NHS
Tees Valley
Clinical Commissioning Group

CCG's COVID-19 response and learning from Waves 1 and 2

1. Introduction

This report draws together some key messages as we reflect on our actions and learning during Phases 1 and 2 so we can continue to move forward and address the challenges to our local health and care system.

Phase 1 saw the NHS operating under a 'command and control' arrangement in order that immediate and co-ordinated actions were implemented urgently across the country in an attempt to slow the spread of the outbreak and free up as much NHS resource as possible so that we could prepare for, and respond to, the anticipated increase in patients requiring respiratory and critical care.

Covering a 3-month period (May 2020-July 2020), phase 2 focussed on the planning for the gradual reopening of the NHS following the suspension or reduction of services during phase 1 to release capacity for the critical care of COVID-19 patients. The purpose was to start to safely 'switch back on' critical non-COVID services and lock in the innovations that had happened as a consequence of the response to the crisis and to also restart some routine services.

The far-reaching impact of the pandemic has brought much grief, sorrow and worry to our population. As a CCG we continue to work closely with partners so that we do all we can to learn from the challenges posed and develop a stronger system that can not only recover from the Pandemic, but can learn and innovate for the benefit of those we serve.

2. Establishing our response framework

a. Legal framework

By way of background, the declaration of an NHS Level 4 national incident on 30 January 2020 marked an unprecedented time for the NHS as we responded to the COVID-19 Outbreak (subsequently declared as a pandemic on 11 March 2020 by the World Health Organisation). This was swiftly followed by the initiation of a 'command and control' arrangement in the early part of 2020, meaning that there were some changes to our operating framework to allow for the required far-reaching repurposing of NHS services, staffing and capacity.

This meant that under the Civil Contingencies Act 2004, NHS England would be responsible for co-ordinating the NHS response in collaboration with local commissioners, such as

ourselves, at a tactical level. NHS England has an Emergency Preparedness, Resilience and Response Framework (EPRR) in place to support their duties under the Act.

This resulted in:

- The CCG being under a duty to cooperate with NHS England in respect of NHS England's plans for reducing and/or mitigating the effects of the Covid pandemic;
- NHS England has the legal power to take such steps as it considers appropriate for facilitating a co-ordinated response to the pandemic by CCGs and relevant service providers;
- The Secretary of State directing NHS England to exercise CCGs' commissioning functions until 31st December 2020 for the purposes of directly or indirectly supporting the provision of services to address the pandemic, and
- NHS England National Command and Control will determine priorities for allocating available resources during a level 4 incident.

The Civil Contingencies Act 2004 specifies that responders to a national incident will be either Category 1 (primary responders) or Category 2 responders (supporting agencies). Category 1 responders are those organisations at the core of emergency response and are subject to the full set of civil protection duties. For health, Category 1 responders are:

- Department of Health on behalf of the Secretary of State
- NHS England
- Acute service providers
- Ambulance service providers
- Public Health England
- Local Authorities

The Act requires Category 1 responders to, amongst other things, maintain plans for the purpose of ensuring that if an emergency occurs or is likely to occur, they are able to perform their functions so far as necessary or desirable for the purpose of:

i. preventing the emergency;
ii. reducing, controlling or mitigating its effects, or
iii. taking other action in connection with it.

CCGs are Category 2 responders for health and, as such, they are expected to provide support to NHS England in relation to the co-ordination of their local health economy and co-operate with Category 1 responders in connection with the performance of those responders.

This work is brought together under the umbrella of Local Resilience Forums (LRF), which are multi-agency partnerships made up of representatives from category 1 and category 2 responders. Together, they work to identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities. The CCG is a member of both the Cleveland LRF and the Durham and Darlington LRF.

