NHS England and NHS Improvement Board meetings held in common

Paper Title: Covid-19 Response and Recovery

Agenda item: 4 (Public session)

Report by: Pauline Philip, National Director for Emergency and Elective Care
Keith Willett, Strategic Incident Director for COVID-19

Paper type: For discussion

Organisation Objective:

NHS Mandate from Government	☐	Statutory item	☐
NHS Long Term Plan	☒	Governance	☐
NHS People Plan	☐		

Action required:
Board members are asked to note the content of this report.

Executive summary:
This paper provides the latest position on the Covid-19 response, as well as an overview of elective and UEC recovery.

Covid-19 response – overview

1. Following the peak of Covid-19 demand in January, the number of patients in hospital with Covid-19 has declined. Admissions continue to be monitored closely and Public Health England (PHE) tracks activity related to variants of concern and particularly the B1.617.2 ('Delta') variant.

2. On 25 March, the NHS transitioned from an EPRR level 4 incident (national command, control and coordination) to an EPRR level 3 incident (regional command, control and coordination but with national oversight). This mirrors how we operated during the summer of 2020. NHS organisations have been asked to retain their incident coordination functions and readiness.

3. We continue to develop and embed new models of Covid care to give resilience and agility to respond to future demand. Throughout 2020/21 local systems have put in place new pathways of care in order both to respond swiftly and effectively to Covid–related activity and to embed infection prevention and control measures– e.g. red/green pathways, use of booked appointments in emergency departments to better manage demand and widespread use of available testing capacity to support clinical decision-making. We have also established, and continue to expand, the use of remote monitoring with home oximetry ("COVID Oximetry @home") and virtual wards to support safe, monitored care in people's homes, avoid unnecessary hospital admissions, and

support early and safe discharge. Data from remote monitoring is also helping to inform surveillance of activity potentially related to variants of concern.

4. We are working with local systems to ensure lessons learned from the Covid surge response to date are integrated into future surge planning. This includes enhancing adult critical care transfer services to support mutual aid, making best use of acute care capacity and reducing pressure on the ambulance service.

5. The recovery of NHS staff will be critical both to our response to a potential further wave of infections and wider NHS recovery. We continue to focus on supporting staff health and wellbeing – including time off and access to psychological support via mental health hubs – as well as increasing workforce supply in key staff groups.

Testing

6. Test and Trace continue to allocate lateral flow tests for asymptomatic NHS staff testing and other agreed use cases (emergency departments, and maternity and end of life care visitors). Over 22.8m PCR tests have also been completed to date across NHS and PHE laboratories. PHE has launched a genotyping and sequencing service for all NHS laboratory positive samples, to identify variants of concern. Type 1 ED sites now have >95% of the 0-4-hour testing capacity required for their average daily ED admissions.

Elective Care Recovery and Transformation

7. A range of initiatives are being implemented through 2021/22 to support recovery of elective recovery, effective demand management, and increased efficiency and effectiveness of elective pathways. Work is underway to accelerate progress where possible and to translate the benefits of the improvement initiatives into potential waiting list reductions.

8. These initiatives include:

    a) The Pathway Improvement Programme including High Volume Low Complexity (HVLC) supported by Getting It Right First Time (GIRFT) team. There are three national areas of focus for the end-to-end pathway transformation (Musculoskeletal, Eye care – with NHSX, and Cardiac / heart). Additionally, the HVLC programme will have a priority focus on interventions across 6 specialties and 29 pathways (Orthopaedics, Ophthalmology, ENT, General Surgery, Gynaecology, Urology)
    b) Diagnostics transformation, including Community Diagnostic Hubs, increased capacity, and digital improvements
    c) Demand Management – including Evidence Based Interventions (EBIs), Supported Self-Management (SSM) and ‘waiting well’.
    d) Outpatients transformation, including Advice & Guidance and Patient Initiated Follow-up (PIFU)
    e) PTL or waiting list management, including waiting list validation and shared decision making

f) Continued optimisation of Independent Sector utilisation

9. The government has made additional funding available to support systems to increase elective care activity through the £1bn Elective Recovery Fund (ERF). Systems will be paid through the ERF for activity delivered above nationally-set thresholds as compared to 2019/20 activity levels (on a value basis), which will be an aggregate of inpatient and outpatient activity delivered by both NHS and IS providers and will include both CCG and specialised activity. The threshold level is set against a baseline value of all elective activity delivered in 2019/20, allowing for available funding, workforce recovery and productivity impacts of the pandemic through 2021/22. In addition to achieving nationally-set thresholds, systems need to demonstrate they have met five elective recovery 'gateways'. The gateways have been designed to ensure that when developing plans, ICS ambitions are aligned with national elective priorities for 2021/22, with tangible deliverables and milestones. The five gateways are:

a) Clinical validation, waiting list and long waits
b) Addressing health inequalities
c) Transforming outpatients
d) System-led recovery
e) People recovery

