Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	26 August 2020
Executive Member:	Councillor Eleanor Wills - Executive Member, Health Social Care and Population Health
Clinical Lead:	Dr Ashwin Ramachandra - CCG Chair
Reporting Officer:	Jessica Williams – Director of Commissioning
Subject:	**THIRD PHASE OF NHS RESPONSE TO COVID-19**
Report Summary:	NHSE and NHSI have outlined the ambition for the 3rd phase of the NHS response to Covid.
Recommendations:	SCB is asked to note: ▪ The significant challenge of delivering the phase three requirements. ▪ The national and Greater Manchester timescales to support phase 3 submissions.

Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	**Budget Allocation (if Investment Decision)**	N/A at this stage
	CCG or TMBC Budget Allocation	CCG
	Integrated Commissioning Fund Section	Will ultimately touch upon entirety of CCG budget
	Decision Body – SCB Executive Cabinet, CCG Governing Body	Strategic Commissioning Board
	Value For money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark	Details of the current financial regime under COVID-19 are set out in section 6 of the report. This has been extended into August and September, with a new financial regime due to be introduced from October. While we know this new regime will involve an STP level financial envelope, we do not know what level this will be set at, or any nuance about how the new regime will operate. Therefore it is currently impossible to assess the affordability or value for money of meeting operational and activity targets set out in the phase 3 letter.

Legal Implications: (Authorised by the Borough Solicitor)	Further to the letter of 31 July 2020 about the third phase of the NHS response to COVID-19, NHS England have published a range of supplementary materials to support implementation of the third phase of the NHS response for accelerating the return to near-normal levels of non-COVID-19 health services, making full use of the capacity available in the 'window of opportunity' between now and winter including 1. Urgent actions to address inequalities in NHS provision and outcomes 2. Mental health planning 3. Restoration of adult and older people's community health services 4. Using patient-initiated follow-ups as part of the NHS COVID-19 recovery 5. Finance: 2020/21 phase 3 planning submission guidance 6. COVID-19 data collections: changes to weekend collections There needs to be a clear plan to address this given the very small window of opportunity.
How do proposals align with Health & Wellbeing Strategy?	Proposals are fully aligned with a focus on reducing health inequalities.
How do proposals align with Locality Plan?	Meets the ambition of the Locality Plan.
How do proposals align with the Commissioning Strategy?	Aligned with national policy
Recommendations / views of the Health and Care Advisory Group:	N/A – not taken to HCAG due to required urgency.
Public and Patient Implications:	Implementation will require close working with patient representatives and the Voluntary, Community, Faith and Social Enterprise sector
Quality Implications:	National indicators will be produced with expectations for delivery at a local and GM level
How do the proposals help to reduce health inequalities?	Clear mandate to identify and effectively address health inequalities.
What are the Equality and Diversity implications?	Clear focus on targeting extra support to groups with higher need.
What are the safeguarding implications?	None identified

What are the Information Governance implications? Has a privacy impact assessment been conducted?	None identified
Risk Management:	This response to national policy will be monitored utilising the CCG risk management processes and will be added to the risk register.
Access to Information:	The background papers relating to this report can be inspected by contacting the report writer Martin Ashton, Associate Director of Commissioning  e-mail: martinashton@nhs.net

1. INTRODUCTION

1.1 In January 2020, NHS England (NHSE) and NHS Improvement (NHSI) declared a Level 4 National Incident, triggering the first phase of the NHS pandemic response (Phase 1).

1.2 At the end of April 2020 as acute Covid pressures were beginning to reduce NHS England and NHS Improvement wrote to Clinical Commissioning Groups (CCGs) to outline agreed measures for restarting urgent services (Phase 2). The Strategic Commissioning Board previously received papers outlining the local assurance process for Phase 2.

1.3 On 31 July 2020 NHSE and NHSI wrote again to CCGs outlining the ambition for the 3 phase of the NHS response to Covid. This was supplemented with implementation guidance in August 2020.

1.4 The Phase 3 letter confirms the move form level 4 to level 3 in terms of incident management. This means there will be a transition from the national command, control and co-ordination structure to a regional command, control and co-ordination structure with national oversight.

2. PRIORITIES OF PHASE 3

2.1 NHSE and NHSI have requested a shared focus on:

- 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.

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

- 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.

3. URGENT ACTIONS TO ADDRESS INEQUALITIES IN NHS PROVISION AND OUTCOMES

3.1 COVID-19 has further exposed some of the health and wider inequalities that persist in our society. Phase three implementation guidance requests local focus on eight urgent actions:

(i) Protect the most vulnerable from COVID-19, 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.

(ii) 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.

(iii) 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.

(iv) Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes; including more accessible flu vaccinations, better targeting of long-term condition prevention and management programmes such as obesity reduction programmes, health checks for people with learning disabilities, and increasing the continuity of maternity carers.

(v) Particularly support those who suffer mental ill health, as society and the NHS recover from COVID-19, underpinned by more robust data collection and monitoring by 31 December.

(vi) Strengthen leadership and accountability, with a named executive board member responsible for tackling inequalities in place in September in every NHS organisation, alongside action to increase the diversity of senior leaders.

(vii) 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 than 31 December, with general practice prioritising those groups at significant risk of COVID-19 from 1 September.

(viii) Collaborate locally in planning and delivering action to address health inequalities, including incorporating in plans for restoring critical services by 21 September; better listening to communities and strengthening local accountability; deepening partnerships with local authorities and the voluntary and community sector; and maintaining a continual focus on implementation of these actions, resources and impact, including a full report by 31 March.

4. PLANNING SUBMISSION AND TIMELINE

4.1 The phase three submission can be broken down into eight planning components, each of which has a GM lead and a local Tameside and Glossop system lead.

