COVID-19 INSIGHT

Issue 13

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COVID INSIGHT

RECOVERY OF NHS HOSPITAL SERVICES

People’s access to hospital care was seriously affected by the COVID-19 pandemic – for many reasons, some people could not get the care they needed. Services offered new and innovative ways of trying to see people who needed care, but many kinds of care or treatments for long-term conditions were less possible.

An inevitable backlog in care has developed. This is because many NHS trusts had to suspend much of their elective care in the pandemic to help ensure their critical care provision – and the critical care was increasingly using theatres and other spaces that might previously be used for non-urgent care. Key staff, such as anaesthetists, were transferred to critical care during the height of the pandemic.

Hospital capacity was also under pressure due to social distancing, infection prevention and control (IPC), cleaning measures, use of personal protective equipment (PPE) and enhanced testing.

This issue of Insight looks at how trusts are now planning for people’s care while tackling the backlog caused by COVID-19 and their assessment of challenges. In May and June 2021, we asked 73 trusts about their approaches to longer waiting lists and how they are considering people’s care in a fair and equal way.

Waiting lists

Hospital waiting lists for elective and outpatient care have increased across the NHS. Trusts have told us that prioritisation is focused on people with the greatest need, following national guidelines, and those who have been waiting the longest – they are using prioritisation coding (from clinicians) and clinical validation to prioritise their waiting lists. We heard that most had systems to identify and reprioritise any patients whose condition deteriorated as they waited.

Priority codes help make sure trusts have a clear view of the number of people waiting, the urgency and which speciality. We heard that all two-weeks waits for cancer referrals are generally treated in the same way as pre-pandemic and patients are contacted and informed about how they can escalate a deterioration of their condition. Trusts described the governance and oversight of this process to ensure that no patients were being missed, guarding against inequality and maximising capacity, as well as re-reviewing waiting lists.

The scale of the task varies. Some trusts report being back to pre-Covid levels [of lists] while others described the position as “hugely challenging”. Trusts say they are focused on communicating well with patients – they have identified challenges including patient hesitation, as well as the continuation of a pre-Covid problem where some people do not attend appointments.

Communicating with patients

Trusts mainly described two approaches to communicating with patients – some by letter, advising their priority status, and some by phone to understand preferred next steps, with GPs also included in the communications. Other trusts spoke to all the patients on their list to understand their preferred next steps. We heard that some patients felt they no longer needed an appointment or preferred to postpone until they felt safer.

There were some good examples of ‘waiting well’ packages – patients being supported and kept informed while they waited. Some trusts had digital platforms which allowed patients to track their progress in the list. Among examples we heard about the use of:

- cancer care coordinators to advocate for patients who may otherwise find it difficult to navigate the system
- communication plans for patients waiting for elective operations – feedback from patients suggested that regular updates to patients in the lower clinical priority group (waiting for longer periods) helped improved people’s experience
- support packages for elective patients with extended wait times, including a focus group involving patient representatives and therapy programmes.

From University Hospital Southampton NHS Foundation Trust we heard that, where it was identified patients were waiting too long and at risk of harm, they were given 24/7 contact details and an escalation plan. And a specialist eye trust wrote to vulnerable older patients to ask whether they required an appointment and to ensure that contact was maintained in uncertainty of the pandemic. The trust described this as a “proactive approach when dealing with vulnerable patients with disabilities or dementia… with joint working with the safeguarding team to write to vulnerable patients in a way they could understand.”

Reviews and identifying deterioration

About half the trusts we spoke to described processes to monitor and prioritise patients to reduce the risk of harm caused by prolonged waits. Generally, oversight of the harm review process was in place. There was also some innovative practice.

University Hospitals Coventry and Warwickshire NHS Trust used a review tool to check on any harm to patients whose wait had breached the 52-week referral to treatment – it was also reviewing definitions of harm to include biological, socioeconomic and psychological harm.

Another trust described the work in primary care to mitigate the risk of deteriorating health for people with long waits – GPs held video consultations to support patients to lose weight, give up smoking, and make sure they were on the right medicines to be in the best possible condition for surgery.

We also heard about good oversight and quality assurance. Trusts told us about assurance for clinical validation and mechanisms for preventing patient harm. There were different operational routes and some trusts had electronic systems to monitor and report on waiting lists. There was also evidence of wider integrated care system (ICS) collaboration, particularly in the North East where trusts described the ICS-wide monitoring programme.

