Improving Healthcare Together 2020 to 2030

Review of the impact of COVID-19 on the clinical model

Emerging Findings

10 June 2020

1. Aim of the paper

This interim assessment of the potential impact and influence of COVID 19 on the current Improving Healthcare Together proposals have been produced as part of the ongoing evidence consideration in relation to the clinical model and options for service change being proposed.

This paper provides a summary of the early lessons learned to date in respect of the pandemic, and in addition draws upon the experience and feedback of NHS staff working at Epsom and St Helier hospitals (ESTH) during the COVID-19 outbreak.

The Trust and Clinical Commissioning Groups are continuing to reflect upon the impact of COVID 19 in terms of operational performance, patient care and experience, and they will continue to review the likely impact of COVID-19 as further local, regional and national evidence becomes clearer

The interim assessment paper is one of the additional pieces of evidence that CCG Governing Bodies will consider as part of their deliberations and final decision-making process.

2. Context: Improving Healthcare Together 2020 to 2030

Improving Healthcare Together 2020–2030 has consulted on a new clinical model for patients in Surrey Downs, Sutton and Merton including:

- integrating services across the combined geographies via Health and Care models and out of hospital initiatives;
- developing and enhancing district hospital services at Epsom and St Helier Hospitals; and
- consolidating Epsom & St Helier University Hospitals NHS Trust (ESTH) major acute services to enable clinical standards to be met.

This model was developed and detailed through 2018–19, including refinements in response to feedback from patients, clinicians and regulators (including the London and South East Clinical Senates).

This was reflected in the pre-consultation business case, published in January 2020.

Since consultation closed in April, Surrey Heartlands and South West London CCGs are considering the feedback from consultation and are developing a decision-making business case (DMBC) which will be considered on July 3 2020.

3. Context: COVID-19

Since this model was developed, the NHS has had to radically change to respond to the global COVID-19 pandemic.

Nationally, this has included:

- creation of emergency capacity (e.g., NHS Seacole Hospital and NHS Nightingale Hospitals);
- reduction in emergency attendances;
- cancellation of elective work;

- virtual outpatient appointments;
- return to work of retired NHS staff; and
- enhanced discharge – low numbers of medically fit for discharge patients in beds.

Though we are still in the midst of this crisis, early indications are that some of the emergency measures taken might continue to be needed as the system recovers. The present focus of the response and recovery includes consideration of:

- splitting of COVID and non-COVID patients and staff;
- system-wide management of ITU capacity;
- resumption of cancer and elective work where possible;
- managing the backlog of urgent care – where individuals have not sought urgent care when needed; and
- new staffing models – adapting to high sickness absence.

Given the impact of this crisis, we have reflected on whether this will require substantive changes in the proposed clinical model and how we might explore these further as plans evolve.

4. Impact of COVID-19 on ESTH

COVID-19 required ESTH to make a number of emergency changes to manage the crisis – as all acute trusts did. But at ESTH this was exacerbated by its long-standing structural issues, especially its ageing estate and challenges staffing two major acute sites.

Early lessons from the crisis include:

The estate cannot adapt to meet the challenges of a pandemic.

- **Limited critical care capacity at St Helier Hospital requiring Level 3 critical care to move to Epsom Hospital**. COVID-19 required an increase in Level 3 ITU beds from 7 to 38. This was not possible at St Helier Hospital (the current Level 3 site) due to the layout of the hospital and physical limitations in the oxygen supply. Therefore, the Level 3 site was moved to Epsom Hospital, requiring the conversion of the standalone South West London Orthopaedic Hospital into a Level 3 unit.
- **Insufficient single rooms meaning potentially infected patients could not be isolated**. Less than 20% of the beds at Epsom and St Helier are in single rooms. This was insufficient to isolate an average of 50 suspected COVID-19 patients each day at the height of the recent peak, requiring these patients to be cohorted on wards – meaning patients cannot be effectively separated (especially in specialist clinical areas). Moreover, the lack of patient bathrooms and bed spacing also meant the Trust could not meet infection control standards for those patients on wards. The Trust also had to forego gender separation to protect patient safety.
- **Difficulties separating patients in emergency spaces, limiting infection control**. Due to the limitations of the existing emergency departments, ESTH has struggled to create separate COVID-19 positive and COVID-19 negative spaces and has not been able to separate patient flows. The only way on both sites to do this required the urgent treatment centres to be converted into majors areas.
- **Planned care cannot be effectively separated from emergency care**. The design of Epsom and St Helier Hospitals makes separate spaces for planned and emergency care very challenging in their current configuration (e.g. eye theatres at St Helier are in the same wing as the ITU).

ESTH's people are stretched and under pressure, leaving limited capacity to respond to a crisis.

- **Pressures on already fragile staffing required rapid re-deployment and staff to go above and beyond**. Before COVID-19, ESTH had significant issues staffing its emergency departments and critical care sufficiently and was not meeting relevant standards. This was exacerbated by the crisis: more staff were needed to treat more patients, but staff sickness (staff sickness rose from 5% to 18%, meaning c. 500 staff were off sick at once) and our staff's own underlying health conditions meant fewer staff were available. To manage this, ESTH had to retrain and redeploy hundreds of staff (including in ITU and acute medicine) and rely significantly on the goodwill of its people to manage the demand. For example, intensive care consultants worked >70 hours a week; consultant dermatologists acted at junior doctors on medical wards; orthopaedic surgeons supported junior staff on ITU; audiologists supported dialysis units.

