Update from the West Yorkshire and Harrogate Health and Care

Purpose

1. The COVID-19 pandemic continues to provide the focus for our work across the Partnership. The purpose of this paper is to update the Joint Scrutiny Committee on the priorities of our Partnership work over the past three months, as well as plans for the remainder of this financial year in the context of both COVID-19 and our Five Year Plan.

A reminder of our context

2. There are well established arrangements at system level, through the West Yorkshire Resilience Forum, and locally with councils, the NHS, community and voluntary organisations and other partners working together in each of our six places (Bradford district and Craven; Calderdale, Harrogate, Leeds, Kirklees and Wakefield) to co-ordinate our response on COVID-19.

3. Within the NHS there is a formal command-and-control structure, with incident management centres at national, regional and organisational levels. All national requirements are communicated through single points of contact (SPOC) at these levels.

4. The West Yorkshire and Harrogate (WY&H) Partnership does not duplicate these arrangements or create additional oversight or reporting mechanisms. We are, however, clear that the relationships and ways of working we have established through the WY&H Partnership over the past four years add value in supporting the response. We also have the staff with the capacity and skills to work in different ways as required. This has proven to be the case.

5. We work to identify specific tasks where WY&H Partnership working can add value, in line with our three tests of a) working at scale to achieve critical mass; b) sharing good practice; and c) tackling issues together. It is clear that this is a uniquely fast moving environment and priorities and pressure points will change frequently and that an agile response is essential.

6. While the specific focus of our work has changed, our Five Year Plan that we agreed in December 2019 continues to set the high level priorities that we are working towards. Some of the work we have been doing related to these and the 'ten big priorities' we set ourselves is covered here.

7. The economic impact of COVID-19 has led to a recession which brings additional risks to the health of our population. It also means that the potential economic benefits of the health and care system in terms of jobs, large capital schemes, innovation and med tech must be secured. The West Yorkshire Economic Recovery Board (ERB) is chaired by Councillor Suzanne Hinchcliffe, Leader of Bradford Council. The Partnership

feeds directly into the ERB and the role of our sectors in supporting the economy and health is reflected in the draft plan.

Current position

8. In the past month there has been a significant increase in the number of positive COVID-19 cases across West Yorkshire and Harrogate. This picture is mirrored across the majority of the country. It is now estimated that the rate of infection is doubling every 7 or 8 days. In the main there have been local rather than national responses to these increases, although nationally the 'rule of six' was introduced on the 14th September.

9. Areas of West Yorkshire and Harrogate have featured in the Government's surveillance list frequently. This has led to restrictions to the easing of lockdown being imposed in Bradford, Calderdale and Kirklees, as well as Wakefield and Leeds being areas of interest. At the time of writing are currently restrictions on household visitors in the Bradford, Calderdale and Kirklees areas.

10. The number of people testing positive for coronavirus in the West Yorkshire region remains higher than the national average. There is also continued evidence of infection being higher in lower income families and among Black Asian and Monitory Ethnic groups.

11. Throughout July and August we have seen outbreaks in a range of settings including care homes and workplaces, and a small number in secondary care settings. Some of the most notable outbreaks have been in the food processing industry and in bed factories; staff working in some of these settings not only work together, but travel to work, live and socialise together, highlighting the need to promote social distancing both inside and outside of the workplace. Most of the cases identified in care home settings have been single cases in staff, sometimes residents; we are not observing the same levels of transmission in care homes that we saw earlier in the year. There is now evidence that these infections are becoming more widespread.

12. Until recently the increase in incidence of coronavirus throughout July and early August has not impacted on hospital activity. COVID-19 related hospital activity continued to fall month on month from the peak in April and remained low throughout the spring and summer. There is now evidence over the past couple of weeks that hospital admissions are increasing. As infections increase we can also expect this hospital activity to further increase.

Phases of the COVID-19 response

13. Nationally, NHS England / NHS Improvement have set out four phases for planning the NHS response to the pandemic. These are as follows:

Phase	Time period	Response
1	Jan-April 2020	Focus on critical care and building capacity to

		respond to COVID-19
2	April-June 2020	Immediate recovery actions post-COVID-19 surge Focus on urgent activities
3	July 2020 – March 2021	More comprehensive planning review Focus on building elective and potential COVID-19 spike during the winter phase
4	April 2021 onwards	Focus on recovering and developing the NHS towards the 'new normal'

Partnership priorities in phase three: July 2020 to March 2021

14. We are currently operating in a phase where we are looking to restore essential services in the context of COVID-19 present in the population. This phase of working is not one of full recovery. Providing care and services while continuing to deal with the presence of COVID-19 in our population is complex. These dual aims increase the complexity of planning and delivery, and require significant agility in places and system, service and staff resilience.