Tackling waiting lists

Trusts were tackling waiting lists in a variety of ways, including use of the private sector, patient-initiated follow-up (PIFU), 'accelerator sites' and virtual outpatients.

One trust example showed how using the private sector minimised the impact of cancellations and enhanced capacity; another showed projections of how using the private sector would rapidly reduce the number of patients waiting; and there was evidence of how one collaboration enabled treatment of nearly 4,000 additional patients.

We have heard how collaboration is already key in service recovery. Primary care services are taking advice and guidance from NHS trusts about diverting patients to more appropriate routes for their care – this was helping to slow the growth of waiting lists. However, we are also aware that this places extra pressures on primary care.

Some patients are using PIFU – this helps clinicians target support where it is most needed. Rather than being given appointments at routine intervals, patients and clinicians can schedule appointments if a condition changes, or not schedule at all. This was working in different ways in different trusts; some in its infancy and some operating for 18 months. A few had evaluated the impact on their services and shown it to be a high-impact intervention at reducing waiting times – we heard from the Mid Yorkshire Hospitals NHS Trust that 74% of patients had declined a follow-up appointment.

All trusts told us that the pandemic had accelerated their use and implementation of virtual outpatients. Virtual, online or telephone appointments were as much as 60% of all activity. Many said they were using NHS-approved 'Attend Anywhere' technology. We heard from Kettering General Hospital NHS Foundation Trust that virtual appointments went from 17,000 in 2019 to 160,000 in 2021.

Trusts are also pursuing other digital solutions such as home testing, remote monitoring and portals and apps to allow patients to access information, advice, correspondence and manage their appointments. But some trusts were more cautious about technology – one described only using it if it considered it 'fully effective in processing patients care'.

Trusts were keen to stress the quality assurance and governance involved, saying that despite the rise in virtual appointments, patients were offered the choice of face-to-face appointments.

We heard about quality impact assessments and patient satisfaction surveys to ensure that patients were receiving a good service – and some also talked about training and support for consultants to ensure they felt confident in the skills required to work in a digital way.

To help accelerate recovery, NHS England is trialling new ways of working in a dozen areas and five specialist children's hospitals. The 'accelerator sites' are reported to be using virtual wards and home assessments, 3D eye scanners, at-home antibiotic kits, 'pre-hab' for patients about to undergo surgery, and AI in GP surgeries. Saturday clinics are also planned, where multi-disciplinary teams can offer more specialist appointments.

Digital care pathways

Technology and digital solutions are a significant part of trusts' plans for helping people who need care while tackling their waiting lists. We have heard directly about digital transformation programmes and digital pathways. These are some examples where we heard about good outcomes for patients:

- An interactive digital outpatient platform within orthopaedics, enabling patients to track their post-operative recovery, check in on any changes in condition and request follow-up or advice and guidance rather than following traditional face-to-face review methods.
- 'Hospital at Home' – people recover from surgery on a 'virtual ward' in their own home, with regular visits from specialist nurses and therapists, plus virtual consultations with doctors.
- Changed delivery of a cystic fibrosis service during the pandemic, to keeping patients safer at home, moving to a fully digital care pathway with the ability to still admit patients to hospital as required. Feedback from the patient group was positive and this new model of care has been maintained after the peak of the pandemic.
- Virtual technology for glaucoma clinics to enable greater productivity and minimising inappropriate hospital visits for a vulnerable group.

Other examples of new digital solutions stated by trusts include:

- use of patient portals for accessing video consultations, appointment information, appointment reminders and a limited patient held record
- use of NHS e-Referral service that enables patients to manage their appointments
- updates to booking and prescription systems
- use of eConsent for people's decision-making about participation in research.

Increasing capacity

For many trusts, increasing capacity starts with the de-escalation of intensive care unit capacity and reclaiming operating theatres, to create elective bed capacity and bringing staff back to their substantive roles.

However, this remains challenging in some areas with high numbers of COVID-19 patients.

Trusts are talking about ring-fencing beds for elective procedures. Some are increasing surgery to seven days a week, using more of their estates and there was recruitment for more consultants. A few trusts mentioned increasing the number of operating theatre sessions each day and expanding surgery into the evenings. Some initiatives require significant funding – for example, one hospital was developing five new clinic rooms. However, we have heard from some trusts and in our provider collaboration reviews about serious concerns for staff wellbeing – many trusts are reporting 'staff burnout'.

