NHS
North Yorkshire
Clinical Commissioning Group

Title of Meeting:	**North Yorkshire Clinical Commissioning Group Governing Body**	**Agenda Item: 7.1 A**
Date of Meeting:	**27 August 2020**	
Paper Title:	**System recovery planning and response to Sir Simon Stevens letter (31 July 2020)**	

Session (Tick)	
Public	X
Private	
Development Session	

Responsible Governing Body Member Lead	**Report Author and Job Title**
Wendy Balmain, Director of Strategy and Integration Jane Hawkard, Chief Finance Officer	Christian Turner, Deputy Director Business Change and Planning

Purpose (this paper if for)

Decision	Discussion	Assurance	Information
X		X	

Has the report (or variation of it) been presented to another Committee / Meeting?

If yes, state the Committee / Meeting: Planning updates have been received by Finance, Performance, Commissioning and Contracting Committee, Business Executive and the Executive Directors Group.

Executive Summary

- Reporting into Gold Command, the North Yorkshire and York Silver Command group has managed the operational incident response to Covid 19 across the system.
- Gold and Silver Command colleagues, led by NYCCG's Accountable Officer, met in May to plan the North Yorkshire and York Covid 19 recovery programme.
- Working closely with the Humber, Coast and Vale (HCV) ICS team an initial recovery programme plan was submitted to NHSE/I in July. The initial plan highlighted key priorities, the tangible deliverables and how these will support system transformation in the longer-term.
- Further guidance on the Phase 3 (August 2020 – March 2021) Covid response requirements was sent from Simon Stevens and Amanda Pritchard to the whole NHS in a letter on 31st July (supplemented by further detail on 7th August).
- The letter (see Appendix 1) sets out three key priorities for Phase 3:
  1. Return to near-normal levels of non-Covid health services
  2. Prepare for winter demand pressures
  3. Do the above in ways that lock in beneficial changes, support our staff, and take action on inequalities and prevention
- To support these priorities an additional HCV planning submission has to be made to NHSE from each ICS on 21st September.
- The Covid 19 North Yorkshire and York recovery workstreams are preparing the narrative content and the activity trajectories to submit to the ICS on 16th September.
- A key requirement from the Simon Stevens letter is during September every NHS organisation to identify a named executive Board member responsible for tackling inequalities.
- For NYCCG it is proposed that this will be the Director of Strategy and Integration.

Recommendations **The Governing Body is being asked to:** • Note the progress made by the Silver Command Group in establishing a system recovery programme. • Note the priorities and key requirements within the Simon Stevens letter from July 31st. • Note that the North Yorkshire and York Silver Command group is working together to complete the required system responses to support the ICS in preparing a HCV submission for NHSE/I. • Note that a draft version of the responses will be submitted to the ICS on 25th August and the final version to be submitted on 16th September. • Support the decision to appoint Director of Strategy and Integration as the NYCCG executive board member responsible for tackling inequalities.	
Monitoring Progress on planning and implementation will be monitored through the North Yorkshire and York System Delivery Executive which is chaired by the NYCCG Chief Finance Officer.	
Any statutory / regulatory / legal / NHS Constitution implications	Simon Stevens has issued a letter (31/07/20) to NHS commissioners and providers which sets out the key system actions as part of phase 3 recovery and the continued system response to Covid-19. These actions are being incorporated into the local recovery and transformation plan.
Management of Conflicts of Interest	No conflicts of interest have been identified prior to the meeting.
Communication / Public & Patient Engagement	As part of the implementation of the recovery programme communications and public engagement will be undertaken within the workstreams.
Financial / resource implications	Financial costs associated with the phase 1 response have been funded through NHS England. Further expenditure, including capital, required for the delivery of phase 3 recovery and transformation will be discussed and agreed between the CCG and NHSE.
Outcome of Impact Assessments completed	Impact assessments will be undertaken where appropriate as part of the process of developing specific projects and workstreams.

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From the Chief Executive Sir Simon Stevens
& Chief Operating Officer Amanda Pritchard

To:
Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers
GP practices and Primary Care Networks
Providers of community health services
NHS 111 providers

Copy to:
NHS Regional Directors
Regional Incident Directors & Heads of EPRR
Chairs of ICSs and STPs
Chairs of NHS trusts, foundation trusts and CCG governing bodies
Local authority chief executives and directors of adult social care
Chairs of Local Resilience Forums

31 July 2020

Dear Colleague

IMPORTANT – FOR ACTION – THIRD PHASE OF NHS RESPONSE TO COVID-19

We are writing to thank you and your teams for the successful NHS response in the face of this unprecedented pandemic, and to set out the next – third – phase of the NHS response, effective from 1 August 2020.

You will recollect that on 30th January NHS England and NHS Improvement declared a Level 4 National Incident, triggering the first phase of the NHS pandemic response. Since then the NHS has been able to treat every coronavirus patient who has needed specialist care – including 107,000 people needing emergency hospitalisation. Even at the peak of demand, hospitals were still able to look after two non-Covid inpatients for every one Covid inpatient, and a similar picture was seen in primary, community and mental health services.

As acute Covid pressures were beginning to reduce, we wrote to you on 29 April to outline agreed measures for the second phase, restarting urgent services. Now in this Phase Three letter we:

- update you on the latest Covid national alert level;
- set out priorities for the rest of 2020/21; and
- outline financial arrangements heading into Autumn as agreed with Government.

Current position on Covid-19

On 19 June 2020 the Chief Medical Officers and the Government's Joint Biosecurity Centre downgraded the UK's overall Covid alert level from four to three, signifying that the virus remains in general circulation with localised outbreaks likely to occur. On 17 July the Government set out next steps including the role of the new Test and Trace programme in providing us advance notice of any expected surge in Covid demand, and in helping manage local and regional public health mitigation measures to prevent national resurgence.

Fortunately, Covid inpatient numbers have now fallen nationally from a peak of 19,000 a day, to around 900 today. As signalled earlier this month, the current level of Covid demand on the NHS means that the Government has agreed that the NHS EPRR incident level will move from Level 4 (national) to Level 3 (regional) with effect from tomorrow, 1 August. This approach matches the differential regional measures the Government is deploying, including today in parts of the North West and North East. The main implications of this are set out in Annex One to this letter.

However Covid remains in general circulation and we are seeing a number of local and regional outbreaks across the country, with the risk of further national acceleration. Together with the Joint Biosecurity Centre and Public Health England (PHE) we will therefore continue to keep the situation under close review, and will not hesitate to reinstate the Level 4 national response immediately as circumstances justify it. In the meantime NHS organisations will need to retain their EPRR incident coordination centres and will be supported by oversight and coordination by Regional Directors and their teams.

NHS priorities from August

Having pulled out all the stops to treat Covid patients over the last few months, our health services now need to redouble their focus on the needs of all other patients too, while recognising the new challenges of overcoming our current Covid-related capacity constraints. This will continue to require excellent collaboration between clinical teams, providers and CCGs operating as part of local 'systems' (STPs and ICSs), local authorities and the voluntary sector, underpinned by a renewed focus on patient communication and partnership.