In addition, the NHS Act 2006 allows for NHS England to take such steps as it considers appropriate for facilitating a co-ordinated response to an emergency by CCGs and relevant service providers. It also provides for the Secretary of State to make directions if they consider that by reason of an emergency it is appropriate to do so. Pursuant to this power,

the Exercise of Commissioning Functions by the National Health Service Commissioning Board (Coronavirus) Directions 2020 came into effect on 20 March 2020.

A further factor was the suspension of the usual operational planning process and implementation of a revised financial regime. As normal financial arrangements were suspended, no new revenue business investments could be entered into unless related to Covid-19 or unless approved by NHSE/I as consistent with a previously agreed plan. Provisions were made by NHSE/I for the reimbursement of costs incurred in responding to the outbreak.

On 19 June 2020 the Chief Medical Officer and the Government's Joint Biosecurity Centre downgraded the UK's overall Covid alert level, signifying that the virus remains in general circulation with localised outbreaks likely to occur. The NHS EPRR incident level moved from Level 4 (national) to Level 3 (regional) on 1 August 2020.

b. CCG Governance processes

As the situation concerning the pandemic and the related national guidance changed rapidly, it was necessary for the CCG to be able to adapt and respond appropriately and effectively. The CCG has a range of options available to it to ensure that it is able to take urgent decisions. This includes the general power outlined within the Constitution and Standing Orders for the use of emergency powers and urgent decisions. In addition, the Governing Body confirmed its agreement that urgent actions could be taken by the Accountable Officer and the members of the Director team and that these would be reported into relevant committees as appropriate.

In practice, the majority of the urgent decisions needing to be taken by the CCG related to the primary care agenda and all such decisions have been subsequently reported into the Primary Care Commissioning Committee, with a summary report also submitted to the Audit & Assurance Committee. Changes in the way our secondary care providers needed to operate (for example, cancellation of non-urgent operations) have been reported through our usual reporting mechanisms.

There was also agreement that some areas of routine local reporting would be postponed, so that priority could be given to those areas requiring urgent discussion or sharing. As pressures on agendas reduced, this reporting has been gradually reintroduced.

The CCG has been able to continue the operation of the Governing Body and Committee structure through the use of virtual technology. To ensure continued transparency, the use of virtual technology had been extended to allow members of the public to join the 'in-public' Governing Body and Primary Care Commissioning Committee meetings from July 2020. We recognise that this can lead to 'digital exclusion' and we aim to reintroduce physical meetings when it is safe to do so.

In response to the revised financial regime and reclaiming of COVID-related costs, our stringent financial governance arrangements continue to be in place to support this.

c. Internal co-ordination and revised working arrangements

To ensure rapid communication routes, business continuity mitigations and internal resilience, we implemented:

- Director on-call rota, 7 days a week, to ensure urgent actions or communications were addressed quickly and efficiently.
- Named directors were identified for:
    - Lead director for the pandemic at an ICP Level.
    - Lead director/SRO for CCG response
    - Lead director for the management of the Programme Management Office (PMO), including staff deployment.
- Involvement in the North East and Cumbria Deployment Hub (co-ordinated by the North of England Commissioning Support Unit), supporting further staff deployment across all organisations.
- The established PMO took on the role of understanding the capacity available across the CCG's staffing base in order to ensure that 'business as usual' and the delivery of our statutory duties was maintained as well as being able to respond to specific issues (such as delivering personal protective equipment or equipment to Practices and co-ordinating Sitreps to feed into the regional HR deployment hub managed by the Commissioning Support Unit).
- Daily (and then twice-weekly) virtual meetings between the Chief Officer and Directors to ensure system and local pressures were understood and shared; co-ordinating the allocation of leads for specific areas (eg. testing, PPE etc) and providing director oversight of the wellbeing of CCG staff.
- Financial regime implemented to support primary care and secondary care while ensuring we continued to adhere to the duties set out in Managing Public Money and other related financial guidance.
- Financial, performance and quality reporting into the Governing Body and its Committees was adjusted to reflect the revised operating environment.

