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Health and Wellbeing Board Agenda

DARLINGTON BOROUGH COUNCIL

3.00 pm Thursday, 3 September 2020
Microsoft Teams

Members of the Public are welcome to attend this Meeting.

1. Introductions/Attendance at Meeting.

2. Declarations of Interest.

3. To hear relevant representation (from Members and the General Public) on items on this Health and Wellbeing Board Agenda.

4. To approve the Minutes of the Meeting of this Board held on 28 November 2019 (Pages 1 - 6)

5. Response to COVID-19 & Local Outbreak Control plan –
   Presentation by Director of Public Health
   (Pages 7 - 28)

6. 2020-21 Tees Valley Winter Plan –
   Presentation by Director of Strategy and Commissioning, NHS Tees Valley Clinical Commissioning Group
   (Pages 29 - 48)

FOR INFORMATION

7. NHS Tees Valley CCG Flu Vaccination Update (Pages 49 - 50)

8. SUPPLEMENTARY ITEM(S) (if any) which in the opinion of the Chair of this Board are of an urgent nature and can be discussed at the meeting.

9. Questions.

Luke Swinhoe
Assistant Director Law and Governance

Wednesday, 26 August 2020

Town Hall
Darlington.

Membership
Councillor K Nicholson, Cabinet Member with Health and Housing Portfolio
Councillor Clarke, Cabinet Member with Children and Young People Portfolio
Councillor Harker
Councillor Mills, Cabinet Member with Adults Portfolio
Councillor Mrs H Scott, Leader of the Council
Suzanne Joyner, Director of Children and Adults Services
Miriam Davidson, Director of Public Health
Dr Posmyk Boleslaw, Chair, NHS Tees Valley Clinical Commissioning Group
David Gallagher, Chief Officer, NHS Tees Valley Clinical Commissioning Group
Michael Houghton, Director of Commissioning Strategy and Delivery, NHS Tees Valley Clinical Commissioing Group
Brent Kilmurray, Chief Executive, Tees, Esk and Wear Valley NHS Foundation Trust
Jennifer Illingworth, Director of Operations, Durham and Darlington, Tees, Esk and Wear Valley NHS Foundation Trust
Richard Chillery, Operational Director of Children's and Countywide Care Directorate, Harrogate and District NHS Foundation Trust
Emma Anderson, Harrogate and District NHS Foundation Trust
Steve White, Interim Police, Crime and Victim's Commissioner, Police, Crime and Victims' Commissioner, Durham Police Area
Sharon Caddell, Interim Chief Executive & Monitoring Officer, Office of the Durham Police, Crime and Victims' Commissioner
Sam Hirst, Primary Schools Representative
Sue Jacques, Chief Executive, County Durham and Darlington Foundation Trust
Rita Lawson, Chairman, VCS Strategic Implementation Group
Alison Slater, Director of Nursing, NHS England, Area Team
Dr Amanda Riley, Chief Executive Officer, Primary Healthcare Darlington
Michelle Thompson, Chief Executive Officer, Healthwatch Darlington
Stephen Cummings, Dean of School of Health and Life Sciences, Teesside University
Carole Todd, Darlington Post Sixteen Representative, Darlington Post Sixteen Representative

Since the last meeting of the Board, the following items have been sent to the Chair/Members of the Board:-

- LGA Health and Wellbeing Boards reset tool – May 2020
- Darlington 2019/20 Better Care Fund: Section 75 approval – May 2020

- Publication of the Local Outbreak Control Plan – 30 June 2020 https://www.darlington.gov.uk/media/11967/darlington-local-outbreak-control-plan.pdf
- Darlington Primary Care Network Influenza Vaccination Programme 2020 – Stakeholder Briefing

If you need this information in a different language or format or you have any other queries on this agenda please contact Hannah Fay, Democratic Officer, Resources Group, during normal office hours 8.30 a.m. to 4.45 p.m. Mondays to Thursdays and 8.30 a.m. to 4.15 p.m. Fridays e-mail hannah.fay@darlington.gov.uk or telephone 01325 405801

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HEALTH AND WELL BEING BOARD

Thursday, 28 November 2019

PRESENT – , Councillor Tostevin (Cabinet Member with Housing, Health and Partnerships Portfolio), Councillor Mills (Cabinet Member with Adult Social Care Portfolio), Councillor Harker, Councillor Mrs H Scott (Leader of the Council), Suzanne Joyner (Director of Children and Adults Services), Miriam Davidson (Director of Public Health), Richard Chillery (Operational Director of Children's and Countywide Care Directorate) (Harrogate and District NHS Foundation Trust), Paula Swindale (Head of Commissioning) (NHS Darlington Clinical Commissioning Group), Michelle Thompson (Chief Executive Officer) (Healthwatch Darlington) and Jo Murray (Right Care Right Place Delivery Lead (Durham and Darlington)) (Tees, Esk and Wear Valley NHS Foundation Trust)

ALSO IN ATTENDANCE – Christine Shields (Assistant Director Commissioning, Performance and Transformation), Dr Deborah Wilson (Public Health England), Jon Lawler (Public Health Speciality Registrar), Nichola Kenny (Director of Performance) (County Durham and Darlington NHS Foundation Trust), Daniel Maddison (Commissioning Lead) (Durham, Darlington and Tees Mental Health and Learning Disabilities Partnership), Carl Bashford (Director of Partnerships and Case Management) (Tees, Esk and Wear Valley NHS Foundation Trust) and Hannah Fay (Democratic Officer)

APOLOGIES – Councillor Crudass (Cabinet Member with Children and Young People Portfolio), Dr Posmyk Boleslaw (Chair) (NHS Darlington Clinical Commissioning Group), Nicola Bailey (Chief Officer) (Darlington Clinical Commissioning Group), Michael Houghton (Director of Commissioning Strategy and Delivery) (NHS Darlington Clinical Commissioing Group), Sam Hirst (Primary Schools Representative), Sue Jacques (Chief Executive) (County Durham and Darlington Foundation Trust), Rita Lawson (Chairman) (VCS Strategic Implementation Group), Jonathan Lumb (Darlington Secondary Schools Representative), Colin Martin (Chief Executive) (Tees, Esk and Wear Valley Mental Health Foundation Trust), Alison Slater (Director of Nursing) (NHS England, Area Team), Stephen Cummings (Dean of School of Health and Life Sciences) (Teesside University) and Carole Todd (Darlington Post Sixteen Representative) (Darlington Post Sixteen Representative)

HWBB8 DECLARATIONS OF INTEREST.

There were no declarations of interest reported at the meeting.

HWBB9 TO HEAR RELEVANT REPRESENTATION (FROM MEMBERS AND THE GENERAL PUBLIC) ON ITEMS ON THIS HEALTH AND WELL BEING BOARD AGENDA.

No representations were made by Members or members of the public in attendance at the meeting.

HWBB10 TO APPROVE THE MINUTES OF THE MEETING OF THIS BOARD HELD ON 4 JULY 2019

Submitted – The Minutes (previously circulated) of the meeting of this Health and Well Being Board held on 4 July 2019.

RESOLVED – That the minutes be approved as a correct record.

REASON – They represent an accurate record of the meeting.

HWBB11 LIVING AND AGEING WELL

In introducing the reports below, the Chair reminded Members of the 'life course' approach that had been adopted by this Board, and stated that the focus of this meeting would be 'Living and Ageing Well'.

(1) MENTAL HEALTH AND AUTISM UPDATE

The Director of Durham, Darlington and Tees Mental Health and Learning Disabilities CCG (Clinical Commissioning Group) Partnership submitted a report (previously circulated) providing Board with details of the key activity for the mental health and autism service provision in Darlington during the 2018/19 financial year, and details of activity commenced in the 2019/20 financial year.

The submitted report stated that Darlington services were based upon a Healthy New Towns approach; focussed on three key areas of regeneration, new models of care and digital technology; and that preventing mental ill health was a joint strategic priority for all partner agencies across the statutory and voluntary sector.

Reference was made to the services in place in Darlington; all targets were being met or exceeded; and CCG spend had increased every year in line with the Future in Mind transformation funding and Mental Health Investment Standard.

Discussion ensued on the support for people with dual diagnosis and co-existing medical conditions; the need for assurance in respect of autism services in Darlington; and that planning of services for 2020/2021 was underway and an update would be provided at a future meeting of the Board.

RESOLVED – (a) That the report be noted.