Planning component	Submission requirement description	Template issued
Activity and performance	1. Activity and performance forecasts for 2020/21 2. Narrative for key strategic actions and assumptions	1. National planning template 2. Regional narrative template 3. No template issued
Workforce	1. WTE forecasts for 2020/21 2. Narrative for key strategic actions and assumptions 3. Local People Plan	
Mental health	1. Mental health plans 2. Mental health finance plans	1. MH national planning template 2. MH finance template
Independent sector	1. Weekly utilisation of independent sector through national contract / framework	1. National planning template
Cancer	1. Summary of resource and other support available and delivery expectations for resumption of LTP 2. Projected spend for remainder of the year	2. Template on projected spend to year end
Winter	1. KLOEs for demand, capacity, workforce, flow and key risks, mitigating actions and further support required	1. System-flow assessment template
Adopt and adapt	1. National submission required for Adopt and adapt initiatives across Outpatients, MRI/CT, Endoscopy, Theatres and Cancer	1. No template issued
Finance	1. Financial forecast for remainder of the year (regional local collection)	1. No template issued

4.2 The full timeline for the GM planning submission is attached in **Appendix 1.**

4.3 For the initial draft submission for Phase 3 planning, due 1 September 2020, a bottom up assessment of capacity per month and expected performance against key targets is planned. The expected submission will include the completion of NHSE/I templates within localities (Providers and Commissioners), collated at GM level.

4.4 The final submission, due 21 September 2020 will acknowledge plans to reduce the shortfall between capacity and demand, with narrative response on the expectations in the Phase 3 letter from NHSE/I.

4.5 A GM recovery dashboard will be developed to reflect measures in the phase 3 letter. This will include hospital, General Practice and Community health and social care indicators

5. ASSURANCE IN TAMESIDE AND GLOSSOP

5.1 A local live assurance document has been produced incorporating the following key fields:

- Priority area
- Responsibility level (local, GM, national)
- Strategic lead & key partners
- Governance
- Current status
- Actions required
- RAG rating.

5.2 Activity level templates are being completed in discussion with key providers to maximise alignment and a system approach.

5.3 Where system groups already exist such as the A&E Delivery Board, these are being used to agree plans and provide narrative.

6. FINANCIAL ASSUMPTIONS

6.1 Since the outbreak of COVID in March 2020, the CCG has been operating under a national command & control financial regime. Under command and control, acute contract payments have been calculated nationally (based on the month 9 agreement of balances exercise), with the CCG unable to pay anything to providers outside of this calculated figure in the first four months of this financial year. Other budgets were also nationally derived, based on 2019-20 costs at month 11 with growth/uplift rates applied. No investment other than that related to the pandemic response is allowed and there is no requirement to deliver efficiency savings.

6.2 CCGs are able to claim top up payments for additional COVID related expenditure and to ensure a break even position is delivered in line with the command and control guidance. In the first four months of 2020/21 the value of COVID claim in Tameside and Glossop was £10,709k (which is in addition to £546k of COVID funding received in March).

6.3 Originally, command and control measures were due to last until the end of July, but as part of the phase 3 letter, the current regime has been extended until the end of September.

6.4 A revised financial framework will be introduced from October onwards. This 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, but operational arrangements for these envelopes and precise values will require further development.

6.5 At this stage, the value of the financial envelope in Greater Manchester is unknown. Preliminary calculations looking at the financial position across the STP suggest there will be material financial risk in the second half of the year. But until further details emerge about the specifics of the new financial regime this risk is impossible to accurately quantify. Likewise we are unable to fully assess the affordability of the activity commitments contained within the phase 3 letter until more information about financial envelopes is published.

7. RISK

7.1 Greater Manchester suffers from worse health inequalities and worse outcomes than other parts of the United Kingdom and this has been exacerbated by Covid which has had a disproportionate impact on certain sections of our population. The longer it takes to restore critical services, the bigger the impact within our vulnerable communities.

7.2 Greater Manchester has experienced Covid later and longer than many other regions and continues to manage outbreaks. This makes the challenge of returning to near-normal levels of activity more difficult.

7.3 The Phase 3 requirements ask for a return to near-normal levels of health services, catch-up delayed treatment, request preparation for winter pressures an proactively target certain vulnerable groups. All this should be done without a clear commitment of financial resources and recognising the infection control measures that prevent many aspects of business as usual provision. There is a risk that the system becomes over-stretched and capacity for local and regional prioritisation is essential.

8. RECOMMENDATIONS

8.1 As set out on the front of the report.

APPENDIX 1

GM capacity and demand group timescales for completion of required templates

Date:	Action:
7th August 2020	DoFs & CFOs to update Adrian Roberts on financial assumptions– to be followed by review and challenge process.
24th August 2020 (Monday) - midday	- Providers, CCGs to submit hospital activity templates and narratives to GM planning team inbox england.gm-assurance@nhs.net, to support assessment of expected capacity levels and impact on targets (request made by email) - Mental Health Executive to coordinate mental health template - Etc (see section 2)
26th August 2020	GM Capacity & Demand Meeting to review collated templates and prepare headline messages for cells
27th August	GM Gold and Community Cell receive and comment
28th August 2020	Provider Federation Board receive and comment.
1st September 2020	Draft submission of GM System plan and relevant templates/narratives.
8th September 2020	Feedback to GM on draft submission
14th September	Organisations to resubmit following feedback
16th September	GM capacity & demand group review collated templates
17th September	GM Gold and Community Cell receive and comment
18th September 2020	Provider Federation Board receive and comment.
21st September 2020 (Monday)	Final submission of GM System templates/narratives, finance plans and Local People Plans.

**Additional Finance element scheduled for 7 Sept to reflect affordability of plans*