10. In addition to the transformation initiatives and additional funding described above, we have recently also launched Elective Recovery Accelerator Programme. The Elective Accelerator Scheme is a 12 week programme working with selected 12 Integrated Care Systems and a group of 5 children's hospitals following a competitive selection process.

11. The accelerator systems are as follows:
- Lancashire & Cumbria
- South Yorkshire & Bassetlaw
- North East and North Cumbria
- Nottingham and Nottinghamshire
- Coventry and Warwick
- Bedfordshire, Luton and Milton Keynes
- Bristol (Bristol, North Somerset and South Gloucestershire)
- Devon
- North Central London
- Surrey Heartlands
- Hampshire and Isle of Wight
- A National Paediatric Provider Collaborative

UEC Recovery and Transformation

12. Urgent and Emergency Care activity has now returned to, or is in some way exceeding, pre-pandemic levels.

13. The response to the UEC clinical review of standards consultation was published on 26 May 2021. There were 354 responses to the online survey, as

well as additional correspondence. correspondence. Forty-four percent of online survey respondents identified themselves as a patient or member of the public. The responses support the model being proposed, and in some cases look for further development beyond that set out in the recommendations. The responses on how best to advise and communicate the proposed new measures to patients and visitors, as well as the opportunities or challenges to implementation, will be considered as part of an implementation plan, subject to Government agreement to implement the proposals.

14. Actions to manage ED demand more effectively through NHS111 include;
    a) Increase utilisation of booked slots in A&E accessible via NHS111 – interim target of 70% of NHS111 heralded patients receiving a booked time slot.
    b) Increase the utilisation of directly bookable urgent secondary care services including SDEC and specialty hot clinics
    c) Establish clinical pathways via NHS 111 into urgent community and mental health services

15. Actions to improve flow through hospitals include:
    a) SDEC and Acute Frailty Services so that Type 1 ED providers provide a minimum of 12 hours per day 7 days per week SDEC and a minimum of 70 hours per week Acute Frailty Services.
    b) Direct referral routes to secondary care, including SDEC and AFS, should be supported through 111/999/Primary and Community care
    c) Systems should safely make use of “Clinical Criteria to Admit” and adoption of virtual wards to monitor patients remotely.
    d) System should ensure acute facing specialties have consultant presence which reflects service demand across any 24h period.
    e) Ensure appropriate specialist support is available to all EDs and SDEC and assessment units, 7 days a week.
    f) Providers should continue to deliver timely, safe and appropriate discharge
    g) Provision of early follow up of patients with specialty needs.

Primary Care Recovery

16. Primary care recovery is crucial in supporting all of the above and we have provided £270m of additional capacity funding over the last year. Appointment activity in general practice is at around 120% of pre pandemic levels including covid vaccination.

17. Access to primary medical and dental care is also critical to support the sustainability of the UEC system. An access improvement programme is currently supporting 10% of general practices. We are ensuring that primary care is an intrinsic part of the work on elective recovery, reflecting the key role general practice will play in referrals as well as the prioritisation of elective lists and the management of patients.

18. Further funding has been made available, set out in the 19th March 2021 letter to the system, to expand capacity between April and September 2021.

Practices have been starting to catch up on the backlog of long-term condition management, in line with the re-introduction of the Quality and Outcomes Framework (QOF) in April 2021.

19. Details were published on 18th May 2021 of additional funding to general practice. This large and vital investment in primary care will help to support general practice both now, as the onus shifts to recovery, and in the future. The funding will support workforce growth, the increased use of technology in practices, and Primary Care Network resilience and development.