A few trusts were offering mutual aid and sharing any capacity they have with other trusts in their ICS. This included work to centralise some services across their patch to maximise capacity. University Hospital Southampton NHS Foundation Trust told us they have run 'super Saturdays', where they have combined [patient] lists across trusts to ensure that patients are treated more promptly and to ensure effective use of weekend capacity. Where capacity wasn't available, they bought in extra help and this was especially effective in ophthalmology, dermatology, ear, nose and throat (ENT) and endoscopy. We also heard about examples of some procedures being treated as day cases rather than inpatients.

Opportunities

While the pandemic has caused enormous stress to the health and social care system, some opportunities have arisen. As part of their recovery, trust have told us these include:

- The chance to review and understand their waiting lists, and to consider the way they delivered services. They have engaged with patients and partners to streamline their work, leading to improved relationships with stakeholders.
- Implementation of digitally enabled pathways and advancements in PIFU which may have been more tentative in roll-out without the imperative of the pandemic.
- System-wide and increased collaboration.

Collaboration

Several trusts referred to Advice and Guidance, a solution included in the NHS Elective Care Transformation programme. This is about conversations between hospital clinicians and primary care clinicians and with patients – the intention is to avoid unnecessary secondary care referrals.

One trust reported a 400% increase in the use of Advice and Guidance. Another trust reported up to 1,200 advice and guidance consultations across all specialities a month – a reported benefit is increased capacity in outpatients. NHS trusts told us about collaborations with primary care, including conversations about how services in an area would restart – GP representatives sat on boards and groups that allowed for “closer working and communication” and bilateral flow of information. However, we have also heard how new arrangements to divert care away from some secondary care services is placing increased pressure on primary care.

We heard how community pathways could help patients outside hospitals and trusts described work to develop these, particularly in areas such as ophthalmology, ENT and dermatology. Other work with a similar focus included remote monitoring and virtual clinics, reducing the need for hospital visits. A few trusts described community hubs in development with a clear ambition to deliver more equitable access for people.

Discussing recovery plans, trusts told us about system-wide meetings or working groups, which have commonly included primary care and community care organisations. A few trusts reported sharing best practice with their partners and others mentioned merged patient waiting lists across their ICS or clinical commissioning group (CCG).

Recovery and monitoring population health

One NHS trust has told us about collaboration with their local partners that involves a shared business intelligence approach to aid post-Covid recovery and to improve monitoring of the local population's health.

We heard how this encourages collaboration and partnerships between all sectors involved in the delivery and commissioning of health and care services, including voluntary care. All partners across the system collaborate and bring their data processing and analytical capabilities together to generate better questions, intelligence and hypotheses for action or intervention.

The trust says business intelligence teams are developing health inequalities profiles for primary care networks and meeting with community partnership leadership teams to help them understand how they can use this information to inform service delivery and developments.

The trust works with the Bradford Institute for Health Research, which supports the gathering and interpretation of intelligence in the development of its health inequalities work.

Challenges

Central to recovery for health services will be tackling the waiting lists for people's care. NHS trusts have highlighted challenges including:

- COVID-19 continues – some hospitals are still experiencing high levels of COVID-19 patients, with intensive care unit beds and operating theatres used for these people
- social distancing and IPC arrangements reduce the capacity of hospitals, especially for those with older estates or reduced space
- trusts report vacancies in key areas that they are struggling to fill.

Trusts have pointed to the wellbeing of their staff, who must take annual leave and cannot be expected to continue to work at the current pace. Some described how new initiatives may place extra pressures on already burned-out staff and that weekend clinics may not be the answer to waiting lists because of the demands on exhausted staff.

NHS trusts have also pointed to some specific problems in tackling recovery. For example, one trust reported it was unable to open its operating theatre capacity because some nurses it was recruiting from India were unable to start work, while we also heard of issues for some hospitals with major trauma centres where the impact of non-elective demand has had an extra impact on waiting lists.

Health inequalities

When we heard from trusts about the challenges of tackling health inequalities as services plan recovery from the pandemic, many told us of work to identify and address the impact of inequality. However, much of this was in the planning and there were few examples of established initiatives or outcomes.

We have heard how inequalities is a focus in many recovery plans. Work is underway to better understand the local issues, including reviewing referral patterns, redesigning pathways, collaborative regional working and identifying barriers to access.

Some trusts have carried out equality impact assessments or had systems for monitoring their waiting lists, patient experience and outcomes by ethnicity or index of multiple deprivation. These findings were commonly shared with trust boards or health inequality-related steering groups.

