Lincolnshire Community Health Services NHS Trust

Report to the Board of Directors

Date of meeting	12th January 2020		Agenda item	1g
Subject	LCHS COVID-19 Trust Board Report			
Report of	Chief Executive and Executive Directors			
Prepared by	Maz Fosh, Chief Executive Tracy Pilcher, Director of Nursing, AHP's and Operations/Deputy CEO Ceri Lennon Director of People and Innovation Yvonne Owen, Medical Director Sam Wilde, Director of Finance and Business Intelligence			
Previously considered by	Trust Board September 2020 Trust Board July 2020 Trust Board May 2020			
Action recommended	Decision	x	To make a decision based on advice or referral	
	Information		To consider an update where no decision is required but input will inform future developments	
	Assurance	x	To provide assurance to the Trust Board	

How the report supports the delivery of the priorities within the Board Assurance Framework		
1. Provide Safe, High Quality, Personalised Population Healthcare	1a. Deliver safe services	x
	1b. To maintain CQC Outstanding in 2020/21 and aspire to be Outstanding in all domains	
	1c. Design services around population healthcare focused on prevention	
	1d. Take a proactive approach in driving services that are focused on self-care and prevention	x
2. Deliver Sustainable 21st Century Community Health Services	2a.With partners, shape and lead the implementation of healthcare change and improvement across Lincolnshire	x
	2b. Homefirst - identify and implement internal opportunities for integration and proactive care	
3. Build A Productive, Quality and Supported Workforce	3a. Make the NHS the best place to work	
	3b. Improve our leadership culture	
	3c. Develop our workforce to deliver 21st century care	
	3d. Enable great care, close to home	
4. Ensure Value For Money and	4a. Sustain service viability while demonstrating value for money	
	4b. Ensuring value for money and financial sustainability	

Financial Sustainability	4c. Create insight to drive great care close to home			
5. Collaborate to Lead System Integration and Innovation	5a. Actively support and lead key programmes to deliver system integration			
	5b. Support move to Integrated Care System			
	5c. Ensure collaboration that makes a positive difference			
	5d. Driving innovation			
Patients and the Public Impact Assessment	*Please outline the potential impact/ expected outcome*	**Positive**	**Neutral** x	**Negative**
Equality Impact Assessment	*Please outline the potential impact/ expected outcome*	**Positive**	**Neutral** x	**Negative**
Quality Impact Assessment	*Please outline the potential impact/ expected outcome*	**Positive**	**Neutral** x	**Negative**
Financial Impact Assessment	*Please outline the potential impact/ expected outcome*	**Positive**	**Neutral** x	**Negative**
Links to risks	Risks 470, 471, 447, 471			
Legal/ Regulation	.			

Executive Summary

This report is for information and seeks approval on key retrospective decisions in order to effectively respond to the COVID-19 national emergency. This report will cover the following key areas relating to COVID-19:

- Chief Executive overview
- Operational response to COVID-19
- System ethic cell progress update
- People Update
- Finance Update
- Board approval on retrospective decisions relating to COVID-19

The Trust Board is asked to note the contents of this report and APPROVE the decisions and policy changes presented for retrospective approval in line with section 5.2 of the Trust's Standings Orders – Utilising the emergency powers and urgent decisions provisions.

The Trust Risk Register along with any policy amendments for COVID-19 will be taken as separate reports on the Trust Board agenda.

Recommendations

This report has provided the board with an update on the LCHS response to the second wave of COVID 19. The Board is asked to consider the following:

1. Note the content of this COVID-19 report
2. Note emergency powers and urgent decision provisions within section 5.2 of the Trust's Standing Orders have been invoked in order to effectively respond to COVID-19 in order to prepare for COVID-19 and protect and save lives.
3. Approve retrospective decisions that are detailed within this report

Appendices

Appendix 1 operational priorities letter

Important for action Operational

Appendix 2

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Glossary

ICC Incident Command Centre
UTC Urgent Treatment Centre

1. Purpose

The purpose of this briefing is to provide the trust board with an update on the organisation approach responding to the COVID 19 pandemic.

2. Key messages

a. Chief Executive Overview

LCHS continues to respond to effectively to the Covid-19 pandemic level 4 national emergency, moving back into respond on the 5th November 2020. Whilst the organisation has moved back into respond, there is also a continued focus on ensuring that services are restored as effectively as possible alongside the pandemic response.

One of the key elements of the response to the COVID 19 pandemic is the delivery of an effective vaccination programme. The NHS has commenced the national vaccination roll out of the first vaccines to have been approved on Tuesday 8th December 2020. In Lincolnshire, United Lincolnshire Hospitals NHS Trust (ULHT), was one of the first 50 hospital hubs to have been approved to commence vaccination with the Pfizer/BioNTech vaccine. The focus is then on rapid roll out through the Primary Care Network (PCN) hubs, and then mass vaccination sites. The vaccination programme is being co-ordinated at a system level through the system vaccination and operational centre. LCHS is working with the Lincolnshire system in developing the mass vaccination sites, with the expectation that there will be 2 mass vaccination sites, which will be operational alongside the hospital hubs, and the PCN locations to maximise delivery to the Lincolnshire population.

LCHS has commenced testing of asymptomatic staff with the introduction of lateral flow testing. This simple at home test kit ensures that there is ongoing surveillance for staff across the organisation. Individuals undertake a test at home on a twice weekly basis, so far there has been approximately a 1% positivity rate. If staff are positive on lateral flow testing, then they need to self isolate and undertake a PCR test to verify this result.