The safety and resilience of our staff was a crucial consideration; and the following safeguards were put in place:

- The CCG's Business Continuity Plan was refreshed, including updating contact numbers and promoting the use of the CCG staff WhatsApp group.
- All staff were provided with equipment and virtual technology (MSTeams) to aid home working and the CCG offices were closed.
- All non-essential meetings were stood down.
- Individual agile working risk assessments were carried out for all staff and wellbeing conversations incorporated as part of 1-1 meetings and team meetings. Staff wellbeing resources continue to be promoted and shared.
- Recognising that not all staff were able to work effectively from home, the office was risk assessed in line with Government guidance and confirmed as being compliant with all measures. A booking system was introduced to ensure that minimal numbers of staff were on-site at any one time and to allow for effective tracking of contacts should a member of staff test positive.

These arrangements helped us to co-ordinate our efforts and focus on key priorities, thus also allowing us to provide support across the wider system.

3. Stronger together – working as a system

Throughout the response, we have worked closely with partners across the system to identify and overcome challenges. Close partnership working has been one of the positive by-products of the pandemic, with frequent joint working between all parts of our local

system. This has helped the development of many positive innovations in the delivery of patient care and the changes in the way health and care services worked together.

As the pandemic continued to spread; so did the knowledge and learning, and as a consequence, we needed to be agile in our response to changing guidance and this was an underlying theme across all areas. Some specific examples of how we have supported the system response include:

a. Senior system leadership

The Chief Officer and the director team have attended the Local Resilience Forum (LRF) meetings at a tactical and strategic level for both Cleveland and County Durham and Darlington; specific regional and national workstream groups and calls relating to, for example, testing, PPE etc. In addition, Chief Executives across the ICS have held calls on a weekly (or twice-weekly) basis since March. This approach has helped with problem solving, communications and implementation and, although time consuming, has harnessed a strengthened way of working. As part of this, the CCG has participated in at least weekly Health Co-ordinating Group virtual meetings chaired by the ICS Executive Lead, including CCG chairs in later months.

At an ICP level the CCG has co-ordinated and chaired the ICP Covid19 group, consisting of NHS provider partners from all sectors and local authority directors. This escalates issues to the ICS-wide meeting and into the LRFs where necessary.

Given the scale of the challenges we all face, we will continue to partner with local authorities and LRFs in providing mutual aid with our colleagues in social care, including care homes.

We are continuing to work across the ICP and ICS to agree collaborative leadership arrangements that support joint working and quick, effective decision making which is in the best interest of our populations, based on co-production, engagement and evidence.

b. Primary Care

The primary care response to COVID-19 has been significant and swift as new ways of working were required from primary care in order to most effectively meet the needs of patients requiring either urgent care or essential routine care. This has been done in line with national guidance and the NHS England 'Guidance and Standard Operating Procedures (SOP): General practice in the context of Coronavirus (COVID-19)' and related updates, although the fast-changing nature of the Guidance did result in some confusion, we have worked closely with colleagues to overcome this.

The CCG supported member practices in implementing a number of changes to deliver a comprehensive COVID-19 response that was in line with the national SOP, referred to above, and was safe for patients and staff.

- In line with national guidance, all practices across the Tees Valley moved to full telephone triage, however seeing patients in a face-to-face consultation where deemed clinically essential. This was achieved through segregating COVID-19 symptomatic and non-symptomatic patients within their own practice.