15. Our partnership priorities during this phase are as follows:

- Continuing to provide **critical and urgent care for COVID-19 patients**, their recovery and rehabilitation
- Providing **essential health and care services during the COVID-19 incident for other groups** of people
- Continuing to support **people who are shielding** from the virus, as well as supporting other groups who are likely to be affected by it
- Keeping **health and care colleagues** safe and well
- Understanding the **wider impact on different groups** of people, including Black Asian and minority ethnic communities (BAME), older people, people with learning disabilities and/or mental health concerns and other vulnerable people
- **Co-ordinating our reset** to the new 'normal' (stabilisation and reset), including responding to future peaks.

16. There is significant work happening in relation to each of these priorities, and all West Yorkshire and Harrogate priority programmes have been refreshed in line with them. Some of the key priorities are set out below:

Services for people with COVID-19

17. We continue to provide **critical and urgent care** for COVID-19 patients, their recovery and rehabilitation. The number of people requiring critical and urgent care has declined significantly since the peak in April 2020.

18. Effective management of critical care capacity is essential during this period, as we will need to manage demand relating to both COVID and non COVID patients as services are restored. Mel Pickup, CEO of Bradford Teaching Hospitals, has agreed to be the senior sponsor for our Critical Care Network to ensure alignment with our wider plans for restoration of services.

19. The NHS Nightingale Hospital Yorkshire and the Humber was established in April 2020 to provide important extra critical care capacity for the region. It is currently on stand-by and could be reactivated at short notice should additional critical care capacity be required. The facility is expected to remain available until the end of March 2021. During the stand-by period the Nightingale hospital is providing an outpatient radiology service, utilising the CT scanner on site, to provide additional diagnostic capacity for patients. To date over 1500 patients have had their scans in Harrogate.

Personal protective equipment (PPE) and testing

20. One of the major challenges we faced in the early stages of the pandemic was the global shortage of PPE. Over Easter we relied on the generosity of local partners and businesses to prevent health and care providers from running out of vital items such as gowns and masks.

21. To reduce the risk of this happening again we set up a joint programme to establish and maintain a resilient supply of PPE for partners in the WY&H Partnership, working closely with the Local Resilience Forum (LRF), with the aim of creating a one month stockpile of PPE. A programme board has been led by Mel Pickup to oversee this work, supported by procurement leads from across the partnership and a clinical reference group to assess the suitability of non-standard items. Through the programme we have been working to develop new sources of supply, including local manufacturing, and ensuring that the stock we have has been used as efficiently as possible. We have now agreed to continue this programme through until March 2021 to support both health and social care partners.

22. Also around April 2020, at the height of the pandemic, we had to work together to build up our capacity for COVID testing in West Yorkshire. Martin Barkley, CEO for Mid-Yorkshire Hospitals NHS Trust, has led a programme on behalf of the ICS and LRF to do this. As well as building up the capacity of our NHS labs we worked with the national programme to open regional testing centres in Leeds and Bradford, and also satellite sites in Wakefield, Halifax, Huddersfield and Keighley, as well as additional walk-in sites and mobile units, initially operated by the army. We have now tested around 140,000 people through these 'pillar 2' sites (accurate at 12 August 2020).

23. At the time of writing the testing system is now under significant pressure as a result of increased demand for tests and limits on lab capacity. This has created difficulties for people requiring tests locally and has led to delays in results of tests becoming available.

24. More recently the programme has been broadened to support our Directors of Public Health and their teams to develop local outbreak management plans, and to share learning and experiences on the management of the outbreaks we have seen in a number of areas of West Yorkshire.

25. The programme is now also rolling out the opportunity for health and care staff to be tested for COVID-19 antibodies, to indicate whether they have previously been infected by the virus.

26. Care home testing whilst in place has not yet reached the planned frequency of weekly test as had been anticipated.

Providing other essential health and care services during the COVID-19 incident

27. A core focus for the majority of our programmes is how we provide essential services in the context of COVID-19. For services such as planned care and cancer the focus is on how we can provide services to those with the greatest need while maintaining separation of COVID and non-COVID facilities. The acute hospitals are working closely together. For mental health services, we are beginning to see an increased demand for services at both ends of the spectrum, whether those with low level anxiety or those with significant mental ill health as the longer term impact of the pandemic and lockdown takes effect and the real risks associated to the worst economic recession experienced for many years. The focus of the Urgent and Emergency Care Programme is embedding the 'talk before you walk' model of access, and ensuring a co-ordinated approach to messaging on access to services, with the potential of a national roll out in December 2020.

28. The WY&H Clinical Forum members have developed 'An Ethical Framework' for the area that can be applied to adults across West Yorkshire and Harrogate health and care system. This has been generated by looking across a wide range of sources of ethical thinking that has been published in recent months. The aim is not to replicate or replace any of this good work, it is to draw on it and make relevant for colleagues across the area.