On the 23rd December 2020 Amanda Pritchard Chief Executive, NHS Improvement and Julian Kelly NHS Chief Financial Officer wrote to all organisation setting out the critical actions for the remainder of the financial year, as well as signally the areas that organisations and systems needed to focus on for 2021/22. In managing the remainder of 2020/21, the focus is on

- A. Responding to Covid-19 demand
- B. Pulling out all the stops to implement the Covid-19 vaccination programme
- C. Maximising capacity in all settings to treat non-Covid-19 patients
- D. Responding to other emergency demand and managing winter pressures
- E. Supporting the health and wellbeing of our workforce

The organisation is working to ensure that these key priorities are embedded within our programmes and priorities as an organisation. In relation to planning for 2021/22, the spending review announced further funding for the NHS for 2021/22 but in the new year, once more is known about the progress of the pandemic and the impact of the vaccination programme, the Government will consider what additional funding will be required to reflect Covid-19 cost pressures. The full letter if provided in appendix 1

b. Operational Response to COVID-19

On 5th November 2020 the NHS returned to a level 4 incident level putting in place national direction of the response to the pandemic and increasing number of cases of Covid-19 in the community and hospitals across the country. In response to this the organisation has put back

in place the Incident Command Centre (ICC), which is now functioning as the single point of contact for the organisation in relation to the three main functions:

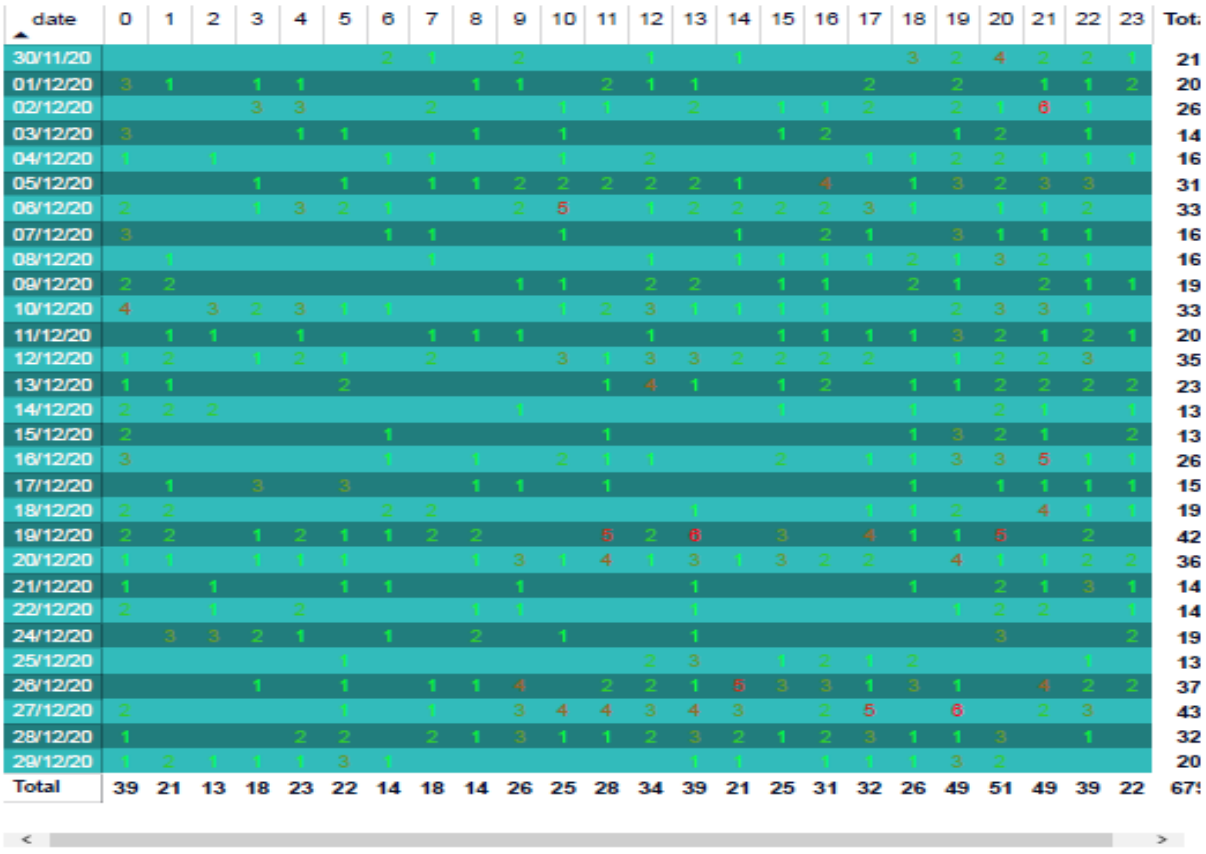
- To co-ordinate the organisations approach to responding to the COVID-19 pandemic
- To ensure the organisation has an effective response for Winter and increased demand for LCHS services across Lincolnshire
- To ensure the organisation is preparing and able to respond to the EU transition exit, and any outcome from these transition negotiations and plans

The ICC is functioning 7 days a week, 12 hours a day, with a full incident command structure in place.