Variation in activity by protected characteristics, particularly deprivation, was often recognised by the trusts that were monitoring health inequalities in this way. Some trusts had identified no inequalities to access at all.

However, we also heard from trusts that people from areas of higher deprivation were more likely to experience longer waits or get admitted to hospital via ambulance, or not attend outpatient appointments. There are some initiatives and alliances to address these concerns.

County Durham and Darlington NHS Foundation Trust told us about regional work to address inequality in two-week referrals for cancer, where there appeared to be a bias towards more affluent communities. Through targeted work with primary care, the local cancer alliance and others they reported earlier identification of cancer cases – particularly in deprived communities – through education, screening, the introduction of lung health check pilots, and other care pathway changes. There is hope that these place-based partnerships will increasingly support patients and transform pathways to reduce pre-pandemic or pandemic health-related inequalities.

Better NHS trust patient records and linkage with primary care datasets will be important for addressing inequality as local systems recover. Some trusts have acknowledged they need to improve the completeness of their records – this could help to identify barriers to care and help ensure that people's characteristics are recorded on initial registration, or fill gaps during subsequent patient interactions.

We did hear about some established initiatives. These included dedicated leads responsible for overseeing how trusts manage and address health inequalities, as well as the adoption of initiatives such as the NHS urgent community response two-hour and two-day programme. Two trusts mentioned how they were offering access to people in prison – they had identified that prisoners on cancer pathways were experiencing delays. We also heard about:

- Problems for people with a learning disability that were resolved with reprioritisation – one trust, Tameside and Glossop Integrated Care NHS Foundation Trust, encouraged COVID-19 vaccine uptake among people with a learning disability by providing psychological support with experienced staff in an area with low vaccine uptake.
- Royal Berkshire Hospital NHS Foundation Trust used local partnerships with foodbanks and the voluntary sector to inform people that secondary care services were still running and how to access them.

Access to care for some people as services recover will be affected by digital solutions. We have heard how this shift towards virtual consultation has been beneficial for some patient groups, but there are people who may feel uncomfortable using technology or others who may have limited access to the necessary equipment.

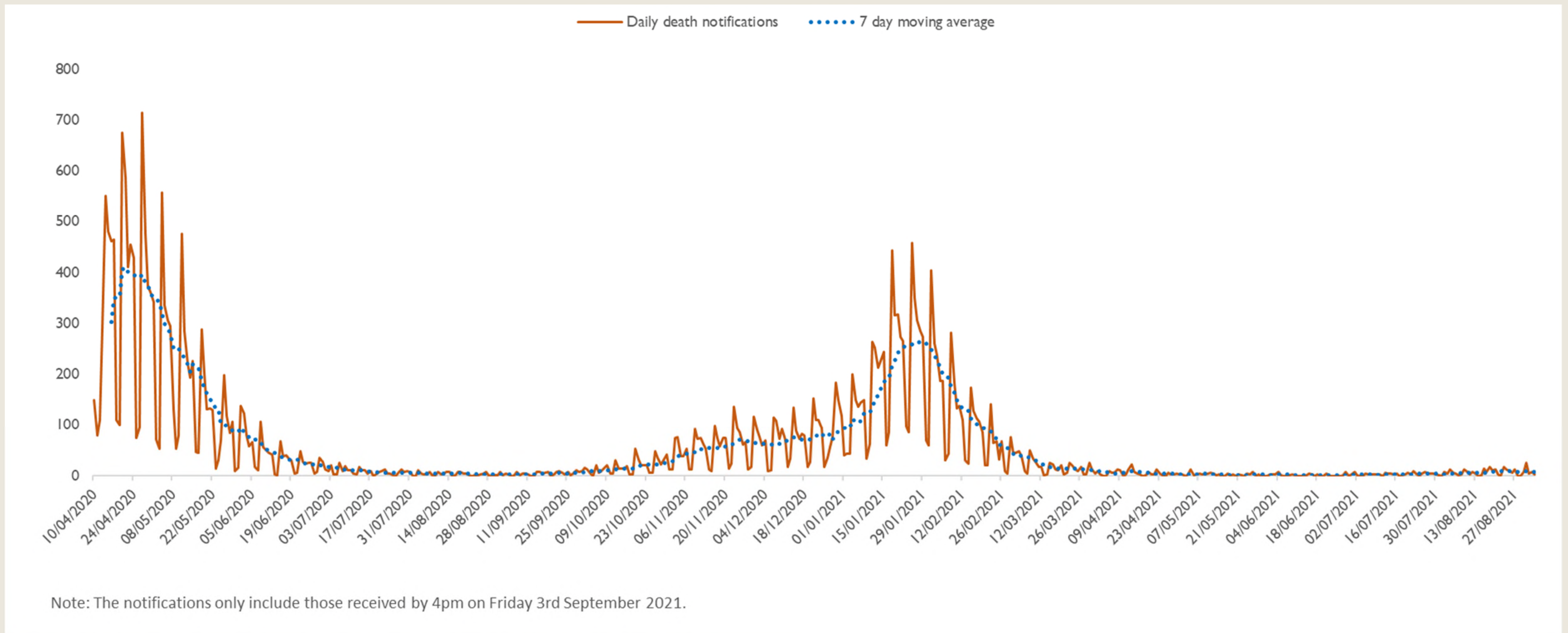
We heard during our provider collaboration reviews this year about examples of digital exclusion and inequality. One trust told us voluntary sector organisations were helping with IT equipment where people have limited access – hybrid models of care with virtual and face-to-face consultations have been the most common solution to the problem of digital exclusion.