29. The take up of the winter flu vaccination has even greater importance this year, given the risk of a flu spike coinciding with spikes in COVID-19. The phase 3 planning guidance sets out requirements for significant expansion of the vaccine programme so that all staff and 75% of people in at risk categories are vaccinated.

30. Our response on this will be led locally, and to support these local arrangements Owen Williams, CEO for Calderdale and Huddersfield NHS Foundation Trust and Carol McKenna, Chief Officer for Greater Huddersfield Clinical Commissioning Group and North Kirklees Clinical Commissioning Group, have agreed to chair a WY&H Forum to share good practice, address common barriers to progress and ensure that the approach is fully aligned with our local places (Bradford district and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield) and priorities on health inequalities.

Support for people who are shielding

31. The overall Government advice to shield at home was paused on 1st August 2020, as prevalence of COVID-19 remains at a low level across England.

32. In West Yorkshire (not including those living in Craven and Harrogate) there are 111,165 people in the shielding group who remain classed as Clinically Extremely Vulnerable and are being advised to resume normal activities wherever possible and it is safe to do so and to take extra precautions to prevent coming into contact with the virus.

33. There are a smaller number of people who remain advised to shield at home because they are in active treatment or are awaiting surgery.

34. The Government provided food boxes were stopped at the end of July 2020 when the pause began, but all local authority areas in West Yorkshire continue to provide direct support to people in the shielding group, through welfare, emotional and social support.

35. The working assumption is that there may well need to be a future iteration of the shielding at home advice, at local or national levels. There are a number of scenarios where the shielding advice might change or be fully re-instated. This includes a combination of factors:
    - Clinical guidance that shielding should restart specifically for the clinically extremely vulnerable population
    - A local or national lockdown is introduced that affects shielding residents: clinical guidance is issued that shielding should restart in a defined local area / or nationally
    - A significant increase in transmission rates that pose a threat to the clinically extremely vulnerable population – locally or nationally – so additional guidance about staying safe is issued.

36. All local places are currently using the pause period to plan for a future scenario when the advice to shield at home may need to be reissued. This includes working across place local health and care systems as well as with other local resilience partners to ensure that lessons are learned from the first period of shielding and that any future iteration of the support offer is done in collaboration with people from the shielding group.

<u>Supporting health and care staff</u>

37. People working in the health and care sector continue to respond magnificently to the pandemic. Supporting them to stay safe and well during our response is our priority.

38. We have adopted several different responses at both place and system level which adds resilience for staff. Local examples include but are not limited to Bradford District Care Trust identifying additional psychological and counselling capacity to supplement local E-support for 12 months and helpline support for all health and care staff across the Calderdale Kirklees Wakefield footprint. We are also progressing work on a resilience hub, to support the ongoing resilience of staff during the pandemic.

39. We have also commissioned, at scale, the WY&H Grief and Loss Support Service for anyone affected by bereavement during the COVID-19 pandemic.

40. We know that the virus impacts more greatly on Black Asian and minority ethnic (BAME) staff and communities. A review into the work we are already doing across the partnership chaired by Professor Dame Donna Kinnair has its final meeting on October 14th, and our expectation is that the report of the review will be published at the end of October.

41. Carers have been disproportionately impacted by this virus. 70% of carers are providing more care as a result of local services reducing. This is alongside 69% of all carers providing more help with emotional wellbeing and 81% of carers are spending more money (Carers UK, State of Caring 2020). Carers' resources have been produced in partnership with local carer organisations, with some activities receiving national recognition via national roll out, for example the carers working passport. All hospital trusts have signed up to using the carers' discharge packs and we have developed a carers' toolkit, including the 'Plan B' support for all carers.

42. The NHS People Plan was published in early August 2020. Our intention is to develop a revised WY&H People Plan for the end of this year. This will cover all sectors. Our response will reflect the breadth of our Partnership, building on our work with the universities sector and the emerging approach to devolution. Initial work will be covered in the high level plans required by the end of September 2020.

Understanding the wider impact on population groups

43. We know that the virus and the impact of the lockdown restrictions impact differentially across different groups of people, and that this will further widen health inequalities. We are working as a system, using intelligence and insight to understand the disproportionate impacts of COVID-19 on population health. Including work with Bradford Institute for Health Research to understand the direct impacts on BAME groups and those in the most deprived decile.

44. We are using this insight to work with programmes and places to identify high impact preventative interventions that we can focus towards groups disproportionately impacted by the indirect impact of COVID-19. E.g. vaccinations and immunisations, health promoting hospital trusts, diabetes prevention.

