Leicestershire County Council

Meeting: **Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 23 September 2020 at 10.00 am**

Location: **Microsoft Teams Video Conferencing.**

Contact: **Euan Walters (0116 3056016)**

Email: **Euan.Walters@leics.gov.uk**

Membership

Dr. R. K. A. Feltham CC (Chairman)

Cllr. T. Aldred	Mr. J. T. Orson JP CC
Cllr. P. Chamund	Mrs. R. Page CC
Cllr. L. Fonseca	Mr T. Parton CC
Mrs. A. J. Hack CC	Cllr. D. Sangster
Mrs S Harvey	Micheal Smith
Dr. S. Hill CC	Underwood
Cllr. P. Kitterick	Miss G. Waller
Cllr. M. March	Cllr. P. Westley
Mr. J. Morgan CC	

Please note: The Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee meeting on Wednesday 23 September 2020 at 10:00am will not be open to the public in line with Government advice on public gatherings.

This meeting will be filmed for live or subsequent broadcast via YouTube: https://www.youtube.com/channel/UCWFpwBLs6MnUzG0WjejrQtQ.

AGENDA

Item	Report by

1. Chairman and Vice Chairman.

   To note that as per the Working Arrangements and Terms of Reference of the Committee, for the 2020/21 year the Chairman Dr. R.K.A Feltham CC has been nominated by Leicestershire County Council and the Vice Chairman Cllr. Patrick Kitterick has been nominated by Leicester City Council.

2. Minutes of the previous meeting. (Pages 5 - 16)

3. Question Time.

4. Questions asked by Members under Standing Order 7(3) and 7(5).

5. Urgent Items.

6. Declarations of Interest.

7. Presentation of Petitions.

8. Covid-19 Update. (Pages 17 - 54)

9. NHS 111 First. (Pages 55 - 70)

10. Director of Public Health for Leicestershire update on Covid-19.

    Mike Sandys, Director of Public Health, will give a verbal update.

11. Date of next meeting.

    The next meeting of the Committee is scheduled for 15 October 2020 at 10:00am.

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

Members serving on Overview and Scrutiny have a key role in providing constructive yet robust challenge to proposals put forward by the Cabinet and Officers. One of the most important skills is the ability to extract information by means of questions so that it can help inform comments and recommendations from Overview and Scrutiny bodies.

Members clearly cannot be expected to be experts in every topic under scrutiny and nor is there an expectation that they so be. Asking questions of 'experts' can be difficult and intimidating but often posing questions from a lay perspective would allow members to obtain a better perspective and understanding of the issue at hand.

Set out below are some key questions members may consider asking when considering reports on particular issues. The list of questions is not intended as a comprehensive list but as a general guide. Depending on the issue under consideration there may be specific questions members may wish to ask.

Key Questions:

- Why are we doing this?
- Why do we have to offer this service?
- How does this fit in with the Council's priorities?
- Which of our key partners are involved? Do they share the objectives and is the service to be joined up?
- Who is providing this service and why have we chosen this approach? What other options were considered and why were these discarded?
- Who has been consulted and what has the response been? How, if at all, have their views been taken into account in this proposal?

If it is a new service:

- Who are the main beneficiaries of the service? (could be a particular group or an area)
- What difference will providing this service make to them – What will be different and how will we know if we have succeeded?
- How much will it cost and how is it to be funded?
- What are the risks to the successful delivery of the service?

If it is a reduction in an existing service:

- Which groups are affected? Is the impact greater on any particular group and, if so, which group and what plans do you have to help mitigate the impact?
- When are the proposals to be implemented and do you have any transitional arrangements for those who will no longer receive the service?
- What savings do you expect to generate and what was expected in the budget? Are there any redundancies?
- What are the risks of not delivering as intended? If this happens, what contingency measures have you in place?

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Agenda Item 2

Leicestershire County Council

Minutes of a meeting of the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee held via Microsoft Teams video conferencing on Friday, 3 July 2020.

PRESENT

Dr. R. K. A. Feltham CC (in the Chair)

Cllr. L. Fonseca
Mr. T. Gillard CC
Mrs. A. J. Hack CC
Mrs S Harvey
Dr. S. Hill CC
Cllr. P. Kitterick
Cllr. M. March
Mr. J. Morgan CC
Cllr. D. Sangster
Mrs B. Seaton CC
Micheal Smith
Janet Underwood
Miss G. Waller
Cllr. P. Westley
Mrs. M. Wright CC

Note: The meeting was not open to the public in line with Government advice on public gatherings however the meeting was broadcast live via YouTube.

In attendance
Andy Williams, Chief Executive LLR Clinical Commissioning Groups (minute 28 refers).
Rebecca Brown, Acting Chief Executive, UHL (minutes 28, 29 and 30 refer).
Angela Hillary, Chief Executive of LPT (minute 28 refers).
Rachel Bilsborough, Director - Community Health Services, LPT (minute 28 refers).
John Edwards, Associate Director of Transformation, LPT (minute 28 refers).
Jonathan Shuter, Deputy Chief Financial Officer, UHL (minute 29 refers).
Mark Wightman, Director of Strategy and Communications, UHL (minute 30 refers).

22. Minutes of the previous meeting.

The minutes of the meeting held on 24 January 2020 were taken as read, confirmed and signed.

23. Question time.

The Chief Executive reported that six questions had been received under Standing Order 7(3) and 7(5).

1. Question by Mrs Jean Burbridge:

Did out breaks of Covid-19 occur in Care Homes in LLR to which patients with Covid had been discharged from UHL?

Reply by the Chairman:

The three Councils across Leicester, Leicestershire and Rutland (LLR) have worked closely with University Hospitals of Leicester NHS Trust (UHL) and Leicestershire Partnership NHS Trust (LPT) to implement Government Guidance to ensure the safe and timely discharge of patients from hospital. Where appropriate, this has included ensuring

that patients recovering from Covid can be discharged on a long or short term basis to care homes. Since March 2020 around a third of care homes in LLR have had a Covid outbreak although a lessor number in Rutland. This means that it is inevitable that some homes with outbreaks also admitted people discharged from hospital. Some of these infections are likely to be linked to these discharged patients, but others will have been as a result of community infection, often through asymptomatic care staff which has been shown through national and international research to be significant. In this respect Leicester, Leicestershire and Rutland is no different to other parts of the region and lower than the all England average

The number of new infections in care homes has declined significantly, and the number of new outbreaks has been very low in the last 2 weeks.

2. Question by Mrs Jean Burbridge:

From what date were patients tested for the Coronavirus before being discharged from Hospitals to Care Homes?

Reply by the Chairman:

I have received the following answer to the question from University Hospitals of Leicester NHS Trust:

> "National COVID-19 hospital discharge service requirements were first published on 19th March – these set out the actions to be taken immediately to enhance discharge arrangements. There was no mandate to test patients being discharged to care homes. At this time most patients were discharged to care homes with no test unless;
>
> - they had been symptomatic, as the directive at this time was to test only symptomatic patients;
> - the receiving care home refused to take the patient without a test result.
>
> The "Admission and Care of Residents during COVID-19 Incident in Care Home" guidelines were published on the 2nd April highlighting the need for care homes to isolate patients – this included no details regarding additional testing prior to discharge.
>
> The UHL approach to the guidance was to share with care homes our view that, 'Hospitals are a high risk environment and there is a case for considering isolation in a care home on admission from secondary care. Trusted Assessors and Discharge Co-ordinators will be able to support care homes with the most up to date information on the individual patients and relevant guidance.'
> In other words our advice to care homes was to be cautious and isolate patients discharged from hospital.
>
> The "Coronavirus (COVID-19): Adult Social Care Action Plan" was published on the 15th April and for the first time the need to test patients prior to discharge to a care home was recommended. With the Government stating "we can now confirm we will move to institute a policy of testing all residents prior to admission to care homes. This will begin with all those being discharged from hospital"
>
> The guidance was very clear stating that 'where a test result is still awaited, the patient will be discharged and pending the result, isolated in the same way as a COVID-positive patient will be'.

Thus from the 15th April – all care home discharges have been tested. The test is requested up to 48 hours prior to discharge, as per the guidance, and we continue to advise all care homes to isolate patients for 14 days from the date of the test."

3. **Question by Mrs Jean Burbridge:**

How many physical real extra beds in community hospitals or community buildings were prepared by Leicester Partnership Trust? A paper presented by LPT to City Council states that 222 could be expanded to 350. LPT made a video showing the preparations of 36 extra beds at the end of April for Loughborough Hospital. Were these beds used? Which other hospitals had the extra beds? What will happen to these beds?

Reply by the Chairman:

I have sought information from Leicestershire Partnership NHS Trust (LPT) on the question and received the following response from LPT:

"In April 2020, the Trust approved a plan to increase community bed capacity in order to accommodate an expected surge in the number of patients requiring in-patient rehabilitation as a consequence of catching Covid-19.

The plan to expand our beds included the conversion of 75 Independent Sector (private hospital) beds into rehabilitation beds. From mid April 2020 onwards, 33 of the 75 beds were converted and 6 were in use at any one time. These beds are no longer being used for rehabilitation purposes and have reverted back to their original use.

In our community hospitals, three wards (53 beds) were refurbished and made ready to accommodate rehabilitation patients. Two of the wards are located at Loughborough community hospital (Charnwood and Gracedieu ward) and one at Coalville community hospital (ward 4). During April, the Trust opened the wards at Loughborough community hospital to ensure additional capacity was available to respond to an expected surge of patients over the Easter period. The expected surge did not materialise and the wards were not required to accommodate any patients. On 1 May 2020 a decision was made to stand the wards down.

The refurbished wards in our community hospitals will enable the Trust to respond to any future wave of the virus, in addition to any bed pressures that the winter months may bring."

4. Question by Mrs Jean Burbridge

I am concerned that a massive reduction in hospital outpatient appointments is forecast in "Covid 19 Restoration and Recovery " (UHL Board meeting paper) and that the projected number of 'virtual' (phone/video) outpatient appointments is too high (70%). It looks as though the local NHS has already made a decision about Digital First implementation without consulting the public. The survey referred to with response from 1400 people was a set of questions on people's experiences during the pandemic and being ONLINE by its very medium will contain bias. Can the UHL Trust assure us that proper formal consultation will take place on these matters and that it will seek evidence that the proposals will not break Equality principles?

Reply by the Chairman:

University Hospitals of Leicester NHS Trust have provided me with the following assurance:

> "The Chief Medical Officer for England has highlighted that we are likely to be living with COVID-19 and its implications for the foreseeable future. The safety of our population and patients is paramount and we are adapting all models of service provision, to ensure that our patients only need to travel to hospital for care they cannot safely receive elsewhere. Outpatients are no different, and the use of virtual technology allows us to maintain the vital services we offer to our patients, in a safe and timely manner. We are aware that virtual appointments will not be the appropriate option for all patients and therefore technology will be used in combination with appointments in our community hospitals, GP practices & traditional UHL sites. The approach to virtual technology will be flexible, meeting the needs of our patients, whilst maintaining their safety. All UHL & LLR transformation programmes are undertaken in collaboration with patient representatives and engagement/consultation will be a key pillar of the changes we make.
>
> The NHS Long Term Plan (Released in January 2019), required all NHS providers to deliver 33% of the outpatient activity virtually and follow ups to only take place when clinically necessary. More recently to reduce the risk of infection and support the safe switch on of services NHSE/I have issued guidance stating that,
>
> "As far as practicable, video or telephone appointments should be offered by default for all outpatient activity without a procedure…"
>
> It should be recognised that for years we have received feedback from patients regarding their frustration with regularly attending our hospitals for 15 minute appointments only to be told they are well and to return in six months. Roughly 30% of all new outpatient activity involves patients traveling to an acute hospital site to receive no ongoing treatment, following the initial appointment. COVID-19 has therefore shown that the original aim of 33% reduction in face to face consultations is at the lower end of what is possible and so we have chosen a stretching target of 70%. Of course there cannot be a one size fits all approach, not least because there are some services where 'face to face and hands on' is essential for diagnostic reasons; equally there are patients who are unable or unwilling to access care virtually BUT the idea that we will continue to ask hundreds of thousands of patients to travel into hospital in a COVID endemic world is counter intuitive when other options exist.
>
> Finally and importantly a digital approach to outpatient activity allows the NHS to contribute to the ambitious national climate change and air quality targets, given that circa 5% of traffic on England's roads is NHS related."