We also heard of examples where face-to-face appointments were held at satellite sites in the community, to get closer to patients' homes. And some trusts offered services to support patients with technology, including interpreter services that were available virtually.

COVID INSIGHT

DATA APPENDIX

Deaths notified by care homes in England



Source: CQC death notifications submitted 10/04/2020 to 03/09/2021

The chart shows the number of death notifications of people in care homes flagged with COVID-19 submitted each day up to 3 September 2021, with a seven-day moving average line showing the smoothed trend. The numbers of notifications of deaths peaked for the second time by late January 2021 and fell steadily until late April 2021. Numbers have remained at low levels since then.

Death notifications of people detained under the Mental Health Act (MHA)

All providers registered with CQC must notify us about deaths of people who are detained, or liable to be detained, under the MHA.* Based on date of notification, from 1 March 2020 to 3 September 2021, we have been notified of 169 deaths that mental health providers indicated were suspected or confirmed to be involving COVID-19 (an increase of one since we reported in July). A further ten deaths of detained patients involving COVID-19 were reported by other (non-mental health) providers (an increase of two since we reported in July).**

* Includes detained patients on leave of absence, or absent without leave, from hospital, and conditionally discharged patients. 'Detained patients' also includes patients subject to holding powers such as s. 4, 5, 135 or 136, and patients recalled to hospital from CTO. These counts may also include notifications about the deaths of people subject to the MHA who are in the community and not in hospital.

** Data on notifications may be updated over time and therefore successive extracts may lead to changes in overall numbers. These changes may relate to data cleaning or delays in notifying CQC of a death of a detained patient.

Of the 623 notifications from mental health providers received in the 2020/21 period (covering all causes of death from 1 March 2020 to 3 September 2021), 498 were from NHS organisations, of which 127 deaths were indicated as involving COVID-19, and 125 were from independent providers, of which 42 deaths were involving COVID-19.

We have identified 36 detained patients whose deaths have been notified to us from 1 March 2020 to 3 September 2021 who had a learning disability and/or were autistic: the majority (25) were not identified as involving confirmed or suspected COVID-19. Of these people, most also had a mental health diagnosis. Please note that these patients were identified both from a specific box being ticked on the notification form and a review of diagnoses in the free text of the form.

Death notifications of people detained under the Mental Health Act (cont.)

The table below shows all notifications of deaths of detained patients (across all provider types) between 1 March 2020 to 3 September 2021, by age band, and COVID-19 status.

Age band	16-17	18-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Unknown	Total
Suspected or confirmed COVID-19	0	1	4	9	12	30	39	50	23	11	179
Not COVID-19	4	21	47	40	59	80	77	73	27	61	489
Total	4	22	51	49	71	110	116	123	50	72	668

The table below shows all notifications of deaths of detained patients (across all provider types) from 1 March 2020 to 3 September 2021, by gender and COVID-19 status.

Gender	Female	Male	Transgender	Unknown or unspecified	Total
Suspected or confirmed COVID-19	57	106	0	16	179
Not COVID-19	149	273	1	66	489
Total	206	379	1	82	668

Death notifications of people detained under the Mental Health Act (cont.)