Following discussion with patients' groups, national clinical and stakeholder organisations, and feedback from our seven regional 'virtual' frontline leadership meetings last week, we are setting out NHS priorities for this third phase. Our shared focus is on:

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' between now and winter

B. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.

C. Doing the above in a way that takes 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.

As part of this Phase Three work, and following helpful engagement and discussion, alongside this letter yesterday we published a more detailed 2020/21 People Plan, and will shortly do the same on

inequalities reduction. DHSC are also expected to set out equivalent phase three priorities and support for social care.

Nationally, we will work with the wide range of stakeholders represented on the NHS Assembly to help track and challenge progress against these priorities. As we do so it is vital that we listen and learn from patients and communities. We ask that all local systems act on the [Five principles for the next phase of the Covid-19 response] developed by patients' groups through National Voices.

A: Accelerating the return of non-Covid health services, making full use of the capacity available in the window of opportunity between now and winter

A1. **Restore full operation of all cancer services. This work will be overseen by a national cancer delivery taskforce, involving major patient charities and other key stakeholders. Systems should commission their Cancer Alliance to rapidly draw up delivery plans for September 2020 to March 2021 to:**

- To reduce unmet need and tackle health inequalities, work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels.
- Manage the immediate growth in people requiring cancer diagnosis and/or treatment returning to the service by:
  - Ensuring that sufficient diagnostic capacity is in place in Covid19-secure environments, including through the use of independent sector facilities, and the development of Community Diagnostic Hubs and Rapid Diagnostic Centres
  - Increasing endoscopy capacity to normal levels, including through the release of endoscopy staff from other duties, separating upper and lower GI (non-aerosol-generating) investigations, and using CT colonography to substitute where appropriate for colonoscopy.
  - Expanding the capacity of surgical hubs to meet demand and ensuring other treatment modalities are also delivered in Covid19-secure environments.
  - Putting in place specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment.
  - Fully restarting all cancer screening programmes. Alliances delivering lung health checks should restart them.
- Thereby reducing the number of patients waiting for diagnostics and/or treatment longer than 62 days on an urgent pathway, or over 31 days on a treatment pathway, to pre-pandemic levels, with an immediate plan for managing those waiting longer than 104 days.

A2. **Recover the maximum elective activity possible between now and winter**, making full use of the NHS capacity currently available, as well as re-contracted independent hospitals.

In setting clear performance expectations there is a careful balance to be struck between the need to be ambitious and stretching for our patients so as to avoid patient harm, while setting a performance level that is deliverable, recognising that each trust will have its own particular pattern of constraints to overcome.

Having carefully tested the feasible degree of ambition with a number of trusts and systems in recent weeks, trusts and systems are now expected to re-establish (and where necessary redesign) services to deliver through their own local NHS (non-independent sector) capacity the following:

- **In September at least 80% of their last year's activity for both overnight electives and for outpatient/daycase procedures, rising to 90% in October** (while aiming for 70% in August);

- This means that systems need to very swiftly return to **at least 90% of their last year's levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October**.

- **100% of their last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August).**

Block payments will flex meaningfully to reflect delivery (or otherwise) against these important patient treatment goals, with details to follow shortly once finalised with Government.

Elective waiting lists and performance should be **managed at system as well as trust level** to ensure equal patient access and effective use of facilities.

Trusts, working with GP practices, should ensure that, between them, **every patient whose planned care has been disrupted by Covid receives clear communication** about how they will be looked after, and who to contact in the event that their clinical circumstances change.

Clinically urgent patients should continue to be treated first, with next priority given to the **longest waiting patients**, specifically those breaching or at risk of breaching 52 weeks by the end of March 2021.

To further support the recovery and restoration of elective services, a modified national contract will be in place giving **access to most independent hospital capacity** until March 2021. The current arrangements are being adjusted to take account of expected usage, and by October/ November it will then be replaced with a re-procured national framework agreement within which local contracting will resume, with funding allocations for systems adjusted accordingly. To ensure good value for money for taxpayers, systems must produce week-by-week independent sector usage plans from August and will then be held directly to account for delivering against them.

In **scheduling** planned care, providers should follow the new streamlined patient self isolation and testing requirements set out in the guideline published by NICE earlier this week. For many patients this will remove the need to isolate for 14 days prior to a procedure or admission.

Trusts should ensure their e-Referral Service is fully open to referrals from primary care. To reduce infection risk and support social distancing across the hospital estate, clinicians should consider avoiding asking patients to attend physical **outpatient appointments** where a clinically-appropriate and accessible alternative exists. Healthwatch have produced useful advice on how to support patients in this way. This means collaboration between primary and secondary care to use advice and guidance where possible and treat patients without an onward referral, as well as giving patients more control over their outpatient follow-up care by adopting a patient-initiated follow-up approach across major outpatient specialties. Where an outpatient

appointment is clinically necessary, the national benchmark is that at least 25% could be conducted by telephone or video including 60% of all follow-up appointments.

A3. **Restore service delivery in primary care and community services.**

- General practice, community and optometry services should **restore activity to usual levels where clinically appropriate**, and **reach out proactively** to clinically vulnerable patients and those whose care may have been delayed. Dental practices should have now mobilised for face to face interventions. We recognise that capacity is constrained, but will support practices to deliver as comprehensive a service as possible.

- In restoring services, GP practices need to make rapid progress in addressing the backlog of childhood **immunisations** and cervical **screening** through specific catch-up initiatives and additional capacity and deliver through their Primary Care Network (PCN) the service requirements coming into effect on 1 October as part of the Network Contract DES.

- GPs, primary care networks and community health services should build on the enhanced support they are providing to **care homes**, and begin a programme of structured medication reviews.

- CCGs should work with GP practices to expand the range of services to which patients can self-refer, freeing-up clinical time. All GP practices must offer face to face **appointments** at their surgeries as well as continuing to use remote triage and video, online and telephone consultation wherever appropriate – whilst also considering those who are unable to access or engage with digital services.

- Community health services **crisis responsiveness** should be enhanced in line with the goals set out in the Long Term Plan, and should continue to support patients who have recovered from the acute phase of Covid but need **ongoing rehabilitation** and other community health services. Community health teams should fully resume appropriate and safe **home visiting care** for all those vulnerable/shielding patients who need them.

- The Government is continuing to provide funding to support timely and appropriate discharge from hospital inpatient care in line with forthcoming updated Hospital Discharge Service Requirements. From 1 September 2020, hospitals and community health and social care partners should fully embed the **discharge to assess** processes. New or extended health and care support will be funded for a period of up to six weeks, following discharge from hospital and during this period a comprehensive care and health assessment for any ongoing care needs, including determining funding eligibility, must now take place. The fund can also be used to provide short term urgent care support for those who would otherwise have been admitted to hospital.