Key Components of the LCHS Response

Integrated Urgent Care Services

A key component of the LCHS response is the provision of urgent and emergency care services. The Clinical Assessment Service (CAS) has been instrumental in supporting patients to be cared for safely at home, and ensuring that patients are only conveyed to hospital if absolutely necessary. CAS capacity has been increased to support increased calls through to CAS from EMAS crews on scene. This initiative commenced at the beginning of November 2020, with a direct impact on ambulance conveyance levels



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Total	39	21	13	18	23	22	14	18	14	26	25	28	34	39	21	25	31	32	26	49	51	49	39	22	67

Ambulance conveyance to ULHT has decreased by approximately 15% with the sustained focus on EMAS crews on scene.

Months	Lincoln County Hospital	Pilgrim Hospital Boston	Total
November 2019	2126	1732	3858
December 2019	2238	1825	4063
January 2020	2194	1803	3997
February 2020	2053	1547	3600
March 2020	2043	1551	3594
April 2020	1778	1342	3120
May 2020	2153	1471	3624
June 2020	2181	1481	3662
July 2020	2469	1717	4186
August 2020	2371	1814	4185
September 2020	2258	1644	3902
October 2020	2352	1711	4063
November 2020	1946	1459	3405
December 2020	1942	1472	3414
Total	**30104**	**22569**	**52673**

Grantham Urgent Treatment Centre

The decision to introduce a temporary UTC was taken by the United Lincolnshire Hospitals NHS Trust Board of Directors, as part of plans to provide a COVID-free 'Green' site at Grantham Hospital. By not admitting emergency patients, who cannot be tested for coronavirus before arrival, the new UTC will help to safeguard the COVID free status of the hospital site and mean urgent treatment for conditions including cancer can be reopened.

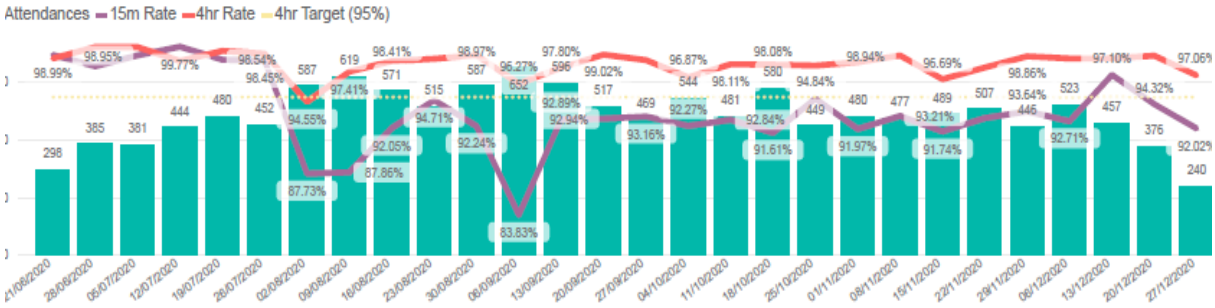
At present the UTC is co-located with the AIR team, and mental health teams within one blue footprint. Supporting the team this has involved a re-design of clinical flow using System 1 for the IT solution and ensuring quality assurance across all parts of procedures including resus, medicines and safeguarding.

Key deliverables

- Ensure consistent collaboration between organisations including ULHT, EMAS, LPFT and Neighbourhood Leads.
- Increase in patient choice, making bookable appointments available to the public of Lincolnshire as part of the UTC Offer.
- Delivering high quality patient care during a temporary change.

Key performance indicators and activity remain stable since the service was transferred, with referral to ED being predominantly below 5%, which compares favourably with national benchmark information

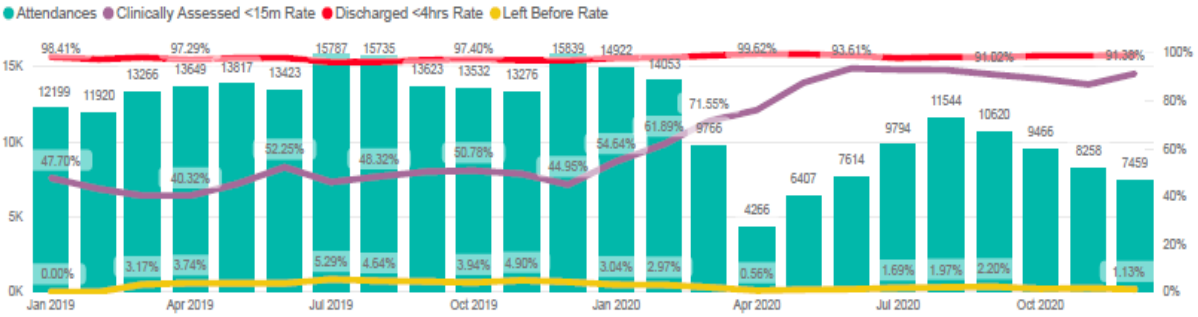
Week Start	Attendances	Average Mins to Assessment	15m Rate	Unassessed Rate	Average Mins to Discharge	<4hr Rate	Left Before Rate	% Referred to A&E	Number Referred to A&E
08/11/2020	477	8	93.21%	0%	96	98.94%	0.42%	4.40%	21
15/11/2020	489	8	91.74%	0%	112	96.69%	0.61%	4.29%	21
22/11/2020	507	7	93.00%	0%	99	97.80%	2.17%	4.54%	23
29/11/2020	446	8	93.64%	0%	104	98.86%	0.45%	3.14%	14
06/12/2020	523	8	92.71%	0%	97	98.66%	0.19%	4.02%	21
13/12/2020	457	7	97.10%	0%	99	98.66%	0.22%	5.25%	24
20/12/2020	376	11	94.32%	0%	100	98.92%	0.53%	2.93%	11
27/12/2020	240	8	92.02%	0%	105	97.06%	5.42%	4.17%	10
Total	3515	8	93.49%	0%	101	98.24%	1.00%	4.13%	145



Urgent Treatment Centres

The integrated urgent care services provided by LCHS has been a fundamental part of the LCHS response to COVID 19. The overall demand on building based services has continue with an atypical pattern. As part of the restore programme, Gainsborough MIU has now re-opened as an UTC, offering a comprehensive range of urgent care services to the local population, including booked appointments and home visiting.