REASON – To enable the Board to consider the work on Mental Health and the Autism.

(2) SUICIDE PREVENTION UPDATE

The Director of Public Health submitted a report (previously circulated) updating Board on the Suicide Prevention Plan (also previously circulated) and local position for Darlington.

The submitted report stated that the action plan for the Darlington Suicide Prevention Group, a multi-agency group, was developed in 2016; the action plan was being

refreshed following a number of key regional and local work streams and would be concluded in 2020. Darlington suicide rates are not statistically different than the national and regional averages; there had been 36 suicides in Darlington between 2016 and 2018 (ONS source data). An early alert system for coordinating information around suspected suicides in Darlington had been reviewed.

Discussion ensued on signposting for counselling and support services.

RESOLVED – (a) That the update on suicide prevention plans for Darlington be accepted, and the revision of the action plan in April 2020, be noted.

(b) That the actions to implement a whole system approach to suicide prevention across Darlington, as set out in submitted report, be supported.

REASON – (a) Suicide remains a high public health priority and local authorities have a responsibility alongside key partners, to implement and deliver local suicide prevention plans.

(b) In line with national and regional strategy, there is a drive to reduce the overall suicide rate with funding attached to encourage local multi-agency action.

(3) WINTER PLANNING

The Director of Performance, County Durham and Darlington NHS Foundation Trust, gave a presentation to update Board on Winter Planning arrangements.

Members were advised of the aims of winter planning, to respond to seasonal demand whilst maintaining patient safety and experience; the pressures on acute services, accident and emergency and referral to treatment; the system response which included additional bed capacity, a reduced elective programme and safe staffing; an investment of £2million to mobilise winter schemes; and the introduction of new and enhanced services.

Discussion ensued in respect of the reduced elective programme.

RESOLVED – That the thanks of the Board be conveyed to the Director of Performance, for her informative presentation.

REASON – To convey the views of the Board.

(4) HEALTH PROTECTION ANNUAL REPORT

The Director of Children and Adults Services submitted a report (previously circulated) requesting that consideration be given to the Annual Health Protection Report (also previously circulated) published by the Public Health England North East Health Protection Team (HPT), entitled 'Protecting the population of the North East from communicable disease and other hazards' (2018/19).

The submitted report stated that the Annual Report summarised the activity of various health protection functions of the HPT; successful health protection required strong working relationships at the North East and local level; and reference was made to

the four elements to the work of Public Health England (PHE) in protecting the health of the population i.e. prevention, surveillance, control and communication.

Dr Wilson, in presenting the report, outlined the role of the HPT and the work it undertook. Particular reference was made to the prevalence of flu and norovirus and Members were advised of the key messages to manage norovirus.

Discussion ensued on vaccination rates and the effectiveness of vaccines.

RESOLVED – (a) That the content of the Public Health England North East Health Protection Team (HPT) Annual Report 2018/19 entitled 'Protecting the population of the North East from communicable disease and other hazards', as appended to the submitted report, be noted.

(b) That the health protection risks that affect some individuals and communities disproportionately resulting in poorer health, be recognised.

REASON – (a) To inform the Board on the work of the Public Health England North East HPT, to deliver safe and effective health protection services.

(b) The report provides evidence to the Director of Public Health in support of their assurance role.

HWBB12 TERMS OF REFERENCE

The Director of Children and Adults Services submitted a report (previously circulated) requesting that consideration be given to the revised Terms of Reference for the Health and Well Being Board (also previously circulated).

The submitted report stated that the revised arrangements and Terms of Reference were considered and approved by the Board at its meeting held on 17 January 2019; it had been agreed to review them on a regular basis; and that a number of minor amendments had been proposed.

RESOLVED – That the terms of reference be approved, with the inclusion of the following amendments:-

i. the deletion of the NHS Darlington Clinical Commissioning Group's Chief Nurse from the Membership of the Board;
ii. the deletion of a representative of the Board of Primary Healthcare from the Membership of the Board;
iii. the addition of Darlington Primary Care Network to the Membership of the Board;
iv. the School of Health and Social Care be renamed to School of Health and Life Sciences, Teesside University; and
v. the frequency of the Board meetings be increased to four meetings per year.

REASON – (a) To enable the Terms of Reference to be updated with a number of minor changes.

(b) To enable the Board to consider any further amendments to the Terms of Reference, as necessary.

FOR INFORMATION

HWBB13 ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2018/19 - HEALTHY NEW TOWNS: DARLINGTON

The Director of Public Health submitted a report (previously circulated) requesting the Members note the Annual Report of the Director of Public Health 2018/2019 (also previously circulated).

The submitted report stated that the Annual Report had been produced as a requirement of the Health and Social Care Act 2012; the subject for discussion in the Annual Report 2018/2019 was Healthy New Towns with a focus on legacy; the report was structured around five chapters reflecting the key strands of the programme; and that the Annual Report had been submitted for information only purposes at this stage and would be considered by the Board at its meeting on 12 March 2020.

RESOLVED – (a) That the Annual Report of the Director of Public Health 2018/2019, as appended to the submitted report, be noted.

(b) That the Annual Report of the Director of Public Health 2018/2019 be received by the Health and Well Being Board at its meeting on 12 March 2020.

HWBB14 BETTER CARE FUND 2019/20

The Director of Children and Adults Services submitted a report (previously circulated) updating the Board on the 2019/20 Darlington Better Care Fund (BCF) Plan submission; and of the BCF plans beyond the current period.

It was reported that the BCF was a programme spanning both the NHS and Local Government; sought to join up health and care services; and brought together ring fenced budgets from Clinical Commissioning Group allocations and funding paid directly to local government.

The submitted report stated that the plan continued to be delivered at expected levels across the seven work streams; detailed the breakdown of the funding package; the future of BCF funding beyond the current period was to be confirmed; and an options exercise was underway across all funded schemes.

The BCF Plan for 2019/20 had been approved with no major changes to the requirements from 2017/19.

RESOLVED – (a) That the submission of the 2019/20 plan and expected timescales for approval, be noted.

(b) That the current position in respect of the BCF for 2020/21 be noted.

REASON – (a) The current year of the BCF plan is a continuation of previous years with the programme delivering well against the required metrics.

(b) Quarterly submissions will continue to be reported and submitted highlighting progress.

HWBB15 HEALTH AND WELL BEING BOARD RESPONSE TO PREVENTION GREEN PAPER CONSULTATION

The Director of Public Health advised the Members that a Health and Well Being Board response had been provided in respect of the Prevention Green Paper consultation; and further information was available on request.

RESOLVED – That the update be noted.

REASON – To provide the Board with an update on the response to the Prevention Green Paper consultation.

HWBB16 CARERS UPDATE

The Director of Children and Adults Service submitted a report (previously circulated) informing the Board of carers in Darlington; and updating Board on Darlington's Carers' Action Plan 2018-20 (also previously circulated).

The submitted report stated that there were 11,048 cares in Darlington as identified by the 2011 census; 25% of cares were providing care for 50 or more hours per week; the largest group of cares were those aged 50-64; and the Darlington Carers' Strategy Steering Group (CCSG) developed a Darlington Carers' Action Plan in response to the national Carers Action Plan.

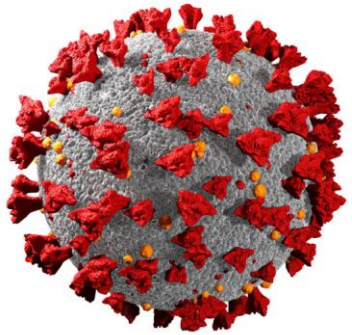
RESOLVED – (a) That the contents of the report be noted.

(b) That Members act as champions for carers in Darlington and consideration be given to support the progress of the carers' agenda in Darlington.

REASON – To enable Darlington to respond to the requirements of the national carers action plan.