The Committee ensures that it is consulted by NHS partners on all major transformation programmes and it is intended that the local response to the NHS Long Term Plan will be on the agenda for a Committee meeting later in the year.

5. Question by Mr Robert Ball

How in practice will UHL manage to 'juggle' between handling ordinary treatments and handling more Covid-19 patients if there is a resurgence of the Coronavirus?

Reply by the Chairman:

University Hospitals of Leicester NHS Trust has stated the following:

> "The Paper on Restoration and Recovery (part of the agenda pack for this 3 July 2020 meeting and the monthly updates in public at the UHL Trust Board https://www.leicestershospitals.nhs.uk/aboutus/our-structure-and-people/board-of-directors/board-meeting-dates/), cover this off in some detail. The summary is that we have managed to turn back on the majority of our services, (whilst still anticipating a second peak). However, it is important to recognise that although services are being restored it is not back to 'business as usual'. For example, a typically efficient theatre list pre-Covid might have seen our surgeons carry put 10 procedures in a session. Now, with the added infection risk posed by COVID, surgeons are working in full PPE, which is changed between patients; the theatre is deep cleaned between each patient and the air is completely exchanged. This means that in the 'new normal' we can only treat half the numbers of patients on a list."

The Committee will discuss this issue further as part of agenda item 7 at this meeting: Covid-19 Leicester, Leicestershire and Rutland NHS Response, and also at future Committee meetings.

6. Question by Mr Robert Ball

How many non-urgent operations were cancelled by UHL to stop hospitals being overwhelmed and provide space to treat Covid-19 patients? Also, assuming no resurgence of the Coronavirus, how long will it take to clear the backlog in operations, in months and years?

Reply by the Chairman:

University Hospitals of Leicester NHS Trust have provided the following information:

> "We postponed almost all of our non-urgent surgery in anticipation of the first peak of the pandemic and given the size of the Trust and the numbers of patients we routinely see, that amounts to some 13,000 patients who did not have their procedures. The numbers who were actually 'cancelled' is much smaller (700) but this is only because we generally book patients a few weeks in advance meaning that only a relative few had dates for their operations at the time we took down lists. There were two drivers for this; the first (and lesser) of the two was to create sufficient surge capacity in our bed base. The second (and more important) was to create sufficient surge capacity for patients requiring Intensive Care and other types of ventilation. This meant that we converted operating theatres into ICUs and diverted theatre staff to support the large number of ventilated patients we were caring for. With theatres and staff 'repurposed', non-urgent activity could not take place. (Though of course we continued urgent and emergency activity throughout).
>
> As the briefing paper in the agenda pack for this 3 July 2020 meeting explains, we are now restoring / recovering services and aim to be at 75% capacity by early July. However, as the example above explains, being at 75% capacity does not equate to being able to run services at their previous levels of efficiency. All of which means that waiting times for non-urgent operations will be much longer than people have been used to. In terms of how long it will take to 'recover' to previous levels, for which we would mean waiting lists back to 'normal'… that is still a work in progress

and also depends on what levels of new referrals we receive but a conservative estimate would be 12 months."

The Committee keeps a close eye on waiting times for operations and will monitor performance going forward in particular the impact of the Covid-19 cancellations.

Mr Ball asked the following supplementary question:

What percentage of the non-emergency operations were undertaken by private providers?

The Chairman replied as follows:

The precise figure would be sought from UHL and provided to Mr Ball after the meeting.

(Note: After the meeting UHL informed Mr Ball that **23%** of their non-emergency activity was being undertaken by the private sector.)

24. Questions asked by members under Standing Order 7(3) and 7(5).

Mrs Amanda Hack CC asked the following question of the Chairman:

Please could we receive an update on the support for 2017 Student Nurses, who put their studies and lives to one side to assist the NHS with the Covid response. There had been reports of student nurses having their 6 month contracts reduced by 2 months, whilst it looks like the 6 month contracts will now be honoured, is this the correct position?

How many 2017 cohort student nurses do we have across our sites and how are our hospitals going to support these student nurses through the next 2 months.

Reply by the Chairman:

I have sought an answer to the question from University Hospitals of Leicester NHS Trust and received the following response:

"Across UHL, we have approximately 100 finalist student nurses and midwives from the 2017 cohort who volunteered to become an aspirant nurse at the beginning of the COVID-19 outbreak in England. Some of the Aspirants are from other universities across England who have chosen to complete their training in Leicester to be nearer to their families during the pandemic. All Aspirant nurses are being paid a Band 4 salary.

We also have 80 x 3rd year finalist students who chose not to be an aspirant nurse or midwife but wanted to have an extended paid placement in UHL. They are being paid a Band 3 salary. At the beginning of the COVID outbreak, Health Education England (HEE), believed that the extended paid placement initiative would be for six months and this was communicated to universities and students. However in UHL we gave all of our students (and all the NHS Bring Back Scheme volunteers) a three month fixed term employment contract in UHL that would end on July 31st 2020. This was a pragmatic decision because of the unpredictable nature of COVID. It is always easier to have a shorter contract that can be extended rather than bringing a longer contract to an end with little notice to an individual (which may be the case elsewhere in the UK). However, HEE announced on Friday 26th June that these paid placements could now continue for six months as per their original decision.

Locally, we will now extend contracts until the 31st August so as of the 1st September the students will revert back to full supernumerary status in order to complete their training. Our finalist students at DMU should complete their training on the 20th September and many have secured jobs in UHL so we will make sure they are supported to complete their programme in the best way possible.

HEE and NHSI/E agreed that students who chose to continue their placements during the pandemic should have an NHS contract and be reimbursed for their time working on wards. This is because as an NHS employee, students would benefit from the COVID legislation around statutory sick pay which would give them the same protection as existing NHS employees should they contract COVID whilst working in the NHS and as a result, become very ill (or in the worst case scenario, die as a result of COVID so, family becoming eligible to receive death in service payment). The salaries for students are being paid for by NHSI/E. Many students across the UK may have given up part-time employment thinking they would be receiving a band 4 salary for six months and this has caused distress to the students. This is not the case we believe, in LLR. However, when the contract ends on August 31st the students will no longer be an NHS employee or be remunerated for the remainder of their training (they should still receive their bursary) but they could still contract COVID but will be no longer eligible for benefits. So, we now await a decision from the Council of Deans who are working with NHSE/I, regulatory bodies, HEE and DoH to agree what needs to be in place that will support students appropriately. The final decision lies with the Department of Health and Social Care under the direction of the Secretary of State.

In relation to the point about “we have 500 vacancies in UHL” and using our students to support this position, we actually have circa 400 RN vacancies in UHL but we cannot use our students as qualified nurses and the most important thing is that we support them to complete their training.”

Mrs Hack CC will be aware that I am open to suggestions for agenda items for future Health Overview and Scrutiny Committee meetings and I am happy to discuss with her the best way to scrutinise this issue. I expect we will have several future agenda items regarding the impact of Covid-19 on the NHS in LLR, and we also have an item on the work programme regarding Recruitment and Retention at UHL and the NHS People Plan.

25. Urgent items.

There were no urgent items for consideration.

26. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

No declarations were made.

27. Presentation of Petitions.

The Chief Executive reported that no petitions had been received under Standing Order 36.

28. Covid-19 - Leicester, Leicestershire and Rutland NHS Response.

The Committee considered a joint report of Leicester and Leicestershire Clinical Commissioning Groups (CCGs), University Hospitals of Leicester NHS Trust (UHL) and Leicestershire Partnership NHS Trust (LPT) which set out how the local NHS had responded to the spread of the Covid-19 virus. A copy of the report, marked 'Agenda Item 7', is filed with these minutes.

The Committee welcomed to the meeting for this item Andy Williams, Chief Executive LLR Clinical Commissioning Groups, Rebecca Brown, Acting Chief Executive, UHL, Angela Hillary, Chief Executive of LPT, Rachel Bilsborough, Director - Community Health Services, LPT and John Edwards, Associate Director of Transformation, LPT.

Statement from the Director of Public Health for Leicestershire.

Prior to the presentation of the NHS report, the Chairman asked the Director of Public Health for Leicestershire to make a statement on the health protection restrictions which were in place in Leicester and parts of Leicestershire. The Director of Public Health informed that a data sharing agreement was now in place with Public Health England and post code level data on positive Covid-19 cases in LLR had now been received. The data indicated that the numbers of Covid-19 cases had stabilised in Leicester City, and in Leicestershire there were less cases of Covid-19 than in the City though the public should not be complacent. The areas of Oadby and Hinckley were higher than the rest of Leicestershire, though not as high as Leicester City. Close working was taking place between Leicester City Council and Leicestershire County Council to manage the spread of the virus and communication strategies and community engagement was in place, particularly in those areas of Leicestershire that were part of the restriction zone.

Arising from the statement the following points were discussed:

(i) Members suggested that the communications strategy should take into account the ethnic and cultural diversity of the residents of Leicester and Leicestershire and messages should be disseminated in different languages using paper leaflets as well as digital methods because not everybody had access to social media technology. The Director of Public Health supported this approach and stated that some of the money received from the Government for the extended public health restrictions locally would be used to improve communications to all communities in Leicester and Leicestershire.

(ii) The Public Health England report entitled 'Preliminary investigation into COVID-19 exceedances in Leicester (June 2020)' only covered Leicester City and not the parts of Leicestershire that had been included in the restriction zone. The Director of Public Health was not aware of any plans to produce an updated version of the report to include the parts of Leicestershire which had been included in the Leicester restriction zone. Data would be published soon regarding Leicestershire but it would not be broken down into ethnicity.

(iii) Members raised concerns regarding the Test and Trace system, particularly how difficult the home testing kit was to use and the length of time the courier took to pick the sample up. The Director of Public Health acknowledged that the home testing system was not as easy to use as the drive-through system but reassured that the Test and Trace system was improving and 91% of people tested received their results within 24 hours.

(iv) In response to a question regarding the difference between pillar 1 and pillar 2 testing and the importance of each, it was explained that pillar 1 testing was prioritised for clinical staff and gave an outline of the spread of Covid-19 in an area, whereas pillar 2 testing gave a more specific idea of the number of cases and was more likely to pick up younger people that had no symptoms and not been admitted to hospital.

NHS response to Covid-19

Arising from the NHS presentation the following points were noted:

(v) In dealing with the pandemic the different NHS organisations had worked closely together and with partners in local government. In order to increase local capacity for treating Covid-19 cases a large number of elected medical procedures had been postponed. Some elective cancer treatment had been provided by private providers and this had been funded nationally. The public had adhered to requests not to attend hospital unless it was urgent and as a result footfall had been low and the capacity of the local NHS had never been exceeded.

(vi) There had been difficulties with obtaining equipment particularly as the pandemic impacted on the supply chain elsewhere in the world but these difficulties had been overcome. Each NHS organisation had an Incident Control Centre and the availability of Personal Protective Equipment was monitored and tracked. Reassurance was given that at all times staff were provided with the required equipment and the correct safety procedures were carried out.