The model of care can be different – with less time in acute hospitals.

- **Significant numbers of outpatient appointments can be delivered virtually.** The crisis has forced all acute trusts to rethink outpatient care. ESTH has found multiple ways of delivering clinics differently without face-to-face interaction; it is currently running 500-1000 virtual outpatient appointments a week.
- **Patients can be discharged from acute care more quickly**. The crisis has required record numbers of patients to be discharged. This has accelerated significant improvements in patient flow and length of stay, supported by our out of hospital system.

5. Implications for the clinical model

The clinical model focused on care in 2025 onwards, whereas it may take several years before the policy is firmly established around meeting future pandemics and future requirements. However, a joint letter from The Health Foundation, The King's Fund and the Nuffield Trust to the Health and Social Care Select Committee[1] discussed five main challenges:

- appropriate infection prevention and control measures will need to be available;
- we need to understand the full extent of unmet need;
- the public's fear of using NHS and social care services needs to be reduced;
- looking after and growing the workforce; and
- wider reconfiguration and improvement of the health and social care system.

The experience from COVID-19 does not change the need for major acute services to be co-located or to have a sufficient number of appropriately skilled staff to run them.

- **The case for change and need to consolidate major acute services is enhanced**. COVID-19 demonstrated the difficulties in responding to this crisis with split-site services, inadequate estate and a stretched workforce. Consolidating major acute service would mean responding to any future crisis with more robust services, in purpose-built estate and with an enriched and enhanced workforce.
- **More staff are needed in key areas**. The shortcomings exposed, especially in ITU, demonstrate a need for more medical staff in each unit. This would be eased by consolidating services to create critical mass and greater staffing resilience, with greater scale enabling better staff-to-patient ratios.
- **The district and out of hospital models needs to work more closely together**. COVID-19 demonstrated that the @Home service and Health and Care services can do more to support the district hospital model. In the PCBC, we expected this to be developed over the next five years – COVID-19 has accelerated a lot of this work and we are now working in a more integrated way.

[1] https://www.nuffieldtrust.org.uk/news-item/letter-to-the-health-and-social-care-select-committee

6. Implications for future capacity

In response to feedback from consultation, we had already planned to extend the planning horizon for IHT to 2029/30. Extending the bed modelling to this date means we required c. 14 more beds than were included in the PCBC. This increase will be included in the DMBC.

As we emerge from COVID-19, the assumptions we previously made about critical care capacity and single room provision may need revisiting to create further capacity for pandemic response and/or surges in demand. COVID-19 means we will need to understand the flexibility we have in the future.

We are currently exploring scenarios where c. 20% additional capacity is required and confirming whether all three potential SECH sites could accommodate this if emergency response was needed. This would be on the basis of further crisis response requiring additional capacity over and above the capacity needed for the clinical model; this would therefore need separate funding if it was needed. The outcome and implications of this review will be included in the DMBC.

This will all continue to be reviewed as part of any subsequent business cases which will revisit capacity requirements and the lessons from COVID-19.

7. Implications for the design of hospital buildings

COVID-19 has given us lots of insights into how hospital buildings need to be designed to make them better able to cope with diseases like this in the future.

- **Buildings need to be designed to be flexible**. To respond to future pandemics and/or changes in demand, healthcare buildings need to be designed so they can be used in different ways, including providing more ITU and/or ventilated capacity when needed.
- **Where possible, access and clinical spaces should be separate/segregated**. Planned spaces should, where possible, be separate from emergency spaces, to support separation of patients – and this would be supported by the split of the SECH from the district hospital sites (meaning we could offer COVID-protected environments). Emergency spaces should also be designed to enable segregation when necessary (e.g., segregating emergency departments in COVID and non-COVID spaces). Departments should, as much as possible, have dual access and egress routes.
- **We need greater capacity and staffing resilience to support planned care**. In future pandemics, we would want to continue more planned care than during COVID-19. This requires better facilities and more resilient staffing, supported by consolidation. The greater separation of planned and emergency care offered by the clinical model would mean we are more able to offer COVID-protected planned care facilities in the future.
- **Digital needs to be embedded in the hospital**. To maintain the shift to virtual care, dedicated facilities and systems will be needed alongside clinic rooms for face-to-face care – including the ability to review outpatient/ambulatory patients virtually and for staff to work remotely. Moreover, the facility should maximise the opportunity offered by digital.

These areas will be explored further through the business case process as plans develop into more detailed pathway and building designs.

These changes may create a pressure on the cost of any new hospital development, which may require a further case to be made to HM Treasury and the Department of Health and Social Care to ensure ESTH is equipped to respond to future pandemics.

8. Conclusion

Our analysis of the impact of COVID-19 on the proposals in the Improving Healthcare Together programme has two conclusions.

Firstly, the need to consolidate acute services in a modern fit for purpose SECH is even more important to do now and remains a pressing priority.

Secondly, we may need to alter the design of both the SECH and the district hospitals to reflect the learning from COVID-19 and we will be requiring ESTH to do this as part of the outline business case that it will submit following our decision on the location of the SECH.

The Trust and Clinical Commissioning Groups will continue to review the likely impact of COVID 19 as further local, regional and national evidence arises. This interim assessment paper will be used as one of the pieces of evidence that CCG Governing Bodies will consider as part of their decision-making process.