DARLINGTON BOROUGH COUNCIL

Darlington
COVID-19
Response, Prevention and Control

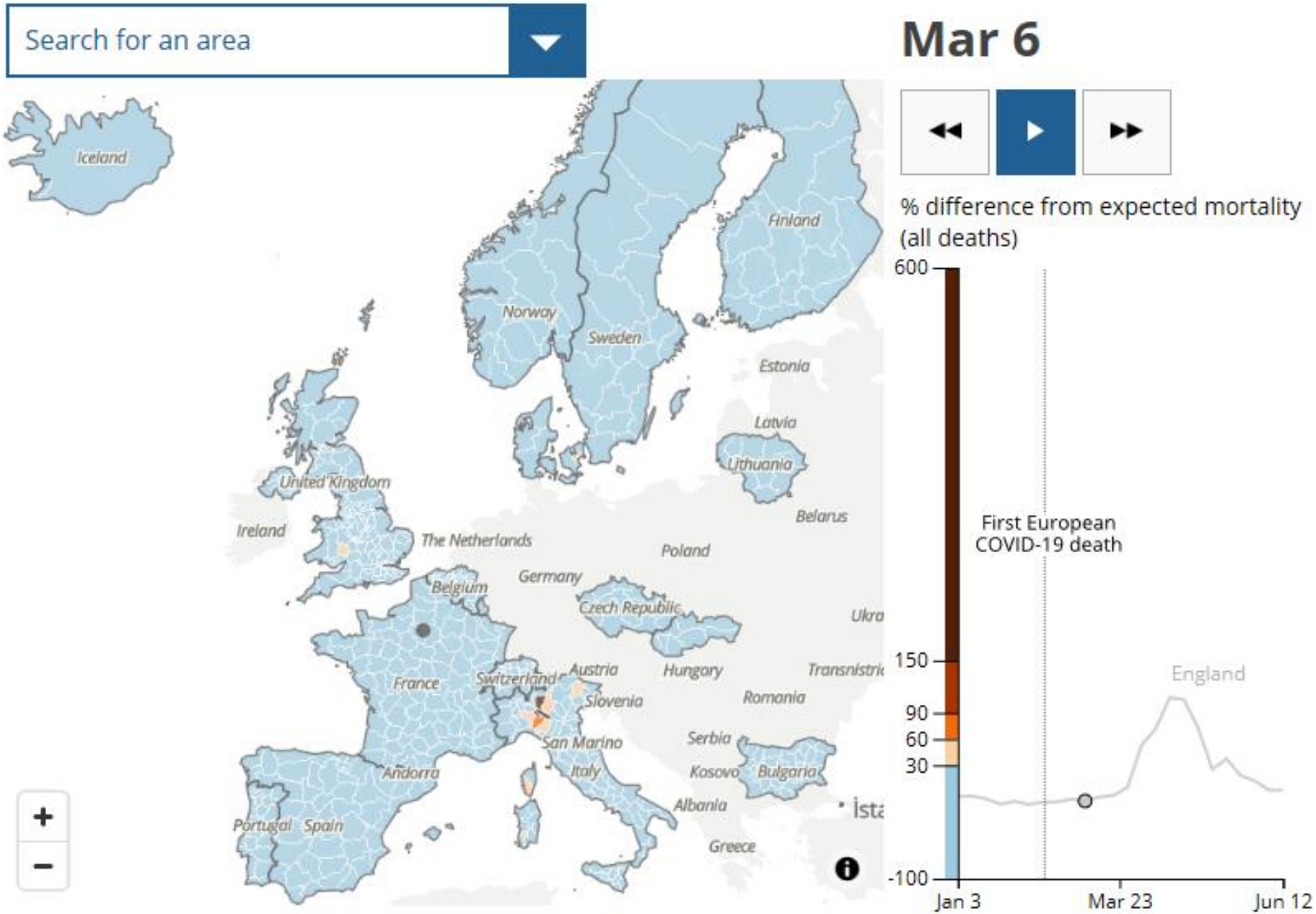


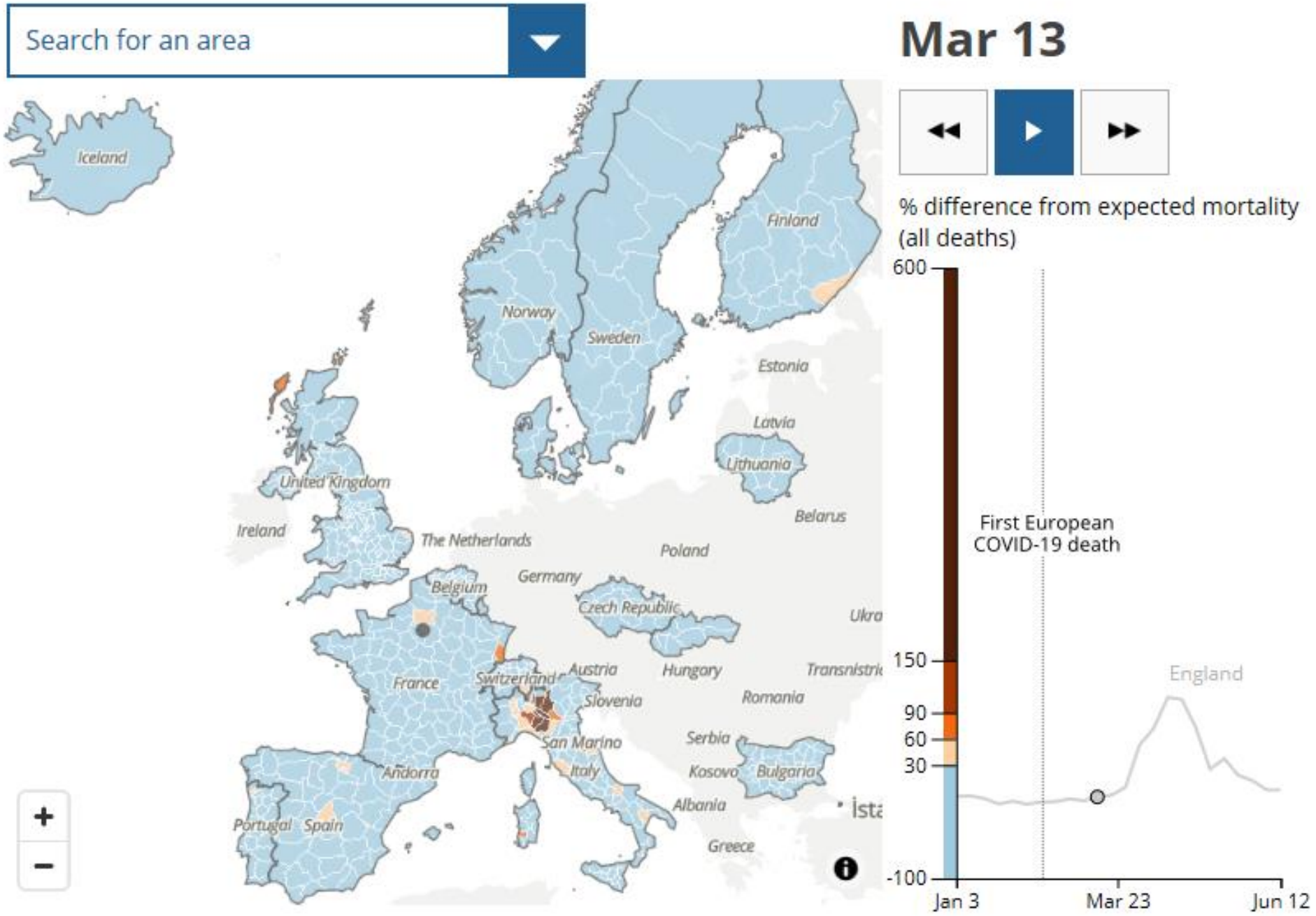
Response 1

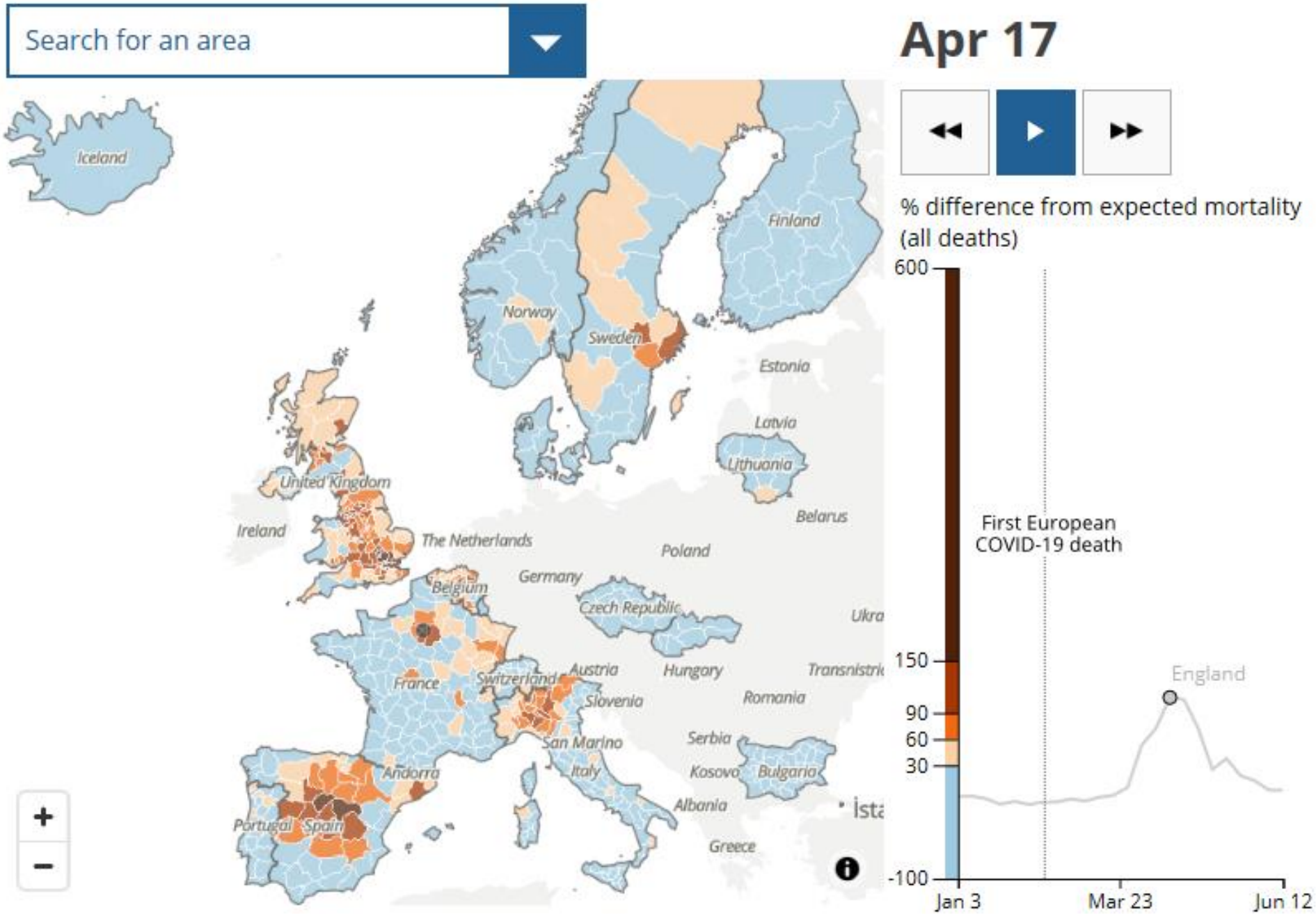
A report to Cabinet (14th July 2020) detailed the response of the Council to the COVID-19 pandemic March – June 2020.

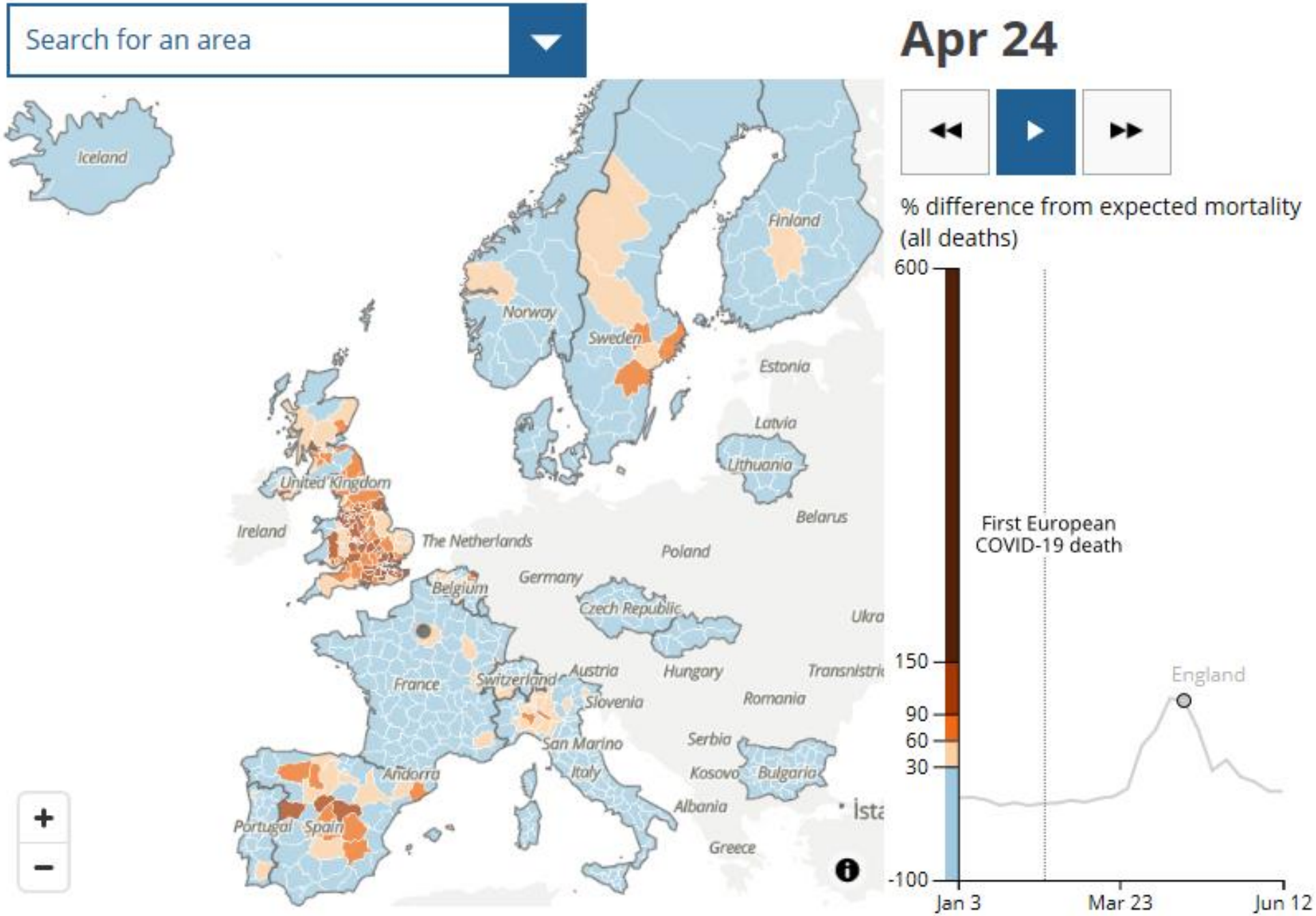
The key elements of response include:

- Strategic management – Local Resilience Forum
- Strategic Steering Group
- Briefing Cabinet and Group Leaders
- Staff briefings




Search for an area
Mar 13
% difference from expected mortality (all deaths)
600
150
90
60
30
-100
First European COVID-19 death
England
Jan 3
Mar 23
Jun 12
Iceland
Finland
Norway
Sweden
Estonia
Latvia
Lithuania
Belarus
United Kingdom
Ireland
The Netherlands
Poland
Germany
Belgium
Czech Republic
France
Switzerland
Austria
Hungary
Slovenia
Romania
San Marino
Serbia
Kosovo
Bulgaria
Andorra
Italy
Albania
Portugal
Spain
Greece