(vii) The biggest problem had been a lack of data regarding the spread of Covid-19 locally and it was important for any future outbreaks that more data was received so that the local NHS could prepare appropriately. A data cell had now been put in place which would hopefully improve data sharing. In response to a request from a member the CCGs agreed to give consideration to whether a service recovery dashboard could be published where data from different organisations could be made available in one place for the public to view.

(viii) The work of NHS staff had been commendable and many staff members had gone above and beyond their duties. Care was being taken to monitor the wellbeing of staff and ensure that their mental health was looked after.

(ix) With regards to the mental health of the general public, the mental health urgent care hub had been put in place which provided a direct phone number for mental health support, and the feedback regarding this service had been positive. LPT would provide an update to a future meeting of the Committee regarding the mental health transformation plans.

(x) A member from Rutland raised concerns regarding a lack of public briefings from the NHS.

(xi) A decision had just been made by local NHS management to restart the recovery process in order that non-covid related treatments could be made but care was being taken not to put staff at risk.

(xii) Planning for winter 2020/21 had already begun and was being led by the Chair of West Leicestershire CCG Professor Mayur Lakhani. As part of this planning,

consideration was being given to ensure there was sufficient capacity to provide influenza vaccinations.

RESOLVED:

(a) That the update from the Director of Public Health regarding the spread of Covid-19 in Leicester, Leicestershire and Rutland and the Health Protection Restrictions in place in Leicester be noted with concern;

(b) That the update on the Leicester, Leicestershire and Rutland NHS response to Covid-19 be noted, and that NHS staff be thanked for their work in responding to the Covid-19 pandemic.

(c) That a further report on the full impact of Covid-19 on the NHS in Leicester, Leicestershire and Rutland be brought to a future meeting of the Committee.

29. Prior Year Adjustment to UHL Trust Accounts.

The Committee considered a report of University Hospitals of Leicester NHS Trust (UHL) which provided an update regarding a prior year adjustment which had to be made to UHL's accounts due to a misstatement in the previous year's final accounts. A copy of the report marked 'Agenda Item 8', is filed with these minutes.

The Committee welcomed to the meeting for this item Rebecca Brown, Acting Chief Executive, UHL and Jonathan Shuter, Deputy Chief Financial Officer, UHL.

Arising from discussions the following points were noted:

(i) The misstatement in the end of year accounts was believed to be the result of an under reporting of expenditure and an over reporting of income but investigations were still ongoing to establish the full reasons for the misstatement. Grant Thornton had been the auditors of UHL for the 2019/20 financial year which was why Pricewaterhouse Coopers (PwC) had been appointed to carry out the investigations. It was not known when PwC would complete their investigations and publish their report. The investigations so far had reviewed the accounts of the previous 3 years and found that the accounts for the previous 2 years required adjusting. Indications were that once the investigations had been completed the prior year adjustment was not likely to be greater than the £46 million which it was currently set at.

(ii) UHL was not expecting to be fined as a result of the misstatement in the accounts but the Trust was likely to receive increased support and oversight from the regulators.

(iii) In the meantime measures had been taken to improve the financial governance and controls at UHL, improve the culture around finance by providing training and staff development, and focusing on financial sustainability.

(iv) In response to concerns raised by a member, reassurance was given that NHS Boards would usually have at least one non-executive member with financial expertise.

RESOLVED:

(a) That the update regarding the prior year adjustment to University Hospitals of Leicester NHS Trust accounts be noted with concern;

(b) That University Hospitals of Leicester NHS Trust be requested to provide a further update to the Committee once Pricewaterhouse Coopers have published the report of their investigation into the Trust's underlying financial position.

30. UHL Acute and Maternity Reconfiguration.

The Committee received an oral update from University Hospitals of Leicester NHS Trust (UHL) regarding the Acute and Maternity Reconfiguration plans.

The Committee welcomed to the meeting for this item Rebecca Brown, Acting Chief Executive, UHL and Mark Wightman, Director of Strategy and Communications, UHL.

Arising from discussions the following points were noted:

(i) UHL had not yet received the £450 million Government funding which they had been awarded for the reconfiguration plans but were confident that the money was forthcoming. It was hoped that the public consultation on the plans would take place in August/September 2020.

(ii) The Covid-19 pandemic had reassured UHL that its reconfiguration plans were the correct approach. At the peak of the Covid crisis 82 patients had required a ventilator and having two Intensive Therapy Units in LLR would have meant that demand could have been managed much better. At the start of the pandemic children's heart surgery had to be transferred from Glenfield Hospital to Birmingham because additional capacity for adults had been required in Leicester, Leicestershire and Rutland (LLR). Had there been a children's hospital in LLR then the children's heart surgery would not have been required to move to Birmingham.

(iii) At the previous Committee meeting a briefing document for the public which summarised all the information already in the public domain regarding the proposals had been requested by members. This document had not yet been put together but would be produced in the near future. Members now asked that the briefing document include any changes made to the reconfiguration proposals as a result of the Covid-19 pandemic.

RESOLVED:

(a) That the lack of progress regarding the University Hospitals of Leicester NHS Trust acute and maternity reconfiguration plans be noted;

(b) That University Hospitals of Leicester NHS Trust be requested to attend a future meeting of the Committee as part of the consultation process for the acute and maternity reconfiguration proposals.

10.00 am - 12.20 pm
03 July 2020

CHAIRMAN

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Agenda Item 8

Leicestershire Partnership NHS Trust

University Hospitals of Leicester NHS Trust

Caring at its best

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

LEICESTERSHIRE, LEICESTER AND RUTLAND HEALTH OVERVIEW AND SCRUTINY COMMITTEE – 23 SEPTEMBER 2020

UPDATE ON COVID - 19

LEICESTER, LEICESTERSHIRE AND RUTLAND NHS RESPONSE

Introduction

1. Members will be aware that a detailed joint update from the three CCGs, University Hospitals Leicester NHS Trust (UHL) and Leicestershire Partnership NHS Trust (LPT) was provided to the Committee at its 3 July 2020 meeting.

2. The report described the extensive actions taken in the local NHS to ensure we were prepared to respond to the anticipated pressures including pausing or adapting some services and taking action to increase capacity within the local NHS.

3. The paper also set out details of action being taken to recover and restore non-COVID services.

4. Part 1 of this paper provides members with an update on specific topics as requested by them. These are: PPE, winter pressures, Student Nurse 2017 intake and Cancer performance and Part 2, details of the Phase 3 response, announced on 31 July 2020.

Part 1

Cancer metrics (Appendix 1)

5. The Covid-19 pandemic meant that UHL resources that would usually be used for cancer diagnostics and treatment were required to respond to the challenges presented by coronavirus. The priority for UHL was to keep patients safe, balancing the risk of covid-19 against the urgency of investigations and surgery. The reduction in capacity required many tumour sites to amend their

pathways following national, regional and/or specialist society protocols and guidelines when available. In some cases this facilitated and/or expedited service transformation already proposed or planned. To ensure governance and Trust oversight, all changes were reviewed at a cancer governance cell that met weekly. In addition, as specified by national guidance, all patients awaiting treatment were categorised with regards to the urgency of proposed treatment and the allocation of surgical resources was made based on this categorisation.

6. For some patients, demographic or underlying health status meant that the risks of treatment outweighed the potential benefit of diagnostic or treatment procedures for cancer. Other patients chose to avoid attendance at hospital. The latter was responded to by the use of virtual consultations which became the preferred method of communication with all patients and between staff whenever possible. The capacity and demand issue was partly mitigated by the fact that, in the community, patients were not presenting with symptoms to their GP and 2-week-wait referrals decreased. As per national guidance, patients fulfilling the criteria for 2-week-wait referral for potential cancer were referred by the GP even if they were unsuitable to progress through the pathway due to the implications of Covid-19 but were safety netted within UHL.

7. During peak-COVID, there were delays to treatment and diagnostics and we ensured that every patient had a contact so we could keep in touch and support patients when they needed it. We have also implemented a robust harm review process which will ensure that every patient who was delayed as a result of COVID (where National guidance was not followed), and for every patient treated over 62 days, an MDT harm review (physical harm) is completed.

8. UHL capitalised on changes that were required as a result of COVID which were made at a faster pace than we have seen previously; as such we have seen a faster recovery of cancer performance and in most areas we are ranked well against our peers and nationally. We have more to do to improve performance against the 31 day surgery target which has been slow to recover due to surgery capacity which has decreased due to PPE and down-time required between cases; and also to recover screening (bowel and breast) as the programmes were halted nationally during the pandemic and re-started in August.

9. Referrals are now back at pre-pandemic numbers and the backlog of patients (those waiting over 62 days) is also at pre-pandemic levels and continuing to fall.

PPE

10. National monitoring of PPE supplies has indicated there are no significant concerns with availability. As a result, following discussions with Local Resilience Forums (LRF), local authority representatives and procurement teams regarding emergency PPE supplies the Department of Health and Social Care (DHSC) will be terminating the current emergency supply channel of PPE to LRFs via the Ministry of Housing, Communities and Local Government (MHCLG) by 12th September.

11. To facilitate this transition the PPE portal (that supported small domiciliary and residential CQC registered providers with free PPE to support the Covid response) has been extended to support a wider cross section of the health and social care system and further work is being undertaken to widen its remit. (more details below on the PPE Portal) .

12. The LRF for Leicester, Leicestershire and Rutland made the decision that it wanted to retain responsibility for the administration of free emergency PPE and has put into place new arrangements to ensure that services not supported by the PPE portal, will continue to have access to essential items. Information has been circulated across the three local authority areas and is now live.

13. Work is now in train to ascertain the level of stock required to ensure the on-going supply via the Department of Health and Social Care (DHSC).

14. The stock is currently being held at a central location and the picking and onward distribution/collection of any orders is being facilitated. There is also a ring-fenced supply being held to support any response to a second wave or local spike in infection that may warrant additional PPE provision.

15. We have no concerns regarding current stock levels, but these are continuously monitored and reported to the LRF PPE Group. The system was established when the MHCLG required weekly Delta returns and will be maintained going forward to mitigate any risk.

PPE Portal

16. The DHSC has partnered with eBay, Clipper Logistics and Royal Mail to develop this service, with orders managed in line with Public Health England (PHE) guidance and wider availability from the NHS Supply Chain's central PPE logistic operations. It went live to this widened cohort on 1st September 2020.

17. The PPE portal is an emergency top-up system and the expectation is that services will continue to use their business-as-usual and wholesaler routes to access PPE and should only use the PPE portal for additional PPE if needed.

18. The PPE Portal can be used by the following services. Each category of service has a weekly order limit:

    - GPs
    - residential social care providers
    - domiciliary social care providers
    - pharmacies
    - dentists
    - orthodontists
    - optometrists
    - children's care homes and secure homes
    - children's residential special schools

19. Turnaround of orders is within a 48 to 72 hours depending on when orders are received. All PPE ordered from the portal is free of charge.

LRF Buffer Stock

20. We have received additional PPE which we have 'ring-fenced' as a buffer stock, to provide resilience in the case of a local spike or a temporary disruption to one of our usual supply routes. Arrangements are in place to replenish the buffer stock quickly if necessary.

LRF PPE Supply

21. The current supply route via the Ministry of Housing, Communities and Local Government (MHCLG) into LRFs will end by the 12th September and will be replaced by a similar arrangement managed by the DHSC. However, this LRF stock can only be allocated to service providers not eligible for the Portal (see above) and to provide the full Covid-19 PPE requirement, above business as usual (BUA) use. This second point is a change to current provision and will need further work with LRF partners to implement.

