Save Our Hospital Services Devon

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The coronavirus (COVID-19) crisis and healthcare services in Devon

Executive Summary

Health and hospital services in Devon were already run-down and over capacity when the COVID-19 crisis struck.

Devon has had a relatively low rate of infections. Despite this, more people have undoubtedly contracted COVID than would have been the case if the Government had acted more promptly and according to the advice of public health experts.

Local health, care and community workers responded heroically to the crisis. But they were hampered by centralised decision-making, especially over testing, tracing, and PPE procurement, that undermined local planning and side-lined the expertise of local bodies.

Outsourcing of key functions to private sector contractors has led to inefficiencies, duplication, confusion, poor communication, and worse outcomes than if existing NHS and local authority capacity had been extended.

We offer urgent recommendations to ensure that Devon healthcare and hospital services are fit for purpose in the case of a second wave of COVID-19 infections, or a similar public health crisis in the future.

Introduction

Save Our Hospital Services (SOHS) is a long-running, non-party-political campaign against NHS cuts and privatisations, active across Devon and affiliated with the national organisation Health Campaigns Together.

Our criticism of Government policy is in the context of our deep gratitude, fellowship and support for healthcare workers. At this time especially we think of the hundreds of NHS and care workers who have died while treating COVID-19 sufferers, and the tens of thousands of frontline workers who continue to risk their lives around the globe. We are indebted to the healthcare workers across Devon who have provided us with information for this report.

No government can be fully prepared for a global pandemic, but the UK Government has led the world in mismanagement, recording 65,000 additional deaths to the end of June and the third worst per capita death rate globally.

Scientists, doctors, epidemiologists and public health experts have challenged the handling of the coronavirus crisis in the UK; independent journalists have

investigated the causes. Our report builds on their efforts. In it, we highlight issues that specifically affected services in Devon, and that relate to the concerns we have campaigned on since 2016. We also suggest solutions that could help Devon health services prepare and respond to future outbreaks of COVID-19 and to other major public health events.

Background – the condition of hospital services in Devon

- In line with other NHS Trusts, headline measures for the performance of Devon hospital trusts have been in decline since 2012 (source: NHS Key Statistics Feb 2020 and NHS Trust CQC reports). Two of the three Devon general hospitals that have had recent CQC inspections 'require improvement' overall, and the third 'requires improvement' in respect of safety[1]. South West Ambulance Service 'requires improvement' in four out of six safety measures.
- The reason is straightforward: a lack of funding. NEW Devon CCG has been in debt since it took over commissioning of services in Northern, Eastern and Western Devon in April 2013. And the Devon system as a whole, including Torbay and South Devon, remains in a 'deficit position', required to make year-on-year cost 'savings'. Devon Trusts have consistently been close to bankruptcy, not least because they have been providing services that the commissioners have been unable to pay for. Two of our four general hospitals (NDDH and Torbay) have been under threat of major cuts to acute services.
- Since 2012, the number of community hospital beds in Devon has been cut from 663 to 273 (source: 2012 Estates Return Information Collection; 2019 Patient Led Assessment of the Care Environment). The number of overnight beds in all settings has been cut by more than 100 (sources give different totals) since the Sustainability and Transformation Plan for Devon proposed cutting up to 400 beds from 2016. 'Rationalisation' of provision and closure of community services has left many rural communities an hour or more from acute and in-patient care.
- Over the same period, the population of Devon has grown by 70,000, with more than half of that growth among the over-65s.
- Devon county has among the highest numbers of elderly and extremely elderly residents in the UK, and the highest rate of care-home residents. Both groups are highly vulnerable to COVID-19.
- When beds are lost, nursing staff associated with that bed capacity are also lost. Even with reduced rotas, 8% of healthcare posts were unfilled in 2019 (SW of England figure) and problems with recruitment/retention of skilled nursing staff were rising.
- Since 2012, health inequalities within Devon have increased, as measured by life expectancy (source: PHE), leaving more people with known risk factors for a severe COVID-19 response.
- There were almost 40m visitor trips to Devon in 2019. As lockdown eases, and with international travel restricted, we are seeing exceptionally high visitor

[1] North Devon District Hospital is currently undergoing inspection.

numbers, each visitor bringing their own ongoing healthcare needs as well as the added risk of virus transmission.