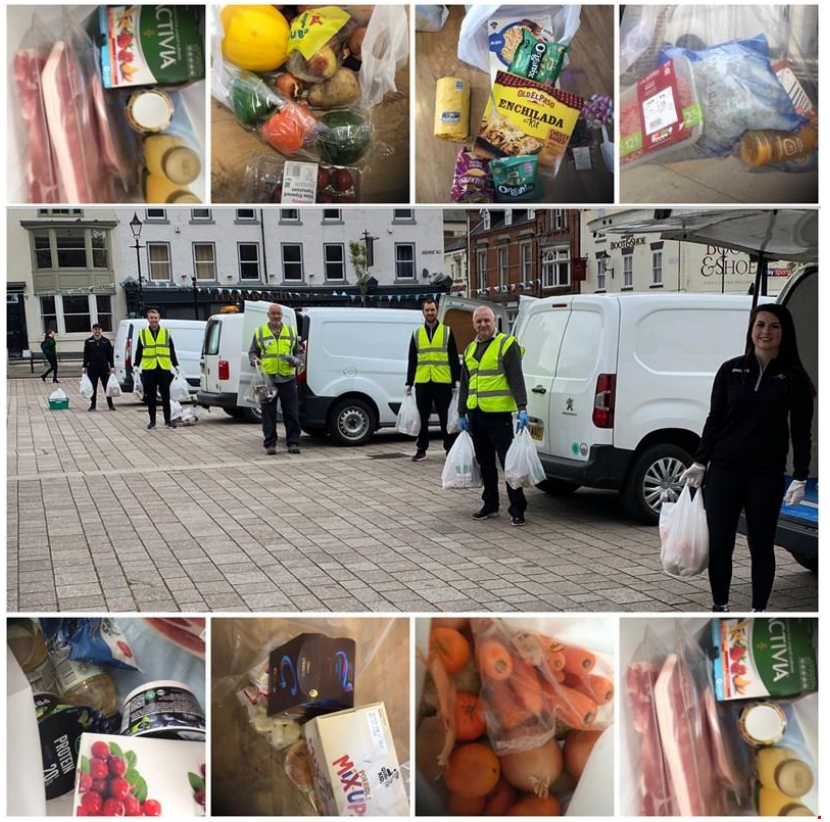




Response 2

- Community Support Hub (Separate report available detailing Hub response) including:

  - Volume of Hub calls
  - Food Parcel distribution
  - Volunteer response



Response 3

- Work with care sector (separate report available)
- Support for “Shielded” people
- PPE
- Business support
- Hardship relief and the Voluntary Sector
- Housing and Homeless services

Response 4

- Neighbourhood services
- Lifeline services
- Education (separate report available)
- Public Health (separate report available)
- Recovery Planning

Local Outbreak Plan

- National requirement for every LA to publish plan
- Prevent local outbreaks, contain locally, minimize spread of virus, avoid escalation to local restrictions
- Plan sets out prevention measures
- Process for early identification
- Steps to manage local outbreaks
- Local Coordination

Local Outbreak Plan Centres on Seven Themes

Theme 1: Schools and Care Homes

- Education settings
- Guidance – FAQs
- Enhanced offer for care homes

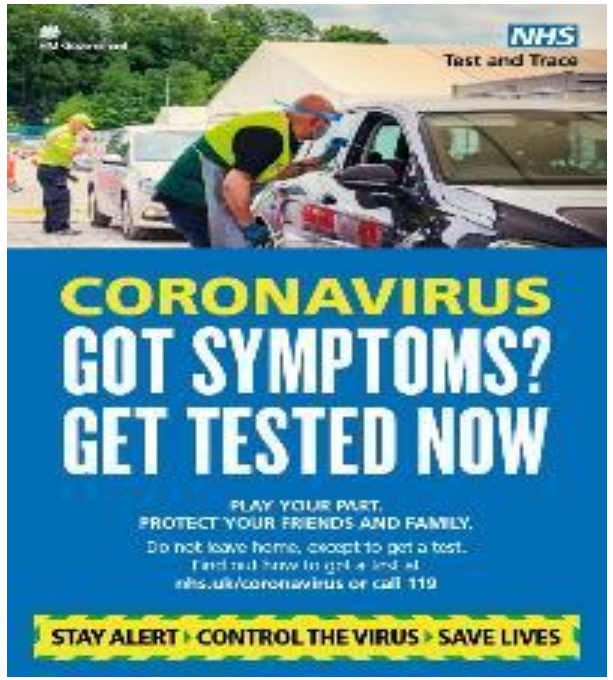
Theme 2: High-Risk Settings

- Areas with a mixture of:
  - Close proximity of people on one site
  - Confined spaces
  - Poor infection control
  - Underlying vulnerabilities of people

Theme 3: Testing

Pillar 1: NHS Foundation Trusts

- NHS staff GP's and Nurse Practitioners
- Social care staff
- Symptomatic care home residents
- Asymptomatic care home residents who are transferring from community or other care home
- Patients being admitted overnight to hospital for overnight stay are tested

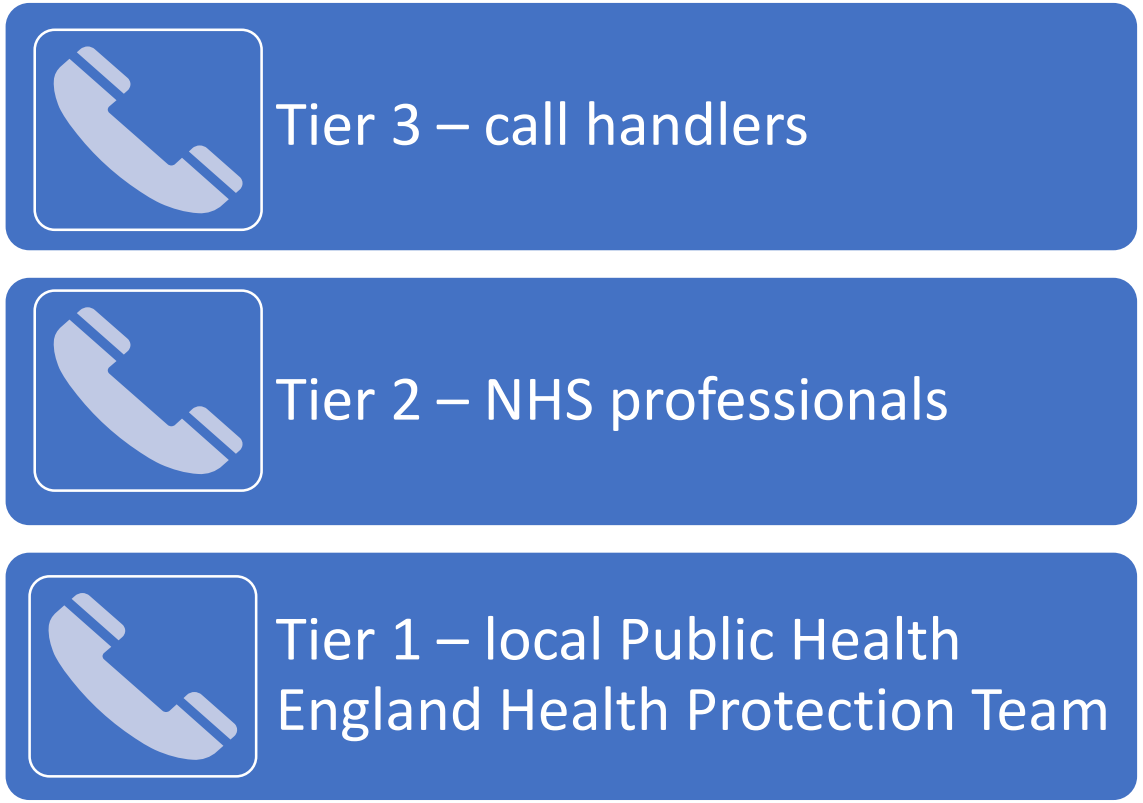


Pillar 2: National Testing Programme

- Anyone who has symptoms of coronavirus, whatever their age
- Essential workers who are self-isolating either because they or member(s) of their household have coronavirus symptoms
- Whole care home asymptomatic testing

Testing can be accessed via the national testing portals https://www.gov.uk/guidance/coronavirus-covid-19-getting-tested.