22. In support of this change the DHSC has asked LRFs to provide detailed modelling, demand/forecast information and logistics - drop-off/delivery points and storage capacity and this is being progressed through the LRF PPE Group.

23. The following is a list of eligible service providers:

    - Local authorities (including children and adult social care workers);
    - Mental health community care;
    - Personal assistants;
    - Domestic violence refuges;
    - Rough sleeping services;
    - All education (and childcare) services – including special schools.

24. There is a recognition however, that the range of services that have been using the current emergency stock will not have access to the PPE Portal. The DHSC seems comfortable for the LRF and LAs to make a judgement but have asked that such services should:

    - provide a health and social care service;
    - have a clinical need for the PPE;
    - use PPE in line with clinical guidance.

25. The PPE supplied via this route will be provided free of charge by DHSC until 31 March 2021.

Local Authority PPE and PPE support

26. Each local authority has arrangements in place to support its own services and the wider health and social care market. The arrangements that each authority

has or has had in place vary, but reflects the difficulty that has been faced in finding PPE that is safe and meets the required quality standards. Price has also been a significant issue across all provision.

27. The introduction of new guidance and its interpretation has also been a challenge, but has also led to significant collaborative/partnership working.

28. A good example concerns aerosol generating procedures (AGPs) where local authorities, procurement teams, trading standards, CCGs, NHS Commissioning and the Fire Service came together to support a FFP3 Fit testing programme (using LRF stock) for staff undertaking these procedures for adults and children. These staff and personal assistants work in nursing and care homes, in the community supporting people/children on personal health budgets and in special schools. Further work is now underway to establish a sustainable model going forward.

Winter Planning

29. Health and social care organisations plan for seasonal pressures on an annual basis, particularly focussing on the period between November - March, when seasonal illness predictably leads to an increase in presentations to health care, attendances at Emergency Departments and admissions to hospital as well as having an impact on the workforce as a result of increased sickness levels. This year, winter planning is being impacted by our escalated response to COVID-19.

30. Winter planning for 2020/21 brings with it added complexities, due to:

- the likelihood of further outbreaks of COVID-19
- an expected increase in non-elective activity pressures due to seasonal illness
- reduced capacity as a result of cohorting patients and staff, and enhanced infection prevention and control requirements
- the need to restore elective activity and deal with a growing back log of routine and planned care

31. Winter planning is being overseen by the LLR Urgent and Emergency Care (UEC) Cell, which is part of the Health Economy Tactical Command arrangements for the COVID incident. The Cell has absorbed some of the functions of the former Accident and Emergency Delivery Board, and includes senior representatives from all health and social care organisations in LLR.

32. The winter plan for 2020/2021 is an integral part of the Health Economy's Phase 3 response to COVID, setting out how we will respond to winter pressures while also managing the restoration of services and dealing with the ongoing presence of COVID infections within the community and health and social care services.

33. Key risks for winter are:

- Increasing attendances at ED, causing overcrowding, capacity issues and poor flow;
- Ambulance handover delays as a result of the high levels of activity or lack of beds to admit patients from ED, resulting in slow ambulance response times and unseen patient risk in the community;
- Pressures on emergency medicine beds and slow flow, causing outliers, elective and cancer cancellations and patients waiting for beds in ED, with the associated performance and safety impact that creates;
- Staffing gaps compromising patient care.

34. Plans for winter pressures are being developed in conjunction with plans for the next phase of the COVID pandemic, and form part of a single plan for how the LLR system will manage the restoration of routine activity alongside the management of winter pressures and the additional pressures arising from COVID.

35. We have developed a LLR surveillance group which monitors a range of metrics in real time including COVID infection rates and both COVID and non-COVID related activity levels, in order to establish the level of pressure that the system is under and assess the likelihood that increases in COVID activity will put pressure on the system's ability to maintain levels of care. The alert level recommended by this group informs actions across the system and is updated weekly, or more often if intelligence indicates that COVID levels are rising rapidly in any part of the LLR system.

36. We will maintain existing, effective methods of managing the urgent care system and responding to different levels of pressure on a day to day basis. This includes daily system calls to review the escalation level in both individual organisations and the system and to agree any actions to de-escalate from higher levels of response and to provide cross system support to maintain effective flow. The UEC cell maintains senior oversight of system actions to respond to pressures and maintain performance and patient safety, meeting weekly.

37. The system surge and resilience plan has been refreshed for winter, to reflect additional triggers related to COVID outbreaks and to incorporate additional surge capacity and actions to maximise system capacity and resilience that have been developed by system partners. This reflects the learning from the first phase of the pandemic about additional COVID related actions as well as having a stronger focus on actions in the wider system to maintain flow.

38. The draft winter plan includes a number of initiatives to increase capacity and manage demand effectively to mitigate the risks above. They include:

- Increasing capacity for urgent telephone and face to face contacts to restore the range of service locations previously in place before COVID. During the emergency response to COVID in March and April, a number of sites were temporarily closed in response to the dramatic reduction in face to face activity. In addition, access arrangements were made in sites

offering walk in access to put in place triage and COVID screening (including calls to NHS 111) before patients were seen face to face. This is to ensure that we are identifying and keeping separate those patients with suspected or confirmed COVID, to protect other people from risk.

- It is proposed to continue to deliver separate 'hot' clinics for patients who have either confirmed or suspected COVID and need to be seen urgently, in addition to the existing urgent care sites across LLR. The model of delivery is currently being reviewed and may change from the current two sites in LLR (Loughborough Urgent Care Centre and New Parks Clinic) to a more dispersed model over the autumn and as we go into winter.

- Strengthening the service delivered through NHS 111 to make sure that patients are seen in the right place at the right time, aiming to reduce unnecessary attendance and crowding in emergency departments and other site. A separate report on this has been provided to JHOSC.

- More support for care homes and East Midlands Ambulance Service crews responding to patients in care homes, with on call specialist consultant advice to agree the right approach to care and to keep patients in their place of residence wherever possible.

- Investment to increase capacity in the Home First service, to recruit more community nurses, therapists and social care staff. This will support us in speedier discharge of patients, meeting new discharge guidance requirements, and avoiding admissions where patients can be kept at home with increased support through a crisis.

- Increasing bed capacity in University Hospitals of Leicester to care for the expected numbers of additional admissions over winter. An additional 75 winter beds are planned.

- Availability of 36 'surge' beds in Leicestershire Partnership Trust which could be opened in case of a significant second COVID surge, or unmanageable winter pressures, conditional on staffing.

- Work with the three Universities in LLR to communicate the right access routes to healthcare to students including access to testing, encouraging GP registration and promoting wellbeing and mental health.

- Plans for flu vaccinations. Health and social care partners plan a large scale flu vaccination campaign each year, which is more important than ever this year as we need to minimise the impact of influenza alongside COVID. The flu vaccine remains one of the best defences available against flu however the delivery of this year's programme is going to be more challenging because of the impact of COVID-19. This includes flu vaccinations taking longer because of the need to observe social distancing rules and the need for clinicians to change personal protective equipment (PPE). The expansion of the programme to an increased number of eligible groups such as people over 50 years, despite the plans for phased approach, also creates practical challenges around vaccine supply and storage. This year we are aiming for 75% coverage of at risk

groups and 100% offer of the vaccine to front line health and social care workers. The vaccination will be delivered by GP practices, pharmacies and by health care providers to their front line staff.

- Preparing for mass COVID vaccinations. Although we do not yet have confirmation of when a vaccine will be made available, NHS systems have been asked to work up plans for COVID vaccination on the basis of this being available before Christmas. The COVID-19 pandemic poses a specific set of challenges to achieving high volume through-put when vaccination becomes available. NHS England and NHS Improvement are exploring options for delivery and further information will be made available as this becomes known.

- The system has developed a strengthened workforce plan in response to COVID which includes mutual aid between organisations and effective monitoring of the workforce situation across health and social care. The workforce group has developed plans to support care homes as a vital part of the health and care system

Student Nurse 2017 cohort

39. Mrs. A. Hack CC submitted a question to the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee meeting on 3 July 2020 regarding the Student Nurse 2017 cohort. The response from UHL was as follows:

    - Across UHL, we have approximately 100 finalist student nurses and midwives from the 2017 cohort who volunteered to become an aspirant nurse at the beginning of the COVID-19 outbreak in England. Some of the Aspirants are from other universities across England who have chosen to complete their training in Leicester to be nearer to their families during the pandemic. All Aspirant nurses are being paid a Band 4 salary.

    - We also have 80 x 3rd year finalist students who chose not to be an aspirant nurse or midwife but wanted to have an extended paid placement in UHL. They are being paid a Band 3 salary.

    - At the beginning of the COVID outbreak, Health Education England, (HEE) believed that the extended paid placement initiative would be for six months and this was communicated to universities and students. However in UHL we gave all of our students (and all the NHS Bring Back Scheme volunteers) a three month fixed term employment contract in UHL that would end on July 31st 2020. This was a pragmatic decision because of the unpredictable nature of COVID. It is always easier to have a shorter contract that can be extended rather than bringing a longer contract to an end with little notice to an individual (which may be the case elsewhere in the UK).

    - However, HEE announced on Friday 26th June that these paid placements could now continue for six months as per their original

decision. Locally, we will now extend contracts until the 31st August so as of the 1st September the students will revert back to full supernumerary status in order to complete their training. Our finalist students at DMU should complete their training on the 20th September and many have secured jobs in UHL so we will make sure they are supported to complete their programme in the best way possible.

- HEE and NHSI/E agreed that students who chose to continue their placements during the pandemic should have an NHS contract and be reimbursed for their time working on wards. This is because as an NHS employee students would benefit from the COVID legislation around statutory sick pay which would give them the same protection as existing NHS employees should they contract COVID whilst working in the NHS and as a result, become very ill (or in the worst case scenario, die as a result of COVID so, family becoming eligible to receive death in service payment). The salaries for students are being paid for by NHSI/E. Many students across the UK may have given up part-time employment thinking they would be receiving a band 4 salary for six months and this has caused distress to the students. This is not the case we believe, in LLR.

- However, when the contract ends on August 31st the students will no longer be an NHS employee or be remunerated for the remainder of their training (they should still receive their bursary) but they could still contract COVID but will be no longer eligible for benefits. So, we now await a decision from the Council of Deans who are working with NHSE/I, regulatory bodies, HEE and DoH to agree what needs to be in place that will support students appropriately. The final decision lies with the Department of Health and Social Care under the direction of the Secretary of State.

- In relation to the point about “we have 500 vacancies in UHL” and using our students to support this position, we actually have circa 400 RN vacancies in UHL but we cannot use our students as qualified nurses and the most important thing is that we support them to complete their training.

40. The updated position with regards to the student nurse 2017 cohort is as follows:

- All ‘paid’ placements came to an end on the 31st August. As of the 1st September 2020, students returned to ‘normalised’ unpaid placements and in the event of contracting COVID-19 will be covered by a new NHS and Social Care Coronavirus Life Assurance (England) Scheme. (Subject to confirmation that they contracted the virus whilst on placement)

- This scheme provides additional financial protection for frontline staff who are employed to deliver care for people and work in environments that carry an increased risk of contracting coronavirus (COVID-19). The scheme will deem

unpaid medical and other healthcare students eligible to claim from the scheme in the event that a student contracts COVID-19.

- As a Trust, we are working with the Universities to ensure our students are ready for their placement by continuing to provide additional infection prevention education and training, personal protective equipment (including individual respirator hoods if students have their placement in ITUs and theatres) and full supervision in the clinical areas.