- Our four major hospitals have been run at or close to capacity for several years (occupancy rate over 90% overall, 80% of beds occupied by emergency cases).
- Analysis by Edge Health in March this year found that ICU bed capacity in the South West of England was the lowest *per capita* in the country, with hospitals having only a sixth of the ICUs required to deal with a significant COVID-19 outbreak.
- A policy of discharging older people from hospital beds at the earliest opportunity, with new roles created specifically to promote rapid discharge (e.g. into private care homes) and intermediate care at home, has led to some of the worst emergency re-admission rates in the country (source: CQC Use of Resources report 2018).
- Social care in Devon faces huge challenges. Mears Care, the major private care provider, was rated 'inadequate' on multiple counts in 2018 (source: CQC report 2018). More than 80 separate providers are currently contracted, but around 2500 hours per week of care are not being delivered (source FOI request February 2020) and more than 100 care posts are unfilled. The adult care budget is still 'overspent' by £3m.
- Under the Public Health England regime, instituted in 2013, local accountability and reporting links have been broken (e.g. between GPs, local authority public health officers, and NHS hospital testing labs). The funding available for public health via local councils was cut by 50%. In 2016, County Councils were instructed to get rid of stores of PPE as they were no longer responsible for responding to an epidemic. Just before the pandemic, the Director of Public Health stated that there was no budget for preventative health measures in the county.
- In March this year, Devon CC's Health and Adult Care Scrutiny Committee was asked to approve a further cut of more than £400m from its projected spending on healthcare.
- Alongside these specific health-related issues, a massive £272m was wiped off Devon County Council's finances by the last Government, leading to catastrophic decline in the services needed for community resilience.

The COVID-19 pandemic and the UK Government response

Our healthcare system in Devon was already vulnerable when the first reports of a novel coronavirus reached the UK in December 2019. Between January and March 2020, some of these vulnerabilities might have been addressed if the response from the UK Government had been focused and urgent. But the Government failed to act.

Crucial failures included:

- Not building capacity for mass testing (reagents, kits, logistics)
- Using a narrower definition of COVID-19 symptoms than recommended by the World Health Organization and used in other countries, leading to cases being missed

- Abandoning test-and-trace efforts in early March
- Delaying lockdown until 23 March, against the recommendation of epidemiologists and the experience of other countries
- Outsourcing a new national test-and-trace programme to Serco, a private provider with a long history of failed public contracts, by-passing local public health officers and Directors of Public Health
- Not requiring Serco to communicate test results promptly and in detail with local agencies
- Despite warnings, not stockpiling or urgently acquiring personal protective equipment (PPE) for frontline workers[2]
- Not establishing step-down sites for COVID patients in transition out of acute hospital care (community hospital beds would be ideal for this), and instead ordering the discharge of elderly patients directly into care-home settings.
- Insisting that oversight and communication were managed centrally (PHE, NSHE, Dept of Health); then failing to set up effective communication systems among the different agencies involved in delivering the COVID response
- Failing to communicate with the public clearly, rationally and with credibility about how to avoid transmission.

These failures have cost lives in Devon, as elsewhere in the country.

The pandemic in Devon

Given the age profile of our population, we are fortunate that our infection rate has been so low. To date (8 August 2020), ONS cites 363 COVID-19 deaths in Devon, 183 in our hospitals and 154 in care homes.

During the first wave, second home owners and holiday makers were largely kept away, thanks to interventions on link roads into the area. These were set up after GPs and pharmacists reported in March that they were being overwhelmed with requests from people with addresses outside the area[3].