20. Reflecting the change in the Government rules on social distancing from 17th May 2021, practices have been asked to ensure that practice reception areas are open for patients, and that face-to-face care should be offered where needed, taking into account patients' preferences, unless there are good clinical reasons to the contrary. Most practices have always been offering an appropriate blend of online, telephone and face to face triage and appointment options for their patients. Over half of appointments continue to be seen face-to-face. An updated version of the general practice standard operating procedure was published on 20th May 2021 to reflect this.

21. Management of patients on the elective waiting list continues to require significant time and capacity in primary care. An elective recovery steering group has been set up to support primary and secondary care to identify joint work to tackle the backlogs. The group will identify areas how best to support clinical prioritisation and validation, advice and guidance, shared decision making and additional communications across the system. The group will also work with regional teams and accelerator sites to adopt and spread best practice.

Community Services

22. 6 out of 7 regions are reporting at least half of community health services are at pre-COVID levels or higher, and 59% of services are fully restored (compared to pre pandemic levels), with the infection control measures being the main impediment to full restoration.

Diagnostics Recovery

23. A range of short-term options have been identified for accelerating the expansion of diagnostic capacity while longer-term growth, through the establishment of Community Diagnostic Hubs (CDHs) in line with recommendations from the October 2020 Richards' Review, is being developed. Outline proposals for CDHs have been submitted and in the region of 44 CDHs will be established during 2021/22.

24. Clinical validation of diagnostic waiting lists has commenced to ensure that patients with the greatest clinical need have their tests expedited 33 staffed mobile CT scanners from the independent sector to supplement existing NHS capacity until the end of September 2021.

Cancer Recovery

25. We have allocated an additional £20m in recovery funding to establish new clinic models, such as teledermatology and nurse-led triage for prostate cancer to manage high referral volumes and speed up diagnosis. We are also planning to build on the success of the recent Help Us Help You campaigns to encourage people to come forward with cancer symptoms.

26. The NHS has adopted new ways of working and innovations to speed up diagnosis and get people into treatment. First cancer treatments were at 98% of usual levels in April 2021, with 24,963 people starting treatment, 94.2% of whom did so within 31 days of a decision to treat. Local hubs set up during the pandemic were crucial in maintaining treatments and are now being used to enable recovery across cancer and other conditions.

27. Diagnosing cancers earlier and faster to save more lives is a cornerstone commitment of the NHS Long Term Plan and we have accelerated the adoption of innovative technologies to achieve this. Cytosponge, which involves a patient swallowing a sponge on a string to show whether they are at increased risk of oesophageal cancer, can lead to a much earlier diagnosis and is being tested in six Trusts with a further 27 Trusts due to start testing soon. Cancer checks are also taking place in the community, with mobile scanners used to offer Targeted Lung Health Checks to current and former smokers in 18 locations across England.

Mental Health Recovery

28. Mental health services continue to remain open throughout the pandemic, though the first national lockdown impacted new referrals to core community mental health services, Indicative data suggests referral rates were not impacted as severely in the second and third national lockdowns, and are returning to (and in some cases significantly exceeding) pre-pandemic levels.

29. £500m was made available for 2021/22 on top of the LTP funding to help address the impact of the pandemic. The LTP also commits almost £1 billion of funding to new integrated community models for adults and older adults with Severe Mental Illnesses (SMI), including care for people with eating disorders and a ‘personality disorder’ diagnosis. At least 370,000 adults will be seen in these integrated models per year by 2023/24. In advance of the 2023/24 target, additional funding in 2021/22 will support mental health practitioners to become embedded in all Primary Care Networks, and fast-track investment in care for adults with eating disorders. Outreach models have also been established to support people with SMI to access physical health checks and vaccinations, to better support people with SMI facing a premature mortality gap of some 15-20 years.

Health Inequalities

30. Apriority is to restore NHS services inclusively, and this is going to be helped by use of timely data and breaking down performance reports by patient ethnicity

and IMD quintile, focusing on under-utilisation of services waiting lists, immunisation and screening, and late cancer presentations.

31. We are working with providers to mitigate against ‘digital exclusion’ to ensure face-to-face care for patients who cannot use remote services.

32. We are accelerating preventative programmes such as the flu and Covid vaccinations, annual health checks for people with severe mental illness (SMI) and learning disabilities, continuity of maternity carers, and targeting long-term condition diagnosis and management.