Supporting the mental health and wellbeing of NHS staff

41. Prior to COVID we had made good progress in respect of working collaboratively on Health and Wellbeing, including providing a comprehensive programme of events, for our people, centred around Mental Health First Aid.

42. During COVID the LLR system has worked effectively to support our people and their health and wellbeing working in collaboration with regional and national NHSI/E and Adult Social Care Health and Wellbeing Teams. Across the LLR system we are doing some amazing work to support staff Health and Wellbeing, enhanced by national NHSI/E and Adult Social Care Health and Wellbeing comprehensive offers. Working closely with system, regional and national partners, we are:

    - Highlighting areas of need where provision is variable, absent or needs scaling at a system level – many private sector organisations and charities have agreed support packages with the National Health and Wellbeing Team and as a system we are targeting those to the areas of greatest need and avoiding duplication

    - Supporting the development of a system-wide Health & Wellbeing Board best practice resource – together setting out what 'good' looks like in relation to restoration and recovery

    - Providing a conduit of original, innovative practice for scaling up at system, regional or national level - sharing some fantastic and inventive ways to support staff at this time and sharing the learning as quickly as possible

43. We send out fortnightly communications across LLR in sharing resources and best practice across the system, utilising internal communication channels.

44. Across social care we have specifically been targeting interventions across care homes and supporting the Personal Assistants (PA) workforce across the system. The PA workforce in LLR is estimated to be close to 10% of the Adult Social Care workforce, which itself is over 30,000 staff across LLR.

Where we want to be

45. We are totally committed to working together to improve the experience of our people across our system. Ultimately, we want to become the best place to

work for all: –one team that brings out the very best in each other. Wellbeing is our business and our priority - we will keep our staff safe and healthy and maintain safety of the population we serve

46. An action plan has been created including the flowing activities focussed on the health and wellbeing of staff:

- All organisations to identify a Well Being Guardian;
- Present a proposal for setting up a system wide Resilience Support Hub working with the regional HWB Team;
- Implement Health and Wellbeing conversation for all staff;
- Implement Health and Wellbeing Champions Network across the System with initial focus on Adult Social Care;
- Increase health and wellbeing education/awareness raising through provision of a range of system wide events and interventions;

Part 2: Phase 3 response to Covid - 19

47. The NHS and partners across LLR have continued to work effectively as part of the Leicestershire and Rutland Local Resilience Forum (LRF) and through the Strategic Co-ordination Group (SCG) in response to the Covid-19 outbreak.

48. Andy Williams, the Accountable Officer for the three CCGs, currently chairs the SCG which continues to meet regularly to set strategic direction, coordinate the complex response across the partners and prioritise resources.

49. The focus has entirely been on doing what is best for our patients and public and ultimately to save lives by working in partnership through the multi-agency response structure.

50. We have achieved this through our continued effort and effective collaboration and partnership working both within the NHS and with other public, private and voluntary sector organisations and also through sheer determination and hard work.

Phase 3 NHS response to COVID-19

51. At the end of July 2020 NHS England issued guidance on the next phase of COVID-19 recovery and restoration requirements. The letter is at Appendix 2.

52. The letter sets out the context for Phase 3: falling inpatient numbers but the continued prevalence of Covid -19 in the community meaning it is a continued threat. The incident level was reduced from Level 4 national command and control to Level 3 local management of the incident through the incident management structures described above.

53. The current concern over the rise in Covid-19 cases in the community means we must remain vigilante and in a high state of alert for the potential impact on NHS services.

54. The guidance requires all NHS systems to develop a Phase 3 recovery and restoration plan which sets out how we will meet the requirements based on the following priorities:

- 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. As part of responding to this priority there is a focus on restoration of Cancer services. The letter explicitly states that systems must tackle unmet need and encourage people to come forward for referral for suspected cancer. Other services highlighted are primary care and community health services, mental health and learning disability and autism.

- Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally. Details of our winter planning are included above within this paper (Paras 24 – 33).

- 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.

The letter at Appendix 2 provides full details of the action needed within each of the priority areas above.

55. An early draft of the Phase 3 plan for Leicester, Leicestershire and Rutland was submitted on 3 September 2020 and more work is currently underway to refine and finalise this for 21 September 2020.

56. Representatives of the LLR NHS will be happy to attend a meeting of the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee to discuss our Phase 3 plan in more detail once this has been approved by the NHS England.

Appendices
Appendix 1 – Presentation slides on Cancer
Appendix 2 – Letter from Sir Simon Stephens dated 31 July 2020
Appendix 3 – Summary of Phase 3 Covid Response National Guidance

Officers to Contact

Andy Williams, Chief Executive, LLR CCGs
Email: Andy.williams12@nhs.net

Angela Hillery, Chief Executive, LPT
Email: Angela.Hillery@leicspart.nhs.uk

Rebecca Brown, Acting Chief Executive, UHL
Email: rebecca.brown@uhl-tr.nhs.uk

University Hospitals of Leicester NHS Trust

Caring at its best

HOSC
UHL CANCER UPDATE
SEPTEMBER 2020

Key achievements

NHS
University Hospitals of Leicester
NHS Trust

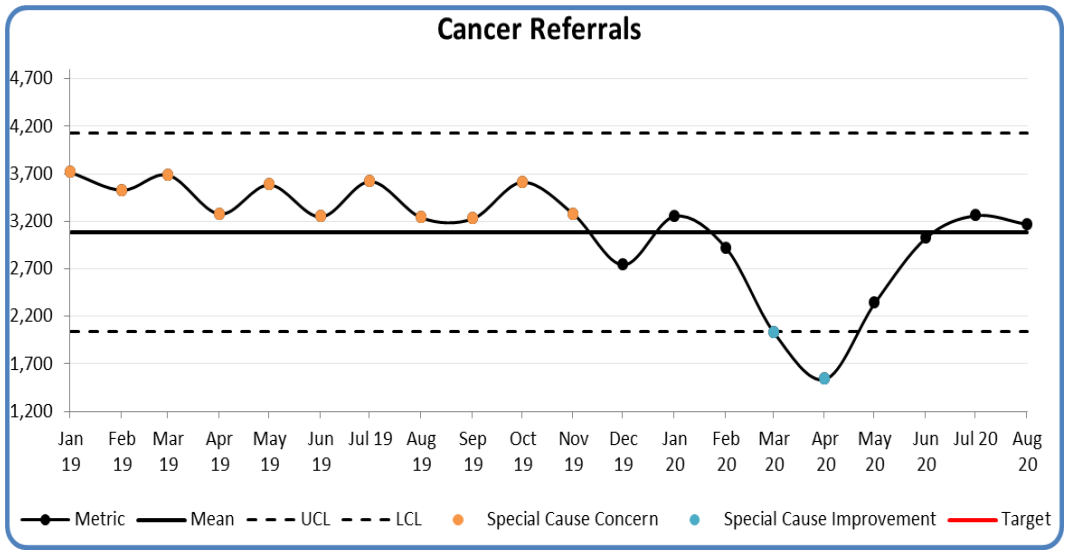
Caring at its best

- Increasing referral numbers
- Robust harm review process in place
- Clinical contact maintained with all patients
- All patients categorised against 4 priority scores ensuring most urgent are seen first
- All pathways reviewed and updated in line with National and Society guidance released during COVID
- Improved performance
- Pre COVID 62 day performance achieved
- Target of 20% reduction in 62 day backlog in 6 weeks set by NHSI/E achieved
- Decrease in 62 day backlog to pre COVID levels
- Decrease 104 day backlog
- Review of Rapid actions with all tumour sites to enable further recovery

2 WW Referral Recovery

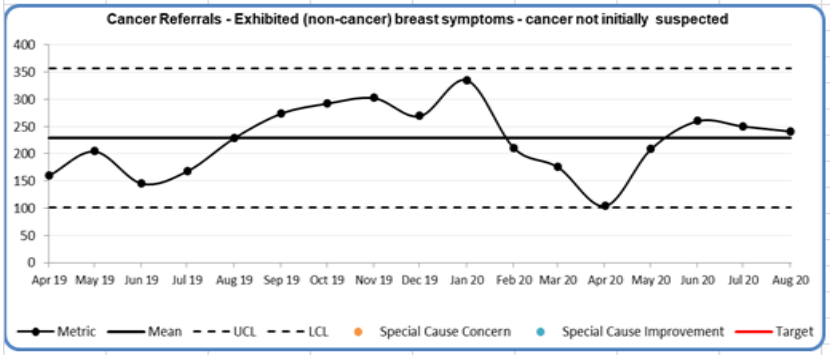
University Hospitals of Leicester NHS Trust

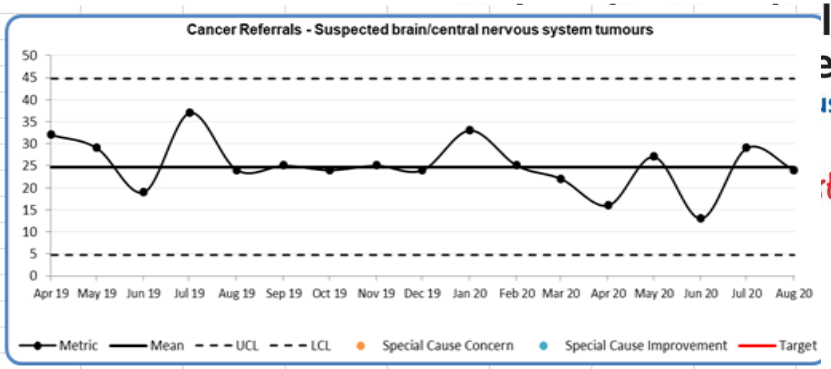
Caring at its best

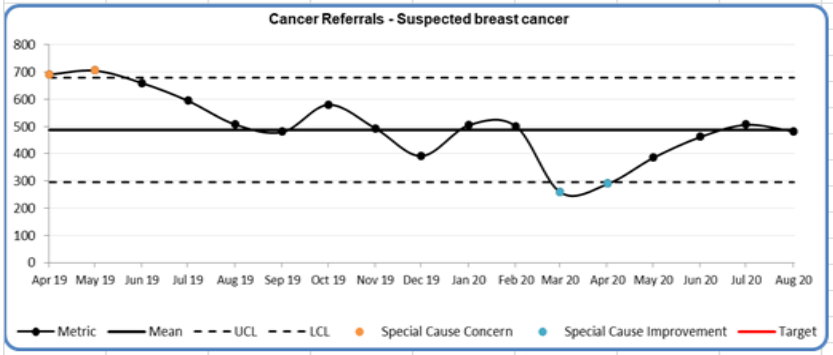


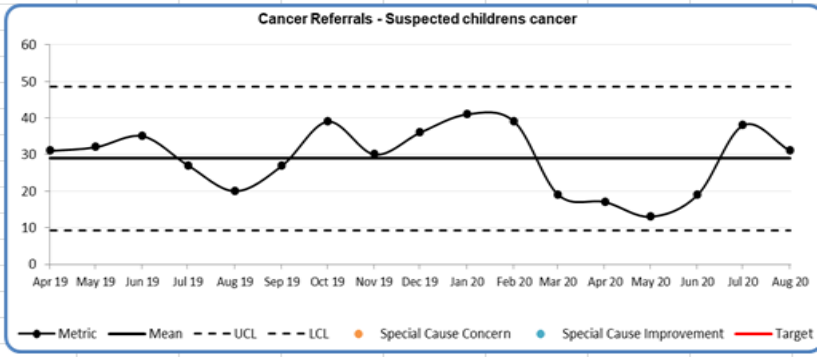
- Referrals have continued to rise month on month since April 2020.
- Currently approximately 200 a month below the same period last year.
- Fast tracked approval for NSS programme (funded by EMCA) currently seconding to posts with an aim to start in November. This will help pick up any patients that may have been delayed during COVID.
- We continue to communicate to the public and to primary care that cancer services are BAU and the measures we have taken to ensure we have done everything possible to reduce the COVID risk.