Month	Attendances	Clinically Assessed <15m	Unassessed	Average Minutes to Clinical Assessment	Discharged <4hrs	4hr Breaches	Average Minutes to Discharge	Left Before Rate
December 2020	7459	91.38%	1%	8	99.18%	60	80	1.13%
November 2020	8258	86.87%	2%	8	98.91%	88	83	1.53%
October 2020	9466	89.30%	2%	7	98.92%	100	84	1.31%
September 2020	10620	91.02%	1%	6	98.18%	188	89	2.20%
August 2020	11544	92.94%	2%	5	98.42%	178	87	1.97%
July 2020	9794	93.08%	2%	6	97.92%	199	84	1.69%
June 2020	7614	93.61%	2%	6	99.00%	75	78	1.16%
May 2020	6407	87.60%	5%	6	99.59%	26	71	0.95%
April 2020	4266	76.19%	11%	9	99.62%	16	68	0.56%
Total	75428	90.07%	3%	6	98.74%	930	82	1.50%



Same Day Urgent Primary Care
In responding to urgent primary care services the organisation has agreed to pilot an approach with an East coast practice in relation to same day urgent primary care. This approach will support GP practices and PCN's to release capacity to support the COVID-19 vaccination programme, as well as support the delivery of urgent primary care services to the local population. The pilot will commence on the 18th January 2020, with 20 booked appointments a day being provided to primary care, alongside the UTC services at Skegness hospital. If successful, this will provide the blue print to roll our this services to a wider number of GP practices across Lincolnshire

Patient Flow
As part of the Lincolnshire system bed management plan the organisation has continued to deliver an effective patient flow response, patient flow includes the follow key areas

- Home-first partnership
- Community hospitals and transitional care
- Assertive in-reach services
- Palliative and end of Life Care

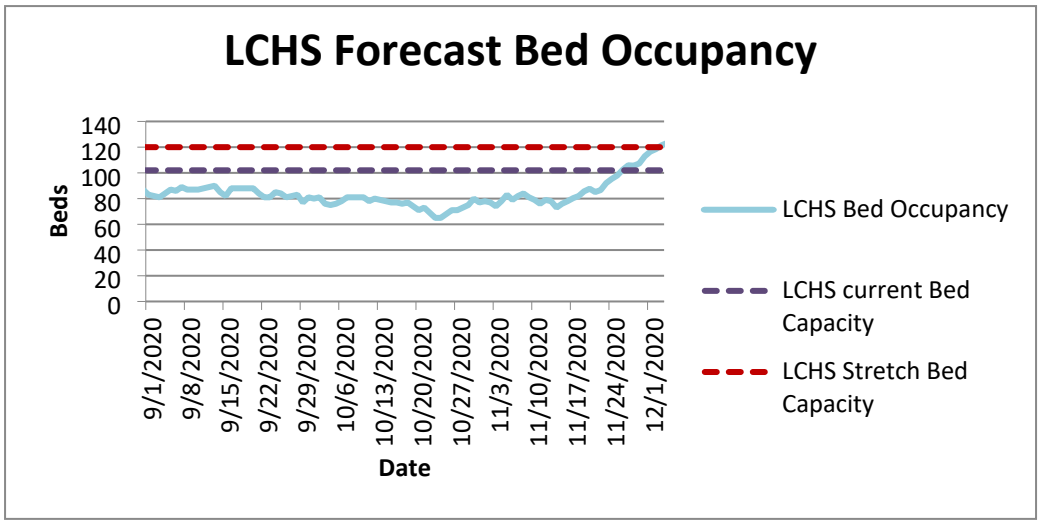
The home first partnership has led the continued the development of the hospital discharge policy, supporting effective discharge from acute and community services. Key achievements so far have been:

- Single point of access created for all referrals for discharge support
- Single trusted assessment documentation
- Ongoing discharge to assess model at Grantham Hospital
- New service set up in collaboration with AgeUK to follow up patients discharged on Pathway 0 within 48hrs of discharge
- Additional senior review of medically optimised patients implemented on a daily basis
- Linked in community partners with long length of stay patient reviews
- Developed and implemented system wide accessible dashboard to monitor patients on pathways 0-3
- Identification and ongoing management of risks associated with accelerated discharge work ongoing with ED to improve use of Transitional care beds in out of hours
- Delivery of the designated settings for COVID positive patients discharge into care home settings
- System wide review and gap analysis for hospital discharge policy

Community Hospitals and Transitional Care
Community hospitals and transitional care beds play a significant part of the Lincolnshire response to COVID 19. There are 4 pathways into community hospital and transitional care beds, including

- step up from the community, as an avoidance for an admission into an acute provider
- step down from the acute, as part of a rehabilitation pathway
- direct admissions from EMAS to avoid an admission to the acute provider, and
- admission for palliative and end of life care services.

Modelling work undertaken as part of the planning for the second COVID 19 pandemic surge identified that the system required up-to 120 community hospital beds.