Theme 4: Contact tracing in complex settings



- Complex cases identified at ‘Tier 2’ are escalated to the ‘Tier 1’ North East PHE HPT based in Newcastle

- The Director of Public Health will support the HPT in the contact tracing in complex setting and high-risk sites

Theme 5: Data Integration

Local authorities receive a range of data, including:

- Daily and cumulative positive results tested through pillar 1 and 2
- Daily and cumulative positive cases in NHS Test and Trace
- Postcode data for all lab-confirmed positive cases
- Exceedance reports for each LA for pillar 1 and 2 testing
- Daily national sit rep
- ONS Covid-19 deaths include place of death
- Daily reports from PHE NE HPT on new outbreaks in care homes
- Weekly reports from care homes

COVID-19 surveillance dashboard

All data accurate as of 25.08.20

Darlington cases summary

619

Total confirmed cases (Pillar 1 and 2)

2

7 day cases

Change in cases from previous week	
Number of cases	2
7 day rate*	+ 0.9

580.9

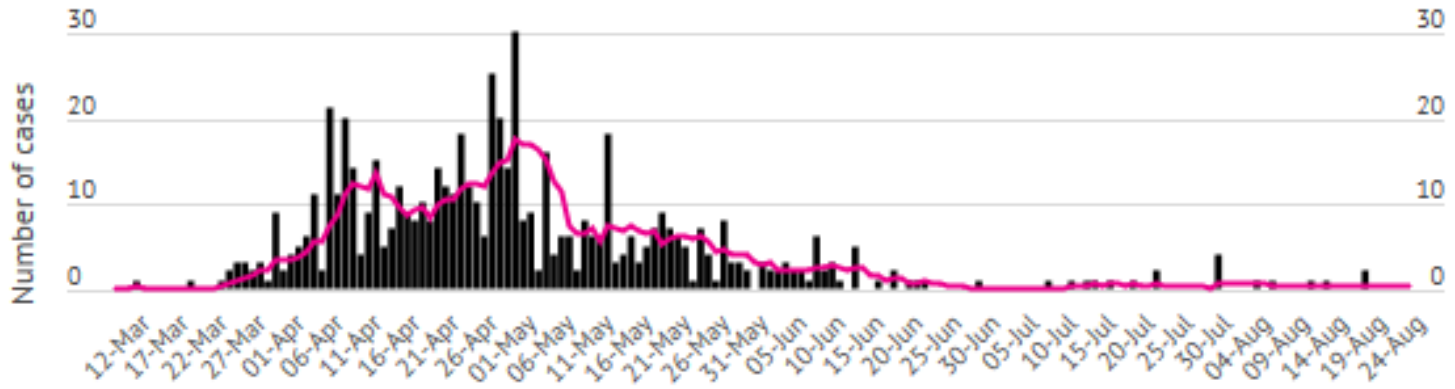
Rank

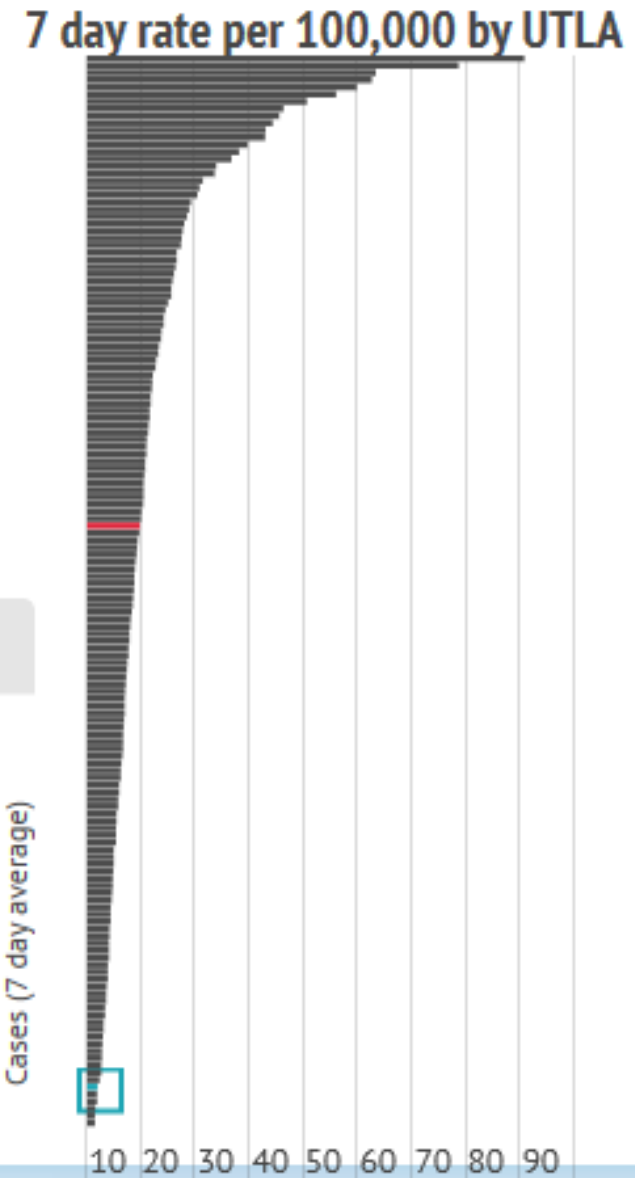
Rate of confirmed cases per 100,000 population

2.8

7 day rate of confirmed cases per 100,000 population*

Daily Cases | 7 day rate per 100,000* | Weekly change in 7 day rate





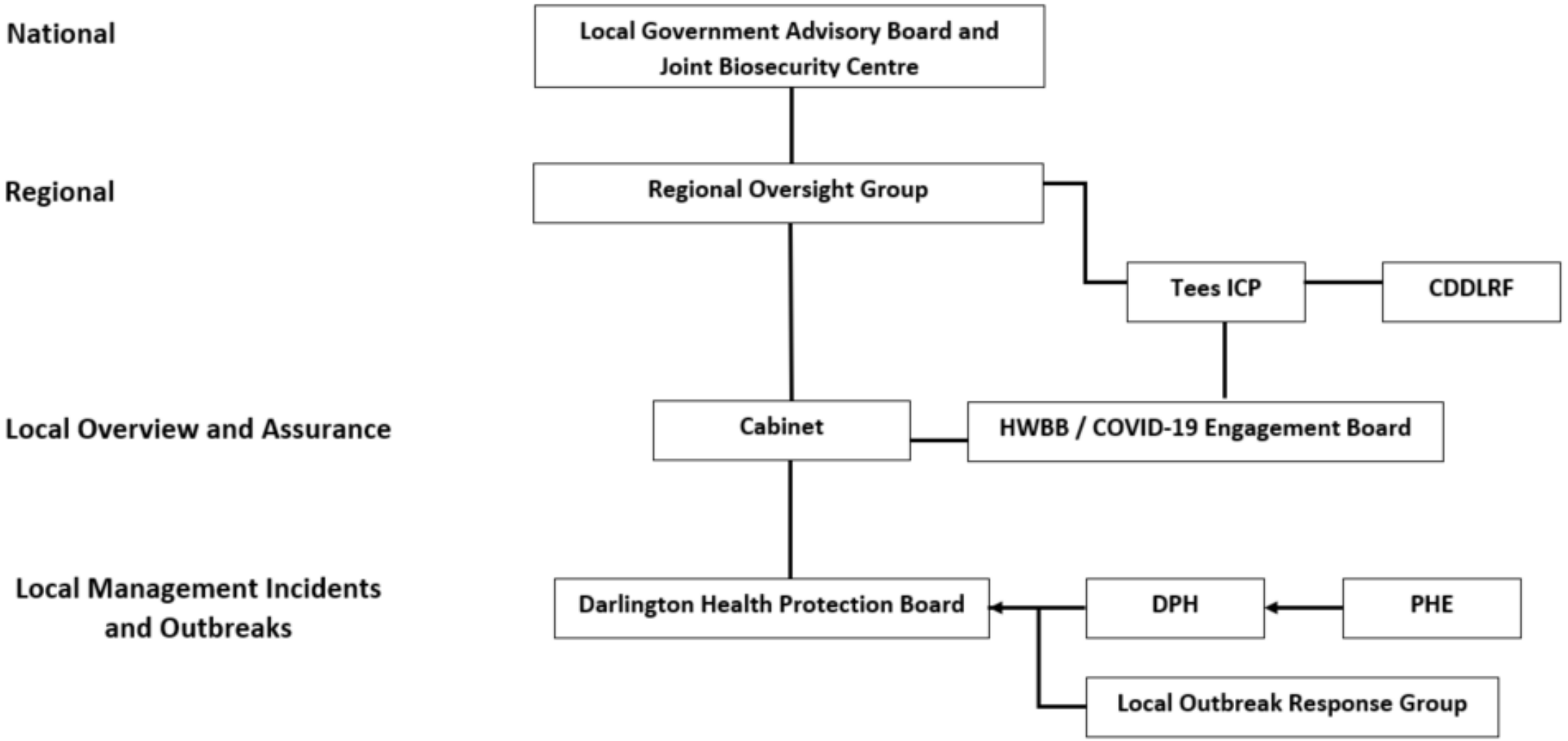
Theme 6: Supporting Vulnerable People To Self-isolate

During the response phase, DBC established a Shielding Hub to coordinate effort across the council and a range of local partners. This hub distributed the national support packages and provided a range of support services to the most vulnerable residents.

The hub will continue to support people identified through NHS Test and Trace who need to self isolate and have little or no support.

The NHS Volunteer Scheme accessed through GP surgeries is an important source of support for many people.