- The Government has further decided that CCGs must resume NHS **Continuing Healthcare assessments** from 1 September 2020 and work with local authorities using the trusted assessor model. Any patients discharged from hospital between 19 March 2020 and 31 August 2020, whose discharge support package has been paid for by the NHS, will need to be assessed and moved to core NHS, social care or self-funding arrangements.

A4. **Expand and improve mental health services and services for people with learning disability and/or autism**

- Every CCG must continue to **increase investment** in mental health services in line with the Mental Health Investment Standard and we will be repeating the independent audits of this. Systems should work together to ensure that funding decisions are decided in partnership with Mental Health Providers and CCGs and that funding is allocated to core Long Term Plan (LTP) priorities.

- In addition, we will be asking systems to validate their existing LTP **mental health service expansion** trajectories for 2020/21. Further advice on this will be issued shortly. In the meantime:
  - IAPT services should fully resume
  - the 24/7 crisis helplines for all ages that were established locally during the pandemic should be retained, developing this into a national service continue the transition to digital working
  - maintain the growth in the number of children and young people accessing care
  - proactively review all patients on community mental health teams' caseloads and increase therapeutic activity and supportive interventions to prevent relapse or escalation of mental health needs for people with SMI in the community;
  - ensure that local access to services is clearly advertised
  - use £250 million of earmarked new capital to help eliminate mental health dormitory wards.

- In respect of support for people with a **learning disability, autism or both**:
  - Continue to reduce the number of children, young people and adults within a specialist inpatient setting by providing better alternatives and by ensuring that Care (Education) and Treatment Reviews always take place both prior to and following inpatient admission.
  - Complete all outstanding Learning Disability Mortality Reviews (LeDeR) by December 2020.
  - GP practices should ensure that everybody with a Learning Disability is identified on their register; that their annual health checks are completed; and access to screening and flu vaccinations is proactively arranged. (This is supported by existing payment arrangements and the new support intended through the Impact and Investment Fund to improve uptake.)

B: Preparation for winter alongside possible Covid resurgence.

B1. Continue 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. This includes:

- Continuing to follow PHE's guidance on defining and managing communicable disease **outbreaks**.

- Continue to follow PHE/DHSC-determined policies on which patients, staff and members of the public should be tested and at what frequency, including the further PHE-endorsed

actions set out on testing on 24 June. All NHS employers should prepare for the likelihood that if background infection risk increases in the Autumn, and DHSC Test and Trace secures 500,000+ tests per day, the Chief Medical Officer and DHSC may decide in September or October to implement a policy of regular routine **Covid testing** of all asymptomatic staff across the NHS.

- Ongoing application of PHE's infection prevention and control guidance and the actions set out in the letter from 9 June on minimising **nosocomial infections** across all NHS settings, including appropriate Covid-free areas and strict application of hand hygiene, appropriate physical distancing, and use of masks/face coverings.

- Ensuring NHS staff and patients have access to and use **PPE** in line with PHE's recommended policies, drawing on DHSC's sourcing and its winter/EU transition PPE and medicines stockpiling.

B2. **Prepare for winter** including by:

- Sustaining current NHS staffing, beds and **capacity**, while taking advantage of the additional £3 billion NHS revenue funding for ongoing independent sector capacity, Nightingale hospitals, and support to quickly and safely discharge patients from NHS hospitals through to March 2021.

- Deliver a very significantly expanded seasonal **flu vaccination** programme for DHSC-determined priority groups, including providing easy access for all NHS staff promoting universal uptake. Mobilising delivery capability for the administration of a Covid19 vaccine if and when a vaccine becomes available.

- Expanding the **111 First** offer to provide low complexity urgent care without the need for an A&E attendance, ensuring those who need care can receive it in the right setting more quickly. This includes increasing the range of dispositions from 111 to local services, such as direct referrals to Same Day Emergency Care and specialty 'hot' clinics, as well as ensuring all Type 3 services are designated as Urgent Treatment Centres (UTCs). DHSC will shortly be releasing agreed **A&E capital** to help offset physical constraints associated with social distancing requirements in Emergency Departments.

- Systems should maximise the use of 'Hear and Treat' and 'See and Treat' pathways for 999 demand, to support a sustained reduction in the number of patients conveyed to Type 1 or 2 emergency departments.

- Continue to make full use of the NHS Volunteer Responders scheme in conjunction with the Royal Voluntary Society and the partnership with British Red Cross, Age UK and St. Johns Ambulance which is set to be renewed.

- Continuing to **work with local authorities**, given the critical dependency of our patients – particularly over winter - on resilient social care services. Ensure that those medically fit for discharge are not delayed from being able to go home as soon as it is safe for them to do so in line with DHSC/PHE policies (see A3 above).

C: Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including support for our staff, action on inequalities and prevention.

C1. **Workforce**

Covid19 has once again highlighted that the NHS, at its core, is our staff. Yesterday we published We are the NHS: People Plan for 2020/21 - actions for us all which reflects the strong messages from NHS leaders and colleagues from across the NHS about what matters most. It sets out practical actions for employers and systems, over the remainder of 2020/21 ahead of Government decisions in the Autumn Spending Review on future education and training expansions. It includes specific commitments on:

- Actions all NHS employers should take to keep staff safe, healthy and well – both physically and psychologically.
- Specific requirements to offer staff flexible working.
- Urgent action to address systemic inequality that is experienced by some of our staff, including BAME staff.
- New ways of working and delivering care, making full and flexible use of the full range of our people's skills and experience.
- Growing our workforce, building on unprecedented interest in NHS careers. It also encourages action to support former staff to return to the NHS, as well as taking steps to retain staff for longer – all as a contribution to growing the nursing workforce by 50,000, the GP workforce by 6,000 and the extended primary care workforce by 26,000.
- Workforce planning and transformation that needs to be undertaken by systems to enable people to be recruited and deployed across organisations, sectors and geographies locally.

All systems should develop a local People Plan in response to these actions, covering expansion of staff numbers, mental and physical support for staff, improving retention and flexible working opportunities, plus setting out new initiatives for development and upskilling of staff. Wherever possible, please work with local authorities and local partners in developing plans for recruitment that contribute to the regeneration of communities, especially in light of the economic impact of Covid. These local People Plans should be reviewed by regional and system People Boards, and should be refreshed regularly.

C2. **Health inequalities and prevention.**

Covid has further exposed some of the health and wider inequalities that persist in our society. The virus itself has had a disproportionate impact on certain sections of the population, including those living in most deprived neighbourhoods, people from Black, Asian and minority ethnic communities, older people, men, those who are obese and who have other long-term health conditions and those in certain occupations. It is essential that recovery is planned in a way that inclusively supports those in greatest need.

We are asking you to work collaboratively with your local communities and partners to take urgent action to increase the scale and pace of progress of reducing health inequalities, and

regularly assess this progress. Recommended urgent actions have been developed by an expert national advisory group and these will be published shortly. They include:

- Protect the most vulnerable from Covid, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics and social and economic conditions; and better engage those communities who need most support.

- Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October. Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways by 31 March.

- Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes. This should include more accessible flu vaccinations, the better targeting of long-term condition prevention and management programmes, obesity reduction programmes including self-referral to the NHS Diabetes Prevention Programme, health checks for people with learning disabilities, and increasing the continuity of maternity carers including for BAME women and those in high risk groups.

- Strengthen leadership and accountability, with a named executive Board member responsible for tackling inequalities in place in September in every NHS organisation. Each NHS board to publish an action plan showing how over the next five years its board and senior staffing will in percentage terms at least match the overall BAME composition of its overall workforce, or its local community, whichever is the higher.

- Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities. All NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later 31 December, with general practice prioritising those groups at significant risk of Covid19 from 1 September.

Financial arrangements and system working

To support restoration, and enable continued collaborative working, current financial arrangements for CCGs and trusts will largely be extended to cover August and September 2020. The intention is to move towards a revised financial framework for the latter part of 2020/21, once this has been finalised with Government. More detail is set out in Annex Two.

Working across systems, including NHS, local authority and voluntary sector partners, has been essential for dealing with the pandemic and the same is true in recovery. As we move towards comprehensive ICS coverage by April 2021, all ICSs and STPs should embed and accelerate this joint working through a development plan, agreed with their NHSE/I regional director, that includes:

- Collaborative leadership arrangements, agreed by all partners, that support joint working and quick, effective decision-making. This should include a single STP/ICS leader and a non-executive chair, appointed in line with NHSE/I guidance, and clearly defined arrangements for provider collaboration, place leadership and integrated care partnerships.

- Organisations within the system coming together to serve communities through a Partnership Board, underpinned by agreed governance and decision-making arrangements including high standards of transparency – in which providers and commissioners can agree actions in the best interests of their populations, based on co-production, engagement and evidence.

- Plans to streamline commissioning through a single ICS/STP approach. This will typically lead to a single CCG across the system. Formal written applications to merge CCGs on 1 April 2021 needed to give effect to this expectation should be submitted by 30 September 2020.

- A plan for developing and implementing a full shared care record, allowing the safe flow of patient data between care settings, and the aggregation of data for population health.

Finally, we are asking you – working as local systems - to return a draft **summary plan by 1 September** using the templates issued and covering the key actions set out in this letter, with **final plans due by 21 September**. These plans need to be the product of partnership working across STPs/ICSs, with clear and transparent triangulation between commissioner and provider activity and performance plans.

Over the last few months, the NHS has shown an extraordinary resilience, capacity for innovation and ability to move quickly for our patients. Like health services across Europe, we now face the double challenge of continuing to have to operate in a world with Covid while also urgently responding to the many urgent non-Covid needs of our patients. If we can continue to harness the same ambition, resilience, and innovation in the second half of the year as we did in the first, many millions of our fellow citizens will be healthier and happier as a result. So thank you again for all that you and your teams have been – and are – doing, in what is probably the defining year in the seven-decade history of the NHS.

With best wishes,

Simon Stevens
NHS Chief Executive

Amanda Pritchard
NHS Chief Operating Officer

ANNEX ONE: IMPLICATIONS OF EPRR TRANSITION TO A LEVEL 3 INCIDENT

As previously signalled, effective 1 August 2020 the national incident level for the Covid19 response will change from level 4 (an incident that requires NHS England National Command and Control to support the NHS response) to level 3 (an incident that requires the response of a number of health organisations across geographical areas within an NHS England region), until further notice.

It is entirely possible that future increases in Covid demands on the NHS mean that the level 4 incident will need to be reinstated. In which case, there will be no delay in doing so. However this change does, for the time being, provide the opportunity to focus local and regional NHS teams on accelerating the restart of non-Covid services, while still preparing for a possible second national peak.

The implications of the transition from a level 4 to level 3 incident are as follows:

- *Oversight*: Transition from a national command, control and coordination structure to a regional command, control and coordination structure but with national oversight as this remains an incident of international concern.

- *Reporting*: We will be stopping weekend sit rep collections from Saturday 8 August 2020 (Saturday and Sunday data will be collected on Mondays with further detail to follow). Whilst we are reducing the incident level with immediate effect reports will still be required this weekend (1 and 2 August 2020) and we will subsequently need to be able to continue to align to DHSC requirements. Additional reporting will be required for those areas of the country experiencing community outbreaks in line with areas of heightened interest, concern or intervention.

- *Incident coordination functions*: The national and regional Incident Coordination Centres will remain in place (hours of operation may be reduced). The frequency of national meetings will decrease (for example IMT will move to Monday, Wednesday, Friday). Local organisations should similarly adjust their hours and meeting frequency accordingly. It is however essential that NHS organisations fully retain their incident coordination functions given the ongoing pandemic, and the need to stand up for local incidents and outbreaks.

- *Communications:* All communications related to Covid19 should continue to go via established Covid19 incident management channels, with NHS organisations not expected to respond to incident instructions received outside of these channels. Equally, since this incident continues to have an international and national profile, it is important that our messaging to the public is clear and consistent. You should therefore continue to coordinate communications with your regional NHS England and NHS Improvement communications team. This will ensure that information given to the media, staff and wider public is accurate, fully up-to-date and aligns with national and regional activity.

ANNEX TWO: REVISED FINANCIAL ARRANGEMENTS

The current arrangements comprise nationally-set block contracts between NHS providers and commissioners, and prospective and retrospective top-up funding issued by NHSE/I to organisations to support delivery of breakeven positions against reasonable expenditure. The M5 and M6 block contract and prospective top-up payments will be the same as M4. Costs of testing and PPE will continue to be borne centrally for trusts and general practices funded by DHSC who continue to lead these functions for the health and social care sectors.

The intention is to move towards a revised financial framework for the latter part of 2020/21, once this has been finalised with Government.

The revised framework will retain simplified arrangements for payment and contracting but with a greater focus on system partnership and the restoration of elective services. The intention is that systems will be issued with funding envelopes comprising funding for NHS providers equivalent in nature to the current block and prospective top-up payments and a system-wide Covid funding envelope. There will no longer be a retrospective payment mechanism. Providers and CCGs must achieve financial balance within these envelopes in line with a return to usual financial disciplines. Whilst systems will be expected to breakeven, organisations within them will be permitted by mutual agreement across their system to deliver surplus and deficit positions. The funding envelopes will comprise:

- CCG allocations – within which block contract values for services commissioned from NHS providers within and outside of the system will continue to be nationally calculated;

- Directly commissioned services from NHS providers – block contract values for specialised and other directly commissioned services will continue to be nationally calculated;

- Top-up – additional funding to support delivery of a breakeven position; and

- Non-recurrent Covid allocation – additional funding to cover Covid-related costs for the remainder of the year.