Butterfly Hospice

Butterfly hospice is a 6 bedded hospice facility located in Boston. LCHS works in partnership with the Butterfly charity to deliver services in this facility. On Monday 6th April 2020 a joint decision was made between the CCG, the hospice and LCHS to temporarily close the hospice due to concerns about the safe staffing of the facility. Whilst the hospice has been temporarily closed LCHS staff had been temporarily re-deployed into End of Life and Palliative care home visiting services in the Boston and surrounding area. The organisation has been working collaboratively with the Butterfly charity, CCG and local PCN to restore Butterfly Hospice, with the Hospice re-opening on the 4th January 2021. This will support the wider palliative and end of life in pathways across Lincolnshire.

Hospital Discharge and Recovery Services

On the 23rd December 2020 Matthew Winn and Dr Cliff Mann from NHS England and Improvement wrote to all organisations to set out expectations in relation to hospital discharge and recovery actions, these covered three main areas:

1. Using all available hospice capacity
2. Designated facilities for people who are COVID+ being discharged from hospital into a care home
3. Strengthening leadership and oversight of discharge arrangements in acute hospitals

The full letter is provided in appendix 2, and LCHS alongside systems partners are working to ensure these key priority areas are embedded into the home first partnership and ways of working across Lincolnshire.

c. System Ethic Cell progress update

The System Ethics Group met on 15/12/20. It was agreed that, in light of current activity levels across the system, monthly meetings would resume. ULHT described the pressures that they were experiencing during wave 2 and they have stood up their daily clinical decision review meetings. Additional Medical Examiners have been drafted in from retired Medic volunteers to take on the management of bereavement services, freeing up Clinical staff to focus on patients. More emphasis is being placed on completion of Respect Forms on admission with greater detail around overall patient intervention/symptom control wishes rather than just DNACPR and escalation to ICU.

- LPFT have an improving staff position and recently re-opened PICU.

- LCHS are maintaining core and specialist services while also taking on the increased workload associated with COVID-19 and System deficits.

- Visiting across the acute hospital sites has been suspended apart from EOL patients in line with guidelines.

- Care Homes generally in a better position compared to wave 1. Highlighted that Carers in Care Homes have been prioritized for first wave vaccination but the majority of Carers work in the Community.

d. People Update

Within LCHS, our people have continued to provide a fantastic support to the response to COVID-19 as we are midst the second wave of the pandemic. As all services continue, redeployment is on a voluntary basis only with some colleagues offering support across service lines. With regard to staff absence levels - following a summer with 4% sickness absence - the last quarter has seen a steady increase to almost 6% by end November with the highest reason remaining consistently anxiety, stress and depression (27%) and followed by COVID related (17%). Lateral flow testing has not to date had a significant impact on staff absence and we are hopeful that the vaccination will have a positive impact on staffing availability into Q4. To support our staff, we are continuing to promote Organisational, system, regional and national wellbeing offers and received a local award for our endeavours in supporting staff during COVID. In line with the National People Plan, LCHS now have a Health and Wellbeing guardian in post to provide a further level of challenge to the organisation and assurance to the Board. The Freedom to Speak up Guardian continues to monitor and support the teams and liaises regularly with Board colleagues. Staff networks have been particularly well attended and valued during the pandemic and the BAME and Allies group have representation at Trust Board in addition to other key groups.

Across the Lincolnshire system there have been two major areas of focus during this period; supporting the wider system workforce challenges and the roll-out of the COVID-19 vaccination programme. In addition to the 3 Trusts working under a Memorandum of Understanding for movement of employees, LCC have now signed and we are working with PCNs to also sign in order to reduce the bureaucracy when needing to provide urgent support across the system. The workforce cell continues to work collaboratively in addressing the staffing pressures whilst sharing best practice in supporting teams at this time. System support for the staffing pressures is by way of increasing activity to divert from the acute and promoting bank work to registered staff in all partner organisations. As part of the People Board the Lincolnshire system is working towards the creation of a formal collaborative bank which has been expedited due to the current pressures. The Vaccination workforce has seen a steady recruitment campaign aiming to provide a temporary workforce band 4-8 to work within the large-scale hubs, PCN sites and the roving teams. A system approach is working well as engaging with voluntary sector for many of the roles also.

e. Finance Update

Monthly finance reporting into the Finance, Performance and Investment Committee has returned and includes both Trust performance and Lincolnshire System performance.

The financial framework for the second half of the financial year is such that the Trust receives a block amount to cover COVID related costs but there is no opportunity for retrospective top-ups.

At the end of month 8 the Trusts COVID related costs in the second half of the financial year to date are £21k below the block amount received to cover these. COVID costs were £90k below the monthly block amount in month 7 but £69k above that amount in month 8.

The increase in month 8 was driven by the decision to offer a 30% premium to staff working on the bank as an incentive. This is intended to be a temporary measure which we expect to reverse in due course. It is currently in place until the end of December 2020.

f. Board approval on retrospective decisions relating to COVID-19

g.

