THIRD PHASE OF NHS RESPONSE TO COVID-19: Assessment against requirements

Requirements			Trust Lead	Trust Assessment	RAG
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.		CDC	Reflected in Clinical Strategy	
	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.	Lisa Shacklock	Full capacity available.	
		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.		Not Applicable, service not provided.	
		Expanding the capacity of surgical hubs to meet demand and ensuring other treatment modalities are also delivered in Covid19-secure environments.	Maggie Maxwell	Cancer surgical capacity was maintained through the pandemic and restoration phase.	
		Putting in place specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment.	Cancer Alliance		
		Fully restarting all cancer screening programmes. Alliances delivering lung health checks should restart them.	Cancer Alliance		
	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.		Lisa Shacklock	Full capacity available.	
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 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.	Maggie Maxwell	CT on track to have cleared it's backlog by 1st September and MRI by 1st October. July, CT at 85.4% and MRI at 92.3%.	
		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).	Carrie Symington	All services re-started as of 3rd August. Currently at 70% of pre-COVID levels. Ramp-up monitored through weekly 6-4-2 meeting. July: first appointment at 95.5% and 79.8 for follow up appointment.	
		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.	STP/ CCG	Discussions on-going through Clinical group for services such as Orthopaedics and Respiratory. The system has agreed that waiting list visibility will be delivered as a first step. Consideration should be given to how waiting lists for regional and national services should be managed.	
		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.	TBC		TBC

		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.	CDC	Prioritisation processes embedded.	
		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.	IPC / Operational leads	HW 04.08.20: The NICE guideline has been noted and a decision has been made by the Trust to continue to abide by 14 day isolation prior to admission for elective surgical and Transplant patients, this decision has been reached due to the greater risk that is posed to these patients should they contract COVID-19. With regard to other elective admissions the Trust needs to agree that it is happy to implement the new guidance and advise patients to follow comprehensive social distancing and hand hygiene measures for 14 days prior to admission, instead of self isolation for 14 days. For all other procedures the Trust is currently performing telephone screening of patients within 24 hours of there attendance to access for symptoms and advice accordingly.	
		Trusts should ensure their e-Referral Service is fully open to referrals from primary care.	Helen Rodriques	Traige system in place and referrals have not been stopped. Migrating to new RAS system for referrals by end of August. Complete 24/8/2020	
		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. 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.	Carrie Symington	All clinics that can effectively be delivered virtually or by phone now changed. Full template review undertaken and templates ammended.	
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.				
	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	Kate Waters	Website to be updated.	TBC
		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.	Ivan Graham	IG 04.08.2020: RPH has a very small number of patients with learning disabilities or autism. RPH takes part in the Annual National Learning Disability Improvement Standards survey which also looks at attendance numbers (Trust lead is IG, Deputy Chief Nurse): the most recent survey (2018/19 data): Number of bed days occupied by learning disabled patients in 2018/19 = 246; Number of outpatient attendances by learning disabled patients in 2018/19 = 44. The patients that are required to come to RPH are for specialist treatment and in partnership with the patients referring clinician; the patient and their family. Also note DN810 Learning Disability and Autism Policy which is a new Policy for approval at the Trust Safeguarding Committee 07.08.2020.	

		Complete all outstanding Learning Disability Mortality Reviews (LeDeR) by December 2020.	Ivan Graham	IG 04.08.2020: RPH has two trained LeDeR reviewers (Penny Martin and Tony Bottiglieri) and we are fully engaged with this process. As per LeDeR requirements, we refer into the programme and our reviewers are invitred to review cases. Control over the reviews is nationally and regionally led. This is covered in Section 14 of DN810 Learning Disability and Autism Policy.	
		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.		DIPC	PHE guidance followed throughout response and restoration of services. IG 04.08.2020: RPH monitors nosocomial infection rates and reports monthly through PIPR.	
	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.		IPC	HW 04.08.20: All inpatients are tested prior to admission or on admission and weekly thereafter. As previously advised asymptomatic staff will be screened as part of the SIREN study. There is a procedure in place to ensure all symptomatic staff are tested in a timely manner. If regular testing of all asymptomatic staff is implemented their will need to be national guidance issued on how this can be achieved without impacting on local patient testing and extra testing capacity provided. The Trust will also need to look at how this provision could be managed and facilitated, should such a policy be implemented. Mass staff testing has been carried out previously but not for a sustained period.	This may need to change as national rules change (green 04.08.20)
	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.		DIPC	PHE guidance followed throughout response and restoration of services.	
	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.		Andrew Selby	PPE dashboard used to monitor stocks daily. Trust has moved to re-useable gowns with a closed loop laundry solution.	
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.		Tim Glenn	Fully engaged in FFPG and working with system partners to bidding for CIF monies.	
	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.		DIPC	IG 04.08.2020: RPH planning started w/c 27.07.2020 in partnership with CUH Occupational Health. Email from CCG Chief Nurse 29.07.2020 confirms the vaccine delivery schedule which says that for hospitals: 25% of their order will be delivered w/c 14th September; 20% of their order will be delivered w/c 5th October; 25% of their order will be delivered w/c 19th October; 30% of their order will be delivered w/c 2nd November. ROH plans to use a peer vaccination programme which has been sucesful in previous years with an aim of as close to 100% vaccination rate as possible.	

	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.		Karen Webster	Limited impact for our patients.	
	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).		Judith Clarke / Lisa Gibbie / Penny Martin	Lisa representing on Domain 1 - Out of Hospital Care group.	
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.	Workforce	In progress. Reflect in draft People plan being developed.	
		Specific requirements to offer staff flexible working.	Workforce	In progress. Reflect in draft People plan being developed.	
		Urgent action to address systemic inequality that is experienced by some of our staff, including BAME staff.	Workforce	In progress. Reflect in draft People plan being developed.	
		New ways of working and delivering care, making full and flexible use of the full range of our people's skills and experience.	Workforce	In progress. Reflect in draft People plan being developed.	
		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	In progress. Reflect in draft People plan being developed.	
		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.	Workforce	In progress. Reflect in draft People plan being developed.	

	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.		Workforce	In progress. Reflect in draft People plan being developed.	
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.		CDC	Reflected in the Clinical Strategy developed by CDC.	
	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.	TBC		TBC
		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.	CDC	Reflected in the Clinical Strategy developed by CDC.	
		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.	Oonagh Monkhouse	WRES action plan in place. Charity has funded a post to support Equality and Diversity.	
		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.	Sophie Harrison		
Financial arrangements and system working	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.	System Leaders	System leaders and Health Gold established and underpinned by Clinical, FFPG and ROG fourms. Trust participation active in all of these forums.	
		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.	FFPG / Tim Glenn		
		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.	Andy Raynes		
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.			Sophie Harrison	Templates awaited but adjustment of dynamic model to reflect actuals for July underway.	

	03-Aug	27-Aug
Red	0	0
Amber	17	14
Green	17	20
TBC	2	2