Funding envelopes will be calculated on the basis of full external income recovery. For relationships between commissioners and NHS providers we will continue to operate nationally calculated block contract arrangements. For low-volume flows of CCG-commissioned activity, block payments of an appropriate value would be made via the Trust's host CCG; this will remove the need for separate invoicing of non-contract activity.

However block payments will be adjusted depending on delivery against the activity restart goals set in Section A1 and A2 above.

Written contracts with NHS providers for the remainder of 2020/21 will not be required.

For commissioners, non-recurrent adjustments to commissioner allocations will continue to be actioned – adjustments to published allocations will include any changes in contracting responsibility and distribution of the top-up to CCGs within the system based on target allocation.

Reimbursement for high cost drugs under the Cancer Drugs Fund (CDF) and relating to treatments under the Hepatitis C programme will revert to a pass-through cost and volume basis, with adjustments made to NHS provider block contract values to reflect this. For the majority of other high cost drugs and devices, in-year provider spend will be tracked against a notional level of spend

included in the block funding arrangements with adjustments made in-year to ensure that providers are reimbursed for actual expenditure on high cost drugs and devices. This will leave a smaller list of high cost drugs which will continue to be funded as part of the block arrangements.

In respect of Medical pay awards, on 21 July 2020 the Government confirmed the decision to uplift pay in 2020/21 by 2.8% for consultants, specialty doctors and associate specialists, although there is no uplift to the value of Clinical Excellence Awards, Commitment Awards, Distinction Awards and Discretionary Points for 2020/21. We expect this to be implemented in September pay and backdated to April 2020. In this event, NHS providers should claim the additional costs in September as part of the retrospective top-up process. Future costs will be taken into account in the financial framework for the remainder of 2020/21, with further details to be confirmed in due course.

North Yorkshire and York Covid 19

System recovery planning and response to Sir Simon Stevens letter (31st July)

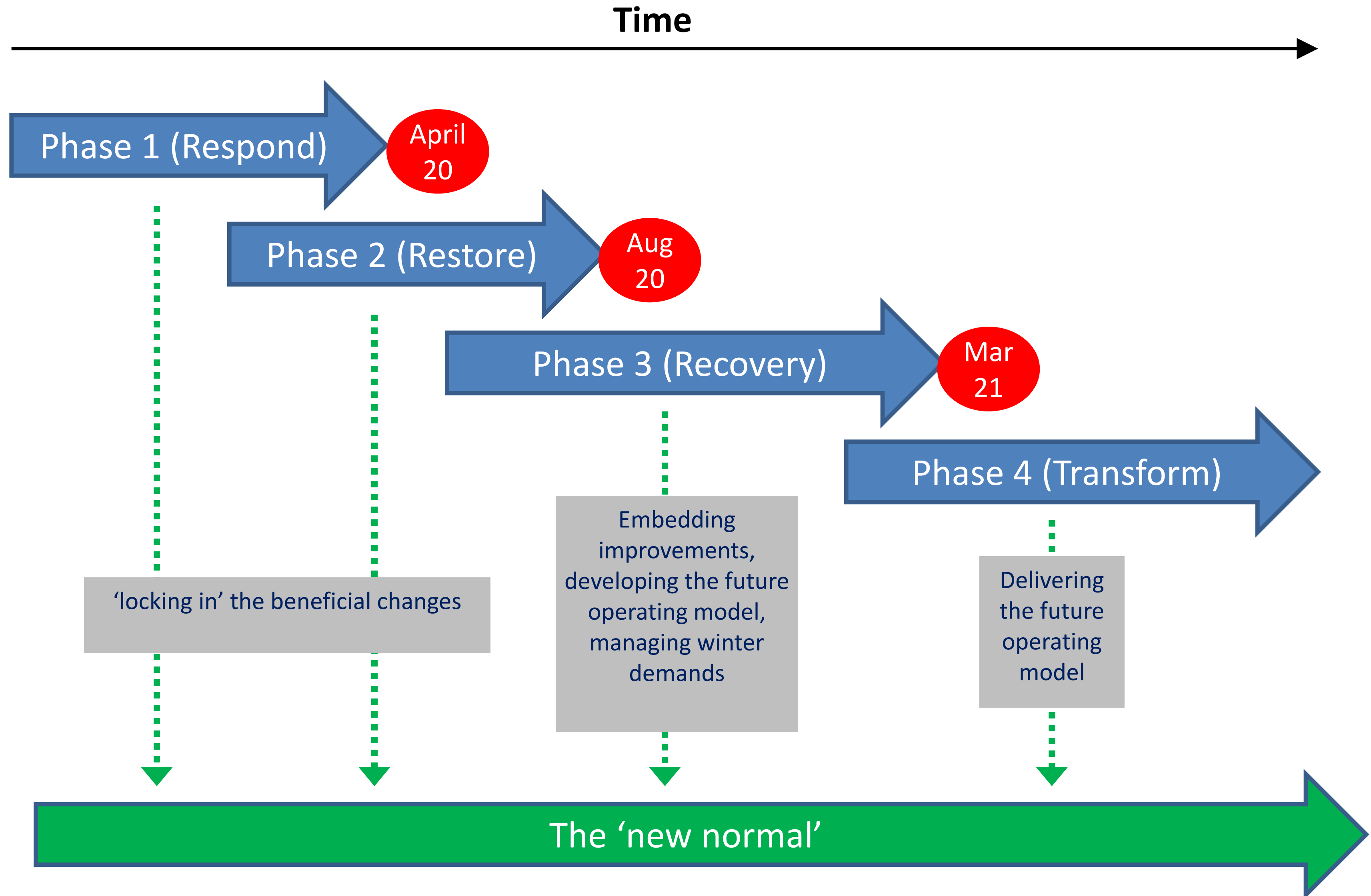
Overview

- Four waves of impact arising from Covid 19
- Recovery planning in North Yorkshire and York
- Planning guidance summary
  - Letter from Simon Stevens and Amanda Pritchard
  - People Plan
  - Implementing Phase 3, guidance issued 7th August
- Governance arrangements
- Current Progress
- Next steps