There are over 300 residential care homes in Devon, and some saw devastating outbreaks in the first wave. However, many care home managers refused to receive patients from hospitals without a negative test result, which undoubtedly saved lives. Care homes remain acutely vulnerable to any further outbreaks of the virus.

An NHS Nightingale hospital with 120 extra beds has been constructed at a former Homebase in Exeter, but there are as yet no public figures for how much it has cost. It is currently being used for diagnostic testing, to help catch up with the back-log created during the first wave of the pandemic. This means private testing equipment and staff are being paid to use the facilities. Private hospitals and contractors have also been

[2] Against the recommendations of its own pandemic response exercise (Cygnus) in 2016, and subsequent annual risk assessments, the Government had failed to maintain a stockpile.

[3] Now, however, visitors are arriving in numbers equal to or even greater than normal for the time of year – indeed, they are being encouraged to do so by the Government. Since the virus continues to be transmitted in other parts of the UK, healthcare services in Devon are preparing for a second wave of infections.

funded to provide 'green' sites for routine operations while NHS hospital wards and staff remain on standby.

We understand from GPs and hospital managers that there were long delays to establishing this system of 'green' and 'red' facilities. In other countries, existing capacity was quickly organised into safe and unsafe zones, so more routine healthcare services could continue and more patients with urgent and life-threatening conditions could get treatment alongside the COVID response.

Community hospital beds are being used to support patients in recovery from COVID-19, and we welcome the fact that they are proving their value. However, we note that this means a further reduction in access to services for non-COVID patients, including minor injury units and clinics. In other regions, such as Staffordshire, community beds and wards are being re-opened. Rather than paying large sums to private hospitals, why not reinstate beds and staff that have been cut from the NHS in recent years? COVID patients often require a long rehabilitation, an ideal role for community hospitals.

Our County and District Councils have collectively – despite the efforts of some individual Councillors – failed to provide leadership, or any challenge to Westminster's disastrous handling of the crisis. Devon County Council's Health and Adult Care Scrutiny Committee voted down a proposal to suspend healthcare 'savings' of more than £400m for the duration of the coronavirus outbreak. South Hams and West Devon District Councils voted effectively to suspend democratic scrutiny. We know that joined-up plans for a county-wide response were on the table, and were circulated and discussed in the early weeks of the pandemic, but were never actioned.

On a positive note, there has been a tremendous community response to the pandemic. GPs and community nurse teams are working closely with voluntary bodies and COVID response hubs. But planning and funding should have been channelled through accountable bodies such as the Director of Public Health and the PCNs, not through ad hoc social networks. GPs and healthcare workers in different parts of Devon have different experiences of how the response has been coordinated and communicated, but all agree that systems should have been localised, with a clear communication structure and a single point of contact at each agency: public health, hospitals, PCNs/CCGs, care homes, testing centres, social care providers, police, councils, schools, community hubs.

Hospital teams and COVID lead nurses have been described by our contacts as '*amazing*' and *'incredibly responsive'* to requests for information and support. But six months into the pandemic, many community health and care workers don't know where to turn if they have questions or cases to report: "*it is still not clear who to contact and how*".

Test, track and trace in Devon

The first cases of COVID-19 in Devon were confirmed on Monday 4 March, among people who had recently returned to Torbay from Italy. (At this time, the Government recommended testing only for people returning from China and parts of South Asia). While the infection rate remained low across the county, public health officers were doing a good job of contact tracing. But by mid-March the Government had called off all contact tracing efforts, deciding instead to let the virus

'*move through the community*' at a rate that – it hoped – would not overwhelm healthcare services. Rather than committing the resources that would be needed for local public health officers to trace the growing number of cases, on 19 March the Government removed COVID-19's classification as a high consequence infectious disease.

NHS labs could have used these weeks to build testing capacity, but they were waiting for PHE to evaluate the available testing kits and reagents. These evaluations were not completed until late March.

A microbiologist at NDDH went on the record to say that he and his lab team had offered to test nursing home residents in early April, as they had the capacity and *"nobody else was doing anything*". But NHS executives ordered his team *"to back off. They said, this is not your job. This is a PHE job."* And it was clear by this time that PHE was completely over-stretched.