- Arrangements for every locality to have a designated site, in hours and at weekends, where COVID-19 symptomatic patients could receive face-to-face consultation, where considered essential following remote triage (Hot Clinics); enabling patients without symptoms to be seen at their own GP practice (Cold Clinics).
- Supported with the roll-out of digital equipment to facilitate remote working, which helped ensure all practices were able carry out remote triage and to access telephone, online and video consultations.
- Developed a workforce sitrep for practices to enable them (and the CCG) to understand the pressures at their Primary Care Network level and offer/receive mutual-aid if required.
- Temporary change to the 'GP Extended Access' services to ensure that during the pandemic, these services were adapted to meet the needs of patients and to offer additional support to GP Practices. Bank Holiday working was arranged where required.
- Developed and implemented processes to enable urgent decision-making for delegated functions, (eg branch closure requests, list closures, etc).
- Temporary suspension of the Local Incentive Scheme (LIS) for Q1 of 2020.
- Implemented a daily Primary Care Bulletin to keep practices updated of national and local guidance and support.
- Established a WhatsApp group in each locality for ease and speed of contact.
- Financial support relating to COVID-related expenses on the basis that this would be reconciled against any nationally directed payments.

A key development was the CCG's success in becoming a national pilot site to implement a COVID-19 virtual 'ward', now known nationally as *'Covid oximetry @ home'*; where patients who were COVID-positive or had symptoms of COVID-19 and not yet tested, would be admitted to the "ward" for up to 14 days and be monitored remotely using pulse oximetry.

The three GP Federations agreed to work collaboratively as an alliance to deliver the remote monitoring service, supported by the use of digital technology. Across the Tees Valley we worked with secondary care, NHSE/I and NHS Digital to develop an integrated service that participated in robust evaluation of the pilot, prior to national service roll out.

The *'Covid oximetry @ home'* was rolled out across the country in primary care from November 2020.

From the pilot it was found that the *'Covid oximetry @ home'* service had the following system benefits:

- Provides patient reassurance and safety
- Offers good clinical care and safety netting
- Provides appropriate escalation and admission pathways
- Enables clinicians to focus on the patients most in need of input whilst providing appropriate surveillance of the at risk cohort
- Provides a means to reduce length of stay with earlier identification of deterioration so better recovery and better outcomes
- Supports patients on discharge from hospital
- Supports patients to manage pressure on Emergency Departments, primary care and secondary care

c. Infection Prevention and Control (IPC) Guidance and support to Care Homes

Within the care homes in Darlington the current IPC service is provided through the existing IPC service from County Durham CCG; in Hartlepool and Stockton localities this is provided through a dedicated Infection Prevention and Control Nurse (IPCN) hosted by North Tees and Hartlepool NHS Foundation Trust (NTHFT) and within Middlesbrough and Redcar & Cleveland locality care homes through a dedicated IPCN hosted by South Tees Hospitals NHS Foundations Trust (STHFT). Due to the past Critical Care experience of the STHFT IPCN, the post holder was repatriated to support the hospital activity. To support this temporary move and continue an IPC service, the Tees Valley CCG Quality and Safeguarding Team made some interim changes to their structure.

Specialist support and advice - guidance on best practice, policy compliance

Specialist support and advice, together with guidance on best practice and policy compliance was provided within the context of evolving national guidance. This also included supporting the Local Authority, Primary Care, North of England Commissioning Support Unit and CCG colleagues. Frequently asked clinical questions included queries on the restrictions of visitors to care homes, recognising correct use of personal protective equipment (PPE) which dominated a number of the initial weeks due to supply constraints and interpretation of the PHE guidance, care and management of residents with Covid-19 symptoms, appropriate discharge from hospital and isolation management.

Training and education

We were able to provide training and education through a variety of resources and delivery platforms that included on-site, virtual or tele-conference to ensure continuity of previous (pre-Covid-19) education, training and support.

Nationally it became evident in early April that care homes were beginning to experience rapidly increasing number of Covid-19 infections and, sadly, an increase in the number of residents' deaths - although not in every care home. This led to a national directive from Ruth May, NHS England Chief Nurse for England, on 30th April 2020, to all Clinical Commissioning Groups to offer a bespoke training session into all Care Quality Commissioned registered care homes within their localities.