Covid 19 – the four waves of impact

WAVE / PHASE	HEALTH NEEDS IMPACT ASSESSMENT	HEALTH IMPACT EXAMPLES	ACTIONS
1. RAPID BUILD UP TO MEET PEAK IN DEMAND	Immediate mortality and morbidity effects of the pandemic	• COVID-related mortality • COVID-related morbidity • Mortality / morbidity from other causes • Preventable mortality under 75 • Specific mortality e.g. Suicide	• Postpone non-urgent elective care/outpatients/ diagnostics • Introduce rapid discharge pathways/ suspend decision support tools (DSTs) • Establish hot and cold 'sites' • Create acute surge capacity • Extend non-face-to-face contact
2. LIVING WITH A HIGH LEVEL OF COVID-19	Impact of resource restriction on healthcare	• Later diagnosis of cancers • Stroke / MI etc late presentation • Other acute infections • Deaths and harm preventable through timely urgent care	• Re-start risk-stratified access to out patients/diagnostics • Active communications to public on presentation to GPs/A&E • Maintain hot/cold facilities
3. INCREASING ACCESS TO PLANNED CARE	Impact of interrupted care on chronic conditions	• Missed prevention opportunities/ uptake of health checks • Poorly controlled chronic conditions & delayed diagnosis • Immunisation/screening uptake • QOF (e.g. glucose, BP, spiro)/Missed medication reviews	• Embed non-face-to-face capacity in out patients/primary care • Strategic use of independent sector to increase elective activity • Strengthen chronic disease management (CDM)assessment • Re-introduction of immunisation and vaccination
4. DELIVERY MODEL TO RETURN TO THE 'NEW NORMAL' (APRIL 2021 ONWARDS)	Health impacts of wider social determinants	• Employment levels • ONS anxiety measure, acuity of TEWV referrals, isolation • Stress/burnout, job uncertainty • Domestic violence. Safeguarding • Alcohol/smoking consumption	• Cross agency work on supporting vulnerable communities • Continued targeting of shielded cohorts • Implement new-world model of community care

Recovery and transformation



Recovery and Transformation: North Yorkshire & York

- A system Covid emergency response was established, overseen by North Yorkshire and York System Leadership Executive (NYYSLE) acting as Gold Command.
- The Silver Command group managed the operational response across the North Yorkshire and York system – primary care, community care, social care, commissioners
- Gold and Silver Command colleagues, led by NYCCG Accountable Officer, met in May to plan the recovery programme.
- Twin track approach developed – recovery *and* transformation.
- Working closely with the Humber, Coast and Vale ICS team an initial recovery plan was submitted to NHSE/I in July.
- The following four slides summarise the initial recovery plan.

North Yorkshire and York – Phase 3 Recovery & Restoration

PRIORITIES FOR RECOVERY

Primary Care	Acute Care	Community Care, Social Care, Healthy People & Places	Mental Health, Vulnerable People, C&YP	Medicines

• GP safe and sustainable service provision through **implementation effective IP measures control**
• Fully rolled out **total triage model and maximisation of digital technology** (including electronic repeat prescribing)
• Agreed and implemented **'hot hub' models across NY&Y**
• **Flu Vac model** agreed and implemented across NY&Y
• **Continue PCN development and embed MDT approach** with community providers and **additional roles implementation**
• Clear and implemented model to **support vulnerable people (including LD patients) including risk stratification**
• Clear approach to **urgent care models across NY&Y**
	• **Optimising none face to face attendances**
	  • Rapid Expert Input
	  • Virtual consults
	  • Patient initiated Follow-ups
	• **Optimising elective care capacity and managing long waits incl. 52 weeks**
	  • Risk stratification
	  • Clinical prioritisation
	  • Elective hubs
	  • Optimising FCPs
	  • Prime Provider Models
	• **Optimising resilience and care of patients waiting** - Self care mgmt framework
	• **Streamlining Urgent Care delivery including:**
	    • Talk before you walk
	    • Increasing SDEC
	• End to end care pathway transformation for fragile and high volume/ backlog
	• **Maintaining efficient discharge pathways including:**
	  • access to domiciliary care packages
	  • Rehabilitation
	  • Step down care home beds
		• **Care Market stabilisation (NY)** – financial support, bed modelling, block beds model.
		• **Home First Approach** (CoY)
		• **Continued accelerated discharge model** – 5 command centres, SPA, brokerage, integrated working
		• Agreed and implemented **safe discharge model for Covid +ve patients**
		• Implementation of agreed **integrated community model of care (NY)** to support step-up and accelerated discharge
		• Continued **enhanced care home model** (working with Primary Care) with **community services MDTs**
		• Develop, **agree and implement frailty models** across NY&Y
		• **Prevention and Live well models agre**ed and implemented to support prevention model.
		• **Community models agreed and implemented with LA** to support self-care an prevention model.
			• **Managing the Surge, expected increase in demand from September onwards:**
			  • CYP 53% inc.
			  • Adult 23% inc.
			  • OP 22% inc.
			• **Maintain the Crisis Response:**
			  • **24/7 crisis line**
			  • **Enhanced offer**
			  • **Resilience Hub**
			• **Clearing the Backlog:**
			- Autism, Children 368, Adults 1,000
			- Children ADHD
			- CAMHS
			• **Long Term Plan Delivery, bring forward development plans to support the recovery and anticipated surge in following areas:**
			  • EIP
			  • CYP
			  • IAPT
			• **Resilience Hub development in NY&Y**
			• **Increase capacity for surge in safeguarding and CAHMS activity**
				• **Access to medicines**: ordering, prescribing, dispensing, delivery and for urgent need
				• **Quality and safety checks:** reactive + structured review programme and drug monitoring
				• **Effective communications** and planning: internal, networks, working groups, joint planning/decision making, IT, PCN development, pharmacy workforce development
				• **Public health pharmacy:** vaccination and treatment programmes, including emergency needs.

North Yorkshire and York – Phase 3 Recovery & Restoration

DELIVERABLES FROM RECOVERY PLANS

Primary Care

- Safe and sustainable **primary care services** to deal effectively with **restored demand with continued Covid**
- **Maximisation of digital** triage, consultations and **services including with care homes**
- **'Hot sites' available** to manage Covid +ve patients
- **S**ervices available to **maximise safe Flu Vac uptake (189k-234k people)**
- Functioning Integrated MDTs to **manage patients optimally and avoid duplication of effort and reduce admission to hospital**

Acute Care

- Provision of expert advice without the need for an outpatient attendance
- **Reduce numbers of unnecessary outpatient attendances**
- **Restore elective capacity**
- **Reduce v long waits over 52 weeks (1750 patients)**
- Treat patients waiting a long time with high clinical needs
- Safely manage patients with long waits
- **Reduce face to face attendances and increase virtual consults**
- Reduce unnecessary visits to hospital and direct patients to the 'right' care setting **for them first time by using 'Talk before you Walk' services (Up to 25% reduction in attends)**
- **Improve service pathways for patients**
- **Provision of more & alternative non-invasive diagnostic testing to support rapid diagnosis**

Community Care, Social Care, Health People & Places

- Create a **sustainable Care Market (NY)**
- Continued **accelerated discharge model to increase hospital capacity** and help patients back to independence
- **Safe discharge for Covid +ve patients (max 38 patients per week in surge)**
- Enhanced community and care home model (working with Primary Care) with community services MDTs **to reduce admissions and maintain independence**
- Improved services for the frail across NY&Y
- Prevention and Live well models agreed and **implemented to support prevention model.**

Mental Health, Vulnerable People, C&YP

- Provide **capacity to C&YP returning to school** in September
- **24/7 Crisis line availability**
- **Reduce Autism waiting** times for assessment. Ambition to reduce backlog by Children 368, Adults 1,000 assessments
- **Increase capacity in IAPT** service to manage expected recovery surge.
- Increase **capacity for surge in safeguarding and CAHMS activity.**
- **Increase capacity in CHC DST assessments.**
- The DST backlog will reach 427 by December 2020
- The FNC backlog will reach 581 by December 2020