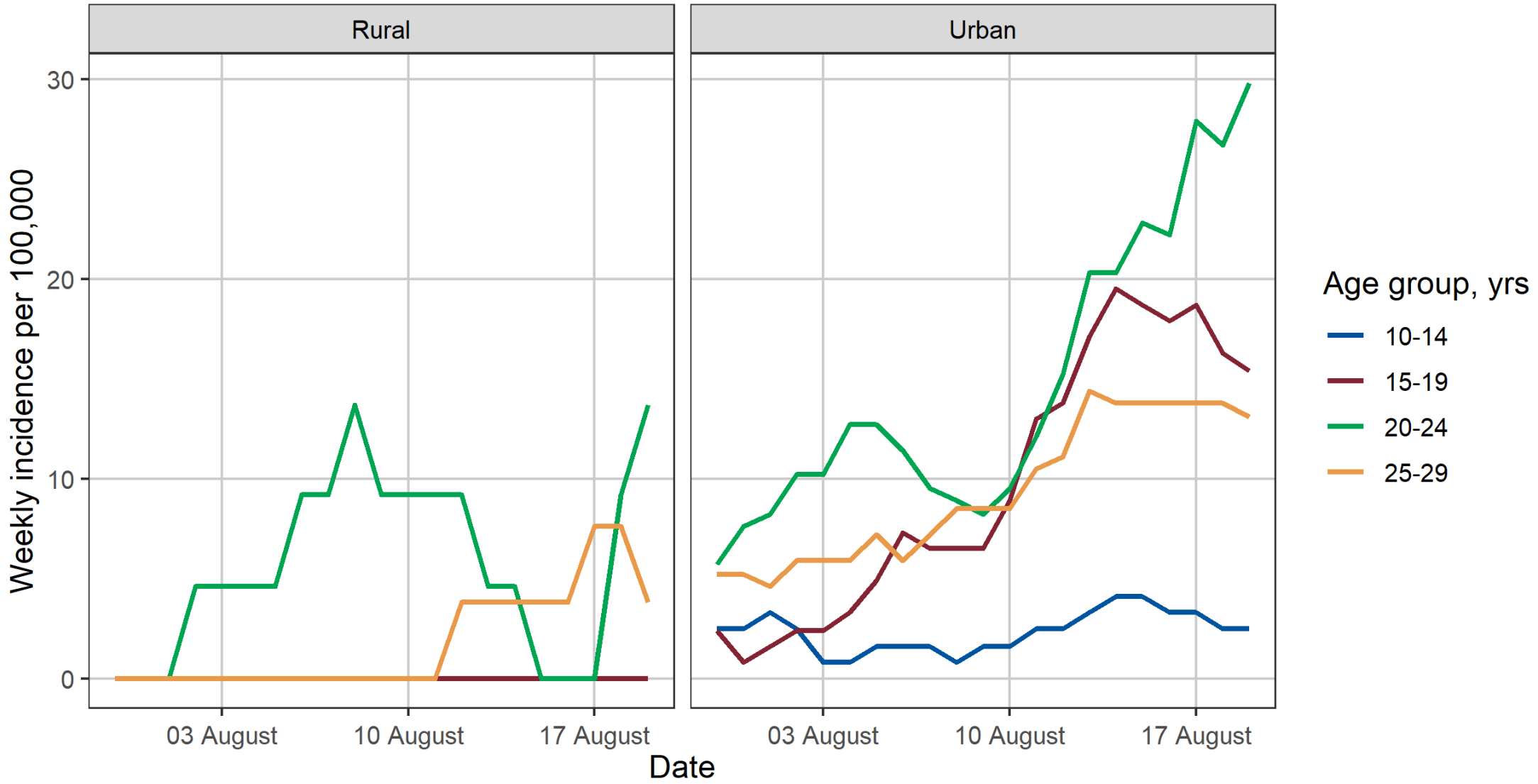
Theme 7: Governance



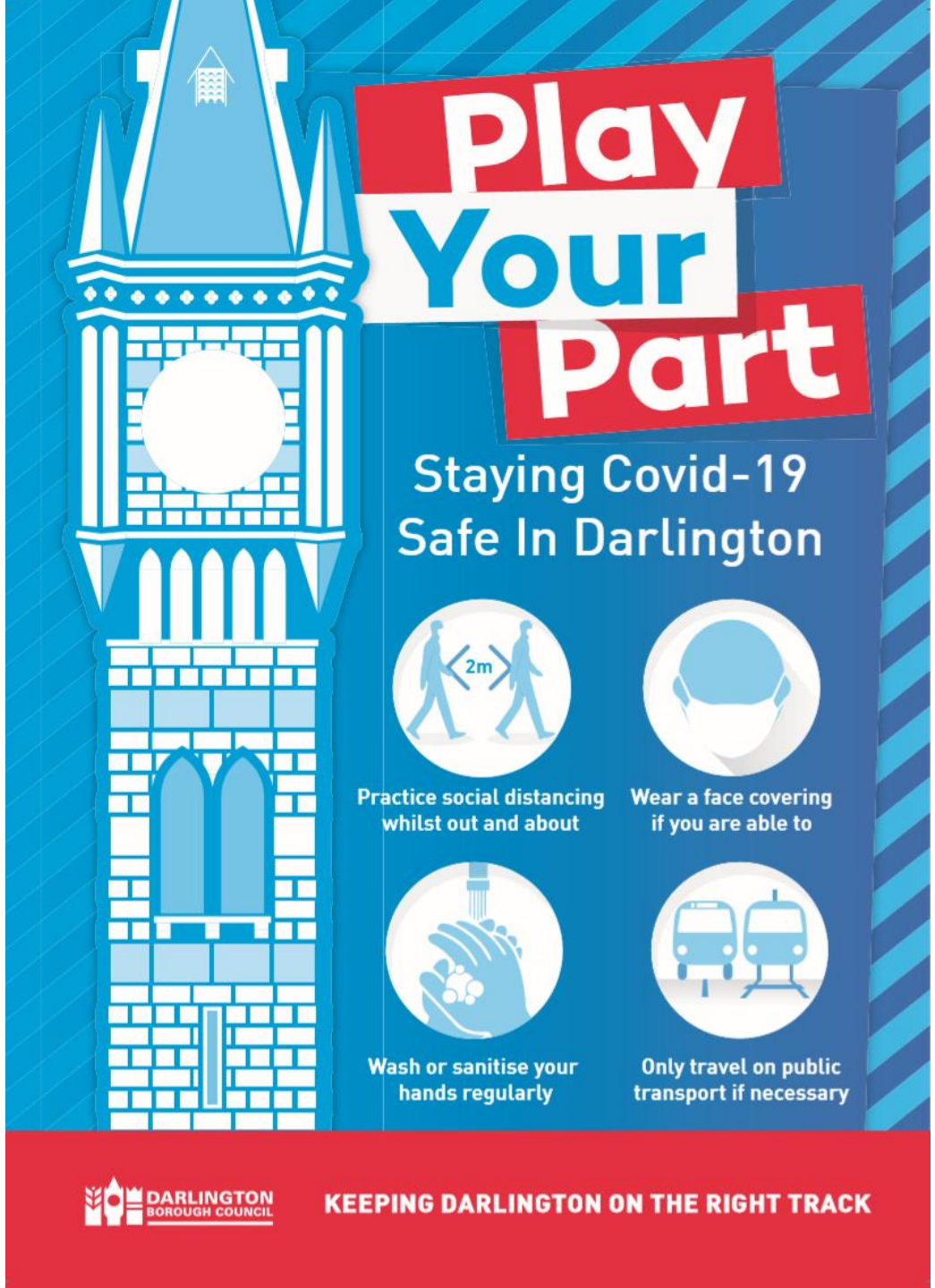
Communication and Engagement

- Preventing local outbreaks of Covid 19 and engaging people across all segments of society with the need to comply with social distancing, be alert to symptoms, access testing where needed and to self-isolate if positive or if contact traced.
- Providing assurance to stakeholders and the public that plans for management and control of outbreaks are effective
- Providing the public with information in the event of outbreak scenarios

Weekly incidence in young people resident in urban and rural areas North East



Rural Urban Classification (2011) of Lower Layer Super Output Areas, ONS
Figure produced by Public Health England


