West Yorkshire and Harrogate
Health and Care Partnership

Response to questions to the Joint Committee of CCGs on 7th July 2020

What, in the view of the JCCC, have been the effects on WYH ICS's ability to respond to the Covid-19 Pandemic, of:

a) decade-long cuts to NHS funding, hospital beds and clinical staff - including ICU beds and staff?

b) the government's failure to promptly authorise and direct widespread testing and tracing, from the start of the pandemic?

c) the government's failure to source and provide adequate PPE?

Response: Integrated Care Systems, including our WY&H health and care partnership, do not have a formal role in co-ordinating the response of partner organisations to the pandemic. The formal response is co-ordinated through well-established arrangements at national and system levels. These include the NHS command-and-control structure for a level four national incident, the West Yorkshire Local Resilience Forum, and local partnerships, 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).

However, we are clear that the relationships and ways of working we have established through the WY&H HCP over the past four years add value in supporting the response. The Joint Committee of the CCGs is a key part of the WYH ICS approach.

At the outbreak of the pandemic the Partnership identified four key priorities to focus our collaborative efforts:

- Supporting an exponential increase in critical care capacity
- Supporting safe and effective discharge to communities, to free up acute beds
- Supporting the 1.4m 'vulnerable' people shielded from the virus, and other groups e likely to be most affected by social distancing
- Ensuring continuation of other essential areas of business.

The NHS successfully ensured that there were enough hospital beds and staff – including in critical care - to meet the needs of all Covid-19 patients who required them in West Yorkshire and Harrogate.

The Partnership has worked closely with West Yorkshire Local Resilience Forum, and with all partner organisations, to ensure that sufficient PPE has always been available to provide the appropriate protection for both staff and patients. We have also supported the implementation and expansion of testing as the pandemic has progressed.

In particular, with regard to a):

What is the view of the JCCC on

- **NHSE's order to decant loads of people from hospital to care homes without testing, at the end of March, leading to lots of people in care homes dying? Your report says, "Our integrated teams and primary care networks ensured that safe discharge and support was in place and operating in line with clinical decisions made in each of our hospitals." Is that really borne out by the evidence of high numbers of infections and deaths in care homes?**
- **The costly block contracts with private hospitals that - at least in the case of CHFT- we understand were barely used?**
- **And the Harrogate Nightingale hospital. Your report says, "we led the development of NHS Nightingale Yorkshire and the Humber". But it was a costly white elephant, not used for Covid19 patients, and is now being used for cancer diagnosis. How are patients from the other side of West Yorkshire going to get there?**

Response: In the initial surge phase of the pandemic there was a critical need to free-up enough hospital beds to meet the anticipated level of demand for Covid-19 patients. Many patients were discharged at that stage, including to care homes, on the basis of clinical decisions regarding what was in the patient's best interests.

Support for care homes across West Yorkshire and Harrogate is a major priority. Working closely with both the NHS regional team and the local place partnerships, we have been ensuring additional support from the NHS is in place and that care homes receive PPE and support for testing. There is a named clinical lead for every care home, training for staff and improved arrangements for multi-disciplinary team working.

As the pandemic progresses, we need to ensure we are developing appropriate and agile responses. Over recent weeks we are seeing fewer people testing positive for Covid-19 in hospitals and care homes, fewer people being admitted to hospital and fewer people dying of Covid-19. We should be in no doubt that the impact on families and friends who have lost loved ones has been significant. This has also sadly included the death of respected and valued colleagues across our Partnership.

Our priorities to support the stabilisation and reset of services in the next phase of our response to Covid-19 include:

- 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 population groups
- Continuing to support **people who are shielded**
- Keeping **health and care colleagues** safe and well, whilst supporting them to manage the impact of the virus.

- Understanding the **wider impact on different population groups**, including Black Asian and minority ethnic (BAME) populations, older people, those with learning disabilities, mental health concerns and other vulnerable people
- Co-ordinating our reset and stabilisation approach to the new 'normal'– including responding to future peaks.

We know there will be a number of constraints on the level of services that can be safely reintroduced, including the requirements of social distancing, the availability of PPE, and the resilience of our workforce. In this context the partnerships that NHS hospitals have been able to develop with independent sector providers, as part of the national contract, will become increasingly important as a source of extra capacity to ensure that as many patients as possible can be treated.