Medicines

- Optimise **access to regular and end of life medicines** (including urgently) during periods of Covid activity
- Improve efficiency to **reduce workload and footfall to minimise infection risk** in ongoing medicines supply systems to practices and pharmacies
- Support to highest risk patients for **safe use of medicines, especially care homes residents**.
- **Update commissioning and formulary processes** to ensure robust and consistent decision making across whole NY&Y
- Effective **system wide communication** and planning

North Yorkshire and York – Phase 3 Recovery & Restoration

THE DIFFERENCE WE WILL MAKE SUPPORTING SYSTEM TRANSFORMATION

Primary Care	Acute Care	Community Care, Social Care, Health People & Places	Mental Health, Vulnerable People, C&YP	Medicines
• **Safe and sustainable primary care services** to deal effectively with restored demand with continued Covid • **Maximisation of digital** triage, consultations and services including with care homes • **'Hot sites' available** to manage Covid +ve patients • Services available to **maximise safe Flu Vac uptake** • **Functioning Integrated MDTs to manage patients optimally** and avoid duplication of effort and reduce admission to hospital	• **Provision of expert advice without the need for an outpatient attendance** • **Reduce numbers of unnecessary outpatient attendances** • **Reduce face to face attendances** and increase virtual consults • **Restore elective capacity** - treat patients waiting a long time with high clinical needs • **Safely manage patients with long waits - develop new support and care offers** to local people while they wait • **Reduce unnecessary and unplanned visits** to hospital and direct patients to the 'right' care setting for them first time by using '**Talk before you Walk' services** • **Improved and new service pathways for patients** • **Increased diagnostic capacity & utilisation**	• **Create a sustainable Care Market (NY)** • Continued accelerated discharge model to **increase hospital capacity and help patients back to independence** • **Safe discharge for Covid +ve patients** • Enhanced community and care home model with community services **MDTs to reduce admissions and maintain independence** (working with Primary Care) • Improved **services for the frail across NY&Y** • Prevention and Live well models agreed and implemented to **support prevention model.**	• Provide **capacity to C&YP returning to school** in September • **24/7 Crisis line availability** • **Reduce Autism waiting times** for assessment • **Increase capacity in IAPT** service to manage expected recovery surge • **Contribute to reducing safeguarding cases**	• **Maximise potential of community pharmacy:** particularly their accessibility for reducing a surge of patients to GP for self-care for minor conditions. • Capitalise on positive developments, e.g., **maintain multi party meetings,** that have been made as a result of Covid situation that can be integrated into future working patterns, relationships and arrangements in medicines and prescribing. • Delivery of measurable **financial savings** through reduction of waste and increase of self-care.

Acute Hospital - Recovering Activity

Acute Hospital Activity Assumptions for Phase 3 planning purposes

	Aug	Sept	Oct	Nov- March 2021
First Outpatient attendances	90%	100%		100%
Ordinary elective spells	70%	80%	90%	100%
Non-Elective spells	97%	97%	97%	97%
CT & MRI Diagnostic capacity			100%	100%
Use of independent acute provider capacity	75%	75%	75%	75%

- Limiting Factors
  - Social distancing rules
  - PPE – time to don and doff
  - Covid positive and negative zoning
  - Capital developments required to manage in new Covid environment

Recovery and Transformation: North Yorkshire & York

- Ongoing planning work for North Yorkshire and York is being co-ordinated by NYCCG Chief Finance Officer.
- The delivery of the recovery plan in North Yorkshire and York will be monitored by the System Delivery Executive (SDE).
- The SDE is chaired by the NYCCG Chief Finance Officer and includes the SROs from the programme workstreams and finance officers from across the system.
- Further guidance on the Phase 3 requirements was sent from Simon Stevens and Amanda Pritchard to the NHS in a letter on 31st July (supplemented by further detail on 7th August).
- NHS People Plan also published in early August.
- Workstreams are now reviewing plans to provide assurance that they will deliver against the Phase 3 requirements.

Priorities for 3rd phase of Covid response

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' between now and winter

B. ***Preparation for winter demand pressures***, alongside continuing vigilance in the light of further ***probable Covid spikes*** locally and possibly nationally.

C. Doing the above in a way that takes 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**

From Simon Stevens and Amanda Pritchard Letter 31st July

Urgent actions to address inequalities in NHS provision and outcomes:

1. Protect the most vulnerable
2. Restore NHS services inclusively
3. Digitally enabled pathways that are inclusive
4. Accelerate preventative programmes
5. Support people with mental health problems
6. Named Executive Board member responsible for tackling inequalities and Boards to publish a five-year action plan
7. Ensure complete datasets
8. Collaborate on planning and engage with communities

From Phase 3 Implementation Guidance 7th August

Key Actions for 3rd phase of Covid response

PRIORITY 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' between now and winter

KEY ACTIONS

- Restore full operation of all cancer services.
- Ensuring that sufficient diagnostic capacity is in place.
- Elective activity, 70% (of previous year's activity) by August, 80% by September, 90% by October
- CT&MRI, endoscopy 100% by October.
- First outpatient attendances and follow-ups (face to face or virtually) 100% from September.
- General practice, community and optometry services should restore activity to usual levels where clinically appropriate, and reach out proactively to clinically vulnerable patients.
- Addressing the backlog of childhood immunisations and cervical screening
- From 1 September 2020, hospitals and community health and social care partners should fully embed the discharge to assess processes.
- Continuing Healthcare assessments from 1 September 2020.
- Continue to increase investment in mental health.
- IAPT services should fully resume.
- the 24/7 crisis helplines that were established should be retained.
- Complete all outstanding Learning Disability Mortality Reviews (LeDeR) by December 2020.
- Ensure that everybody with a Learning Disability is identified on their register; that their annual health checks are complete.

Key Actions for 3rd phase of Covid response

PRIORITY B

Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.

KEY ACTIONS

- Ensuring NHS staff and patients have access to and use PPE.
- All NHS employers should prepare for the likelihood of regular routine Covid testing of all asymptomatic staff across the NHS.
- Sustaining current NHS staffing, beds and capacity.
- Utilise independent sector capacity.
- Deliver a very significantly expanded seasonal flu vaccination programme.
- Increasing the range of dispositions from 111 to local services, such as direct referrals to Same Day Emergency Care and specialty ‘hot’ clinics, as well as ensuring all Type 3 services are designated as Urgent Treatment Centres.
- maximise the use of ‘Hear and Treat’ and ‘See and Treat’ pathways for 999.
- Continuing to work with local authorities on resilient social care services.