45. We have also distributed over £0.5m of funding to thirteen local voluntary and community sector organisations with a specific focus on supporting groups most impacted by the virus. Seven of which directly focus on BAME health inequalities.

46. The West Yorkshire and Harrogate Health Inequalities Network within the Improving Population Health Programme brings together system approaches to understand and address health inequalities. Progress includes prioritising areas of transformation, for example £100,000 to improve access to specialist mental health services for rough

sleepers, £100,000 to improve support for young carers, £50,000 for reducing violent crime towards women and girls.

47. The NHS England / NHS Improvement phase 3 letter provides a number of requirements for system action to reduce health inequalities. A central part of responding to COVID-19 and restoring services must be to increase the scale and pace of the action to tackle health inequalities to protect those at greatest risk. NHS England and NHS Improvement commissioned a national advisory group of leaders (July 2020), chaired by Dr Owen Williams, CEO for Calderdale and Huddersfield NHS Foundation Trust. This group identified eight urgent actions which will give us the opportunity to accelerate existing work across the Partnership to better understand and address health inequalities. The asks centre around eight themes; protecting those vulnerable to COVID-19, inclusive reset, digital inclusion, targeted prevention, mental health, strengthened leadership, improved understanding of inequalities and local collaboration and planning. The Improving Population Health Programme will aim to support and facilitate the system delivery of these ambitions through working with place planners and partnership programmes.

Co-ordinating our stabilisation and reset planning

48. Local planning processes have been in place since late May to co-ordinate planning for the remainder of this year. During July we held conversations with each place to understand their priorities, constraints, and what support could be provided. This process demonstrated the strength of leadership and collaboration in each place. At the end of July NHS England issued further guidance on the requirements of the system for phase 3. These included:

- Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter;
- Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally; and
- 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, and action on inequalities and prevention.

49. This letter was followed on 7 August by further national guidance on implementing these priorities. This included details of the urgent actions to be taken to address inequalities in NHS provision and outcomes, and detailed requirements for mental health planning.

50. On 20 August details were published of a set of financial incentives and deductions that will be applied at ICS level to support the achievement of national expectations on the levels of planned care to be provided. The expected activity levels include returning by October to 90% of normal levels of planned care procedures, 100% of diagnostic procedures, and 100% of outpatient attendances. Trusts and CCGs are now

working to determine what is operationally achievable to get as close as possible to meeting these expectations. The preparatory work that partners in WY&H have undertaken already has meant that we have been well placed to respond to these national requirements.

Economic Recovery

51. Colleagues have been contributing to the work of the West Yorkshire Economic Recovery Board. This Board has been developing the West Yorkshire Economic Recovery Plan. This includes a broad and ambitious package of interventions to support good jobs and resilient businesses to ensure everyone can have the skills they need, whilst developing an infrastructure that unlocks economic opportunities and delivers resilience to our communities. This plan includes a detailed set of asks for investment from the Government for a total of £1.1bn, including a significant asks that are vital for population health, such as investment into employment support and innovation. We continue to work closely with the West Yorkshire Combined Authority to ensure our economy recovers in a way that is most beneficial to people's health and reduces inequalities.

Third Sector Resilience: Before and during COVID-19

52. Our voluntary community partners and charities are playing a crucial role in supporting those who are most in need, building on the strength and relationships they already have with local communities and neighbourhoods. We need to do all we can to support them and to address the future of the sector. Targeted funds, a new series of support via webinars to share learning and good practice and working together have helped so far.

53. The Partnership's Harnessing the Power of Communities Programme published a report in July 2020 titled 'Third Sector Resilience: Before and during COVID-19'. Over 300 VCS organisations employing over 7,000 members of staff and thousands of volunteers, responded to the WY&H survey. Of these organisations 55% do not expect to be financially sustainable beyond the end of 2020, unless something changes. The report highlights the impact of COVID-19 on the sector and made the following five recommendations for the Partnership to take forward.
    - NHS, councils and other funders and commissioners commit to putting in place a strategy for longer term, joined up investment in the VCS.
    - All partners formally recognise the social and economic value of volunteering and actively plan to better connect the volunteering infrastructure across NHS, VCS and councils. This includes: working together to consider developing and adopting a volunteer passport; investing in volunteer training and development across sectors; and working together to develop a WY&H wide integrated volunteering strategy
    - Commissioners and funders work together to simplify contracting and commissioning arrangements including monitoring requirements and to develop a shared application format

- The Partnership works with the VCS to put in place a workforce offer which enables the further development of: workforce capacity including health and well-being; finance and business adaptation; governance and planning
- All partners ensure the VCS and community voice is listened to and reflected in service design and delivery from the outset.

All of these recommendations were supported by the Partnership Board in September

Recommendation

54. Members of the Joint Scrutiny Committee are recommended to note this report.