- The decision on the 8th December 2020 to provide the CQC registration for the mass vaccination sites

- The decision on the 2nd December 2020 to commence lateral flow testing for patient facing staff

- The decision on the 3rd December to increase bank rates to a standard 30% enhancement until the end of December 2020

3. Conclusion/Recommendations

This report has provided the board with an update on the LCHS response to the second wave of COVID 19. The Board is asked to consider the following:

1. Note the content of this COVID-19 report
2. Note emergency powers and urgent decision provisions within section 5.2 of the Trust's Standing Orders have been invoked in order to effectively respond to COVID-19 in order to prepare for COVID-19 and protect and save lives.
3. Approve retrospective decisions that are detailed within this report

To:

- STP and ICS Leaders
- 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

Skipton House
80 London Road
London
SE1 6LH

23 December 2020

CC:

- 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

Dear colleague

Important – for action – Operational priorities for winter and 2021/22

As we near the end of this year, we are writing to thank you and your teams for the way you have responded to the extraordinary challenge of Covid-19 and set out the key priorities for the next phase.

An extraordinary 2020

In the past year we have cared for more than 200,000 of those most seriously ill with Covid-19 in our hospitals. At the same time NHS staff have also worked incredibly hard to keep essential services such as cancer, mental health, general practice, urgent, emergency and community healthcare running and restore non-urgent services that had to be paused. Community nurses, pharmacists, NHS 111 staff and other NHS workers have cared for countless others, and been supported by the wider NHS team, from HR and finance to admin and clerical staff. The number of cancer treatments is above the level at the same time last year. GP appointments are back to around pre-pandemic levels. Mental health services have remained open and more than 400,000 children have accessed mental health services, above the target for 2020/21. Community services are supporting 15 per cent more people than they were at the same point last year. And we have had a record number of people vaccinated against flu, including a higher percentage of NHS staff than in the last three years. It has been an incredible team effort across our health and care system.

The response to the pandemic has also demonstrated our health service's enormous capacity for innovation with rapid development and implementation of new treatments, such as dexamethasone, rolling out of pulse oximetry and at-home patient self-monitoring, and the move to virtual and telephone consultations. We are already in the third week of our world-leading vaccination programme – the largest in NHS history.

We know that this relentless pressure has taken a toll on our people. Staff have gone the extra mile again and again. But we have lost colleagues as well as family and friends to the virus; others have been seriously unwell and some continue to

experience long-term health effects. The response of the NHS to this unprecedented event has been magnificent. We thank you and your teams unreservedly for everything that you have given and achieved and the support you continue to give each other.

You have asked us for a short statement of operational priorities going forward. This letter is therefore intended to help you and your staff over the next few months by:

- ensuring we have a collective view of the critical actions for the remainder of this financial year, and
- signalling the areas that we already know will be important in 2021/22.

Managing the remainder of 2020/21

Given the second wave and the new more transmissible variant of the virus, it is clear that this winter will be another challenging time for the NHS. Our task is five-fold:

A. Responding to Covid-19 demand
B. Pulling out all the stops to implement the Covid-19 vaccination programme
C. Maximising capacity in all settings to treat non-Covid-19 patients
D. Responding to other emergency demand and managing winter pressures
E. Supporting the health and wellbeing of our workforce

In addition, as the UK approaches the end of the transition period with the European Union on 31 December 2020, we will provide updates as soon as the consequences for the NHS become known. We are following a single operational response model for winter pressures, including Covid-19 and the end of the EU transition period. All CCGs and NHS trusts should have an SRO to lead the EU/UK transition work and issues should be escalated to the regional incident centre established for Covid-19, EU transition and winter.

A. Responding to ongoing Covid-19 demand

With Covid-19 inpatient numbers rising in almost all parts of the country, and the new risk presented by the variant strain of the virus, you should continue to plan on the basis that we will remain in a level 4 incident for at least the rest of this financial year and NHS trusts should continue to safely mobilise all of their available surge capacity over the coming weeks. This should include maximising use of the independent sector, providing mutual aid, making use of specialist hospitals and hubs to protect urgent cancer and elective activity and planning for use of funded additional facilities such as the Nightingale hospitals, Seacole services and other community capacity. Timely and safe discharge should be prioritised, including making full use of hospices. Support for staff over this period will need to remain at the heart of our response, particularly as flexible redeployment may again be required.

Maintaining rigorous infection prevention and control procedures continues to be essential. This includes separation of blue/green patient pathways, asymptomatic testing for all patient-facing NHS staff and implementing the ten key actions on infection prevention and control, which includes testing inpatients on day three of their admission.

All systems are now expected to provide timely and equitable access to post-Covid assessment services, in line with the commissioning guidance.

B. Implementing the Covid-19 vaccination programme

On 8 December, after the MHRA confirmed the Pfizer BioNTech vaccine was safe and effective, the biggest and most ambitious vaccine campaign in NHS history began.

The Joint Committee for Vaccination and Immunisation (JCVI) priorities for roll out of the vaccine have been accepted by Government, which is why the priority for the first phase of the vaccination is for individuals 80 years of age and over, and care home workers, with roll out to care home residents now underway. It is critical that vaccinations take place in line with JCVI guidance to ensure those with the highest mortality risk receive the vaccine first. To minimise wastage, vaccination sites have been ensuring unfilled appointments are used to vaccinate healthcare workers who have been identified at highest risk of serious illness from Covid-19. Healthcare providers have been undertaking staff risk assessments throughout the pandemic to identify these individuals and it remains important that this is organised across the local healthcare system to ensure equitable access.

If further vaccines are approved by the independent regulator, the NHS needs to be prepared and ready to mobilise additional vaccination sites as quickly as possible. In particular, Covid-19 vaccination is the highest priority task for primary care networks including offering the vaccination to all care home residents and workers. All NHS trusts should be ready to vaccinate their local health and social care workforce very early in the new year, as soon as we get authorisation and delivery of further vaccine.