The NHS Nightingale Hospital Yorkshire and the Humber is part of a wider national response to the Covid-19 pandemic and is an insurance policy for our region. The Nightingale Hospital remains on standby to provide additional critical care beds in our region should our existing hospital critical care provision reach capacity in the event of a second wave of covid-19 over the coming weeks and months.

There are still many unknowns with this pandemic and whilst cases have been low, the numbers are beginning to rise with local arrangements already introduced in three areas of our region to try and limit the transmission of this deadly virus.

In the meantime, the facility is being utilised to support some hospitals in the region by providing diagnostic and surveillance imaging services to enable us to see patients whose care has been delayed due to the pandemic. More than 1000 patients have now undergone CT scanning at the facility and positive feedback for this service has been received from patients.

We believe that the provision of this facility is important in ensuring that we can meet the healthcare needs of our population in the coming months. We hope that the facility is never needed to provide critical care but we are assured that it can be 'stood up' to deliver care to local people should it be required.

With regard to b):

What work was carried out by the WYH ICS programme for test, track and trace? As far as I know, apart from Pillar 1 tests in hospitals for NHS staff and patients etc, testing and tracing has been carried out by the hastily set up parallel privatised system - with the exception of recent local outbreaks in workplaces and schools where apparently public health contact tracers have done a high proportion of the work.

Response: In each place in West Yorkshire and Harrogate the Director of Public Health has led the development and implementation of an outbreak control plan, including arrangements for testing and tracing. To support these plans a West Yorkshire Covid-19 Test, Trace and Isolate programme has been established, in partnership between the ICS and West Yorkshire Local Resilience Forum. A co-ordinating group includes Directors of Public Health from councils, colleagues from Public Health England, NHS England and clinical commissioning groups.

Pillar 1 testing is provided by a number of hospital labs, primarily covering NHS staff and patients. Pillar 2 testing has been developed through a national programme led by DHSC to provide additional testing capacity, initially to key workers, and subsequently expanded to the public. Our testing capacity includes regional testing centres in Leeds and Bradford, local satellite sites in Halifax, Huddersfield, Keighley and Wakefield, walk-to testing centres, mobile testing unit sites and the deployment of additional mobile units as requested by the local directors of public health to respond to outbreaks.

Relatedly, what in the JCCC's view, have been the effects of the failure to follow statutory duties for reporting notifiable diseases? As you know, these require GPs to notify local Public Health about all patients with Covid-19 symptoms. But the government directed the public to report symptoms to 111, not to GPs; and there has been no process for 111 to pass information to GPs about Covid-19 symptomatic patients. The upshot has been that neither local public health people nor GPs have had any idea about the spread of Covid 19 in their areas. And are now reliant on the new parallel privatised test and trace service that still isn't giving Public Health adequate data for outbreak prevention and control and still doesn't give GPs any info.

Response: Arrangements are now in place to update patients' GP records with the outcome of Covid-19 tests.

As local outbreak control plans have been developed, the data available to local Directors of Public Health and regional Public Health teams has been significantly enhanced, supporting surveillance, the management of outbreaks, and informing targeted prevention activities.

How has this affected WYH ICS's ability to respond to the Covid-19 pandemic?

With regard to c):

There have been massive problems with lack of PPE, for reasons to do with the mess created by the 2018 redisorganisation of the NHS Supply Chain, the government's failure to act on the 2016 Cygnus pandemic planning exercise which identified the need for an adequate stockpile of PPE, the government's delay in procuring additional supplies of PPE and the chaotic and ill informed contracting process when they did belatedly get round to this.

What is the JCCC's view of the impact of these failings on the ICS ability to respond to the pandemic?

Response: There has been widespread disruption to the normal supply chains for PPE across the world as a consequence of the pandemic. To mitigate the impact of this we have established a West Yorkshire and Harrogate Personal Protective Equipment (PPE) Programme Group. The purpose of the group is to ensure PPE supply chain arrangements are in place to maintain, manage and forecast need. The group includes colleagues from across the Partnership, including clinicians, procurement /supply specialists and representation from West Yorkshire Local Resilience Forum and NHS England. The Programme is supported by a Clinical Reference Group. The work also covers primary care and smaller healthcare providers. The aim is to have enough PPE to keep our staff protected and to ensure there are local reserves stored and available to draw upon when needed.

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