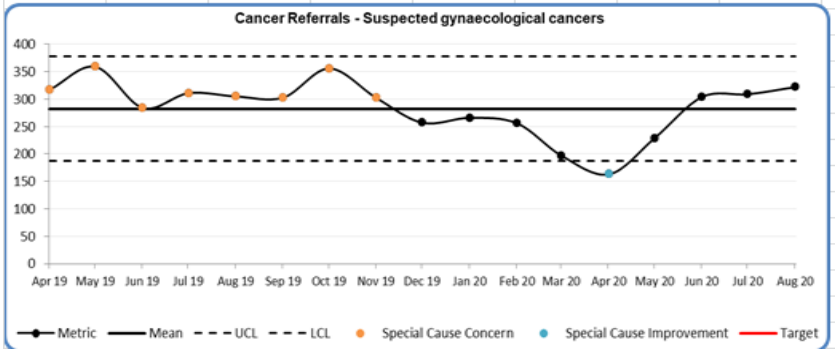
2WW Recovery by tumour site

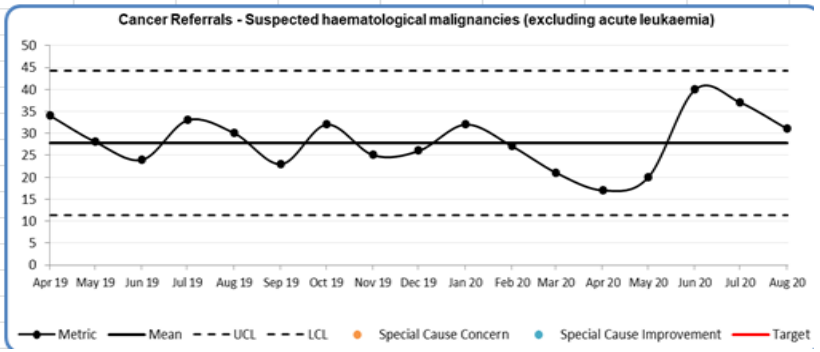




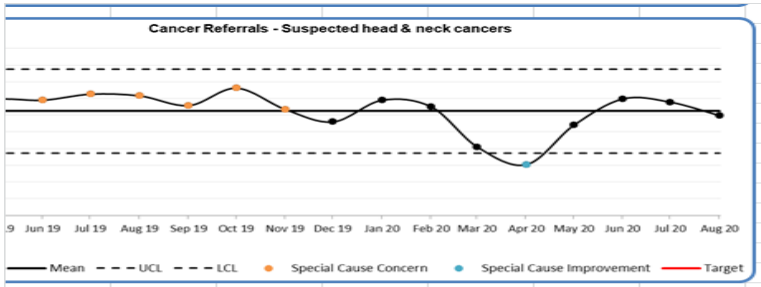


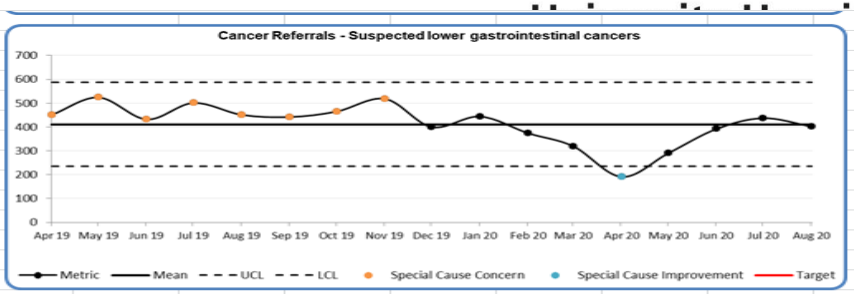


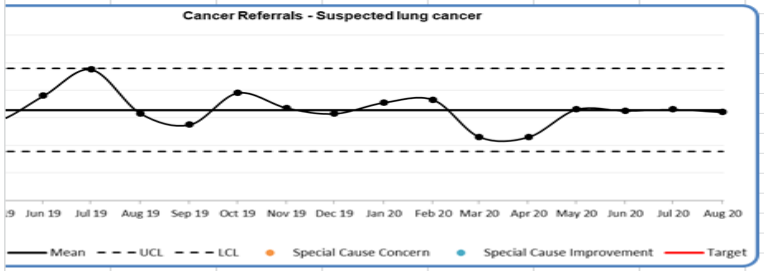


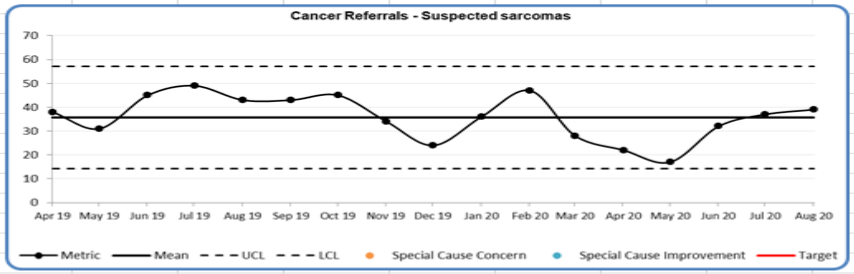


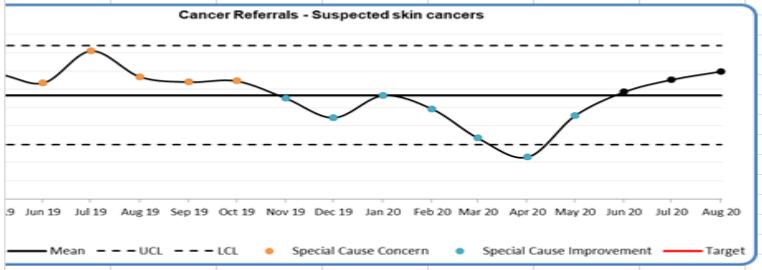
2WW Recovery by tumour site

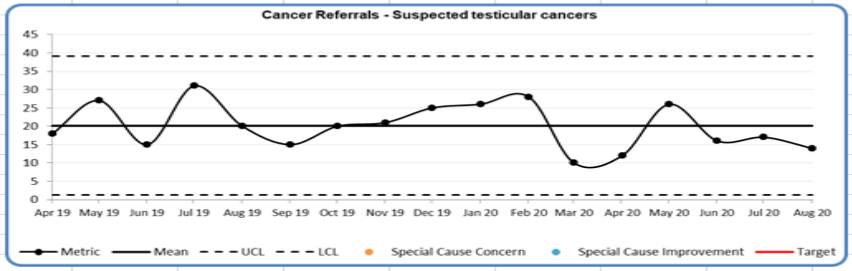


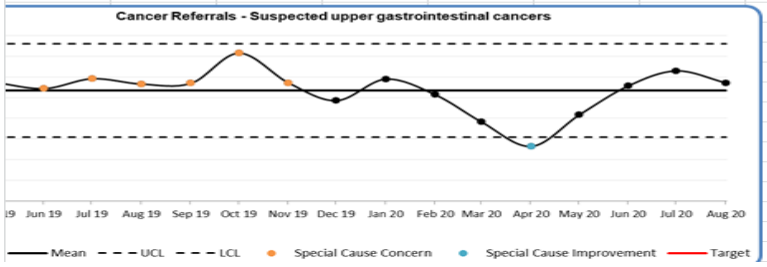


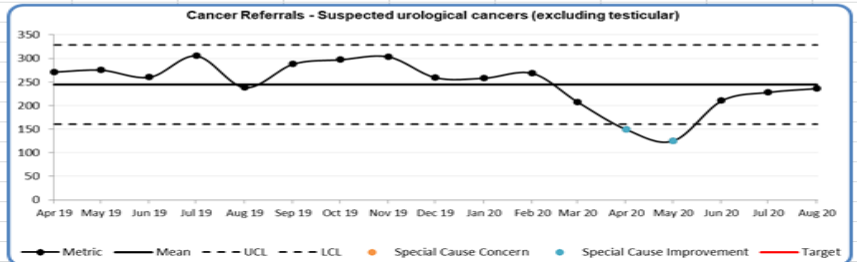




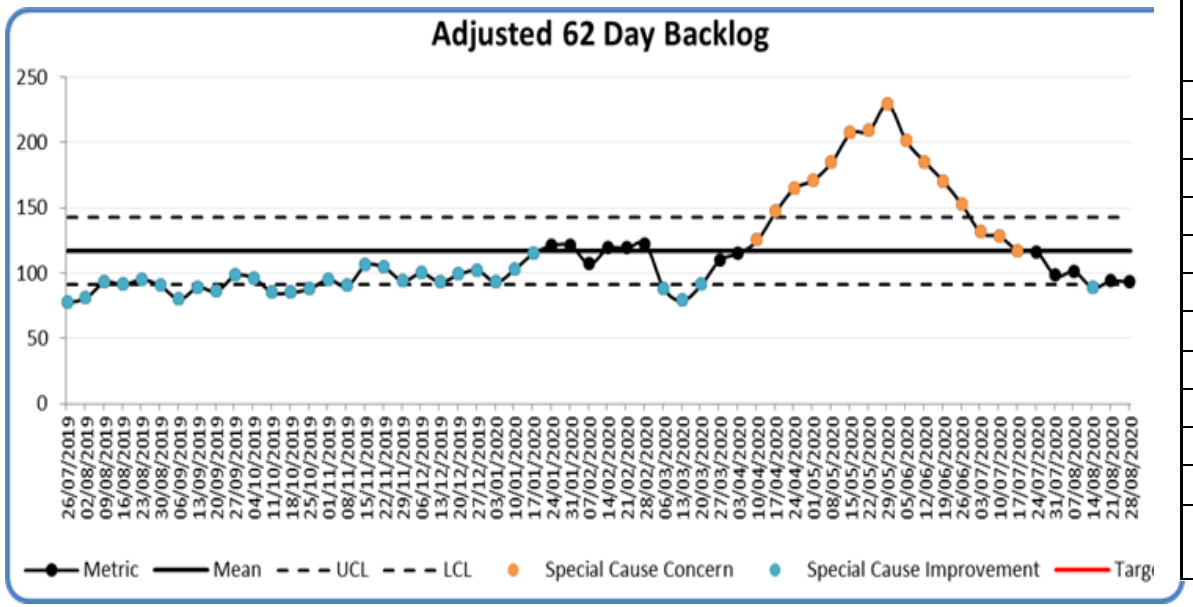








62 Day recovery



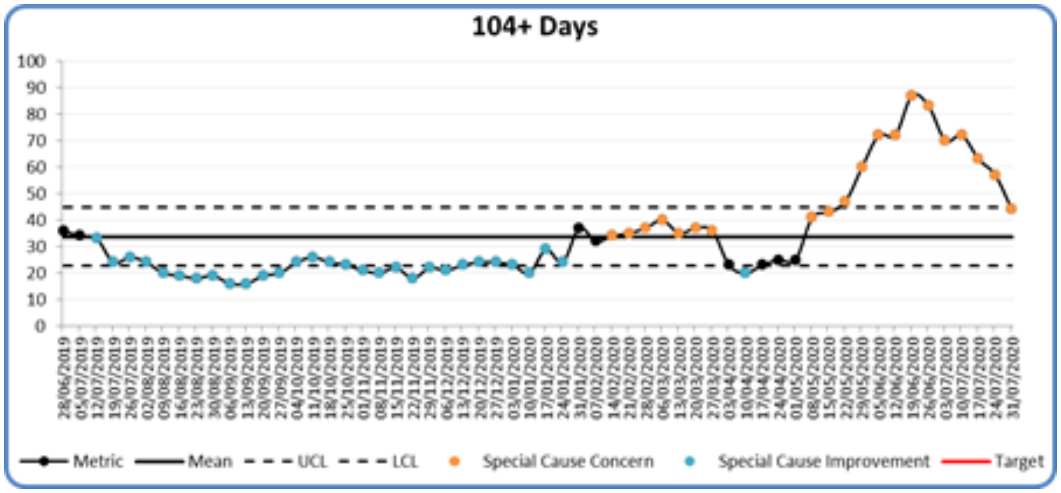
Tumour Site	Target Non Adjusted	Actual	Trend
Haematology	0	1	
HPB	2	5	
H&N	4	9	
Lower GI	6	15	
Upper GI	1	8	
Urology	15	41	
Skin	1	2	
Breast	2	9	
Sarcoma	0	0	
Lung	8	3	
Gynae	8	6	
Other (eg CUP, Brain)	0	1	

Backlog week ending 28th Aug. Trend based on previous week's position, amber = no change.