This involved each CCG identifying at least one member of staff to complete the national "Super Training", a virtual, practical session. Two Tees Valley CCG staff completed their super training and were then responsible for training a number of trainers to deliver the national training material (refresher on hand hygiene and the donning and doffing of PPE). These are both critical in ensuring staff are minimising the risk of infection transmission.

In terms of coverage, of the 206 care homes in the CCG's geographical remit, 97 had accessed virtual training, 106 had accessed face to face training and only three had declined the offer (these 3 were part of larger care home groups who had provided alternative training directly).

In addition, there have also been six bespoke sessions for Local Authority staff who visit care homes, two sessions for Domiciliary Care providers and one for the Continuing Health Care Team.

These interventions will have undoubtedly improved IPC practices and led to the reduction in Covid-19 and other infection transmission and consequently prevented the infection of residents, staff and the wider population.

d. Emergency Personal Protective Equipment (PPE)

The national supply chain challenges and availability of PPE was widely reported in the press and many industries and public sector offered support to help produce PPE to support the NHS. Although primary and social care providers (including primary care, adult social care, dentists, pharmacies, third sector, adult care homes and hospices) were required to continue to order PPE from their wholesalers, there was a need to support this with the provision of an emergency PPE 'service', which included the establishment of an emergency PPE hub. Daily discussions were in place across the ICS to support the system and co-ordinate the sourcing of products. Local and regional peer networks were established to support with advice and guidance.

The CCG played an important role in this, ensuring that strategic and operational leads were in place together with identified members of staff to support the sourcing, receipt, checking, storage, packaging and, along with members of Cleveland Fire Brigade, the distribution of PPE. Close working with CCG IPC colleagues ensured appropriate quality reviews and clinical advice was available. This was a challenging agenda to co-ordinate and manage; however there were no instances of us fully exhausting our PPE supply.

The team also worked closely with colleagues in continuing healthcare to ensure the provision of PPE to this vulnerable cohort.

e. Quality Surveillance

The National Quality Board Executive Quality Group had shared principles for the monitoring of quality during the pandemic period, which includes regional decisions on levels of quality surveillance in place, including those under the auspices of improvement boards and risk summits.

During the pandemic, quality and safety functions need to be delivered in a proportionate manner that supports the focus on the response to COVID-19 while, at the same time, ensures the oversight of quality is maintained.

The CCG has worked closely with providers to use existing internal monitoring methods and a shared approach to data flows.

During this period, we also revised our approach to the function of the CCG's committee and formed a new Quality Committee that includes membership from provider Trusts across our ICP. The first meeting was held on 3 November and provided an excellent springboard for us to further strengthen this more collaborative approach.

f. Working with providers on the implementation of NHSE's requirements

Some of the key response milestones during phases 1 and 2 included:

- Some clinical CCG staff deployed to work into clinical roles (in secondary or primary care as appropriate)
- Implementation of discharge from hospital guidance
- Responding to the instructions from NHSE on prioritisation of acute and community services during the pandemic
- Non-urgent elective operations cancelled
- Close working with Local Authority to discharge medically fit patients
- Block purchase of additional beds to support discharges
- Implementation of telephone triage, video consultations and face to face appointments based on clinical need
- Planning for stepping back up services.

The following gives a flavour of some of the areas of learning across our providers:

General

The importance of establishing an operational and tactical response framework at an early stage was recognised by providers so that the high volume of activity required and requests received are co-ordinated and addressed quickly and effectively. The involvement of staff across disciplines (including: community services, clinical, pathology, IT, estates & facilities, administrative staff) is crucial. This has strengthened the understanding that all staff have a huge contribution to make in planning and decision making.

Workforce Flexibility

A plan to review the medical and nursing workforce particularly in respect of respiratory, acute medical and chronic healthcare provision within the community in preparation for the anticipated resurgence of COVID activity and an emerging cohort of COVID survivors with associated medical needs.

Critical care workforce plan to be reviewed to consider a register of designated critical care staff who have maintained their training.