Play Your Part
Staying Covid-19 Safe In Darlington
2m
Practice social distancing whilst out and about
Wear a face covering if you are able to
Wash or sanitise your hands regularly
Only travel on public transport if necessary
DARLINGTON BOROUGH COUNCIL
KEEPING DARLINGTON ON THE RIGHT TRACK

NHS
Tees Valley
Clinical Commissioning Group

NHS
North of England
Commissioning Support

2020-21 Tees Valley Winter Plan

Presented to the Darlington Health & Well Being Board 3rd September 2020

Presented by M Houghton, Director of Strategy & Commissioning Tees Valley CCG

2020-21 Tees Valley ICP Winter Plan

Introduction:

- *The Winter Plan is part of an annual planning process in collaboration with the South Integrated Care Partnership (ICP) led by the Tees Valley Local AE Delivery Board.*

- *There are 4 ICP Winter Plans prepared within the NENC Region: North, South, Central & North Cumbria, which all feed into an overarching Integrated Strategic Partnership Regional Winter Plan*

ICP Winter Plan Timetable:

- *1st Draft 2020-21 Winter Plan Submission 30 June 2020 to the UEC Network*
- *Winter Plan Testing Virtual Event 14 August 2020*
- *ICP Scenario Template Submission 24 August 2020:*

  Scenario 1:A hypothetical peak of a similar magnitude to wave 1 in mid/late September

  Scenario 2: Continued local outbreaks over the autumn/winter, without a second peak but with continued social distancing/IPC restrictions and BAU winter pressures

- *Winter Virtual Masterclass 23rd September 2020 with a focus on:*
  - *NHSE/I Winter Daily Reporting Arrangements*
  - Triggers and actions at ICP level and mutual aid offers
- *Final Submission of Plan end September 2020*

2020-21 Tees Valley ICP Winter Plan

Progressing the Winter Plan:

- *Capturing within plans the Phase III letter 'ask' issued by the NHS Chief Executive on 31st July 2020*
- *Gap Analysis undertaken including Risks & Mitigations currently being developed within the plan*
- *Restoring and maintaining normal levels of elective, diagnostic and outpatient activity throughout Winter alongside providing safe services for both Covid & Non Covid patients across the health and social care system.*
- *Workforce Planning across the Tees Valley partnership to ensure Business Continuity with the flexibility to redeploy staff across services during surges in activity with specific support to Nursing Homes ensuring staff and patient safety.*
- *Identifying an anticipated increase in demand on Mental Health services in the Community mitigating the risks and building into ICP Escalation Triggers and Actions.*
- *Working with Public Health and the wider partnership to review processes and communications in response to local outbreaks and potential lockdowns as well as delivering a strong flu vaccine programme.*
- *Preparing clear Public Communications in line with National and Regional messaging to manage access to services: NENC launch of Talk Before You Walk 1st September with the strapline:*

Phase III Covid Response

Phase III Ask: 9 Themes with 79 Elements:

1. *Restore full operation of all cancer services* *(9 elements)*
2. *Recover the maximum elective activity possible between now and winter* *(13 elements)*
3. *Restore service delivery in primary care and community services* *(12 elements)*
4. *Expand and improve mental health services and services for people with learning disability and/or autism* *(12 elements)*
5. *Continue to follow good Covid-related practice* *(5 elements)*
6. *Prepare for winter* *(7 elements)*
7. *Workforce* *(6 elements)*
8. *Health inequalities and prevention* *(10 elements)*
9. *Financial arrangements and system working* *(5 elements)*

A South ICP comprehensive Phase III response is currently being populated to be shared with all partners across the ICP for further review.

Further Guidance has been released following the phase III letter requiring (submissions coordinated by the TVCCG in collaboration with partners across the ICP:

1. *Performance Activity & Workforce Templates with supporting narrative (Submission 26 August)*
2. *Mental Health finance and performance trajectory with supporting narrative (Submission 24 August)*
3. *Finance template (Submission date tbc)*

Theme: Prepare for winter:

- *Each theme of the Phase III 'ask' has a CCG Director lead identified to ensure each element is progressed in collaboration with wider system partners.*
- *The work for 'The Prepare for Winter ' theme will be captured within the ICP Winter Plan with the elements of this theme listed below:*

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.
Expanding the **111 First** offer to provide low complexity urgent care without the need for an A&E attendance
Increase 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).
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**

Questions?

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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 COVID19

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 1st 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 29th 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

On 19th 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 17th 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, 1st 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 1st September** using the templates issued and covering the key actions set out in this letter, with **final plans due by 21st 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 8th 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 (1st and 2nd 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.

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Tees Valley CCG Flu Vaccination up date

In the past primary care has been called upon to provide emergency vaccination to reduce the spread of disease and it now is apparent that a similar scale of emergency vaccination will be needed from primary care, as a result of the COVID-19 pandemic. This now may well include significantly expanding the seasonal flu vaccination programme, to include other cohorts of patients in particular the “not at risk” patients in the age range 50 – 64 years old

The current COVID-19 pandemic poses a specific set of challenges to achieving high volume through-put. For example, enhanced standards of infection prevention and control will be needed, and larger spaces may be necessary to maintain safe social distancing. Premises normally used to undertake vaccination (GP surgeries, pharmacies, schools) are likely to be impacted by any restrictions of social distancing. Creating a safe flow of patients to achieve the high throughput to vaccinate large numbers may be difficult and impossible in some.

In the context of social distancing, use of personal protective equipment and increased time necessary for immunisers to prepare for each patient, it is likely that additional time will be required.

Regional ICS (Integrated Care System) response - North East and North Cumbria

The regional ICS response to the extra pressure on providers to deliver the flu programme in times of Covid has led to the setting up of an ICS level - North East & North Cumbria (NENC) System Flu Board

The aim of the board is to lead, coordinate and deliver assurance across the NENC system to maximise delivery of influenza vaccination to the eligible population in 2020/21.

This process will be enabled by a series of task and finish groups

- Covid safe delivery models
- Specialist settings
- Data & digital
- Social care settings
- Healthcare workers
- Demand & capacity
- Communications & marketing
- PPE requirements

All the groups are due to report out at the end of August and all relevant information will be shared with all relevant providers locally via our CCG flu co-ordinator

Local ICP (Integrated Care Partnership) response

Tees Valley CCG has now convened a local Flu vaccination delivery board; the aim of the local board is to provide support to practices and facilitate sharing of best practice and novel flu vaccination delivery models.
Members of the local board represent all relevant providers in terms of flu vaccination delivery

- CCG medical director
- CCG flu co-ordinator

- CCG care home lead
- CCG project manager
- LMC and LPC representatives
- GP and PCN clinical director representation
- Practice nurse representative
- Practice Managers
- Local PHE lead
- Community nursing reps from STHFT and UHNT
- Local school nursing lead
- Reps from GP federations
- NECS comms team

Currently we are developing a robust flu plan to ensure we are able to understand all the strands of this year's flu vaccination programme, and gain an understanding of where potential gaps or risks may exist. Our themes cover similar strands to the regional T&F groups. We are keen to share our findings and give assurances to all providers that there is a local plan to ensure all current at risk groups are covered during this coming flu vaccination programme.

As a group we are keen to support the delivery of this year's programme, and understand what support practices need to deliver to their at risk groups to get to the aspirational 75% coverage.

Clearly there are still more flu vaccination programme updates due nationally and the board will consider these in the ever evolving local flu plan

Delivering the flu programme at practice or PCN level?

Practices across the Tees Valley CCG were recently asked to complete audit information of vaccines ordered, and insights as to whether flu vaccination plans are planned for practice delivery or at scale PCN delivery. There is clearly a mix of models planned across the CCG.

The local flu vaccination board would be keen to learn more about individual practice or PCN plans, and is in a position to share solutions to issues that others may be currently experiencing in their planning process

Practices will be asked further if they are willing to share practice or PCN plans in order to assist sharing best practice

Delivering Mass Vaccinations during COVID-19 - A Logistical Guide for General Practice

The RCGP has produced this document to assist GPs, lead practice nurses, Practice Managers, Clinical Directors, GP Federations, PCNs and CCGs/Health Boards in understanding the practicalities and challenges of delivering mass vaccination programmes in a context when COVID-19 remains in general circulation. It sets out key areas that will need to be considered, offers possible solutions and highlights areas where risk assessments are required, particularly where these may differ from normal practice.

https://elearning.rcgp.org.uk/pluginfile.php/149506/mod_page/content/75/Mass%20Vaccination%20at%20a%20time%20of%20COVID%20V2.0.pdf