Attempts to establish a national testing scheme began again in April, not through local public health experts but with a series of contracts under the overall management of Serco (who received £46m). Health workers across Devon told us of a chaotic situation:

- Busy NHS staff being offered appointments hundreds of miles away
- An entire hospital work force being told to attend for testing in a car park, only for tests to run out within a few hours
- Health workers waiting two weeks for the results of urgent tests – and being told to continue working meanwhile
- Tests coming back 'inconclusive' because trained healthcare workers had apparently not been able to swab effectively using the kit provided
- Hospitals refusing to send staff to 'unsafe' commercial testing sites because of evidence that testers were not wearing PPE and not handling test materials safely
- Shielding patients unable to access testing when they were symptomatic, especially if they were infirm or disabled

Throughout this time, testing was unavailable in care homes, and residents were being sent back from hospital without being tested. At least one care-home manager in South Devon refused to receive potentially COVID-positive patients, but other care homes saw dozens of cases, and tragically some residents did not pull through. Care homes are now routinely swabbing their own staff, but supplies and turn-around times for test results are still far from satisfactory. The recall of thousands of Randox tests, sourced by Deloitte, has further set back the care-home testing regime.

By June, it was clear that public health teams – despite their lack of funding, and being 'out of the loop' of the national testing regime – were doing a far better job of tracing contacts than the call centres set up by Serco. A quarter of the 31,000 people referred to national Test and Trace in June were not reached, and almost a third of those who were reached did not provide any contacts. Pillar 1 NHS hospital testing with local authority follow-up traced almost 100% of contacts. Our local councils have finally been offered £2.6m to expand this work. But much of the testing continues to be done at private 'lighthouse' laboratories, with novice testers producing a high proportion of inaccurate results (up to 30% wrong or inconclusive). And our local CCGs, hospital trusts and

councils are still not being given access to the data fast enough or at enough detail to support local planning and response[4].

Tests are also not routinely available to community care workers or staff at GP surgeries, who have a high level of patient contact. And patients need fast, reliable testing themselves so they can be admitted for non-COVID treatment without putting other patients and staff at risk.

Instead of setting up a new, inefficient, potentially unsafe scheme in the private sector, existing public health systems should have been given the resources to expand. GP surgeries are ideally placed to manage testing for their local area. Most patients could self-test, and skilled support would be on hand for anyone who found this difficult. Samples could be taken to the local NHS hospital lab and returned on the daily run with other routine tests, or sent to PHE labs if capacity was strained. Data would then be shared with hospitals and GPs as soon as it was available, and could be passed on to public health officers through established contacts.

Registered community volunteers – including retired or ex health workers - could be employed to support testing and help track people at risk, linking them to sources of support so they could stay in quarantine without hardship. Surgery staff, community carers and district nurses could be tested regularly, and in time the system could be extended to local schools and colleges. And once we get this system working, it could also be used to promote and deliver a vaccine.

An informal pilot scheme launched from NDDH in May showed what could be done with this kind of approach. By interviewing and testing care workers regularly, and having an experienced sexual health worker track contacts, the team were able to identify new cases rapidly. Local care homes under the scheme have remained COVID-free.

Every public health expert agrees that in the case of further infection spikes we need community-based testing with local results delivered quickly to local decision-makers. Internationally this approach has been shown to build trust and compliance. It requires investment in public health and in local communities, not private contracts with corporations that have repeatedly been fined for data breaches and for breaches of contract.

Personal protective equipment (PPE) in Devon

The Government was warned last year that the country did not have enough gowns, gloves, visors, swabs and body bags to cope with a pandemic, yet missed several opportunities to secure supplies during February and March.