The table below shows all notifications of deaths of detained patients (across all provider types) from 1 March 2020 to 3 September 2021, by ethnicity and COVID-19 status.

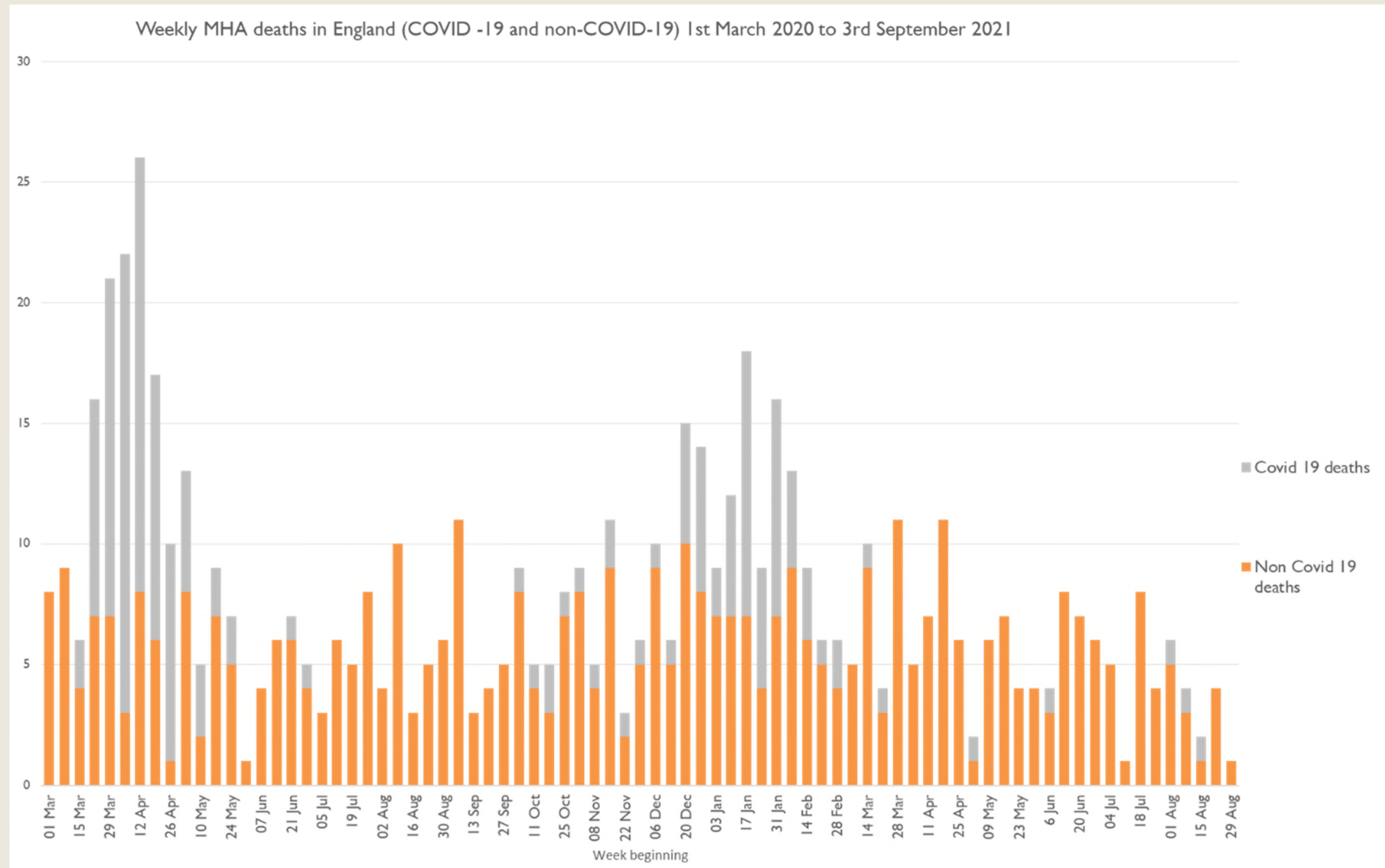
Ethnicity	Suspected or confirmed COVID-19	Not COVID-19
Asian	7	9
Black	21	32
Mixed	7	11
Other ethnic groups	1	4
White	99	268
Unknown	23	45
Not stated	21	120
Total	179	489

Death notifications of people detained under the Mental Health Act (cont.)

The table below shows all notifications of deaths of detained patients (across all provider types) from 1 March 2020 to 3 September 2021 by place of death and COVID-19 status.