- Significant reduction in backlog due to CMG prioritisation and focus as well as a reduction in referrals during COVID
- The backlog is at pre COVID levels and we aim to decrease further where possible
- Delays include patient choice, process delays and capacity delays; all of which are being actioned to decrease delays where possible

One team shared values

104 Day recovery



Service	LLR	Tertiary	Patients with a treatment date confirmed
Breast	3	1	1
Lower GI	1	0	0
Head & Neck	0	0	0
Lung	0	0	0
HPB	2	0	0
Haematology	1	0	0
Skin	0	0	0
Upper GI	0	0	0
Urology	14	3	7

Data for week ending 28.8.20

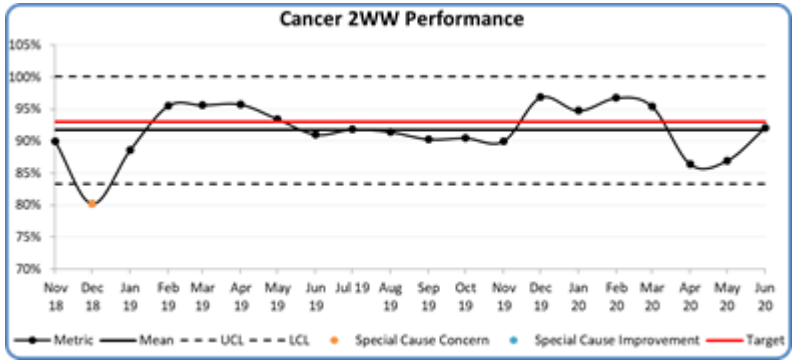
- 104 days excluding consultant upgrades split for LLR and Tertiary patients by tumour site
- Of the 25 patients, 10 have a confirmed diagnosis
- Of the remaining 15 patients without a diagnosis, 3 have TCI dates with the remaining either in the diagnostic phase or delayed pathways due to patient choice.
- There are 4 tertiaries in the 104 day backlog
- RAG rating added to indicate trend based on previous weeks reporting
- Daily updates, actions and chases led by DOI are in place for patients over 90 days

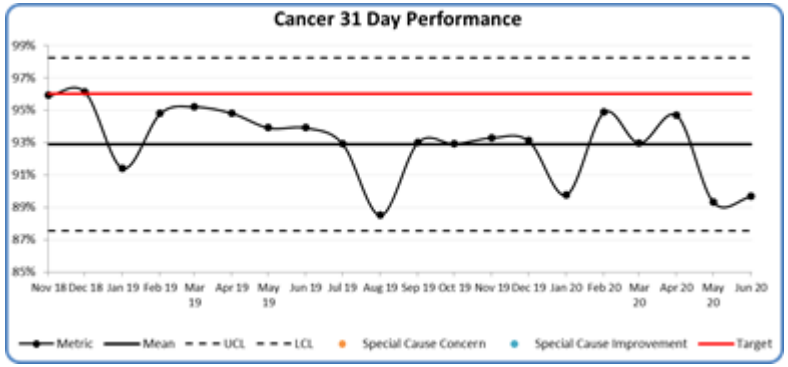
June Performance

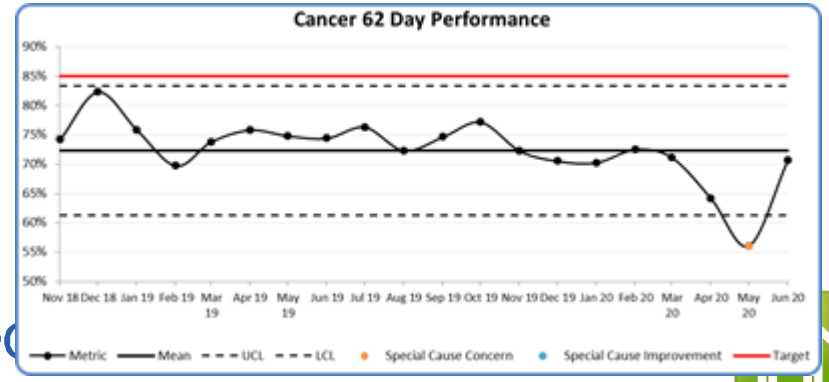
University Hospitals of Leicester NHS Trust

Caring at its best

Standard	Target	Position	Pts treated within target	Pt treated outside target
2WW	93%	92.1%	2253	194
2WW Breast	93%	96.3%	236	9
31 Day 1st Treatments	96%	89.7%	338	39
31 Day SUB Surgery	94%	70.5%	67	28
31 Day DRUGS	98%	98.9%	93	1
31 Day Radiotherapy	94%	94.4%	101	6
62 Day	85%	70.6%	151.5	63
62 Day Screening	90%	0.0%	0	15
28 Day FDS 2WW	75%	83.2%	1863	376
28 Day FDS Breast 2WW	75%	99.6%	237	1
28 Day FDS Screening	75%	2.6%	1	37







One team shared

July and August predicted performance

University Hospitals of Leicester NHS Trust

Caring at its best

Standard	Target	SCR Position July	SCR Position August
2WW	93%	89.7%	89.2%
2WW Breast	93%	97.7%	94.3%
31 Day 1st Treatments	96%	91.4%	88.1%
31 Day SUB Surgery	94%	68.9%	69%
31 Day DRUGS	98%	100%	100%
31 Day Radiotherapy	94%	100%	98.9%
62 Day	85%	71.5%	70.1%
62 Day Screening	90%	0	25%
62 Day Consultant Upgrades	N/A	80%	86.1%
28 Day FDS 2WW	75%	83.8%	81.6%
28 day FDS Screening	75%	31%	78.8%
28 Day FDS Breast	75%	99.2%	96.5%

- Data as of week ending 28.8.20
- Non validated position and is subject to change
- Screening programmes have restarted
- IS and Alliance being used as a priority for Cancer and urgent patients that meet their criteria (diagnostic and treatment)
- Chemotherapy and Radiotherapy are managing capacity
- Surgical capacity and endoscopy decreased due to COVID restrictions, but is recovering

Transformation

University Hospitals of Leicester NHS Trust

Caring at its best

- Transformation programme (against strategy) has been on hold during COVID

- Transformation as a result of COVID
  - Telephone appointments
  - Pathway changes eg decrease fraction times and frequency in radiotherapy
  - Capsule endoscopy
  - Use of hormones

- NSS plan

APPENDIX 2

Skipton House
80 London Road
London SE1 6LH
england.spoc@nhs.net

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

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

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

31 July 2020

Dear Colleague

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

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

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

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

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

Current position on Covid-19

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

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

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

NHS priorities from August

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

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

A. Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter

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

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

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

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

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

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

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

- To reduce unmet need and tackle health inequalities, work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels.

- Manage the immediate growth in people requiring cancer diagnosis and/or treatment returning to the service by:

  - Ensuring that sufficient diagnostic capacity is in place in Covid19-secure environments, including through the use of independent sector facilities, and the development of Community Diagnostic Hubs and Rapid Diagnostic Centres
  - Increasing endoscopy capacity to normal levels, including through the release of endoscopy staff from other duties, separating upper and lower GI (non-aerosol-generating) investigations, and using CT colonography to substitute where appropriate for colonoscopy.
  - Expanding the capacity of surgical hubs to meet demand and ensuring other treatment modalities are also delivered in Covid19-secure environments.
  - Putting in place specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment.
  - Fully restarting all cancer screening programmes. Alliances delivering lung health checks should restart them.

- Thereby reducing the number of patients waiting for diagnostics and/or treatment longer than 62 days on an urgent pathway, or over 31 days on a treatment pathway, to pre-pandemic levels, with an immediate plan for managing those waiting longer than 104 days.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B: Preparation for winter alongside possible Covid resurgence.

B1. Continue to follow good **Covid-related practice** to enable patients to access services safely and protect staff, whilst also preparing for localised Covid outbreaks or a wider national wave. This includes:

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

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

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

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

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

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

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

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

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

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

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

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

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

C1. **Workforce**

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

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

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

C2. **Health inequalities and prevention.**

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

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

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

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

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

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

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

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

Financial arrangements and system working

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

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

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

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

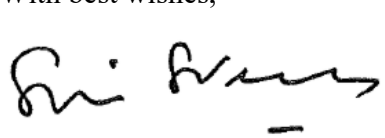
- Plans to streamline commissioning through a single ICS/STP approach. This will typically lead to a single CCG across the system. Formal written applications to merge CCGs on 1 April 2021 needed to give effect to this expectation should be submitted by 30 September 2020.

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

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

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

With best wishes,



Simon Stevens
NHS Chief Executive

Amanda Pritchard
NHS Chief Operating Officer

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

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

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

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

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

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

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

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

ANNEX TWO: REVISED FINANCIAL ARRANGEMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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APPENDIX 3

Phase 3 Covid Response National Guidance
Snapshot view

W: www.carnallfarrar.com
E: admin@carnallfarrar.com
T: 020 3770 7535

Accelerating the return of non-Covid services

Fully restore Cancer Services

- Restore the number of referrals for suspected cancer to at least pre-pandemic levels
- Ensure sufficient capacity in diagnostics and endoscopy, using the independent sector, community hubs and rapid access centres
- Expand capacity of surgical hubs to meet demand and deliver in a Covid secure environment
- Fully restart all cancer screening programmes

Recover maximum elective activity possible

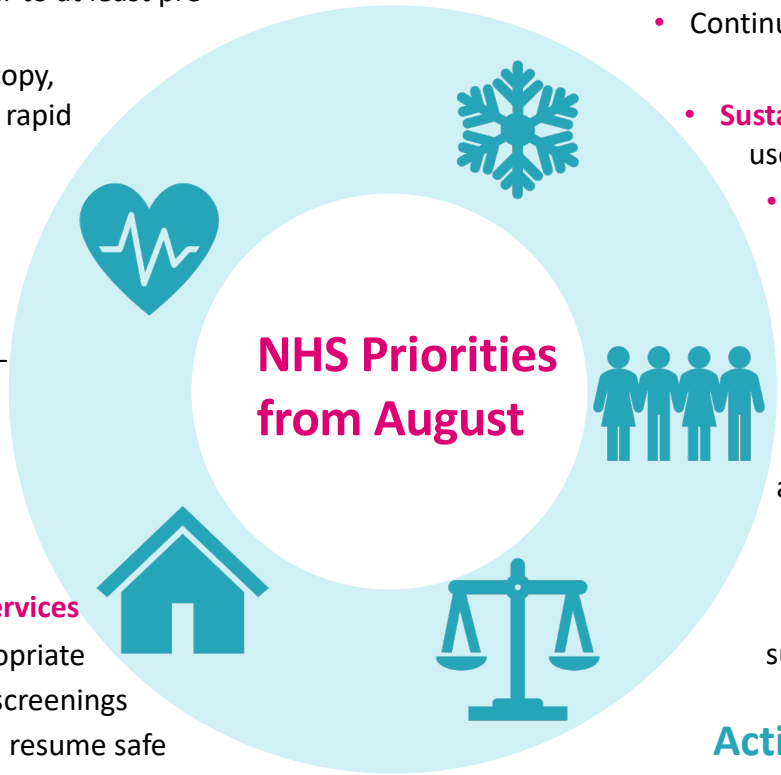
- Restore elective activity to between 90-100% of pre-pandemic levels by October
- Develop a week by week plan to optimise use of independent sector capacity
- Follow new streamlined patient self-isolation and testing requirements