Rather than allowing local trusts to procure their own equipment, the Government insisted that they go through a single national scheme. Many trusts protested this directive and it was eventually withdrawn - though not before the national PPE contract had been outsourced to DHL for a total of £4bn. During this time we learned from

[4] In Devon, we well remember what happened when Serco took over neighbouring Cornwall's out of hours service in 2016, contributing to the deaths of two children and falsifying over 250 data records before the whistle was blown. In fact, local managers have told us they would prefer for Serco to just take the money and leave the test-and-trace service to people who know how to deliver it.

hospital managers that the NHS supply chain was not functioning, but alternative suppliers were being frozen out. We learned from GPs of PPE being sourced from building suppliers and even from school 3D printing labs.

We know of at least one SW business that approached the Government with an offer to supply tens of thousands of units of PPE in April, but was ignored. Instead, contracts were issued to companies with no track record in healthcare or protective clothing, a scandal that continues to emerge in our national press. As a consequence of these central supply failures, health workers were being asked to use masks, gloves and aprons that did not meet WHO guidelines, or that were faulty, or out of date.

Local NHS hospital managers and GPs were resolute in addressing the PPE issue, and we are happy to report that we do not know of any deaths from COVID-19 among frontline workers in Devon. But the problems with centralised PPE supply remain, and PPE shortages in Devon's care homes have not been fully resolved. We have been told about:

- An emergency PPE hotline that took orders for weeks without producing any equipment
- GP surgeries buying masks online from China, then having to lend them to care homes
- Pharmacies running out of masks for their staff to use when dispensing prescriptions – and staff being asked to buy their own

The community response to the PPE shortage has been heroic, with schools turning their 3D printers to production of face visors, and local sewing bees producing hundreds of cloth masks and scrub suits. But frontline professionals should not have to source life-saving equipment in this way. Hospitals should never have had crucial supply chains cut and replaced by a mishmash of dodgy contracts, many of which have yet to deliver a single item of PPE.

Other preventive measures in Devon

All the people we spoke to believe that prevention is key to defeating the virus, unless and until there is an effective vaccine. They are most concerned to see:

- Risks to health and care workers minimised, and to the public while they are in health and care settings
- No more discharges of patients into care-home and community settings until they have tested negative (including consideration of the possibility of virus shedding in faeces)
- Rehabilitation support for COVID patients in recovery, including the use of current and recently closed community hospital beds
- Support for quarantine, so those at most risk of spreading the virus are able and willing to stay at home
- Careful management of seasonal visitors, using a multi-agency approach and local messaging to avoid overcrowding of visitor sites/attractions
- A managed return to school/college, in collaboration with the teaching and head teachers' unions, with risks minimised to vulnerable teaching staff and children/family members, and with regular routine testing to give early warning of outbreaks

- Clear advice to the public about how to avoid personal and situational risks, under the control of our local Director of Public Health – because local advice is trusted

Recommendations

We invite other organisations to use this report to draw up their own recommendations and to inform their own campaigns. SOHS itself makes the following recommendations, based on our experience of campaigning for hospital services in recent years:

- Fit-for-purpose PPE for all frontline staff and key workers
- A review of ICU and acute bed capacity across Devon's hospitals
- Permanent reinstatement of the beds brought into service during the pandemic crisis, and associated nursing staff, all under NHS funding and control
- A long-term plan to bring overnight beds and nursing capacity up to a safe level to meet the needs of a growing elderly population and growing numbers of seasonal visitors
- Local coordination plans for future outbreaks, with a single point of contact at each agency, clear lines of responsibility, and appropriate resources devolved locally
- Proper funding and powers restored to our Director for Public Health and local public health teams to coordinate testing, contact tracing, and community support
- GP surgeries restored to the heart of community health, with the COVID-19 clinical assessment service integrated into primary care
- Effective coordination and planning within the NHS: an end to obstacles such as private out-sourcing, internal market rules, and private ownership of public data
- An end to profiteering in our health and social care system; all private contracts to be subject to public scrutiny and transparency rules, and privatised services to be brought back into public provision
- Decent pay and conditions for all healthcare workers, and financial support for their families if they become ill or die in service

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