Place of death	Suspected or confirmed COVID-19	Not COVID-19
Medical ward	124	156
Psychiatric ward	40	150
Hospital grounds	1	9
Patient’s home	0	48
Public place	0	9
Other household	0	3
Other	3	57
Not stated	11	57
Total	179	489

Death notifications of people detained under the Mental Health Act (cont.)

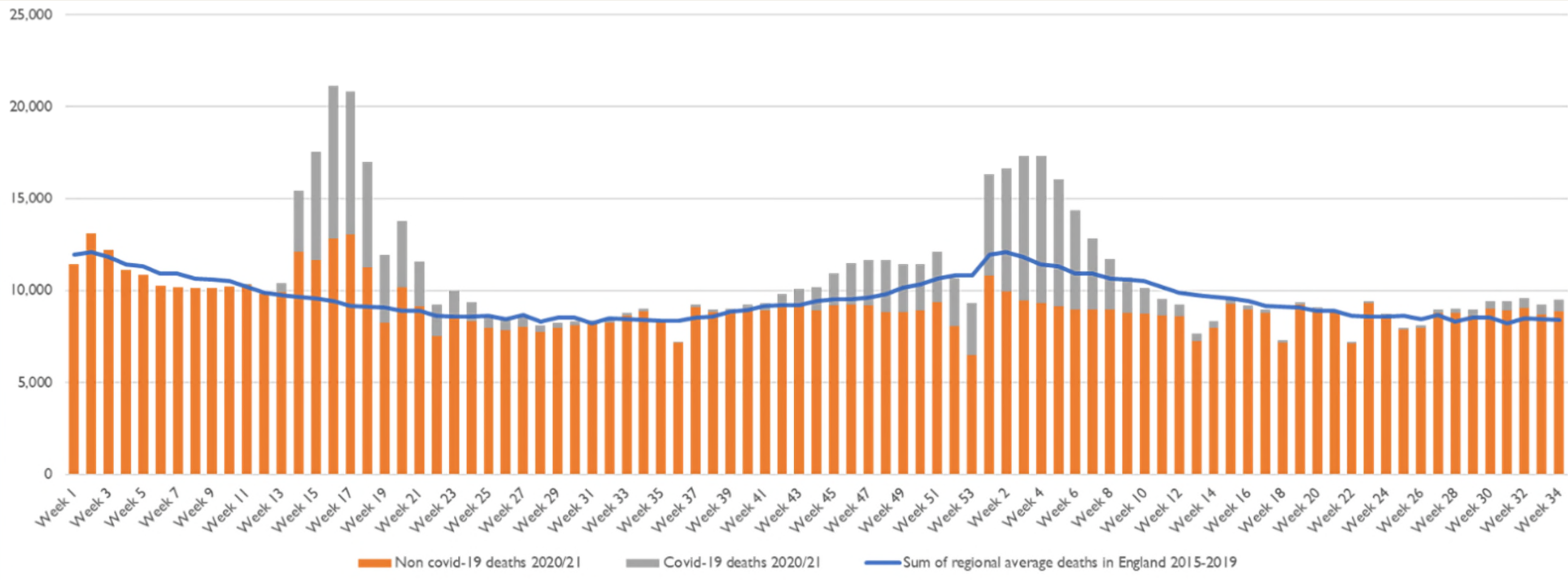


Source: CQC death notifications

The chart above shows the number of deaths notified to CQC based on the date of death. These figures will be lower than the counts of notifications presented in the previous section due to time lags in reporting and data cleaning. Data may be updated over time and therefore successive extracts may lead to changes in overall numbers.

We will also be reporting on the deaths of detained patients and deaths of patients subject to community treatment orders from 1 April 2020 to 31 March 2021 in our MHA annual report later in the year. This report will include further information about the causes of deaths, including COVID-19. The cause of deaths in detention is usually determined through the coroners' courts, which leads to a delay for accurate statistical reporting.

ONS data on all weekly deaths in England (COVID and non-COVID) compared with the average for 2015-2019



Source: ONS COVID/non-COVID 2020 and 2021 death data:
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/deathregistrationsandoccurrencesbylocalauthorityandhealthboard
and 2015-2019 death data from:
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/11674fiveyearaverageweeklydeathsforenglishregionsandwalesdeathsthatoccurredbetween2015and2019
Week 34, 2021: week ending 27 August 2021