Restore service delivery in primary and community services

- Restore activity to usual levels where clinically appropriate
- Address the backlog of immunisations and cervical screenings
- Enhance community services for crisis response and resume safe home visiting care for vulnerable patients that need it

Expand and improve mental health service

- Restore and expand services e.g. IAPT and 24/7 crisis helplines
- Validate system plans for mental health service expansion trajectories
- Continue to reduce the number of people with a learning disability in specialist inpatient settings by providing better alternatives and using Care and Treatment Reviews



Preparing for winter and possible Covid resurgence

- Continue to follow **good Covid-related practice** to enable safe access to services and protect staff
- Continue to follow **PHE infection prevention and control guidance** to minimise nosocomial infections
- **Sustain current staffing, beds and capacity**, and make use of independent sector and Nightingale hospitals
- Deliver an expanded **flu vaccination** programme
- Expand the **111 First offer** and maximise 'hear and treat' and 'see and treat' pathways for 999

Supporting the Workforce

- Deliver the commitments in the **NHS People Plan for 2020/21** including urgent action to address **systemic inequality** experienced by some of our staff including BAME staff
- Develop a local People Plan to cover the **expansion of staff numbers**, mental and physical support for staff, and setting out **new initiatives to develop and upskill staff**

Action on inequalities and prevention

- **Protect the most vulnerable** from Covid with enhanced analysis and community engagement to mitigate identified risk in the community
- **Accelerate preventative programmes** which proactively engage those at the greatest risk of poor health outcomes
- **Strengthen leadership and accountability** for tackling inequalities
- Ensure **data is complete and timely** to support understanding and response to inequalities

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Agenda Item 9

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

NHS

LEICESTERSHIRE, LEICESTER AND RUTLAND HEALTH OVERVIEW AND SCRUTINY COMMITTEE – 23 SEPTEMBER 2020

NHS111 First

REPORT OF LEICESTER, LEICESTERSHIRE AND RUTLAND NHS

Introduction

1. During the peak months of the coronavirus pandemic the number of people attending the Emergency Department at Leicester Royal Infirmary reduced significantly although more recently the number of people attending has begun to rise. At the same time, due to social distancing and infection prevention and control precautions, the capacity including physical space has significantly reduced.

2. The challenge of increased attendances combined with the reduction in available space means that the NHS system has to respond by reducing the number of patients using Emergency Departments (ED). This will be achieved by guiding the public to make the right healthcare choices to ensure their safety and the safety of others, as well as making sure they get the right treatment in the most appropriate place.

3. NHS111 First will:

   - Make it easier and safer for patients to get the right advice or treatment when they urgently need it; and
   - Increasingly, use booked timeslots/appointments for a service that is right for them.

NHS111 First in LLR

4. NHS 111 First refers to the development of the current NHS 111 service to offer patients and the public a different approach to the accessing healthcare. As a programme it means:

   - NHS 111 or your GP practice are the primary places to go when experiencing a health issue that is urgent but not immediately life threatening;

   - A move away from going to a physical location as the first choice to access healthcare (but not removing, when it is the most appropriate place to go);

- Embracing virtual assessment and the technology which supports it;

- Preventing nosocomial (hospital acquired) infection by ensuring patients do not need to congregate together in Emergency Department waiting rooms;

- Ensuring patients get a clear direction of what they need to do and where they need to go in order to resolve their issue; and

- Protecting those most at risk (e.g. shielded patients) by giving them an enhanced service.

5. Key features of the model are:

    - **Establishing NHS 111 to ED referral processes and booked appointments** to ensure EDs can plan ahead in the day to day running of their services and, potentially, smooth their intra-day attendance profile through the booking of patients referred by NHS 111 services;

    - **Establishing NHS 111 to Ambulatory Care Emergency Services referral processes and booked appointments** to ensure that patients presenting as an emergency can be diagnosed and treated on the same day with ongoing clinical support and supervision as required, without having to wait in ED first;

    - **Enhancing clinical triage through 111 and increasing alternative services suitable for direct booking via NHS 111 Services** such as (list not exhaustive):
        - Other secondary care specialties
        - Mental Health Services
        - Respiratory Services

6. Communications to the public will play a significant role in the successful implementation of NHS111 First. Through our communications we will:

    - Explain the developments and new arrangements to support NHS 111;

    - Raise awareness and promote NHS 111 as the first point of contact for Urgent care needs;

    - Promote the benefits of calling NHS 111 first: helping people get the right treatment at the right place; and

- Engage with patients to understand their experiences of the new system: use these insights to influence development of the model and how we communicate about the service to achieve long-term behaviour change of those who visit Emergency Departments for minor illnesses.

7. NHS 111 First is an important evolution of the current model of 111 and the principle of expanding clinical assessment to ensure people access the right service, first time. We will begin to launch some of the changes to 111 in LLR from the 28th September, and develop the 111 First model in a phased way over the coming months. The presentation to the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee on 23 September 2020 will summarise some of these key changes.

Appendix

Powerpoint slides to be shown on 23 September 2020.

Officer to contact

Tamsin Hooton, Assistant Director of Urgent and Emergency Care, LLR CCGs

Tel: 01509 567708

Email: Tamsin.Hooton@westleicestershireccg.nhs.uk

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NHS 111 First

Joint Health Overview and Scrutiny September 2020

Case for change

* During COVID attendances at Emergency Departments (ED) dropped dramatically in Leicestershire as well as nationally
* COVID infection control arrangements require the separation of COVID suspected and COVID negative patients, with separate staff teams
* Significant shift towards virtual consultations over the phone or video link, which has transformed the way that a lot of clinical care is provided
* Imperative to keep the public and staff safe as ED attendances start to rise again
* 111 First is a national initiative aiming to retain some of the positive changes achieved through COVID

111 First Initiative

* National initiative being rolled out at pace across the county before Christmas
* Extensive national engagement has taken place with Royal Colleges
* Has been piloted in Devon and London
* First Midlands system to go live Hereford and Worcester
* LLR is the East Midlands 'fast follower'
* Local engagement with stakeholders is beginning
* Soft Launch in the last week of September

111 First Objectives

* See patients in the right place at the right time, the first time.
* Avoid unnecessary face to face clinical presentation across the LLR system.
* Ensure appropriate clinical triage is provided to all patients whether they call or present at ED.
* Ensure ED is for emergency patients only and minimise over-crowding in the department.

Key principle: clinical triage before all face to face consultations

5 National Expectations

* Aim for 20% of 'unheralded' attendances at ED or urgent care centres to be re-directed elsewhere, either through calling 111 or by triage at the front door of the ED
* Increase the number of alterative pathways available directly through NHS 111, such as ambulatory and 'hot' clinics at hospital
* Enable direct booking from 111 into timed slots in ED
* A clear communication & engagement strategy, local and national messages
* Structured evaluation of outcomes and impact, national SITREP requirements

NHS 111 FIRST PROJECT

OBJECTIVES		
REDUCE UNHEARALDED ACTIVITY INTO ED	111 BOOK DIRECTLY IN ED	111 BOOK DIRECTLY INTO ALTERNATIVE PATHWAYS
ED WALK IN PATIENTS TO BE TRIAGED AND ONLY APPROPRIATE ED ACTIVITY TO ACCESS ED	REDUCE THE NUMBER OF PATIENTS CROWDING IN ED WAITING AREAS DURING COVID	PATIENTS AVOID ED AND ARE BOOKED DIRECTLY INTO APPROPRIATE COMMUNITY, UHL SPECIALITY, OR HOT CLINIC PATHWAY
INAPPROPRIATE ED ACTIVITY REDIRECTED TO OTHER SERVICES	REDUCE INAPPROPRIATE ED ACTIVITY WITHIN ED	PATIENTS DO NOT NEED TO ATTEND ED TO GET A REFERRAL
REDUCE THE NUMBER OF PATIENTS CROWDING IN ED WAITING AREAS DURING COVID	PATIENTS GIVEN TIME SLOTS TO ATTEND ED RATHER THAN ADVISED TO ED WITH 1, 4, OR 12 HOURS	PRIMARY CARE TO BE ABLE TO BOOK DIRECTLY IN ADDITION TO NHS 111

LLR Project Timeline

Programme Plan Timeline for Implementation for LLR NHS 11 First	03-Aug	10-Aug	17-Aug	24-Aug	31-Aug	07-Sep	14-Sep	21-Sep	28-Sep	05-Oct	12-Oct	19-Oct	26-Oct	02-Nov	09-Nov	16-Nov	23-Nov	30-Nov	07-Dec	14-Dec	21-Dec	28-Dec	04-Jan
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
				Local System stakeholder and system engagement																			
		System plan developed and agreed			Local System plan sign off		Regional Sign off	National Sign off	Go live with direct booking from 111 into ED, SDEC, Hot Clinics etc.		Close monitoring, learning, feedback. Make adaptations to the plan if required		Launch public facing messagings	Review impact on the 111 provider and wider system									

Communications Objectives

Communications objectives:

* Explain the developments and new arrangements to support NHS 111
* Raise awareness and promote NHS 111 as the first point of contact for Urgent care needs
* Promote the benefits of calling NHS 111 first: helping people get the right treatment at the right place
* Engage with patients to understand their experiences of the new system: use these insights to influence development of the model and how we communicate about the service
* To achieve long-term behaviour change of those who visit Emergency Departments for minor illnesses

Public messages

* Contact NHS111 before going to an Emergency Department to ensure you get the right help in the right place. This could be self-care or through an appointment with a GP, or by going to a pharmacist or Urgent Treatment Centre.
* Benefit from a booked time slot at an Emergency Department, an Urgent Treatment Centre, or another suitable service shortening the time you wait
* Help keep our staff, you, your family and friends safe. Contacting NHS 111 in advance means we can keep everyone waiting in an Emergency Department safe
* If it's not urgent you can call your GP direct or use NHS App to make a GP appointment or request a repeat prescription.
* If you attend an ED options for your treatment will be discussed with you to ensure you get the right treatment for your needs. This may be at an alternative location.

Key communications activities

* Engagement with the Council of Faiths and CCGs Patient and Public Participation Group has already taken place
* Communications to staff in health and care settings about the objectives and key changes prior to launch
* Share materials for staff in ED and other settings
* Public facing messages including in ED
* Engagement with local media after the soft launch 28/9
* National/regional media campaign from end of October
* Use feedback from patients to continually improve pathway

Equalities Impact

* A detailed Equalities Impact Assessment has been carried out and signed off
* Further work to develop messages targeted at key groups; those that don't traditionally use NHS 111 or who may find phone or online access to NHS 111 difficult
* Interpreting services are available through NHS 111
* Communications materials will be translated into the main languages used in Leicester, Leicestershire and Rutland

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