The introduction of a '*Consultant Passport'* to allow consultant staff to work between Foundation Trust sites worked well and this is being further explored to allow more flexible workforce planning in future.

Rapid Hospital Discharge

Providers and social care working together to review and build on redesigned processes and protocols to facilitate discharge across the Tees Valley in a safe way.

g. Children and adult safeguarding

The pressures of the pandemic and associated 'lockdown' added to the potential for increased safeguarding concerns and this was exacerbated by the reduced footfall through provider services (eg. health, education and social care) meaning that less face-to-face contact with vulnerable adults or children could hide instances of harm. Sadly, there was

also an increase in nationally reported cases of domestic abuse. In terms of Looked After Children, there were additional complications regarding foster carers who needed to self-isolate.

To address this, the portfolios within the CCG's quality and safeguarding team were reconfigured so that essential work was prioritised. Key actions included:

- Lists of vulnerable children identified within local authorities – monitoring of children via school (face-to-face or telephone contacts for children not in school).
- Looked After Children requiring an Initial Health Assessment were assessed by clinical need and seen face-to-face with appropriate PPE if needed.
- Telephone contacts with vulnerable adults or those that were shielding were arranged via NHS/Local Authority partners.
- Designated Nurses maintained regular contact with acute providers and local authorities to address local issues and to share learning.
- The Cumbria and North East Designated Forum collated local intelligence in order to share learning and inform services.

h. **Children and Young People's Services and SEND**

To ensure that we were able to fulfil our statutory responsibilities in line with the revised operating framework, we worked closely with Trust colleagues and Designated Clinical Officers to ensure appropriate sharing of information so that we could continue to support vulnerable children and young people during the pandemic.

Again, the use of technology was harnessed and, working with providers, Zoom sessions were introduced with parent carer forums and excellent feedback has been received on this approach.

4. Phase 3

This report focusses on the lessons learned from Phases 1 and 2 – which helped us plan and respond to the requirements of Phase 3 shown below.

Phase 3 priorities:

a. Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' in the run up to winter.

i. Restoring full operation of all cancer services.
ii. Recovering the maximum elective activity possible in the run-up to winter, making full use of the NHS capacity available, as well as re-contracted independent hospitals.
iii. Restoring service delivery in primary care and community services.
iv. Expanding and improving mental health services and services for people with learning disability and/or autism.

b. **Preparing for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes**.

i. Continuing to follow good Covid-related practice to enable patients to access services safely and protect staff, whilst also preparing for localised Covid outbreaks or a wider national wave.
ii. Preparing for winter.

c. Undertaking the above in a way that took 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.

Through our local group, whose membership includes local Foundation Trusts, the Local Medical Council, GP Federations, NHSE / I, Directors of Public Health and Directors of Adult Services, we have been coordinating the Tees Valley response to Sir Simon Stevens' Covid19 Phase 3 Planning letter to ensure the restoration and resetting of local health and social care services. The sharing and partnership working in this group is an encouraging sign for the future, where a focus on people, places and systems, rather than individual organisations is both encouraged and necessary.

5. Conclusion and next steps

This summary paper belies the amount of work and dedication shown by the CCG and all our partner organisations in dealing with system pressures on a scale never previously experienced. We must not forget that our staff are fatigued from the previous phases and are also supporting their families and friends cope with the daily challenges this pandemic has brought. We must ensure that we do all we can to work together to lessen the load wherever we can so that we can continue to support our population's health.

The system has responded remarkably well and has learned lessons along the way, which are invaluable as we continue to tackle the current phase of the pandemic.

Key priorities for the CCG and the Tees Valley ICP at the time of writing include:

- Continuing to respond to Covid-19 demand
- Progressing the Covid-19 vaccination programme
- Maximising capacity in all settings to treat non-Covid-19 patients
- Responding to other emergency demand and managing winter pressures
- Supporting the health and wellbeing of our workforce

David Gallagher

Chief Officer

25 January 2021