Key Actions for 3rd phase of Covid response

PRIORITY C

Doing the above (Priorities A and B) in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including support for our staff, action on inequalities and prevention

KEY ACTIONS

- All systems should develop a local People Plan.
- Offer staff flexible working.
- Address systemic inequality that is experienced by some of our staff, including BAME staff.
- New ways of working and delivering care, making full and flexible use of the full range of our people's skills and experience.
- Workforce planning and transformation that needs to be undertaken by systems.
- Work with local authorities and local partners in developing plans for recruitment that contribute to the regeneration of communities.
- Work collaboratively with local communities and partners to increase the scale and pace of progress of reducing health inequalities.
- Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes.
- Named executive Board member responsible for tackling inequalities in place in September in every NHS organisation.
- Proactively review and ensure the completeness of patient ethnicity data by no later 31 December.
- General practice prioritising those groups at significant risk of Covid19 from 1 September.

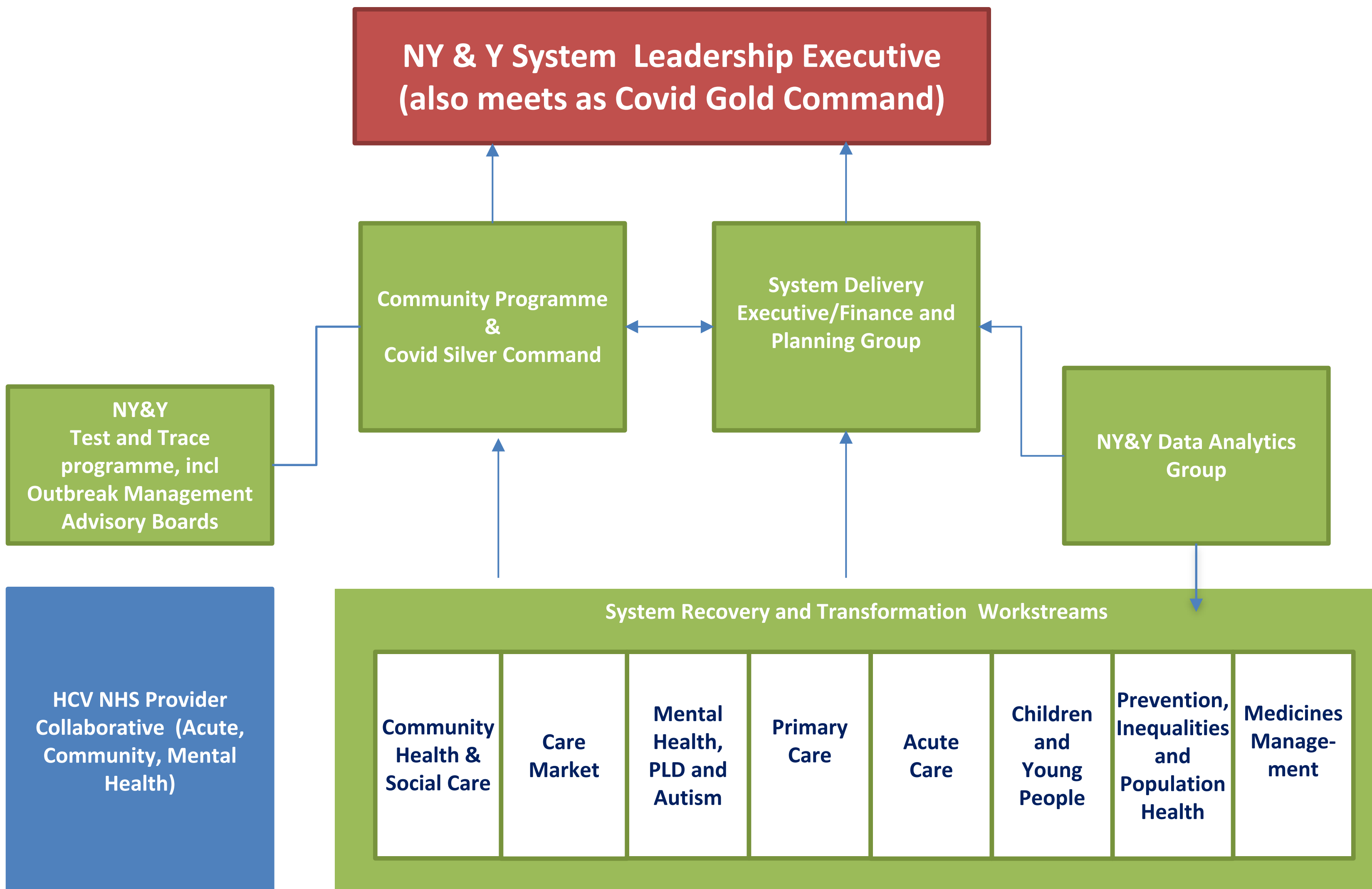
People's Plan

- The People Plan includes a number of key ambitions and commitments for teams, organisations and systems across the NHS:

Ask	How
Looking after our people	• Prioritising staff safety • Looking after physical and psychological well-being of all staff • Supporting flexible working
Belonging in the NHS	• Creating organisational culture of belonging, including through overhauling recruitment processes to achieve representation at all levels • Listening, and acting upon, views and experiences of workforce • Promoting compassionate and inclusive leadership
New ways of working and delivering care	• Building strong multidisciplinary teams, using skills of all staff • Using the skills and energy of our wider workforce, including volunteers • Resuming education and training priorities
Growing for the future	• Focusing on local domestic and international recruitment • Supporting former staff to return to NHS • Taking steps to retain staff, especially those nearing retirement, for longer • Undertaking robust workforce planning and transformation to enhance system-level recruitment, deployment and retention of staff

- All systems are expected to:
  – Develop a local People Plan which will be reviewed by regional People Boards and refreshed regularly; currently being led by the ICS on behalf of the Partnership
  – Strengthen the approach to workforce planning and transformation, and make sure it is aligned to service and financial planning.

Delivering through our NY&Y Governance Arrangements



Current Progress

- System Transformation and Recovery plans developed through the Silver Command Group.
- System Delivery Executive established to oversee delivery of the plans and link with the HCV ICS.
- Acute provider collaborative established to monitor and assess acute activity across the system.
- Capital bids submitted for investment to support Phase 3.
- Additional planning submissions being prepared by workstreams for submission to NHSE/I on 21st September (as an amalgamated ICS plan).
- **XX??????** Nominated as the NYCCG Executive Board lead for addressing inequalities.

Next Steps - Planning

Action	Date
Confirm and Challenge HCV Finance, Planning and Performance Board Meeting	24 August
DRAFT: North Yorkshire and York sub-system submission to ICS of draft activity, performance and workforce template and supporting narrative	**25 August**
Draft HCV Partnership plans and templates submitted to the Regional / National NHSE/I Teams	1 September
Draft Partnership plan reviewed by HCV Partnership Board	9 September
Confirm and Challenge HCV Finance, Planning and Performance Board Meeting	14 September
FINAL: North Yorkshire and York sub-system submission to ICS of draft activity, performance and workforce template and supporting narrative	**16 September**
Final Partnership plans and templates submitted to the Regional / National Team	21 September