C. Maximising capacity in all settings to treat non-Covid-19 patients

Systems should continue to maximise their capacity in all settings. This includes making full use of the £150m funding for general practice capacity expansion and supporting PCNs to make maximum use of the Additional Roles Reimbursement Scheme, in order to help GP practices maintain pre-pandemic appointment levels. NHS trusts should continue to treat as many elective patients as possible, restoring services to as close to previous levels as possible and prioritising those who have been waiting the longest, whilst maintaining cancer and urgent treatments.

To support you to maximise acute capacity, as set out in Julian Kelly and Pauline Phillip's letter of 17 December, we have also extended the national arrangement with the independent sector through to the end of March, to guarantee significant access to 14 of the major IS providers. NHS trusts have already been notified of the need for a Q4 activity plan for their local IS site by Christmas; this should be coordinated at system level. If you need it, we can also access further IS capacity within those providers subject to the agreement of the national team. However, we will need to return to local commissioning from the beginning of April and local systems, in partnership with their regional colleagues, will need to prepare for that.

The publication of the Ockenden Review of maternity services is a critical reminder of the importance of safeguarding clinical quality and safety. As set out in our letter of 14 December there are twelve urgent clinical priorities that need to be implemented. All Trust Boards must consider the review at their next public meeting along with an assessment of their maternity services against all the review's immediate and essential actions. The assessment needs to be reported to and assured by local systems, who should refresh their local programmes to make maternity care safer, more personalised and more equitable.

D. Responding to emergency demand and managing winter pressures

Alongside providing £80m in new funding to support winter workforce pressures, we are asking systems to take the following steps to support the management of urgent care:

- Ensure those who do not meet the 'reasons to reside' criteria are discharged promptly. We know that maximising capacity over the coming weeks and months is essential to respond to seasonal pressures. We are asking all systems to improve performance on timely and safe discharge, as set out in today's letter, as well as taking further steps that will improve the position on 14+ and 21+ day length of stay, aided by 100% completion of discharge and reasons to reside data.

- Complete the flu vaccination programme, including vaccinating our staff against flu and submitting vaccination uptake data to the National Immunisation and Vaccination system (NIVS).

- To minimise the effects of emergency department crowding, continue to develop NHS 111 as the first point of triage for urgent care services in your locality, with the ability to book patients into the full range of local urgent care services, including urgent treatment centres, same day emergency care and speciality clinics as well as urgent community and mental health services.

- Maximise community pathways of care for ambulance services referral, as a safe alternative to conveyance to emergency departments. Systems should also ensure sufficient arrangements are in place to avoid unnecessary conveyance to hospital, such as the provision of specialist advice, including from emergency departments, to paramedics as they are on scene.

E. Supporting the health and wellbeing of our workforce

Our NHS people continue to be of the utmost importance, and systems should continue to deliver the actions in their local People Plans. Please remind all staff that wellbeing hubs have been funded and will mobilise in the new year in each system.

Planning for 2021/22

The Spending Review announced further funding for the NHS for 2021/22 but in the new year, once we know more about the progress of the pandemic and the impact of the vaccination programme, the Government will consider what additional funding will be required to reflect Covid-19 cost pressures.

In the meantime, systems should continue to:

- **Recover non-covid services**, in a way that reduces variation in access and outcomes between different parts of the country. To maximise this recovery, we will set an aspiration that all systems aim for top quartile performance in productivity on those high-volume clinical pathways systems tell us have the greatest opportunity for improvements: ophthalmology, cardiac services and MSK/orthopaedics. The Government has provided an additional £1bn of funding for elective recovery in 2021/22. In the new year we will set out more details of

how we will target this funding, through the development of system-based recovery plans that focus on addressing treatment backlogs and long waits and delivering goals for productivity and outpatient transformation. In the meantime we are asking you to begin preparatory work for this important task now, through the appointment of a board-level executive lead per trust and per system for elective recovery.

- Strengthen delivery of local **People Plans**, and make ongoing improvements on: equality, diversity and inclusion of the workforce; growing the workforce; designing new ways of working and delivering care; and ensuring staff are safe and can access support for their health and wellbeing.

- Address the **health inequalities** that covid has exposed. This will continue to be a priority into 2021/22, and systems will be expected to make and audit progress against the eight urgent actions set out on 31 July as well as reduce variation in outcomes across the major clinical specialties and make progress on reducing inequalities for people with learning disabilities or serious mental illness, including ensuring access to high-quality health checks.

- Accelerate the planned expansion in **mental health** services through delivery of the Mental Health Investment Standard together with the additional funding provided in the SR for tackling the surge in mental health cases. This should include enhanced crisis response and continuing work to minimise out of area placements.

- Prioritise investment in **primary and community care**, to deal with the backlog and likely increase in care required for people with ongoing health conditions, as well as support prevention through vaccinations and immunisations. Systems should continue to focus on improving patient experience of access to general practice, increasing use of online consultations, and supporting the expansion of capacity that will enable GP appointments to increase by 50 million by 2023/24.

- Build on the development of effective **partnership working at place and system level**. Plans are set out in our Integrating Care document.

These priorities should be supported through the use of data and digital technologies, including the introduction of a minimum shared care record in all systems by September 2021 to which we will target some national funding, and improved use of remote monitoring for long term conditions.

