Harvey 2 elective ward to accept urgent admissions, therefore some elective activity has to be cancelled. An urgent response was required due to Covid demand and staffing levels.	Changes remain in place however additional beds in other ward areas has minimised the impact on cancer and urgent cases. Some operations have been deferred however alternative dates can be rapidly offered.	Weekly review at ICS level
City Care	Continuing Care team to step down some parts of the service to release staff to support community nursing.	Address significant staffing issues in community nursing.	Review 21/1/22
NHT	Ongoing review of staffing issues to ensure capacity maximised to deliver prioritised work in line with nationally suggested criteria	NHT monitoring ongoing.	Ongoing

Appendix 2: ICS Decision Making Framework

Current System State/Escalations						**Actions for Consideration** *NB ensure supported by comms to patients and system partners and in line with agreed guidance and policy. Ensure decisions are made collaboratively and rationale clearly documented.*
Staff capacity	**Urgent Care – System level**	**Discharge and flow**	**Admission Avoidance**	**Bed Capacity**	**Service delivery Capacity**	
Workforce pressures that can no longer by addressed by sharing of resource, however which through planning and reprioritisation can be managed by short term changes within organisations	Opel 3 or 4 requires partner intervention	High levels of MSFT patients, limited step down, step down delayed and breaching 4 hours target with limited community or care capacity to accept discharges with increased threshold parameters	Limited ability within primary, community, health and social care resources to provide support to allow people to remain at home, high proportion of home care support unfilled	Likelihood bed capacity will be breached *Or* Capacity unusable due to IPC	Individual service provision unable to continue as lack of specific capacity – i.e. theatres, specialist staff, equipment.	• Implement IPC derogations for partner agreement to use bed capacity impacted by infection • Implement staff derogation policy to maximise staff use • LA undertaking statutory roles only • Move PC to virtual calls • Ensure maximum number of patients in virtual wards • Maximum use of IS capacity • Maximum use of LRF capacity/support ***If all these actions complete or no impact*** Stand down non-urgent clinical activity – i.e. non urgent outpatients If no impact consider short term benefit of suspending routine P3/4 elective activity **NB limit this to area impacted if possible,** i.e. single hospital or single specialty. (these decisions should be made in a system space and reflected in agreed NHSE/I return) **NB this is to ensure that P2 and** Cancer care continue
Workforce levels require the immediate implementation of raised clinical thresholds, or severe shortages of specialist staff	Opel 4 requires outside of system / regional intervention	High levels of MSFT patients, no community or care capacity to accept discharges. No additional step-down options available and emergency resources utilised.	No ability within primary, community, health and social care resources to provide active support to allow people to remain at home, high proportion of home care support unfilled. Addition pressures in residential services that may trigger admission	All contingencies full	System overload and no capacity to safely move specialists/equipment/ technology/or source to address problems.	***All above actions taken with no impact and a clearly worsening position*** Implement triaging of all planned care and undertake highest priority only Implement triaging of cancer care in line with national guidance and undertake highest priority only – this should not be an out of hours decision