The 2021/22 financial framework

For the reasons set out above, we won't know the full financial settlement for the NHS until much closer to the beginning of the new financial year, reflecting, in particular, uncertainty over direct Covid-19 costs. We will, however, need to start work early in the new year to lay the foundation for recovery. The underlying financial framework for 2021/22 will therefore have the following key features:

- Revenue funding will be distributed at system level, continuing the approach introduced this year. These **system revenue envelopes will be consistent with the LTP financial settlement**. They will be based on the published CCG allocation and the organisational Financial Recovery Fund each system would

have been allocated in 2021/22. There will be additional funding to offset some of the efficiency and financial improvements that systems were unable to make in 2020/21.

- Systems will **need to calculate baseline contract values to align with these financial envelopes** so there is a clear view of baseline financial flows. Our planning guidance will suggest that these should be based on 2019/20 outturn contract values adjusted for non-recurrent items, 2020/21 funding growth and service changes, not on the nationally-set 2020/21 block contracts.
- Systems and organisations should start to develop plans for **how Covid-19 costs can be reduced and eliminated** once we start to exit the pandemic.
- **System capital envelopes** will also be allocated based on a similar national quantum and using a similar distributional methodology to that introduced for 2020/21 capital planning.

We will aim to circulate underlying financial numbers early in the new year. We will then provide fuller planning guidance once we have resolved any further funding to reflect the ongoing costs of managing Covid-19. Further detail of non-recurrent funding announced in the recent Spending Review for elective and mental health recovery will also be provided at that point.

Conclusion

This year has arguably been the most challenging in the NHS's 72-year history. But even in these most testing times, people across the service have responded with passion, resilience and flexibility to deal with not only the virus but also the needs of patients without Covid-19. The rollout of the vaccine will bring hope to 2021 and we will need to maintain the energy and effort to meet the needs of all we serve throughout the year. Thank you for all that you have done and continue to do to achieve this.

With best wishes,

Amanda Pritchard
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To:
CEOs of NHS Trusts and Foundation Trusts
CEOs of Clinical Commissioning Groups
CEOs of Community Health Providers
CEOs of private, not-for-profit community providers and community interest companies
Chief Executives of Councils

Cc:
NHS England and NHS Improvement Regional Directors

23 December 2020

Dear colleague,

COVID-19 Hospital discharge and recovery services

This letter sets out measures to support improvements in the performance and oversight of the discharge to assess services across England. All systems are asked to prioritise these actions.

1. Using all available hospice capacity

Hospices have played an important part in the response to COVID-19. They provide vital care to patients of all ages through both inpatient and community provision.

The NHS should use all available hospice capacity, including re-purposing existing provision either in beds or home services, for both COVID and non-COVID patients. Hospices are required to submit data on their hospice beds and community capacity onto the National Capacity Tracker daily, including weekends and bank holidays, with non-compliance affecting funding.

Up to £125m extra funding has been made available for the period 1 November 2020 until 31 March 2021. Payments will be made by NHS England and NHS Improvement nationally, working with Hospice UK, on the basis of capacity used. CCGs should honour existing agreements and continue to pay any funding agreed with hospices – including business-as-usual and local agreements for COVID-19, both of which will be funded from resources already allocated to local systems.

2. Designated facilities for people who are COVID+ being discharged from hospital into a care home

Some systems have yet to agree designated care settings. Where that remains the case, we are asking local NHS leaders to engage with the Director of Adult Social Services (DASS) in the Local Authority and care provider organisations to explore whether NHS community hospital sites could provide a solution for that area. It would of course need to meet the infection prevention and control standards stipulated by the CQC.

To maintain existing capacity and support patient flow from acute hospitals, it is essential that local systems replace the number of beds that are used in NHS rehabilitation units for designation purposes with the comparable number of

rehabilitation beds commissioned from vacant units/beds in care homes. Therapists and other specialists would be transferred to work in the care home rehabilitation beds.

Where Council owned and operated care home beds are used as a designated facility, CCGs / LAs would commission the comparable number of beds in vacant care homes in the private sector.

The cost of the designated facilities would be met by the COVID discharge funding. Where this is not necessary because already commissioned beds are being used, the replacement care capacity commissioned can instead be charged to the COVID discharge fund.

3. Strengthening leadership and oversight of discharge arrangements in acute hospitals

Systems that have fully implemented the 'home first' approach successfully cite a range of factors that have helped their hospital and discharge teams with the discharge to assess approach. The seven actions below are key issues that each acute hospital and discharge system is asked to prioritise implementing, where they are not already in place.

Action
1. Clinical champions are identified in each trust to support the implementation of the discharge to assess approach.
2. As early as possible, daily ward rounds/reviews are undertaken, including the comprehensive use of the reasons to reside criteria.
3. Achieve 100% data completeness of discharge and daily patient information, by no later than 31 January 2021.
4. Instil the culture and processes of 'home first' ethos across hospital wards and discharge teams- fully implementing the hospital discharge guidance. This includes continuing to discharge people using 'without prejudice' funding arrangements between health and social care.
5. Maintain the Government policy on the choice of care home at the point of discharge.
6. Maximise the number of support packages of care and rehabilitation at home using the £588m COVID discharge funding.
7. Set improvement targets (from November baseline) for each acute hospital site: ➢ for 14+ and 21+ length of stay categories; ➢ % of people not meeting the 'reasons to reside criteria', discharged each day by 5pm

The actions above will be overseen by leads at a system and regional level, who will support discharge systems to learn from and adopt best practice approaches over the remainder of the winter period.

Yours faithfully

Matthew Winn
NHS England and NHS Improvement

Dr Cliff Mann
NHS England and NHS Improvement